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Melvin I. Urofsky

ARTICLES

LEAVING THE DOOR AJAR: THE SUPREME COURT AND ASSISTED SUICIDE

*Melvin I. Urofsky**

> *"I had thought it self-evident that all men were endowed by their Creator with liberty as one of the cardinal unalienable rights. It is that basic freedom which the Due Process Clause protects, rather than the particular rights or privileges conferred by specific laws or regulations."*
>
> —John Paul Stevens[1]

In June, 1997, the Supreme Court ruled that a constitutional right to assisted suicide exists in neither the Due Process nor the Equal Protection Clauses of the Fourteenth Amendment.[2] But while a federal right does not exist, the Court made it quite clear that the states had ample leeway in which to fashion law on this issue; moreover, the concurring opinions of five Justices strongly implied that, should the states enact legislation that would severely limit end-of-life choices, the Supreme Court would revisit the issue. Far from slamming the door shut on assisted suicide, the Court left it more than a little ajar.

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* Professor of History and Public Policy, Virginia Commonwealth University; Adjunct Professor of Law, University of Richmond School of Law. A.B., 1961, Ph.D., 1968, Columbia University; J.D., 1983, University of Virginia. I wish to thank the following for commenting on the manuscript: John Paul Jones and Michael A. Wolf of the University of Richmond School of Law; Jill Norgren of CUNY; Philippa Strum of the Woodrow Wilson Center; and Philip E. Urofsky of the Justice Department.

1. Meachum v. Fano, 427 U.S. 215, 230 (1976) (Stevens, J., dissenting).

2. *See* Washington v. Glucksberg, 117 S. Ct. 2258 (1997); Vacco v. Quill, 117 S. Ct. 2293 (1997).

Part I of this article looks at the context in which the assisted suicide debate has been taking place; namely, the growing acceptance both in American law and society of an individual right to die, a right grounded both in common law and in the Constitution. Part II examines the debate over assisted suicide. Parts III and IV analyze the lower court cases in Washington and New York, while Part V examines the Supreme Court decisions and their impact on the current debate. Part VI ventures some conclusions on the cases and the subject.

I

Since the questions of assisted suicide and of a right to die have been in the news so much in recent years, it is easy to forget that the issue barely existed either in the public consciousness or in much of the legal community until 1976. In that year, the Supreme Court of New Jersey decided *In re Quinlan*,[3] and triggered a growing public awareness of and debate over what choices an individual should have at the end of life.

A

In the early evening of April 15, 1975, Karen Ann Quinlan, a vivacious, attractive twenty-one year old, was rushed to the hospital. Apparently, she had been drinking and took some drugs. Then she stopped breathing. Friends called a rescue squad, and the paramedics were able to revive the woman's breathing. During the several minutes when she had not been breathing, however, she had suffered anoxia, in which the brain receives an insufficient amount of oxygen. At the Catholic Newton Memorial Hospital, doctors placed the young woman on a respirator and waited for her to recover consciousness. She never did. Three months later, Karen Ann's parents signed a release to have the doctors take their daughter off life-support, but the hospital and the doctors refused. The doctors held out no hope for recovery, but, at the same time, feared they would incur liability in a wrongful death suit. Joseph Quinlan then went to court to have himself appointed guardian of his daugh-

3. 355 A.2d 647 (N.J. 1976). The full story of the *Quinlan* case is in JOSEPH QUINLAN & JULIA QUINLAN, WITH PHYLLIS BATTELLE, KAREN ANN: THE QUINLANS TELL THEIR STORY (1977).

ter and to secure authority to cease all heroic measures to keep her alive.

What had hitherto been a private family trauma now hit the front pages of the nation's newspapers. At the trial, a number of expert witnesses testified in support of the parents' request. Dr. Julius Korein, a neurologist, explained what he called "judicious neglect" in which a doctor would say: "Don't treat this patient anymore, . . . it does not serve either the patient, the family, or society in any meaningful way to continue treatment with this patient."[4]

The trial court refused to allow termination of treatment because Karen Ann did not meet the standard for brain death, namely, a flat electroencephalogram (EEG).[5] "There is a duty to continue the life-assisting apparatus," Judge Robert Muir wrote.[6] "There is no constitutional right to die that can be asserted by a parent for his incompetent adult child."[7] The Supreme Court of New Jersey reversed the trial judge and ordered that the respirator could be removed without any legal or civil liability attaching to the hospital or the medical staff.[8] The doctors removed the respirator, but the nuns at the hospital, anticipating the decision, already had begun to wean their patient from the machine. When the doctors removed the apparatus, Karen Ann was able to breathe on her own. Much to the anguish of her family, she lived on in a persistent vegetative state, never regaining consciousness. She finally died in July, 1985.

The problems raised in the *Quinlan* case were not new to the medical profession or to families that had to face the problem of caring for a terminally ill person. Moreover, advances in medical care now make it possible to keep people alive longer—people like Karen Ann Quinlan who would have died from their illness or injury had it occurred only a few years earlier. The questions of whether a terminally ill person ought to be allowed to die without medical intervention, whether passive or

4. *Quinlan*, 355 A.2d at 657.
5. *See In re* Quinlan, 348 A.2d 801, 811 (1975).
6. *Id.* at 819.
7. *Id.* at 822.
8. *See Quinlan*, 355 A.2d at 671-72.

active euthanasia should be allowed, or whether a person should be allowed, even assisted, to commit suicide involve moral questions that are beyond the scope of this article.[9] Here, we are concerned only with the legal questions.

B

While the actual form of the question in *Quinlan* may have been novel, the underlying issue, namely, the right to resist an unwanted touching, had been familiar to common law judges for many years. Courts have construed this right to mean that unauthorized medical treatment constitutes a battery, so that a competent person almost always may refuse treatment. An Illinois court declared in 1905,

> [u]nder a free government, . . . the free citizen's first and greatest right, which underlies all others—the right to the inviolability of his person . . . is the subject of universal acquiescence, and this right necessarily forbids a physician or surgeon . . . to violate, without permission, the bodily integrity of his patient by . . . operating upon him without his consent or knowledge.[10]

In the same year, in a Minnesota case still studied by first-year law students, a court ruled that a doctor could not perform, in the absence of an emergency, a procedure unauthorized by the patient.[11] "If the operation was performed without plaintiff's consent, and the circumstances were not such as to justify its performance without, it was wrongful; and if it was wrongful, it was unlawful."[12] Benjamin Cardozo, considered by many to be the finest common law jurist of this century, declared that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body."[13]

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9. The literature on this subject is vast, and growing ever larger. A brief summary of the views of major religions can be found in MELVIN I. UROFSKY, LETTING GO: DEATH, DYING AND THE LAW ch. 1 (1993), which refers to some of the more important works on this topic.

10. Mohr v. Williams, 104 N.W. 12, 14 (Minn. 1905) (quoting Pratt v. Davis, 37 CHICAGO LEGAL NEWS 213 (1905)). The earliest reported case taking this view is the English case of *Slater v. Baker & Stapleton*, 95 Eng. Rep. 860 (K.B. 1767).

11. *See Mohr*, 104 N.W. at 16.

12. *Id.*

13. Schloendorff v. Society of N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914).

The common law spoke less to the idea of a right to die than to the question of individual autonomy, the control a person has over his or her body against any unwanted action, be it a brutal assault or a medical procedure. A person has a right to consent to treatment, and thus a corollary right to refuse treatment,[14] even if refusal may lead to death.[15] Moreover, this right is personal, and the decision need not conform to what a majority of society thinks a person ought to do. Warren Burger, while still an appeals judge, pointed out that it is the individual and not society who should determine what is best for that individual:

> Mr. Justice Brandeis, whose views have inspired much of the "right to be let alone" philosophy, said: "The makers of our Constitution . . . sought to protect Americans in their beliefs, their thoughts, their emotions, and their sensations. They conferred, as against the Government, the right to be let alone—the most comprehensive of rights and the right most valued by civilized man." Nothing in this utterance suggests that Justice Brandeis thought an individual possessed these rights only as to *sensible* beliefs, *valid* thoughts, *reasonable* emotions, or *well-founded* sensations. I suggest he intended to include a great many foolish, unreasonable, and even absurd ideas which do not conform.[16]

By the time the New Jersey court heard the *Quinlan* appeal, it also had some constitutional law to rely upon, namely the right to privacy which was first enunciated by the United States Supreme Court in the landmark case of *Griswold v. Connecticut*[17] and later expanded upon in the Court's abortion

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14. The law demands informed consent, which means that a person electing either to accept or to forego treatment must be mentally competent, act voluntarily, and have sufficient information upon which to base the decision.

15. Much of the litigation in this area involves Jehovah's Witnesses who object to blood transfusions on religious grounds. In general, courts have permitted adults to decline treatment. *See, e.g.*, St. Mary's Hosp. v. Ramsey, 465 So.2d 666 (Fla. Dist. Ct. App. 1958). Courts, however, often intervene when children's lives are involved. *See* Kenneth J. Rampino, Annotation, *Power of Court or Other Public Agency to Order Medical Treatment Over Parental Religious Objections for Child Whose Life is Not Immediately Endangered*, 52 A.L.R.3d 1118 (1974).

16. *In re* President of Georgetown College, 331 F.2d 1000, 1015 (D.C. Cir. 1964) (Burger, J., dissenting) (quoting Olmstead v. United States, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting)).

17. 381 U.S. 479 (1965).

ruling in *Roe v. Wade.*[18] New Jersey Chief Justice Richard J. Hughes drew on these two cases to conclude that the federal Constitution guarantees certain areas of privacy, and "presumably this right is broad enough to encompass a patient's decision to decline medical treatment under certain circumstances."[19]

In the years following *Quinlan,* state courts expanded the notion that individual autonomy included a right to decline treatment, even if it would lead to death. Since most states had laws against suicide, attempted suicide or assisting suicide, judges had to come up with a rationale that distinguished between suicide and the termination of medical treatment that would lead to death. In *Quinlan,* the court argued that the real cause of death would not be the termination of life-sustaining treatment, but the underlying illness.[20] The disease, or in Karen Ann Quinlan's case, the condition, would be the cause of death.[21] Other courts have reasoned that there can be neither a homicide nor a suicide if the patient exercises his or her right to forego treatment. This is the underlying philosophy of the Uniform Rights of the Terminally Ill Act, namely, that "[d]eath resulting from the withholding or withdrawal of life-sustaining treatment pursuant to a declaration and in accordance with this [Act] does not constitute, for any purpose, a suicide or a homicide."[22] In the late 1970s and early 1980s, state courts expanded what many people have come to call a right to die by upholding the claims of patients that they had a right to stop treatment.[23] In addition, state courts also recognized the use of living wills, by which a competent person could direct what medical treatment he or she wanted or did not want in the future.[24]

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18. 410 U.S. 113 (1973).

19. *In re* Quinlan, 355 A.2d 647, 663 (N.J. 1976).

20. *See id.*

21. *See id.* at 670.

22. UNIF. RIGHTS OF THE TERMINALLY ILL ACT § 10(a), 98 U.L.A. 620 (1987).

23. *See, e.g.*, Satz v. Perlmutter, 379 So.2d 359 (Fla. 1980); Superintendent of Belchertown State Hosp. v. Saikewicz, 387 N.E.2d 1145 (Mass. 1977); *In re* Dinnerstein, 380 N.E.2d 134 (Mass. App. Ct. 1978); Eichner v. Dillon, 426 N.Y.S.2d 517 (1980).

24. *See infra* Part C.

C

Living wills or advance directives[25] allow a person to make contingency plans. Although courts have established a right for a competent person to make decisions about cessation of treatment, what if a person is in an automobile accident and is brought to a hospital in a comatose condition? Without instructions to the contrary, the hospital automatically will put that patient on life-support. Advance directives, which provide a durable power of attorney, allow a second person, a child, a spouse or attorney, to say to the hospital, "the patient has clearly indicated that she does not want heroic measures taken in such circumstances, and that she is not to be put on life-support."

An Illinois attorney, Luis Kutner, is given credit for proposing a formal advance directive in 1969,[26] although the notion did not catch on immediately. Following *Quinlan*, however, the idea rapidly expanded, and, at present, all fifty states and the District of Columbia have adopted some form of advance directive statute. Forty-eight states also have legislation providing for a health care proxy through a durable power of attorney, and twenty-five have enacted some form of surrogate decision making statute.[27]

Although courts have consistently upheld the validity of these state statutes,[28] not all patients had living wills, and even when they did, not all doctors and hospitals were willing to abide by these instructions.[29] To ensure the greatest possible autonomy for patients, Congress, in October, 1990, passed the

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25. Although the terms "advance directive" and "living will" are often used interchangeably, they are not the same. A living will is one form of advance directive, although it is popularly used in reference to all kinds.

26. *See* Luis Kutner, *Due Process of Euthanasia: The Living Will, A Proposal*, 44 IND. L.J. 539 (1969).

27. For evaluations of the different state laws, see Christopher J. Condie, *Comparison of the Living Will Statutes of the Fifty States*, 14 J. CONTEMP. LAW 105 (1988), and Shari Lobe, *The Will to Die: Survey of State Living Will Legislation and Case Law*, 9 PROB. L.J. 47 (1989). For the Virginia law, see VA. CODE ANN. §§ 54.1-2981-2993 (Michie 1994), which codifies the Health Care Decisions Act.

28. *See, e.g.*, John F. Kennedy Mem'l Hosp. v. Bludworth, 452 So.2d 921 (Fla. 1984); *In re* Peter, 529 A.2d 419 (N.J. 1987); Saunders v. State, 492 N.Y.S.2d 510 (1985).

29. For one particularly onerous example, see Englebert L. Schucking, *Death at a New York Hospital*, LAW, MED. & HEALTH CARE, Dec. 1985, at 261.

Patient Self-Determination Act.[30] The law, which went into effect in December, 1991, requires all hospitals receiving Medicare or Medicaid funds to provide entering patients written information about their rights under state law to accept or refuse medical treatment, as well as their right to formulate advance directives and durable powers of attorney. The hospitals are obliged to record in each patient's records whether or not an advance directive has been provided, and to train their staffs on the subject.[31]

The law appears to have an effect in making patients aware of their rights, and doctors and hospitals are finding themselves in court when they ignore advance directives. In Michigan, a jury awarded Brenda Young and her family $16.5 million in a suit against Genesys St. Joseph Hospital for ignoring Ms. Young's directions that she not be put on a ventilator.[32] After she suffered another in a series of seizures, the hospital and attending doctors put her on life-support, saving her life, but also leaving her in the kind of existence she had feared and had wanted to avoid.[33] Ms. Young now needs round-the-clock attendance, is mentally incompetent, has little control over her bodily functions, and must be tied to the bed to prevent her from hurting herself.[34] The Michigan case is seen as part of a trend to force health care providers, accustomed to doing what they consider in the best interests of the patient or their own religious beliefs, to pay attention to patient's wishes. According to Richard Wade, a spokesperson for the American Hospital Association, "we are human beings whose training and background are in saving lives. So it's going to take us awhile to learn to deal with these end-of-life issues."[35]

The federal law did not affect the rights of states to establish standards in their advance directive laws, and not all states follow the Uniform Rights of the Terminally Ill Act, which is

30. Pub. L. No. 101-508, 104 Stat. 1388 (1990) (codified as 42 U.S.C. §§ 1395cc(f)(i), 1396a(a)).

31. *See id.*

32. *See* Tamar Lewin, *Suits Accuse Medical Community of Ignoring Right to Die Orders*, N.Y. TIMES, June 2, 1996, at A1.

33. *See id.*

34. *See id.*

35. *Id.*

generally liberal in its provisions for proving the wishes of individuals. Missouri and a few other states had a higher standard of evidence, and that led to the first case before the United States Supreme Court testing whether the Constitution protected the right to die.

D

On the night of January 11, 1983, coming home from her job on the night shift at a cheese factory, twenty-five-year-old Nancy Beth Cruzan lost control of her old Nash Rambler on an icy road near the small town of Carthage, Missouri.[36] The car slid off the road and flipped over, throwing her some thirty-five feet out of the car and facedown into a ditch. Emergency help came promptly, but not soon enough. The rescue squad resuscitated Nancy Cruzan, but her brain had been deprived of oxygen too long. Like Karen Ann Quinlan, Cruzan never regained consciousness and sank into a persistent vegetative state, seemingly awake, but totally unaware of her surroundings. Unlike Quinlan, Cruzan could breathe on her own, but for seven years she lay curled in a fetal position at the Missouri Rehabilitation Center in Mount Vernon. She had been kept alive by a tube inserted into her stomach that provided nutrients and water. She had been a healthy person before the accident, and her doctors said that her heart and lungs might function for another thirty years. Her parents finally gave up hope that she would recover, and went to court to have the feeding tube removed.[37]

The Cruzans went into the local probate court in their hometown of Carthage. If Nancy had been a minor, her parents would have had the authority to act on their own. Because Nancy was not a minor, Judge Robert E. Teel appointed a guardian, Thad C. McCanse, to represent her interests. McCanse agreed with the parents, and Judge Teel granted the Cruzans' request. But William L. Webster, acting under his

36. *See* Cruzan v. Harmon, 760 S.W.2d 408, 410-11 (Mo. 1988).

37. *See id.* at 410. Although the American Medical Association and many medical ethicists consider artificial feeding and hydration a medical treatment that, like a respirator, could be withdrawn from a terminally ill patient, the idea horrified many people. Food and water, even through a tube, are the basic necessities of life and evoke a far more emotional response than do respirators.

authority as Missouri Attorney General, decided to appeal the case and claimed that, under Missouri law, there had to be clear and convincing evidence that Nancy Cruzan had earlier indicated that she would want all medical assistance terminated in such circumstances. Although her parents had said this was her wish, Webster claimed they had not met the burden of proof required under state law. The state, in its role as special guardian of incompetent persons, placed a high value on life.[38] Webster did not dispute that people had the right to stop treatment; he argued, however, that the state had an equally compelling right to insist that there be clear evidence of the patient's wishes. The Missouri Supreme Court, by a 4-3 vote, reversed Judge Teel and agreed with the attorney general.[39] The Cruzans appealed to the Supreme Court, which accepted the case and held oral argument in December, 1989.

In an extremely cautious opinion written by Chief Justice William H. Rehnquist, the majority ruled that as part of personal autonomy, there was indeed a constitutionally protected right to die.[40] The opinion emphasized that this right did not derive from any constitutional guarantee of privacy (which had been utilized by the New Jersey court in *Quinlan*), but from the Fourteenth Amendment's Due Process Clause. "The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions."[41] The key word is "competent," and the Court noted that this is an area normally assigned to state jurisdiction, not federal law. Although only two other states, New York and Maine, required the same high level of proof that Missouri did, under a federal system, a state's powerful interest in protecting life gives it the authority to establish such a test. Missouri law, the Chief Justice con-

38. *See id.* 760 S.W.2d at 419.

39. *See id.* at 426-27.

40. *See* Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261 (1990).

41. *Id.* at 278. The prior decisions included: *Jacobson v. Massachusetts*, 197 U.S. 11 (1905), in which the Court upheld a state's interest in preventing disease over the individual's liberty interest in refusing a smallpox vaccination; *Washington v. Harper*, 494 U.S. 210 (1990), administering antipsychotic medication to a prisoner; *Parham v. J.R.*, 442 U.S. 584 (1979), involuntary confinement of a child for medical treatment; and reference to various Fourth Amendment cases involving seizure and body searches.

cluded, did not unduly burden the individual's constitutionally protected right to autonomy.[42]

Perhaps the element of the majority opinion most disturbing to civil libertarians was the discussion of balancing an individual's liberty interest against countervailing state concerns. Declaring that a liberty interest exists merely begins the judicial inquiry; courts must then determine whether the liberty interest outweighs the claims of the state. Chief Justice Rehnquist seemed to indicate that the courts should use little more than a rational basis test, the lowest standard of constitutional review, in weighing individual liberty interests against state concerns in this area. Thus, if a state could show a rational basis for depriving an individual of his or her liberty interest, such as administrative convenience, the courts could, under *Cruzan*, uphold the state's claim. Moreover, the burden of proof rests on the family of an incompetent person to "prove" that the patient, if competent and able to make his or her wishes known, would want medical treatment or artificial feeding terminated. In states with a high evidentiary standard, this might be a difficult or even impossible demand.

Missouri, of course, wanted a high standard, not in order that Nancy Cruzan should live as a vegetable, but that there be clear and convincing evidence that she would have indeed chosen death in these circumstances. Missouri did not act in a heartless manner, but in fact carried on a long and honorable tradition, that of the state legitimately seeking to protect the lives of its citizens, even the life of a person in a persistent vegetative state. In January, 1990, after the case had been argued in the Supreme Court, but before a decision had been handed down, Attorney General William L. Webster proposed legislation to Missouri lawmakers to establish clearer guidelines on who would be able to make decisions in cases like Nancy Cruzan's, and what criteria should govern the decisions.[43]

Both Justices Antonin Scalia and Sandra Day O'Connor filed concurring opinions. Justice Scalia, while declaring his sympathy for the Cruzans, nonetheless believed that the Constitution

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42. *See Cruzan*, 497 U.S. at 281-82.

43. *See Guidelines on Dying Argued by Both Sides of Case in Missouri*, N.Y. TIMES, Jan. 14, 1990, at A18.

had nothing to say in this matter, that laws governing end-of-life choices properly belonged in the jurisdiction of the states. He wrote:

> I would have preferred that we announce, clearly and promptly, that the federal courts have no business in this field; that American law has always accorded the State the power to prevent, by force if necessary, suicide—including suicide by refusing to take appropriate measures necessary to preserve one's life; 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. . . . [44]

The assumptions of Justice O'Connor's concurrence run in just the opposite direction from those of Justice Scalia. Where he would have denied any constitutional factor in end-of-life decisions, Justice O'Connor believed that the Constitution did, in fact, provide a "protected liberty interest in refusing unwanted medical treatment" and "that the refusal of artificially delivered food and water is encompassed within that liberty interest."[45] Justice O'Connor wanted to emphasize the narrowness of the majority opinion—what it said and what it did not say. The decision, she wrote, "does not preclude a future determination that the Constitution requires the States to implement the decisions of a patient's duly appointed surrogate. Nor does it prevent States from developing other approaches for protecting an incompetent individual's liberty interest in refusing medical treatment."[46] "Today," she concluded, "we decide only that one State's practice does not violate the Constitution," and that procedures for safeguarding incompetents are left, at least for the moment, in the hands of the states.[47]

Justice William Brennan's minority opinion, joined by Justices Marshall and Blackmun, reads as if it may have origi-

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44. *Cruzan*, 497 U.S. at 293 (Scalia, J., concurring).
45. *Id.* at 287 (O'Connor, J., concurring).
46. *Id.* at 292.
47. *Id.*

nally been drafted as a majority opinion, with Justice O'Connor holding the decisive fifth vote. (Justice John Paul Stevens also dissented). The four Justices in the minority would have struck the balance more in favor of the individual rather than the state. The Missouri rule, Justice Brennan charged, transforms human beings into "passive prisoner[s] of medical technology,"[48] and, in essence, gives the final power to decide to the state and not to the individual. The majority opinion, he claimed,

> robs a patient of the very qualities protected by the right to avoid unwanted medical treatment. His own degraded existence is perpetuated; the memory he leaves behind becomes more and more distorted . . . [and] the idea of being remembered in their persistent vegetative state rather than as they were before their illness or accident may be very disturbing.[49]

Despite the several opinions, two things stand out in the decision. Most important, the Court for the first time acknowledged a constitutionally protected right to die and grounded it in the liberty interests of the Fourteenth Amendment's Due Process Clause. Second, the Court allowed states great leeway in establishing appropriate procedures for exercising that right. Even Justice Scalia, the least sympathetic of the Justices to a federally protected right, concurred with the majority's ruling; he would have allowed the right, but set it within the context of state rather than federal law.

Cruzan may not have been the best test case for a constitutionally protected right to die, because while Missouri's application of its laws certainly appeared harsh and unfair to the Cruzans, it clearly fell within the states' traditional powers as *parens patriae* to protect life and to look after the interests of incompetent persons. Since only three states had such a high evidentiary level, and the Court quite explicitly did not condition a right to die on adoption of such a test, it, in essence, left the states to devise their own procedures even while confirming that a federal threshold had to be met. As Justice O'Connor noted approvingly, the Court had left "the more challenging

48. *Id.* at 302 (Brennan, J., dissenting).
49. *Id.* at 311-12, 320.

task of crafting appropriate procedures for safeguarding incompetents' liberty interests . . . to the 'laboratory' of the States."[50]

And what about Nancy Cruzan? Following the Court's ruling in June, 1990, the Cruzans went back to Judge Teel's chambers with "new" evidence, testimony from friends that their daughter had said she would never have wanted to be kept alive by machines or feeding tubes. Attorney General Webster had won his legal point, but aware of the immense sympathy the case had generated for the Cruzans, he withdrew the state from the case. Judge Teel heard the new evidence in November, 1990, and, on December 14, 1990, gave the Cruzans what they had sought for so long, an order permitting the withdrawal of the feeding tube. The hospital removed the tubes and, twelve days later, Nancy Beth Cruzan quietly died at 2:55 a.m. on the day after Christmas.

In many ways, the cases leading up to and including *Cruzan* presented the "easy" legal questions. Although different courts had adopted differing notions of how a right to die may be expressed and what its bases are, there is a clear line from *Quinlan* to *Cruzan*: competent patients, and lawful surrogates for incompetent persons, may terminate medical treatment, even if that termination will result in their death. The harder cases would come as courts and society faced the more difficult issue of people who wanted to end their lives immediately, and not wait for the ravages of a disease to take its toll.

II

To many people, it is one thing for a terminally ill person who is suffering great pain and loss of dignity to request that life-support be withdrawn; the resulting death is, in many ways, "natural," even a "blessing." They do not understand, however, how someone who is not suffering from the ravages of an incurable disease, who may have months—perhaps even years—of life left to live, can deliberately elect death.

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50. *Id.* at 292 (quoting New State Ice Co. v. Liebmann, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting)).

A

Suicide puzzles and scares people; life, after all, is so precious, how can anyone not at death's door wish to open and pass through that portal? As Shakespeare wrote: "Then is it sin/ To rush into the secret house of death/ Ere death dare come to us?"[51] Western religions and law have both frowned on suicide for centuries, yet it now appears that the miracles of medical technology that can prolong life have also triggered a new debate: is it acceptable to allow a person to choose death, and if so, how may it be done, and who, if anyone, may assist?

Although some ancient Greek philosophies supported suicide, popular attitudes in the West for many centuries have generally viewed taking one's own life as unnatural. In Athenian law, the hand that committed the suicide would be cut off and buried apart from the rest of the body, which itself would be denied normal funeral rites. Yet many Greek writers acknowledged the legitimacy of suicide under certain circumstances, and the Romans found it even more acceptable; Roman law never included any general prohibition of suicide. There were, however, some special provisions. If a person committed suicide to avoid forfeiture of property for a crime, the property would still be forfeited. A soldier could also be punished for attempted suicide, on the ground that this constituted a desertion of duty, which was itself a crime against the state.[52]

Prohibitions against suicide made their way into canon law beginning with St. Augustine, who, in *The City of God*, written in the early fifth century, condemned self-murder as "a detestable and damnable wickedness."[53] Augustine interpreted a number of different biblical sources to "prove" that God had forbidden suicide.[54] Since secular authorities in the middle ages recognized canon law as binding in any area related to church teaching, the various pronouncements of the Catholic

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51. WILLIAM SHAKESPEARE, ANTONY AND CLEOPATRA act 4, sc. 15 (1623) *quoted* in Joseph Fletcher, *In Defense of Suicide, in* SUICIDE AND EUTHANASIA: THE RIGHTS OF PERSONHOOD 40 (Samuel E. Wallace & Albin Eisen eds., 1981) [hereinafter Fletcher, *In Defense of Suicide*].

52. *See* GLANVILLE WILLIAMS, THE SANCTITY OF LIFE AND THE CRIMINAL LAW 251-54 (1957).

53. AUGUSTINE, THE CITY OF GOD, Bk. I, ch. 19 (1945).

54. *See id.*

Church regarding self-murder quickly crowded out earlier pagan acceptance of suicide. The edicts of the Council of Orleans, in 533, implied that suicide was worse than any other crime, and the Council of Braga, in 563, denied to suicides normal funeral rites, such as the eucharist and the singing of psalms. In England, the Council of Hereford, in 673, adopted canon law, and King Edgar, in 967, specifically affirmed the denial of burial rites; in 1284, the Synod of Nîmes ruled that suicides could not be interred in holy ground. Dante, in *The Inferno,* put suicides with murderers and blasphemers in the seventh circle of Hell.

The growth of the common law in England saw the canonical rules, including the practice of dishonoring the corpse, absorbed and strengthened. An early seventeenth-century writer noted that the suicide "is drawn by a horse to the place of punishment and shame, where he is hanged on a gibbet, and none may take the body down but by the authority of a magistrate."[55] A century and a half later, Blackstone wrote that suicides would be buried at a crossroads, with a stake driven through the heart and a stone placed over the face. The last known crossroads burial of a suicide in England took place in 1823, after which Parliament passed a law calling for private burial in a churchyard, but at night and without religious rites. In 1882, an amendment allowed daytime interment, although still without the Church of England ritual. Only a verdict by a coroner's jury that the deceased had been mentally unbalanced, and therefore not responsible for his or her actions, would allow a normal church burial to proceed.[56]

The early settlers of New England brought with them both legal and religious proscriptions against suicide. In 1660, the Massachusetts General Court, in "bear[ing] testimony against such wicked and unnatural practices," ruled that self-murderers

> shall be denied the privilege of being buried in the common burying place of Christians, but shall be buried in some common highway where the selectmen of the town . . . shall appoint, and a cartload of stones laid upon the grave, as a

55. Fletcher, *In Defense of Suicide, supra* note 51, at 42.
56. *See* WILLIAMS, *supra* note 52, at 259-60.

> brand of infamy, and as a warning to others to beware of the like damnable practices.[57]

Although the practice fell into disuse, the statute itself was not repealed until 1823. The United States, however, did not adopt English common law crimes, so suicide was considered criminal only in those states that specifically made it so by statute.[58]

The self-murderer, being beyond the reach of the magistrate, is no longer concerned with the law. But what of those who fail in their attempts, who do not take sufficient poison or sedatives, whose aim is off, or whose boobytraps fail to work? Although no state at this time criminalizes either suicide or attempted suicide, that was not always the case. In many states, attempted suicide was long considered a crime, and the person who woke up after a failed attempt might well face criminal prosecution.[59] These statutes also traced back to English common law. The courts reasoned that every attempt to commit a crime is punishable; if suicide was a crime, attempted suicide could be punished.

But how did suicide itself get to be a crime? Self-murder violated canon law, but the church, while condemning it as mortal sin, only called for a denial of burial rites. Around the tenth century, King Edgar ruled that a suicide's property would be forfeited to his feudal lord; somewhat later the rule changed so that a suicide's estate would be forfeited to the Crown. In order to justify this change, the royal courts noted that every felon forfeited his goods to the king; by making suicide a felony, the general rule could be applied to suicide as well. In *Hales v. Petit*,[60] one of the first cases to classify suicide as a felony, the court condemned self-murder as a criminal act, an offense

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57. Commonwealth v. Mink, 123 Mass. 422, 426 (1877).

58. *See* 40 AM. JUR. 2d *Homicide* § 583 (1988). For an account of English and American practice, as well as changing popular attitudes, see HOWARD J. KUSHNER, SELF-DESTRUCTION IN THE PROMISED LAND: A PSYCHOCULTURAL BIOLOGY OF AMERICAN SUICIDE (1989).

59. *See, e.g.*, State v. La Fayette, 188 A. 948 (Camden County Ct. 1937) (holding that an attempt at suicide is an indictable offense even though suicide itself was not punishable under New Jersey law); State v. Willis, 121 S.E.2d 854 (N.C. 1961) (holding that an attempt to commit suicide is an indictable misdemeanor under state law).

60. 75 E.R. 398 (1562). The case rose out of the supposed suicide by drowning of Justice Hales, and, incidentally, is considered to have inspired the gravedigger's colloquy in *Hamlet*.

against nature, God, and the king. Blackstone denounced suicide as "a double offence: one spiritual, in invading the prerogative of the Almighty, and rushing into his immediate presence uncalled for; the other temporal, against the king, who hath an interest in the preservation of all his subjects."[61]

The first known case involving the legal punishment of attempted suicide dates to 1854, in which the learned judges held the criminality of attempted suicide a self-evident truth.[62] Within a few years other decisions confirmed the rule, and what began as a moral indictment, enlarged by the monarch's greed for property, became an accepted rule of common law—suicide constituted a felony, and if the successful felon escaped the law's punishment, the failed suicide would certainly stand in the dock. Not until the Suicide Act of 1961 did Her Majesty's Government finally stop making suicide or its attempt a crime.

Other European countries had taken that step long before. The writings of the eighteenth century criminologist Beccaria led to the decriminalization of attempted suicide shortly after the French Revolution, and most of the other countries of the continent followed suit in the early nineteenth century. Even when Germany, Italy, and Russia fell under the rule of totalitarian governments in the twentieth century and introduced strict population policies, they did not re-enact criminal laws regarding suicide or its attempt. In the United States, even in those few jurisdictions which at one time made attempted suicide a crime, there were no prosecutions. At worst, a failed attempt, now as then, may lead to mandated therapy or perhaps incarceration in a mental hospital.[63] The criminal stigma has disappeared, for the most part, although many religions and many people still condemn self-murder as morally wrong.

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61. 4 WILLIAM BLACKSTONE, COMMENTARIES *189.

62. *See* Regina v. Doody, 6 Cox 453 (1854).

63. The notion of a "death wish" as evidence of mental incompetence has appeared in a few judicial opinions. *See, e.g.*, People v. Stanworth, 71 Cal.2d 820 (1969). The Supreme Court, however, has refused to make this connection. "The empirical relationship between mental illness and . . . a suicide attempt need not always signal an 'inability to perceive reality accurately.'" Drope v. Missouri, 420 U.S. 162, 181 n.16 (1975) (citation omitted).

Despite the traditional antipathy toward suicide, in recent years there has been a growing body of thought that looks upon suicide as primarily an individual decision, and which holds that a society that truly believes in individual autonomy should permit suicide. Here, too, there is a tradition that goes back at least to 1516, when Thomas More allowed for suicide in his *Utopia*. A century later John Donne, in *Biathanotos* (published posthumously in 1644), argued that contrary to classical Christian teachings, the taking of one's life is not incompatible with the laws of nature, of reason, or of God. Perhaps the most famous of the early justifications is David Hume's essay, *On Suicide* (also published posthumously in 1777), in which he reasoned that a suicide is wrong only if it offends God, one's neighbor, or one's self. Other writers of the Enlightenment, including Voltaire, Rousseau, Montesquieu and d'Holbach, all endorsed Hume's argument. The sheer number of volumes on library shelves dealing with suicide from ethical, sociological, religious and metaphysical viewpoints show conclusively that it is far from a moot issue today.

Recent studies also indicate that a majority of Americans simply do not see ending one's life when one is terminally ill or in great pain as suicide.[64] Polls show that as many as 90% of Americans support the idea that terminally ill patients, or their families when a patient is comatose, ought to have the right to speed up their death by refusing medication.[65] The support for physician-assisted suicide also seems to be growing. In April 1990, the Roper poll found that 64% of Americans believed terminally ill people should be able to ask for and receive help from a doctor in order to die.[66] A year later this number had climbed to two out of three Americans, and in 1994 a Harris poll set the figure at 73%.[67]

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64. *See, e.g.*, Sanford H. Kadish, *Letting Patients Die: Legal and Moral Reflections*, 80 CAL. L. REV. 857, 860 & n.16 (1992).

65. *See id.*

66. *See* Robert Risley, *Voluntary Active Euthanasia: The Next Frontier, Impact on the Indigent*, 8 ISSUES IN L. & MED. 361, 365 (1992).

67. *See Euthanasia Favored in Poll*, N.Y. TIMES, Nov. 4, 1991, at A16; *see also* Compassion in Dying v. Washington, 79 F.3d 790, 810 n.10 (9th Cir. 1996) (citing THE ARIZ. REPUBLIC, May 13, 1995).

Nowhere is it legal for doctors, or for that matter anyone else, to assist in suicide. Forty-four states, the District of Columbia and two territories prohibit or condemn assisted suicide.[68] In April, 1997, President Clinton signed into law the Federal Assisted Suicide Funding Restriction Act,[69] which prohibits the use of federal funds in support of physician-assisted suicide. In the Netherlands, the penal code forbids such practice, but the courts and the medical profession tacitly allow active euthanasia under fairly well-defined guidelines. There is, however, a great deal of dispute over the Dutch experience, with both sides of the physician-assisted suicide debate in the United States pointing to the Netherlands to support their claims.[70]

This brief foray into the history of suicide and popular attitudes towards "self-murder" are necessary to understand the furor that greeted news of Dr. Jack Kevorkian's one-man crusade to legitimize assisted suicide as well as the intense emotions generated by the debate over whether assisted suicide should be legalized.

B

On June 4, 1990, in an old van parked outside Detroit, Dr. Jack Kevorkian, a retired pathologist, hooked up what he called his "Mercy Machine" to fifty-four-year-old Janet Adkins, a Portland, Oregon, school teacher suffering from the early stages of Alzheimer's disease.[71] Ms. Adkins had read about Kevorkian, a longtime advocate of physician-assisted suicide, and she had contacted him in the fall of 1989. After some correspondence and phone calls, Kevorkian agreed to help her end her life, and Janet Adkins and her husband, Ron, had flown east to meet

68. *See Compassion in Dying*, 79 F.3d at 847 (Beezer, J., dissenting). A list of the statutes can be found in *Washington v. Glucksberg*, 117 S. Ct. 2258, 2287 n.14 (1997) (Souter, J., concurring).

69. Pub. L. 105-12, 111 Stat. 23 (1997) (codified as 42 U.S.C. §§ 14401-08).

70. For arguments on both sides, see the citations in *Glucksburg*, 117 S. Ct. at 2292. I have deliberately avoided utilizing the Dutch experience in this article because I believe the evidence is contradictory, and can be manipulated to support a variety of positions.

71. *See* Cynthia Gorney, *Dr. Death's Life Obsession*, WASH. POST, Dec. 20, 1990, at D1. Kevorkian had tried in vain to secure rooms at either a motel or a funeral home, but when he had explained what he wanted to do, he had been turned away. So the only place he had was an old 1968 Volkswagen van.

with him. To provide evidence that she understood exactly what she was doing, Kevorkian set up a video camera in a hotel room, and recorded a forty-minute conversation with the woman.

The next morning, Kevorkian showed Janet Adkins his device, three vials suspended over a metal box containing a small electric motor. Once the doctor had inserted an intravenous tube into her arm, she could press a button that would start the flow of saline solution; then it would open the valve to the second vial, releasing thiopental, which would induce unconsciousness; finally, the contents of the third vial, potassium chloride, would cause her heart to stop. Kevorkian again asked Adkins if she understood what would happen, if she wanted to go ahead, and if she knew what to do. She assured him she did; Kevorkian then attached her to an electrocardiograph and left the van. When he came back a little while later, Janet Adkins was dead, and Kevorkian called the police to report the death.[72]

As of this writing, Jack Kevorkian has reportedly helped nearly one hundred people to die.[73] Despite repeated efforts by Michigan prosecutors and the state legislature, he has yet to be convicted of any crime. Although denounced as a murderer by many, there are others who consider him a hero, not just for what he does, but for bringing the whole issue of physician-assisted suicide into the public debate.

Kevorkian had decided to test his suicide machine in Michigan because he believed that the state had no laws against assisted suicide.[74] After several efforts to indict and convict Kevorkian failed, after his license to practice medicine was revoked, and after a court barred the use of his suicide machine, Kevorkian continued to help people to die. After the number of assists had grown to fifteen, Michigan enacted an anti-assisted suicide bill.[75] The law, which went into effect on February 25, 1993, had two major provisions. The first estab-

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72. *See id.* at D1, D2.

73. *See Lawyer Puts Kevorkian Cases at "Nearly 100"*, N.Y. TIMES, Aug. 14, 1997, at A21.

74. *See* JACK KEVORKIAN, PRESCRIPTION: MEDICIDE 192 (1990).

75. *See* MICH. COMP. LAWS ANN. § 752.1024(1) (West 1997).

lished a twenty-member Commission on Death and Dying, which had fifteen months to "develop and submit to the legislature recommendations as to legislation concerning the voluntary self-termination of life."[76] The second provision temporarily criminalized assisted suicide for twenty-one months, and spelled out the elements of the crime.[77] That law, after being declared invalid by the court of appeals,[78] was eventually held constitutional by the Michigan Supreme Court.[79] Kevorkian continues his crusade, however, confident that juries sympathetic to the plight of his patients (one can hardly call them victims) will acquit him.[80]

C

Kevorkian is unique in that he sees himself as a prophet and, along with his highly outspoken attorney, Geoffrey N. Fieger, seeks publicity for his cause.[81] The fact of the matter is that doctors help their patients commit suicide every day of the year. Most of them do so quietly and indirectly, with perhaps only the family knowing or guessing the truth. The columnist Anna Quindlen recalled a conversation she had once had with a friend whose mother suffered from the pain of ovarian cancer.[82] Her friend spoke of the wonderful oncologist treating her mother, and how kind, patient and considerate he was, but those were not his greatest virtues. "He told me how many of my mother's painkillers constituted a lethal dose."[83]

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76. *Id.*

77. *See id.* § 752.1027.

78. *See* People v. Kevorkian, 518 N.W.2d 487 (Mich. Ct. App. 1994).

79. *See* People v. Kevorkian, 527 N.W.2d 714 (Mich. 1994).

80. According to one news report, Kevorkian was actually encountering fewer hurdles in his work as Michigan state and local prosecutors appeared unwilling to bring charges until a new and supposedly more enforceable law was on the books. *See Kevorkian Encountering Fewer Hurdles in Suicides*, N.Y. TIMES, Oct. 17, 1997, at A26. There is very little case law on doctors assisting with suicide, but in nearly all known cases, juries acquitted the physicians or the prosecution, aware it could not secure a conviction, decided not to press the case. *See* Antonios P. Tsarouhas, *The Case Against Legal Assisted Suicide*, 20 OHIO N.U. L. REV. 793, 798-99 (1994); Note, *Physician-Assisted Suicide and the Right to Die with Assistance*, 105 HARV. L. REV. 2021, 2021 n.8 (1992).

81. *See, e.g.*, Geoffrey N. Fieger, *The Persecution and Prosecution of Doctor Death and His Mercy Machine*, 20 OHIO N.U. L. REV. 659 (1994).

82. Anna Quindlen, *Seeking a Sense of Control*, N.Y. TIMES, Dec. 9, 1990, Section 4 (The Week in Review), at 17.

83. *Id.*

Many doctors admit that the rate of suicide among the elderly is far higher than the statistics indicate, and the known suicide rate is twice that of younger groups.[84] Elderly people often are prescribed powerful medicines, which if taken improperly can cause death; the warnings indicating what is improper use can also serve as a guide to suicide. One doctor, speaking anonymously, said:

> So the sick old man died at home in his own bed last night instead of next fall in some intensive care unit. He was in pain. He was suffering a lot. What good would come from an autopsy that finds some lethal dose? I'm not suspicious of the family. So I sign the death certificate for "natural causes."[85]

Another doctor, who had treated more than four hundred AIDS patients, told each of them that whenever they thought treatment or pain had become too much, he would provide medicine for a painless suicide. Only four accepted his offer, but he reported that they all felt that they had regained some control over their lives. In 1989, when the doctor himself developed AIDS, he took his own prescription, and his death certificate did not list suicide as the cause of death.[86]

Doctors swear to protect life, but far more than most people in society, they see death. They see people so diseased and wracked with pain that death is preferable to life, and they are unique in that they have the power and resources to release people from their suffering. Although some newspapers condemned Kevorkian for "disgracing" the medical profession, doctors may, both legally and ethically, help patients to die. The doctor who agrees to forego treatment, or to help patients avoid further treatment, is not assisting in suicide. Courts have consistently ruled that foregoing treatment is not suicide because the act of refusing treatment is not the cause of death; people die from their illness, not from withdrawal of treatment. Sui-

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84. *See Western States Have the Highest Suicide Rate, U.S. Study Finds,* BOSTON GLOBE, Aug. 29, 1997, at A12.

85. Andrew H. Malcolm, *Giving Death a Hand: Pending Issue,* N.Y. TIMES, June 9, 1990, at A6.

86. *See id.*

cide is self-inflicted death; the illness that leads to death is not self-inflicted.[87]

To some people, this appears as sophistry, the drawing of fine lines to disguise or rationalize murder. But the law is made of fine distinctions, not just in the criminal area, but in civil law as well. One has to take into account the facts of the situation, the motives of the actors, and the rights of both society and the individual. Nor is the law immune from morality or compassion, and that is as it ought to be.

Since doctors can help their patients die as well as live, it is not surprising that people turn to them for assistance. Some doctors are affronted by such requests; they have sworn to heal people, not to kill them, and they refuse to be accessories to suicide because of their own deeply felt moral convictions.[88] On the other hand, many doctors will, in one way or another, quietly assist their patients to commit suicide. Despite the official position of the American Medical Association, polls of doctors show them to be greatly divided on this issue.[89] A few months after the Kevorkian story broke, one doctor came forward and admitted that he had done just that.

D

Dr. Timothy Quill practices medicine in upstate Rochester, New York. In March, 1991, he did what no doctor had done before. He publicly discussed his role in assisting a patient to

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87. *See, e.g., supra* note 3 and accompanying text; *In re* Gardner, 534 A.2d 947, 955 (Me. 1987); *In re* Quinlan, 355 A.2d 647 (N.J. 1976); *In re* Lydia E. Hall Hosp., 455 N.Y.S.2d 706, 711 (Sup. Ct. 1982). Courts have also ruled, in states that have Natural Death Acts, that "acts in accordance with a directive are not deemed suicide . . . and the cause of death shall be that which placed the patient in a terminal condition." *In re* Colyer, 660 P.2d 738, 751 (Wash. 1983). According to the American Medical Association, "[w]hen a life-sustaining treatment is declined, the patient dies primarily because of an underlying disease." *Report of the Council on Ethical and Judicial Affairs of the American Medical Association*, 10 ISSUES IN L. & MED. 91, 93 (1994).

88. The official position of the American Medical Association is that "physician-assisted suicide is fundamentally incompatible with the physician's role as healer." CODE OF ETHICS RULE 2.211 (1994). But doctors will sometimes see that "healing" may not be in the best interests of the patient, and how wrenching an issue this can be for doctors is explored in Richard Selzer, *A Question of Mercy*, N.Y. TIMES MAG., Sept. 22, 1991, at 32.

89. *See* Washington v. Glucksberg, 117 S. Ct. 2302, 2309 n.12 (1997) (O'Connor, J., concurring) (citing studies on this issue).

commit suicide, and he did so in an article in the prestigious *New England Journal of Medicine.*[90] Unlike Kevorkian, who often met his patients only a day or two before he helped them to die, Quill had been the longtime physician to a patient he called "Diane." When she developed acute leukemia he urged her to begin chemotherapy and have a bone-marrow transplant. But Diane knew that the odds of success were slim, the pain and distress great, and she decided to commit suicide. At first, Quill refused to help her, and referred her to the Hemlock Society. Then she called and asked him for barbiturates—sleeping pills—because she was having trouble sleeping. Quill knew this was true, but he also suspected that Diane intended to hoard the pills and then take an overdose; nonetheless, he wrote the prescription.[91]

Diane's condition grew worse. She made her farewells to friends and family, and asked Quill to come over to say goodbye. A few days later, her husband called and said Diane had died quietly on the couch; Quill reported the cause of death as acute leukemia. It was the truth, but not the whole truth, and he did it to protect both the family and himself from investigation and possible prosecution for assisting in a suicide.[92]

Up until this point, Quill's story is similar to hundreds, perhaps thousands, of deaths that occur in the United States every year. But then, Timothy Quill decided to talk about it, in part to relieve the intense emotional stress the experience had produced, but also to lift the shroud on a widespread practice, bring it into the open, and make it more honest. He consulted with state attorneys before deciding to publish his account and was told he would probably not face prosecution. Since, however, assisting suicide is a felony in New York, punishable by a five to fifteen-year prison sentence, local prosecutors did bring the case to a Rochester grand jury. The panel, however, refused to indict Quill, and the prosecutor declined to file an information.[93]

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

91. *See id.* at 693.

92. *See id.* at 694.

93. *See* Lawrence K. Altman, *Jury Declines to Indict a Doctor Who Said He Aided in a Suicide*, N.Y. TIMES, July 27, 1991, at A1.

For the most part, Quill's story elicited as much praise as Kevorkian's had brought forth condemnation. Medical ethicists Arthur Caplan and George Annas, both of whom had been critical of Kevorkian, found Quill's situation far different. Annas put it quite simply: "I want this guy as my doctor. The vast majority of people . . . would want somebody like this."[94] Quill went on to write two books advocating physician-assisted suicide,[95] and became the lead plaintiff in attempting to overturn the New York law under which he might have been indicted.[96]

E

The debate that Kevorkian and Quill triggered has operated on several levels, but it has certainly not been hidden. In particular, a series of referenda in western states demonstrates vividly not only how attitudes are changing, but also how open the debate has been. In November, 1991, voters went to the polls in the State of Washington to cast their ballots on Initiative 119. Entitled a "death with dignity" measure, the proposal would have authorized doctors to administer lethal injections to incurably ill patients. The patient had to make the request in writing, and had to have been diagnosed by two doctors as having less than six months to live. Two impartial persons, who were not members of the patient's family, had to witness the written request. If Initiative 119 had passed, the state would have become the first jurisdiction in the world to legalize a form of euthanasia.

The Hemlock Society provided the major backing for Initiative 119, arguing that the proposal would provide terminally ill people with freedom of choice. Both proponents and opponents of the initiative flooded the state with media spots. In one advertisement, a hospice worker charged that "Initiative 119

94. Julianne Malveaux, *For Millions, This Isn't the Issue*, USA TODAY, Mar. 12, 1991, at 8A. Polls taken at the time indicated that five to seven out of every ten adults believed that people suffering from incurable disease should be allowed to commit suicide. *See* Peter Steinfels, *Beliefs: Euthanasia, a Radical Issue That Demands Careful Consideration, Rather Than Drifting Judgment*, N.Y. TIMES, May 11, 1991, at A9.

95. *See* TIMOTHY E. QUILL, DEATH AND DIGNITY: MAKING CHOICES AND TAKING CHARGE (1993); TIMOTHY E. QUILL, A MIDWIFE THROUGH THE DYING PROCESS: STORIES OF HEALING AND HARD CHOICES AT THE END OF LIFE (1996).

96. *See infra* Part IV.

would let doctors kill my patients,"[97] while in another a woman who had been diagnosed with cancer seven years earlier told how glad she was to still be alive. Yes, there had been some rough moments, and if Initiative 119 had been in effect, she might have chosen death; but she was happy to still be alive.

Supporters of the measure ran equally emotional advertisements, with stories of people who died agonizing deaths. One woman, Vera Belt, told how her mother had died in great pain from throat cancer after doctors had refused her pleas for help in ending her life.[98] When Belt's sister became similarly ill, she knew what awaited her, and so she killed herself by putting a gun in her mouth and pulling the trigger.

The proposal split religious and medical groups. The Catholic Church strongly opposed the measure, but more than two hundred Protestant ministers from mainstream and liberal groups endorsed it. United Church of Christ minister Dale Turner, a supporter of Initiative 119, declared that "[w]e're on the frontier of the world," and dismissed concerns that people too readily would choose suicide if it became so easily available.[99] The seventy-four year old Turner said that "[n]obody loves life like an old man . . . . A person has to be pretty ill and desperate to want to leave."[100]

A number of doctors bitterly fought the proposal. They had been trained to save lives, not to take them, and they saw Initiative 119 as opening the doors to a flood of abuse. When the Washington State Medical Society debated the issue, delegates voted five to one against it, but a poll of the general membership taken earlier in the year showed doctors split rather evenly. One can surmise that although doctors do help some of their patients die, they prefer to keep this part of their practice quiet. To legalize physician-assisted suicide would mean additional regulation of medical practice. Although early signs indicated that Initiative 119 would pass, opponents gained ground as election day approached. Critics claim that American

97. Lou Cannon, *Assisted Killing of Fatally Ill on State Ballot*, WASH. POST, Nov. 3, 1991, at A6.

98. *See id.*

99. *Id.*

100. *Id.*

voters are apathetic, but Initiative 119 galvanized the populace, and voters came out in large numbers. The initiative failed by a 54-46% margin.[101] Both sides agreed that the debate had been useful and that an important public policy issue had been raised, one that would not quietly go away.[102] "If we don't deal with the problems raised by 119, we'll be facing this issue again and again and again," said Dr. Peter McGough, an opponent of the measure. McGough stated further that "[s]aying no to assisted death is not enough. Now we have a responsibility to deal with the problems that brought out this concern."[103]

Although lawyers and legal scholars played little public role in the Initiative 119 campaign, they too could not ignore the legal questions engendered by the measure. To begin with, proponents of Initiative 119 spoke not only of a right to die and death with dignity, both of which are now generally accepted notions, but also of a *right* to physician-assisted suicide. In a New York Times/CBS News poll taken in the spring of 1990 on the question of whether a doctor should help a terminally ill person die, 53% said "yes," 42% said "no," with the rest undecided.[104] Moreover, even before the vote on Initiative 119, courts had begun to hear arguments asserting a constitutionally protected right to assisted suicide.

In 1986, Elizabeth Bouvia, one of the best-known patients seeking to end her life, filed a suit in California court to have her feeding tube removed. In a concurring opinion, Judge Lynn D. Compton wrote:

> The right to die is an integral part of our right to control our own destinies so long as the rights of others are not affected. That right should . . . include the ability to enlist assistance from others, including the medical profession, in making death as painless and quick as possible.[105]

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101. *See id.*

102. *See id.*

103. *Id.* The following year, a similar ballot initiative in California, Initiative 161, was also defeated by an identical margin. *See* Robert Reinhold, *Move to Limit Terms Gathers Steam After Winning in 14 States*, N.Y. TIMES, Nov. 5, 1992, at B8.

104. *See* Malcolm, *supra* note 85, at A6.

105. Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 1147 (1986).

In January, 1987, lawyers for Hector Rodas filed a petition in Mesa County District Court in Colorado asserting that their client had a right to assisted suicide. In particular, Rodas' attorneys requested that he "be confirmed as having the constitutional and privacy right to receive medication and medicinal agents, from a consenting health care professional or institution, which will result in a comfortable and dignified demise."[106] At the time, Rodas was dying of self-imposed starvation and dehydration, after having won a battle in the same court a week earlier to force the Hilltop Rehabilitation Hospital to withdraw his feeding tubes and allow him to remain in the hospital until he died. Rodas had not been considered terminally ill, but the thirty-four-year-old man was paralyzed from the neck down and did not want to continue living. The local court had no problem with disconnecting the feeding tubes on a theory of personal autonomy, even though it recognized that such an action would lead to Rodas' death. The magistrate, however, had a great deal of difficulty with the request for assistance, and must have breathed a sigh of relief when Rodas died before he had to rule on the question.[107]

F

In November, 1992, a measure similar to Washington's Initiative 119 was defeated in California, by an identical 54-46%.[108] On Election Day 1994, however, Oregon voters, by a margin of 627,980 to 596,018, passed Measure 16, the Oregon Death with Dignity Act, making Oregon the first jurisdiction in the world to make assisted suicide legal.[109] The Oregon initiative was more carefully constructed than the measures that were defeated in neighboring states. To safeguard against abuses, the Act applies only in the last six months of life, mandates a second opinion about the patient's condition, requires multiple requests, has two waiting periods, and limits the type of aid that

106. James Bopp, Jr., *Is Assisted Suicide Constitutionally Protected?*, 3 ISSUES IN L. & MED. 113, 113 (1987) (quoting Complaint for Declaratory Relief, Rodas v. Erkenbrack, No. 870UK12 (Dist. Ct. Mesa County, Colo. 1987), *reprinted in* 2 ISSUES IN L. & MED. 499 (1987)).

107. *See id.*

108. *See* Reinhold, *supra* note 103, at B8.

109. OR. REV. STAT. §§ 127.800-.897 (1996). The full text is also found in *Lee v. Oregon*, 107 F.3d 1382, 1392 (9th Cir. 1997).

a physician can offer to prescribing, but not administering, medication.[110]

The debate in Oregon followed much the same pattern as the debates in California and Washington, with religious and advocacy groups arguing primarily on moral grounds. Oregon doctors, however, breaking with the national office of the American Medical Association, which opposed Measure 16, decided to remain neutral. After a heated debate, the state's medical association could find no consensus among its members.[111]

Almost immediately after passage of Measure 16, a group of physicians, patients and hospitals challenged the law on the grounds that it violated the Equal Protection and the Due Process Clauses of the Fourteenth Amendment, as well as the First Amendment and the Americans with Disabilities Act. The gist of their complaint was that Measure 16 denied terminally ill patients the same type of safeguards against committing suicide under undue influence or while suffering from depression as that provided for nonterminally ill people.[112] Chief Judge Michael R. Hogan of the federal district court found numerous inadequacies in the Act's protections for the terminally ill,[113] no rational basis for the distinction between terminally ill and nonterminally ill,[114] and concluded that the act did violate the Equal Protection Clause.[115] The state appealed, and, in a relatively brief opinion, Judge Melvin Brunetti of the Ninth Circuit vacated the lower court ruling on grounds that the claims were not ripe and the plaintiffs had no standing.[116]

It is too early to tell how the Oregon program will work. Although Measure 16 is fairly specific, there are a number of

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110. *See* OR. REV. STAT. §§ 127.800-.897 (1996); *see also The Uncharted Waters of Oregon's Assisted Suicide Law,* CHOICES, Summer 1995, at 1 [hereinafter *Uncharted Waters*].

111. *See* Timothy Egan, *Suicide Law Placing Oregon on Several Uncharted Paths,* N.Y. TIMES, Nov. 25, 1994, at A1.

112. *See Lee*, 891 F. Supp. at 1431.

113. *See id.* at 1434-37.

114. *See id.* at 1434.

115. *See id.* at 1434-37.

116. *See* Lee v. Oregon, 107 F.3d 1382 (9th Cir. 1997). The case had been argued before the Ninth Circuit panel on July 9, 1996, but the court withheld judgment once it learned that the Supreme Court had accepted two cases dealing with assisted suicide.

technical problems to be resolved. Doctors are still discussing how a patient's request for lethal medication should be honored. Pharmacists, who are often called upon by customers for information about medications, wonder what advice they should give to persons who hand them prescriptions for lethal drug dosages, and whether any liability will result from filling these prescriptions. The law provides for adult Oregon residents, but how is that to be defined, and will that definition conflict with federal and constitutional provisions about residency? Will other options, such as hospice care, be ignored by people for whom that may be the best choice?[117]

Even those who favor physician-assisted suicide recognize that there are many potential problems. Doctors educated to save lives as their primary concern will have to learn new skills and attitudes. Dr. Martin Skinner, an internist in suburban Portland, had mixed feelings about Measure 16. He told a reporter, "I don't know how to deal with it. I can conceive of myself being in a position to make such a decision, but I honestly do not know what I would do."[118] The law's definition of a terminally ill patient, one with six months or less to live, is also problematic. According to Skinner, doctors are fairly accurate in determining how long someone has to live when the illness is cancer, but there is far less certainty with other diseases.[119] There is also concern about how the law will affect the vulnerable, which was one of the main concerns that led Judge Hogan initially to block Measure 16's implementation. Will there be undue pressure on elderly patients, whose illness is a financial and emotional drain on their families, to do the "right" thing and opt for suicide? Arthur Caplan, director of the Center for Bioethics at the University of Pennsylvania School of Medicine, could not predict what the exact consequences of the Oregon initiative would be. He did declare, however, that the "legalization of any form of assisted suicide will have just tremendous consequences that will reverberate through American society . . . ."[120]

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117. *See Uncharted Waters, supra* note 110, at 6.

118. Egan, *supra* note 111, at B14.

119. *See id.*

120. *Voters in Oregon Allow Doctors to Help the Terminally Ill Die*, N.Y. TIMES, Nov. 11, 1994, at A28.

III

A

Even as interest groups sought to bypass legislatures through initiatives, other supporters of physician-assisted suicide went to court in efforts to overturn existing statutes criminalizing such practice. The first case to test a state's assisted suicide law in federal court arose in Washington, where Initiative 119 had been so vigorously debated in 1991.[121] On January 29, 1994, three terminally ill patients, five doctors, and a nonprofit organization called "Compassion in Dying" filed suit in the federal district court in Seattle.[122] The suit challenged a Washington statute that held "[a] person is guilty of promoting a suicide attempt when he knowingly causes or aids another person to attempt suicide."[123] Promoting suicide is a class C felony punishable by imprisonment for up to five years and by a fine of up to ten thousand dollars.[124] The Washington law had been on the books in one form or another since 1854, but had rarely been enforced. Even Compassion in Dying, while seemingly operating in violation of the statute, had never been threatened with prosecution.[125] The state, it should be noted, had no law prohibiting suicide or attempted suicide.

"Jane Roe," a sixty-nine-year-old retired pediatrician, suffered from cancer that had metastasized throughout her skeleton. She had been almost completely bedridden and in constant pain since June, 1993.[126] "John Doe," a forty-four-year-old artist, had been diagnosed with AIDS in 1991, and his physical condition had deteriorated consistently since that time. He had also been the primary caregiver for his long-term companion who had died of AIDS in June, 1991.[127] Both of these patients died before the case came to trial. The third patient, sixty-nine-year-old "James Poe," suffered from emphysema, which caused him a

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121. *See supra* Part II.E.

122. *See* Compassion in Dying v. Washington, 850 F. Supp. 1454 (W.D. Wash. 1994) [hereinafter *Compassion in Dying I*].

123. WASH. REV. CODE § 9A.36.060(1) (1988).

124. *See id.* §§ 9A.36.060(2), 9A.20.020(1)(c).

125. *See* Timothy Egan, *Federal Judge Says Ban on Suicide Aid is Unconstitutional*, N.Y. TIMES, May 5, 1994, at A1.

126. *See Compassion in Dying I*, 850 F. Supp. at 1456.

127. *See id.*

constant sensation of suffocating, for which he had to take morphine on a regular basis to calm the panic reaction.[128] All three patients were mentally competent and all wished to commit suicide by taking physician-prescribed drugs.

The five physicians regularly treated terminally ill patients. Harold Glucksberg was an assistant professor of oncology at the University of Washington School of Medicine. In his declaration to the court, Glucksberg wrote:

> Plain management at this stage often requires the patient to choose between enduring unrelenting pain or surrendering an alert mental state because the dose of drugs adequate to alleviate the pain will impair consciousness. Many patients will choose one or the other of these options; however, some patients do not want to end their days racked with pain or in a drug-induced stupor. For some patients pain cannot be managed even with aggressive use of drugs.[129]

The other doctors were John P. Geyman, chair of the Department of Family Medicine at the University of Washington School of Medicine; Thomas A. Preston, chief of cardiology at the Pacific Medical Center in Seattle; Abigail Halperin, a family practitioner; and Peter Shalit, an internist whose practice included a large number of HIV and AIDS patients. Drs. Halperin and Shalit were also clinical instructors at the University of Washington School of Medicine.[130]

Compassion in Dying provides information, counseling and assistance to terminally ill patients considering suicide and to their families. The organization has a strict protocol regarding the eligibility of people it will help. Patients must be terminally ill and, in the judgment of the primary care physician, mentally competent and able to understand the consequences of their decisions. Requests must come from the patient, in writing or on videotape, at least three times, with an interval of forty-eight hours between the second and third request. The organization will not assist anyone who expresses ambivalence or

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128. *See id.* at 1457.
129. *Id.* (quoting Declaration of Harold Glucksberg, M.D., at 3-5).
130. *See id.* at 1457-58.

uncertainty about committing suicide, and, if members of the immediate family express objections, Compassion in Dying will not help.[131]

The plaintiffs all challenged the Washington law, but on somewhat differing grounds. The patients alleged that they had a constitutionally protected liberty interest recognized in the Fourteenth Amendment's Due Process Clause to secure physician assistance for suicide without undue governmental interference.[132] They also attacked the statute on equal protection grounds.[133] The physicians claimed that the Fourteenth Amendment protects their right to practice medicine consistent with their best professional judgment, including the right to assist competent, terminally ill patients end their lives. Compassion in Dying feared that in carrying out its mission of assisting terminally ill patients commit suicide, it could be criminally prosecuted for its activities "in assisting dying persons as they exercise their alleged constitutional right to hasten their own deaths."[134]

Chief Judge Barbara Rothstein began her legal analysis, handed down on May 3, 1994, by granting the plaintiffs' claim of a liberty interest. The Supreme Court, she noted, had established "through a long line of cases that personal decisions relating to marriage, procreation, contraception, family relationships, child rearing and education are constitutionally protected."[135] She cited the Court's decision in *Planned Parenthood v. Casey*[136] that matters "involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment."[137] Although *Casey* dealt with abortion, Rothstein found the decision of a terminally ill person to end his or her own life to be of the same catego-

131. *See id.* at 1458.
132. *See id.* at 1459.
133. *See id.*
134. *Id.* at 1459.
135. *Id.*
136. 505 U.S. 833 (1992).
137. *Compassion in Dying I*, 850 F. Supp. at 1459 (citing Planned Parenthood v. Casey, 505 U.S. 833, 851 (1992)).

ry of "the most intimate and personal choices" and "central to personal dignity and autonomy."[138]

Similarly, the Supreme Court in *Casey* had spoken of the suffering of the pregnant woman, which "is too intimate and personal for the State to insist, without more, upon its own vision of the woman's role, however dominant that vision has been in the course of our history and our culture."[139] The district court therefore concluded "that the suffering of a terminally ill person cannot be deemed any less intimate or personal, or any less deserving of protection from unwarranted governmental interference, than that of a pregnant woman."[140]

The court also found a liberty interest recognized in the *Cruzan* decision, in which Chief Justice Rehnquist had held "that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition."[141] The court then asked rhetorically whether a constitutional difference could be drawn between "refusal or withdrawal of medical treatment which results in death, and the situation in this case involving competent, terminally ill individuals who wish to hasten death by self-administering drugs prescribed by a physician."[142] "From a constitutional perspective," Judge Rothstein concluded, "the court does not believe that a distinction can be drawn between refusing life-sustaining medical treatment and physician-assisted suicide by an uncoerced, mentally competent, terminally ill adult."[143]

As both *Cruzan* and *Casey* showed, liberty interests are not absolute, and the question then becomes what standard of review is necessary to determine if the state has trespassed onto constitutionally protected territory. The court adopted the standard enunciated in *Casey*, whether the "state regulation imposes an undue burden on a woman's ability to make [a] decision" concerning whether or not to procure an abortion.[144] Applying

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138. *Id.* at 1459-60.
139. *Casey*, 505 U.S. at 852.
140. *Compassion in Dying I*, 850 F. Supp. at 1460.
141. *Id.* at 1461 (citing Cruzan v. Director, Mo. Dept. of Health, 497 U.S. 261, 279 (1990)).
142. *Id.*
143. *Id.*
144. *Id.* at 1462 (citing Planned Parenthood v. Casey, 505 U.S. 833, 874 (1992)).

that analysis, the court then looked at the two interests the state had put forward in justification of the statute, namely, preventing suicide and preventing improper influence and abuse.

The state had a very weak case from the start because Washington prohibits neither suicide nor attempted suicide and, in 1975, had repealed a previous law that did, in fact, bar attempted suicide.[145] While conceding that the state had a strong interest in deterring suicide by young people, the court drew a sharp distinction between abruptly cutting a young life short and the situation of terminally ill patients, for whom preventing suicide meant only the prolongation of an often painful dying process. While the state had a legitimate interest in protecting the young, it had gone too far in extending the prohibition to terminally ill patients.[146]

The state's second interest, protecting people from undue influence and abuse, has been one of the major arguments utilized by opponents of assisted suicide. They fear that when a person becomes elderly and a burden on her family, she will be subject to pressure to "take the easy way out" for the sake of the family. The court, however, found little to distinguish between permitting withdrawal of medical treatment that led to death and providing drugs that led to the same desired result. As for the potential risks and abuses, tests already existed to evaluate the mental competency of the patient as well as the voluntariness of the decision. "Undoubtedly the legislature can devise regulations which would set up a mechanism for ensuring that people who decide to commit physician-assisted suicide are not acting pursuant to abuse, coercion or undue influence from third parties."[147]

Having found that the state did impose an undue burden on the exercise of a liberty interest protected by the Fourteenth Amendment, Judge Rothstein then turned to the most interesting part of her analysis, equal protection. The Fourteenth Amendment's Equal Protection Clause, she noted, "is essentially a direction that all persons similarly situated should be treated

145. *See id.* at 1464 (referencing 1975 Wash. Laws § 9A.36.060)).
146. *See id.* at 1464-65.
147. *Id.* at 1465 n.10.

alike."[148] In equal protection analysis, a higher standard of review, that of strict scrutiny, is used as opposed to the undue burden standard of a liberty interest. The plaintiffs claimed that Washington State law unconstitutionally distinguished between two groups of similarly situated people, those on life-support or under medical treatment whose withdrawal would mean death, and those who were likewise terminally ill, but not on life-sustaining equipment or treatment. The Washington Natural Death Act clearly stated that "adult persons have the fundamental right to control the decisions relating to the rendering of their own health care, including the decision to have the life-sustaining treatment withheld or withdrawn in instances of a terminal condition or permanent unconscious condition."[149]

The court agreed, finding that no significant difference existed between adult, mentally competent, terminally ill patients on life-support, who could decide to end their suffering by turning off the equipment, and adult, mentally competent, terminally ill patients who wished to end their suffering by committing suicide. By making such a distinction, Washington "creates a situation in which the fundamental rights of one group are burdened while those of a similarly situated group are not."[150] The state's law, therefore, violated the Fourteenth Amendment's Equal Protection Clause.[151]

Judge Rothstein granted summary judgment in favor of the plaintiff patients, and for the doctors insofar as they "purport to raise claims on behalf of their terminally ill patients."[152] She denied, however, judgment insofar as any claims raised on their own behalf. Similarly, she denied judgment for Compassion in Dying, since it also sought relief for itself as opposed to its clients. Finally, Judge Rothstein declined to enter an injunction barring the state from enforcing the law on the grounds that the responsibility for enforcing criminal laws rests primarily on

148. *Id.* at 1466 (citing City of Cleburne v. Cleburne Living Ctr., Inc., 473 U.S. 432, 439 (1985)).

149. WASH. REV. CODE § 70.122.010 (Supp. 1998).

150. *Compassion in Dying I,* 850 F. Supp. at 1467.

151. *See id.*

152. *Id.*

county prosecuting attorneys, and not on the Attorney General, who had been named as a defendant.[153]

Proponents of assisted suicide hailed Judge Rothstein's decision. Ralph Mero, a Unitarian minister who served as executive director of Compassion in Dying, said he expected a "tremendous increase" in the number of people coming to the organization for aid. "Today, every time I pick up the phone, there are three more people on voice mail asking for help."[154] Just as predictably, opponents attacked the ruling. The Roman Catholic bishops of Washington State, who had played a leading role in fighting Initiative 119, declared that assisted suicide "undermines the moral integrity of the medical profession whose duty it is to heal and comfort, not kill. And it tramples on our conviction that life, no matter how feeble or impaired, is a sacred gift from God."[155]

William F. Buckley, in his nationally syndicated column, attacked Rothstein's decision as one more unreasonable expansion of the so-called right of privacy.[156] He also saw no difference between a doctor who prescribed lethal medication and a mechanic

> who plants a bomb under your car, runs an electrical line to your window sill but leaves it to you to depress the button when your wife enters the car. What was worse, in terms of a democratic society, is that once again judges had usurped the right of the people to decide such matters through their elected representatives.[157]

B

The State of Washington appealed Judge Rothstein's decision, and a panel of the Court of Appeals for the Ninth Circuit consisting of Eugene A. Wright, John T. Noonan, Jr., and Diarmuid F. O'Scannlain heard arguments on December 7, 1994. By a vote of 2-1, the panel reversed the district court.[158]

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153. *See id.* at 1468 n.13.

154. Egan, *supra* note 125, at A1.

155. *Id.*

156. *See* William F. Buckley, *Giving Life to New "Rights" in the Advancement of Death*, RICH. TIMES-DISPATCH, May 11, 1994, at A13.

157. *Id.*

158. Compassion in Dying v. Washington, 49 F.3d 586 (9th Cir. 1995) [hereinafter

In an opinion written by Judge Noonan, the majority held that the district court's conclusion that the Washington statute deprived plaintiffs of both a liberty interest protected by the Fourteenth Amendment and equal protection "cannot be sustained."[159]

Judge Noonan noted that the lower court had relied on the wording of *Casey* to analogize between the privacy involved in pregnancy and a similar intimacy in dying.[160] In a remarkably refreshing comment, he declared that

> [a]ny reader of judicial opinions knows they often attempt a generality of expression and a sententiousness of phrase that extend far beyond the problem addressed. It is commonly accounted an error to lift sentences or even paragraphs out of context and insert the abstracted thought into a wholly different context.[161]

Judge Noonan found completely inapposite the district court's effort to equate the terms "personal dignity and autonomy" as used in *Casey* with the decision to choose death.

> The category created is inherently unstable. The depressed twenty-one year old, the romantically-devastated twenty-eight year old, the alcoholic forty-year old who choose suicide are also expressing their views of the existence, meaning, the universe, and life; they are also asserting their personal liberty. . . . The attempt to restrict such rights to the terminally ill is illusory. If such liberty exists in this context, as *Casey* asserted in the context of reproductive rights, every man and woman in the United States must enjoy it. . . . This conclusion is a *reductio ad absurdum.*[162]

Judge Noonan's argument, which relied heavily on an article by a long-time opponent of assisted suicide, Professor Yale Kamisar of Michigan,[163] is, indeed, an absurdity in the form

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Compassion in Dying II]. The case had already drawn a great deal of attention, and numerous groups, most of whom wanted to allow physician-assisted suicide, had entered *amici briefs*. For a list of the *amici* in the district court, see *Compassion in Dying I*, 850 F. Supp. at 1456 n.1. For the much larger list of *amici* in the court of appeals, see *Compassion in Dying II*, 49 F.3d at 587-588.

159. *Compassion in Dying II*, 49 F.3d at 590.

160. *See id.*

161. *Id.*

162. *Id.* at 590-91.

163. *See* Yale Kamisar, *Are Laws Against Assisted Suicide Unconstitutional?*, 23

stated, but it avoided coming to grips with the heart of the autonomy argument. If people are truly autonomous, and if that autonomy is protected by the law (either as a Fourteenth Amendment liberty interest or as a Ninth Amendment reserved right), then suicide is an option that must be open to one who is adult and competent.[164] The three examples Judge Noonan cited are all, arguably, not competent, and there is certainly a significant difference between the alcoholic of whatever age and a terminally ill patient in great pain, also of whatever age.

Judge Noonan went on to attack Judge Rothstein's ruling on other grounds. While *Cruzan* certainly dealt with end-of-life issues, the Supreme Court had made it quite clear that the enunciated right to die was circumscribed by a state's interest in preserving life, a portion of *Cruzan* ignored in the lower court ruling.[165] He dismissed the lower court's analysis as lacking "foundation in the traditions of our nation," and noted that "[i]n the two hundred and five years of our existence no constitutional right to aid in killing oneself has ever been asserted and upheld by a court of final jurisdiction."[166] Judge Noonan went on to lecture Judge Rothstein on the importance of judicial restraint. "Unless the federal judiciary is to be a floating constitutional convention, a federal court should not invent a constitutional right unknown to the past and antithetical to the defense of human life that has been a chief responsibility of our constitutional government."[167] Judge Noonan also found the facial invalidation of the statute unwarranted by the *Casey* precedent.[168] Most importantly, the district court had completely ignored the State of Washington's real interest in protecting life.[169] In addition, the lower court had entered a judgment on behalf of two plaintiffs already dead. "This unheard-of judgment was a nullity."[170] Finally, Judge Noonan dismissed the equal

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HASTINGS CENTER REP. 32 (1993).

164. The argument for suicide as an expression of personal autonomy, with appropriate safeguards, is set forth in TOM L. BEAUCHAMP AND JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 87 (1979); for a defense of suicide from a humanist viewpoint, see JOSEPH FLETCHER, HUMANHOOD: ESSAYS IN BIOMEDICAL ETHICS (1979).

165. *See Compassion in Dying II*, 49 F.3d at 591.

166. *Id.*

167. *Id.*

168. *See id.*

169. *See id.* at 591-92.

170. *Id.* at 593.

rights analysis by stating that ending life-support for a terminally ill patient, and letting the underlying condition bring on death, was a far different thing than actively terminating life.[171]

The strongest part of Judge Noonan's argument lay in his analysis of the state's interest. Chief Justice Rehnquist in *Cruzan* had made it clear that a right to die existed, although circumscribed by state interests. Judge Noonan completely ignored the end-of-life issues for those in pain from an incurable disease. In part, Judge Noonan wanted to rectify what he saw as a major error in Judge Rothstein's analysis, her dismissal of alleged state interests.

Judge Noonan listed five such interests: (1) The interest in not having doctors act as the killers of their patients; (2) the interest in not subjecting the elderly and the infirm to psychological pressure to consent to their own deaths; (3) the interest in protecting the poor and minorities, who would be especially susceptible to exploitation; (4) the interest in protecting all of the handicapped from societal indifference and antipathy; and (5) the interest in preventing abuses similar to those occurring in the Netherlands.[172] In his opinion, Judge Noonan made no reference to Judge Rothstein's extended analysis of which standard of review to utilize,[173] but in dismissing both the liberty interest and equal protection arguments, he adopted what amounted to a simple rational basis test. The state had legitimate interests, and, therefore, the statute was constitutional.

Judge Noonan was undoubtedly right in his assertion that the state has interests in preserving life. If, however, the lower court decision went too far in its efforts to address the concerns of the terminally ill, the majority opinion in the court of appeals had little to say on that score, except a sort of apologia at the end. Judge Noonan agreed that compassion is a great virtue, and "[n]o one can read the accounts of the sufferings of the deceased plaintiffs supplied by their declarations, or the accounts of the sufferings of their patients supplied by the physi-

171. *See id.*
172. *See id.* at 592-93.
173. *See Compassion in Dying I*, 850 F. Supp. at 1462-64.

cians, without being moved by them."[174] But "[c]ompassion cannot be the compass of a federal judge. That compass is the Constitution of the United States. Where, as here in the case of Washington, the statute of a state comports with that compass, the validity of the statute must be upheld."[175]

Judge Eugene A. Wright entered a relatively brief dissent in which he asserted that the real right involved was that of privacy, and the "right to die with dignity falls squarely within the privacy right recognized by the Supreme Court."[176] Judge Wright agreed with the lower court that no constitutional distinction could be drawn between refusing life-sustaining treatment and taking a physician prescribed drug to hasten death.[177] Additionally, he was able to point to a higher authority for this argument, Justice Scalia's concurrence in *Cruzan*, in which he stated that "starving oneself to death is no different from putting a gun to one's temple as far as the common-law definition of suicide is concerned . . . ."[178]

In answer to Judge Noonan's appeal for judicial restraint, Judge Wright argued that substantive due process had always evolved to meet new societal needs.[179] An appeal to history and tradition is useless where medicine is concerned because of the rapid changes taking place in that field. In essence, one has to craft a law dealing with the medical realities of the late twentieth century, not that of the late eighteenth. Even if one appeals to history and tradition, Judge Wright found the values of self-determination and privacy regarding personal decisions to always have been highly prized.

> "No right is held more sacred, or more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others unless by clear and unquestioned authority." The right to die with dignity accords with

174. *Compassion in Dying II*, 49 F.3d at 594.
175. *Id.*
176. *Id.* at 595 (Wright, J., dissenting).
177. *See id.*
178. *Id.* at 596 n.4 (quoting Cruzan v. Director, Mo. Dep't of Heath, 497 U.S. 261, 296 (1990) (Scalia, J., concurring)).
179. *See id.* at 596.

the American values of self-determination and privacy regarding personal decisions.[180]

C

Although losing parties in the courts of appeal often ask for a rehearing en banc, it is rarely granted. In this case, however, the Ninth Circuit granted the request on August 1, 1995,[181] and heard oral argument before a panel of eleven judges on October 26, 1995. By a vote of eight to three, the court reversed the earlier panel's decision and found that the Washington statute violated the Due Process Clause of the Fourteenth Amendment.[182]

Judge Stephen Reinhardt, in a forty-six page opinion for the majority, described Judge Rothstein's lower court opinion as "extremely thoughtful."[183] Judge Noonan had gone out of his way to declare absurd the lower court decision in favor of two dead plaintiffs.[184] Judge Reinhardt drew the obvious parallel to the Supreme Court's initial decision in *Roe v. Wade*,[185] where the original plaintiff was no longer pregnant, but the Court recognized that other women would become pregnant.[186] A case is not mooted when the controversy is capable of repetition, yet evading review. The fact that two of the original plaintiffs had died before the case came to trial did not matter; the issue they raised remained important because other people would also suffer end-of-life crises, and they, too, might die before their cases could come to trial.

The important thing about the Ninth Circuit's opinion is that Judge Reinhardt decided to focus his opinion entirely on the Due Process Clause, and therefore did not feel it was necessary

180. *Id.* (quoting Union Pacific R.R. Co. v. Botsford, 141 U.S. 250 (1891)). Judge Wright also agreed with the lower court in its analysis of the proper standard of review as well as the equal protection claim. *See id.* at 596-97.

181. *See* Compassion in Dying v. Washington, 62 F.3d 299 (9th Cir. 1995) [hereinafter *Compassion in Dying III*].

182. *See* Compassion in Dying v. Washington, 79 F.3d 790 (9th Cir. 1996) [hereinafter *Compassion in Dying IV*].

183. *Id.* at 797.

184. *See Compassion in Dying II*, 49 F.3d at 590-91.

185. 410 U.S. 113 (1973).

186. *See Compassion in Dying IV*, 79 F.3d at 796 (citing Roe v. Wade, 410 U.S. 113, 125 (1973)).

to deal with the equal protection analysis. Although he fleshed out his argument with copious references, Judge Reinhardt made it clear from the start that he believed the Constitution protected a right to die;[187] he then phrased the question as whether "prohibiting physicians from prescribing life-ending medication for use by terminally ill patients who wish to die violates the patients' due process rights."[188] While recognizing that, as in all liberty interests, a balancing was required between the rights of the individual and the legitimate interests of the state, the larger panel, unlike Judge Noonan, would impose more than the simple rational basis test.

The court quickly found that a liberty interest existed, and like Judge Rothstein, the panel found "compelling similarities between right-to-die cases and abortion cases."[189] The majority went further than the district court, however, in noting that the balancing test might yield different outcomes at different points along the life cycle. In *Roe*, the Court had utilized a trimester arrangement, in which the woman's interests and choices were paramount in the first trimester, while the state's interests took precedence in the last trimester. So, in determining end-of-life decisions, the majority held differing circumstances could dictate differing outcomes, directly repudiating Judge Noonan's *reductio ad absurdum*.[190]

The key to the panel's analysis is that Judge Reinhardt, at all times, focused on what he considered the larger liberty interest; namely, the right to die, which had already been articulated by the Supreme Court in *Cruzan*. Judge Noonan, by defining the alleged liberty interest only as a right to assisted death, could ignore the larger issue, and in doing so he could dismiss much of the district court's analysis. Judge Reinhardt's approach was more encompassing.

> We do not ask simply whether there is a liberty interest in receiving "aid in killing oneself" because such a narrow interest could not exist in the absence of a broader and more important underlying interest—the right to die. In

187. *See id.* at 798-99.
188. *Id.* at 799.
189. *Id.* at 800.
190. *See Compassion in Dying II*, 49 F.3d at 590-91.

> short, it is the end and not the means that defines the liberty interest.[191]

Once the court framed the argument in these terms, and with a majority believing that the "larger" issue constituted the right to die, all that remained was to formulate the liberty interest, identify an appropriate standard of review, and then examine Washington's prohibition on assisting suicide in light of that standard. The Ninth Circuit, however, went further in its expansive reading of what substantive due process meant. It began with Justice John Marshall Harlan's dissent in *Poe v. Ullman,*[192] in which he argued that "the full scope of the liberty guaranteed by the Due Process Clause is . . . a rational continuum which, broadly speaking, includes a freedom from all substantial arbitrary impositions and purposeless restraints. . . ."[193] In his dissent, Justice Harlan had hinted that some liberty interests are weightier than others and, according to Judge Reinhardt, the Supreme Court appeared to be "heading towards the formal adoption of the continuum approach, along with a balancing test, in substantive due process cases generally."[194] The problem then became determining what criteria courts would use in defining the scope of the continuum and in enumerating the values found along it.

Again responding to Judge Noonan's decision, Judge Reinhardt indicated that history and tradition could play only a limited role in such judgments. Times changed and "[w]ere history our sole guide, the Virginia anti-miscegenation statute that the Court overturned in the 1967 case of *Loving v. Virginia,*[195] as violative of substantive due process and the Equal Protection Clause, would still be in force because such anti-miscegenation laws were commonplace both when the United States was founded and when the Fourteenth Amendment was adopted."[196] Moreover, according to Judge Reinhardt, the Supreme Court itself had "reject[ed] the view that substantive due pro-

191. *Compassion in Dying IV,* 79 F.3d at 801.
192. 367 U.S. 497 (1961).
193. *Id.* at 543 (Harlan, J., dissenting from dismissal on jurisdictional grounds).
194. *Compassion in Dying IV,* 79 F.3d at 804.
195. 388 U.S. 1 (1967).
196. *Compassion in Dying IV,* 79 F.3d at 805 (citation omitted).

cess protects rights or liberties only if they possess a historical pedigree."[197]

Judge Reinhardt then went into an analysis of historical attitudes toward suicide and the changes that had taken place, citing polls showing that a large majority of Americans endorsed recent legal decisions granting terminally ill patients the right to terminate treatment. He also discussed a variety of books and articles, as well as examples of people who had taken their own life.[198]

The analysis of the liberty interest under both *Casey* and *Cruzan* generally followed the outline of the lower court,[199] but with the difference that, after finding the liberty interest, Judge Reinhardt did not dismiss the state's concerns as easily as Judge Rothstein had done. Judge Reinhardt identified six important state interests: (1) the state's general interest in preserving life; (2) the more specific interest in preventing suicide; (3) avoiding involvement of third parties in the decision, and precluding arbitrary, unfair or undue influence; (4) protecting family members and loved ones; (5) protecting the integrity of the medical profession; and (6) avoiding adverse consequences that might ensue if the statute were found unconstitutional.[200]

The difference in wording from Judge Noonan's list is instructive. Judge Noonan apparently started with an assumption that if a right to die existed, under *Cruzan* it was limited and had to take a secondary role to the state's interests. His balancing is not a balancing at all, but a simple rational basis test. Judge Reinhardt starts with the assumption that the right to die is an important liberty interest, fully protected by substantive due process, and while there is a continuum, the individual's rights are presumed to trump those of the state, absent some compelling reason. In his analysis of the six state interests, as balanced against those of the individual, Judge Reinhardt found no such reason.[201] Judge Reinhardt did not declare that the state could not regulate physician-assisted

197. *Id.* at 806 (citing Planned Parenthood v. Casey, 505 U.S. 833, 847-48 (1992)).
198. *See id.* at 810-12.
199. *See id.* at 812-16.
200. *See id.* at 830-32.
201. *See id. at* 817-32.

suicide or that it might not establish procedures to limit that choice to a particular group of people, but he found that the total ban as embodied in the state statute went too far. "By adopting appropriate, reasonable, and properly drawn safeguards Washington could ensure that people who choose to have their doctors prescribe lethal doses of medication are truly competent and meet all requisite standards."[202]

There was one final point in Judge Noonan's opinion that Judge Reinhardt chose to answer, and that was the call for judicial restraint, the charge that courts should not be involved in this sort of policy-making. Judge Reinhardt agreed that matters involving life and death should not be made by courts. He then stood the argument on its head by declaring that

> by permitting the *individual* to exercise the right to *choose* we are following the constitutional mandate to take such decisions out of the hands of the government, both state and federal, and to put them where they rightly belong, in the hands of the people. We are allowing people to make the decisions that so profoundly affect their very existence—and precluding the state from intruding excessively into that critical realm.[203]

The decision did not force anyone to commit suicide.

> Those who believe strongly that death must come without physician assistance are free to follow that creed, be they doctors or patients. They are not free, however, to force their views, their religious convictions, or their philosophies on all the other members of a democratic society, and to compel those whose values differ with theirs to die painful, protracted and agonizing deaths.[204]

There were three dissents from the majority opinion. Judge Robert R. Beezer believed that terminally ill patients did not have a fundamental right to physician-assisted suicide, because such a right was neither deeply "rooted in the nation's history" nor implicit in the concept of ordered liberty.[205] His dissent

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202. *See id. at* 833.
203. *Id.* at 839 (emphasis added).
204. *Id.*
205. *Id.* at 848-49 (Beezer, J., dissenting).

rejected the majority notion that *Casey* supported the creation of a right to assisted suicide in any manner. In any case, he explained, abortion rights were no longer fundamental after *Casey*, and thus inapplicable to termination of a viable life.[206] Since the asserted liberty interest was not fundamental, a rational basis standard would be acceptable, although Judge Beezer believed that the law would survive strict scrutiny as well.[207] Similarly, he thought the equal protection argument could also be measured on a rational basis, because the plaintiffs' challenge involved neither a fundamental right nor a suspect classification.[208] Judges Ferdinand F. Fernandez and Andrew J. Kleinfeld joined Beezer's dissent, but each added a reservation. Judge Fernandez stated that nothing in either the majority or the minority opinions convinced him that there was any constitutional right to suicide, and he believed end-of-life choices ought to be left to the legislature, and not the courts, to decide.[209] Judge Kleinfeld also doubted there was any constitutional right to suicide, and he thought that there was a clear difference between withdrawing from treatment and actively overdosing on lethal drugs.[210]

IV

A

On the East Coast, Dr. Timothy Quill, the doctor who had leaped into national prominence with his admission that he had helped one of his patients commit suicide,[211] launched a legal attack against the law under which local prosecutors had tried to indict him.[212] In July, 1994, Quill, along with two other

206. *See id.*
207. *See id.* at 851.
208. *See id.* at 856.
209. *See id.* at 857 (Fernandez, J., dissenting).
210. *See id.* at 857-58 (Kleinfeld, J., dissenting).
211. *See* sources cited *supra* note 95.
212. *See* Quill v. Koppel, 870 F. Supp. 78 (S.D.N.Y. 1994). The doctors' decision to file the suit may have been triggered by the report of a special panel, the New York State Task Force on Life and the Law, which on May 25, 1994, issued its long-awaited report on physician-assisted suicide. The influential advisory panel unanimously recommended that the state not legalize physician-assisted suicide for the terminally ill. The report argued that such a step would benefit only a few people but would open the door to widespread abuse. The panel expressed concern that doctors, instead of trying to improve the relatively poor medical care dying patients receive, might tend to prescribe lethal drugs as an easier treatment. *See* New York State Task

doctors, Samuel C. Klagsbrun and Howard A. Grossman, brought suit in the Southern District of New York to have New York's ban on assisted suicide declared unconstitutional. Three terminally ill patients also were plaintiffs, but all of them died before the case went to trial, leaving only the physicians.[213]

In his declaration, Quill explained that, due to the criminal investigation following the death of his patient, he was afraid to provide other terminally ill patients with barbiturates for fear of violating the criminal law. This fear was substantiated by the other two doctors as well. They sought an injunction to bar enforcement of those portions of the New York Penal Code which made assisting suicide a second-degree felony (manslaughter).[214] The state asserted that no actual case or controversy existed, and therefore the suit was nonjusticiable.[215] Although Chief Judge Thomas P. Griesa held that the action did provide a justiciable controversy, he went on to rule that patients did not have any fundamental right to physician-assisted suicide, and that the state laws criminalizing assisted suicide did not violate the Equal Protection Clause.[216]

The first issue, that of justiciability, might not have arisen had any of the original patient plaintiffs lived long enough, but unlike Judge Rothstein, Chief Judge Griesa did not keep them listed as plaintiffs, nor did he invoke the "capable of repetition yet evading review" rationale used in the Ninth Circuit. The state argued that the doctors had no standing because they could not show more than a speculative possibility of prosecution.[217] Chief Judge Griesa found this to be an easy question, since the Supreme Court had held in a number of cases that when challenging the constitutionality of a criminal

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Force on Life and the Law, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT (1994).

213. *Quill*, 870 F. Supp. at 79.

214. The New York Penal Code Section 125.15(3) provides that "a person is guilty of manslaughter in the second degree when . . . he intentionally . . . aids another person to commit suicide." N.Y. PENAL LAW § 125.15(3) (McKinney 1965). Section 120.30 provides that "[a] person is guilty of promoting a suicide attempt when he intentionally . . . aids another person to attempt suicide." *Id.* § 120.30.

215. *See Quill*, 870 F. Supp. at 81.

216. *See id.* at 78.

217. *See id.* at 81.

statute, the plaintiff need not expose himself to actual prosecution.[218]

On the second question, Chief Judge Griesa agreed that under the Fourteenth Amendment, "there are certain subjects which are so fundamental to personal liberty that governmental invasion is either entirely prohibited or sharply limited."[219] Like the judges in the Ninth Circuit, he too found a supporting statement in *Casey* about due process protecting "the most intimate and personal choices a person may make in a lifetime."[220] Chief Judge Griesa, however, was unwilling to draw the analogy between the "intimate and personal choices" relating to abortion and those made at the end of life.[221] He found the Supreme Court's ruling in *Cruzan* less than enlightening, believing that "the Court stopped short of actually deciding that there is a constitutional right to terminate medical treatment necessary to sustain life, although the Court *assumed* the existence of such a right for the purpose of going on to the other issues in the case."[222]

Since the plaintiffs read *Roe, Casey* and *Cruzan* as embodying a due process protection of all intimate and personal choices, they believed such protection should cover whether a person wanted to end her own life, certainly one of the most intimate and personal of all choices. This, according to the court, was where the plaintiffs had erred. "Plaintiffs' reading of these cases is too broad."[223] Moreover, there has been no historic recognition of any right to physician-assisted suicide, even in the case of terminally ill patients. Suicide was long considered a crime in its own right, and a majority of states had long imposed penalties on those who aided others to kill themselves. Even the Model Penal Code, which embodies the most enlightened thought, makes it a crime to assist a suicide.[224] As far as the court was concerned, even the very limited form of assisted

218. *See id.* (citing Babbitt v. United Farm Workers Nat'l Union, 442 U.S. 289 (1979); Doe v. Bolton, 410 U.S. 179 (1973)).

219. *Id.* at 82.

220. *Id.* (citing Planned Parenthood v. Casey, 505 U.S. 833, 851 (1992)).

221. *See id.*

222. *Id. at* 83 (emphasis in original).

223. *Id.*

224. *See id.* at 84 (citing to MODEL PENAL CODE § 210.5(2)).

suicide advocated by the plaintiffs, helping terminally ill people end their suffering, could hardly be characterized as a liberty interest protected under the Fourteenth Amendment.[225]

The three doctors also put forward an equal protection argument; namely, that people who wanted to end their suffering through active euthanasia were not treated equally as those already on life sustaining treatment, whom the law allowed to terminate that treatment.[226] Chief Judge Griesa made short shrift of that argument as well. Did the distinction drawn by the legislature between the two classes have a reasonable and rational basis? He admitted that some people would see little or no difference, while others would see a great difference. "In any event, it is hardly unreasonable or irrational for the State to recognize a difference between allowing nature to take its course, even in the most severe situations, and intentionally using an artificial death-producing device."[227] The state had obvious interests in preserving life and protecting vulnerable persons, and under the Constitution, in the absence of an identifiable individual right, the state had the discretion over what way it chose to protect these interests. Chief Judge Griesa then granted summary judgment.[228]

B

The New York decision came down seven months after Judge Rothstein decided the Washington case, and only a week after the latter case had been argued before the three-judge panel of the Ninth Circuit. Yet, the New York case did not draw as much attention as the Washington case, and the decision mentions no *amici* briefs filed on either side. This situation changed dramatically when the Second Circuit heard argument on the case at the beginning of September, 1995, and a significant number of groups, many of whom had also filed in the Ninth Circuit, now joined the fray on the East Coast.[229] The case was heard before Judges Roger J. Miner, Guido Calabresi, and

225. *See id.*
226. *See id.*
227. *Id.*
228. *See id.* at 85.
229. *See* Quill v. Vacco, 80 F.3d 716, 718 (2d Cir. 1996) (listing *amici* briefs). The name of the case also changed, after Dennis C. Vacco replaced G. Oliver Koppel as Attorney General of New York. *See id.* at 716.

Milton Pollack, a senior district judge from the Southern District of New York sitting by designation. Judge Miner wrote the opinion for a unanimous panel.

One could immediately sense where Miner was heading by his statement of the background. Where Chief Judge Griesa merely had mentioned that the three patient-plaintiffs died before the trial began, Judge Miner quoted extensively from their declarations, in which they detailed their illnesses and the pain and suffering they endured.[230] Unlike Chief Judge Griesa, he entered sections of the physicians' declarations, and the problems they confronted in treating terminally ill patients.[231]

Like the lower court, the Second Circuit rejected the state's claim that no justiciable issue existed. Judge Miner referred not only to *Babbitt v. United Farm Workers National Union*[232] and *Doe v. Bolton*,[233] but took judicial notice that an attempt had been made to indict Dr. Quill after he acknowledged helping a patient end her life. Although New York County District Attorney Robert M. Morganthau (also named as a defendant) had claimed that the plaintiffs had not shown that they were in any jeopardy, Judge Miner quoted from a newspaper clipping reporting that Morgenthau had announced a grand jury indictment of George Delury on manslaughter charges for helping his wife commit suicide the previous summer. "The physician plaintiffs," Judge Miner concluded, "have good reason to fear prosecution in New York County."[234]

The court then began its inquiry into whether assisted suicide qualified as a fundamental liberty interest. "Rights that have no textual support in the language of the Constitution but qualify for heightened judicial protection include fundamental liberties so 'implicit in the concept of ordered liberty' that 'neither liberty nor justice would exist if they were sacrificed.'"[235] While the Supreme Court counted privacy among the rights

230. *See id.* at 720-21.
231. *See id.* 721.
232. 442 U.S. 289 (1979).
233. 410 U.S. 179 (1973).
234. *Quill*, 80 F.3d at 723 (citing N.Y. TIMES, Dec. 15, 1995, at B1).
235. *Id.* (citing Palko v. Connecticut, 302 U.S. 319, 325-26 (1937)).

protected by due process, it had been reluctant to expand the meaning of privacy, and had given lower courts tenuous guidelines on how to proceed. That line, "albeit a shaky one," could be found in *Bowers v. Hardwick*,[236] where the high court had held there was no "fundamental right to engage in consensual sodomy . . . [since] the statutes proscribing such conduct had 'ancient roots.'"[237] Taking its cue from that case, the appellate court declined to define physician-assisted suicide as a right implicit in the concept of ordered liberty. As in *Bowers*, no historical justification existed to make it so; "[i]ndeed, the very opposite is true. The Common Law of England, as received by the American colonies, prohibited suicide and attempted suicide. . . . Clearly, no 'right' to assisted suicide has ever been recognized in the United States."[238] The court explained that, if the Supreme Court was hesitant to expand due process rights, then "[o]ur position in the judicial hierarchy constrains us to be even more reluctant than the Court to undertake an expansive approach in this uncharted area."[239]

Such restraint, however, seemed to evaporate as the court turned to plaintiffs' other argument, that a denial of physician-assisted suicide violated the Equal Protection Clause. Seeking an appropriate level of review, the court reviewed those types of legislation that called for rational basis (matters of social welfare and economics), intermediate scrutiny (gender and illegitimacy), and strict scrutiny (involving suspect classes).[240] The court then concluded that the prohibition against physician-assisted suicide fell into the class of social welfare and could be examined under a rational basis test.[241]

One might speculate that the appellate court took this route to avoid the perception that it was creating a new right or expanding an existing one. By treating the statute as a form of social welfare regulation, it could apply the lowest form of review and find that it made no rational sense to distinguish between allowing people to terminate treatment to hasten deaths

236. 478 U.S. 186 (1986).
237. *Quill*, 80 F.3d at 724 (quoting *Bowers*, 478 U.S. at 192 (1986)).
238. *Id.*
239. *Id.* at 725.
240. *See id.* at 726.
241. *See id.* at 727.

and allowing people to hasten death by other means. In 1987, the New York legislature had specifically amended its laws to allow citizens to refuse treatment and to direct doctors and hospitals not to resuscitate should they go into cardiac arrest.[242] Three years later, the state provided for health care proxies, empowering such proxies to terminate treatment for comatose patients.[243]

After reviewing the Supreme Court's holding in *Cruzan*, Judge Miner concluded:

> [I]t seems clear that New York does not treat similarly circumstanced people alike: those in the final stages of terminal illness who are on life-support systems are allowed to hasten their deaths by directing the removal of such systems, but those who are similarly situated, except for the previous attachment of life-sustaining equipment, are not allowed to hasten death by self-administering prescribed drugs.[244]

As far as the court was concerned, there seemed little difference between assisted suicide and the withholding or withdrawal of treatment.

Having found unequal treatment, the court had to determine whether there was a rational basis for establishing such inequality. At oral argument, the state had argued that its "principal interest is in preserving the life of all its citizens at all times and under all conditions," to which Miner responded:

> But what interest can the state possibly have in requiring the prolongation of a life that is all but ended? Surely, the state's interest lessens as the potential for life diminishes . . . . And what business is it of the state to require the continuation of agony when the result is imminent and inevitable? What concern prompts the state to interfere with a mentally competent patient's "right to define [his] own concept of existence, of meaning, of the universe, and of the mystery of human life," when the patient seeks to have drugs prescribed to end life during the final stages of a terminal illness? The greatly reduced interest of the state

242. *See* N.Y. PUB. HEALTH LAW §§ 2960-79 (McKinney 1993).
243. *See id.* §§ 2980-94.
244. *Quill*, 80 F.3d at 729.

> in preserving life compels the answer to these questions: "None."[245]

In conclusion, the court found that New York statutes criminalizing assisted suicide violated the Equal Protection Clause, because preventing a doctor from prescribing drugs to a mentally competent patient bore no rational relationship to any legitimate state interest.[246]

Judge Guido Calabresi concurred in the judgment—that the laws as written should be struck down—but he entered a separate opinion because he believed it was premature to reach either the due process or equal protection analysis regarding the larger question of whether all laws prohibiting assisted suicide might fail.[247] Judge Calabresi began with a lengthy analysis of English and New York laws on suicide and assisted suicide and concluded that "the bases of these statutes have been deeply eroded over the last hundred and fifty years; and . . . few of their foundations remain in place today."[248] As he read the history, the original reason for the statutes was to criminalize other conduct that at the time had itself been prohibited, suicide and attempted suicide. Since then, at least one form of suicide had become legally recognizable, the withdrawal of life-sustaining treatment, and one could find little distinction between that conduct and the taking of prescribed drugs to end life. The legislature, faced by these changing conditions, had not acted affirmatively to reassert the state's policy while, at the same time, the older laws were unenforced.[249]

Normally, this would not make much difference, since

> [w]e regularly uphold laws whose original reason has vanished, whose fit with the rest of the legal system is dubious, whose enforcement is virtually nil, and whose continued presence on the books seems as much due to the strong

245. *Id.* at 729-30 (quoting Planned Parenthood v. Casey, 505 U.S. 833, 851 (1992)). Judge Miner had read the initial decision of the three-judge panel of the Ninth Circuit and briefly noted its elucidation of state interests, but he found none of them compelling. *See id.* at 730-31.

246. *See id.* at 731.

247. *See id.* at 731-32 (Calabresi, J., concurring).

248. *Id.* at 735.

249. *See id.*

> inertial force that the framers of our constitutions gave to the *status quo* as to any current majoritarian support.[250]

When fundamental, substantive rights are in danger, however, there is also "a long tradition of constitutional holdings that inertia will not do."[251] The answer, Judge Calabresi believed, lay in notifying legislatures of the potential unconstitutionality of a particular statute. The legislature should then have the opportunity either to reaffirm the law and face the constitutional test, abandon the requirement, or amend the statute to cure it of perceived defects. This could be done in a variety of ways. One was to nullify the law, as had been done here, but he would add an invitation to the legislature to reconsider the matter. This approach, he believed, was not only a better way for courts to handle matters of such far-reaching import, but also had precedents in the Supreme Court.[252] On a number of occasions, the Justices had struck down particular laws or administrative regulations but had invited the Congress or an agency to rethink and revise the rule.[253] Judge Calabresi believed this law of nineteenth-century origins to be of doubtful validity and joined the majority in striking it down. He did so, however, in what he described as "a constitutional remand"[254] and noted specifically that he had not dealt with the merits of the plaintiffs' case; that, he urged, should wait until New York's legislature had acted.[255]

V

A

While advocates for particular interest groups, such as the Hemlock Society and the American Civil Liberties Union, cheered the decisions in the Second and Ninth Circuits, legal

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250. *Id.*

251. *Id.*

252. *See id.* at 735-38.

253. *See id.* at 738-40 (citing Thompson v. Oklahoma, 487 U.S. 815 (1988); Califano v. Goldfarb, 430 U.S. 199 (1977); Greene v. McElroy, 360 U.S. 474 (1959); Barenblatt v. United States, 360 U.S. 109 (1959); Kent v. Dulles, 357 U.S. 116 (1958); Abele v. Markle, 342 F. Supp. 800 (D. Conn. 1972)). Judge Calabresi had written extensively on how courts should deal with questionable statutes. *See* GUIDO CALABRESI, A COMMON LAW FOR THE AGE OF STATUTES (1982).

254. *See Quill,* 80 F.3d at 738.

255. *See id.* at 743.

commentators proved considerably more hostile. Susan R. Martyn and Henry J. Bourguignon attacked what they considered the "lethal flaws" in the Second and Ninth Circuit opinions.[256] According to Martyn and Bourguignon, the two opinions "mark a decisive turning point in American law that must not pass unnoticed or unchallenged."[257] They considered the line drawn by the courts to be untenable and stated that "the sole purpose of this Essay is to drive home the many compelling reasons to maintain the traditional line between killing and letting die."[258] As for the pain and suffering of terminally ill patients who suffered unrelievable pain and voluntarily sought a doctor's help to end their lives, they explained that "we must continue to treat these rare cases, however, as tragic, isolated occurrences."[259] Above all, the slippery slope running perilously near the surface in the two decisions had to be avoided, lest Americans repeat the same tragic pattern of events that led to euthanasia in the Netherlands.[260]

An article in the *Harvard Civil Rights-Civil Liberties Law Review* took a different tack, asserting that the courts had erred in limiting the right to the terminally ill.[261] If a liberty interest existed, then bans on doctor-assisted suicide ought to be unconstitutional as applied not only to terminally ill patients but to others as well. "The case for the balance tipping in favor of the individual is clearest with respect to those who are incurably in pain or have an ailment that portends imminent death."[262] Here, the individual liberty interest clearly trumped any state interests in protecting life and regulating the medical profession.

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256. *See* Susan R. Martyn & Henry J. Bourguignon, *Physician-Assisted Suicide: The Lethal Flaws in the Ninth and Second Circuit Decisions,* 85 CAL. L. REV. 371 (1997).

257. *Id.* at 373.

258. *Id.* at 374, 385-90.

259. *Id. at* 375.

260. *See, e.g.,* Margaret P. Miller, *Boot-Strapping Down a Slippery Slope in the Second and Ninth Circuits: Compassion in Dying is Neither Compassionate nor Constitutional,* 30 CREIGHTON L. REV. 833 (1997).

261. *See* 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 (1997).

262. *Id.* at 219.

What about nonterminally ill individuals? If a liberty interest exists that allows one category of people to end their lives, why should it be restricted to just that class? The authors believe an equal protection analysis would support their argument that the right has to be broader. If a person suffered from terrible pain that could not be medically alleviated, but that person was not terminally ill, why should she have to suffer with no hope of release except through a death that might be years away? The notion that people who have years to live face many options for a fruitful life is not convincing to a bedridden man who cannot even get up to walk to the bathroom. There is little difference between allowing a person who might have years to live if she stayed on dialysis to stop that treatment and die, and a person not on such a regimen who suffered from a debilitating, painful, but nonfatal disease to choose death.[263]

The state could adopt selective restrictions in which state interests would be considered greater than those of the individual. This would be especially true in cases of minors and other legal incompetents, to prevent undue influence, and in those cases where the would-be suicide had minor dependents. The state also could authorize who might assist in suicides, perhaps limiting it to just physicians, and ensure that the choice is informed and made freely.[264]

Perhaps the most sustained and reasoned attack on the decisions came from Chicago Law School Professor Cass R. Sunstein, who argued that the Supreme Court should not invalidate state laws prohibiting physician-assisted suicide.[265] Sunstein's argument has less to do with the morality of the issue but instead focuses on the institutional dynamics of a democracy attempting to deal with a difficult problem. Even if a case could be made out for a liberty interest and physician-assisted suicide qualified as fundamental under the Due Process Clause, the bans could still be upheld on the grounds of the state's paramount interests. "The Court should reach this conclusion partly because of appropriate judicial modesty in the

263. *See id.* at 220.

264. *See id.* at 221-22. For a more elaborate "calculus" on whether the state should allow certain individuals to commit suicide, see TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 67-119 (3d ed. 1989).

265. *See* Cass R. Sunstein, *The Right to Die,* 106 YALE L. J. 1123 (1997).

face of difficult underlying questions of value and fact; it should emphasize these institutional concerns in explaining its conclusion."[266] The gist of Sunstein's essay is that the courts should not short-circuit the democratic process. The question of physician-assisted suicide was not languishing due to popular indifference; to the contrary, intense discussion was occurring in the states, and, in at least three states, the issue had been put to a popular referendum. Moreover, many cases involving so-called fundamental rights, including the cases on privacy and equal protection, "are best seen not as flat declarations that the state interest was inadequate to justify the state's intrusion, but more narrowly as democracy-forcing outcomes designed to overcome problems of discrimination and desuetude."[267] That situation did not exist here.

In fact, there were practically no law review articles praising the circuit court decisions.[268] Everyone expected the issue to go up to the Supreme Court, and given the reluctance of the Rehnquist Court to expand rights under either Due Process or Equal Protection, hardly anyone expected the appeals courts' decisions to survive. Moreover, even if one agreed with the notion that terminally ill patients ought to be able to end their lives, this did not mean that such a right existed or that it could be found in the Constitution.

Shortly after the Supreme Court had accepted the Washington and New York cases for review, Yale Professor Stephen L. Carter published an article in *The New York Times Magazine* urging the courts not to, as he put it, "rush to lethal judgment."[269] Carter sees the controversy over assisted suicide primarily as a moral debate and feels that "[e]xcept in emergencies, a court decision is the worst way to resolve a moral dilemma."[270] If the courts decided this question, it would preempt a moral debate that was just beginning; the courts should stay out of the issue and let the questions "be answered through

266. *Id.* at 1124.

267. *Id.*

268. For the lone voice in support of the decisions, see Tom L. Beauchamp, *The Justification of Physician-Assisted Deaths*, 29 IND. L. REV. 1173 (1996).

269. Stephen L. Carter, *Rush to Lethal Judgment*, N.Y. TIMES MAG., July 21, 1996, at 28.

270. *Id.* at 29.

popular debate and perhaps legislation, not through legal briefs and litigation."[271]

Carter believes that the judiciary had become involved too early and that there had not yet been a significant, popular debate on the question. I would suggest, however, that by the time the courts of appeal heard these cases, popular debate had been going on for a number of years. Public opinion polls, popular referenda, books, articles in lay and scholarly journals and discussions on talk shows have made the question one that many Americans have thought about. The debate is far from over, but given the fact that, as de Tocqueville noted many years ago, "scarcely any political question arises in the United States that is not resolved, sooner or later, into a judicial question,"[272] it is neither surprising nor disturbing that assisted suicide has wound its way through the judicial labyrinth to the marble palace.

B

In recent years, the Supreme Court has been fairly stingy in granting certiorari. Regarding assisted suicide, two circuits disagreed on the rationale for their findings, and not on whether a right to physician-assisted suicide existed. Nonetheless, the Court granted certiorari to both cases at the beginning of the October 1996 Term.[273]

The Court scheduled oral arguments on January 8, 1997, and, well before dawn, protesters and people seeking tickets to hear the arguments gathered on the steps of the marble palace. Diane Coleman, the founder of a group called Not Dead Yet, showed up in her wheelchair to protest the whole notion of physician-assisted suicide, while members of the Hemlock Society, which supports voluntary euthanasia, carried their banner nearby.[274] Bob Castagna, the executive director of the Oregon Catholic Conference, asked "[w]ill nature take its course, or will

271. *Id.*

272. ALEXIS DE TOCQUEVILLE, 1 DEMOCRACY IN AMERICA 290 (Phillips Bradley ed., 1945).

273. *See* Washington v. Glucksberg, 117 S. Ct. 2302 (1996); Vacco v. Quill, 117 S. Ct. 2293 (1996).

274. *See* Laura Blumenfeld, *At Dawn, Activists Greet Matters of Death in Shades of Gray*, WASH. POST, Jan. 9, 1997, at A1.

we turn doctors into angels of death?"[275] Many of those in line had more complex responses to reporters' questions. Doris Kuehn's father had been a strong right-to-die proponent, and he had lost a lung and seven ribs because of tuberculosis. "I'm more pro than con," he said, "but you can't pin it down. Does it have to be severe pain, or is it just a feeling that I want to die? I know there are gray areas."[276]

At ten o'clock, the marshal called out the traditional "Oyez, oyez," and the nine Justices filed in through the curtain to take their seats. Chief Justice Rehnquist called on Senior Assistant Attorney General for the State of Washington, William L. Williams, to defend the Washington statute. Williams declared,

> We are here today representing the people of the State of Washington to defend their legislative policy judgment to prohibit assisted suicide. . . . The issue here today is whether the Constitution requires that the social policy developed by Washington voters must be supplanted by a far different social policy, a constitutionally recognized right to physician-assisted suicide that is contrary to our traditions . . . .[277]

Justice Ruth Bader Ginsburg began the questioning by noting that the Court's ruling in *Cruzan* recognized a liberty interest even while acknowledging the right of the state to regulate it. Why could not the Court do the same thing in this case—recognize a liberty interest and then give the states leeway to regulate it? Williams responded that recognizing a liberty interest would greatly limit the states' ability to regulate the problem. If the Court, however, did find a liberty interest, he believed the states' interests here were as strong as those the Court had recognized in *Cruzan*.

Justice Sandra Day O'Connor wanted to know what the state's interests would be if the Court decided to recognize a

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275. *Id.*

276. *Id.*

277. *Excerpts from the Supreme Court Arguments on Physician-Assisted Suicide*, WASH. POST, Jan. 9, 1997, at A16 (alterations in original) [hereinafter *Excerpts*]. For a discussion of oral arguments, see also *Arguments Before the Court*, 65 U.S.L.W. 3481 (Jan. 14, 1997); Linda Greenhouse, *High Court Hears 2 Cases Involving Assisted Suicide*, N.Y. TIMES, Jan. 9, 1997, at A1.

liberty interest in assisted suicide. Williams responded that the states were beginning to reassess where a line should be drawn, but that clearly the highest priority remained preserving life and preventing suicide; other important interests included prevention of abuse and undue influence, as well as regulation of the medical profession to protect patients.[278]

The Chief Justice asked whether "it would be very difficult to assume a liberty interest and rule in your favor in this case, would it not? Because if we assume a liberty interest but nonetheless say that, even assuming a liberty interest, a state can prohibit it entirely, that would be rather a conundrum."[279]

Williams disagreed, trying to argue that the states' interests here were similar to those in *Cruzan*, but Chief Justice Rehnquist cut him off. In *Cruzan,* the Court had dealt only with an evidentiary rule; here, Washington wanted an outright prohibition.

Williams got no further than saying, "That's correct," when Justice Antonin Scalia broke in. Declaring a liberty interest would be cost-free, he wanted to know if Williams immediately could say it would be outweighed by the various social policies adopted by the states. Williams conceded that, but noted that in *Oregon Employment Security Division v. Smith*,[280] the Court had supported an absolute ban on the use of peyote in the face of an even stronger individual interest—the First Amendment right to free exercise of religion.[281]

The state contended that allowing assisted suicide to the terminally ill who wanted to end their lives raised the risk that the practice would expand to include those who did not want to hasten their deaths, as well as to those who were not terminally ill. Justice David Souter asked a number of questions, wanting to know how realistic those fears were. "It's a plausible argument," he declared, "but how realistic is it? What method should I use [in evaluating the risk]? What basis is there to evaluate the claim that slippage will occur?"[282]

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278. *See Excerpts, supra* note 277, at A16.
279. *Id.*
280. 494 U.S. 872 (1990).
281. See *Excerpts, supra* note 277, at A16.
282. *Arguments Before the Court*, 65 U.S.L.W. 3481 (Jan. 14, 1997) [hereinafter

Williams conceded that no empirical evidence existed in the American experience to assess the risk, but studies of the Netherlands indicated that acceptance of physician-assisted suicide had led to instances of involuntary euthanasia. Moreover, while proponents here claimed they wanted physician-assisted suicide in only a narrow class, he feared that if they won these cases the next time around they would seek assisted suicide for a broader range of people and not just for the terminally ill.[283]

Justice John Paul Stevens wanted to know whether states had the legislative authority to approve assisted suicide, and Williams agreed that they did. In response to a similar question on state power from Justice Anthony Kennedy, Williams noted that "if you accept a rational basis level of review, states have the maximum flexibility to decide [the issue] on a state-by-state basis."[284]

Where did one draw the line in actual practice, Justice Stevens asked. He knew of no instances where a doctor had been convicted for giving assistance in a suicide. Williams admitted he, too, knew of no convictions. "But . . . if one assumes that there is a covert practice going on under current law and [as] the line gets muddier, the potential for abuse is much worse."[285]

Williams then surrendered the balance of his time to Acting United States Solicitor General Walter Dellinger, since the United States had filed an amicus brief on behalf of the states. Justice O'Connor immediately asked him how one could reconcile the government's position that a liberty interest existed but that the Washington state law should be upheld.

Dellinger responded that the interest involved was not a liberty interest in dying, but in avoiding severe pain for which state law prevented certain patients from obtaining relief. While important, this did not rise to the level of a fundamental liberty interest such as the Court had found in *Cruzan*; namely, that the state cannot compel a person to continue unwanted medical treatment. "If the state is the only thing standing be-

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Arguments].

283. *Id.*

284. *Id.* (alterations in original).

285. *Id.* at 3482.

tween you and pain relief," Dellinger said, "we think the person has a cognizable interest."[286] But while "the individual stories [in appellants' briefs] are heartrending, . . . it's important for this court to recognize that, if you were to affirm the judgments below, lethal medication could be proposed as a treatment, not just to those in severe pain, but to every competent terminally ill person . . . in the country."[287]

Justice Scalia then asserted that Dellinger's response had nothing to do with suicide, nor with prohibitions against it. "[W]hat's critical," Dellinger argued, "is . . . if you affirm the judgments below, lethal medications could be prescribed as treatment for anyone."[288]

"Now or ever," Justice Ginsburg interjected, "the case raises the basic issue of who decides. Is it ever a proper question for courts as opposed to the legislature to decide?"[289]

Before Dellinger could answer, Justice Souter suggested that "[m]aybe the Court should wait until it can know more [about the actual risks]."[290]

Some studies exist, Dellinger answered, which show it is possible to set up safeguards, "but the reality is that they can't be met all the time."[291] In an ominous final comment, he noted that in a health care system attempting to treat pain and depression, lethal medication is the least costly treatment.[292]

Kathryn L. Tucker of Seattle then rose to argue on behalf of the doctors and patients who had brought the suit. For her clients, the basic issue in the case was whether patients on the threshold of death have a right to choose to end their lives with dignity.

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286. *Id.*
287. *See Excerpts, supra* note 277, at A16.
288. *Arguments, supra* note 282, at 3482.
289. *Id.*
290. *Id.*
291. *Id.*
292. *See id.*

Before she could go any further, Justice Scalia wanted to know why she would limit the right to such a small group, those "on the threshold," and why not to other patients, some of whom may be in pain for years.[293]

Tucker responded that the only group for whom time is a critical element are those on the threshold, whose only real remaining choice is the manner of their imminent death. This is a relatively easy determination for a doctor to make. A person who still has potential for a fruitful life is not on that threshold; he or she has other choices.[294]

Justice Ginsburg wanted to know how Tucker would deal with a person on the threshold of death whose pain was so severe that she could not herself administer the lethal drug, but would need a doctor's help.

Here, Tucker avoided a direct answer, because she knew that the medical associations who opposed physician-assisted suicide had hammered on the notion that doctors were supposed to save lives, not become executioners. She conceded that the state could impose a requirement of self-administration to ensure voluntariness, which she termed essential. The state could even impose a waiting period to ensure that the patient is making a reasoned decision. "We want the Court to find a protected right," she said, but also to allow experimentation on the state level.[295]

Justices Rehnquist and Scalia then wanted Tucker to explain the difference between a liberty interest in refusing or withdrawing treatment and an interest in assisted suicide. In *Cruzan*, according to the Chief Justice, the Court had affirmed the right to refuse treatment which merely carried on a right long embedded in common law. Rejecting treatment, Justice Scalia interjected, is not the same as suicide. "Why can't society decide as a matter of public morality that it's wrong to kill yourself," just as it is wrong to kill another person?[296]

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293. *Id.*
294. *See id.*
295. *Id.*
296. *Id.*

Here, Tucker had a ready answer; namely, assisted suicide in the circumstances of a terminally ill patient involves a very personal decision. It deals with one's own body and health care, not that of another person. The state may have a stronger interest in preserving life early on in the course of a person's illness, when that person still has a chance for a fruitful life. The state's interest, however, grows weaker as the person nears death, and it practically disappears when a person's only choice is how to die—not whether to live or die. Moreover, the state is inconsistent when it allows a person to make that choice in other circumstances, such as through advance directives.[297]

As her time wound down, Tucker faced one final question from Justice O'Connor about the ability of a person to refuse life-sustaining treatment, such as kidney dialysis. When Tucker responded that the state could intervene if that person had suicidal tendencies, Justice Scalia commented that Tucker's position would have to be broader than that if she truly wants to leave decisions to individuals.[298]

It took only a few minutes for the attorneys from the Washington case to leave the counsel tables and for those who would argue the New York case to take their place. The clerk then called case number 95-1858, Dennis C. Vacco, Attorney General of New York, et al. v. Timothy E. Quill et al. Chief Justice Rehnquist invited Vacco to step up to the podium and begin.[299]

Vacco began by asserting that the New York law did not implicate any equal protection analysis because persons who decline medical treatment are not similarly situated to those who seek assistance in suicide.[300] The key difference is that, in withdrawal from treatment, death comes because of the underlying illness or condition; in suicide, death comes from a deliberately administered lethal drug.

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297. *See id.*

298. *See id.*

299. For an article about Vacco, see Dan Barry, *New York's Chief Lawyer Argues Suicide Case*, N.Y. TIMES, Jan. 9, 1997, at B9. The Attorney General of Washington, Christine O. Gregoire, was in the courtroom, but had chosen to let one of her staff members argue the case because Williams had spent years working on assisted suicide and related issues.

300. *See Arguments*, *supra* note 282, at 3482.

The legislature could draw the line where it wanted and, in fact, could permit assisted suicide. "[W]e're here today to say [that the legislature] shouldn't be constitutionally compelled [to do so]."[301] The legislature had decided, through the law currently in effect, that allowing physician-assisted suicide could lead to euthanasia, a policy it did not want.[302]

Justice Stevens asked Vacco whether the state could totally forbid the right to refuse treatment. "We'd be back here," Vacco responded. He did not believe a legislature could constitutionally forbid a dying person from refusing treatment.[303]

Justice Scalia then wanted to know whether a state could authorize force-feeding for a person refusing treatment if that person was not at death's door. "Why limit the discretion of the legislature?"[304] He also noted the not uncommon practice of force-feeding a person who has gone on a hunger strike.

Vacco said he thought there was a big difference between force-feeding a person and violation of a person's bodily integrity through medication. This led the Chief Justice to note that "[i]t seems odd that bodily integrity is not violated by sticking a spoon in your mouth but is by a needle in the arm."[305]

It all depends, Vacco responded, on whether a person's intent is suicidal. While it was true that suicide was no longer a crime in New York, barriers to it still existed. The state-erected barriers were rational, and had the legitimate purpose of preventing abuse.[306]

Justice Ginsburg asked the Attorney General to explain why he thought the Second Circuit had erred.[307] He responded that the basic error lay in the lower court equating people on life-support who wished to terminate that treatment and people not on life-support who wished to end their lives. These two groups are not similarly situated, and therefore an equal protection analysis did not apply. But, Justice Ginsburg continued, the

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301. *Id.*
302. *See id.*
303. *See id.*
304. *Id.*
305. *Id.*
306. *See id.*
307. *See id.* at 3483.

results are the same; one turns off a machine and one dies, or one takes a pill and one dies. The Attorney General insisted, however, that there is a difference. "It's rationally distinguishable because it is consistent medical practice. . . . Providing drugs specifically and solely for the purpose of killing someone has never been embraced by the medical profession."[308]

Next, Justice Souter engaged in a fairly lengthy exchange with Vacco over the difference in giving medication for pain relief that might, incidentally, lead to death, and giving the same medication for the express purpose of causing death. To justify this distinction, Justice Souter noted, one had to differentiate between people on life-support, who had a right to end treatment and therefore could be overmedicated to alleviate pain, and those not on life-support. Isn't the line one of abuse?[309]

Vacco agreed. "The principal . . . justification indeed, one of the most compelling reasons, state interest, is the risk of abuse."[310] While there was also a risk of abuse in the treatment of patients going off life-support, the state believed that the risk of abuse is far greater for the terminally ill not on life-support.[311]

Acting Solicitor General Dellinger then returned to the lectern and, in a nutshell, summarized the essence of the Second Circuit's argument: "if the state may, as a general matter, legitimately prohibit the granting of lethal medication, the fact that these state[s] permit practices that are in the respondents' view medically, ethically, and morally indistinguishable from lethal medication requires that these states also do that."[312] Dellinger said that the United States disagreed with that view and, like Vacco, believed a common-sense distinction could be drawn between the two groups. "The historic distinction between killing someone and letting them die is so powerful that we believe that it fully suffices here."[313]

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308. *Excerpts, supra* note 277, at A16.
309. *See id.*
310. *Id.*
311. *See id.*
312. *Id.*
313. *Id.*

Justice Ginsburg asked the Solicitor General if he could deal with what she termed the "winks and nods" argument, that the issue was a great sham because doctors had historically provided suicide assistance for "anybody who is sophisticated enough to want it."[314] Dellinger denied that any evidentiary practice existed to support this claim.[315]

When Harvard Law School Professor Laurence H. Tribe rose to support the case for physician-assisted suicide, he immediately attacked as a "fantasy" the notion that "at the end you're either in this closed class of people who luckily have a plug that can be pulled, or you're in some other group."[316] When Justice Kennedy said there was a historic common law distinction, Tribe tried to pull the Justices into the real world. "None of these patients is in a state of nature. They're in a hospital or a hospice."[317] The state certainly has a right to characterize certain actions as suicide, but "the government's characterizations can't control the constitutional analysis."[318]

Tribe took what appears, on paper at least, to be a fairly belligerent stance. The difference between patients on life-support and other terminally ill patients was a fantasy. He agreed that the states could differ in how they wanted to deal with the problem, that they could, in Justice Brandeis's words, be laboratories for experimentation.[319] But "these laboratories . . . are

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314. There is nothing new about the desire of terminally ill patients to end their suffering by hastening death. Developments in modern health care have simply brought into the open a previously private practice that society has long condoned. Until the early part of this century, patients suffering from incurable conditions overwhelmingly died at home due to the limitations of the health care system. Their deaths were frequently eased by the ministrations of alcohol and opiates. . . . [T]his gentle quitting of a life ravaged by terminal disease became dependent on the aid of compassionate physicians. The evidence shows that, despite the strictures of the criminal law, many physicians have long been willing to provide such assistance . . . .

Brief Amicus Curiae for American Civil Liberties Union on its Behalf and on Those of Other Groups, *available in* 1996 WL 711194 at *27-28 (citing Julia Pugliese, *Note: Don't Ask—Don't Tell: The Secret Practice of Physician-Assisted Suicide,* 44 HASTINGS L.J. 1290, 1297-99 (1993)).

315. *See Excerpts, supra* note 277, at A16.

316. *Id.*

317. *Id.*

318. *Id.*

319. *See* New State Ice Co. v. Liebmann, 285 U.S. 262, 280, 311 (1932) (Brandeis,

now operating largely with the lights out. They're operating with the lights out because it's not just New York."[320] The reason was because they had combined two principles and in doing so the whole logic of opposition to physician-assisted suicide collapsed.

One principle provides that you can medicate to reduce pain, even if you know it will hasten death—providing that death is "not your real intent."[321] The other principle is the right of a patient to refuse treatment or have treatment terminated. The result is over-medication allegedly to kill pain but that in reality is designed to hasten death. This "terminal sedation," as he called it, "is overwhelmingly documented everywhere in the country, it's not some sneaky practice."[322]

Tribe also gave what may have been the best definition of the claimed liberty interest in response to a question from Justice Stevens.

> [T]he liberty interest in this case is the liberty, when facing imminent and inevitable death, not to be forced by the government to endure a degree of pain and suffering that one can relieve only by being completely unconscious. Not to be forced into that choice, that the liberty is the freedom, at this threshold at the end-of-life, not to be a creature of the state but to have some voice in the question of how much pain one is really going through.[323]

C

The Justices handed down their decisions in the two cases on June 26, 1997, at the very end of the term. Their finding, that the Constitution did not provide a right to physician-assisted suicide, did not surprise anyone, although the fact that the holding was unanimous raised a few eyebrows.[324] The three

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J., dissenting).

320. Transcript of Oral Arguments, Vacco v. Quill, 117 S. Ct. 2293 (1997) (No. 95-1858), *available in* 1997 WL 13672, at *43-44.

321. *Id.* at *44.

322. *Id.* at *44.

323. *Id.* at *55-56.

324. In both cases, Justices O'Connor, Scalia, Kennedy and Thomas joined the Chief Justice's opinions for the Court; Justice Scalia's vote came as a surprise to no one, since he had earlier publicly announced that he saw no constitutional "right to

Justices in *Cruzan,* however, who would have found a stronger liberty interest—Justices Brennan, Marshall and Blackmun—had left the bench, and the centrists who had taken their place shared the view that the Court had to be careful in finding new rights. As in *Cruzan*, Chief Justice Rehnquist delivered the Court's opinions.

In *Washington v. Glucksberg*,[325] the Court rejected the Ninth Circuit's claim that physician assisted suicide constituted a fundamental liberty interest protected by the Due Process Clause. Chief Justice Rehnquist began, "as we do in all due-process cases, by examining our Nation's history, legal traditions, and practices."[326] The history and tradition yielded no support that assistance in suicide has ever been considered a personal right, and "for over 700 years, the Anglo-American common-law tradition has punished or otherwise disapproved of both suicide and assisting suicide."[327] Although, in recent years, there had been a trend away from the common law's harsh sanctions, this reflected not an acceptance of suicide, but rather a belief that the suicide's family should not be punished for his wrongdoing. As for assisting suicide, the various states have, in recent years, re-examined and generally reaffirmed the ban.

But now, individuals die primarily in institutions such as hospitals and nursing homes, and "[p]ublic concern and democratic action are therefore sharply focused on how best to protect dignity and independence at the end of life, with the result that there have been many significant changes in state laws and the attitudes these laws reflect."[328] Nonetheless, "[d]espite changes in medical technology and notwithstanding an increased emphasis on the importance of end-of-life decision making, we have not retreated from this prohibition [on assisted suicide]."[329] Having recited this historical antipathy toward

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die." Justice O'Connor filed a concurring opinion, in which Justices Ginsburg and Breyer joined in part; Justices Stevens, Souter, Ginsburg and Breyer each filed a concurring opinion. The concurrences are treated *infra,* notes 363-407, following the exposition of the majority opinions in both cases.

325. 117 S. Ct. 2258 (1997).

326. *Id.* at 2263.

327. *Id.*

328. *Id.* at 2265-66.

329. *Id.* at 2267.

assisted suicide, the Chief Justice turned to the constitutional claims.

Chief Justice Rehnquist began by agreeing that "[t]he Due Process Clause protects more than fair process, and the 'liberty' it protects includes more than the absence of physical restraint."[330] The Chief Justice listed a long line of cases in which the Court had found fundamental rights and interests but stated "we 'ha[ve] always been reluctant to expand the concept of substantive due process because guideposts for responsible decision making in this unchartered area are scarce and open-ended.'"[331] The Court's established due process analysis involves determining whether the claimed liberty interest is "'deeply rooted in this Nation's history and tradition,'"[332] and whether there is a "'careful description'" of the asserted liberty interest.[333]

Did the asserted interest in assisted suicide have any place in the Nation's traditions? The answer could only be in the negative. "To hold for respondents, we would have to reverse centuries of legal doctrine and practice, and strike down the considered policy choice of almost every State."[334]

In the second part of the analysis, the need for "careful description," the Court also rejected the respondents' claim that the liberty interest in assisted suicide was consistent with the Court's long line of due process decisions enumerating rights protected under the Fourteenth Amendment. Here, the Chief Justice went to great pains to declare what the Court had said and had not said in the two cases relied upon in the Ninth Circuit, *Casey* and *Cruzan*.

In the latter case, the Court, indeed, held that a right existed to terminate life-sustaining equipment, but it also upheld the state's right to require clear and convincing evidence that this was the patient's wish, especially in the case of an incompetent. In doing so, Chief Justice Rehnquist noted, the Court did not deduce a right "from abstract concepts of personal autono-

330. *Id.* (citing Collins v. Harker Heights, 503 U.S. 115, 125 (1992)).
331. *Id.* (quoting *Collins*, 503 U.S. at 125).
332. *Id.* at 2268 (quoting Moore v. East Cleveland, 431 U.S. 494, 503 (1977)).
333. *Id.* (quoting Reno v. Flores, 507 U.S. 292, 302 (1993)).
334. *Id.* at 2269 (citing Jackman v. Rosenbaum Co., 260 U.S. 22 (1922)).

my."[335] Rather, there existed a long common law tradition that treated forced medication as a battery as well as upheld a person's right to refuse unwanted medical treatment. That was the extent of the court's analysis with regard to *Cruzan* and it "certainly gave no intimation that the right to refuse unwanted medical treatment could be somehow transmuted into a right to assistance in committing suicide."[336]

In *Casey*, the Court had concluded that "the essential holding of *Roe v. Wade* should be retained and once again reaffirmed."[337] The case dealt with abortion, but it did note that many of the rights and liberties subsumed under due process "'involv[e] the most intimate and personal choices a person may make in a lifetime.'"[338] The lower courts, however, had gone too far and had read this phrase to mean far more than the Court had intended. The Court had summed up rights it had already found, and had not issued a formula for identifying new rights. "That many of the rights and liberties protected by the Due Process Clause sound in personal autonomy does not warrant the sweeping conclusion that any and all important, intimate, and personal decisions are so protected."[339]

Chief Justice Rehnquist then went into an extended analysis of the state's interest in preventing suicide and found all of them convincing—preservation of human life,[340] protecting the integrity of the medical profession,[341] protecting vulnerable groups such as the poor and the elderly,[342] and fear of a slippery slope, that permitting assisted suicide will lead to voluntary and perhaps even involuntary euthanasia.[343] In the Court's opinion, all of these interests are legitimate, and "Washington's ban on assisted suicide is at least reasonably related to their promotion and protection."[344]

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335. *Id.* at 2270.
336. *Id.*
337. *Id.* (citing Planned Parenthood v. Casey, 505 U.S. 833, 846 (1992)).
338. *Id.* (quoting *Casey*, 505 U.S. at 851) (alteration in original).
339. *Id.* at 2271.
340. *See id.* at 2272-75.
341. *See id.* at 2273.
342. *See id.* at 2273-74.
343. *See id.* at 2274-75.
344. *Id.* at 2275.

In conclusion, the Court reversed the en banc decision of the court of appeals, but the Chief Justice noted that "[t]hroughout the Nation, Americans are engaged in an earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a democratic society."[345] Despite the fact that states had traditionally opposed assisted suicide, nothing in the Court's opinion was intended to foreclose them from changing their minds. The decision followed almost precisely the prescription that Professor Sunstein had endorsed, an opinion that did not constitutionalize a right to assisted suicide, did not foreclose that as an option for the states, and did not silence the democratic dialogue.[346]

D

In the companion case of *Vacco v. Quill*,[347] Chief Justice Rehnquist took less than seven pages to overturn the Second Circuit, in part because he did not find it necessary to reiterate his lengthy historical analysis from the *Glucksberg* opinion. He began by noting that, facially, New York's ban on assisted suicide and its statutes permitting patients to refuse life-sustaining treatment do not "treat anyone differently than anyone else or draw any distinctions between persons. *Everyone*, regardless of physical condition, is entitled, if competent, to refuse unwanted lifesaving medical treatment; *no one* is permitted to assist a suicide."[348] In general, according to the Chief Justice, "laws that apply evenhandedly to all 'unquestionably comply' with the Equal Protection Clause."[349]

The Second Circuit had based its opinion on the conclusion that people who refused physician-assisted suicide stood in the same position as those on life-sustaining equipment, and the state, by allowing one group to hasten death yet denying this to the other, thus violated the strictures of the Equal Protection

345. *Id.*
346. *See* Sunstein, *supra* note 265.
347. 117 S. Ct. 2293 (1997).
348. *Id.* at 2297-98 (emphasis in original).
349. *Id.* at 2298 (citing New York City Transit Auth. v. Beazer, 440 U.S. 568, 587 (1979)).

Clause. The Supreme Court, however, disagreed completely with this analysis. "Unlike the Court of Appeals, we think the distinction between assisting suicide and withdrawing life-sustaining treatment, a distinction widely recognized and endorsed in the medical profession and in our legal traditions, is both important and logical; it is certainly rational."[350]

The Court found legal justification in the "fundamental legal principles of causation and intent."[351] If a patient declines treatment, he dies from the underlying cause; if he takes a lethal dosage of a drug, he is killed by that action. As to the purported claim that there is no difference between a doctor honoring a patient's wishes to have treatment terminated and giving a patient a lethal overdose, the Court found that, in the former instance, the physician is respecting his patient's request and "cease[s] doing useless and futile or degrading things to the patient when [the patient] no longer stands to benefit from them."[352] Even when a patient dies from "aggressive palliative care," the intent of the doctor is to alleviate the pain, not to kill the patient. However, the physician who assists a suicide "must, necessarily and indubitably, intend primarily that the patient be made dead."[353]

The Chief Justice did not think this distinction a difficult one, and, in fact, a number of state courts had clearly distinguished one from the other.[354] Looking to the most famous of the lower court assisted-suicide cases, that of Dr. Jack Kevorkian, Chief Justice Rehnquist noted that the "Michigan Supreme Court also rejected the argument that the distinction 'between acts that artificially sustain life and acts that artificially curtail life' is merely a 'distinction without constitutional significance—a meaningless exercise in semantic gymnastics,' insisting that 'the *Cruzan* majority disagreed and so do we.'"[355] Similarly, state legislatures had no difficulty under-

350. *Id.* (citation omitted).

351. *Id.*

352. *Id.* (citing *Assisted Suicide in the United States: Hearing Before the Subcomm. on the Constitution of the House Comm. on the Judiciary*, 104th Cong., 368 (1996) (testimony of Dr. Leon R. Kass) [hereinafter *Hearing*]).

353. *Id.* at 2299 (quoting *Hearing, supra* note 352, at 367).

354. *See id.* at 2299 n.8 (listing several supporting cases).

355. *Id.* at 2299 (citing People v. Kevorkian, 527 N.W.2d 714, 728 (Mich. 1994)).

standing the difference and had written that distinction into law.[356]

Contrary to claims of the petitioners, New York had not written an irrational or idiosyncratic bias into its law; rather, the legislature had deliberated prudently, held numerous hearings and mandated studies. The legislature had carefully delineated patients' rights while defining the interests of the state and, in doing so, had reaffirmed what it saw as a clear line between "letting die" and "killing." In this, the Court's ruling in *Cruzan* had been misinterpreted below, since in that case the majority had "recognized, at least implicitly, the distinction between letting a patient die and making that patient die."[357] *Cruzan*, the Chief Justice emphasized, "provides no support for the notion that refusing life-sustaining medical treatment is 'nothing more nor less than suicide.'"[358]

Since logic and practice supported New York's judgment that a clear and important distinction existed between allowing a patient to die and making that patient die, the state could treat these two groups of patients differently without violating the Constitution. In conclusion, the Chief Justice reiterated what he saw as the important state interests—prohibiting intentional killing; preserving life; protecting the role of physician as healer; sheltering vulnerable people from abuse, prejudice, and financial pressure to end their lives; and "avoiding a possible slide towards euthanasia"—all discussed in *Glucksburg*.[359] "These valid and important public interests easily satisfy the constitutional requirement that a legislative classification bear a rational relation to some legitimate end."[360]

E

We turn now to the various concurring opinions which, in many ways, are more interesting and nuanced than the straightforward approach of the majority decisions. In reversing the Ninth Circuit's finding of a liberty interest in *Glucksberg*,

356. *See id.* at 2300 n.9 (listing the relevant parts of forty-eight state codes as well as that of the District of Columbia and some of the island territories).
357. *Id. at* 2301.
358. *Id.*
359. *Id.* at 2302.
360. *Id.*

Chief Justice Rehnquist appealed to history to show that suicide had always been disfavored, and that even after the states repealed their laws criminalizing self-murder, they kept those laws on the books prohibiting assistance in suicide. Neither history nor contemporary developments had ever created a liberty interest that demanded the state permit physician-assisted suicide, and the Ninth Circuit had totally misread the key cases of *Casey* and *Cruzan* in reaching its decision.[361] In *Vacco,* the majority had denied that the Equal Protection Clause demanded that states treat terminally ill patients the same as those on life-support systems; it emphatically rejected the idea that allowing the latter to die was the same as helping the former to their deaths.[362] The only hope that advocates of assisted suicide could draw from the majority opinions was that the Court had not barred a state from permitting physician-assisted suicide.

Justice David Souter wrote an eighteen page concurrence in *Glucksberg*, in which he carefully explored the history of substantive due process, from its beginnings in the early days of the Republic to its repudiation after its abuse by conservatives attacking economic regulation.[363] However, Justice Souter also noted that substantive due process had been used to defend individual liberties as well as property rights; here, he clearly considered Justice John Marshall Harlan's dissent in *Poe v. Allman*[364] the most important statement of the type of rights subsumed within due process. Justice Souter found three elements of that opinion necessary to any analysis of Fourteenth Amendment liberty interests. First, he noted Harlan's "respect for the tradition of substantive due process review," and the necessity for the courts to undertake that review.[365] "For two centuries American courts, and for much of that time this Court, have thought it necessary to provide some degree of review over the substantive content of legislation under constitutional standards of textual breadth."[366] Justice Harlan saw

361. *See supra* notes 171-223 and accompanying text.

362. *See supra* notes 253-59 and accompanying text.

363. *See* Washington v. Glucksberg, 117 S. Ct. 2258, 2275, 2277-81 (1997) (Souter, J., concurring).

364. 367 U.S. 497 (1961).

365. *Glucksburg*, 117 S. Ct. at 2280 (Souter, J., concurring).

366. *Id.*

due process as far more than procedural correctness. "Were due process merely a procedural safeguard it would fail to reach those situations where the deprivation of life, liberty or property was accomplished by legislation which by operating in the future could, given the fairest possible procedure in application to individuals, nevertheless destroy the enjoyment of all three."[367] Therefore, Justice Souter concluded, the very text of the Due Process Clause imposes on the courts "nothing less than an obligation to give substantive content to the words 'liberty' and 'due process of law.'"[368]

Justice Harlan's second point in *Poe* reminded the Court that the purpose of such review "is not the identification of extratextual absolutes but scrutiny of a legislative resolution (perhaps unconscious) of clashing principles, each quite possibly worthy in and of itself, but each to be weighed within the history of our values as a people."[369] The courts weigh the strengths of opposing claims and do not substitute their judgment based on what Justices see as first premises. Thus, even if the judges personally prefer one form of resolution over another, they cannot substitute their judgment for that of the legislature, unless that body has exceeded clear constitutional parameters. This leads to Harlan's third point, the necessity to pay attention to detail as an element no less essential than understanding the positions of the competing sides or recognizing the extent of legislative judgment.

Justice Souter went into this extended buildup, I believe, because he found the majority opinion devoid of compassion or awareness of the claims of terminally ill patients. The majority had said there was no historic basis for recognizing assisted suicide as a liberty interest, and therefore no liberty interest existed. Justice Souter understood that due process had been used in the past to create or at least to recognize hitherto latent rights.[370] While not ready to create a right to assisted suicide, he wanted to acknowledge that even if the legislature was well within its powers to make the choice it did, and even

367. *Id.* at 2281 (citing *Poe*, 367 U.S. at 541).
368. *Id.*
369. *Id.*
370. *See id.* at 2280-81 (listing examples of such rights).

if judicial deference required the courts to respect that decision, those seeking the right also had a claim that the courts needed to hear even if they did not agree with it. Justice Souter also implied that the majority had been far too rigid in its analysis, and he quoted from both Justice Harlan and Justice Lewis Powell that appropriate review of substantive due process claims comes not from drawing arbitrary lines, but from understanding the historic bases of those claims as well as the recognition of shared social values.[371]

Courts, according to Justice Souter, had "to assess the relative 'weights' or dignities of the contending interests, and to this extent the judicial method is familiar to the common law."[372] In doing so, however, courts had to be careful to confine any liberty interests they recognized to those that truly deserved constitutional stature, those "so rooted in the traditions and conscience of our people as to be ranked as fundamental."[373] Courts also had to remember that their business involved constitutional review, not judicial lawmaking. Thus, judges had to review the competing claims carefully and with great attention to detail, but they had no right to substitute their preferences for those of the legislative branch. Justice Harlan had set clear standards for courts to follow in due process review, a path that, on the one hand, avoids the arbitrariness of absolutes and, on the other, stands firm against making simple reasonableness a standard for declaring rights.

With these standards in mind, Justice Souter turned to the question before the Court. Unlike the majority, Justice Souter framed the question in very limited terms. "[H]ere we are faced with an individual claim not to a right on the part of just anyone to help anyone else commit suicide under any circumstances, but to the right of a narrow class to help others also in a narrow class under a set of limited circumstances."[374] To this claim the state responded "that rights of such narrow scope

371. *See id. at* 2282 (citing Justice Harlan in *Poe*, 367 U.S. at 542, and Justice Powell in *Moore v. City of East Cleveland*, 431 U.S. 494, 503 (1977)).

372. *Id.* at 2283.

373. *Id.* (citing Palko v. Connecticut, 302 U.S. 319, 325 (1937)).

374. *Id.* at 2286.

cannot be recognized without jeopardy to individuals whom the State may concededly protect through its regulations."[375]

Justice Souter's analysis of the patient and doctor claim showed far greater sensitivity to nuance than did the majority opinion. The respondents did not base their claim on history but, in fact, acknowledged that, historically, there had been prohibitions. The lesson of history was not that suicide had at one time been considered a criminal act, but rather that it had long since been decriminalized. Justice Souter, however, refused to follow the respondents' argument that this opened the door to requiring the decriminalization of assisting in suicide. The reasons for decriminalization may have had far more to do with the practical ability of the state to prevent such acts than any change in popular moral views. "Thus it may indeed make sense for the State to take its hands off suicide as such, while continuing to prohibit the sort of assistance that would make its commission easier."[376] Decriminalization, by itself, did not imply the existence of any constitutional right or liberty interest.

Both the Ninth Circuit and the respondents had made much of the Court's analysis of bodily autonomy in *Casey*, and Justice Souter acknowledged that analogies existed between the abortion cases and those dealing with assisted suicide—most importantly, the need for a doctor in both instances. Without a doctor's assistance in abortion, "the woman's right would have too often amounted to nothing more than a right to self-mutilation, and without a physician to assist in the suicide of the dying, the patient's right will often be confined to crude methods of causing death, most shocking and painful to the decedent's survivors."[377]

Justice Souter also agreed that one could make a strong case that physician-assisted suicide fell within "the accepted tradition of medical care in our society."[378] In the abortion cases, the Court recognized the need for a doctor, and not just to perform the medical procedure. The Court "recognized that the

375. *Id.*
376. *Id. at* 2287.
377. *Id.* at 2288.
378. *Id.*

good physician is not just a mechanic of the human body whose services have no bearing on a person's moral choices, but one who does more than treat symptoms, one who ministers to the patient."[379] The idea of the physician treating the whole person is just as important in end-of-life decisions as in abortion. The patients in this case wanted not only to end their pain (which Justice Souter noted they might have done, although only at the price of stupor), "but an end to their short remaining lives with a dignity that they believed would be denied them by powerful pain medication, as well as by their consciousness of dependency and helplessness as they approached death."[380] One could hardly imagine any other circumstances in which the call for bodily autonomy carried greater weight, and in which the role of the physician, including assistance, fell within the "traditional norm" of health care.[381] In fact, the state had already recognized this right in its willingness to allow terminally ill patients to stop treatment and to withdraw life-sustaining medication, thus hastening death. It even allowed physicians to administer powerful pain-killing medication in this terminal condition, even if such dosages bring on death.

Up until this point, one might have thought Justice Souter was preparing a dissent rather than a concurrence. He summed up the respondents' arguments as going through "three steps of increasing forcefulness."[382] First, that there is a decriminalization of suicide; second, that decriminalization provides freedom of choices analogous to individual options in recognized areas of bodily autonomy, such as abortion; and third, that the claim for assistance is not based on some broad principle, but rather on the traditional role of doctors in ministering to all the medical needs of their patients.[383] This was a powerful argument, Justice Souter noted, one demanding, under the *Poe* criteria, "careful scrutiny of the State's contrary claim."[384]

379. *Id.* (citing Roe v. Wade, 410 U.S. 113, 153 (1973); Griswold v. Connecticut, 381 U.S. 479, 482 (1965)).
380. *Id.* at 2289.
381. *See id.*
382. *Id.*
383. *See id.* at 2289-90.
384. *Id.* at 2290.

Justice Souter then proceeded to do just that. The State had essentially put forward three interests to justify its law—protecting life generally, discouraging suicide (even if knowing and voluntary), and protecting terminally ill patients from involuntary euthanasia. Justice Souter found it unnecessary to discuss the first two, since the third argument proved dispositive for him. The State had argued that a very slippery slope existed, and that it would be all too easy, perhaps inevitable, to progress down that slope.

> [M]istaken decisions may result from inadequate palliative care or a terminal prognosis that turns out to be error; coercion and abuse may stem from the large medical bills that family members cannot bear or unreimbursed hospitals decline to shoulder. Voluntary and involuntary euthanasia may result once doctors are authorized to prescribe lethal medication in the first instance, for they might find it pointless to distinguish between patients who administer their own fatal drugs and those who wish not to, and their compassion for those who suffer may obscure the distinction between those who ask for death and those who may be unable to request it.[385]

In Justice Souter's opinion can be found what is so absent from Chief Justice Rehnquist's, i.e., not only the suffering of the individual patient, but also the concerns of a compassionate state. The Chief Justice had found the state interests rational and the history opposed to assisted suicide, and there is barely a hint of the individual, patient or doctor, who must live within this system with no recourse. Justice Souter seemed to imply that should conditions change, the Court might also reconsider. The example of the Netherlands, where fairly strict regulation exists, had been invoked by both sides, the respondents to support their claim that strong rules would prevent abuse, the state to prove that euthanasia had gotten out of control.[386] Justice Souter took the middle route, and the one supported by the bulk of the evidence; namely, that "a substantial dispute" existed about what the Dutch experience meant.[387] While that dispute might someday be resolved, until it is, there exists

385. *Id.*
386. *See id.* at 2292.
387. *Id.*

enough evidence to support the state's concern about legitimizing assisted suicide. "The day may come when we can say with some assurance which side is right [in what the Dutch practice means], but for now it is the substantiality of the factual disagreement, and the alternatives for resolving it, that matter. They are, for me, dispositive of the due process claim *at this time*."[388]

Given this dispute, Justice Souter would defer to the legislative judgment, but added that there was still much learning to be done on the subject. For the moment, the legislature is as well suited as the judiciary to undertake that examination. Moreover, in declaring constitutional rights courts ought to act with finality and cannot experiment with what might or might not be done under differing circumstances.[389]

> Legislatures, however, are not so constrained. The experimentation that should be out of the question in constitutional adjudication displacing legislative judgment is entirely proper, as well as highly desirable, when the legislative power addresses an emerging issue like assisted suicide. . . . *While I do not decide for all time that respondents' claim should not be recognized*, I acknowledge the legislative institutional competence as the better one to deal with that claim at this time.[390]

Justice Souter's opinion, I suggest, is a far better opinion than that of the majority. The latter is rigid and formalistic, with barely a hint of the great emotional issues involved, the pain and suffering of individuals and their families, the moral dilemmas of doctors, and the effect on society. Justice Souter is cognizant of these matters, and if he cannot give those in pain the answer they want, he at least acknowledges that they have a legitimate claim, that mere recourse to history is an evasion rather than an answer. He also clearly leaves the door open for the Court to revisit this matter, even as he urges the states to grapple with it further.

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388. *Id.* at 2292 (emphasis added).
389. *See id.* at 2293.
390. *Id.* (emphasis added).

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Justice Sandra Day O'Connor, the only Justice to file a concurrence who also signed onto the Court's opinion, wrote an opinion that also implied that, given another set of factual circumstances and claims, she too would be willing to reconsider the decision. In Justice O'Connor's opinion, the majority had framed the issue fairly narrowly; namely, whether the Due Process Clause protects a right to commit suicide which includes the right to have assistance in doing so. She then concluded that the Nation's history and legal traditions did not support such a right. She agreed "that there is no generalized right to 'commit suicide.'"[391] Justice O'Connor recognized, however, that respondents had asked the Court to address a narrower question: whether a mentally competent person experiencing great pain and suffering has a constitutionally protected right to control the circumstances of his or her imminent death?[392]

This claim need not be reached in either case, Justice O'Connor noted, because such people could already get the relief they sought. "The parties and amici agree that in these States a patient who is suffering from a terminal illness and who is experiencing great pain has no legal barriers to obtaining medication, from qualified physicians, to alleviate that suffering, even to the point of causing unconsciousness and hastening death."[393] Given this fact, she saw no reason why the state should not be allowed to pursue its legitimate interests in protecting those who are not competent or whose decisions might not be truly voluntary.

What Justice O'Connor left unsaid was what she would do were the states to change that situation. What might happen should the states, in their efforts to protect those needing protection, impinge upon the ability of the competent to gain this relief? She urged the states to continue in their "extensive and serious evaluation of physician-assisted suicide and other relat-

391. *Id.* at 2303 (O'Connor, J., concurring).
392. *See id.*
393. *Id.*

ed issues," adding, on a highly unusual personal note, that "[e]very one of us at some point may be affected by our own or a family member's terminal illness."[394]

Justice Ruth Bader Ginsberg noted briefly that she concurred in the judgments in the two cases, "substantially for the reasons stated by Justice O'Connor in her concurring opinion."[395] Justice Stephen Breyer also joined in Justice O'Connor's concurrence, but not insofar as it joined in the majority reasoning. Justice Breyer went on to explain that, in *Vacco*, he agreed that the state interests justified differentiating between physician-assisted suicide and withdrawal of life-support, and he also agreed with the majority that the critical question was whether a liberty interest existed under the Fourteenth Amendment to support the respondents' claim.[396] He differed with the Court, however, on how it formulated that right; namely, a right to commit suicide with another's assistance.[397] Justice Breyer said he would not reject the claim without considering a different formulation that might have greater support within the American legal tradition. "That formulation would use words roughly like a 'right to die with dignity.' But irrespective of the exact words used, at its core would lie personal control over the manner of death, professional medical assistance, and the avoidance of unnecessary and severe physical suffering—combined."[398]

Justice Breyer referred to Justice Souter's due process analysis and agreed "that this Court need or now should decide whether or not such a right [to die with dignity] is 'fundamental.'"[399] He reasoned that the avoidance of severe physical pain would be essential to such a claim, and as Justice O'Connor had pointed out, the laws of both New York and Washington did not force a dying person to undergo that pain. Doctors could prescribe palliative medication, even to the point of hastening death. Thus, state law did not infringe upon a central interest the way that anti-contraceptive laws had done in *Poe* or

394. *Id.*
395. *Id.* at 2310 (Ginsburg, J., concurring).
396. *See id.* at 2311 (Breyer, J., concurring).
397. *See id.*
398. *Id.*
399. *Id.*

Griswold. However,

> [w]ere the legal circumstances different—for example, were state laws to prevent the provision of palliative care, including the administration of drugs as needed to avoid pain at the end-of-life—then the law's impact upon serious and otherwise unavoidable physical pain (accompanying death) would be more directly at issue. And as Justice O'Connor suggests, the Court might have to revisit its conclusions in these cases.[400]

The lone member of the *Cruzan* minority still sitting on the Court, Justice John Paul Stevens, also concurred in the judgment. The majority noted that its holding remained consistent with the ongoing debate over the morality, legality, and practicality of physician-assisted suicide. Justice Stevens wrote separately "to make it clear that there is also room for further debate about the limits that the Constitution places on the power of the States to punish the practice."[401]

The respondents had filed a facial challenge to the laws, and, while the Court has not always been clear on what criteria are to be used in evaluating a facial challenge, plaintiffs generally have to show a broader violation of constitutional rights than they would in an "as applied" challenge, such as where a statute's constitutionality is challenged as applied to a particular plaintiff or group of plaintiffs. Facial challenges are the most difficult, "since the challenger must establish that no set of circumstances exists under which the Act would be valid."[402] Referring to the Court's previous decisions in capital punishment cases, Justice Stevens noted that

> just as our conclusion that capital punishment is not always unconstitutional did not preclude later decisions holding that it is sometimes impermissibly cruel, so is it equally clear that a decision upholding a general statutory prohibition of assisted suicide does not mean that every possible application of the statute would be valid. A State, like Washington, that has authorized the death penalty and thereby has concluded that the sanctity of human life does

400. *Id.* at 2312.
401. *Id.* at 2304 (Stevens, J., concurring).
402. *Id.* (citing United States v. Salerno, 481 U.S. 739 (1987)).

> not require that it always be preserved, must acknowledge that there are situations in which an interest in hastening death is legitimate. Indeed, not only is that interest sometimes legitimate, *I am also convinced that there are times when it is entitled to constitutional protection.*[403]

Justice Stevens referred to *Cruzan*, which was used by both circuit courts to justify their decisions, and which the majority claimed had been misinterpreted. The majority in that case had agreed that a liberty interest existed, but that it might be outweighed by relevant state interests. Justice Stevens agreed, but he believed that Nancy Cruzan's right went beyond a common law rule.

> Rather, this right is an aspect of a far broader and more basic concept of freedom that is even older than the common law. This freedom embraces, not merely a person's right to refuse a particular kind of unwanted treatment, but also her interest in dignity, and in determining the character of the memories that will survive long after her death.[404]

The majority in *Cruzan*, he believed, recognized that right at least implicitly.

Cruzan also means that some state intrusions on how individuals choose to encounter death will not be tolerated. The original patients in these two cases, now dead, "may in fact have had a liberty interest even stronger than Nancy Cruzan's because, not only were they terminally ill, they were suffering constant and severe pain."[405] While Justice Stevens agreed that there is no absolute right to physician-assisted suicide, he believed that *Cruzan* meant that people who no longer had a choice in whether to live or die, who were already at death's door, had "a constitutionally protected interest that may outweigh the State's interest in preserving life at all costs."[406] Justice Stevens believed that, in such situations, the liberty interest was different from, and far stronger than, the common

403. *Id.* at 2305 (emphasis added).
404. *Id.* at 2306.
405. *Id.* at 2307.
406. *Id.*

law rule and also trumped any state interest. "It is an interest in deciding how, rather than whether, a critical threshold shall be crossed."[407]

Justice Stevens concurred in the New York case because he believed a difference existed between letting someone die and hastening that person's death. He concurred in the Washington case because he did not think a broad liberty interest existed. But he, like Justices Souter, O'Connor, Ginsberg and Breyer, did not believe that the issue was definitively resolved. Justices Stevens, like the other Justices, also encouraged the states to experiment and explore the issue further, but there is no question that he, too, wanted to keep the door to the Court ajar.

VI

What is one to make of this plethora of opinions? First, it is clear that considerations other than constitutional interpretation were involved. The Court's decision in *Cruzan* elicited little negative comment, since most Americans believe that people on life-support should have the choice of refusing treatment, and a long line of common law cases confirmed the legal rationale for supporting that choice. Moreover, medical and religious groups do not equate the cessation of treatment with suicide, on the grounds that the illness or condition is the actual cause of death.[408] Nevertheless, popular attitudes toward suicide are quite diverse; there is no consensus on whether people have a "right" to kill themselves, much less on whether others should be permitted to help them. While doctors covertly provide prescriptions for lethal doses of medication, the medical profession as a whole is on record as opposed to legalizing physician-assisted suicide. I would suggest that in these cases, the Court did not want to get out ahead of public opinion and call down upon itself the same firestorm of criticism that had greeted its decision in *Roe v. Wade*.[409] The Court wisely has allowed the debate to continue, but has left itself the option, if needed, of

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407. *Id.*

408. The Catholic Church, for example, is unalterably opposed to euthanasia, and in a papal document had lumped euthanasia with murder, genocide and abortion. The Vatican, however, has absolved Catholic physicians from any obligation to use heroic measures on terminally ill patients, and Catholics are permitted to refuse treatment. *See* GERALD A. LARUE, EUTHANASIA AND RELIGION 35-43 (1985).

409. 410 U.S. 113 (1973).

revisiting the issue. From the viewpoint of judicial politics, the Court reached the "right" decision in both cases.

What about the issues in these cases? Has the Court provided any guidance other than allowing the states great leeway in what they choose to do? The Chief Justice's opinions in the two cases are extremely formalistic, and, while paying lip service to the fact that end-of-life decisions may be emotionally distressing, there is very little humanity in the analysis. In essence, the majority utilized a test for determining liberty interests that is simple and simplistic: is there a historic basis for such an interest? If yes, then we are willing to grant it some level of constitutional recognition. If no, then there is no right, and the states are free to ignore the claim.

While attractive in that such a test provides a relatively straightforward analytic scheme, it also ignores the fact that the world in which we live is not the world of 1789, nor that of 1868. We inhabit a world of automobiles, airplanes, telephones, computers and medical sophistication undreamed of at the time the Constitution and the Fourteenth Amendment were adopted.[410] To insist on interpreting the Due Process Clause as if nothing has happened in the last 130 years is to put the Constitution into a straightjacket.[411] As Judge Reinhardt noted in his opinion for the Ninth Circuit,[412] were history the sole guide for interpreting the Fourteenth Amendment, the Court could never have overturned the anti-miscegenation statutes.

Over the Court's long history, its majority opinions have often been overshadowed and even replaced by concurring or dissenting opinions. In the assisted-suicide cases, Justice Souter's concurrence may well become the opinion that lower

410. For example, in the eighteenth and nineteenth century, nearly everyone died at home; today approximately 80% of people die in hospitals. According to Dr. Susan W. Tolle, director of the Center for Ethics in Health Care at the Oregon Health Sciences University in Portland, "generally, if you get to a hospital alive, we can extend that life." Egan, *supra* note 111, at A1. The problem, as she acknowledges, is not all people want their lives extended. Oregon's Measure 16, she says, is not so much about suicide as about patients' desire for more control over their end-of-life choices. *See id.*

411. *See* Todd David Robichaud, *Toward A More Perfect Union: A Federal Cause of Action for Physician Aid-in-Dying*, 27 U. MICH. J. L. REFORM, 521, 529 (1994).

412. *See* Compassion in Dying v. Washington, 79 F.3d 790, 805 (9th Cir. 1996), *rev'd*, 117 S. Ct. 2258 (1997).

courts look to in the future. His elucidation of Justice Harlan's dissent in *Poe v. Ullman*[413] is not only a more persuasive argument for how one determines when a liberty interest is implicated, but is also a far better constitutional analysis. Justice Souter recognized, as did the other Justices who refused to sign on to Chief Justice Rehnquist's opinions, that end-of-life issues will become increasingly important in American society. Merely stating that they were not an issue in 1868 will neither serve as a guide to lower courts nor provide much comfort to Americans who will have to wrestle with these issues on a personal basis.

The critical issue is to what extent we, as a society, are willing to grant individual autonomy to people who will then use that autonomy to make decisions with which a majority may not agree. American democracy has been unique in that it has relied not only on faith in the people as a whole to govern themselves, but also in the great latitude it has given individuals to choose how to lead their own lives. There are some critics who believe that we have allowed this individualistic strain to grow too large, overbalancing the needed sense of community that keeps society in balance. Surely, however, the lower courts were right in their view that end-of-life choices, just like abortion, involve "the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, [and] are central to the liberty protected by the Fourteenth Amendment."[414]

Moreover, the reasoning of both courts and various medical groups regarding the distinction between terminating life-support and taking an overdose of lethal medication strikes me as spurious. The conscious, competent person who turns off a ventilator or who stops going to dialysis sessions knows what the result will be, as does the conscious, competent person who washes down 100 Seconal pills with vodka. If the second person is suffering from a painful and incurable illness, but is not on life-support, why shouldn't she have the same option as the first person, to end a life which has lost meaning and contains nothing but pain and suffering? This was the lesson Lawrence

413. 367 U.S. 497 (1961).
414. Planned Parenthood v. Casey, 505 U.S. 833, 851 (1992).

Tribe tried to teach the Justices; namely, that in the real world people who are suffering, but not on life-support, are still suffering. Why should they be treated differently from those on life-support who have the choice of ending their misery?

One of the more disturbing features of the Court's decision is that the Justices seem aware of the fact that every day doctors help patients die, and that they are willing to allow this practice to continue in a form of gray market. Mark Graber, in his book on abortion, describes a gray market as a quasi-legal arrangement whereby governmental authorities acquiesce and sometimes even aid in the distribution of goods or services that nominally are supposed to be forbidden to all.[415] Under the guise of "pain relief," authorities will allow a doctor to prescribe barbiturates in lethal doses under the fiction that all the physician is trying to do is ease the suffering, and, should death occur, it would be an unintended by-product.[416] The result of continuing this practice will be that middle and upper-middle class people who have access to the health care system and comprehend how it works will be able to exercise individual autonomy in their end-of-life choices. Others without such access and knowledge will have no control over their deaths.

What about the moral arguments? What about people who believe that suicide, even for those who are terminally ill and suffering, is an affront to God? Those people have every right not to commit suicide, just as women who do not believe in abortion have every right not to have one. In fact, the case here is even stronger than in the abortion debate. Opponents of abortion say they are defending the life and the rights of the unborn who are powerless to protect themselves. End-of-life decisions, however, involve no innocent, mute and powerless third parties, just the man or woman who wants to end his or her torment. As for doctors who do not want to participate in

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415. *See generally* MARK A. GRABER, RETHINKING ABORTION: EQUAL CHOICE, THE CONSTITUTION, AND REPRODUCTIVE POLITICS (1996).

416. Washington State "generally permits physicians to administer medication to patients in terminal conditions when the primary intent is to alleviate pain, even when the medication is so powerful as to hasten death and the patient chooses to receive it with that understanding." Washington v. Glucksberg, 117 S. Ct. 2258, 2289 (1997) (Souter, J., concurring) (citing to WASH. REV. CODE § 70.122.010 (1994); and referring to several journal articles confirming that statement).

such a practice, they also have a choice. No one is forcing them to prescribe lethal overdoses, just as no doctors are forced to perform an abortion against their will.

A stronger argument deals with protecting the vulnerable—the poor, the elderly, the less than fully competent—who may be under pressure from their family to end it all and to stop being a financial and emotional burden on their loved ones. This is a legitimate interest of the state, and no one in favor of assisted suicide believes it should be anything other than a voluntary choice, free from undue pressure. There is a slippery slope out there that could lead, as one of my students put it, to a "drive-through McDeath." It does not follow, however, that stringent and effective means cannot be put into place to ensure that the option of physician-assisted suicide is not abused and misused.[417] The law, as Ronald Dworkin has argued, must protect people "who think it would be appalling to be killed, even if they had only painful minutes to live. 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."[418]

Nor should one ignore the fact that end-of-life treatment for many people is terribly bad, often little more than a warehousing of the sick and infirm until they die. One reason that juries have refused to convict Jack Kevorkian is that many jurors see his "mercy machine" as the only available option to weeks or months of suffering under horrible conditions. Opponents of assisted suicide recognize this problem and are calling for better treatment of the terminally ill rather than what they see as the easy fix of euthanasia.[419] In an ideal world, there would be a range of options that would include good hospital treatment for the terminally ill, effective pain management, hospice care, as well as physician-assisted suicide. The debate

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417. On this matter, I disagree strongly with Professor Robert A. Burt of Yale Law School, who believes that the United States is too diverse and large to ever put effective safeguards in place. That might be true if this became a national policy, but I see no reason why such safeguards cannot be successfully created in the states. *See* Robert A. Burt, *Death Made Too Easy,* N.Y. TIMES, Nov. 16, 1994, at A19.

418. Ronald Dworkin, *When Is It Right to Die?,* N.Y. TIMES, May 17, 1994, at A19.

419. *See e.g.*, Herbert Hendin, *Scared to Death of Dying,* N.Y. TIMES, Dec. 16, 1994, at A39.

should not be allowed to become one of all or nothing, suicide or suffering.

For the time being, the Court, despite the unconvincing opinion of the Chief Justice, has done the right thing. One needs to keep in mind that the whole question of the right to die is a relatively new one, and that of assisted suicide even newer. There is a national debate going on, and it should be allowed to continue uninterrupted. The closeness of the initiative votes in Washington and California, as well as the passage of Measure 16 in Oregon, indicate that a large number of Americans want to have the option of controlling their own end-of-life choices. Attention will now be focused on the Oregon experience, to see if a program can be effective in giving some people the choice they want without it being abused by others.[420] Many years ago, Justice Brandeis wrote that "[i]t is one of the happy incidents of the federal system that a single courageous state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country."[421] That experiment is about to begin, and one cannot predict how it will proceed. However, one does not have to be a prophet to know that the issue of assisted suicide will not go away, and that it will, at some time, return through the door that the Supreme Court has left ajar.

420. As this issue went to press, the first known legal suicide under Oregon's Death with Dignity Law took place. An unidentified woman in her mid-80s, suffering from terminal breast cancer, took a lethal dose of barbiturates washed down by a glass of brandy. The announcement of the woman's death was made by Compassion in Dying, the lead plaintiff in the Washington case; state officials, citing the privacy provisions of the law, would not confirm the case. Timothy Egan, *First Death Under an Assisted-Suicide Law*, N.Y. TIMES, Mar. 26, 1998, at A1.

421. New State Ice Co. v. Liebmann, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting).