Physician-assisted suicide: New protocol for a rightful death

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PHYSICIAN-ASSISTED SUICIDE: NEW PROTOCOL FOR A RIGHTFUL DEATH

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I. INTRODUCTION

"And sweet is death who puts an end to pain."
Alfred Lord Tennyson,
Idylls of the King [1859-1885]
Lancelot and Elaine, 1,1000

The United States Supreme Court granted review of two physician-assisted suicide decisions from the Second and Ninth Circuits. These cases involved state statutes that regulate and criminalize assisting in death. The Second Circuit in Quill v. Vacco found a Fourteenth Amendment equal protection violation in a New York statute because similarly situated individuals were classified in a manner that was not rationally related to a legitimate state interest. This decision pertained to competent, terminally ill adults who would be legally prohibited from seeking active intervention in hastening death, e.g., by a prescription of a lethal dose of medication, as compared to similarly situated persons who would be permitted passive intervention, e.g., by the removal of life support. In a unanimous decision, however, the United States Supreme Court reversed the Second Circuit ruling and held that New York's prohibition on assisted suicide does not violate the Equal Protection Clause of the Fourteenth Amendment. The Ninth Circuit in Compassion in Dying v. Washington recognized a liberty interest in the determination of the time and manner of death based upon the Fourteenth Amendment Substantive
Due Process Clause. The United States Supreme Court reversed the Ninth Circuit, however, essentially allowing states to legislate and prohibit physician-assisted suicide.

This Article discusses the decisions of the circuit courts in the above-mentioned cases and then analyzes the two United States Supreme Court opinions which provide room for speculation as to future decisions in this area. Thereafter, a proposed model state act to authorize and regulate physician-assisted suicide is assessed along with a discussion of state legislative activity.

II. BACKGROUND OF THE “RIGHT TO DIE” CASES

An age-old dilemma plaguing mankind is the need to balance the rights of the individual with the rights of the larger group, the state. Such a conflict of rights inevitably arises in any society, but in a society as committed to individual autonomy as the United States, the country whose consistent promise to generations of immigrants has been the right to control their own destinies, this conflict becomes central to preserving our way of life. We have attempted to negotiate between conflicting rights many times in judicial history. Such negotiations are rarely satisfactory to either side of the conflict since both the individual and the larger society obviously lose something in the negotiation. Never, however, in this long history of balancing rights, perhaps with the exception of the right to life and abortion clash, has there been a debate more difficult than the current debate over the right to die. This complicated conflict embodies the classic dilemma: on one side is the individual's right to control his most intimate decisions, such as the decision to avoid needless suffering and to die with dignity; on the other side is the right of the larger society to preserve the value of life.

The United States Constitution recognizes the inevitability of this conflict in areas like the right to die. In fact, the Due Process and Equal Protection Clauses in the Fourteenth Amendment are meant to make certain that when the state abrogates the rights of an individual

9. See id.
10. See Washington v. Glucksberg, 117 S. Ct. 2258 (1997). This outcome was not unexpected. See, e.g., Linda Greenhouse, High Court Hears 2 Cases Involving Assisted Suicide; Justices, in an Unusually Personal Session, Reveal Their Reluctance to Intervene, N.Y. TIMES, Jan. 9, 1997, at A1; see also Patricia Zapor, News Analysis, Assisted Suicide Rulings: An open door to legalization?, PILOT, July 18, 1997, at 21 (discussing how Supreme Court Justices left open the possibility of permitting assisted suicide under different circumstances, especially in the con-currences of Justices Stevens, Souter and O'Connor). As will be discussed in Part III of this paper, Justices Ginsberg and Breyer aligned their views most closely with Justice O'Connor.
to preserve the rights of the group, it does so fairly, rationally and only when absolutely necessary. Two cases recently decided by federal circuit courts address the manner in which constitutional due process and equal protection enter into the negotiation between the right of a terminally ill adult to receive aid in dying and the right of the state to preserve the value of human life. These cases were recently heard and reversed by the United States Supreme Court. An analysis of the circuit court decisions in *Compassion in Dying v. Washington* and *Quill v. Vacco* reveals both the complexity and the unpredictability of using constitutional protections to negotiate a conflict of rights.

A. The Ninth Circuit: *Compassion in Dying v. Washington*

The first of these cases, *Compassion in Dying v. Washington*, was actually the first right to die case decided by a federal court of appeals. The plaintiffs included four physicians who treat terminally ill patients, three terminally ill patients and the non-profit Washington group, *Compassion in Dying*. Together, these plaintiffs challenged the constitutionality of a Washington statute which stated that “[a] person is guilty of promoting a suicide attempt when he knowingly causes or aids another person to attempt suicide.” The penalty for such action, a felony under this statute, was imprisonment for up to five years and a fine of up to $10,000. The plaintiff physicians did not challenge the “knowingly causes” portion of this statute. Rather, they centered their suit on the “or aids” provision, claiming this provision deterred them from exercising their best professional judgment in providing aid to terminally ill, competent adults who wish to hasten their deaths. In essence, the plaintiffs charged that the “or aids” provision violated both the Due Process Clause and the Equal Protection Clause of the Fourteenth Amendment and thus was unconstitutional “both on its face and as applied to terminally ill, mentally competent adults who wish to hasten their own deaths with the help of medication prescribed by their doctors.”

When deciding this case, the district court held that the Washington statute violated both the Due Process and Equal Protection

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Clauses. The district court did not, however, declare this statute unconstitutional in its entirety, but only as applied to physician-assisted suicide for terminally ill, mentally competent adults. A three-judge panel for the Ninth Circuit heard the appeal and reversed the district court's decision. Finding neither a due process nor equal protection violation, this panel ruled that the Washington statute was not invalid either on its face or as applied. Recognizing the "extraordinary importance" of this case, the Ninth Circuit decided to rehear Compassion in Dying en banc. On rehearing, the Ninth Circuit affirmed the district court's holding that the "or aids" provision of the statute as applied to physicians prescribing life-ending medication at the request of terminally ill, mentally competent adults violated the Due Process Clause of the Fourteenth Amendment. Having found the statute unconstitutional in this context, the Ninth Circuit found it unnecessary to consider the constitutionality of this law in the context of the Equal Protection Clause.

The disagreement among the courts underscores the abstract nature of the determinations being made and the difficulty of negotiating competing rights. While judicial tradition has established guidelines for resolving such statutory dilemmas, the application of these guidelines is inconsistent, because judicial discussion of such issues often involves as much personal value judgment as it does judicial precedent. A look at the Ninth Circuit's en banc decision in Compassion in Dying will illuminate this problem more completely.

When deciding whether a statute violates the Constitution's Due Process Clause, the courts, recognizing that this clause is meant to prevent capricious infringement of constitutionally-guaranteed individual liberties, must first decide whether the statute actually involves an individual liberty interest. In making this determination, the Ninth Circuit cites three pivotal United States Supreme Court decisions describing such a liberty interest. The first of these cases was offered in a dissenting opinion by Justice Harlan in Poe v. Ullman, which postulated that the United States Constitution guarantees more than the rights specifically enumerated. Here, Justice Harlan claimed that "the full scope of the liberty guaranteed by the Due Process Clause . . . broadly speaking, includes a freedom from all substantial arbitrary impositions and purposeless restraints." In the same

17. See id. at n.7.
20. See Compassion in Dying v. Washington 79 F.3d 790, 798 & n.9 (9th Cir. 1996)(en banc).
22. Id. at 543. See infra notes 121-129 and accompanying text discussing Justice Souter's concurrence in Washington v. Glucksberg.
vein, Justice Brandeis, dissenting in *Olmstead v. United States*,23 asserted that the Constitution guarantees the very broad "right to be let alone—the most comprehensive of rights and the right most valued by civilized men."24 Finally, the Ninth Circuit, noting the similarities between right-to-die and abortion cases, cited the United States Supreme Court's decision in *Planned Parenthood v. Casey*.25 Here, the Court found that matters like abortion, "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."26

While the right to die is not specifically guaranteed by the Constitution, the Ninth Circuit found this right to be of the type described above. This is a pivotal determination which, as the United States Supreme Court determination in this case proves, could easily be seen differently by reasonable people. Citing *Casey*, the Ninth Circuit first determined that the fundamental issue was whether a person had the right to die, rather than whether one had the right to "aid" in dying. Here, the circuit court further emphasized that the term "physician-assisted suicide" solely means the "prescribing of medication by a physician for the purpose of enabling a patient to end his life."27 Having established these parameters, the Ninth Circuit went on to cite the United States Supreme Court's decisions in *Palko v. Connecticut*28 and *Moore v. East Cleveland*29 as identifying the traditional benchmarks of a liberty interest guaranteed by the Due Process Clause. Here, the *Compassion in Dying* court found that the right to die must be so clearly "'implicit in the concept of ordered liberty'" that "'neither liberty nor justice would exist if [they] were sacrificed.'"30 In addition, such a liberty right was defined by the Supreme Court in *Moore* as "'deeply rooted in this Nation's history and tradition.'"31

In addressing these benchmarks, the Ninth Circuit noted that the approach to using such guidelines has been evolving as the conditions of medical culture have changed. Thus, the Ninth Circuit found that the traditional balancing test which first classifies a disputed right as fundamental, important or marginal and then applies to the state's action in protecting its conflicting right, a strict, substantive, or ra-

23. 277 U.S. 438 (1928).
24. Id. at 478.
27. Id. at 802 n.14.
31. Id. at 803 (quoting *Moore v. East Cleveland*, 431 U.S. 494, 503 (1977)).
tional basis standard of review, was gradually being replaced by a continuum approach.\textsuperscript{32} Citing the United States Supreme Court's decisions in \textit{Casey} and \textit{Cruzan v. Director, Missouri Department of Health},\textsuperscript{33} the Ninth Circuit noted that these decisions suggest fine-tuning the balancing test so that categories of rights and review standards are not so rigidly arbitrary. In these cases, the Supreme Court seemed to be using an approach which assumed that the rights of the individual and of the state can be placed on a continuum in terms of importance. The test then becomes simple. The more important the individual right upon which the state is attempting to infringe, the more important and persuasive must be the state's reason for infringing upon this right.\textsuperscript{34} This approach recognizes the arbitrary nature of traditional categories and the difficulty of classifying specific rights when using these categories.

Again, the Ninth Circuit rejected the concept that to qualify as a liberty interest, a particular right must have been culturally accepted in a nation's history.\textsuperscript{35} Rather, the Ninth Circuit cited decisions, including \textit{Casey}, which make clear that rights once denied to individuals by the states, such as miscegenation,\textsuperscript{36} have subsequently been recognized by the United States Supreme Court as rights guaranteed by the Constitution. The reason for this changing lexicon of rights is that the United States Constitution was meant to be a flexible document, capable of adapting to a constantly evolving society.

The Ninth Circuit noted that a majority of Americans believe that competent, terminally ill adults should have the right to request and receive the aid of a physician in dying.\textsuperscript{37} This changed cultural attitude reflects a changed medical culture. Today, Americans are more likely to die a lingering, undignified death with the dubious help of modern medical technology. However, while no state currently has a statute prohibiting suicide or attempted suicide, the majority of states have statutes against assisting in suicide.\textsuperscript{38} Here, the Ninth Circuit believes that state statutes lag behind and thus do not reflect current cultural attitudes. In this context, the Ninth Circuit suggested that the Constitution is dynamic enough to provide legal protection for an individual's due process liberty interest in hastening death. With this increasingly flexible approach to finding constitutional inclusion of a liberty right, the Ninth Circuit, not surprisingly, concluded that there

\begin{footnotesize}
\begin{enumerate}
\item See id. at 804.
\item 497 U.S. 261 (1990).
\item See Compassion in Dying v. Washington, 79 F.3d 790, 804 (9th Cir. 1996)(en banc).
\item See Loving v. Virginia, 388 U.S. 1 (1967).
\item See Compassion in Dying v. Washington, 79 F.3d 790, 810 & nn.48-50 (9th Cir. 1996)(en banc).
\item See id. at 810 nn.45-46.
\end{enumerate}
\end{footnotesize}
exists a "strong liberty interest in determining how and when one's life shall end" and that such an interest is protected by the Due Process Clause of the Fourteenth Amendment.\(^{39}\) As the Ninth Circuit recognized, however, reasonable jurists may not find this same liberty interest to be within the purview of the Fourteenth Amendment. Such a jurist might point out that constitutional protection of a right to assistance in dying might be attributing to the Constitution an elasticity it was not meant to have.

However, the Ninth Circuit saw support for the assertion of a due process liberty interest in the right to die by analogizing to two recent Supreme Court decisions, \textit{Casey} and \textit{Cruzan}. As suggested above, the Ninth Circuit found \textit{Casey} informative because of its description of the kind of choices which constitute a liberty interest. In \textit{Casey}, the Court found abortion to be one of the most "intimate and personal choices a person may make in a life-time," and thus "central to personal dignity and autonomy."\(^ {40}\) The Ninth Circuit concluded that the right to hasten one's death claimed by the plaintiffs in \textit{Compassion in Dying}, is a similar choice, and, like abortion, comes under the purview of the Due Process Clause. Again, however, this conclusion is by no means certain. Reasonable jurists may well find a difference between the nature of the choice to have an abortion and the nature of the choice to end one's life when terminally ill. In fact, this is a clear example of an area where the constitutional flexibility claimed by the Ninth Circuit, while sensitive to changing cultural mores and historical contexts, is also likely to result in more room for personal values to impact legal decisions.

The circuit court then cited the Supreme Court's \textit{Cruzan} decision as a more specific definition of the right to make the choice to die. In \textit{Cruzan}, the Court found that an individual has a "due process liberty interest in rejecting unwanted medical treatment, including the provision of food and water by artificial means."\(^ {41}\) This decision clearly affirms an individual's right to hasten his or her death.\(^ {42}\) While not addressing the right to receive aid in hastening death, \textit{Cruzan} opened the door for recognition of such a right. For many, the difference between refusing food and water and requesting and receiving a prescription of lethal medication is negligible. However, again, many people will conclude this difference is determinative.

Having found a constitutional liberty interest in determining the time and manner of one's death, the Ninth Circuit proceeded to the second phase of its analysis, the question of whether the Washington

\(^{39}\) See id. at 812. But see id. at 839 (Beezer, J., dissenting).


\(^{42}\) See Compassion in Dying v. Washington, 79 F.3d 790, 816 n.70 (9th Cir. 1996)(en banc).
statute abridged this right. In making this determination, the circuit court considered the importance of the state’s interests protected by the statute, the method used by the statute to protect these interests, the importance of the individual liberty interest abridged by the statute and the degree to which this interest is burdened by the statute. In this context, the circuit court found the State of Washington to have legitimate interests in preserving life, preventing suicide, avoiding involvement in suicide of third parties who might exert undue influence on the decision, mitigating the effect on family members, protecting the integrity of the medical profession and preventing adverse consequences.

To protect these interests, Washington could prohibit assisted suicide or regulate it. The Ninth Circuit found that the statute in question constituted a virtual prohibition to exercising the liberty interest in hastening death. Without physician assistance, the court noted most terminally ill adults will be unable to satisfactorily control the timing and circumstances of their deaths. Such patients generally lack the requisite knowledge and mobility to assure the desired outcome, and may, on their own, actually execute a failed suicide attempt which leaves them in a less autonomous position than prior to the attempt. Instead of such a prohibition, the Ninth Circuit suggested that the statute could have been written in a less restrictive manner which, instead of prohibiting assisted suicide, effectively regulated its occurrence. In fact, a model statute that has been proposed to accomplish this goal will be discussed later in this analysis.

The Supreme Court espoused the statutory regulation of liberty interests in *Cruzan*. While that decision upheld an individual’s right to refuse or terminate life-sustaining medical treatment, it also made clear that states have a legitimate regulatory role to play in such decisions. Thus, a Missouri statute requiring clear and convincing evidence of a patient’s wishes was upheld by the *Cruzan* Court. The Ninth Circuit suggested that such reasonable regulation, designed to protect the integrity of the decisionmaking process while minimally burdening the terminally ill patient’s liberty interest, is preferable to the blanket ban on assisted suicide in the Washington statute. Such a complete ban, the court noted, unfairly burdened a person’s liberty interest. In short, the circuit court’s decision in *Compassion in Dying* concluded that states should not completely proscribe important lib-

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43. See id. at 816.
44. See id. at 816-31.
45. See id. at 832.
46. See id. at 832-33.
47. See *Cruzan v. Director, Missouri Dept. of Health* 261, 280-81 (1990).
48. See *Compassion in Dying v. Washington*, 79 F.3d 790, 833 (9th Cir. 1996)(en banc).
erty interests. Rather, states should regulate the exercise of these interests to minimize the occurrence of abuses. The Ninth Circuit intended this argument to refute the argument of jurists who are loathe to recognize new rights beyond those recognized by the original framers of the Constitution. However, the court's reasoning seems to fall short of its objective. For reasonable jurists may conclude that the holding, which does not allow states to prohibit an important liberty interest, is not identical to deciding that the judiciary should refrain from identifying new rights in the Constitution.

Having evaluated the legitimate state interests and the means used to preserve those interests, the Ninth Circuit then analyzed the strength of the liberty interest involved in this case and the burden imposed on that liberty interest by the Washington statute. In this context, the court found that the law in question impacted the plaintiffs when their liberty interest in hastening their deaths was at its height. The court emphasized the continuum approach: while a young, healthy person's liberty interest in the right to die is at the lowest point on this continuum, a terminally ill, mentally competent adult's liberty interest falls at the high point. To support this conclusion, the Ninth Circuit stated that, for such an adult, prohibiting assisted suicide may be equivalent to mandating the kind of pain and suffering the Casey Court found to result from banning abortions, "'pain . . . [and] suffering that is too intimate and personal for the State to insist upon.'"

The Ninth Circuit then found the Washington statute did indeed unduly burden this strong liberty interest. Citing abundant anecdotal and medical evidence attesting to the suffering imposed on terminally ill patients by such a statute, as well as to the gruesome means of suicide to which patients who wish to end their suffering are then forced to resort, the court also emphasized the emotional toll on family members who either agree to assist in suicide or refuse to provide such assistance. In this phase of its analysis, the Ninth Circuit determined that the plaintiffs had a strong liberty interest which was being unduly burdened.

The Ninth Circuit then applied the balancing test, weighing the legitimate state interests against the conflicting individual liberty interests. Recalling the existence of a continuum along which the strength of these rights can be represented, the court concluded that the strength of the state's interests actually varies inversely with the strength of the individual's liberty interest. Thus, while the liberty interest of a suffering, competent, terminally ill adult is at its height,

49. See id. at 834.
50. Id. (quoting Planned Parenthood v. Casey, 505 U.S. 833, 852 (1992)).
51. See id. at 836.
52. See id. at 836-37.
the state's interest in preserving that person's life, and all the permutations of that interest, is at its low point. The Ninth Circuit acknowledged that in the case of a terminally ill adult, Washington has a strong interest in preventing undue influence on that adult's decision as well as a strong interest in preventing other abuses of the individual's liberty right. However, the court found that the strength of the individual's liberty interest in such a case still outweighed the strength of the state's interest in preventing abuse, particularly in light of the state's ability to prescribe the involvement of a physician and other procedural safeguards. In fact, the Ninth Circuit strongly asserted that, if the Washington statute was allowed to stand, "it is hard to envision where the exercise of arbitrary and intrusive power by the state can be halted." It should be noted that at every point where the court made decisions about the relative strength of competing interests, there were subjective value judgments involved which, while reasonable in themselves, could easily be reversed by other reasonable jurists.

The final legal authority examined by the Ninth Circuit in Compassion in Dying was the district court decision in Lee v. Oregon. The Ninth Circuit gave this decision short shrift. In Lee, the district court held that the Oregon Death with Dignity Act, a statute which allows physicians to prescribe medication for use by terminally ill patients to end their lives, "violates the Equal Protection Clause of the Fourteenth Amendment because it deprives terminally ill persons of a benefit that is accorded to the non-terminally ill." The circuit court in Compassion in Dying emphasized the Lee decision's lack of logic. For, what the Lee court termed a benefit, protection of the terminally ill patient from physician assistance in committing suicide, is the very burden from which the plaintiffs in Compassion in Dying sought relief. Conversely, the Lee court saw the burden of continuing a life of unmitigated pain, which is certain to end in death, as a benefit. While the Lee decision seems clearly erroneous, it can also be viewed as the result of a world view which puts a supreme value on life, no matter what its form, to bear on facts about which reasonable individuals may draw different conclusions.

While rejecting the Lee decision about the reach of the Equal Protection Clause over the right to hasten one's death, the Ninth Circuit refused to analyze this issue on its own. Instead, the court deter-

53. See id.
54. Id.
55. 891 F. Supp. 1429 (D. Or. 1995). This decision was vacated and remanded by the appeals court. See 107 F.3d 1382 (9th Cir. 1997), cert. denied sub nom. Lee v. Harcleroad, 118 S. Ct. 328 (1997); see also infra notes 232-95 and accompanying text discussing Lee.
56. Compassion in Dying v. Washington, 79 F.3d 790, 837 (9th Cir. 1996)(en banc).
mined that the Washington statute banning assisted suicide violated constitutional due process protection as applied to terminally ill adults who wish to hasten their deaths by obtaining medication prescribed by doctors.\(^{57}\) Having found a constitutional violation sufficient to uphold the district court’s finding that the Washington statute was unconstitutional, the Ninth Circuit found it unnecessary to consider whether this statute also violated the Fourteenth Amendment’s Equal Protection Clause.\(^{58}\)

As suggested above, the Ninth Circuit’s decision in *Compassion in Dying* represents a reasonable approach to the issues in this case. However, as the Ninth Circuit acknowledged, there is much in this case which may be viewed differently in the light of different value systems. Again, the degree to which the Constitution can be construed to encompass rights not specifically enumerated, also looks different in the light of differing judicial philosophies. Perhaps this is why the United States Supreme Court rendered the decision it did when considering this case. A conservative approach to applying the Constitution to right to die cases may be necessary to prevent too much bending of the Constitution to changing cultural mores. While the Constitution may have been meant to evolve with society, it was also meant to guide the evolution of that society according to certain principles which were indeed incontrovertible and clearly essential to the preservation of liberty and justice for all.

**B. The Second Circuit: *Quill v. Vacco***

Within one month of the Ninth Circuit’s decision in *Compassion in Dying*, the Second Circuit decided *Quill v. Vacco*,\(^{59}\) another “right to die” case. In *Quill*, however, the Second Circuit reached a similar conclusion but on different grounds. Here, the court found unconstitutional two New York statutes which made assisting in suicide a felony.\(^{60}\) However, the Second Circuit did this, not because the statutes violated the Due Process Clause, but because they violated the Equal Protection Clause.

In this case, the plaintiffs, three physicians and three individuals in the final phase of terminal illness, challenged the constitutionality of the New York statutes on the same grounds as those on which the *Compassion in Dying* plaintiffs challenged the Washington statute. The district court granted summary judgment in favor of the defendants, rejecting the plaintiffs’ due process and equal protection claims.\(^{61}\) The plaintiffs appealed and the Second Circuit upheld the

\(^{57}\) See id. at 838.

\(^{58}\) See id.

\(^{59}\) 80 F.3d 716 (2d Cir. 1996).

\(^{60}\) See id. at 719.

\(^{61}\) See id. at 718.
district court's decision on the due process claim, but reversed on the equal protection claim.62

When considering whether the New York statutes violated the Fourteenth Amendment's guarantee that important liberty interests will not be abridged without due process, the Second Circuit viewed the issue differently than the Ninth Circuit. Here, the susceptibility of these questions to differing interpretations by differing jurists, all of whom are presumably reasonable, becomes obvious. The Quill court found there was no important liberty interest or fundamental right to hasten one's death.63 The court considered the Palko and Moore precedents for determining which rights not enumerated in the Constitution should be afforded due process protection. However, the Second Circuit concluded that the right to control the time and manner of one's death did not meet the criteria set forth in these precedents. In opposition to the Ninth Circuit decision, the Quill court did not see the right to die as meeting the Palko prerequisite of being so "implicit in the concept of ordered liberty" that "neither liberty nor justice would exist if they were sacrificed."64

When considering the imperative in Moore, that a fundamental liberty interest must be "deeply rooted in this nation's history and tradition," the Second Circuit rejected the Ninth Circuit's dynamic view of the Constitution as a flexible document which could adapt to a changing society. Rather, the Quill court noted the United States Supreme Court's reluctance to expand the list of fundamental rights protected by the Due Process Clause, citing the holding in Bowers v. Hardwick65 which refused to strike down sodomy laws because of their deep historical roots. The Second Circuit emphasized that the Supreme Court's refusal to discover new fundamental rights reflected that Court's belief that the judiciary comes "nearest to illegitimacy when it deals with judge-made constitutional law having little or no cognizable roots in the language or design of the Constitution."66 Here, the Second Circuit clearly recognized the danger implicit in adapting the Constitution too freely to a changing society in an attempt to validate a desired social policy, as perhaps was done by the court in Compassion in Dying.

Having found no due process liberty interest in the plaintiffs' challenge of the New York statutes, the Quill court, unlike the Compassion in Dying court, turned to an analysis of the plaintiffs' equal protection challenge. Here, the plaintiffs sought to invoke the protection afforded by the Equal Protection Clause's mandate that "all per-

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62. See id.
63. See id. at 725.
64. Id. at 724; see also supra note 30.
66. Quill v. Vacco, 80 F.3d 716, 724 (2d Cir. 1996).
sons similarly circumstanced shall be treated alike.”67 This clause does not undermine the ability of the state to treat differently things that are, in fact, different. In fact, in *Plyler v. Doe,*68 the United States Supreme Court held that “[t]he initial discretion to determine what is ‘different’ and what is ‘the same’ resides in the legislatures of the states.”69 In line with this holding, the general rule has been that state legislation “carries a presumption of validity if the statutory classification is ‘rationally related to a legitimate state interest.’”70 The *Quill* court settled on rational basis scrutiny, which usually governs judicial review of social welfare legislation or economic legislation, after having rejected the strict scrutiny review which is reserved for fundamental rights and intermediate scrutiny review.71

The Second Circuit then determined that the right to refuse medical treatment has long been established in New York through case law72 and later by statute.73 In fact, in acknowledgment of this judicial precedent, in 1987 the New York legislature enacted a statute which gave competent citizens the right to issue “do not resuscitate” orders. This statute established the kinds of procedural safeguards suggested by the Ninth Circuit as acceptable methods for narrowing the Washington statute.74 Again, in 1990, the New York legislature enacted a statute which accords competent citizens the right to sign a health care proxy, authorizing a designated agent to make health care decisions, including decisions about administration of artificial hydration and nutrition for the patient. This law also includes extensive procedural safeguards designed to prevent abuses.75 Finally, the *Quill* court cited *Cruzan* which assumed that “the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition.”76

Given the fact that competent, terminally ill New York citizens have the statutory right to refuse life-sustaining medical treatment, the Second Circuit in *Quill* found that New York does not treat similarly situated persons alike because “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

67. *Id.* at 725 (quoting *Plyler v. Doe,* 457 U.S. 202, 216 (1982)).
69. *Id.* at 216.
70. *Quill v. Vacco,* 80 F.3d 716, 725 (2d Cir. 1996) (quoting City of Cleburne v. Cleburne Living Center, Inc., 473 U.S. 432, 440 (1985)).
71. See *id.* at 726-27; see also *Bowen v. Owens,* 476 U.S. 340, 345 (1986).
74. *See id.*
75. *See id.*
similarly situated, except for the previous attachment of life-sustaining equipment, are not allowed to hasten death by self-administering prescribed drugs." The obvious question arising here is whether the "except for" clause in the previous sentence negates the Second Circuit's finding: If patients are similarly situated except for dependence on life-support systems, are such patients actually similarly situated?

Having found unequal treatment, the Second Circuit then applied a "rational basis" test to determine if the unequal treatment was rationally related to a legitimate state interest. Because the Quill court saw the state as having little interest in "requiring the prolongation of life that is all but ended," or in any of the possible state interests considered by the Ninth Circuit in Compassion in Dying, the Second Circuit found that the New York statutes were not rationally related to a legitimate state purpose. Therefore, the Quill court struck down the New York statutes, holding that 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."

Interestingly, the Second Circuit declined to find a due process violation in the New York statutes, which the Ninth Circuit posited for the Washington statutes, because the Second Circuit refused to find abstract concepts not specifically rooted in the Constitution. However, in finding that the New York statutes violate the Equal Protection Clause, the Second Circuit itself seems to expand upon the meaning of "similarly circumstanced," positing a specific meaning to the phrase which cannot necessarily be proven.

These two appellate decisions, Compassion in Dying v. Washington and Quill v. Vacco, clearly reveal the problems attendant on this issue which are yet to be fully resolved. Is there a fundamental right to hasten one's death? Can such a right be safely legislated? Is there a meaningful distinction between terminating artificial hydration and nutrition and taking prescribed drugs in a lethal dose? When are terminally-ill patients truly "similarly circumstanced?" What constitutes a rational relationship to a legitimate state interest? In light of the United States Supreme Court's recent resolution of these two cases, what case, if any, would provide a better vehicle to successfully challenge a state statute prohibiting physician-assisted suicide? Finally, will state statutes authorizing assisted suicides prevail against future constitutional challenges? As illustrated in Compassion in Dying and

77. Id.
78. Id.
79. See id. at 730 n.2.
80. Id. at 727.
Quill, there are indeed questions about which reasonable jurists might disagree. In fact, perhaps reasonable disagreement is the proper course in such a debate. Such tugging to the right and left of center is what, in the long run, actually maintains an accurate balance between the rights of the individual and the rights of the state. While this alternate tugging may be viewed in the two appellate decisions examined above, it also seems clear that the general tendency of lower courts is to allow competent, terminally ill adults to control the time and manner of their death. This is the conclusion that both the Ninth and Second Circuits reached, apparently by bringing that conviction to bear on the abstract language of the Constitution.

III. THE UNITED STATES SUPREME COURT

“They’ll give him death by inches”
William Shakespeare
Cariolanus, V, iv, 43

A. No Rightful Death

In the final days of its 1997 term, the United States Supreme Court handed down its decisions on the two “right to die” cases. The Court voted unanimously to uphold the constitutionality of state bans on physician-assisted suicide in Washington and New York. While legal experts generally expected the Court to leave the regulation of physician-assisted suicide to individual states, the opinions reflect an interesting divergence of analytical viewpoints among the Justices, further indicating that a future challenge may be viable. For now, however, for good or ill, the states will provide the legislative

83. See Carey Goldberg, Oregon Moves Nearer to New Vote On Allowing Assisted Suicide, N.Y. TIMES, June 10, 1997, at A25 (noting most legal observers expect Justices to rule that assisted suicide should be left to state regulation); Richard A. Knox, Suicide fight seen shifting to the states; High Court is expected to reject a right to doctor-assisted death, BOSTON GLOBE, June 16, 1997, at A1; David E. Rosenbaum, Americans Want a Right to Die. Or So They Think, N.Y. TIMES, June 8, 1997, § 4, at 3 (stating in reference to the two pending cases that “[t]he almost universal view in legal circles is that the Supreme Court will overturn the appeals courts and let the state laws stand”).
84. See generally The Supreme Court: Physician-Assisted Suicide, Excerpts From Decision That Suicide Bans Are Constitutional, N.Y. TIMES, June 27, 1997, at A18 (illustrating varying perspectives among Justices despite their general agreement to reverse the Ninth and Second Circuits’ rulings that the Washington and New York statutes banning assisted suicide were unconstitutional).
'laboratory' for measures that either prohibit, restrict or authorize physician-assisted suicide.\textsuperscript{85}

The Court provided a rapt audience of constitutional scholars with two lengthy and seemingly overlapping opinions. In \textit{Washington v. Glucksberg}, no fundamental liberty interest in assisted suicide was recognized by the Court pursuant to its substantive due process analysis.\textsuperscript{86} Thus, there will be no 'rightful death' actions as there are 'wrongful death' actions.\textsuperscript{87} Absent direct precedent supporting a right to assisted suicide, this outcome was predictable in light of the Court's increasing resistance to ad hoc proclamations of fundamental rights or interests that deserve Fourteenth Amendment due process protection.\textsuperscript{88} The Court refused to adopt an expansionist approach, hesitat-


\textsuperscript{86} See \textit{Washington v. Glucksberg}, 117 S. Ct. 2258, 2275 (1997). As will be discussed, while the Court proclaimed no fundamental liberty interest in the right to die, various Justices indicated their leanings and implicitly or explicitly projected some prerequisites for a different outcome in a future case.

\textsuperscript{87} The authors pose this designation as an original legal term, one that clearly contrasts with the wrongful death concept. Of course, theoretically, a state could legislate such a claim. Wrongful death actions involve a cause of action for the benefit of decedent's beneficiaries on the basis that a defendant negligently or willfully caused the death. \textit{See BLACK'S LAW DICTIONARY} 1612 (6th ed. 1990). A "rightful death" refers to the individual's right to control the "how" of his or her death, rather than "whether" he or she will die. \textit{See Vacco v. Quill}, 117 S. Ct. 2293, 2307 (1997)(Stevens, J., concurring)(positing a liberty interest in "deciding how, rather than whether, a critical threshold shall be crossed"); \textit{Washington v. Glucksberg}, 117 S. Ct. 2258, 2307 (1997)(Stevens, J., concurring)(disclaiming an "absolute right to physician-assisted suicide" but referring to a "liberty interest in deciding, rather than whether, a critical threshold shall be crossed" as a "specific interest in making decisions about how to confront an imminent death").

\textsuperscript{88} See Richard S. Myers, \textit{An Analysis of the Constitutionality of Laws Banning Assisted Suicide from the Perspective of Catholic Moral Teaching}, 72 U. DET. MERCY L. REV. 771, 776-84 (1995) (discussing problem the Court would encounter in declaring a new fundamental right to die in light of its conservative approach over the past decade, and differentiating the Supreme Court precedents that circuit courts later relied upon in \textit{Compassion in Dying v. Washington} and \textit{Quill v. Vacco}, the two right to die cases); \textit{see also} Cass R. Sunstein, \textit{Essay, The Right to Die}, 106 YALE L. J. 1123, 1124 (1997)(advising that the "Court should be wary of recognizing rights of this kind" but if the Court "assumes that the right to physician-assisted suicide qualifies as 'fundamental' under the Due Process Clause, a legal ban on physician-assisted suicide is constitutionally permissible in light of the state's legitimate and weighty interests in preventing abuse, protecting patient autonomy, and avoiding involuntary death"); Hon. Daniel A. Manion, \textit{Lecture, Rights That Are Wrong}, 72 NOTRE DAME L. REV. 1, 4-5 (1996)(criticizing tendency of litigants who press for constitutional rights and commenting on the
ing to extrapolate from the context of abortion or other reproductive rights to the active termination of the lives of competent adults.\textsuperscript{89}

The withdrawal of life support, or even of food and water, is a legally protected method of hastening the death of a terminally ill, competent adult who requests such passive intervention.\textsuperscript{90} The right to refuse treatment has long been recognized at common law, as has the distinction between active and passive means, the latter proving particularly critical to the Court's finding that there was no equal protection violation in \textit{Vacco}.

\textsuperscript{91} The Court declined to "reverse centuries of [Anglo-American jurisprudential] doctrine and practice" in order to honor the respondent's claim of a fundamental liberty interest in assisted suicide.\textsuperscript{92} Consequently, there is no right to suicide itself, but just a lightening of criminal sanctions that primarily penalized the actor's survivors.\textsuperscript{93} Absent fundamental right status for assisted suicide, the Washington statute needed only be rationally related to legitimate governmental interests, which standard the Court found was unquestionably met.\textsuperscript{94}

The Court deferred to the legislative and democratic processes as appropriate vehicles to further the assisted suicide debate.\textsuperscript{95} As a territorial or even jurisdictional question, the Court did not see itself as

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“right to assisted suicide recently found by the Second and Ninth Circuits” [in \textit{Quill v. Vacco} and \textit{Compassion in Dying v. Washington} while at the same time no right to sue was permitted for an unborn baby killed by an amniocentesis needle in Florida [no citation on this case was provided]]. Judge Manion's comparison raises the wrongful death concept (denied to a fetus in this instance) and contrasts it with the right to assisted suicide which we have labeled "rightful death." \textit{See supra} note 1. Another commentator compares the claimed right to assisted suicide to the emergence of the recognition of a cause of action for wrongful life. \textit{See} Lois Shepherd, \textit{Sophie’s Choices: Medical and Legal Responses to Suffering}, 72 \textit{Notre Dame L. Rev.} 103, 108-15 (1996).
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\begin{itemize}
  \item \textsuperscript{89} \textit{See} \textit{Washington v. Glucksberg}, 117 S. Ct. 2258, 2270-71 (1997) (distinguishing other personal autonomy cases from physician-assisted suicide).
  \item \textsuperscript{90} \textit{See} \textit{Vacco v. Quill}, 117 S. Ct. 2293, 2297-98 (1997). The Court makes much of intent and the (primary) cause of death as well as of the distinction between “killing” and “letting die.” \textit{See id.} at 2298-2301.
  \item \textsuperscript{91} \textit{Cf. id.} at 2305-06 (Stevens, J., concurring). Justice Stevens interpreted \textit{Cruzan} as authorizing “affirmative conduct that would hasten [the petitioner’s] death.” \textit{Id.} Justice Stevens saw this right to refuse treatment as “an aspect of a far broader and more basic concept of freedom that is even older than the common law.” \textit{Id.} at 2306.
  \item \textsuperscript{92} \textit{Washington v. Glucksberg}, 117 S. Ct. 2258, 2269 (1997).
  \item \textsuperscript{93} \textit{See id.} at 2264. The confiscation of the decedent’s goods primarily harmed the remaining heirs and likely did little to discourage the act of suicide. Suicide is generally thought to be the product of psychological or psychiatric problems. Studies illustrate that ninety-five percent of those who kill themselves have a diagnosable mental disorder at death. \textit{See The New York State Task Force On Life and The Law, When Death Is Sought 9-11} (1994) [hereinafter, \textit{New York State Task Force}].
  \item \textsuperscript{94} \textit{See} \textit{Washington v. Glucksberg}, 117 S. Ct. 2258, 2275 (1997).
  \item \textsuperscript{95} \textit{See id.} at 2275 and 2303 (O'Connor, J., concurring).
\end{itemize}
vested with the power to create a right to assisted suicide. Rather, the people of any state may act by ballot initiative or bicameral legislative process to delineate a model that represents the majority view. This has been the route followed by Oregon, where a second vote on the nation's first law permitting physician-assisted suicide reinstated the law in November 1997.

B. Comparing Opinions: Where the Justices Stand on the Issues

The Court's opinions in the two 'right to die' cases are intertwined. This is because the cases both determined the validity of state prohibitions on assisted suicide. The difference between the cases is largely the constitutional basis for the challenge to the state statute in question. In Vacco v. Quill, the challenge devolved upon the Fourteenth Amendment's Equal Protection Clause, whereas in Washington v. Glucksberg, the Fourteenth Amendment's Due Process Clause set the standard for review. The rationale provided by the Justices in their opinions is inclined to overlap from one decision to the other. In fact, Justice O'Connor's concurrences are identical in the two decisions, as are Justice Breyer's two concurring opinions and Justice Stevens' opinions.

96. The Court repeatedly referred to the states' activity in this matter and noted their trend to prohibit assisted suicide. See id. at 2265-67.


98. See Timothy Egan, The 1997 Elections: Right to Die: In Oregon, Opening a New Front in the World of Medicine, N.Y. Times, Nov. 6, 1997, at A26 (discussing victory of right-to-die camp that Oregon law survived repeal effort); Goldberg, supra note 83. At this time, the Federal Drug Enforcement Administration has warned physicians who prescribe drugs under the Oregon law that they will face severe sanctions. See Timothy Egan, Threat From Washington Has Chilling Effect on Oregon Law Allowing Assisted Suicide, N.Y. Times, Nov. 19, 1997, at A18.


100. See Vacco v. Quill, 117 S. Ct. 2293, 2302 (1997)(Souter, J., concurring). "The reasons that lead me to conclude in Glucksberg that the prohibition on assisted suicide is not arbitrary under the due process standard also support the distinction between assistance to suicide, which is banned, and practices such as termination of artificial life support and death-hastening pain medication, which are permitted." Id.

101. See Washington v. Glucksberg, 117 S. Ct. 2258, 2303 (1997)(O'Connor, J., concurring); see id. at 2310-12 (Breyer, J. concurring); see id. at 2304-2310 (Stevens, J., concurring); see also Vacco v. Quill, 117 S. Ct. 2293, 2303 (1997)(O'Connor, J., concurring); see id. at 2310-12 (Breyer, J., concurring); see id. at 2304-10 (Stevens, J., concurring). Justice Ginsburg's single sentence concurrence in both decisions is identical as well. See Washington v. Glucksberg, 117 S. Ct. 2258, 2310 (1997) (Ginsburg, J., concurring); Vacco v. Quill, 117 S. Ct. 2293, 2310 (1997) (Ginsburg, J., concurring).
In *Glucksberg*, as in *Vacco*, Chief Justice Rehnquist delivered the opinion of the Court. Justice O'Connor, Scalia, Kennedy and Thomas joined the Chief Justice's opinion. Justice O'Connor's joinder created a seemingly bare majority opinion, but at least prevented the weaker appearance of a plurality opinion for the Court. Justice O'Connor filed the same concurring opinion in both cases and Justice Ginsberg concurred in the Court's judgments "substantially for the reasons stated by Justice O'Connor in her concurring opinion." Justice Breyer's opinions concurred in the Court's judgments, but he expressly adopted the views of Justice O'Connor, except where she joined the majority.

Justice Stevens wrote a forceful opinion, concurring with the Court's judgments, but made clear that he saw a number of issues differently. For instance, there is "room for further debate about the limits that the Constitution places on the power of the States to punish" physician-assisted suicide. Another point Justice Stevens raised is that the Court has not always placed the same value on every life; for example, in the instance of capital punishment, state legislatures create categories of lives that the state may terminate.

While the Court has deemed such capital punishment schemes constitutional pursuant to a facial challenge, other *applied* challenges have been successful. The analogy to assisted-suicide statutes and challenges concerning their constitutional validity seems appropriate.

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103. See id. Justices Scalia, Kennedy and Thomas did not file separate opinions in the two decisions.
107. Id.
108. See id. Because Washington has authorized the death penalty, Justice Stevens concluded that the state already varies the value placed upon lives and the hastening of death in some circumstances. See id. at 2304-05.
109. See id. at 2304. Justice Stevens noted that mounting a facial challenge to a statute is the most difficult and he criticizes the strict standard for a facial challenge.
Justice Stevens projected optimism concerning an applied challenge to an assisted suicide ban. At the same time, he perceived an interest in dignity and in determining how imminent death occurs. Furthermore, while Justice Stevens agreed with the Court's active/passive distinction as a basis for state classification in Vacco, he questioned whether there is in fact much difference in the intent behind the two methods. He referred to the practice of terminal sedation as an example of the "illusory character of any differences" between termination of treatment (passive means) and assisted suicide (active means). In terminal sedation, medication as pain relief is known to hasten death. Yet the practice of terminal sedation falls into a gray area where it is not categorized as assisted suicide. It is an acceptable practice medically and legally in large part because the primary intent is to relieve pain and suffering. Justice Stevens questioned where the line should be drawn in these close cases. The question at this time seems to turn upon the primary intent of the medication—whether it is administered to alleviate suffering or to hasten death. The actual immediate cause of death may be the lethal sedatives, whether the practice is terminal sedation or assisted suicide. It is arguable whether the same intent and causation apply in physician-assisted suicide cases that hover at the border of terminal sedation.

It is noteworthy that Justices O'Connor and Breyer specifically relied upon the ability of a patient to obtain relief from pain and suffering to a legislative act pronounced in United States v. Salerno, 481 U.S. 739 (1987), a standard that Justice Stevens did not believe the Court has ever actually applied. See Washington v. Glucksberg, 117 S. Ct. 2258, 2304-05 (1997)(Stevens, J., concurring). Others criticize the Salerno rule as well. See Law, supra note 1, at 325-330 (stating that standard from Salerno is unwise).

11. See id. at 2306-07.
12. See id. at 2309-10; see also George Annas, Legal Issues in Medicine, Death By Prescription, The Oregon Initiative, 331 NEW. ENG. J. MED. 1240, 1241-42 (1994)(noting importance of intent in terms of accepted medical practice and criminal law).
14. See id. In many instances of terminal sedation, food and hydration are withdrawn to hasten the patient's passage from coma to death. See Vacco v. Quill, 117 S. Ct. 2293, 2301 (1997). Informed consent and the "double effect" justify the practice of terminal sedation "in that the intent is to relieve pain." Id. at 2302 n.11 (citing Reply Brief for Petitioners 12 (quoting P. Rousseau, Terminal Sedation in the Care of Dying Patients, 156 ARCHIVES INTERNAL MED. 1785, 1785-86 (1996))). "Double effect" refers to the secondary outcome of hastened death produced by pain relief medication. See NEW YORK STATE TASK FORCE, supra note 93, at 163.
16. See id.
ing under current law as they justified allowing state prohibitions on assisted suicide to stand. Justice Breyer predicated the avoidance of "severe physical pain (connected with death)" as comprising "an essential part of any successful claim." This is not present in the instant cases where the state laws in question "do not prohibit doctors from providing patients with drugs sufficient to control pain despite the risk that those drugs themselves will kill." The New York State Task Force on Life and the Law determined that the provision of pain relief, in the form of sedatives and analgesics, is ethically and professionally acceptable even if a secondary or double effect of the drugs is to hasten the patient's death, so long as the intent is to relieve severe discomfort, not to cause death.

Justice Souter concurred in the judgments of the Court, writing a separate opinion in each case. In Glucksberg, Justice Souter outlined his reasons for concluding that Washington's ban on assisted suicide is not arbitrary under the due process standard; thereafter, he summarily applied this rationale in support of New York's ban on assisted suicide. This ban, of course, can be distinguished from the legally permissible termination of artificial life support and administration of pain relief that simultaneously hastens death. Justice Souter concluded "that assisted suicide is not a fundamental right entitled to recognition at this time, . . . [but] accord[s] the claims raised . . . a high degree of importance, requiring a commensurate justification."

In Glucksberg, Justice Souter saw an applied challenge to the Washington statute, one that was narrower than the Court ac-

117. See id. at 2303 (O'Connor, J., concurring) (noting that there are no legal barriers "to obtaining medication . . . to alleviate . . . suffering, even to the point of causing unconsciousness and hastening death," and thus "there is no need to address the question whether suffering patients have a constitutionally cognizable interest in obtaining relief from the suffering that they may experience in the last days of their lives"). Justice Breyer agreed with Justice O'Connor that there is no need for the Court to decide whether a right is fundamental since state law does not prevent administration of drugs to avoid pain at life's end. If the law did not allow "avoidance of severe physical pain," then the "core of the interest in dying with dignity" would be more affected, and "the Court might have to revisit its conclusions in these cases." Id. at 2311-12 (Breyer, J., concurring).

118. Id. at 2311. Here, one supposes that Justice Breyer refers to a future claim.

119. Id. (citing New York State Task Force, supra note 93, at 163 n.29).

120. See New York State Task Force, supra note 93, at 162-63.


123. Vacco v. Quill, 117 S. Ct. 2293, 2302 (1997) (Souter, J., concurring) (emphasis added) (referring to claims raised by patients and physicians in both cases).
In his discussion of the parties' arguments, Justice Souter reviewed the state's concern about the difficulty in confining an assisted suicide right to voluntary decisions of competent terminally ill adults. He then provided an historical overview of substantive due process methodology, focusing particularly upon the dissent of Justice Harlan in Poe v. Ullman. Valuing the competing interests of the state and the individual is but the first step of such an analysis. The question then becomes whether the justification for the legislation is so at odds "with the individual interest as to be arbitrarily or pointlessly applied." If so, the statute must fail and the individual may be said to have a constitutional right.

The balancing of interests called upon the Court to form a reasoned judgment. As with the common law generally, the boundary is ever evolving and the recognition of new claims must proceed slowly from existing recognized claims. It seems that assisted suicide hardly falls into this category, in Justice Souter's view, since most states still criminally punish the act of assistance. That suicide itself is decriminalized in Washington does not answer the question. Justice Souter concluded that "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." He also noted that analogies to the instant case may be made to abortion cases, wherein the state has an interest in discouraging abortion, and that this must be balanced with the individual's right to a physician's counsel and care. The legality of the practice of terminal sedation

125. See id. at 2276; see also id. at 2285-86 (describing a claimed right for a narrow class to help others also in a narrow class).
128. Id.
129. See id. (citing Cruzan v. Director, Mo. Dept. of Health, 497 U.S. 261, 279 (1990)). Justice Souter would reserve the term "right" for cases where the individual's interest trumps the state's interest.
130. See id. at 2284 (Souter, J., concurring). The reasons provided for selecting statements of the competing interests are as important as the results in substantive due process cases. See id.
131. See id.
132. See id. at 2286. This accords with Chief Justice Rehnquist's rationale in Glucksberg. See id. at 2266.
133. Id. at 2287 (citing Model Penal Code § 210.5 Comment 5 (1980)).
134. See id. at 2288.
evoked further support for the respondent's argument that physician-assisted suicide is simply part of the evolution of patient care. 135

Justice Souter followed the respondent's arguments through three steps which he characterized as "of increasing forcefulness." 136 He concluded that "[t]here can be no stronger claim to a physician's assistance than at the time when death is imminent," further stating that the important individual interest, "as within that class of 'certain interests' demanding careful scrutiny of the State's contrary claim . . . cannot be gainsaid." 137 Whether "in some circumstances or at some time," this interest which might be "seen as fundamental" need not be decided here because of the seriousness of the state's interests which "defeat the present claim." 138

Justice Souter perceived the emergence of a slippery slope: a dangerous progression from the limited right that respondents purport to seek to involuntary euthanasia. 139 The lines are not easy to draw in ascertaining a patient's competence or the voluntariness of a decision for assisted suicide. Likewise, the step from patient self-administration of lethal medication to physician administration is small. Unfortunately, the "gatekeepers" of the medical system have their own economic agenda that may bias their judgment in such matters. 140

Just how successful state legislation will be remains to be seen, but there is much factual disagreement as to how effective similar guidelines in the Netherlands have been in protecting the voluntariness of patient decisions. 141 The specter of involuntary euthanasia clearly

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135. See id. Critical to the legality of such pain relief administration is that the primary intent of the action is to alleviate pain. See supra notes 90, 113-16 and accompanying text (discussing importance of intent and the practice of terminal sedation).

136. Washington v. Glucksberg, 117 S. Ct. 2258, 2289-90 (1997)(Souter, J., concurring). The steps are: (1) the decriminalization of suicide itself takes away the underpinning or leaves the criminality of assisted suicide "open to questioning," (2) decriminalization of suicide makes the act a free choice sounding somewhat like an individual's option in recognized instances of bodily autonomy (such as abortion), and (3) the claim to physician-assisted suicide follows from "the traditional right to medical care and counsel, subject to the limiting conditions of informed, responsible choice when death is imminent." Id.

137. Id. at 2290 (citing Poe v. Ullmann, 367 U.S. 497, 543 (1961)).

138. Id. The state interests are: "protecting life generally, . . . discouraging suicide even if knowing and voluntary, . . . and protecting terminally ill patients from involuntary suicide and euthanasia, both voluntary and nonvoluntary." Id. The final interest justified the ban on physician-assisted suicide in Justice Souter's opinion.

139. See id.

140. See id. at 2291.

141. See id. at 2292. The Netherlands provide the sole example of a foreign country that has allowed assisted suicide to seep into medical practice, albeit without explicit statutory authorization. The Dutch experience provided no comfort to Justice Souter. See also Barney Sneiderman and Marja Verhoef, Patient Autonomy and the Defense of Medical Necessity: Five Dutch Euthanasia Cases, 34 Al-
casts a dark shadow over the formalization of a right to physician-assisted suicide in the United States. A state may experiment with legislation while protecting the incompetent in particular and preventing euthanasia.\textsuperscript{142} Beyond that, Justice Souter agreed with the Court and with Justice O'Connor that state legislatures are the appropriate place for factfinding and experimentation on this important and evolving issue.\textsuperscript{143} It would be poor form for the Court to announce a new and perhaps fleeting unenumerated constitutional right when the legislative branch, with its "more flexible mechanisms," is the superior forum for "moving forward and pulling back as facts emerge within [the State's] jurisdictions."\textsuperscript{144}

Returning to the Court's opinion, discussed briefly at the beginning of this section,\textsuperscript{145} Chief Justice Rehnquist writing for the Court found no due process violation in Washington's prohibition against causing or aiding suicide.\textsuperscript{146} The historical treatment of suicide and assisted suicide in Washington and other states contributed to the Court's holding.\textsuperscript{147} The Court relied in both cases upon widespread state opposition to physician-assisted suicide.\textsuperscript{148} Particular emphasis was placed upon the continual reaffirmation of prohibitions on assisted suicide by voters and legislators.\textsuperscript{149} Additionally, New York State's Task Force on Life and the Law, touted as a "blue-ribbon commission" by the Court, unanimously recommended against changing the existing law that bans assisted suicide.\textsuperscript{150} President Clinton also expressed his opposition to assisted suicide when he signed the Federal

\begin{thebibliography}{99}
\bibitem{143} See \textit{id.} at 2293 (suggesting that legislative experimentation is "entirely proper, as well as highly desirable"); see also supra notes 95-96 and accompanying text (discussing the Court's view).
\bibitem{145} See supra notes 81-98 and accompanying text.
\bibitem{147} See \textit{id.} at 2262 (citing Compassion in Dying v. Washington, 79 F.3d 790, 842 nn.10-13 (9th Cir. 1996)(Beezer, J., dissenting)(referring to weight of state authority prohibiting assisted suicide)).
\bibitem{148} See \textit{id.} at 2263-64 (1997)(discussing state statutory bans and common law tradition); Vacco v. Quill, 117 S. Ct. 2293, 2300 (1998)(discussing "overwhelming majority of state legislatures [that] have drawn a clear line between assisting suicide and withdrawing or permitting the refusal of unwanted lifesaving medical treatment by prohibiting the former and permitting the latter"); see also Thomas J. Marzen et al., \textit{Suicide: A Constitutional Right?}, 24 Duq. L. Rev. 1, 17-56 (1985).
\bibitem{149} See \textit{Washington v. Glucksberg}, 117 S. Ct. 2258, 2266 (1997)(noting Oregon as the only exception to this trend, while Iowa and Rhode Island recently joined those states banning assisted suicide); see also \textit{id.} at 2263 n.8 (discussing Louisiana's enactment of statutory ban).
\bibitem{150} See \textit{id.} at 2267 (citing \textit{New York State Task Force}, supra note 93, at 120).
\end{thebibliography}
Assisted Suicide Funding Restriction Act of 1997, which prohibits the use of federal funds for physician-assisted suicide. \(^{151}\) In addition, the Model Penal Code favors prohibiting aiding or soliciting another to commit suicide. \(^{152}\)

The Court expressed its ongoing reluctance to expand substantive due process rights. \(^{153}\) The liberty protected therein should not “be subtly transformed into the policy preferences of the members of this Court.” \(^{154}\) Implicit in this is the notion that the legislative branch would provide a more representative, and thus a more democratic perspective, than the nine Justices. The Court sought an objective determination of fundamental rights based upon interests “deeply rooted in this Nation’s history and tradition.” \(^{155}\) The fundamental right must be implicated by the challenged state action as a threshold requirement before the balancing of competing interests will occur. \(^{156}\)

The question formulated in *Glucksberg* was “whether the ‘liberty’ specially protected by the Due Process Clause includes a right to commit suicide which itself includes a right to assistance in doing so.” \(^{157}\) The Court responded to this question by noting the “almost universal tradition,” that, even today, rejects the asserted right. \(^{158}\) Withdrawing treatment, as in *Cruzan*, is simply a different case from assisted suicide. This is true in part because unwanted treatment is often invasive and violative of a patient’s privacy. The common law of battery frowns upon a touching without informed consent. This, as well as past Supreme Court precedent, supported the Court’s recognition of a competent person’s “constitutionally protected liberty interest in refusing unwanted medical treatment.” \(^{159}\) This right was assumed to

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151. See id. at 2266 (citing Federal Assisted Suicide Funding Restriction Act of 1997, Pub. L. No. 105-12, 111 Stat. 23 (codified at 42 U.S.C. §§14401-14408 (1997))). The Act prohibits federal funding in support of suicide, euthanasia and mercy killing or assistance in these acts, even if the acts become lawful. See 42 U.S.C. § 14401 (a)(2)-(4)(1997); see also The White House Statement by the President, May 1, 1997, available in LEXIS, News Library, Wires File (noting appropriateness of legislation that taxpayer dollars not subsidize or promote assisted suicide and President Clinton’s personal opposition to assisted suicide).


153. See id. at 2267.

154. Id. at 2268 (citing Moore v. East Cleveland, 431 U.S. 494, 502 (1977)(plurality opinion)).


156. See id.

157. Id. at 2269.

158. See id.

159. Id. (citing Cruzan v. Director, Missouri Dept. of Health, 497 U.S. 261, 278 (1990)).
include the right to refuse lifesaving hydration and nutrition.\textsuperscript{160} Assisted suicide “has never enjoyed similar legal protection” as the right to refuse unwanted medical treatment.\textsuperscript{161}

The Court also disposed of the respondents’ argument that precedent on the abortion right is analogous to the instant cases.\textsuperscript{162} Assisted suicide does not enjoy historical or even contemporary support, and the right is not a fundamental liberty interest protected by the Due Process Clause.\textsuperscript{163} Washington’s ban on assisted suicide “unquestionably” is “rationally related to legitimate government interests.”\textsuperscript{164} The state’s interests include: preventing suicide; protecting depressed or mentally ill persons, or those suffering from untreated pain; protecting the integrity and ethics of the medical profession; protecting vulnerable groups (the poor, the elderly and the disabled) from abuse, neglect and mistakes; and preventing the slippery slope to involuntary euthanasia.\textsuperscript{165} In the Court’s view, these are important and legitimate interests that Washington’s ban, either on its face or as applied to competent, terminally ill adults who seek to hasten death by physician prescription, is reasonably related to promoting.\textsuperscript{166} Nonetheless, the Court did “not absolutely foreclose” the possibility that an individual could prevail in a more particularized judicial challenge.\textsuperscript{167}

\textsuperscript{160} See id. (citing Cruzan v. Director, Missouri Dept. of Health, 497 U.S. 261, 279 (1990)(O'Connor, J., concurring)).
\textsuperscript{162} See id. at 2270-71; see also Zapor, supra note 10. Brother Daniel Sulmasy, a physician and director of Georgetown University’s Center for Clinical Bioethics, comments that the Court’s ruling contrasts with its legalization of abortion in 1973, where the Court essentially ruled by “judicial ‘fiat’” in Roe v. Wade. The Court’s resistance to announcing new rights was evident in Bowers v. Hardwick, 478 U.S. 186 (1986), where the Court sought to assure that unenumerated constitutional rights derived from more than “the Justices’ own choice of values.” Id. at 191. See also, Mark E. Chopko & Michael F. Moses, Assisted Suicide: Still A Wonderful Life?, 70 NOTRE DAME L. REV. 519, 579 (1995)(advocating that issue of assisted suicide be determined by democratic process, and not “judicial fiat”); Brenton K. Morris, Physician Assisted Suicide: The Abortion of the Nineties, 20 LAW & PSYCH. REV. 215, 228-29 (1996)(arguing against legalization of assisted suicide in light of danger of abuse).
\textsuperscript{164} Id.
\textsuperscript{165} See id. at 2272-74.
\textsuperscript{166} See id. at 2275. The Court determined that the “relative strengths of these various [state] interests” need not be weighed. Id. The Court explicitly rejected the court of appeals’ holding that the Washington ban was unconstitutional “as applied” to a particular class. See id. at 2275 & n.24.
\textsuperscript{167} See id. at 2275 & n.24. The Court noted that “such a claim would have to be quite different from the ones advanced by respondents here.” Id. at 2275 n.24. The Court derived its language from Justice Stevens’ view that a particularized challenge may prevail, but the Court seems to set the standard slightly higher than Justice Stevens.
In *Vacco v. Quill*, the petitioners faced similar historical hurdles as the petitioners in *Glucksberg*. New York’s assisted suicide ban was not something new. At the same time, however, New York patients had the right to refuse medical treatment or to have such treatment withdrawn, even where it would result in death. The Court of Appeals for the Second Circuit found that New York’s ban on assisted suicide violated the Equal Protection Clause because of the inequality of treatment among competent, terminally ill adults who seek to hasten death. The Court stated that “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.” The Second Circuit equated the withdrawal of life-support with assisted suicide and thus determined that the distinction drawn by New York’s ban on assisted suicide was not rationally related to any legitimate state interest.

In *Vacco*, the United States Supreme Court noted that the Equal Protection Clause “creates no substantive rights.” In *Glucksberg*, where the Court’s determination resulted from a substantive due process analysis, the physicians also raised an equal protection argument; however, as Justice Souter wrote in his concurrence, “that source of law does essentially nothing in a case like this that the Due Process Clause cannot do on its own.” The Equal Protection Clause merely prevents states from denying persons within their jurisdiction the equal protection of the laws by requiring similarly situated people to be treated alike; the Equal Protection Clause does not prohibit treating different situations differently. Because the Court determined in *Glucksberg* that no fundamental right to assisted suicide was present and no suspect classification was involved, the classification made by New York needed to bear merely a rational relation to a legitimate end or purpose.


169. See id. at 2301 n.10 (“It has always been a crime, either by statute or under the common law, to assist a suicide in New York.” (citing Marzen et al., supra note 148, at 205-10)).

170. See id. at 2296 n.2.

171. Id. at 2297 (citing Quill v. Vacco, 80 F.3d 716, 727, 729 (2d Cir. 1996)).

172. See Quill v. Vacco, 80 F.3d 716, 729, 731 (2d Cir. 1996).


176. See id.
The Second Circuit found the withdrawal or refusal of life-support to be "nothing more nor less than assisted suicide." However, the Supreme Court reinforced the longstanding distinction between a passive and active deed, a distinction endorsed by the medical profession and legal tradition. The principles of causation and intent support the separate classification even though the result may not vary. The line drawn between assisting suicide and refusal of medical treatment has been recognized and supported by courts as well as the "overwhelming majority of state legislators." In recent years, New York has legislatively reaffirmed its approval of the "letting die" methodology/protocol, while at the same time prohibiting "killing." Furthermore, in 1994 the New York State Task Force on Life and the Law unanimously recommended against legalizing assisted suicide. The Supreme Court in Cruzan also implicitly recognized the "letting die" versus "making die" distinction, with the right to refuse treatment grounded on "traditional rights to bodily integrity and freedom from unwanted touching." Thus, in the Court's view, Cruzan provided no precedential support for a broad right to assisted suicide. Even if the line is not always clear, "logic and contemporary practice support New York's judgment that the two acts are different, and New York may therefore, consistent with the Constitution, treat them differently."

Justice O'Connor's concurrence in the two decisions may prove to be pivotal. Although she joined the majority, Justice O'Connor also

177. Quill v. Vacco, 80 F.3d 716, 729 (2d Cir. 1996).
179. See id.
180. Id. at 2299 n.8, 2300 n.9 (referencing case and statutory law supporting the classification).
181. See id. at 2301 (citations omitted).
185. Justice O'Connor filed the same opinion in both decisions and as discussed earlier, her signature upon the Court's opinion created a majority opinion. See Washington v. Glucksberg, 117 S. Ct. 2302, 2303 (1997). Some would argue that Justice Souter's concurrence in Glucksberg provides more scholarly analysis and a natural law perspective that may prove influential in the future.
carried weight among the minority. Thus her centrist position may carry the day in a future, more particularized 'right to die' decision. Justice Ginsberg placed her vote behind Justice O'Connor's reasons for the judgment,\textsuperscript{186} as did Justice Breyer, except where Justice O'Connor sided too closely with the Court.\textsuperscript{187} Other support for Justice O'Connor's view is evident in Justice Stevens' approval of Justice O'Connor's language in \textit{Cruzan} which implied a fundamental right to make the "deeply personal decision" to withdraw artificial life support.\textsuperscript{188} Justice Stevens, like Justice O'Connor, was also concerned with the pain and suffering that precedes death,\textsuperscript{189} and both Justices indicated that a future applied challenge would not be foreclosed by the \textit{Glucksberg} and \textit{Vacca} judgments.\textsuperscript{190} In addition, Justice Breyer expressed that an essential part of any successful claim would have to include severe physical pain connected with the death, aligning himself closely with Justices O'Connor, Stevens and Ginsburg on this issue.\textsuperscript{191} He, too, awaits a more direct infringement upon a central core interest that sounds like death with dignity.\textsuperscript{192} Justice Souter is not far behind. He is likely to side with this group when the importance of the individual interest so demands in a narrower case, and after legislatures have conducted further experimentation.\textsuperscript{193}

Justice O'Connor noted that respondents "urge us to address the narrower question whether a mentally competent person who is experiencing great suffering has a constitutionally cognizable interest in controlling the circumstances of his or her imminent death."\textsuperscript{194} She saw "no need to reach that question in the context of the facial challenges" to the two statutes at issue, because patients "can obtain palliative care, even when doing so would hasten their deaths."\textsuperscript{195} The state interests that hold sway for Justice O'Connor are the uncertainties in defining terminal illness and the danger that a request for as-

\textsuperscript{187} See \textit{id.} (Breyer, J., concurring).
\textsuperscript{188} See \textit{id.} at 2307 (Stevens, J., concurring)(citing \textit{Cruzan v. Director, Mo. Dept. of Health}, 497 U.S. 261, 289 (1990)(O'Connor, J., concurring)).
\textsuperscript{190} See \textit{id.} at 2303 (O'Connor, J., concurring); \textit{id.} at 2304 (Stevens, J., concurring).
\textsuperscript{192} See \textit{id.} at 2311-12.
\textsuperscript{193} See \textit{id.} at 2290, 2293 (Souter, J., concurring); see also supra notes 142-44 and accompanying text. It is noteworthy that the Court in general wanted to let the debate continue among the American people. See David J. Garrow, \textit{Letting the Public Decide About Assisted Suicide}, N.Y. TIMES, June 29, 1997, § 4 (The Nation), at 4.
\textsuperscript{195} \textit{Id.}
assisted suicide may not be truly voluntary. If these deficiencies were adequately addressed in state legislation legalizing assisted suicide, a later, more particularized applied challenge by a suffering patient might succeed with Justice O'Connor and a majority of the Justices who appear willing to follow her lead.

Also, a narrow case involving a physician who aids a suicide in accordance with carefully designed statutory safeguards that authorize physician-assisted suicide in limited instances would appear to provide a potentially successful challenge. That is, if district attorneys can be counted on to indict such physicians. The key to a good test case will depend upon the particular facts such as the intractable nature of the patient's pain, the inevitability and closeness of death, and the injuries to a participating physician or family member who assists with a suicide.

Simply because the Court did not find a fundamental right to assisted suicide in two cases that involved facial challenges (or at least overly broad challenges) to state bans on assisted suicide does not mean that this Court will continue to hold the line on assisted suicide. The opinions displayed were "fractured", as one commentator wrote, and the Court will inevitably be faced with more cases.

Whether the standard of constitutional review will remain at the rational basis level when the Court eventually evaluates a viable challenge to a statute authorizing physician-assisted suicide is an important question. If the standard of review remains the same, which appears to be likely, a challenge to a statute authorizing assisted suicide will meet the same barriers as a challenge to a statute that criminalizes assisted suicide.

196. See id.

197. See Garrow, supra note 193.

198. A petition for certiorari was recently denied in a case challenging the Oregon measure that authorized assisted suicide. See Lee v. Harclerode, 118 S. Ct. 328 (1997); see also infra notes 232-94 and accompanying text (discussing the Oregon Death With Dignity Act and the legal challenges that have ensued).

199. This is not to say that physician-assisted suicide will be legal in most states shortly. The barriers to legislation authorizing assisted suicide are formidable, as evidenced by the near universal absence of such statutes at this time. The Supreme Court and Justice Souter, in particular, seemed especially influenced by the absence of such authorizing or legalizing statutes. See generally Annas, supra note 112, at 143 (discussing the use of ballot initiatives so public may vote and thus circumvent unresponsive legislature, and the weakness of the initiative method unless question is simple); Garrow, supra note 193 (discussing barriers to legislation). See also Laurence H. Tribe, American Constitutional Law § 16-2, at 1443 (2d ed. 1988) (depicting rational basis standard as "largely equivalent to a strong presumption of constitutionality"); Paul J. Zwier, Looking for a Nonlegal Process: Physician-Assisted Suicide and the Care Perspective, 30 U. Rich. L. Rev. 199, 247-48 (1996)(advocating limited right to physician-assisted suicide pursuant to care model of decision making). But cf. Rachael D. Kleinberg & Toshiro M. Mochizuki, Recent Developments, The Final Freedom: Maintaining Autonomy
The Supreme Court has left the states with a formidable task. It has cleared the way for protracted public debate, voter initiatives, legislative attempts and judicial attacks upon numerous legal angles. The next section surveys legislative activity on assisted suicide including commentary on a proposed model statute.

IV. LEGISLATIVE ACTIVITY

A. Model Legislation

The recent Supreme Court decisions have reinforced the conclusion that courts are not the best forum within which to adjust the final balance between an individual's right to die and the state's interest in preserving life. Not only has the Supreme Court been unwilling to find constitutional support for the right to die, but the Court has also emphasized that the judiciary should not delineate the parameters of this right. Rather, this delicate balance must be calibrated more directly by American citizens through state legislatures or at the polls.200

In addition to Oregon, at least eleven states have pending legislation to legalize physician-assisted suicide.201 Constitutional challenges to state statutes have multiplied in recent years.202 In recent polls, a majority of Americans believe that terminally ill, mentally competent adults should have this right.203 The majority of doctors concur.204 Many doctors already assist their terminally ill patients to die, unlawfully and surreptitiously. When a doctor's complicity in assisted suicide becomes public knowledge, prosecutors and juries often refuse to hold the doctor legally responsible for a criminal act.205 Many observers have pointed out that, since the rights to refuse or withdraw from life-sustaining treatment, to have a living will and to

and Valuing Life in Physician-Assisted Suicide Cases, 32 HARV. C.R.-C.L. L. REV. 197, 217 & n.144 (1997)(finding district court's ruling in "inconsistent with the deference usually granted to states under an equal protection rational basis test" and categorizing state interest analysis under Due Process Clause as different since it "pits state interests against individual liberties").


202. See Baron et al., supra note 11, at 7 n.24.

203. See Pugliese, supra note 200, at 1317-18 nn.208-12.

204. See id. at 1315; see also Larry Tye, Right to die gains favor in survey, More doctors found willing to help AIDS cases in suicide, BOSTON GLOBE, Feb. 6, 1997, at A1.

205. See Pugliese, supra note 200, 1297-99. Perhaps this is why some doctors practice doctor-assisted death without too much concern. See generally Dick Lehr, Death & The Doctor's Hand, Increasingly, secretly, physicians are helping the incurably ill to die, BOSTON GLOBE, Apr. 25, 1993, at 8.
authorize another to make decisions about extraordinary measures, have already been recognized, logic suggests the recognition of a right to physician-assisted suicide. As medical technology advances, public opinion will grow more vocal in support of the right to a doctor's help in dying. This is the reality of society's current position on this issue.

Those who believe that the law should recognize this reality, support the legalization of physician-assisted suicide as an acknowledgment of individual autonomy. On the other hand, those who believe that the law should function as a bulwark against the rising tide of public opinion, see the legalization of physician-assisted suicide as the first step towards a slippery slope, leading ultimately to the denial of the essentially spiritual nature of life. The former group believes the integrity of the choice to die can be preserved with statutory procedures. The latter group believes that no statute can adequately protect against the human corruptions of these procedural safeguards.

Perhaps the best example of how states should legislate the right to die is represented by the Model State Act to Authorize and Regulate Physician Assisted Suicide. This Model Statute was proposed in 1996 by nine experts in their respective fields, including attorneys, physicians and academics who suggested a framework for permitting and regulating physician-assisted suicide among patients suffering from terminal illness or unbearable pain. Only a physician who has a long-standing relationship with the patient, or a physician who has assumed full or partial responsibility for the patient's care, can lawfully assist in a suicide. Such a physician can grant the patient's request if the request is competent, fully informed, voluntary and enduring.

The statute outlines procedures for determining whether these conditions have been met and assigns accountability for this determination to the responsible physician. In determining compliance, the physician is held to a subjective standard of an "honest belief" that the statute's requirements have been met. The statute also contains corroboration requirements, including a second medical opinion

206. See Pugliese, supra note 200, at 1309-12.
207. See id. at 1308-10.
208. See FitzGibbon & Lai, supra note 201, at 164-73.
209. See Baron et al., supra note 11, at 4 n.1.
210. See id. at 1-33. The authors of the Model Statute continue to use the term physician-assisted suicide. See supra note 1 (discussing terminology); see also infra notes 243-95 (discussing Oregon physician-assisted suicide measure).
211. See Baron et al., supra note 11, at 17.
212. See id. at 18-19.
213. See id. at 18-20.
214. See id. at 19.
about diagnosis and prognosis, and an independent opinion as to the appropriateness of physician-assisted suicide in a particular case.215 The corroborating physician must also vouch for the primary physician's statement that statutory requirements have been met.216 This corroboration protects the attending physician from liability for assisting in the suicide. Accordingly, the physician may not be accused of murder or manslaughter, but may instead be held responsible for medical malpractice if an error is made in diagnosis or treatment.217

Under the Model Statute, the responsible physician must promptly document the provision of medical means of suicide in the patient's records and with the state regulatory authority.218 Most importantly, the statute requires that the final physical act of administering the means of suicide must be the "knowing, intentional, and voluntary act of the patient."219

The Model Statute assigns responsibility for oversight to the State Department of Public Health, or a similar regulatory agency. This agency receives reports from responsible physicians, collects and analyzes data, monitors and enforces the statute's requirements and makes necessary rules for implementation.220 Although data is reported, the statute requires that patient information be kept confidential.221 To preserve the right to act on personal values, physicians and hospitals may refuse to participate in physician-assisted suicide on grounds of conscience.222 Health care providers and insurers, on the other hand, are prohibited from requiring a patient to request physician-assisted suicide in order to guarantee services, benefits or insurance.223

Proponents of this statute see it as a tool for allowing an individual access to physician-assisted suicide in a way which protects the rights of the individual, the attending physician and the larger society. For opponents of physician-assisted suicide, the Model Statute invites abuse. Critics argue that neither the patient nor the doctor is fully protected by the provisions of the Model Statute.224 Their objections coalesce in three areas.

215. See id. at 21.
216. See id. at 29.
217. See id. at 23.
218. See id. at 21.
219. Id. at 22.
220. See id.
221. See id. at 22-23.
222. See id. at 23.
223. See id.
224. See Daniel Callahan & Margot White, The Legalization of Physician-Assisted Suicide: Creating a Regulatory Potemkin Village, 30 U. RICH. L. REV. 1, 72-77 (1996). The Model State Act is criticized by these authors for many reasons. The Act sidesteps the issue of euthanasia in what the authors call "the triumph of politics over ethics." Id. at 73. The eligibility for assisted suicide is too broad, the proce-
The first problem opponents have with this statute is that it does not require, as does the Oregon Death with Dignity Act,\(^\text{225}\) that patients be terminally ill to request a physician's aid in dying. Rather, this statute requires only that a patient suffer from a terminal illness or unbearable pain. The intent of the statute was to recognize that quality of life is assessed subjectively and that a person who suffers enough pain as to make life unbearable should be permitted to seek aid in ending that life even if death is not imminent or certain. However, critics see a significant leap from sanctioning suicide for those who will die soon, to sanctioning suicide for those who could live indefinitely, albeit in pain. Within this leap, critics see the beginning of the slide down a slippery slope, ultimately leading to an unacceptable erosion of the societal belief in the sanctity of life.\(^\text{226}\) For, if people are allowed to elect to die rather than endure an uncomfortable life, will not death be eventually seen as preferable to old age and disability?

The second problem opponents of physician-assisted suicide find in the Model Statute is its lack of an objective body to monitor physician compliance with the statute's procedural safeguards. Critics find ludicrous the statute's reliance on the "honest belief" of the physician that the patient is making an informed and competent decision. They do not find sufficient the requirement that a second physician corroborate compliance with the procedural safeguards. Rather, opponents feel that before the assisted suicide may proceed, there should be a requirement for judicial review of procedural compliance.\(^\text{227}\) Clearly, these opponents are sensitive to the possibility that a responsible physician will unduly pressure the patient to elect suicide. The authors of the Model Statute, on the other hand, were mindful of the vulnerability of a doctor who consents to help a patient die, particularly because the issues involved are subject to intense disagreement.

The last objection to this statute challenges the value system of those who support physician-assisted suicide. Opponents of this approach see the Model Statute as a testament to an unhealthy belief in individualism.\(^\text{228}\) They contend that the statute does not require the patient to consult family members about the decision to elect suicide.

\[^{225}\text{OR. REV. STAT. §§ 127,800-897 (1995); see also FitzGibbon & Lai, supra note 201, at 130-31 & n.15.}\]
\[^{226}\text{See id. at 130, 134 nn.35-38.}\]
\[^{227}\text{See id. at 137.}\]
\[^{228}\text{See id. at 137-38.}\]
In fact, the patient need not even notify family members of this decision. 229 Here, again, the authors of the statute saw this issue differently from their critics. They believed the patient must be protected from any kind of pressure from family members and that, conversely, family members should be protected from the difficulty of counseling a loved one about such a decision. For critics of assisted suicide, however, the exclusion of the family from this decision is a denial of the essentially communal nature of society. To allow an individual to make the decision to request aid in dying solely on the basis of his own suffering becomes an assault on the importance of relationships. Such a statute bespeaks a society where the individual's will is supreme, rather than a society which reflects the traditional religious belief that the meaning of human existence resides not in individual autonomy but in the individual's connection to a larger spiritual sphere. 230

In reality, this last objection comes closest to the heart of the assisted suicide debate. Those who wished the courts to find a fundamental right to physician-assisted suicide generally support the concept of the Model Statute. They have faith in the individual's ability to chart his or her own course, and believe that making these choices provides a way for individuals to determine the meaning of their own existence. On the other hand, those who do not see any guarantee of the right to die in the Constitution do not think that state legislatures can guarantee this right either. Rather, opponents of physician-assisted suicide do not assign much value to individual choice and believe that the meaning of human existence defies such narrow, egotistical considerations, existing instead in a realm where morality is absolute and does not bend to accommodate any individual's plight. The two sides in this debate proceed from opposite philosophical assumptions which explains why the parameters of the debate are the same when discussing potential statutes as they are when discussing constitutional theory.

As with the abortion debate, the fact that the right to die involves a choice which is seen differently by two equally worthy camps is perhaps the best argument for a statute which leaves the individual patient free to make this choice according to his own conscience. While the specifics of the Model Statute might benefit from some fine-tuning in terms of definition and corroboration, 231 the concept of the statute, which allows individuals to choose assisted suicide within the parameters of a predetermined procedure, is sound according to the proponents of the right to die. Such a statute would not force terminally ill patients, who find spiritual meaning in suffering through the process of dying, to choose suicide. It would merely preserve this choice for

229. See id. at 137 n.50.
230. See FitzGibbon & Lai, supra note 201, at 171-73.
231. See id. at 130.
terminally ill patients who find comfort and relief, or spiritual meaning, in this choice rather than resignation to a deity’s choice.

Designed to meet the objections to physician-assisted suicide raised by courts and legislatures, the Model Statute attempts to strike an appropriate balance between the rights of the individual patient and the rights of the larger community. Significantly, this statute provides specific procedures to safeguard these various rights and a mechanism for monitoring and enforcing these procedures. However, perhaps the most important feature of this statute, and the most important way in which it serves as a model for possible future statutes, is the fact that it is precisely tailored to achieve a goal on which most Americans agree, without unduly infringing upon the rights of those Americans who do not agree.

B. Oregon Death With Dignity Act (Measure 16): A New Oregon Trail

In 1994, Oregon voters passed the Oregon Death with Dignity Act (Measure 16),232 the first legislation in the world which legalizes physician-assisted suicide.233 A stated purpose of the statute was preventing unnecessary pain and suffering.234 However, the Measure was prevented from implementation by numerous judicial challenges and was subjected to a new vote in November 1997.235 In this section, the present status of the Oregon Act will be discussed, including the basis for the federal courts’ decisions to date. After the Supreme Court’s decisions in Glucksberg and Vacco, sending the issue of physician-assisted suicide back to state legislators and public debate, Ore-


235. See Goldberg, supra note 83; see also Jane Meredith Adams, Ethics, Assisted suicide gains in propriety, Oregon vote confirms years of steadily growing public support, BOSTON GLOBE, Nov. 9, 1997, (Focus), at D3 (discussing Oregonians' reinstatement of its assisted-suicide law); Carey Goldberg, Oregon Braces for New Fight On Helping the Dying to Die, N.Y. TIMES, June 17, 1997, at A1 [hereinafter, Goldberg, New Fight]; Joseph P. Shapiro, On Second Thought. . .Oregon reconsiders its pioneering assisted-suicide law, U.S. NEWS & WORLD REP., Sept. 1, 1997, (Culture & Ideas) at 58 (discussing prospects that Oregon Death with Dignity Act may be repealed); supra note 98 and infra note 242 (discussing recent federal agency action to chill the use of Oregon’s law).
gon became the eye of the storm with its solitary status on physician-assisted suicide.236

The Supreme Court in Glucksberg mentioned Lee v. Oregon only in passing.237 The case “is not before us, any more than it was before the Court of Appeals below, and we offer no opinion as to the validity of the Lee courts’ reasoning.”238 However, in the very next sentence, the Court refers to the fact that in Vacco, the Court held “that New York’s assisted-suicide ban does not violate the Equal Protection Clause.”239 If the Court had granted certiorari in Lee v. Harclerode,240 we would have had a better picture of the Court’s view of the Oregon statute.241 Of course, if Oregon voters had repealed the Measure in November 1997, the petition would have raised moot questions and resolution of the issues would have awaited a new statute and fresh challenge. In addition, if United States Attorney General Janet Reno had not refused to allow U.S. drug agents to enforce the Federal Drug Enforcement Administration’s pronouncement that it would revoke the federal narcotics licenses of doctors who prescribe lethal medication for the purpose of suicide, we would have been faced with a valid statute that would have remained unused.242

236. See Goldberg, New Fight, supra note 235 (discussing Oregon as principal arena for battle on issue if Supreme Court leaves matter to states); see also Ellen Goodman, The country's first draft on assisted suicide, BOSTON SUNDAY GLOBE, Nov. 9, 1997, at D7 (discussing Oregon’s citizens taking death into their own hands and Oregon as proving ground).


238. Id. The Supreme Court refers to the court of appeals’ opinion in Compassion in Dying which had “sharply criticized” the district court opinion in Lee v. Oregon, a case then pending review by the Ninth Circuit. See Washington v. Glucksberg, 117 S. Ct. 2258, at 2262 n.7 (citing Compassion in Dying v. Washington, 79 F.3d 790, 838 n.139 (9th Cir. 1996)(criticizing Lee v. Oregon, 891 F. Supp. 1429 (Or. 1995)). As will be discussed, the district court in Lee found that the Oregon Act violated the Equal Protection Clause due to a lack of adequate safeguards against abuse, but the Ninth Circuit vacated this decision due to a lack of Article III standing in Lee v. Oregon, 107 F.3d 1382 (9th Cir. 1997).


241. See generally Peter M. McGough, Medical Concerns About Physician-Assisted Suicide, 18 SEATTLE U. L. REV. 521, 521 (1995) (discussing in reference to Oregon’s Measure 16 that “passage and popularity of a public initiative does not ensure its legality”). See also Don Stenberg, Steve Grasz, Public Pulse, Suicide’s a State Affair, OMAHA WORLD-HERALD, Oct. 25, 1997, at 66 (noting that Supreme Court’s denial of certiorari does not mean that the Court favors assisted suicide, and a denial of review does not bespeak the Court’s view of the merits of a case).

242. See Goldberg, supra note 83 (discussing that initial measure was approved with only 51 percent of the vote and no sides of debate predicted victory; David J. Garrow, The Oregon Trail, N.Y. TIMES, Nov. 6, 1997, at A31 (discussing the 60 to 40 percent vote to retain the Oregon Act); see also Terminally ill lose as fed pull plug on Oregon law, U.S.A TODAY, Nov. 12, 1997, at 22A; DEA Fights Assisted Suicide in Oregon, National Public Radio, Nov. 11, 1997, Morning Edition, tran-
1. Case History: Lee v. Oregon

On November 8, 1994, Oregon voters authorized physician-assisted suicide for the terminally ill.\textsuperscript{243} Plaintiffs, two physicians, four terminally ill patients, a residential care facility, and individual operators of residential care facilities, opposed implementation of Measure 16 and moved for a preliminary injunction.\textsuperscript{244} The plaintiffs claimed the Measure violated the Equal Protection and Due Process Clauses of the Fourteenth Amendment, the First Amendment rights of free exercise of religion and association, as well as the Americans with Disabilities Act.\textsuperscript{245} District Judge Hogan granted plaintiffs' request for a temporary restraining order on December 7, 1994, and thereafter granted a preliminary injunction on December 27, 1994, finding that the profound questions of constitutional dimension raised by Measure 16 warranted postponing the legislation's implementation until such questions were resolved.\textsuperscript{246}

Judge Hogan proceeded to find that the plaintiffs satisfied Article III standing requirements.\textsuperscript{247} The requisite "injury in fact" or concrete, particularized, legally-protected interest that is "actual or imminent" might present problems where the death of terminally ill patients leads to mootness of their claims; however, "if a terminal patient does not have standing, who does?"\textsuperscript{248} Because Judge Hogan found that the physicians and residential care providers had standing, he deemed it unnecessary to definitively decide whether the patients had standing as well.\textsuperscript{249}

The physician-plaintiffs met their standing burden primarily as third parties by showing: (1) a direct financial impact on their practices in that, when a patient commits suicide, the physicians no longer continue to receive payment for services; (2) significant numbers of patients would seek physician-assisted suicide if Measure 16 took effect; and (3) they had a sufficiently close relationship to terminal patients who are hindered from asserting their own claims due to the possibility of death occurring prior to judicial resolution.\textsuperscript{250} Standing was similarly recognized for the residential care providers. Addition-
ally, the physician-plaintiffs were found to have standing to assert their First Amendment claims.\textsuperscript{251} The standard for preliminary injunction was also met in that serious questions were raised by the plaintiffs' claim, and irreparable harm to plaintiffs' First Amendment rights and shortening of patients' lifespans could result if Measure 16 was implemented pending ascertainment of its constitutionality.\textsuperscript{252} The district court deemed it unnecessary to reach the plaintiffs' Americans with Disabilities Act claims because there were already sufficient grounds to warrant granting the preliminary injunction.\textsuperscript{253} The court determined that the "balance of hardships" favored the plaintiffs; thus, on December 27, 1994, the court granted a preliminary injunction barring Measure 16's implementation pending a resolution of the merits.\textsuperscript{254} The court noted that, "[s]urely, the first assisted suicide law in this country deserves a considered, thoughtful constitutional analysis."\textsuperscript{255}

In August 1995, Chief Judge Hogan issued further decisions in \textit{Lee v. Oregon}.\textsuperscript{256} In the first of these opinions, the court decided the status of parties to assert and defend their claims.\textsuperscript{257} Considering the two terminally ill plaintiffs who had expressed opposition to physician-assisted suicide but who had histories of depression, the court found sufficient evidence to conclude that they were at significant risk of harm (death) due to their inability to control the timing and severity of their depression, such that if Measure 16 was to take effect, the patients might avail themselves of assisted suicide.\textsuperscript{258} These two plaintiffs had standing to assert a facial challenge to Measure 16, primarily because the Measure would lessen the physician's standard of care and disciplinary laws for those participating in the assisted-suicide process.\textsuperscript{259}

The Oregon Board of Medical Examiners and Douglas Harcleroad, a representative District Attorney from Lane County, Oregon were deemed appropriate defendants in that they would have enforcement responsibility under Measure 16.\textsuperscript{260} Several intervenors were excluded by the district court because the same interests were already adequately represented by other named parties.\textsuperscript{261} In contrast to an

\textsuperscript{251} See \textit{id.} at 1495.
\textsuperscript{252} See \textit{id.} at 1496, 1501-02.
\textsuperscript{254} See \textit{id.} at 1502 & n.6.
\textsuperscript{255} \textit{Id.} at 1502.
\textsuperscript{258} See \textit{id.} at 1426.
\textsuperscript{259} See \textit{id.} at 1426-27.
\textsuperscript{260} See \textit{id.} at 1427.
\textsuperscript{261} See \textit{id.} at 1427-1428.
earlier finding of standing for plaintiff-physicians at the preliminary injunction phase, upon a more complete record the court found only an attenuated financial impact that was inadequate for the court to grant third party standing.\textsuperscript{262} Individual administrators at residential care facilities were permitted to assert First Amendment claims, but claims against the State Attorney General and Governor were dismissed for lack of justiciability due to their Eleventh Amendment immunity.\textsuperscript{263} 

In the district court's companion opinion on the merits of the plaintiffs' claims, Chief Judge Hogan ruled that Measure 16 violated the Equal Protection Clause of the Fourteenth Amendment, in that the "terminally ill" classification was not rationally related to a legitimate state interest.\textsuperscript{264} The district court stated that no state shall "deny to any person within its jurisdiction the equal protection of the laws."\textsuperscript{265} The standard for equal protection analysis requires that the classification "rationally furthers" the state interest.\textsuperscript{266} 

The district court in \textit{Lee} deemed Measure 16's procedures for differentiating between competent and incompetent persons insufficient.\textsuperscript{267} Also, the court criticized the provisions which gave too much decisionmaking power to an "attending" physician who need not be qualified to adjudge the patient's psychiatric condition nor the voluntariness of the individual's request.\textsuperscript{268} Other problems the district court perceived in Measure 16 included the requirement of "terminal" disease or illness, a definition which is imprecise and often ascertainable only through hindsight.\textsuperscript{269} Further, no truly independent second physician must verify the capacity and voluntariness of the patient, because the initial attending or consulting physician makes the referral.\textsuperscript{270} 

The subjective "good faith" standard of care for physicians who participate under Measure 16 provides an additional shield, in that physi-

\textsuperscript{262} See \textit{Lee v. Oregon}, 891 F. Supp. 1421, 1428 (D. Or. 1995). The physicians had no patients who wished to request a Measure 16 prescription, and these physicians did not have a "sufficient personal stake" to represent such patients in that the physicians opposed the Measure. See \textit{id}. Dr. Petty was permitted to pursue First Amendment claims. See \textit{id}. at 1429.

\textsuperscript{263} See \textit{id}. at 1428-1429.


\textsuperscript{265} \textit{Id}. at 1437 (citing U.S. Const. amend. XIV, § 1).

\textsuperscript{266} See \textit{id}. at 1432 (citing Burlington Northern Railroad Co. v. Ford, 504 U.S. 648, 653-54 (1992)); see also Kleinberg & Mochizuki, \textit{supra} note 199, at 204.


\textsuperscript{268} See \textit{id}. at 1435. See \textit{generally} Shepherd, \textit{supra} note 88, at 120-21 n.98 (outlining deficiencies district court found in Oregon Measure); Clark, \textit{supra} note 85, at 63-64 (questioning Judge Hogan's preference for a psychiatric evaluation rather than general internist physician evaluation as permitted by Oregon Act).


\textsuperscript{270} See \textit{id}. at 1435-36.
cians normally are held to an objective duty of care. The court concluded that this good faith standard inappropriately injected the motivations of the defendant physician into the equation. Immunizing physicians from an objective duty to act with reasonable care was held to be a "defect [that] goes to the very heart of the state's reliance on a person's consent to die." The district court envisioned negligent misdiagnoses as to the patient's condition that would still meet the good faith standard of care under the Oregon statute. This reduced standard was not rationally related to any legitimate state interest. That Measure 16 required no physician supervision of the patient's ingestion of a lethal drug posed the danger that vulnerable individuals may be subjected to abuse and that the decision to commit suicide may not be rational or voluntary at the time of death. The district court looked for further safeguards during this critical time. The court found that the class of patients eligible for assisted suicide under Measure 16 was "severely overinclusive," perhaps because of the difficulty in containing the group permitted the right under the loose terms of the Act. Consequently, the court issued a declaratory judgment and permanent injunction against the Oregon Act.

The Ninth Circuit vacated and remanded the district court's decision in *Lee v. Oregon* on February 27, 1997. Circuit Judge Brunetti, writing for a three-judge panel, ruled that the federal courts did not have Article III jurisdiction over the plaintiffs' claims and re-

271. *See id.* at 1436. An objective standard of reasonable care incorporates community standards and by its very objectivity, provides a higher level of protection for the patient. *See id.*

272. *See id.* at 1436-37.

273. *Id.* at 1437.

274. *See Lee v. Oregon, 891 F. Supp. 1429, 1439 (D. Or. 1995); cf.* Clark, *supra* note 85, at 64 (criticizing Judge Hogan's review, asserting that it did not follow accepted rational-basis standard jurisprudence); *see also supra* note 199 and accompanying text.

275. *See Lee v. Oregon, 891 F. Supp. 1429, 1439 (D. Or. 1995); see also Goldberg, New Fight, *supra* note 235. Reporter notes that during floor debate in April, proponent of repealing Measure 16 "brandished a plastic bag as a reminder" that oral medication alone does not always bring an easy death. The right to die camp maintained that this fact was known all along. *See also Eric Marcus, Why Suicide?* 188 (1996) (criticizing Oregon Act's expectation of patient self-administration of drugs and calling it a "coat-hanger euthanasia bill" comparing to women performing own abortion).


277. *Id.*

278. *See id.* at 1438 (discussing Measure 16's "lowered standards and reduced protections" and its "inability to limit 'rational suicide' to hard cases of suffering competent, terminally adults).
manded the matter with instructions to dismiss. The court's concerns were standing and ripeness. For standing to be present, the plaintiff must be a proper party to litigate, having suffered an injury in fact (either actual or imminent) that is causally connected to the challenged conduct, and that the injury would likely be redressed by an auspicious decision. With respect to ripeness, the issues must be ready for decision.

The Court of Appeals for the Ninth Circuit found that the one remaining individual plaintiff, whom they assumed to qualify as terminally within the meaning of Measure 16, did not have standing because no individualized showing of future harm was established. The third party standing of residential care facilities and doctors suffered from the same problem, because these parties asserted "the interest of unnamed patients who are no closer to suffering the asserted injury than" the lone remaining individual plaintiff. Absent "injury in fact," no further elements of standing need be analyzed.

The plaintiffs also asserted First Amendment and Religious Freedom Restoration Act claims based upon their projected required activities under Measure 16; however, these claims likewise suffered standing and ripeness defects. Measure 16 has no specific penalties for violation of most of its provisions, thus no injury, nor fitness for judicial consideration was established. Should noncompliance with Measure 16 result in a civil enforcement action, then it would be more appropriate for the plaintiff doctors and health care organizations to challenge the validity of the Oregon Act. Thus, the judgment of the district court was vacated with instructions to dismiss the plaintiffs' complaint.

The Ninth Circuit appended the text of the Oregon Act to its decision. From the definitions to the procedures for "death by prescription," the provisions of the Act have been subjected to much analysis.

281. See id. at 1386, 1392.
282. See id. at 1387.
283. See id. (citing Lujan v. Defenders of Wildlife, 504 U.S. 555, 560-61 (1992)).
284. See Lee v. Oregon, 107 F.3d 1382, 1387-88 (9th Cir. 1997).
285. See id. at 1388-89. A chain of speculative contingencies would have to occur in order for the plaintiff to suffer an injury. See id.
286. Id. at 1390.
287. See id.
288. See id. at 1391. These activities included mere transfer of medical records to another physician.
289. See Lee v. Oregon, 107 F.3d 1382, 1391 (9th Cir. 1997). No hardship would befall the plaintiffs if their claims were not heard at this time. See id.
290. See id. at 1392.
291. See id.
292. See id. at 1392-97.
and criticism.\textsuperscript{293} Clearly, better definitions, procedures and safeguards would alleviate some of the concerns, but there would remain the same, almost unresolvable, quagmires that have been raised about the Model Act.\textsuperscript{294} If physician-assisted suicide is to be available, then who should qualify for it? Who will evaluate the patient and who will track compliance with the procedures? Will patients be entitled to more direct assistance at the time of death? Perhaps it is easy to find aspects of both the Oregon Act and the Model Act which could be improved, but whether any statute could address \textit{all} of the concerns inherent in institutionalizing physician-assisted suicide is the more difficult question. Had the Supreme Court determined that the plaintiffs in \textit{Lee} had standing and that the matter was ripe for review, then the provisions of the Oregon Act would clearly have been subjected to further analysis.\textsuperscript{295}

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\textbf{C. Beyond Oregon to Other State Legislative Activity}

With this philosophical debate as context, an overview of current state laws and pending legislation is important. While an accurate tally of the many permutations of these laws is difficult, the general outlines of the legislative picture are clear. At present, state legislatures seem to take very seriously the objections to the Model Statute. In fact, only Oregon has a law which sanctions physician-assisted suicide. While several states have such laws pending,\textsuperscript{296} no others have

\begin{itemize}
  \item \textsuperscript{293}See Annas, \textit{supra} note 112, at 1241 (outlining salient provisions); Callahan & White, \textit{supra} note 224, at 30, 37, 43, 60-61 (criticizing various provisions of Oregon Act, especially that scheme tends to provide "blanket immunity" for those who participate in good faith under the Act). \textit{But cf.} Clark, \textit{supra} note 85, at 58-65 (analyzing Measure 16's provisions in a more positive light); Zwier, \textit{supra} note 199, 217 n.89 (comparing Oregon's safeguards as more careful than those found in the Netherlands). \textit{See also supra} notes 258-78 and accompanying text (discussing district court's analysis of Act's deficiencies).
  \item \textsuperscript{294}See \textit{Lee} \textit{v.} Harcleroad, cert. denied, 118 S. Ct. 328 (1997). The questions presented in the petition for certiorari were:
    \begin{enumerate}
      \item Does dying patient whose recurring clinical depression makes her vacillate between wanting suicide and life have standing to challenge Measure 16 on equal protection, due process and statutory grounds, both individually and as representative of class? (2) May physicians who assert their terminally ill patients' interest in equal protection, due process, and statutory challenges to Measure 16, successfully assure third party standing? (3) Do health care providers have standing to challenge Measure 16, and is their challenge ripe? \textit{See id.} This petition for certiorari was filed on May 16, 1997, by James Bopp Jr., Richard E. Coleson, Bopp, Coleson & Bostron, Terre Haute, Ind., and Thomas Alderman of Eugene, Ore. \textit{See also National Court leaves way clear for assisted suicide in Oregon}, \textit{Pilot}, Oct. 17, 1997, at 13 (discussing Court's denial of review as permitting Oregon law to take effect absent voter repeal).
      \item Nine states had pending bills as of that time. \textit{See An Act Concerning Assisted Suicide}, H.B. 6083, 1997 Leg., Reg. Sess. (Conn. 1997) legalizing assisted sui-
yet made it through a passing vote. The law which has taken effect is the Oregon Death with Dignity Act.\textsuperscript{297} While passed by a narrow majority of the popular vote in 1994, this statute encountered substantial legal challenges and has only been implemented fully since November 1997.\textsuperscript{298} In addition, the Oregon Medical Association has abandoned its neutral stance toward this Act and now actively opposes it.\textsuperscript{299} Also, the Oregon Legislature became so uncomfortable with voters' reactions to the Act that it decided to send the Act back to the voters for reconsideration in November 1997.\textsuperscript{300}

Several other salient points emerge from an examination of the statutes legalizing physician-assisted suicide which are pending or stalled in state legislatures. None appears to incorporate the Model Statute's allowance for physician-assisted suicide solely to end unendurable pain. Rather, pending legislation seems to limit approval of physician-assisted suicide to cases where death is clearly imminent. Thus, the proposed Nebraska statute which promises "superior safe-
guards" against possible abuse, is titled the “Physician Aid-in-Dying Act,”301 leaving no doubt about situations in which doctors can assist in suicide. The pending Vermont bill allows a patient to request life-ending medication from a physician only if that patient is expected to die within one year.302 Other statutes generally authorize aid to a patient suffering from a “terminal” illness or, like the Nebraska statute, to a patient who wishes to have help in dying.303

Clearly, such legislation indicates a desire on the part of legislators to define as narrowly as possible the situations in which physician-assisted suicide is permissible. In fact, this legislative stance is actually more permissive than the current stance of the American people. Recent polls suggest that, while the majority of Americans believe that terminal patients suffering from unremitting pain should be allowed to request physician-assisted suicide, far fewer Americans are willing to extend this right to terminal patients who have merely lost their desire to live or fear becoming a burden to loved ones.304 Rather, Americans seem to fear sliding down a slippery slope toward loss of respect for the sanctity of life if physician-assisted suicide is allowed in other than the most narrowly defined situations.

Another reality which becomes clear when examining pending legislation is that legislative opinion within states considering such bills is also divided. For example, in Vermont, two bills on this issue were filed in 1997. While the first bill authorizes a patient to end a terminal illness with prescription medication,305 the second bill makes physician-assisted suicide a crime.306 The Illinois legislature is considering three bills dealing with this issue. The first of these bills would legalize physician-assisted suicide,307 but the other two bills would amend two different statutes to specifically allow civil equity actions to enjoin physicians from aiding in suicide.308 Interestingly, in Oregon, while the fate of the Measure 16 Death with Dignity Act

304. See Emanuel & Emanuel, supra note 298 and accompanying text.
305. See Rights of Patients Suffering a Terminal Condition, H.B. 109, 64th Biennial Sess. (Vt. 1997).
306. See H.B. 347, 64th Biennial Sess. (Vt. 1997)(proposing to make it a crime to cause or assist someone to commit suicide).
remained uncertain, two other bills were pending, one of which would prohibit the use of public funds to pay for assisted suicide.\(^{309}\)

The legislative activity in Illinois and Oregon emphasizes another trend which uses the law to curtail physician-assisted suicide through civil actions or financial controls. Thus, Oregon, Missouri and North Dakota have legislation pending which would restrict the use of state funds or state health insurance funds to underwrite physician-assisted suicide.\(^{310}\) In Massachusetts, the legislature is considering a bill which would deny death benefits to anyone who assists in suicide,\(^{311}\) while legislation pending in Missouri would revoke the license of a physician who assists in suicide.\(^{312}\) A bill was introduced in Montana which specifies disciplinary measures and monetary damages against physicians who assist in suicide.\(^{313}\) Thus, legislators who are acutely aware of the dangers attendant on legalizing physician-assisted suicide, seem intent to apply brakes on any attempt to do so.

At the heart of this discussion is the reality that, while only Oregon has a law in effect which permits physician-assisted suicide, thirty-six states and territories have laws explicitly prohibiting such practices.\(^{314}\) In addition, three states have homicide statutes worded

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\(^{309}\) See H.B. 2965, 69th Leg., Reg. Sess. (Or. 1997)(adding to definition of informed decision); H.B. 2955, 69th Leg., Reg. Sess. (Or. 1997)(proposing to prohibit the use of state funds to pay for assisted suicide).


\(^{312}\) See H.B. 480, 55th Leg., Reg. Sess. (Mo. 1997)(revoking license of physicians who assist in suicides).

\(^{313}\) See S.B. 230 (Mont. 1997)(providing for discipline as well as monetary damages and equitable relief against medical professionals who assist in suicides).

broadly enough to encompass physician-assisted suicide as criminally negligent homicide,315 while eight states and territories in the absence of a law specifically prohibiting such suicides, have generally condemned the practice.316 In the same context, the Maryland Attorney General has issued an opinion that physician-assisted suicide constitutes reckless endangerment.317

In general, state laws prohibiting physician-assisted suicide forbid both providing the means for a patient to commit suicide and the participation in the act of suicide.318 Some states prohibit the act of advising or encouraging a person to commit suicide as well,319 while other states prohibit the more ambiguous action of “causing” a suicide.320 States with such prohibitive statutes assign different grades


316. See D.C. CODE ANN. § 6-2428 (1995 & Supp. 1996)(referring to assisted suicide as a crime); IDAHO CODE § 39-152 (Supp. 1996) (making clear that state’s ‘do not resuscitate’ statute does not make legal or condone assisted suicide); MASS. GEN. LAWS ANN. ch. 201D, § 12 (West Supp. 1997)(distinguishing state law regarding health care proxies, by noting that this law does not condone or authorize assisted suicide); NEV. REV. STAT. ANN. § 449.670(2) (Michie 1996)(noting state’s ‘do not resuscitate’ statute does not condone or authorize assisted suicide); OHIO REV. CODE ANN. § 2133.12(D) (Anderson 1993 & Supp. 1996)(noting state’s ‘do not resuscitate’ statute does not condone or authorize practice of assisted suicide); S.D. CODIFIED LAWS § 44-78-50(A) (Michie 1996) (excluding from state’s ‘do not resuscitate’ law, any authorization or legalization of assisted suicide); W. VA. CODE § 16-30c-14 (1996)(condemning assisted suicide in state’s ‘do not resuscitate’ law).


318. See supra notes 314-16.


of felony to the "crime" of assisted suicide, resulting in a range of fines and possible prison sentences.\(^{321}\)

Even these prohibitive statutes, however, reveal ambivalence about criminalizing physician-assisted suicide. For example, in Rhode Island, state prosecutors may seek an injunction against assisted suicides, or if an assisted suicide is conducted, participants are guilty of a felony.\(^{322}\) Again, Louisiana's statute, like many others, prohibits physician-assisted suicide and specifically exempts from this prohibition the withholding or withdrawal of medical treatment and the provision of medication for the purpose of alleviating pain, even in doses which might cause death.\(^{323}\)

In addition to state statutes prohibiting physician-assisted suicide which are already in effect, eight additional states have similar bills pending.\(^{324}\) The governor of Texas has recently signed such a bill which amends the Medical Practice Act.\(^{325}\) This went into effect in September 1997.\(^{326}\) Several features of these pending bills bear comment. The Texas bill specifically excludes from criminalization the withholding or withdrawal of medical treatment and the prescribing of medicine for pain.\(^{327}\) Articulating a pervasive fear of undue influence on patients, a Virginia bill, recently signed by the governor, prohibits the act of causing another to commit suicide "by force or duress."\(^{328}\) The Virginia legislation also forbids advertising publicly the service of assistance in committing suicide.

What emerges from an examination of these laws is the reality that states are far from leading the charge toward legalizing physician-assisted suicide. The authors of the Model Statute described above are clearly more comfortable with the possible effects of such

\(^{321}\) See, e.g., Minn. Stat. Ann. § 609.215 (West 1987 & Supp. 1997) (ranging from up to 15 years imprisonment or up to $30,000, or both); Miss. Code Ann. § 97-3-49 (Supp. 1996) (sentencing up to 10 years imprisonment, or up to $1,000 and 1 year in county jail); Mont. Code Ann. § 45-5-105 (1995) (sentencing up to 10 years imprisonment, or up to $50,000, or both); P.R. Laws Ann. tit. 33, § 4009 (1992) (sentencing up to 3 years imprisonment, longer under aggravated circumstances, and possible restitution payments); V.I. Code Ann. tit. 107, § 2141 (Supp. 1996) (sentencing up to 5 years imprisonment).


\(^{323}\) See La. Rev. Stat. Ann. § 32.12 (West 1997); see also supra note 316 and accompanying text.


\(^{326}\) See id.

\(^{327}\) See id.

legislation than are people actually empowered to enact legislation. In reality, statutes which attempt to legalize physician-assisted suicide do so within the most narrowly defined parameters, and the legislation seems to take account of the real possibility of abuse. On the other hand, even statutes which criminalize assisted suicide seem to recognize that doctors who help terminal patients to commit suicide are not really criminals and that terminal patients have the right to control aspects of their treatment which might affect the timing of their deaths. In short, the issues which characterized judicial discussion of physician-assisted suicide and which fueled response to the Model Statute are much the same as the issues which emerge from an analysis of current state laws. Overall, however, state laws seem more oriented toward the state's interest in preserving life than in the individual's right to control his or her own death. In fact, state laws seem to emphasize that individual rights are best protected by recognizing the importance of the state's interest in preserving life.

V. CONCLUSION

"Into the darkness they go, the wise and the lovely."
Edna St. Vincent Millay,
"Dirge Without Music,"
The Buck in the Snow [1928]

"And life is perfected by death."
Elizabeth Barrett Browning,
A Vision of Poets [1844]

"Death will be different for each of us."
Hauntingly so, some might add. Just as our lives and our births have differed. And, in other cases, deaths will be all too similar to each other, although one may wish otherwise. What is considered to be a good death will vary for each individual and will be evaluated differently depending upon the perspective of the various assessors of this process: the patient, physician and the patient's family. Each of these assessors may look for something different in a good death. The patient may look for relief, last-minute love and support, or a reprieve. The physician aspired for a more successful outcome, but is ultimately resigned to alleviating symptoms of the patient's decline and departure and perhaps to avoiding negative legal and economic ramifications. The family

330. See Sheryl Gay Stolberg, The Good Death, Embracing a Right to Die Well, N.Y. Times, June 29, 1997, Week in Review, § 4, at 1. Stolberg discusses an unsettling idea at the heart of the assisted suicide question: for most Americans, modern medicine has made dying worse. She posits that the fear of a painful, lonely and protracted high-tech death has fueled the movement to make assisted suicide legal. She also discusses the various parties affected by death and how a good death “is in the eye of the beholder,” quoting Dr. Sherwin B. Nuland.
looks to do the right thing, but for whom? Their emotions are often in upheaval and they are fraught with guilt at decisions they must make, decisions they may not want to make. If assisted suicide becomes a widely lawful option, some would argue that there will be decisions the family should not have to make. But families will make them and have to live with them. As society adjusts to this new medical method, we are likely all to be diminished.

Professor Kadish, in his argument against substituted judgments about a patient's life, expresses concern about the paternalistic nature of quality of life assessments. The question is not whether the demented person can reason or talk, but can he/she feel. Perhaps this is not even the bottom line. The question may be more basically phrased—whether they still are. Yes, they still are. No doubt, most can feel. The problem is that we feel for them. We do not want to watch them feel, especially when what they are feeling is painful. This may be a reason why public opinion continues to move toward acceptance of assisted suicide. We are a culture that does not want to face death, at least not for protracted periods. It seems that we want to manage our deaths in the same way that we have sought to manage our lives.

In the wake of the Supreme Court's 1997 decisions, the tug of war between a rightful death and the right to life continues afresh. We may yet see a right to die proclaimed and implemented in America through one legal avenue or another. In the new millennium, one wonders just what choices the dying will face, and what choices society will make for them. One wonders, too, why more attention is not paid to making the end of life more dignified and less painful, and to ensuring that better medical care for this stage of life is universally attainable.

331. See Shepherd, supra note 88, at 103. Professor Shepherd believes that choosing assisted suicide is akin to the choice of which child to save when one of the two will be sent to the gas chamber. She concludes that in both cases, no choice should be made.


333. See Kadish, supra note 184, at 881-87.

334. See generally Rosenbaum, supra note 83.

335. See John Aloysius Farrell, Justices voice doubt on a 'right to die,' BOSTON GLOBE, Jan. 9, 1997, at 1 (quoting Kathryn L. Tucker, the attorney who argued the Washington case, that "ours is a culture of denial of death").

336. See Orentlicher, supra note 184, at 47 (discussing that laws permitting assisted suicide in limited circumstances will likely be adopted to bring society's laws more in line with its moral values). But cf. Yale Kamisar, Against Assisted Suicide—Even a Very Limited Form, 72 U. DET. MERCY L. REV. 735, 739, 747-48 (1995) (discussing problem with limiting right to terminally ill, and the slippery slope to euthanasia).
ble. If more attention were paid to these critical issues, the dying as well as society might be more willing to look death in the eye, not just to stare it down, but to experience the final stage of life that provides its full meaning.

337. See Warren E. Leary, Many in U.S. Denied Dignified Death, Health Panel Asserts That Too Little Is Done To Ease End of Life, N.Y. TIMES, June 5, 1997, at 14; Sheryl Gay Stolberg, Considering the Unthinkable: Protocol for Assisted Suicide, N.Y. TIMES, June 11, 1997, at A1 (noting, inter alia, the coercive aspect of financial, family, and health insurance concerns at the time patient makes a decision about assisted suicide). Professor Annas sees a great paradox in America that we are more concerned about the right to refuse treatment and the right to die than in providing universal health care coverage, improved pain control and other support for the terminally ill to help them live better. See George J. Annas, The "Right to Die" in America: Sloganeering from Quinlan and Cruzan to Quill and Kevorkian, 34 DUQ. L. REV. 875, 897 (1996). Professor Annas raises another thought-provoking point, that most physician-assisted suicide cases (especially the Doctor Kevorkian cases) involve men killing women. See id. at 892; see also McGough, supra note 241, at 524 (discussing irony of right to assisted suicide where no correlative right to health care); Kamisar, supra note 336, at 769 (same).

338. See Evelyn Storr Smart, Who lives, Who dies, Who Decides; Death is a Part of Life, Facing and Accepting Terminal Illness Can Help Both the Dying and Those They Are Leaving Behind., L.A. TIMES, June 11, 1997, at B7. The author argues against physician-assisted suicide because “facing death gives real meaning to our lives” and loving, palliative care during the process of closing down is preferable to the cost-effective method of assisted suicide. See id. She relates the story of a forty-two year old cancer patient whose “emaciated body was curved in a fetal position, with her mouth hanging open like a baby bird’s waiting to be fed. ‘How do I look?’ she whispered. ‘Beautiful,’ I answered. And I meant it. Her simple humanity overpowered everything else in the room.” Id.