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"Suicide: A Constitutional Right?" - Reflections Eleven Years Later

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I. INTRODUCTION

Eleven years ago, the *Duquesne Law Review* published an article written by these authors entitled "Suicide: A Constitutional Right?" ("Suicide").[1] In the Fall of 1985, when the article was published, only a few authors had argued that the Constitution of the United States protected assisted suicide.[2] The developments of the intervening decade, however, have been so rapid and dramatic that these authors write in the Fall of 1996 on the eve of a Supreme Court decision likely to definitively settle this issue.

On October 1, 1996, the Supreme Court of the United States granted certiorari to two cases involving physician-assisted suicide.[3] In each case, a federal court of appeals concluded that there is a constitutional right to suicide. In the short window of time between those decisions and the Supreme Court's review of

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1. Thomas J. Marzen et al., *Suicide: A Constitutional Right?*, 24 DUQ. L. REV. 1 (1985).

2. *Id.* at 8 n.27.

3. Quill v. Vacco, 80 F.3d 716 (2d Cir. 1996), *cert. granted*, Vacco v. Quill, 65 U.S.L.W. 3254 (U.S. Oct. 1, 1996) (No. 95-1858); Compassion in Dying v. Washington, 79 F.3d 790 (9th Cir. 1996) *en banc*, *cert. granted*, Washington v. Glucksberg, 65 U.S.L.W. 3254 (U.S. Oct. 1, 1996) (No. 96-110).

them, these authors now write to make some selected points about those cases and their implications. This is not an attempt at duplicating the comprehensive sweep of the original article, the bulk of which these authors believe, however, remains relevant to the debate over the constitutional issue. The focus, instead, will be on four distinct questions. This article will argue that:

1) the Ninth Circuit substantially misinterpreted our account, on which its citations indicate it largely relied, of the history of the attitude of American law toward suicide;

2) the Ninth Circuit misunderstood, and based on that misunderstanding wrongly denied the validity of the distinction between the provision of pain relief entailing the risk of death, on the one hand, and the provision of a lethal prescription or lethal injection intended to kill, on the other hand;

3) the Second and Ninth Circuits wrongly denied the rationality of the state drawing a line between the withholding and withdrawal of life-saving medical treatment, on the one hand, and direct killing, on the other hand; and

4) the finding of a constitutional right to voluntary assisted suicide would necessarily entail the legalization of nonvoluntary euthanasia, *not* as the consequence of a speculative "slippery slope," but as the inescapable product of existing legal precedent.

II. The Ninth Circuit and the Legal History of Suicide in America

In elevating suicide to the status of a constitutional right under the Fourteenth Amendment's Due Process Clause, the Ninth Circuit was at pains to affirm that it was not bound by the treatment of suicide and assisted suicide in American law during the period when the Fourteenth Amendment was proposed and ratified. The court wrote, "the fact that we have previously failed to acknowledge the existence of a particular liberty interest or even that we have previously prohibited its exercise is no barrier to recognizing its existence."[4]

The Ninth Circuit did, however, devote a twelve paragraph section to "Historical Attitudes Toward Suicide," a section that focused more on the attitudes of the Greeks and Romans toward suicide (whom it characterized as considering "suicide to be acceptable or even laudable") than on the history of the treatment of suicide in America.[5] Indeed, only two of the twelve

4. *Compassion in Dying*, 79 F.3d at 805.

5. *Id.* at 806-07.

paragraphs in that section discussed suicide in American history.[6]

The present authors are somewhat chagrined that while six of the eight footnotes naming sources on which the court relied for those two paragraphs cited the original article, the court seemed to misunderstand the history these authors described. The Ninth Circuit wrote:

> English attitudes toward suicide, including the tradition of ignominious burial, carried over to America where they subsequently underwent a transformation. By 1798, six of the thirteen original colonies had abolished all penalties for suicide either by statute or state constitution. There is no evidence that any court ever imposed a punishment for suicide or attempted suicide under common law in post-revolutionary America. By the time the Fourteenth Amendment was adopted in 1868, suicide was generally not punishable, and in only

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6. *Id.* The Ninth Circuit did spend three paragraphs on American law's near ancestor, English common law. *Id.* at 808-09. The first paragraph, however, got a key part of the history of English common law wrong. These authors feel some obligation to correct that paragraph, since that paragraph relied entirely on citations from the original article.

Henry de Bracton, the author of a crucial early treatise on English law probably written sometime between 1220 and 1260, is principally responsible for establishing the condemnation of all suicide that characterized the common law at the time of the colonization of America. With regard to suicide, Bracton's treatise began by restating the Roman law of suicide as found in Justinian's *Digest*.

The Roman law punished suicide only when committed by an individual who had been accused of a crime the conviction of which would result in confiscation of the accused's property by the Emperor. That prohibition was designed to make sure an accused could not protect the accused's family from disinheritance by committing suicide before being convicted and thus dispossess the Emperor of property that would otherwise go to him. 9 The Civil Law 129 (S. Scott trans. 1932) (Digest, bk. 48, tit. 21, para. 3).

Bracton repeated this aspect of the Roman law, but then added his key innovation: Bracton declared that the personal property (although not the land) of an individual who commits suicide would be confiscated by the King "if a man slays himself in weariness of life or because he is unwilling to endure further bodily pain." 2 BRACTON ON THE LAWS AND CUSTOMS OF ENGLAND, 424 (George E. Woodbine ed. & Samuel E. Thorne trans., 1968). Bracton, innovation, therefore, was to *add* a penalty for suicide. William E. Mikell, *Is Suicide Murder?* 3 COLUM. L. REV. 379, 380-81 (1903); *Suicide*, *supra* note 1, at 57-59.

Perhaps confused by the distinction Bracton drew between personal and real property, and focusing on Bracton's statement that the real property (land) of an individual who commits suicide was not subject to confiscation, the Ninth Circuit wrote, "Bracton's innovation was incorporated into English common law, which has thus treated suicides resulting from the inability to 'endure further bodily pain' with compassion and understanding ever since a common law scheme was firmly established." *Compassion in Dying*, 79 F.3d at 807-08.

This is an odd way to describe the introduction of a severe penalty, the seizure of all personal property of the individual who commits suicide by the state, for such suicides. While American law eventually came to view suicidal individuals with "compassion and understanding," *not* the same thing as affirming suicide as a liberty right, that is not a very accurate characterization of the official attitude of the English common law. *See generally Suicide*, *supra* note 1, at 57-59.

> nine of the thirty-seven states is it clear that there were statutes prohibiting assisting suicide.
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> The majority of states have not criminalized suicide or attempted suicide since the turn of the century. The New Jersey Supreme Court declared in 1901 that since suicide was not punishable it should not be considered a crime. "[A]ll will admit that in some cases it is ethically defensible," the court said, as when a woman kills herself to escape being raped or "when a man curtails weeks or months of agony of an incurable disease." Today, no state has a statute prohibiting suicide or attempted suicide, nor has any state had such a statute for at least ten years. A majority of states do, however, still have laws against assisting suicide.[7]

The statements in these two paragraphs, almost wholly based on the original article, are drawn from it so selectively and out of context that, taken as a whole, the statements can only be described as severely mischaracterizing both the article and the American legal history concerning suicide that the Ninth Circuit purports to recount.

As the original article demonstrated at some length, it is simply wrong to imply that abolition of penalties for suicide itself in late Eighteenth Century America meant that suicide was treated as a freedom or even tolerated under the legal system.[8] Under the English common law, which was to some extent applied in the early colonies, suicide was "punished" through ignominious burial of the individual who committed suicide and forfeiture of personal property.[9] These "penalties" were indeed abolished by the time of independence, but not because early Americans approved of suicide. In 1796, Zephaniah Swift, who later became Chief Justice of Connecticut, explained that these "penalties" were discontinued because it was seen as "contemptible" to exercise a "mean act of revenge upon lifeless clay, that is insensible of punishment" and cruel to inflict "a punishment, as the forfeiture of goods, which must fall solely on the innocent offspring of the offender."[10]

Smith wrote, "it is evident that where a person is so destitute of affection for his family . . . as to wish to put an end to his existence, that he will not be deterred by a consideration of their future subsistence. *Indeed, the crime of suicide is so abhorrent to the feelings of mankind and that strong love of life which is*

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7. *Compassion in Dying*, 79 F.3d at 809-10 (citations omitted) (quoting Campbell v. Supreme Conclave Improved Order Heptasophs, 49 A. 550, 553 (N.J. 1901)).

8. *Suicide*, *supra* note 1, at 67-70.

9. *Id.* at 63-65.

10. Zephanaiah Swift, A System of Laws of the State of Connecticut 304 (n.p. 1796).

implanted in the human heart that it cannot be so frequently committed as to become dangerous to society."[11]

The colonies and states continued to punish the acts of assisting and even attempting suicide.[12] In the latter part of the nineteenth century and in the early twentieth century, penalties for attempting suicide were generally repealed, but not, once again, because suicide was seen as a liberty. The theory grew, rather, that those who attempted suicide should be given treatment for mental disorders rather than punished.[13] Typical was the 1902 statement of a Pennsylvania court about an individual who attempted suicide: "It is the result of disease. He should be taken to a hospital and not sent to a prison."[14] In 1980, the Supreme Court of Iowa wrote, "the only reason we view suicide [as] noncriminal is that we consider inappropriate punishing the suicide victim or attempted suicide victim, not that we are concerned about that person's life any less than others' lives. To say that aiding and abetting suicide is a defense to homicide would denigrate these views."[15]

The statements made by the Ninth Circuit in the last two sentences of the first paragraph of the excerpt quoted above are technically and literally accurate, but, especially in combination, are certainly misleading. The Ninth Circuit wrote: "There is no evidence that any court ever imposed a punishment for suicide or attempted suicide under common law in post-revolutionary America."[16] There are, indeed, no recorded instances in which courts imposed punishments for attempted suicide *under common law* in post-revolutionary America,[17] but for a considerable period after the Revolution, courts did so under statutory law.[18] The sentence just quoted was restricted to common law, avoiding statutory law, but the next sentence of the Ninth Circuit's opinion was restricted to statutory law, ignoring common law: "By the time the Fourteenth Amendment was adopted in 1868, suicide was generally not punishable, and in only nine of the thirty-seven states is it clear that there were statutes prohibiting assisting suicide."

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11. *Id.* (emphasis added).
12. Marzen, *supra* note 1, at 73-77.
13. *Id.* at 85-89.
14. Commonwealth v. Wright, 11 Pa. 144, 146 (1902).
15. Iowa v. Marti, 290 N.W.2d 570, 581 (Iowa 1980).
16. *Compassion in Dying,* 79 F.3d at 809.
17. Courts did, however, impose such penalties under common law in *pre*-revolutionary America. Marzen, *supra* note 1, at 64-66.
18. *Id.* at 80-81.

Years after independence, however, many U.S. states still recognized and enforced not merely statutory crimes enacted by the legislature, but also the court-made criminal law known as the common law of crimes. In fact, some states still do today. If the common law of crimes is considered along with statutes at the time of the ratification of the Fourteenth Amendment, twenty-one of the thirty-seven states (including eighteen of the thirty states that voted to ratify) had laws against assisted suicide, not merely nine.[19]

A cynical observer might be pardoned for thinking that the Ninth Circuit focused on common law when it could be made to appear non-condemnatory of suicide, ignoring statutes to the contrary, and then focused on statutory law when this, standing alone, could be made to appear to minimize condemnation of suicide, ignoring common law to the contrary.

The Ninth Circuit, furthermore, exercised particularly questionable judgment in presenting, as though it were typical, a statement made in 1901 by a New Jersey court in *Campbell v. Supreme Conclave Improved Order Heptasophs.* The *Campbell* court stated that suicide was ethically defensible "when a man curtails weeks or months of agony of an incurable disease."[20]

This was the *only* American case quoted by the Ninth Circuit in all of its account of the legal history of suicide in America. Yet, as was made clear in the original article, *Campbell* is "the *only* pre-1980 case these authors have been able to locate that articulates such a view. It is isolated not only in contrast to cases in other jurisdictions, but within New Jersey as well."[21]

Two years later, in *State v. Carney*,[22] the court upheld a conviction for attempted suicide, criticizing *Campbell* and writing: "Suicide is none the less criminal because no punishment can be inflicted. . . . If one kills another, and then kills himself, is he any less a murderer because he cannot be punished?"[23] Then, in 1922, New Jersey's highest court wrote in *State v. Ehlers,* "[S]o strong is this concern of the state [in "the preservation of the life

19. Marzen, *supra* note 1 , at 75-76. In a footnote, the Ninth Circuit did acknowledge that the original article concluded this, but, with seeming disparagement, said the article "hypothesized" this, "extrapolating from incomplete historical evidence and drawing inferences . . . ." *Compassion in Dying*, 79 F.3d at 809 n.42.

20. *Compassion in Dying*, 79 F.3d at 809-10 (quoting Campbell v. Supreme Conclave Improved Order Heptasophs, 49 A. 550 (N.J. 1901)). The Marzen article, *supra* note 1, was credited by the Ninth Circuit for providing the source of the *Campbell* quote.

21. Marzen, *supra* note 1, at 84 (emphasis added).

22. 55 A. 44 (N.J. 1903).

23. *Carney,* 55 A. at 45.

of each of its citizens"] that it does not even permit a man to take his own life. . . ."[24]

More to the point, the original article spent over twenty pages citing literally hundreds of cases throughout the nineteenth and twentieth centuries in an effort to provide a comprehensive account of the historical attitude of American law toward suicide, all of which were ignored by the Ninth Circuit.[25] As the article painstakingly demonstrated, the *Campbell* decision was distinctly at odds with these cases. Citing one anomalous case in a manner that suggests to the unwary reader that it represents the American law of suicide simply cannot be considered responsible scholarship.

The virtually universal pre-1980 consensus of American jurisprudence is, in fact, best summarized by the 1933 words of the Florida Supreme Court: "No sophistry is tolerated . . . which seek[s] to justify self-destruction as commendable or even a matter of personal right."[26] Certainly no pre-1980's court ever suggested that assisted suicide might be protected by the Constitution. Indeed, the United States Supreme Court in 1973 described laws regarding suicide as "constitutionally unchallenged."[27]

There is little point in repeating or further summarizing the evidence set forth in thirty-seven pages of the original article[28] that led these authors to conclude that "the weight of authority in the United States, from colonial days through at least the 1970's has demonstrated that the predominant attitude of society and the law has been one of opposition to suicide."[29] The original article may be consulted to evaluate whether it appears persuasive.[30] What is clear, however, is that the two paragraphs

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24. 119 A. 15, 17 (N.J. 1922) (alteration in original).

25. Marzen, *supra* note 1, at 74-97.

26. Blackwood v. Jones, 149 So. 600, 601 (Fla. 1933).

27. Paris Adult Theater I v. Slaton, 413 U.S. 49, 68 n.15 (1973).

28. Marzen, *supra* note 1, at 63-100. These pages in turn relied upon a ninety-four page appendix that traced the legal history of suicide in America, state by state, in much greater detail. *Id.* at 148-242.

29. *Id.* at 100.

30. A number of commentators on both sides of the issue have cited the historical analysis in the original article. Michael Ariens, *Suicidal Rights*, 20 RUTGERS L.J. 79, 85 n.27, 88 n.41, 90 n.60, 92 n.76, 93 n.78, 115 n.210 (1988); Maria CeloCruz, *Aid-In-Dying: Should We Decriminalize Physician-Assisted Suicide and Physician-Committed Euthanasia?* 18 AM. J.L. & MED. 369, 374 nn.37, 39-40, 375 n.42, 377 n.60 (1992); Mark Chopko, *Intentional Values and the Public Interest- A Plea for Consistency in Church/State Relations*, 39 DEPAUL L. REV. 1143, 1186 n.239 (1990); Kathy Graham, *Last Rights: Oregon's New Death With Dignity Act*, 31 WILLAMETTE L. REV. 601, 605 nn.25-26 (1995); Edward Grant and Paul Linton, *Relief or Reproach?: Euthanasia Rights in the Wake of Measure*, 16 OR. L. REV. 449, 482 nn.128-30 (1995); Seth Kreimer, *Does Pro-Choice Mean Pro-Kevorkian? An Essay on Roe, Casey, and the Right to Die*, 44 AM. U. L. REV. 803, 817 n.42

the Ninth Circuit devotes to the history of the attitude of American law on suicide cannot be relied upon as giving an accurate summary of the article or of the history the article relates, although the Ninth Circuit's footnotes indicate that they are based predominately on our article.

III. Pain Control and Euthanasia

After establishing that suicide is a constitutionally protected liberty interest, the Ninth Circuit went on to conclude that no state interests are sufficient to justify absolutely barring assisted suicide. An important factor in drawing this conclusion was the court's position that states have already acquiesced in doctors administering "death-inducing medication, as long as they can point to a concomitant pain-relieving purpose," a practice which, in the Ninth Circuit's view, cannot truly be distinguished from physician-assisted suicide.[31] The Ninth Circuit wrote:

> As part of the tradition of administering comfort care, doctors have been supplying the causal agent of patient's death for decades. Physicians routinely and openly provide medication to terminally ill patients with the knowledge that it will have a "double effect"—reduce the patient's pain and hasten his death.[32]

The Ninth Circuit quoted the American Medical Association's Council on Ethical and Judicial Affairs: "The intent of palliative treatment is to relieve pain and suffering, not to end the patient's life, but the patient's death is a possible side effect of the treat-

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(1995); Jonathan McBride, Comment, *A Death Without Dignity: How the Lower Courts Have Refused to Recognize That The Right of Privacy and the Fourteenth Amendment Liberty Interest Protect an Individual's Choice of Physician-Assisted Suicide*, 68 Temp. L. Rev. 755, 759 nn.28, 31 (1995); Richard Myers, *An Analysis of the Constitutionality of Laws Banning Assisted Suicide from the Perspective of Catholic Moral Teaching*, 72 U. Det. L. Rev. 771, 775 nn.26-27 (1995); Steven Neeley, *The Constitutional Right to Suicide, The Quality of Life, and the "Slippery-Slope": An Explicit Reply to Lingering Concerns*, 28 Akron L. Rev. 53, 54 n.10 (1994); Shari O'Brien, *Facilitating Euthantic, Rational Suicide: Help Me Go Gentle Into That Good Night*, 31 Saint Louis U. L. J. 655, 657-58 nn.14, 20, 21, 22, 24-27 (1987); Rhonda Rivera, *Lawyers, Clients, and AIDS: Some Notes from the Trenches*, 49 Ohio St. L.J. 885, 889 n.97; James Rogers, *Punishing Assisted Suicide: Where Legislators Should Fear to Tread*, 20 Ohio N.U. L. Rev. 647, 651 n.35 (1993); Andrew Sims, *Tort Liability for Physical Injuries Allegedly Resulting from Media Speech: A Comprehensive First Amendment Approach*, 34 Ariz. L. Rev. 231, 261 n.227 (1992); George Smith, II, *All's Well That Ends Well: Toward a Policy of Assisted Rational Suicide or Merely Enlightened Self-Determination?*, 22 U.C. Davis L. Rev. 275, 289-90 nn.86-95,103-105, 292n.120 (1989); Benjamin Zipursky, *The Pedigrees of Rights and Powers in Scalia's Cruzan Concurrence*, 56 U. Pitt. L. Rev. 283, 295 n.60 (1994).

These authors are unaware of any challenges to the accuracy of the article's account of the legal history of suicide in America.

31. *Compassion in Dying*, 79 F.3d at 822.

32. *Id.* at 823.

ment."[33] The court maintained that there is no difference between this practice and giving an individual a lethal prescription; if one is legal, then the other ought to be as well. Here, however, the court made a mistake in logic.

Acceptance of the Ninth's Circuit's conflation of the two would lead to the absurd consequence that most modern medicine must be considered homicidal and most of the activities of daily living must be considered suicidal. Whenever an individual drives a car, crosses the street, or goes skiing, the individual chooses a course of action that entails the *risk* of death. Even if an individual remains at home in bed with the covers drawn over his or her head, the individual risks death: from lack of exercise, from starvation for failure to earn money for food, and even from dying in an earthquake that might strike. It is literally impossible to live without making choices that entail some risk of death.

This is certainly true of medical treatment. Even comparatively minor operations typically involve some risk, however small, of death. As the severity of the condition to be treated increases, the risks associated with the treatment frequently do so, as well. Oncologists, for example, must constantly balance the side effects of chemotherapy or radiotherapy against the potential life- or health-saving benefits hoped from the treatment.[34]

When an individual drives on the highway to get to work, knowing there is the danger of a deadly accident, the individual's action is not the logical equivalent of suicide. When a doctor prescribes a cancer drug, knowing there is some risk, perhaps a substantial risk, that it will weaken the patient's heart and lead

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33. *Id.* at note 95, (citing *Report of the Council on Ethical and Judicial Affairs of the American Medical Association*, 10 ISSUES L & MED. 91, 92 (1994)). The notion of incurring a significant risk of death in order to give adequate pain relief may be more a theoretical than a practical program. Howard Brody, M.D., Ph.D., who teaches medicine and bioethics at the Michigan State University School of Medicine, notes:

> Caregivers experienced in hospice settings know that it is extremely difficult to produce a fatal overdose by increasing the amount of opioid administered to a patient suffering pain. This is especially true when the agent is titrated with care and when the patient has been receiving an opioid long enough to build up tolerance.

Howard Brody, M.D., Ph.D., *Compassion in Dying v. Washington: Promoting Dangerous Myths in Terminal Care*, 2 BIOLAW S:154, S:156 (1996).

Brody points to the results of a study comparing the time of death of patients receiving high dose narcotics and that of patients receiving no narcotics. It showed no difference in survival time, contrary to the assumptions of the physicians administering the narcotics. *Id.* (citing W.C. Wilson et al., *Ordering and Administration of Sedatives and Analgesics during the Withholding and Withdrawal of Life Support from Critically Ill Patients*, 267 JAMA 949, 949-53 (1992)).

34. *See, e.g.*, Ian Tannock, M.D.,Ph.D. & Michael Boyer, M.D., *When Is a Cancer Treatment Worthwhile?* 323 NEW ENG. J. MED. 989 (1990).

to death, the doctor's action is not the logical equivalent of euthanasia.

Similarly, prescribing medication to a patient in order to relieve the patient's pain, knowing there is a greater or lesser degree of risk that the medication will weaken the respiratory system and thereby cause death, is not the same as giving a lethal injection *in order to cause death*, even if the intent to cause death is for the sake of alleviating the patient's pain. In the first case, the patient's death is risked in an effort to relieve pain, with the objective of controlling the pain without ending the patient's life; in the second case, the patient's death is caused, based on the belief that death is better than a life with pain. In this instance, if the objective is to end pain, it is only by means of ending the patient's life.

The Ninth Circuit, referring to the American Medical Association's Council on Ethical and Judicial Affairs statement on palliative treatment, said:

> The euphemistic use of "possible" and "may" may salve the conscience of the AMA, but it does not change the realities of the practice of medicine or the legal consequences that would normally flow from the commission of an act one has reason to believe will likely result in the death of another.[35]

The language that the Ninth Circuit dismissed as "euphemistic" in fact lies at the heart of the fundamental distinction. It is the distinction between a risk you cannot avoid, but which may well, if you are lucky, never come to pass, and a result that is certain or virtually certain.

It is always difficult to balance the risks of death against the benefits hoped for from a course of action, and undoubtedly there are times when sound judgment would conclude it is culpably reckless to run too great of a risk. Nevertheless, running a risk of death is clearly not the same as intending death.[36]

IV. Lethal Prescriptions and Withdrawals of Treatment: Is there a Difference?

Central to the Second and Ninth Circuits' opinions is the claim that no valid distinction can be drawn between the withholding

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35. *Compassion in Dying*, 79 F.3d at 823 n.95.

36. Of course, it is possible in particular cases to use the language of risk as a subterfuge for what is in fact an intent to kill. *See* the example recounted in Julia Pugliese, *Don't Ask—Don't Tell: The Secret Practice of Physician-Assisted Suicide*, 44 Hastings L.J. 1291, 1306 (1993). The particular language used does not vitiate the validity of the distinction. Giving a dose of painkiller greater than reasonable medical judgment deems necessary to control pain but sufficient to be certain or nearly certain to induce death could well be enough to conclude that, whatever the *professed* intent of the physician, the action was a case of euthanasia rather than pain control with a risk of death.

or withdrawal of life-saving medical treatment now permitted virtually without check in every state and direct killing by lethal prescription. The Ninth Circuit stated:

> Opponents of physician-assisted suicide must now explain precisely what it is about the physician's conduct in assisted suicide cases that distinguishes it from the conduct that the state has explicitly authorized.[37]

The Ninth Circuit also found:

> No ethical or constitutionally cognizable difference between a doctor's pulling the plug on a respirator and his prescribing drugs which will permit a terminally ill patient to end his own life. . . . To us, what matters most is that the death of the patient is the intended result as surely in one case as in the other.[38]

Reality, however, is more complex than as described by the Ninth Circuit. Undoubtedly, patients who reject and doctors who withhold or withdraw life-saving medical treatment sometimes, perhaps often, do so with the intent to end the patient's life. This, however, is not always the case.

Patients and their doctors must constantly make decisions among alternate courses of treatment, each course with its own risks of death and probabilities of benefit. Treatment A may have a 40% chance of long-term benefit but a 50% chance of immediate death; treatment B may have a 5% risk of immediate death but only a 10% chance of preventing death in the long term. In some cases, the probability of death from accepting, or rejecting, a particular course of life-saving treatment may be higher than in these examples, but these probabilities exist along a lengthy continuum.

In a case in which life-saving medical treatment is deliberately omitted with intent to cause death, that conscious rejection of treatment may be the ethical equivalent of suicide. For every such case, however, there are many more instances in which life-saving treatment is rejected with an intent other than that of bringing about death, perhaps as a result of balancing risks of death against probabilities of benefit.[39]

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37. *Compassion in Dying*, 79 F.3d at 822. *See also Quill*, 80 F.3d at 727-30.

38. *Compassion in Dying*, 79 F.3d at 824. The Second Circuit used similar language: "Physicians do not fulfill the role of 'killer' by prescribing drugs to hasten death any more than they do by disconnecting life-support systems." *Quill*, 80 F.3d at 730.

39. Indeed, one of the ironies in the history of withdrawal of treatment cases is that one early precedent, *In re* Yetter, 62 Pa. D. & C.2d 619 (1973), held that Mrs. Yetter's right to forgo treatment was an exercise of her right to die when in fact, as Robert Byrn observed, "Mrs. Yetter did not assert any such right. . . . In fact, Mrs. Yetter refused treatment precisely because she feared she would die from it." Robert Byrn, *Compulsory Lifesaving Treatment for the Competent Adult*, 44 FORDHAM L. REV. 1, 5 (1975). This point was made in the original article. Marzen, *supra* note 1, at 12 (citing Byrn, *supra*).

Suppose, for a moment, that a state wished to prevent those instances of treatment withholding or withdrawal motivated by an intent to cause death. How could the state in practice separate treatment decisions that involve suicidal intent from those that do not? How would the state distinguish, for example, between rejection of chemotherapy with the intent to die and rejection of chemotherapy with the intent to allow recovery from certain devastating side effects? How would the state distinguish between rejection of prostate surgery with the intent to die and its rejection with the intent to substitute a course of "watchful waiting?" How would the state distinguish between rejecting an aggressive course of therapy and choosing a conservative one with the hope that death will come soon, and a similar choice based on the belief that the risks are greater with the aggressive course?

In all of these examples and myriads more, such a distinction would have to be highly fact specific, made on a case by case basis. The state could hardly promulgate a set of regulations mandating for every illness or injury what treatment must be accepted and what may legally be forgone. States would instead have to set up some type of decision-making bodies, perhaps akin to ethics committees. These decision-making bodies would have to be numerous enough to investigate and evaluate the thousands of cases that occur every day in which decisions not to employ lifesaving medical treatment are made. It is true that some cutoffs might be established; perhaps the committees would review only decisions to forgo treatment in circumstances in which there was more than a 50% probability of mortality, for example. Yet, in application, such a standard would give rise to an extraordinary number of factual disputes.

There might indeed be a number of cases in which a clear intent to die was openly proclaimed or the death-causing consequence of forgoing treatment was especially undebatable. Yet, if such a regime were actually established, those individuals who sought death or were the cause of death would quickly learn to hide their intent, and while rejecting crucial lifesaving medical treatment, agree to undergo other, far less effective, treatment regimens in order to cloud the issue. To have any efficacy at all, the committees would have to probe beneath the declared intents and the superficial appearances, digging and delving into the subjective intent of doctor and patient and the objective efficacy of various alternative treatment modalities. These committees would somehow have to subject all or a large class of treatment decisions that involve a risk of death to a review designed to tease out the actual intent of the decisionmakers in each case. In

short, states would have to institute an inquisitorial process at once both utterly impractical and tyrannical. The invasion of privacy, the interference with ongoing medical care, and the waste of resources would be immense.

Of course, it is unimaginable that such a governmental process would ever seriously be proposed, let alone implemented. The thought experiment previously discussed has shown the infeasiblity and unacceptable consequences in practice of the state trying to regulate such treatment decisions.

Is it truly irrational, then, for states to draw a bright line between a patient's decision to accept or reject treatment, on the one hand, and action by doctors and others designed directly to cause death by lethal injection or other similar means, on the other? A clear intent to cause death is normally obvious when direct action is taken to kill the patient.[40] States *can*, in practice, prohibit assisting suicide and active euthanasia. Surely a state pursuing its legitimate interest in protecting human life is not required to do the impossible in order to be allowed to do that which it effectively can.[41]

The bottom line is that the Second and Ninth Circuits maintain that there is no difference in intent between individuals who withdraw or withhold lifesaving medical treatment and those who provide or obtain a lethal prescription; all equally intend death. This is sometimes the case but by no means always. Since it is impractical for states to implement a mechanism to differentiate between those cases of treatment refusal that are tantamount in intent to suicide or euthanasia and the much greater number of cases in which the intent is quite different, it is rational for states to refrain from interfering in such treatment decisions except in extraordinary circumstances. It is practical, however, for states to bar direct killing.[42] It is rational, there-

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40. It is true that even here states may encounter some practical difficulties in particular cases, such as in distinguishing between genuine attempts to control pain with an attendant risk of death and attempts to cause death under cover of pain control. These difficulties pale in comparison, however, to those involved in regulating decisions to withhold or withdraw treatment.

41. "A legislature must have substantial latitude to establish classifications that roughly approximate the nature of the problem perceived, that accommodate competing concerns both public and private, and *that account for limitations on the practical ability of the State to remedy every ill*." Plyler v. Doe, 457 U.S. 202, 216 (1982)(emphasis added).

42. Some may maintain that it is impractical for the state to prevent assisted suicide. Based on the acquittals of Jack Kevorkian and the paucity of cases of successful prosecution for assisting suicide, Guido Calabresi, the concurring judge in *Quill*, argued that the laws preventing the assistance of suicide have "fallen into virtual desuetude." *Quill*, 80 F.3d at 735 (Calabresi, J., concurring).

Yet, the prominent authors of "A Model State Act to Authorize and Regulate Physician-Assisted Suicide" consider the deterrent effect of existing legal obstacles to physi-

fore, for states, as far as the law is concerned, to draw a bright line between the two, and to prohibit assisted suicide, but not treatment withdrawal, without violating the Equal Protection Clause.

V. Nonvoluntary Euthanasia

It is useful to begin a discussion of nonvoluntary euthanasia by distinguishing among voluntary, nonvoluntary and involuntary forms of euthanasia.

Voluntary euthanasia refers to the killing of a competent individual at the individual's request, or to the killing of a currently incompetent individual in accordance with clear instructions that the individual had previously given while still competent.

Nonvoluntary euthanasia refers to the killing of an incompetent individual whose wishes are unknown, either because the individual has always been incompetent or because the individual left no clear instructions one way or the other about euthanasia.

Involuntary euthanasia refers to the killing of a competent individual against the individual's expressed will, or to the killing of a currently incompetent individual in violation of clear instructions that the individual had previously given while still competent.

While the holdings of the Second and Ninth Circuits on their face legalize physician-assisted suicide *only* when it is voluntarily chosen by terminally ill patients,[43] that limitation only occurs because the particular plaintiffs before those courts fell into that specific category and framed the relief they sought in those terms. The reasoning employed by the two courts sweeps much more broadly. Indeed, had the plaintiffs all happened to have had blue eyes and blond hair, the courts' holdings might just as well have been phrased in language finding a right to physician-assisted suicide for those with blue eyes and blond hair.

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cian-assisted as a major reason why, from their perspective, such a law is needed. Charles H. Baron et al., *A Model State Act to Authorize and Regulate Physician-Assisted Suicide*, 33 Harv. J. on Legis. 1, 6-7 (1996). The authors cite a poll of physicians which they summarize as "noting that although 35.2% of physicians responding had been asked to perform euthanasia and 27.8% would be willing to perform euthanasia if it were legal, only 2.2% had actually performed it." *Id.* at 7 n.23 (citing Robyn S. Shapiro et al., *Willingness to Perform Euthanasia: A Survey of Physician Attitudes*, 154 Archives Internal Med. 575, 581 (1993)).

The laws against rape and bank robbery do not deter all rapes or all bank robberies, yet can it be doubted there would be many more rapes and bank robberies if penalties against them ceased to exist? It is practical for states to make and enforce these laws, however, even though the laws are not perfectly effective. The same is true with the laws against assisted suicide, as the physicians' poll demonstrates.

43. *Quill*, 80 F.3d at 730; *Compassion in Dying*, 79 F.3d at 793-94.

That limitation would have had about as much connection to the analysis of the courts in these cases as does the "voluntary, terminally ill" limitation.

Of the two opinions, the Ninth Circuit's opinion was more explicit about this, although not, as shall become evident, more sweeping than that of the Second Circuit. The Ninth Circuit wrote, "our conclusion is strongly influenced by, but not limited to, the plight of mentally competent terminally ill adults."[44] The language used in the Ninth Circuit's opinion explicitly declared a right on the part of surrogates to choose lethal prescriptions for patients incapable of making health care decisions themselves. In the context of what it declared the right to obtain a lethal prescription, the court wrote, "we should make it clear that a decision of a duly appointed surrogate decision maker is for all legal purposes the decision of the patient himself."[45] When previously discussing surrogate decision-making, the court noted, "in cases in which an incompetent individual has not completed a living will or executed a durable power of attorney, some states permit a court to appoint a guardian to make medical decisions on the incompetent individual's behalf."[46] The court's language is evidently referring to nonvoluntary euthanasia, since the court is declaring the right of a guardian/surrogate to authorize the killing of an incompetent patient who has never expressed a desire to be killed.

While the decision of the Second Circuit was not as explicit, the consequences of the court's reasoning are similar. The Second Circuit essentially concluded that it is unconstitutional for any state to make a distinction between withholding of treatment, on the one hand, and providing a lethal prescription for direct killing, on the other. Laws that allow treatment withholding but prevent direct killing, the court held, violate the Equal Protection Clause of the Fourteenth Amendment.

In summary of its analysis, the Second Circuit wrote:

> It seems clear that : 1) the statutes in question [the New York laws preventing assisting suicide] fall within the category of social welfare legislation and therefore are subject to rational basis scrutiny upon judicial review; 2) New York law does not treat equally all competent

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44. *Compassion in Dying*, 79 F.3d at 816. The court went on to offer as examples, "those whose existence is reduced to a vegetative state or a permanent and irreversible state of unconsciousness" as categories of people who are obviously incompetent. *Id.*

45. *Id.* at 832 n.120.

46. *Id.* at 818 n.75. The court also said, "[E]ven though the protection of life is one of the state's most important functions, the state's interest is dramatically diminished if the person it seeks to protect is terminally ill or permanently comatose and has expressed a wish that he be permitted to die without further medical treatment (*or if a duly appointed representative has done so on his behalf*)." *Id.* at 820 (emphasis added).

> persons who are in the final stages of fatal illness and wish to hasten their deaths; 3) the distinctions made by New York law with regard to such persons do not further any legitimate state purpose; and 4) accordingly, to the extent that the statutes in question prohibit persons in the final stages of terminal illness from having assistance in ending their lives by the use of self-administered, prescribed drugs, the statutes lack any rational basis and are violative of the Equal Protection Clause.[47]

Noting that the lower court identified "a difference between allowing nature to take its course even in the most severe situations and intentionally using an artificial death-producing device,"[48] the Court of Appeals disagreed.[49] That court stated:

> The withdrawal of nutrition brings on death by starvation, the withdrawal of hydration brings on death by dehydration, and the withdrawal of ventilation brings about respiratory failure. By ordering the discontinuance of these artificial life-sustaining processes or refusing to accept them in the first place, a patient hastens his death by means that are not natural in any sense. It certainly cannot be said that the death that immediately ensues is the natural result of the progression of the disease or condition from which the patient suffers. . . . Withdrawal of life support requires physicians or those acting at their direction physically to remove equipment and, often, to administer palliative drugs which may themselves contribute to death. The ending of life by these means is nothing more nor less than assisted suicide.[50]

The Second Circuit noted that, "[a] finding of unequal treatment does not, of course, end the inquiry, unless it is determined that the inequality is not rationally related to some legitimate state interest."[51] After reviewing the state interests advanced to justify laws preventing assisted suicide through direct killing, however, the court wrote, "the New York statutes prohibiting assisted suicide . . . do not serve any of the state interests noted, in view of the statutory and common law schemes allowing suicide through the withdrawal of life-sustaining treatment."[52] In effect, the second half of the court's inquiry essentially collapsed into the first, since any interest the state could possibly assert would be dismissed on the ground that, in the court's view, it would equally tell against rejection of treatment permitted by the state.

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47. *Quill*, 80 F.3d at 727.

48. Quill v. Koppell, 870 F. Supp. 78, 84 (S.D.N.Y. 1994), *rev'd sub nom.* Quill v. Vacco, 80 F.3d 716 (2d Cir. 1996), *cert. granted*, Vacco v. Quill, 65 U.S.L.W. 3254 (U.S. Oct. 1, 1996) (No. 95-1858).

49. *Quill*, 80 F.3d at 729.

50. *Id.*

51. *Id.*

52. *Id.* at 730.

Since the Second Circuit could see no constitutionally supportable distinction between rejecting life-saving treatment and taking active measures to end life, it follows that *whenever* states permit rejection of treatment, they must equally permit active killing. The implications of this rationale necessarily extend beyond the terminally ill, competent adults to whom the Second Circuit's opinion ostensibly refers. In particular, in any state that authorizes surrogate decisionmakers to withdraw and withhold life-saving medical treatment from incompetent patients whose wishes are unknown, the rationale of the Second Circuit's decision will require that surrogates have an equal right to direct active measures designed to kill incompetent patients in similar circumstances.

The plaintiffs in *Quill* officially only sought the ability of doctors to prescribe lethal drugs for competent terminally ill patients who voluntarily request them, and, technically, the court's holding applies only to that class of individuals assisting suicide. Throughout its opinion, the Second Circuit couched its Equal Protection analysis in terms of the facts of that particular case; that is, the court referred to the New York law that permits terminally ill, competent patients to reject treatment and compared that with the New York law preventing such patients from obtaining assistance in committing suicide.

Nothing in this comparison, however, limits the force of the logic in the court's reasoning to terminally ill or to competent patients. If drawing a line between rejecting treatment and direct killing is irrational and unconstitutional in the context of terminally ill competent patients, how can drawing such a line suddenly be regarded as rational and constitutional in the context of incompetent patients or patients who are not terminally ill? The "irrationality," as the Second Circuit sees it, turns not on an issue unique to terminally ill or competent patients, but, rather, on the lack of relevant difference between what the court sees as two alternative means (treatment withdrawal or lethal prescription) to the same end (intended death).

Under the Second Circuit's broad rationale, as distinct from its narrow holding, it is difficult to see how New York can place limits on direct killing in any circumstances in which it does not equally place them on rejection of treatment. In particular, in states which permit surrogates or guardians to direct the withholding or withdrawal of life support from an incompetent patient who has never expressed any views on the subject, the Second Circuit's reasoning logically requires that surrogates or

guardians be equally empowered to direct the active killing of such patients, or nonvoluntary euthanasia.[53]

The Second Circuit opinion does attempt to dismiss the prospect of nonvoluntary euthanasia:

> As to the interest in avoiding abuse similar to that occurring in the Netherlands, it seems clear that some physicians there practice nonvoluntary euthanasia, although it is not legal to do so . . . . The plaintiffs here do not argue for euthanasia at all but for assisted suicide for terminally-ill, mentally competent patients, who would self-administer the lethal drugs. It is difficult to see how the relief the plaintiffs seek would lead to the abuses found in the Netherlands.[54]

The gravamen of this argument seems to be that the plaintiffs sought the right to lethal prescriptions which they would take themselves, but incompetent people cannot take lethal prescriptions themselves. The *reasoning* the court employed in order to grant the plaintiffs what they sought, however, is not so limited. It is the court's reasoning that allows no distinction between withholding treatment and administering lethal agents, and that requires nonvoluntary euthanasia in any state that permits a surrogate to reject life-saving treatment for an incompetent patient whose wishes are not clear.

As Yale Kamisar has argued,[55] there is equally no basis for limiting assisted suicide to those with terminal illness. If there is no rational, constitutionally cognizable difference between assisted suicide and withdrawal or withholding of life-saving medical treatment, then the fact that such treatment may be rejected in many instances when the patient is not terminally ill, in fact, effectively in *any* instance in which a patient wishes to reject it, forces the conclusion that the right to direct killing must be equally available.

Combining these realities yields the consequence that surrogates and guardians must, under the reasoning of the Second Circuit, be permitted to direct the killing of their incompetent wards with brain damage, Alzheimer's disease, mental illness or retardation, indeed, of incompetent individuals with virtually

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53. Since it held that physician-assisted suicide was covered by the Fourteenth Amendment's Due Process Clause, the Ninth Circuit saw no need to reach the Equal Protection Clause issue on which the Second Circuit relied, although it made a point of describing it as "not insubstantial." *Compassion in Dying*, 79 F.3d at 838 n.139. The same conclusion, however, appears to follow from the Ninth Circuit's dismissal of any constitutionally cognizable distinction between withholding or withdrawal of life-saving medical treatment and lethal prescriptions. *Id.* at 824.

54. *Quill*, 80 F.3d at 730-31 (citations and footnote omitted).

55. Yale Kamisar, *Against Assisted Suicide—Even a Very Limited Form*, 72 U. DET. L. REV. 735, 739-43 (1995).

any disability that, in the guardians' judgment, makes their lives not worth living.

Suppose for a moment that the majority of the Supreme Court wished to declare a constitutional right to physician-assisted suicide but *not* to nonvoluntary euthanasia. The Court might accomplish this by seeking solace in the Court's earlier holding in *Cruzan v. Director, Missouri Department of Health*.[56] In *Cruzan*, the Court held that, under the United States Constitution, a state may, *if it chooses*, require clear and convincing evidence that a patient would have wanted to reject food and fluids before authorizing their denial. The Court could thus say that, while it is unconstitutional for states to prevent voluntary euthanasia, states may constitutionally prevent nonvoluntary euthanasia by requiring clear and convincing evidence that an incompetent individual in fact wanted to be killed under these circumstances.

Only a small minority of states, however, take the position upheld by the Supreme Court in *Cruzan*.[57] The majority position gives surrogates or guardians of incompetent individuals authority to deny life support even though the incompetent individuals never expressed a view on whether or not life support should be provided.[58] If the Supreme Court adopts the equal protection

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56. 497 U.S. 261 (1990).

57. Two such states are Michigan, *In re* Martin, 538 N.W.2d 399 (Mich. 1995), *cert. denied*, 116 S. Ct. 912 (1996) and New York, where the *Quill* case originated, *In re* Westchester County Medical Ctr., 531 N.E.2d 607 (N.Y. 1988); *In re* Storar, 420 N.E.2d 64 (N.Y. 1981). The highest courts of Maryland and Missouri have also upheld the minority position, ruling that, in order to withhold food and fluids from a patient who is incompetent, there must be "clear and convincing evidence" that, while competent, the patient indicated that the patient would want them withheld. Mack v. Mack, 618 A.2d 744 (Md. 1993); Cruzan v. Harmon, 760 S.W.2d 408 (Mo. 1988). The effect of the Maryland *Mack* decision, however, has essentially been reversed by the passage of the Maryland Health Care Decisions Act in 1993. MD. CODE ANN., Health-Gen. §§ 5-601 to 5-618 (1994). *See esp.* § 5-605 (Surrogate decision-making).

Furthermore, the continued viability of *Cruzan*, the Missouri precedent, is called into question by the disposition of the highly publicized Christine Busalacchi case. *In re* Busalacchi, No. 59582, 1991 WL 26851 (Mo. App. Mar. 5, 1991). Christine Busalacchi's parents argued that they should have the right to decide on behalf of their severely disabled daughter that Christine would not want food or fluids, despite the conceded absence of clear and convincing evidence that Christine had rejected them. A newly elected Missouri Attorney General, fulfilling a campaign promise to support the parents' position, withdrew the state's objection and the Supreme Court of Missouri dismissed an effort by intervenors to require that Christine be fed, as would have been required by the "clear and convincing evidence" *Cruzan* standard.

Finally, New York has by statute provided for surrogacy decisions with respect to "Do Not Resuscitate" orders. N.Y. [PUB. HEALTH] LAW §2965 (McKinney 1994).

58. In 1993, before the *Martin* case in Michigan joined the minority position, the Kentucky Supreme Court wrote: "In all but two states, Missouri and New York, even when the court has been unable to precisely determine the express wishes of the patient, it has allowed the patient's family, or the patient's guardian, to exercise substituted judgment as to what the patient would wish." DeGrella *ex rel.* Parrent v. Elston, 858 S.W.2d

analysis of the Second Circuit, then, regardless of *Cruzan*, all states whose statutes or court decisions authorize surrogate decisionmaking for patients who have not left instructions or appointed a health care agent with respect to decisions regarding treatment will be required to allow surrogate authorization of

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698, 706 (Ky. 1993). Such surrogacy decisionmaking power is established in some form by statute or case law in thirty-nine jurisdictions (thirty-eight states and the District of Columbia): ARIZ. REV. STAT. ANN. §36-3231 (1992); Rasmussen v. Fleming, 741 P.2d 674, 685-86 (Ariz. 1987); ARK. CODE ANN. §20-17-214 (Michie 1993); *In re* Drabick, 245 Cal. Rptr. 840, 852 (Cal. Ct. App. 1988); Barber v. Superior Court, 195 Cal. Rptr. 484, 493 (Cal. Ct. App. 1983); COLO. REV STAT. ANN. §15-18.5-103 (1994); CONN. GEN. STAT. §19a-571 (1993); Foody v. Manchester Memorial Hosp., 482 A.2d 713, 721 (Conn. 1984); McConnell v. Beverly Enters.-Conn., Inc., 553 A.2d 596, 604 (Conn. 1989); D.C. CODE ANN. §21-2210 (1994); *In re* A.C., 573 A.2d 1235, 1247 (D.C. 1990); *In re* Tavel, 661 A.2d 1061, 1068-69 (Del. Ch. 1995); Severns v. Wilmington Medical Ctr., Inc., 421 A.2d 1334, 1347 (Del. 1980); FLA. STAT. ANN. §765.401 (West 1992); *In re* Browning, 568 So. 2d 4, 12 (Fla. 1990); John F. Kennedy Memorial Hosp. v. Bludworth, 452 So. 2d 921, 926 (Fla. 1984); Corbett v. D'Alessandro, 487 So. 2d 368, 370 (Fla. Dist. Ct. App.), *review denied*, 492 So. 2d 1331 (Fla. 1986); *In re* Barry, 445 So. 2d 365, 370-71 (Fla. Dist. Ct. App. 1984); GA CODE ANN. §31-9-2 (1993); *In re* Doe, 418 S.E.2d 3, 6 (Ga. 1992); *In re* L.H.R., 321 S.E.2d 716, 722-23 (Ga. 1984); IDAHO CODE §39-4303 (1993); ILL. REV. STAT. ch. 755, para. 40/25 (1994); *In re* C.A. v. Morgan, 603 N.E.2d 1171, 1180 (Ill. App. Ct. 1992); *In re* Longeway, 549 N.E.2d 292, 299 (Ill. 1989); *In re* Greenspan, 558 N.E.2d 1194,1201-02 (Ill. 1990); IND. CODE §16-8-12-4 (1990); *In re* Lawrance, 579 N.E.2d 32, 39 (Ind. 1991); IOWA CODE §144A.7 (1992); Morgan v. Olds, 417 N.W.2D 232, 236 (Iowa Ct. App. 1987); KY. REV. STAT. ANN. §311.631 (Michie/Bobbs-Merrill 1994); DeGrella v. Elston, 858 S.W.2d 698, 706 (Ky. 1993); LA. REV. STAT. ANN. §40:1299.58.1 to 10 (1991); *In re* P.V.W., 424 So. 2d 1015, 1019 (La. 1982); ME. REV. STAT. ANN. tit. 18-A, §5-801 to §5-817 (West 1995); MD. CODE ANN., [Health-Gen.] §5-605 (1994); *In re* Beth, 587 N.E.2d 1377, 1382 (Mass. 1992); *In re* Doe, 583 N.E.2d 1263, 1267-68 (Mass. 1992); Brophy v. New England Sinai Hosp., Inc., 497 N.E.2d 626, 633 (Mass. 1986); Custody of a Minor, 434 N.E.2d 601, 605 (Mass. 1982); *In re* Spring, 405 N.E.2d 115, 119 (Mass. 1980); Superintendent of Belchertown State School v. Saikewicz, 370 N.E.2d 417, 427-28 (Mass. 1977); *In re* Hier, 464 N.E.2d 959, 961, *review denied*, 465 N.E.2d 261 (Mass. 1984); *In re* R.H., 622 N.E.2d 1071, 1075-76 (Mass. App. Ct. 1993); *In re* Torres, 357 N.W.2d 332, 341 (Minn. 1984); MISS. CODE ANN. §41-41-3 (1993); MONT. CODE ANN. §50-9-106 (1993); NEV. REV. STAT. §499.626 (1991); *In re* Jobes, 529 A.2d 434, 451 (N.J. 1987); *In re* Peter, 529 A.2d 419, 423 (N.J. 1987); *In re* Quinlan, 355 A.2d 647, 664 (N.J. 1976); *In re* Clark, 510 A.2d 136, 141 (N.J. Super. Ct. Ch. Div. 1986); *In re* Visbeck, 510 A.2d 125, 129 (N.J. Super. Ct. Ch. Div. 1986); 1995 N.M. LAWS 182; N.Y. [Pub. Health] §2965 (McKinney 1994); N.C. GEN. STAT. §90-322 (1994); N.D. CENT. CODE §23-12-13 (1993); OHIO REV. CODE ANN. §2133.08 (Anderson 1992); *In re* Crum, 580 N.E.2d 876, 881-82 (P. Ct. Franklin County, 1991); *In re* Myers, 610 N.E.2d 663, 669-70 (P. Ct. Summit County, Ohio 1993); *In re* McInnis, 584 N.E.2d 1389, 1390 (P. Ct. Stark County, Ohio 1991); Leach v. Akron Gen. Medical Ctr., 426 N.E.2d 809, 813-14 (P. Ct. Summit County, Ohio 1980); OR. REV. STAT. §127.635 (1993); *In re* Fiori, 673 A.2d 905, 912 (Pa. 1996); Gray v. Romeo, 697 F. Supp. 580, 587-88 (D.R.I. 1988); S.C. CODE ANN. §44-66-30 (Law. Co-op. 1992); S.D. CODIFIED LAWS ANN. §34-12C-3 (1993); TEX. [Health & Safety] CODE ANN. §672.009 (West 1992); TEX. [Health & Safety] CODE ANN. §674.0001 to .024, specifically §674.008(b) (West 1995); UTAH CODE ANN. §75-2-1105,- 1105.5,-1107 (1993); VA. CODE ANN. §54.1-2986 (Michie 1992); WASH. REV. CODE §7.70.065 (1993); *In re* Grant, 747 P.2d 445, 449 (Wash. 1987), *modified*, 757 P.2d 534 (Wash. 1988); *In re* Ingram, 689 P.2d 1363, 1369 (Wash. 1984); *In re* Hamlin, 689 P.2d 1372, 1376 (Wash. 1984); *In re* Colyer, 660 P.2d 738, 744 (Wash. 1983); *In re* L.W., 482 N.W.2d 60, 67 (Wis. 1992); W. VA. CODE §16-30B-1 to -16 (1994); WYO. STAT. §3-5-209 (1994); WYO. STAT. §35-22-105(b) (1992).

lethal prescriptions for incompetent patients who have never expressed a desire to be killed.

These states will then be confronted with the dilemma of either allowing such nonvoluntary euthanasia or changing the state laws to make it more difficult (or impossible) for surrogates to direct the withholding of life-sustaining treatment for incompetent patients who have not left directions to do so.

The Supreme Court, alternatively, could disregard the equal protection analysis of the Second Circuit and rely instead on a due process theory, but one that would differ from that of the Ninth Circuit by not relying on an asserted equation of rejection of life-saving treatment and direct killing. In an opinion based on this theory, the Court could conceivably acknowledge a distinction between rejection of life-saving treatment and direct killing, while holding that, on balance, the state's interests nevertheless could not overcome a right to assisted suicide, at least in certain circumstances.

Even this approach, however, could not avoid resulting in the mandated legalization of nonvoluntary euthanasia in a significant number of states. The reason is that, even if the Supreme Court does not require a constitutional equation of direct killing with rejection of treatment, many state courts have established precedent requiring that rights available to competent individuals must also be made available to incompetent individuals, to be exercised on the behalf of incompetent individuals by surrogates or guardians. If assisted suicide becomes a federal constitutional right for competent individuals, many states will also require that nonvoluntary euthanasia be a right for incompetent individuals.

The question of whether states may constitutionally limit a constitutional right so that the right is available only to competent individuals who choose to exercise it voluntarily has already been addressed by numerous state courts in the life and death context of deciding whether food and fluids or lifesaving medical treatment can be withheld from an incompetent individual, resulting in the individual's death.

State courts have generally ruled that, in the words of the Washington Supreme Court, "[a]n incompetent's right to refuse treatment should be equal to a competent's right to do so."[59] Courts have held that constitutional equal protection guarantees require that guardians be permitted to "substitute their judgment" for the unknown preference of the incompetent patient and thus be able to opt for the patient's death. Specifically,

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59. *In re* Guardianship of Grant, 747 P.2d 445, 449 (Wash. 1987).

courts have so ruled in fourteen states: Arizona,[60] California,[61] Connecticut,[62] District of Columbia,[63] Florida,[64] Georgia,[65] Indiana,[66] Louisiana,[67] Massachusetts,[68] Minnesota,[69] New Jersey,[70] Ohio,[71] Washington,[72] and Wisconsin.[73]

In ruling that a constitutional right of competent individuals cannot be denied to incompetent people, state courts have held that a state *cannot even do so on the ground that it is thus protecting people who are incompetent from being nonvoluntarily forced to avail themselves of it*. Instead, to be constitutional, the law must permit guardians to exercise the right on behalf of the incompetent wards.

In the 1988 California case *In re Drabick*,[74] for example, the court held that since competent individuals may legally reject life-saving treatment, a conservator (the term used in California for a legal guardian) must be able to direct that the incompetent ward be allowed to die from discontinuation of food and fluids.[75] The court rejected an argument that the state's interest in protecting William Drabick from being nonvoluntarily allowed to die justified preventing the conservator from directing that Drabick's food and fluids be stopped by stating:

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60. Rasmussen v. Fleming, 741 P.2d 674, 685-86 (Ariz. 1987).

61. *In re* Drabick, 245 Cal. Rptr. 840, 852 (Cal. Ct. App. 1988); Barber v. Superior Court, 195 Cal. Rptr. 484, 492-93 (Cal. Ct. App. 1983).

62. Foody v. Manchester Mem'l Hosp., 482 A.2d 713, 721 (Conn. Super. Ct. 1984).

63. *In re* A.C., 573 A.2d 1235, 1247 (D.C. 1990).

64. *In re* Guardianship of Browning, 568 So. 2d 4, 12 (Fla. 1990); John F. Kennedy Mem'l Hosp. v. Bludworth, 452 So. 2d 921, 926 (Fla. 1984); Corbett v. D'Alessandro, 487 So.2d 368, 370-71 (Fla. Dist. Ct. App.); *In re* Barry, 445 So. 2d 365, 369-70 (Fla. Dist. Ct. App. 1984).

65. *In re* L.H.R., 321 S.E.2d 716, 722-23 (Ga. 1984).

66. *In re* Lawrance, 579 N.E.2d 32, 39 (Ind. 1991).

67. *In re* P.V.W., 424 So.2d 1015, 1020 (La. 1982).

68. *In re* Beth, 587 N.E.2d 1377, 1381-83 (Mass. 1992); *In re* Doe, 583 N.E.2d 1263, 1267-68 (Mass. 1992); Brophy v. New England Sinai Hosp., Inc., 497 N.E.2d 626, 633-34 (Mass. 1986); Custody of a Minor, 434 N.E.2d 601, 608-09 (Mass. 1982); *In re* Spring, 405 N.E.2d 115, 119 (Mass. 1980); Superintendent of Belchertown State School v. Saikewicz, 370 N.E. 2d 417, 427-28 (Mass. 1977); *In re* Hier, 464 N.E.2d 959 (Mass. App. Ct. 1984).

69. *In re* Torres, 357 N.W.2d 332, 339-40 (Minn. 1984).

70. *In re* Jobes, 529 A.2d 434, 444, 447 (N.J. 1987); *In re* Peter, 529 A.2d 419, 423, 429 (N.J. 1987); *In re* Quinlan, 355 A.2d 647, 664 (N.J. 1976); *In re* Clark, 510 A.2d 136 (N.J. Super. Ct.Ch. Div. 1986); *In re* Visbeck, 510 A.2d 125, 129 (N.J. Super. Ct. Ch. Div. 1986).

71. *In re* Crum, 580 N.E.2d 876, 879, 881, 883 (Probate Ct. Franklin County, 1991); Leach v. Akron Gen. Medical Ctr., 426 N.E.2d 809, 814, 816 (1980).

72. *In re* Grant, 747 P.2d 445, 449 (Wash. 1987); *In re* Ingram, 689 P.2d 1363, 1368 (Wash. 1984); *In re* Hamlin, 689 P.2d 1372, 1376 (Wash. 1984); *In re* Colyer, 660 P.2d 738, 744 (Wash. 1983).

73. *In re* L.W., 482 N.W.2d 60, 67 (Wis. 1992).

74. 245 Cal. Rptr. 840 (Cal. Ct. App. 1988).

75. *See id.*

> To delegate an incompetent person's right to choose inevitably runs the risk that the surrogate's choices will not be the same as the incompetent's hypothetical, subjective choices. Allowing someone to choose, however, is more respectful of an incompetent person than simply declaring that such a person has no more rights. Thus, by permitting the conservator to exercise vicariously William's right to choose, guided by his best interests, we do the only thing within our power to continue to respect him as an individual and to preserve his rights . . . .
>
> [T]he state has an interest in protecting William's right to have appropriate medical treatment decisions made on his behalf. The problem is not to preserve life under all circumstances but to make the right decisions. A conclusive presumption in favor of continuing treatment impermissibly burdens a person's right to make the other choice . . . .
>
> . . . . Both the fundamental right to life . . . and the right to terminate unwanted treatment deserve consideration. Someone acting in William's best interests can and must choose between them.[76]

The conclusion is that incompetent individuals cannot be denied the death the individual would have been able to choose were the individual competent on the basis that, being incompetent, the individual is not in fact seeking it. Rather, state constitutional grounds compel allowing a third party to make the choice for the individual.

If voluntary active euthanasia in the form of physician-assisted suicide is declared a constitutional right, the same logic would apply. States could not "deny" the right to physician assisted suicide to an incompetent individual who had never asked for it; rather, a third party would have to be entitled to choose directly to cause the individual's death, purportedly on behalf of the individual.[77]

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76. *Id.* at 209-10 (footnote & citations omitted).

77. Among those affected by this conclusion would be minor children, whose parents or guardians would thus be empowered to authorize giving the children lethal prescriptions.

In reaction to cases of parentally authorized denial of life-saving medical treatment to children born with disabilities, such as the Bloomington, Indiana baby with Down Syndrome, *In re* Infant Doe, No. GU 8204-004A (Monroe County Cir. Ct. Apr. 14, 1982), *reprinted in* 2 ISSUES IN L. & MED. 77 (1986), Congress acted. As part of the Child Abuse Amendments of 1984, 98 Stat. 1749 (1984), Congress sought to ensure that "disabled infants with life-threatening conditions" would not be the subject of "withholding of medically indicated treatment," 42 U.S.C.A. § 5106a(b)(10)(1995), a term it defined with considerable precision, 42 U.S.C.A. § 5106g(10) (1995). Congress, however, merely made it a requirement that state child abuse and neglect agencies enforce this provision as a condition of receiving federal funding. 42 U.S.C.A. § 5106a(a) & (b) (1995). A state court's interpretation, therefore, of the state's constitution as mandating that incompetents, including minor children, have equal access to lethal prescriptions as competent individuals would not be overruled by the federal law. The only consequence of such a state court holding would be to make the state ineligible for the particular federal child neglect and abuse funds governed by the federal provisions.

It deserves emphasis that the concern that in many states nonvoluntary euthanasia will flow inexorably from a Supreme Court decision finding a constitutional right to physician-assisted suicide *is not* simply another example of the typical "slippery slope" argument. The "slippery slope" argument normally makes a sociological or psychological prediction about what society is likely to do if certain barriers are breached, even in a small way at first. This, however, is a stronger form of argument, since there is not merely a danger, or a likelihood, of nonvoluntary euthanasia if voluntary euthanasia is declared a constitutional right; nonvoluntary euthanasia will be *logically compelled* as a result of existing state court precedents if the Supreme Court establishes a right to voluntary euthanasia.

VI. Conclusion

These authors have felt compelled to correct the misinterpretation of the account of the history of American law concerning suicide in the original article by the Ninth Circuit. In the authors' view, the Ninth Circuit also erred in equating pain control with a risk of causing death and lethal prescriptions with the objective of causing death. Both the Second and Ninth Circuits also improperly concluded that a state cannot rationally distinguish between the withholding of life-saving medical treatment, on the one hand, and direct killing on the other.

Beyond making the case against these errors, these authors have sought to demonstrate that if a constitutional right to voluntary assisted suicide is established, nonvoluntary direct killing of incompetent patients who have never asked to die simply cannot be avoided under existing legal precedent in many states.

All of these considerations, like others set forth in much greater detail in the original article, combine to suggest that the answer to the question whether suicide should be treated as a constitutional right is "no".