Death With Dignity or Unlawful Killing: The Ethical and Legal Debate Over Physician-Assisted Death

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The activities of Dr. Jack Kevorkian, and the ability of modern medicine to prolong the life of patients whose conditions are unlikely ever to improve, have led to an intense debate concerning physician-assisted suicide and euthanasia, and whether there is a "right to die." As we await the Supreme Court's decision regarding the constitutionality of statutes prohibiting assisted suicide, the authors review the ethical and legal considerations.

During 1996, two federal courts of appeal held, in separate cases, that state laws prohibiting assisted suicide violate the Fourteenth Amendment to the U.S. Constitution.[1] On October 1, 1996, the Supreme Court granted certiorari in both cases,[2] and the Court heard oral arguments on January 8, 1997.

Although less virulent than the abortion debate, the potential decriminalization of physician-assisted suicide is the most significant bioethical issue to have come before the Court since the abortion cases. An understanding of its significance and likely outcome requires an appreciation not only of the development of the public debate concerning the "right to die," but also of the judicial quagmire in which the federal courts have been mired since *Roe v. Wade*, the Court's obvious desire to stem the tide of abortion cases, and the likelihood that, in deciding the assisted-suicide cases, the Court will attempt to limit future federal litigation concerning this topic.

The past 50 years have seen significant changes in the debate concerning euthanasia and physician-assisted suicide. After World War II, euthanasia became associated with the Nazi extermination of mentally and physically handicapped people, for reasons that had nothing to do

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[1] Compassion in Dying v. Washington, 79 F3d 790, reh'g denied, 85 F3d 1440 (9th Cir. 1996); Quill v. Vacco, 80 F3d 716 (2d Cir. 1996).

[2] Washington v. Glucksberg, No. 95-1858, 65 USLW 3085 (Oct. 1, 1996), Vacco v. Quill, No. 96-110, 65 USLW 3052 (Oct. 1, 1996).

with mercy, and the eventual murders of millions of Jews, gypsies, homosexuals, and others. This legacy continues to haunt the debate today. Proponents of voluntary euthanasia insist that there is all the difference in the world between killing someone who does not want to die, and helping a suffering, terminally ill person who wants to die to end his or her life. Opponents of euthanasia, voluntary or otherwise, fear that if killing people becomes acceptable, there may be no way to stop the killing.

Right to Refuse Treatment

In the 1970s, the focus turned from the permissibility of killing patients who requested death (active voluntary euthanasia) and toward the right of patients to refuse, or to request cessation of, life-prolonging treatment. For the first time in history, it had become possible to resuscitate people who previously would have died and to sustain life under extremely debilitating conditions, including persistent vegetative state (PVS). Between 1976, when the New Jersey Supreme Court decided *In re Quinlan*[3] and California became the first state to enact a "right to die" law, and 1990 when the Supreme Court decided *Cruzan v. Director, Missouri Department of Health*,[4] the right of patients, even those permanently unconscious, to the withdrawal of unwanted medical treatment, including respirators and feeding tubes, became firmly established.[5] As one ethicist has noted: "Most Americans believe there should be a 'right to health care'; instead what they have is a right to refuse health care."[6]

Advance directives, such as living wills and health care proxies, enable individuals to make known their preferences regarding treatment when they are no longer able to express their wishes. However, though the right to refuse treatment is well established in law, a recent study published in the *Journal of the American Medical Association (JAMA)* indicates that doctors often misunderstand or ignore the wish of dying patients to avoid life-prolonging treatment. Discussing that study, one writer noted that, "Twenty-five years since the living will movement began, the study's authors say they have discovered that the wills, which are supposed to give terminally ill patients legal safeguards against unwanted medical treatment, offer virtually no protection."[7] So, the gap between the theoreti-

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[3] In re Quinlan, 70 NJ 10, 355 A2d 647 (1976).

[4] Cruzan v. Director, Mo. Dep't of Health, 497 US 261 (1990).

[5] For details, see the excellent account in Meisel, The Right to Die ch. 8 (2d ed. 1995 & 1997 Supp. No. 1).

[6] Annas, "The 'Right to Die' in America: Sloganeering from *Quinlan* and *Cruzan* to *Quill* and *Kevorkian*," 34 Duq. L. Rev. 875 (1996).

[7] Susan Gilbert, "Doctors Often Fail to Heed Wishes of the Dying Patient," New York Times, Nov. 22, 1995, at A1 (describing findings of "The SUPPORT Study, A

cal right to refuse life-prolonging treatment and what really happens in a hospital setting remains depressingly large.

Euthanasia Vs. Assisted Suicide

During the past decade, the debate has returned to the morality of voluntary euthanasia and physician-assisted suicide and since 1993, when Dr. Kevorkian assisted his first suicide, the pace of developments has accelerated. Euthanasia and assisted suicide differ in the degree of physician involvement:

> Euthanasia involves a physician performing the immediate life-ending action (e.g., administering a lethal injection). Assisted suicide occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g., the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide).[8]

In 1991 and 1992, ballot initiatives in California and Washington state to legalize physician aid in dying (which included both euthanasia and assisted suicide) were defeated by narrow margins. In 1994, Oregon became the first state to expressly legalize physician-assisted suicide when the voters approved Measure 16, subsequently enacted as the Death With Dignity Act.[9] Implementation of the Act was enjoined by a federal district court judge who held that the statute violates the Fourteenth Amendment.[10]

The Oregon statute legalizes physician-assisted suicide: it does not legalize suicide assistance provided by anyone other than a physician,

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Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients," 274 JAMA 1591 (Nov. 22/29, 1995).

[8] American Medical Association, "Council on Ethics and Judicial Affairs, Decisions Near the End of Life," 267 JAMA 2229 (Apr. 22–29, 1992).

[9] Euthanasia and physician-assisted suicide have been tolerated in the Netherlands since the 1970s. Although euthanasia is technically still a crime, physicians are guaranteed immunity from prosecution as long as certain guidelines are followed. For an English translation of the guidelines, see Lagerwey, 3 Issues in L. & Med. 429 (1988). For recent accounts of the Dutch experience, see Angell, "Euthanasia in the Netherlands: Good News or Bad?" 335 N. Eng. J. Med. 1676 (Nov. 28, 1996); Battin, "Seven Caveats Concerning the Discussion of Euthanasia in Holland." 34 Perspectives in Biology and Medicine 73 (Autumn 1990); Van der Maas, "Euthanasia, Physician-Assisted Suicide, and Other Medical Practices Involving the End of Life in the Netherlands 1990–1995," 335 N. Eng. J. Med. 1699 (Nov. 28, 1996).

[10] Lee v. Oregon, 891 F. Supp. 1429 (D. Or. 1995), vaeated, 1997 U.S. App. LEXIS 3478 (9th Cir. Feb. 27, 1997). However, it is likely that implementation of the statute will be stayed until the U.S. Supreme Court issues its decision.

nor does it legalize euthanasia, even when performed by a physician. Many ethicists see no intrinsic difference between voluntary euthanasia and assisted suicide, because in both cases a doctor prescribes a lethal dose to bring about the death of the patient. According to one commentator:

> A paradigm case of physician-assisted suicide is a patient's ending his or her life with a lethal dose of a medication requested of and provided by a physician for that purpose. A paradigm case of voluntary active euthanasia is a physician's administering the lethal dose, often because the patient is unable to do so. The only difference that need exist between the two is the person who actually administers the lethal dose—the physician or the patient. In each, the physician plays an active and necessary causal role.[11]

Why does it matter who actually administers the lethal dose? Some patients are too sick even to swallow pills; and, if medical supervision is not allowed, a patient may botch the suicide attempt and make the situation worse than before. Thus, in the Netherlands both voluntary euthanasia and assisted suicide are options. According to one physician:

> Under the penumbra of the double effect, physicians perform the equivalent of slow euthanasia at home, or in a hospital or hospice. Methods vary, but to be acceptable, the act must extend long enough to preclude the appearance of direct euthanasia. . . . Whether we assist a patient in dying by withdrawal of life-sustaining treatment, by the double effect, by assisted suicide, or by euthanasia, we are involved in ending life. . . . However, in the view of the patients who consent to any of them, we do not harm, and the use of the word kill to negatively define these acts is incorrect and counter-productive unless the act constitutes murder.[12]

Two Different Physicians

The public debate in the United States has largely been shaped by the activities of two very different physicians. Dr. Jack Kevorkian, a retired pathologist, has performed dozens of assisted suicides, or medicides as he calls them. There has been substantial controversy concerning just how ill some of Dr. Kevorkian's "medicide" patients were. For instance, in the case of Patricia Cashman, the medical examiner first claimed that the autopsy showed no sign of cancer. When presented with medical records that showed that Cashman had metastatic,

[11] Dan W. Brock, "Voluntary Active Euthanasia," in Life and Death 204 (1993).

[12] Preston, Physician Involvement in Life-Ending Practices, 18 Seattle U.L. Rev. 531, 539, 543 (1995).

inflammatory breast cancer that involved her skull, ribs, and spine, the medical examiner conceded that "bone cancer was very likely in this case," and added that "she probably was in considerable pain." But he said that there was nothing to indicate she was near death, or that the pain was not treatable.[13]

Very different is the case publicized by Dr. Timothy Quill in his famous 1991 article in the *New England Journal of Medicine.*[14] Dr. Quill had been treating his patient, Diane, for many years when she was found to have a very severe form of leukemia. Upon learning that the only available treatment would be arduous and would have only a 25 percent chance of curing her, Diane decided to forgo treatment. Dr. Quill asked her to talk to a psychologist to confirm that her decision was well thought out and not simply the result of depression. She did, and the psychologist confirmed clearly and unequivocally that her decision was rational.

As her disease progressed, Dr. Quill prescribed antibiotics and blood transfusions. When she began to deteriorate and to experience a great deal of pain and weakness, she told Dr. Quill that she wanted to die in the least painful way. He advised her to get help from the Hemlock Society, an advocacy group for the right to die. A week later, Diane phoned Dr. Quill with a request for barbiturates to help her sleep. He was well aware that these were an essential ingredient in a typical Hemlock Society suicide, and therefore he made sure that she knew both how to use the barbiturates for sleep and also the amount needed to commit suicide. Diane then planned a good-bye party for her family and friends. Two days later, she asked her husband and son to leave her alone for an hour. She took the barbiturates and died peacefully.

This is not an unusual story, except that Dr. Quill described what he did in the *New England Journal of Medicine*. In part, he was motivated by horror at the actions of Dr. Kevorkian. Kevorkian has not known the people—virtually all have been women—that he has helped to die. He was not familiar with their medical histories, their values, or their lives. He is not a clinician at all, much less their own doctor, but a retired pathologist. As such, it is doubtful whether he has the ability to confirm their diagnoses or that they are terminally ill, to rule out temporary and treatable depression, or to recommend other approaches to pain. In all these ways, Dr. Quill's treatment of Diane compares favorably with the methods of "Dr. Death," as Kevorkian has become known. Quill lim-

[13] "After Kevorkian-Aided Suicide, Clash Over How Ill Woman Was," New York Times, Nov. 10, 1995, at A20.

[14] Quill, "Death and Dignity: A Case of Individualized Decision Making," 324 N. Eng. J. Med. 691 (Mar. 7, 1991).

ited his help to one person, a long-term patient, whom he knew very well. Moreover, he prescribed barbiturates only after long discussions with her and an independent evaluation by a psychologist. Quill could have avoided exposure to liability if he had kept quiet with regard to his role in Diane's death, but he decided to publish her story because he thinks the law should be changed so that patients do not have to kill themselves in a violent way or resort to a Dr. Kevorkian.

Despite their illegality, physician-assisted suicide and euthanasia have occurred throughout history.[15] A sample of U.S. oncologists found that 57 percent had received a request for euthanasia or assisted death at some time, and that 14 percent had actually engaged in those practices.[16] Another study found that 21 percent of Oregon physicians had received a request for physician-assisted suicide in the past year and that 7 percent had written at least one lethal prescription at a patient's request.[17] In Washington state, 12 percent of physicians had received requests for physician-assisted suicide and 4 percent had received a request for euthanasia during the preceding year. In both cases, 24 percent of requests were granted.[18]

A former senior adviser to the American Bar Association's Commission on Legal Problems of the Elderly recently defended state laws against physician-assisted dying, because of the need to protect "the most vulnerable segments of our society—the elderly, the poor and the persons with disabilities." However, he concluded by saying: "At the same time I selfishly reserve my right to do in private what my family, my doctor and pastor and I, in loving consultation, voluntarily agree is best."[19] According to a leading authority:

> There are at least two serious problems with this "open secret" approach to "negotiated death." The first is that it is arbitrary and discriminatory, and the second, that it is subject to potentially grave abuse. . . . [I]t is discriminatory because it favors those who have the sophistication, the financial resources,

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[15] Emanuel, "Euthanasia: Historical, Ethical, and Empiric Perspectives," 154 Archives Int'l Med. 1890 (1994).

[16] Emanuel et al., "Euthanasia and Physician-Assisted Suicide: Attitudes and Experiences of Oncology Patients, Oncologists, and the Public," 347 Lancet 1805 (1996).

[17] Lee et al., "Legalizing Assisted Suicide: Views of Physicians in Oregon," 334 N. Eng. J. Med. 310 (1996).

[18] Black et al., "Physician-Assisted Suicide and Euthanasia in Washington State: Patient Requests and Physician Responses," 275 JAMA 919, 1996.

[19] Pickering, "The Continuing Debate Over Active Euthanasia," 3 ABA Bioethics Bulletin, 1, 15 (1994), quoted in Law, "Physician-Assisted Death: An Essay on Constitutional Rights and Remedies," 55 Md. L. Rev. 292 (1996).

> the connections, and the time and energy to find a cooperative doctor, but sometimes it favors those who are just plain lucky to be able to find the doctor they need. The other problem is that there is no guarantee that a willing doctor will necessarily await the request of the dying patient. . . . More than a few must have been unknowingly and possibly unwillingly assisted to die. In part this unilateral decisionmaking occurs because of doctors' fears of opening up the topic for discussion and in part because of the tradition of medical paternalism applied to all medical practices, illicit as well as licit.[20]

Is there a constitutional "right to die" that includes a right to physician assistance in committing suicide? Should physician-assisted suicide be a legal option? If so, under what conditions? Should assisted suicide be limited to patients who are terminally ill and who are suffering unbearable and irremediable pain? Or, should people who are suffering horribly be able to choose death, even if they are not terminally ill; for example, if they are faced with the loss of mental or physical capacities? And, if patients have a right to die, is helping patients to die something doctors ought to do? Is this consistent with their role as healers? Finally, society needs to determine what are the likely consequences, for individual patients, for the medical profession, and for society as a whole, if physician-assisted suicide is legalized.[21]

Arguments in Favor of Euthanasia and Assisted Suicide

There are basically two independent, though related, arguments in favor of legalizing voluntary euthanasia and assisted suicide. The first is the argument from cruelty: If a dying patient is suffering great pain that cannot be controlled with medication, it is cruel to force that person to continue living. Dying is bad enough: Why should a person have to die in pain? If animals that are hopelessly ill or in terrible pain are put "out of their misery," how can it be right to allow people to suffer?

Argument From Cruelty

The scope of the argument from cruelty is quite broad. It justifies not merely physician-assisted suicide and voluntary euthanasia, but also nonvoluntary euthanasia. Suffering is obviously not limited to individuals who are competent to request death: Mentally handicapped people and infants can also experience agonizing and irremediable pain. If

[20] Alan Meisel, The Right to Die 491–492 (2d ed. 1995).

[21] For further readings on the ethical issues, see Tom L. Beauchamp, Intending Death: The Ethics of Assisted Suicide and Euthanasia (1996).

avoidance of pain is the rationale for euthanasia, there is no reason to restrict it to voluntary euthanasia. Additionally, the argument from cruelty justifies helping patients die who are not terminally ill. For, if it is cruel to force someone to go on living who will die shortly anyway, it would seem even more cruel to force someone to endure suffering for a longer period.

Some opponents of euthanasia reject pain or suffering as a justification for causing death. An archbishop of the Catholic Church once wrote that experiencing pain provides us with the opportunity to participate in the suffering of Jesus Christ on the cross and therefore is to be welcomed, not avoided. Of course, this is an argument not merely against euthanasia, but also against pain medication in general. As such, it has little plausibility, at least for non-Catholics. The fact that some people find suffering to be meaningful provides no reason why suffering ought to be imposed on those who prefer to avoid pain. The degree to which one should accept pain and disability would seem to be a very personal matter, and one best left to individuals.

The argument from cruelty is not limited to physical pain and suffering. Many people do not fear pain so much as being kept alive after there is no reasonable hope for recovery. They want aggressive treatment if it can restore them to health or give them a reasonably good quality of life, but they do not want heroic measures that merely prolong biological life. Many people regard this as a misuse of medical technology and contrary to human dignity. Someone who is being kept alive in a persistent vegetative state by a mechanical ventilator does not experience pain. The argument from cruelty does not literally apply in this sort of case. Yet, many would argue that the prospect of being kept alive "as a vegetable" causes them more suffering than the prospect of physical pain, and therefore it too is cruel. Others maintain that while keeping a person in a permanently unconscious state alive is not cruel, it is nevertheless wrong if that person does not want to be kept alive: The decision should be the patient's.

Argument From Self-Determination

The second argument in favor of voluntary euthanasia or assisted suicide is the argument from self-determination: In general, people should be able to decide for themselves how to live their lives. John Stuart Mill, perhaps the most eloquent exponent of self-determination, wrote:

> The only freedom which deserves the name, is that of pursuing our own good in our own way, so long as we do not attempt to deprive others of

> theirs, or impede their efforts to obtain it. Each is the proper guardian of his own health, whether bodily, or mental and spiritual. Mankind are greater gainers by suffering each other to live as seems good to themselves, than by compelling each to live as seems good to the rest. . . .[22]

Some maintain that the moral and legal rights to bodily self-determination, which are the basis of the right to refuse treatment, should be interpreted and expanded to cover a right to die; that is, a right to commit suicide or, if the patient is unable to commit suicide unaided, to be killed or to be helped in dying. In this vein, according to one writer:

> The central ethical argument for euthanasia is familiar. It is that the very same two fundamental ethical values supporting the consensus on patients' rights to decide about life-sustaining treatment also support the ethical permissibility of euthanasia. These values are individual self-determination or autonomy and individual well-being.[23]

There are risks in recognizing such a right. Some people will choose to die who could have recovered and gone on to years of healthy existence. Some people will make the choice out of temporary depression. Allowing people to make their own choices always involves the risk that they will choose unwisely. This is the price of self-determination, a price its defenders think is well worth the risk. As one proponent of self-determination eloquently argues:

> Whether it is in someone's best interests that his life end in one way rather than another depends on so much else that is special about him—about the shape and character of his life and his own sense of his integrity and critical interests—that no uniform collective decision can possibly hope to serve everyone even decently. So we have that reason of beneficence, as well as reasons of autonomy, why the state should not impose some uniform, general view by way of sovereign law but should encourage people to make provision for their future care themselves, as best they can, and why if they have made no provision the law should so far as possible leave decisions in the hands of their relatives or other people close to them whose sense of their best interests—shaped by intimate knowledge of everything that makes up where their best interests lie—is likely to be much sounder than some universal, theoretical, abstract judgment born in the stony halls where interest groups maneuver and political deals are done. . . . Making someone die in a way that others approve, but he believes a horrifying contradiction of his life, is a devastating, odious form of tyranny.[24]

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[22] J.S. Mill, On Liberty ch. 1, 13 (Indianapolis, 1955).

[23] Dan W. Brock, Voluntary Active Euthanasia, in Life and Death 205 (1993).

[24] Ronald Dworkin, Life's Dominion 213, 217 (1993).

The alternative is paternalism, the view that others should be able to make decisions for us, against our will, for our own good. The history of medical ethics during the past 30 years is a rejection of medical paternalism and the idea that "doctor knows best." Patients have fought hard to gain control over their medical treatment. Physician-assisted suicide can be seen as part of the movement for self-determination in medical care. It allows patients to determine when life has become unbearable and death is preferable. The assistance of physicians is needed to make death easy, quick, painless, and certain.

Role of Physician

The American Medical Association (AMA) acknowledges that the right to self-determination "requires that physicians respect the decision to forgo life-sustaining treatment of a patient who possesses decision making capacity,"[25] but holds that both euthanasia and physician-assisted suicide "[are] fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks."[26] However, opinion within the medical profession is far from unanimous; others, like Dr. Quill, regard helping patients achieve "a good death," that is, a death without suffering, as compatible with, indeed entailed by, the doctor-patient relationship, if it is done in the right way with the proper safeguards.

In a 1994 survey of physicians in Washington state, 54 percent of the respondents agreed that there are some situations in which euthanasia should be legal, and 33 percent said that they would be willing to participate in euthanasia in some situations; the corresponding figures for physician-assisted suicide were 53 percent and 40 percent.[27] In a 1995 survey of Michigan physicians and the public, 56 percent of the responding physicians, and 66 percent of the public, thought that the legislature should probably or definitely legalize physician-assisted suicide.[28] Finally, in a 1995 survey of Oregon physicians, 66 percent of the respondents said that physician-assisted suicide would be ethical in

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[25] American Medical Association, Council on Ethical and Judicial Affairs, Code of Medical Ethics § 2.20 (1994 ed.).

[26] Id. §§ 2.21, 2.211.

[27] Cohen et al., "Attitudes Towards Assisted Suicide and Euthanasia Among Physicians in Washington State," 331 N. Eng. J. Med. 89 (July 14, 1994).

[28] Bachman et al., "Attitudes of Michigan Physicians and the Public Toward Legalizing Physician-Assisted Suicide and Voluntary Euthanasia," 334 N. Eng. J. Med. 303 (Feb. 1, 1996).

some circumstances, 60 percent said that it should be legal in some circumstances, and 46 percent said that they might be willing to prescribe a lethal dose for a terminally ill patient, if that were legal. However, the survey also identified some causes for concern:

> At present, physicians in Oregon have no guidelines for responding to a patient's request for assisted suicide if they think the request is prompted by financial pressure. Half the respondents in our study are not confident they could predict that a patient has less than six months to live. . . . In addition, one third of the respondents are not confident they could recognize depression in a patient asking for a lethal dose of medication.[29]

Danger of Unwarranted Expansion

Proponents of autonomy believe that it is beneficial for patients to have additional choices. However, others have argued that to allow the choice of hastening death may not be in the patient's best interests:

> Will we not sweep up, in the process, some who are not really tired of life, but think others are tired of them; some who do not really want to die, but who feel they should not live on, because to do so when there looms the legal alternative of euthanasia is to do a selfish or a cowardly act? Will not some feel an obligation to have themselves "eliminated" in order that funds allocated for their terminal care might be better used by their families or, financial worries aside, in order to relieve their families of the emotional strain involved?[30]

Still others argue that creating an assisted-suicide option, in today's youth-obsessed culture, is like creating a right to duel in a culture obsessed with personal honor:

> By eliminating the option of dueling (if we can), we can eliminate the reasons that make it rational for people to duel in most cases. To restore the option of dueling would be to give people reasons for dueling that they didn't previously have. Similarly, I believe, to offer the option of dying may be to give people new reasons for dying.[31]

The strongest justifications for physician-assisted suicide use both the argument from cruelty and the argument from self-determination, as in the case of Dr. Quill's patient, Diane. If either is used alone, there

[29] Lee et al., "Legalizing Assisted Suicide—Views of Physicians in Oregon," 334 N. Eng. J. Med. 310 (Feb. 1, 1996).

[30] Yale Kamisar, "Some Non-Religious Views Against Proposed 'Mercy-Killing' Legislation," 42 Minn. L. Rev. 969, 990 (1958).

[31] Velleman, "Against the Right to Die," 17 J. Med. & Phil. 665, 676 (1992).

is a danger of unwarranted expansion. Thus, the argument from cruelty can be used to justify nonvoluntary euthanasia, raising the specter of widespread killing of senile, mentally handicapped, or infant patients. This prospect is avoided if euthanasia is limited to mentally competent patients who wish to commit suicide. However, the argument from self-determination is potentially as expansive as the cruelty argument. For, if the basis of the right to die is self-determination, why should it be limited to those who suffer uncontrollable pain or are terminally ill?

Arguments Against Legalizing Euthanasia and Physician-Assisted Suicide

There are essentially three arguments against legalizing physician-assisted suicide and euthanasia. Again, they are related and often tend to elide.

Discouraging Suicide

The first argument asserts simply that killing is wrong: Even though suicide is no longer illegal, it should still be discouraged.

Corruption of Medical Profession

The second argument, reflected in the ethics opinions of the AMA, asserts that to involve physicians in assisted suicide or euthanasia would corrupt the integrity of the medical profession: Physicians are healers, not killers. In this form, the argument begs the fundamental question: What is the physician's obligation to a dying patient who has expressed a desire for death? Is it to continue to treat the inevitable death as an enemy, or should the physician strive, to the extent possible, to ease the patient's inevitable passing. After all, death with dignity, though a laudable goal, is unattainable for most of us. Death is messy, unpleasant, generally painful, and emotionally draining, not only for the patient, but also for the family and caregivers. Should we not strive to minimize the unpleasantness?

A more sophisticated version of this argument is that assisted suicide and euthanasia, if legalized, would offer physicians and family members an easy way out; a less time-consuming, and less emotionally draining death to deal with would, thus, discourage physicians from discussing alternatives and providing optimal palliative care, and would discourage further research into improving the care of the dying. This seems to ignore the fact that all responsible proponents of physician-

assisted suicide and euthanasia agree that palliative care should be improved and that euthanasia or assisted suicide should be a last resort, used only in rare cases.

Slippery Slope

The final, and easily most substantial argument is the fear-of-abuse/slippery-slope argument: Once society legalizes physician-assisted suicide, how does it prevent euthanasia? Once we allow these practices for the terminally ill, how do we avoid expansion to others who are, temporarily or otherwise, disenchanted with their lives? How long will it be before the practices are extended to the incompetent, and how long before familiarity with voluntary euthanasia leads us to an easy acceptance of involuntary euthanasia? These are substantial concerns, particularly given the fundamental inadequacies and inequality of the health care system. Do these concerns require that we sacrifice the best interests of suffering patients who want to die for the good of society generally, or do we instead attempt, at least initially, to limit access to physician-assisted suicide and euthanasia and develop procedural safeguards to limit, if not prevent, abuses? In this context, it is important to acknowledge the truth of the comment that, no matter how carefully such safeguards are crafted, ultimately the physician will have enormous discretion in determining whether the criteria are satisfied.[32] We may feel comfortable trusting a Dr. Quill with this discretion, but how many of us can realistically expect to enjoy the sort of physician-patient relationship he describes? On the other hand, we already entrust doctors with enormous discretion in matters of life and death.

Concerns regarding abuse following legalization have been eloquently stated. In an influential article published in 1958,[33] one author argued that euthanasia should remain illegal, and he has not changed his mind.[34] This is not because he thinks that euthanasia would always be wrong. In fact, this writer said that if he could know that a person was (1) terminally ill, (2) suffering terrible pain that (3) couldn't be relieved, and (4) had a desire to die that was (5) unwavering and (6) rational, he would "hate to stay the hand of death." The trouble is that it's hard to know any of these things with any degree of certainty.

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[32] Bernard Lo, M.D., "Presentation at 1996 AALS Annual Meeting Joint Program, Physician-Assisted Suicide," San Antonio, Texas (Jan. 4, 1996).

[33] Kamisar, supra note 30.

[34] For a recent statement of his views, see Kamisar, "Against Assisted Suicide: Even a Very Limited Form," 72 U. Det. Mercy L. Rev. 735 (1995).

Diagnosis of Terminal Illness. The first problem is the diagnosis of terminal illness. How should this be interpreted? Is a person terminally ill if he or she has a disease that is invariably fatal, like AIDS? Or, does death have to be relatively soon? If so, must death occur within a year? Six months? One month? In addition to terminological uncertainty, there is the problem of reliability of diagnosis. Almost everyone knows of someone who was diagnosed as terminally ill who lived longer than the doctors expected. Sometimes someone diagnosed as "terminal" even gets better.

Relief of Pain. How about pain? It is undeniable that many terminally ill individuals die in terrible pain. In its report on physician-assisted suicide and euthanasia, the New York State Task Force[35] characterized the treatment of severe pain in hospitalized patients as "regularly and systematically inadequate":

> In one study of 897 physicians caring for cancer patients, 86 percent reported that most patients with cancer are undermedicated. Only 12 percent characterized their pain management training in medical school as excellent or good. In another study . . . 81 percent of respondents agreed with the statement, "The most common form of narcotic abuse in the care of the dying is undertreatment of pain." [36]

The *JAMA* study cited earlier[37] found that of conscious patients who died in the hospital, 50 percent experienced moderate to severe pain in the last three days of life.

Critics of legalization do not deny the existence of pain in terminally ill patients, but they argue that the correct approach is not to legalize physician-assisted suicide, but rather to improve this sorry record. The World Health Organization has endorsed palliative care as an integral component of a national health care policy and has strongly recommended to its member countries that they not consider legalizing physician-assisted suicide and euthanasia until they have addressed the needs of their citizens for pain relief and palliative care.[38]

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[35] New York State Task Force on Life and the Law, When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context (Albany, NY, May 1994).

[36] Id. at 43.

[37] Susan Gilbert, "Doctors Often Fail to Heed Wishes of the Dying Patient," New York Times, Nov. 22, 1995, at A1 (describing findings of "The SUPPORT Study, A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients", 274 JAMA 1591 (Nov. 22/29, 1995).

[38] World Health Organization, Cancer Pain Relief and Palliative Care (Geneva, 1989), as cited in Foley, "Competent Care for the Dying Instead of Physician-Assisted Suicide," 336 N. Eng. J. Med. 54 (Jan. 2, 1997).

Similarly, a member of the New York State Task Force, when it issued its report, argues:

> Instead of launching a highly divisive and dangerous campaign for PAS, why not attack the problem at its root with an ambitious program of reform in the areas of access to primary care and the education of physicians in palliative care? At least as far as the "slippery slope faction" within the Task Force is concerned, we should thus first see to it that every person in this country has access to adequate, affordable, and nondiscriminatory primary and palliative care. At the end of this long and arduous process, when we finally have an equitable, effective, and compassionate health care system in place, we might well want to reopen the discussion of PAS and active euthanasia.[39]

Some claim that there is no reason for anyone to experience terrible pain as the result of terminal illness, given the array of painkillers and other techniques for managing pain. The problem is not that pain is inevitable, but that too often doctors are not sufficiently concerned about pain or are inappropriately worried about addiction to painkillers.

Another cause of inadequate pain management is hospital routine. If pain medication must be administered by nurses, it may not be given frequently enough to control pain. And, if a patient begins to feel pain, the resultant anxiety makes the pain worse. For this reason, many post-operative patients today are put on a morphine drip that allows them to control their own pain medication. Studies have shown that with such control patients actually require less medication.

The question, then, is whether euthanasia or assisted suicide would be necessary if good pain management techniques were adopted. There is no consensus, however, regarding this issue. The physician plaintiffs in *Compassion in Dying v. Washington*[40] pointed out that the choice for a terminal patient may be the unpalatable one between being pain free or being "doped up," confused, even hallucinating. Others argue that if euthanasia or physician-assisted suicide are options, there will be even less incentive for doctors to improve the relief of pain and suffering.

Genuine Desire to Die. Two more problems remain. The first is determining that death is genuinely desired. Someone may express a desire for death during a low period, but feel better later. A patient may be

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[39] John Arras, "On the Slippery Slope in the Empire State: The New York State Task Force on Physician-Assisted Death," 95 Am. Phil. Ass'n Newsls. 80 (Spring 1996). See also Foley, "Competent Care for the Dying Instead of Physician-Assisted Suicide," 336 N. Eng. J. Med. 54 (Jan. 2, 1997).

[40] Compassion in Dying v. Washington, 79 F3d 790, reh'g denied, 85 F3d 1440 (9th Cir. 1996).

unduly influenced by temporary pain, or have his or her thinking clouded by pain medication. All of these factors may make it difficult to know when an individual is possessed of a fixed and rational desire to die.

Specific Legislation. But, even if we can know in individual cases that a person is really terminally ill and really wants to die, can legislation be drafted that ensures that *only* these people will be helped to die? What some fear is that, from motives of compassion, we might change the law with disastrous results. The worry is that external pressures will influence people who do not really want to die, but who are afraid of being a burden to their families, to choose death. Is this a choice we want to offer very ill and suffering patients?

Dr. Quill and two colleagues published proposed guidelines for the care of the terminally ill.[41] Two psychiatrists commented that:

> The guidelines of Quill and colleagues require effective, collaborative, and committed doctor-patient relationships. They rely on the abilities of physicians to detect or determine when contemplation is rational and not "distorted". Such relationships between patients and skilled physicians exist, no doubt, but how common are they in 1993? Indeed, current social and economic pressures make these qualities more precarious, not less. Managed competition and cost control are necessary and likely, but they will not encourage leisurely interactions or time to "just talk."[42]

Moreover, at a time and in a society where access to care is so limited, there is a real risk that some patients might be pressured to opt for assisted suicide. Advocates for the disabled worry that they might be especially susceptible to such pressures, along with poor people and minority group members. One commentator in the *New York Times* expressed this fear:

> Even if the right to assisted suicide were restricted to terminally ill people, it seems likely that some—the poor, elderly, unassertive, clinically depressed, members of disfavored minorities or some combination of all these—would be especially vulnerable to subtle or not-so-subtle promptings to choose a quick, easy (and inexpensive) exit.[43]

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[41] Quill, Cassel, and Meier, "Care of the Hopelessly Ill: Proposed Clinical Criteria for Physician Assisted Suicide," 327 N. Eng. J. Med. 1380 (Nov. 5, 1992).

[42] Caine and Conwell, "Self-Determined Death, the Physician, and Medical Priorities: Is There Time to Talk?" 270 JAMA 875 (1993).

[43] Robert A. Burt, "Death Made Too Easy," New York Times, Nov. 16, 1994, at A19.

Another concern is that women would be vulnerable to physician-assisted death, partly because of their general role in society and also because studies have shown women to be at greater risk for inadequate pain relief and for depression, both factors associated with suicidal ideation.[44]

How one assesses the arguments for and against legalizing physician-assisted suicide may depend on one's perspective. If one considers the issue from the perspective of an individual patient, it seems outrageous that the state should prevent a doctor from helping a suffering, terminally ill patient to die. No one wants to suffer at the end of life, nor would we want to see our parents or other relatives in agony. This may incline us to support a change in the law. However, we must also consider the social impact of such a change and the risk of undue pressure's being placed on the elderly and infirm to make a dignified exit. From this perspective, the criminal prohibition against assisted suicide may appear as a protection of the especially vulnerable.

To resolve the issue, two perspectives must be balanced: the needs of the individual patient and the impact on society of relaxing the present prohibitions. We also need to ascertain the need for physician-assisted suicide. How many suffering, terminally ill patients who truly wish to die are being prevented by the current law? Many doctors *are* willing to prescribe potentially lethal pain killers, even under current restrictions, knowing that it is extremely unlikely that they will ever be indicted, much less tried or convicted. Next, the risks of mistake and abuse must be ascertained. We should be observing very carefully the jurisdictions, particularly Oregon (assuming that its statute does go into effect), where physician-assisted suicide and/or euthanasia are legal, to see if the fears of those who oppose legalization materialize. In view of the potential for subtle and not-so-subtle pressure on vulnerable populations, a careful "go slow" approach is warranted.

Logic is not sufficient to resolve the problem:

> On the one hand, we want to respect patients' wishes, relieve suffering, and put an end to seemingly futile medical treatment. Hence we allow patients to refuse life-sustaining treatment. On the other hand, we want to affirm the supreme value of life and to maintain the salutary principle that the law protects all human life, no matter how poor its quality. Hence the ban against assisted suicide and active voluntary euthanasia.
>
> I venture to say that one of the purposes of the distinction between the termination of life support and assisted suicide (or active voluntary

[44] Susan M. Wolf, "Gender, Feminism, and Death: Physician-Assisted Suicide and Euthanasia," in Feminism and Bioethics (S.M. Wolf ed., 1996).

euthanasia)—or at least one of its principal effects—is to have it both ways. The two sets of values are in conflict, or at least in great tension. Nevertheless, until now at any rate, we have tried to honor both sets.

Unless we carry the principle of "self-determination" or "personal autonomy" or "control of one's own destiny" to its ultimate logic—assisted suicide (and active euthanasia) by any competent individual who firmly requests it for any reason the individual deems appropriate—we have to draw a line somewhere along the way. But where? I submit that no intermediate line, certainly not the one Sedler and his colleagues suggest, would be any more defensible than the one we have now. So why cross the line we have now?[45]

Legal Background

Euthanasia is not a separate category of crime in Anglo-American law. The intentional or deliberate taking of the life of one human being by another is homicide. The fact that the motive for killing is mercy, and the fact that the dead person was terminally ill or asked to be killed, are irrelevant. Prosecutors have often been reluctant to indict, and juries have been reluctant to convict, those who perform acts of euthanasia unless the prosecutors think that the motive was actually something other than mercy. Nevertheless, many doctors are understandably hesitant to prescribe lethal drugs to their dying patients from fear of breaking the law, and some believe that the law should be changed.

Under English common law, suicide was considered "self-murder," was ranked "among the highest crimes,"[46] and was punished by forfeiture of the suicide's property to the crown. Neither suicide nor attempted suicide is now a crime anywhere in the United States, on the ground that "there is no form of criminal punishment that is acceptable for a completed suicide and that criminal punishment is singularly inefficacious to deter attempts to commit suicide."[47]

However, 37 states have statutes that explicitly criminalize assisted suicide, an increase from only 25 in 1985.[48] In seven more

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[45] Kamisar, "Against Assisted Suicide—Even a Very Limited Form," 72 U. Det. Mercy L. Rev. 735 (1995).

[46] Blackstone, Commentaries, vol. 4, *189 (1769).

[47] American Law Institute, Model Penal Code and Commentaries, vol. 2 § 210.5, Cmmt. at 94 (1980).

[48] The 37 states are Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Oklahoma, Pennsylvania, Rhode Island, South Dakota, Tennessee, Texas, Washington,

states[49] and the District of Columbia, assisted suicide is a common-law crime. In five states, it is unclear whether assisted suicide is a criminal offense.[50] Finally, Oregon is the lone state in which physician-assisted suicide is legal, in certain circumstances.[51]

None of these state laws distinguishes between euthanasia or suicide assistance provided by a physician or by a nonphysician (typically a family member). However, prosecutions of physicians for assisted suicide or euthanasia are very rare, primarily because the act is generally done with the agreement of not only the patient but also the patient's family and, unlike Dr. Quill, few physicians publicly admit what they have done.

There appears to be no reported conviction of a physician for assisting a patient to commit suicide.[52] Since 1950, seven American physicians have been prosecuted for homicide following euthanasia or assisted suicide: four (including Dr. Kevorkian) were acquitted; one committed suicide after arrest; one pleaded guilty to manslaughter and was sentenced to two years' probation; and one pleaded guilty to murder and was sentenced to five years' probation.[53] In 1992, an English physician, Nigel Cox, was convicted of attempted murder after he administered a lethal dose to a patient. He received a one-year suspended sentence and was admonished by the General Medical Council.

In 1994 and 1995, four separate governmental commissions considered changes to the criminal laws governing euthanasia and assisted suicide. In January 1994, the British House of Lords Select Committee on Medical Ethics recommended no change.[54] The Committee said that

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and Wisconsin: see "Choice in Dying," Right-to-Die L. Dig. (Sept. 1996 Supp); Alan Meisel, The Right to Die, table 18-1 (2d ed. 1995 & 1997 Supp. No. 1); Marzen, "Suicide: A Constitutional Right?" 24 Duq. L. Rev. 1 (1985). The states that have enacted statutes since 1986 are Georgia, Hawaii, Illinois, Indiana, Iowa, Kentucky, Louisiana, Michigan, Missouri, Nevada, North Dakota, Rhode Island, and Tennessee; Oregon has left the list.

[49] The seven states are Alabama, Idaho, Maryland, Massachusetts, South Carolina, Vermont, and West Virginia.

[50] The five states are North Carolina, Ohio, Utah, Virginia, and Wyoming.

[51] For a description and discussion of the provisions of the Oregon statute, see Graham, "Last Rights: Oregon's New Death With Dignity Act," 31 Willamette L. Rev. 601 (1995); Alpers and Lo, "Physician-Assisted Suicide in Oregon," 274 JAMA 483 (Aug. 9, 1995).

[52] CeloCruz, "Aid-in-Dying: Should We Decriminalize Physician-Assisted Suicide and Physician-Committed Euthanasia?" 18 Am. J. L. & Med. 369, 378 (1992).

[53] Stone and Winslade, "Physician-Assisted Suicide and Euthanasia in the United States," 16 J. Legal Med. 481, 493 (1995).

[54] Her Majesty's Stationery Office, HL Paper 21-I 1993-1994 (1994).

"we do not think it possible to set secure limits on voluntary euthanasia," expressed concern "that . . . vulnerable people . . . would feel pressure, whether real or imagined, to request early death," and concluded:

> As far as assisted suicide is concerned, we see no reason to recommend any change in the law. We identify no circumstances in which assisted suicide should be permitted, nor do we see any reason to distinguish between the act of a doctor or of any other person in this connection.[55]

The Committee did, however, recommend that the mandatory life sentence for "mercy killing" should be abolished.[56]

In May 1994, the New York State Task Force on Life and the Law issued its comprehensive and much-quoted report, "When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context."[57] Though acknowledging that individual members had different views as to the permissibility of these practices, the Task Force summarized its central conclusion as follows:

> In this report, we unanimously recommend that New York laws prohibiting assisted suicide and euthanasia should not be changed. In essence, we propose a clear line for public policies and medical practice between forgoing medical interventions and assistance to commit suicide or euthanasia. . . . We believe that the practices would be profoundly dangerous for large segments of the population, especially in light of the widespread failure of American medicine to treat pain adequately or to diagnose and treat depression in many cases. The risks would extend to all individuals who are ill. They would be most severe for those whose autonomy and well-being are already compromised by poverty, lack of access to good medical care, or membership in a stigmatized social group. The risks of legalizing assisted suicide and euthanasia for these individuals, in a health care system and society that cannot effectively protect against the impact of inadequate resources and ingrained social disadvantage, are likely to be extraordinary.[58]

The Task Force identified several specific shortcomings in current treatment practices that it associated with suicidal ideation, among them the underdiagnosis and undertreatment of depression, particularly in the elderly:

> Because of the many physical illnesses and social and economic problems of the elderly, individual health care providers often conclude that depression

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[55] Id. ¶¶ 238, 239, 262.

[56] Id. ¶ 261.

[57] See supra note 35.

[58] Id., pref., at vii–viii.

> is a normal consequence of these problems, an attitude often shared by the patients themselves. All of these factors conspire to make the illness underdiagnosed and, more important, undertreated.[59]

The Task Force also cited the failure to provide adequate pain relief, saying:

> Despite dramatic advances in pain management, the delivery of pain relief is grossly inadequate in clinical practice. . . . Studies have shown that only 25 to 70 percent of post-operative pain, and 20 to 60 percent of cancer pain, is treated adequately.[60]

After examining state and federal case law, affirming the right to forgo life-sustaining treatment, the Task Force concluded that "Rather than establishing a broad constitutional right to determine the timing and manner of death, these cases stand for the more limited proposition that individuals have a right to resist bodily intrusions, and to preserve the possibility of dying a natural death," and that "It is this right against intrusion—not a general right to control the timing and manner of death—that forms the basis of the constitutional right to refuse life-sustaining treatment."[61]

Only a month later, the Michigan Commission on Death and Dying, established by the legislature in response to Dr. Kevorkian's activities in that state, issued its final report. In stark contrast to the New York Task Force, the 22 members of the Commission who voted were deeply split, and the Commission sent three separate reports to the legislature. The majority report (nine in favor, seven opposed, four abstentions) recommended that the legislature decriminalize and regulate "aid in dying." The second report (nine in favor, five opposed, six abstentions) made no recommendation for legalization, but recommended specific procedural safeguards if assisted suicide were legalized. The third report (five in favor, nine opposed, six abstentions) recommended that the temporary statutory ban on assisted suicide be made permanent.

The majority report stated that:

> Current law simply ignores the needs, autonomy, and dignity of acutely suffering individuals. A modification of the law which encourages individuals to explore all possible alternatives to aid-in-dying but reserves it as a legal,

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[59] Id. at 32 (citing National Institutes of Health Consensus Development Panel on Depression in Late Life (1992)).

[60] Id. at 43.

[61] Id. at 68, 71.

> well-regulated option of last resort would provide considerable peace of mind to those who suffer or fear suffering. Knowing this option is available should suffering become unbearable will help most individuals cope with their conditions and go on living. For those few who choose aid-in-dying, their relief could not be greater. In this spirit, we submit the model statute to decriminalize and regulate aid-in-dying in limited circumstances.

The model statute would have legalized not only physician-assisted suicide, but also any form of

> assistance in the form of medical services provided by or under the direct supervision of an attending physician that will end the life of a declarant in a painless, humane and dignified manner when voluntarily requested by the declarant at the time the medical services are to be provided.

The administration of aid-in-dying would be performed by the attending physician or under the direct supervision of the attending physician, who must be physically present at the time of death.

Finally, in June 1995, the Canadian Senate Special Committee on Euthanasia and Assisted Suicide issued its report, "Of Life and Death." While reporting "considerable difference of opinion on the issue of assisted suicide," the majority recommended that the current prohibition against assisted suicide remain intact. The majority also recommended that voluntary euthanasia remain illegal, with provision for a less severe penalty "in cases where there is the essential element of compassion or mercy, to be clearly and narrowly defined." The minority recommended that voluntary euthanasia be legalized for competent individuals who are physically incapable of assisted suicide.

Although they differed in their conclusions, all of these reports agreed that existing palliative care and pain relief practices are inadequate and recommended that they be improved.

Recent Cases

The dearth of compelling precedent regarding the constitutionality of statutes prohibiting assisted suicide is illustrated by the widely differing interpretations, in the recent assisted-suicide cases, of the three most commonly invoked Supreme Court decisions, *Bowers v. Hardwick*,[62] *Cruzan v. Director, Missouri Department of Health*,[63] and *Planned Parenthood of Southeastern Pennsylvania v. Casey*.[64]

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[62] 478 US 186 (1986).

[63] 497 US 261 (1990).

[64] 505 US 833 (1992).

In *Bowers*, the Court held by a 5–4 majority that homosexuals had no fundamental constitutional right to engage in private, consensual sexual activity. The significance of *Bowers* lies less in its central holding, which has been widely criticized, than in its expression of unwillingness on the part of the Court to recognize new constitutional rights.

In *Cruzan*, which is cited by both sides in the assisted-suicide debate, Chief Justice Rehnquist wrote for the five-judge majority that "The principle that a competent person has a constitutionally protected liberty interest in refusing unwarranted medical treatment may be inferred from our prior decisions," and assumed, for purposes of the case, that the Constitution would grant a competent person "a constitutionally protected right to refuse lifesaving hydration and nutrition."[65] In upholding the Missouri statute, Justice Rehnquist said:

> Whether or not Missouri's clear and convincing evidence requirement comports with the United States Constitution depends in part on what interests the State may properly seek to protect in this situation. Missouri relies on its interest in the protection and preservation of human life, and there can be no gainsaying this interest. As a general matter, the States—indeed, all civilized nations—demonstrate their commitment to life by treating homicide as a serious crime. Moreover, the majority of states in this country have laws imposing criminal penalties on one who assists another to commit suicide. We do not think a State is required to remain neutral in the face of an informed and voluntary decision by a physically able adult to starve to death.[66]

In his emphatic dissent, Justice Stevens said, in a passage often quoted by proponents of physician-assisted suicide:

> Choices about death touch the core of liberty. Our duty, and the concomitant freedom, to come to terms with the conditions of our own mortality are undoubtedly 'so rooted in the traditions and conscience of our people as to be ranked as fundamental,' . . . and indeed are essential incidents of the unalienable rights to life and liberty endowed us by our Creator . . . The more precise constitutional significance of death is difficult to describe; not much may be said with confidence about death unless it is said from faith, and that alone is reason enough to protect the freedom to conform choices about death to individual conscience.[67]

The significance of *Casey* has also been described very differently by supporters and opponents of physician-assisted suicide. Justice O'Connor's opinion represents a withdrawal by the Court from the "fun-

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[65] 497 US at 278, 279.

[66] Id. at 280.

[67] 497 US at 343.

damental rights" language used in earlier cases, a strong argument that stare decisis precludes overruling *Roe v. Wade*, and a holding that states may impose limits on abortions as long as those limits do not constitute an "undue burden."

Opponents of physician-assisted suicide argue first that, as the Court's abortion jurisprudence is unique, the holding and rationale of *Casey* cannot be extended to cases involving death and dying.[68] Second, they argue that *Casey* was essentially grounded on the principle of stare decisis, and that language from Justice O'Connor's decision cannot be quoted outside its immediate context.

By contrast, proponents of assisted suicide quote Justice O'Connor's statement:

> Our law affords constitutional protection to personal decisions relating to marriage, procreation, contraception, family relationships, child rearing, and education. . . . Our cases recognize "the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child". . . . Our precedents "have respected the private realm of family life which the state cannot enter." . . . These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of our liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the state.[69]

The *Kevorkian* Cases

Not surprisingly, the constitutionality of statutes prohibiting assisted suicide has been an issue in several cases involving Dr. Kevorkian.

The first case in which the central issue was the constitutionality of a state statute prohibiting assisted suicide was *People v. Kevorkian*,[70] decided in December 1993 by Judge Richard Kaufman of the Wayne

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[68] See Kreimer, "Does Pro-Choice Mean Pro-Kevorkian? An Essay on *Roe*, *Casey*, and the Right to Die," 44 Am. U. L. Rev. 803 (1995); Capron, "Easing the Passing," 24 Hastings Center Rep. 25 (1994) (stating that the rhetoric of *Casey* might support a right to suicide, but the reasoning does not); Annas, "The 'Right to Die' in America: Sloganeering from *Quinlan* and *Cruzan* to *Quill* and *Kevorkian*," 34 Duq. L. Rev. 875 (1996); Spindelman, "Are the Similarities Between A Woman's Right to Choose an Abortion and the Alleged Right to Assisted Suicide Really Compelling?" 29 U. Mich. J. L. Ref. 775 (1996).

[69] 112 S. Ct. at 2807 (1992).

[70] 1993 WL 603212 (Mich. Cir. Ct., Wayne County Dec. 13, 1993).

County Circuit Court in Michigan, who became the first judge in the United States to hold such a statute unconstitutional. In a long and thoughtful opinion, Judge Kaufman held that the Michigan statute violated the due process clause of the Fourteenth Amendment in prohibiting "rational suicide." He held:

> [A] state may proscribe attempted suicide by competent adults where no objective medical condition is present. Accordingly, this Court finds that when a person's quality of life is significantly impaired by a medical condition and the medical condition is extremely unlikely to improve, and that person's decision to commit suicide is a reasonable response to the condition causing the quality of life to be significantly impaired, and the decision to end one's life is freely made without undue influence, such a person has a constitutionally protected right to commit suicide.

The Michigan court of appeals held that the statute violated the requirements of the state constitution governing the legislative process. In dicta, the court relied heavily on *Bowers* in concluding that the statute did not violate the due process clause of the U.S. Constitution.[71]

In *Kevorkian v. Arnett*,[72] the plaintiffs were Dr. Kevorkian and a terminally ill patient. They alleged that the California statute prohibiting assisted suicide violated the due process and equal protection clauses. In September 1996, U.S. District Court Judge Consuelo B. Marshall held that the patient had standing, but Dr. Kevorkian did not, and granted the plaintiffs' motion for summary judgment on the due process claim.

Unlike *Compassion in Dying*, in which the challenge was to the statute as applied, the plaintiffs made a facial challenge to the statute. Judge Marshall followed *Compassion in Dying*, in finding the *Salerno* standard (that no set of circumstances exists under which the law would be valid) inapplicable, and instead applied the *Casey* undue burden standard:

> Applying this standard, it is clear that Cal. Penal Code § 401 places a 'substantial obstacle' in a 'large fraction of the cases' in which the section is relevant. This conclusion is readily apparent by the fact that § 401 does not merely place some restrictions on the right to assisted suicide, but categorically prohibits all such conduct. Accordingly, this Court finds that Cal. Penal Code § 401 violates the Due Process Clause of the Federal Constitution.

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[71] *Hobbins v. Attorney Gen., People v. Kevorkian*, 205 Mich. App. 194, 518 NW2d 487 (Mich. Ct. App. 1994).

[72] 939 F. Supp. 725 (CD Cal. 1996).

Judge Marshall did not address the federal equal protection claim, but found that the statute did not violate the equal protection clause of the California Constitution.

In the most recent case, decided on January 4, 1997, U.S. District Judge Gerald Rosen found that a mentally competent, terminally ill, or intractably suffering adult does not have a liberty interest in assisted suicide that is protected by the due process clause, and that the equal protection clause is not violated by denying to such a person the right to assisted suicide.[73]

In denying the due process claim, Judge Rosen relied on *Bowers* and the Second Circuit's decision in *Quill.* He stated his belief that the reasoning in Judge Reinhardt's opinion in *Compassion in Dying* was "seriously flawed" and preferred the approach of the original three-judge panel in that case:

> This Court agrees that attempting to equate abortion rights and their constitutional status with a right to have someone assist in a suicide confuses constitutional analysis with individual or moral notions of "human dignity." . . . [T]his Court believes that rather than supporting a liberty interest in assisted suicide for those who are able to sustain life without life-support systems, the abortion decisions—by affirming the states' paramount interest in protecting viable life—actually support the view that the state has a strong interest in protecting vulnerable, but viable, life.

Concerning the equal protection claim, Judge Rosen found that there is a rational basis for distinguishing between withdrawal of life support and assisted suicide and, disagreeing with the Second Circuit's opinion in *Quill*, found that legitimate state interests were furthered by the distinction, particularly the interest in denying to physicians the role of killers of their patients.

A week after the decision was issued, the new Oakland County, Michigan, prosecutor dismissed all assisted-suicide charges filed by his predecessor against Dr. Kevorkian and two assistants. Kevorkian still faces a trial in Ionia County.[74]

Compassion in Dying

The first assisted suicide case decided by a federal court was *Compassion in Dying v. Washington.*[75] The case was brought by a coalition

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[73] Kevorkian v. Thompson, 947 F. Supp. 1152 (D. Mich. 1997).

[74] A Prosecutor Drops Kevorkian Charges, New York Times, Jan. 12, 1997, at A20.

[75] 850 F. Supp. 1454 (WD Wash. 1994).

of three terminally ill patients, five physicians, and Compassion in Dying, an organization that provides counseling and emotional support to mentally competent, terminally ill adults considering suicide. The plaintiffs alleged that Washington state's criminal prohibition of physician-assisted suicide violates the Fourteenth Amendment liberty interests of terminally ill, mentally competent adults, contending that individuals in those circumstances "have a constitutionally protected right to be free from undue governmental intrusion on their decision to hasten death and avoid prolonged suffering."[76]

U.S. District Judge Barbara Rothstein held that the Washington statute violated both the due process clause and the equal protection clause. Concerning the due process claim, she found the reasoning in *Casey* to be "highly instructive and almost prescriptive:"

> Like the abortion decision, the decision of a terminally ill person to end his or her life "involves the most intimate and personal choices a person may make in a lifetime" and constitutes a "choice central to personal dignity and autonomy."[77]

In *Casey*, the Supreme Court acknowledged that some of its members "find abortion offensive to our most basic principles of morality," but added that this "cannot control our decision. Our obligation is to define the liberty of all, not to mandate our own moral code. The underlying constitutional issue is whether the State can resolve these philosophic questions in such a definitive way that a woman lacks all choice in the matter. . . ."[78]

Similarly, Judge Rothstein held:

> [T]he underlying constitutional issue [in the present case] is whether the State of Washington can resolve the profound spiritual and moral questions surrounding the end of life in so conclusive a fashion as to deny categorically any option for a terminally ill, mentally competent person to commit physician-assisted suicide. This court concludes that the suffering of a terminally ill person cannot be deemed any less intimate or personal, or any less deserving of protection from unwarranted governmental interference, than that of a pregnant woman.[79]

Judge Rothstein also cited *Cruzan*'s recognition of a constitutionally protected right to refuse lifesaving treatment, and held that, "From

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[76] 850 F. Supp. at 1458.

[77] 850 F. Supp. at 1459–1460.

[78] 112 S. Ct. at 2806.

[79] 850 F. Supp. at 1460.

a constitutional perspective, the Court does not believe that a distinction can be drawn between refusing life-sustaining medical treatment and physician-assisted suicide by an uncoerced, mentally competent, terminally ill adult."[80]

Judge Rothstein then applied the undue burden test and concluded that neither of the interests alleged by the state, preventing suicide and protecting people against undue influence, would be impeded by allowing physician-assisted suicide for mentally competent, terminally ill patients. Accordingly, the statute's total prohibition against assisted suicide constituted an undue burden on the exercise of the protected liberty interest.[81]

Judge Rothstein also held that the statute violated the equal protection clause because it unconstitutionally distinguished between two similarly situated groups of mentally competent, terminally ill adults: those who were receiving life-sustaining treatment, who could request termination of treatment; and those not receiving life-sustaining treatment, who did not have the option of hastening death with medical assistance.[82]

Judge Rothstein's equation of the refusal of life-prolonging treatment and physician-assisted suicide was not novel. More than 20 years earlier, a commentator had maintained that "the distinction between a refusal of compulsory lifesaving treatment and euthanasia is all but illusory."[83] In both cases, the intended result is death. Why, then, should a patient "lucky" enough to require lifesaving medical treatment be permitted to choose death, while this option is denied to a terminally ill, suffering patient who can survive without life support?

In response, it can be said that the right to refuse treatment does not obviously entail a right to be killed because the basis for the two alleged rights differs. The right to refuse treatment, whether derived from the right to bodily self-determination or the right to privacy, is essentially a right against the invasion of one's own body. In general, one cannot be forced to undergo medical treatment. Because of this, one may be said to have a right to be left alone, to be free of unwanted bodily intrusions, even at the risk of death. However, a right to be killed or helped to die is not merely a right to be left alone. Thus, more argu-

[80] 850 F. Supp. at 1461.

[81] Id. at 1464–1466.

[82] 850 F. Supp. at 1467.

[83] Scher, "Legal Aspects of Euthanasia," 36 Alb. L. Rev. 674, 692 (1972). For a discussion of this and related issues, see Killing and Letting Die (Bonnie Steinbock & Alastair Norcross eds., 2d ed. 1994).

ment is needed to show that the right to self-determination includes a right to physician-assisted suicide.

Compassion in Dying subsequently gave rise to three separate decisions by the U.S. Court of Appeals for the Ninth Circuit. In the first, handed down in March 1995, Judge Barbara Rothstein's decision was reversed by a 2–1 majority.[84] Judge Noonan rejected her reliance on *Casey* and warned against taking its language out of context.[85] In particular, he argued, if the right to assisted suicide is based on a right of personal autonomy, this right cannot be limited, as the district court attempted to do, to terminally ill individuals:

> The depressed twenty-one year old, the romantically-devastated twenty-eight year old, the alcoholic forty-year old who choose suicide are also expressing their views of the existence, meaning, the universe, and life; they are also asserting their personal liberty. If at the heart of the liberty protected by the Fourteenth Amendment is this uncurtailable ability to believe and to act on one's deepest beliefs about life, the right to suicide and the right to assistance in suicide are the prerogative of at least every sane adult. The attempt to restrict such rights to the terminally ill is illusory.[86]

Judge Noonan also faulted the district court's decision for having declared the statute unconstitutional "without adequate consideration of Washington's interests, that . . . outweigh any alleged liberty of suicide."[87]

Six months after Judge Noonan's decision, *Compassion in Dying* was reheard by the Ninth Circuit, en banc, which held, by a majority of 8–3, that "insofar as the Washington statute prohibits physicians from prescribing life-ending medication for use by terminally ill, competent adults who wish to hasten their own deaths, it violates the Due Process Clause of the Fourteenth Amendment."[88] The court did not address the plaintiffs' equal protection claim.

Writing for the majority, Judge Reinhardt began by referring to "the compelling similarities between right-to-die cases and abortion cases," and stated that "*Casey* in particular provides a powerful precedent. . . ."[89] In defining the liberty interest, Judge Reinhardt said:

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[84] 49 F3d 586 (1995).

[85] 49 F3d at 590.

[86] 49 F3d at 590–591.

[87] 49 F3d at 591.

[88] 79 F3d at 793–794 (1996).

[89] 79 F3d at 800.

> We do not ask simply whether there is a liberty interest in receiving "aid in killing oneself" because such a narrow interest could not exist in the absence of a broader and more important underlying interest—the right to die. . . . The liberty interest we examine encompasses a whole range of acts that are generally not considered to constitute "suicide." Included within the liberty interest we examine is, for example, the act of refusing or terminating unwanted medical treatment.[90]

He then continued by saying that:

> A common thread running through these cases [delineating the boundaries of substantive due process] is that they involve decisions that are highly personal and intimate, as well as of great importance to the individual. Certainly, few decisions are more personal, intimate or important than the decision to end one's life, especially when the reason for doing so is to avoid excessive and protracted pain. [*Casey* and *Cruzan*] . . . are fully persuasive, and leave little doubt as to the proper result, [and] *Cruzan*, by recognizing a liberty interest that includes the refusal of artificial provision of life-sustaining food and water, necessarily recognizes a liberty interest in hastening one's own death.[91]

Judge Reinhardt then turned to the various state interests in preventing assisted suicide, and noted:

> During the course of this litigation, the state has relied on its interest in the prevention of suicide as its primary justification for its statute. . . . that interest, like the state's interest in preserving life, is substantially diminished in the case of terminally ill, competent adults who wish to die.

He then discussed the various arguments made by the state, for distinguishing physician assisted suicide from permissible practices, and concluded that

> [W]e see little, if any, difference for constitutional or ethical purposes between providing medication with a double effect and providing medication with a single effect, as long as one of the known effects in each case is to hasten the end of the patient's life. Similarly, we see no ethical or constitutionally cognizable difference between a doctor's pulling the plug on a respirator and his prescribing drugs which will permit a terminally ill patient to end his own life. . . . what matters most is that the death of the patient is the intended result as surely in one case as in the other.[92]

Following the Ninth Circuit's en banc decision, a judge of the court requested that the full court rehear the case. This request was rejected

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[90] 79 F3d at 801–802.

[91] 79 F3d at 813, 816.

[92] 79 F3d at 820, 824.

in June 1996, with three judges dissenting.[93] The Supreme Court granted certiorari on October 1, 1996.[94]

The *Quill* Case

The original plaintiffs in *Quill v. Koppel* were three physicians who regularly treat terminally ill patients who request assistance in terminating their lives, and three terminally ill patients who desired such assistance. All three of the patients died before the district court issued its decision.

The plaintiffs sought a preliminary injunction against enforcement of the New York statutes prohibiting assisted suicide, claiming that the statutes violated both the due process clause and the equal protection clause. In December 1994, Judge Thomas P. Griesa denied the plaintiffs' motion, and granted the defendants' motion to dismiss.[95]

Regarding the due process issue, the plaintiffs claimed that the reasoning and holdings in *Roe* and *Casey* were broad enough to establish that there is a fundamental right on the part of a terminally ill patient to decide to end his or her life, and to do so with the assistance of a physician. Judge Griesa said:

> Plaintiffs' reading of these cases is too broad. The Supreme Court has been careful to explain that the abortion cases, and other related decisions on procreation and child rearing, are not intended to lead automatically to the recognition of other fundamental rights on different subjects. . . . In any event, it would appear clear that suicide has a sufficiently different legal significance from requesting withdrawal of treatment so that a fundamental right to suicide cannot be implied from *Cruzan*.[96]

He then said that plaintiffs had not argued that physician-assisted suicide has "any historic recognition as a legal right" and held that "the type of physician assisted suicide at issue in this case does not involve a fundamental liberty interest protected by the Due Process Clause of the Fourteenth Amendment."[97]

Concerning the equal protection issue, the plaintiffs argued that refusal of life-sustaining treatment is essentially the same as physician-assisted suicide. In a remarkably perfunctory fashion, Judge Griesa

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[93] 85 F3d 1440 (1996).

[94] Washington v. Glucksberg, No. 95-1858, 65 USLW 3085 (Oct. 1, 1996).

[95] 870 F. Supp. 78 (SDNY 1994).

[96] 870 F. Supp. at 83.

[97] 870 F. Supp. at 83–84.

simply concluded that "it is hardly unreasonable or irrational for the State to recognize a difference between allowing nature to take its course, even in the most severe situations, and intentionally using an artificial death-producing device."[98]

In April 1996, the Second Circuit, somewhat surprisingly for a court that is generally conservative regarding such issues, upheld the plaintiffs' appeal on the equal protection claim and rejected the due process claim.[99]

With regard to the due process claim, Judge Miner relied heavily on *Bowers*:

> As in *Bowers*, the statutes plaintiffs seek to declare unconstitutional here cannot be said to infringe upon any fundamental right or liberty. As in *Bowers*, the right contended for here cannot be considered so implicit in our understanding of ordered liberty that neither justice nor liberty would exist if it were sacrificed. Nor can it be said that the right to assisted suicide claimed by plaintiffs is deeply rooted in the nation's traditions and history. Indeed, the very opposite is true. . . . We therefore decline the plaintiffs' invitation to identify a new fundamental right, in the absence of a clear direction from the Court whose precedents we are bound to follow.[100]

With regard to the equal protection claim, Judge Miner said that the New York statutes were subject to rational basis scrutiny rather than strict scrutiny, as no fundamental right or suspect classification was involved.[101] He then proceeded to hold that:

☐ New York law does not treat equally all competent persons who are in the final stages of fatal illness and wish to hasten their deaths.[102]

☐ The distinctions made by New York law with regard to such persons do not further any legitimate state purpose, asking: ". . . what interest can the state possibly have in requiring the prolongation of a life that is all but ended? Surely, the state's interest lessens as the potential for life diminishes. . . . And what business is it of the state to require the continuation of agony when the result is imminent and inevitable? . . . The greatly reduced interest of the state in preserving life compels the answer to these questions: 'None.'"[103]

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[98] 870 F. Supp. at 84.

[99] Quill v. Vacco, 80 F3d 716 (2d Cir., 1996).

[100] 80 F3d at 724, 725.

[101] 80 F3d at 726, 727.

[102] 80 F3d at 729.

[103] 80 F3d at 729–730.

☐ Accordingly, the New York statutes "violate the Equal Protection Clause because, to the extent that they prohibit a physician from prescribing medication to be self-administered by a mentally competent terminally ill person in the final stages of his terminal illness, they are not rationally related to any legitimate state interest."[104]

Judge Calabresi concurred in the result, but would have refrained from reaching the ultimate due process and equal protection issues:

> I would hold that, on the current legislative record, New York's prohibitions on assisted suicide violate both the Equal Protection and Due Process Clauses of the Fourteenth Amendment of the United States Constitution to the extent that these laws are interpreted to prohibit a physician from prescribing lethal drugs to be self-administered by a mentally competent, terminally ill person in the final stages of that terminal illness. I would, however, take no position on whether such prohibitions, or other more finely drawn ones, might be valid, under either or both clauses of the United States Constitution, were New York to reenact them while articulating the reasons for the distinctions it makes in the laws, and expressing the grounds for the prohibitions themselves.[105]

The Supreme Court granted certiorari on October 1, 1996.[106]

Lee vs. Oregon

The plaintiffs in *Lee* (two physicians, four terminally ill or potentially terminally ill patients, a residential care facility, and individual operators of residential care facilities) claimed that the Oregon Death With Dignity Act violated the equal protection and due process clauses. In August 1995, U.S. District Judge Michael Hogan held that the statute violated the equal protection clause, and enjoined implementation of the Act.[107] He did not find it necessary to discuss the due process claim.

Judge Hogan's opinion is seriously flawed. He first concluded that the law distinguishes between individuals who are not terminally ill, who have an array of protections against suicide and assisted suicide, and the terminally ill who, under the statute, do not. After stating, correctly, that the correct standard of review was the rational basis stan-

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[104] 80 F3d at 731.

[105] 80 F3d at 743.

[106] Vacco v. Quill, No. 96-110, 65 USLW 3052 (Oct. 1, 1996).

[107] 891 F. Supp. 1429 (D. Or. 1995).

dard, he applied a strict scrutiny approach in determining that the state had no rational basis for distinguishing between the two groups.

On February 27th, 1997, the Ninth Circuit vacated the judgment on the grounds that the plaintiffs lacked standing, and remanded the case to the district court with instructions to dismiss the complaint.[108] The court did not address the merits of the case.[109]

McIver v. Krischer

On January 31, 1997, Florida Circuit Judge S. Joseph Davis held that the state may not prevent the physician of a terminally ill patient from giving him or her a lethal dose of medication and being present when the patient takes the medication.[110] The state has appealed, which stays the decision and prevents the physician from taking any action to help the patient die.

The Supreme Court's Alternatives

In his constitutional law treatise, Professor Tribe, who appeared for Dr. Quill and his fellow respondents before the Supreme Court, observed as follows:

> The judiciary's silence regarding such constitutional principles probably reflects a concern that, once recognized, rights to die might be uncontainable and might prove susceptible to grave abuse, more than it suggests that courts cannot be persuaded that self-determination and personhood may include a right to dictate the circumstances under which life is to be ended. In any event, whatever the reason for the absence in the courts of expansive notions about self-determination, the resulting deference to legislatures may prove wise in light of the complex character of the rights at stake and the significant potential that, without careful statutory guidelines and gradually evolved procedural controls, legalizing euthanasia, rather than respecting people, may endanger personhood.[111]

The Court's grant of certiorari, in the absence of a conflict between circuits, suggests that the justices are anxious to put the issue to rest.

In its amicus briefs in the two cases, the United States supports the petitioner States of New York and Washington. Contrary to the Ninth's

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[108] Lee v. Oregon, 1997 US App. LEXIS 3478 (9th Cir. Feb. 27, 1997).

[109] Id. at *19.

[110] McIver v. Krischer, 65 USLW 2544 (Feb. 25, 1997).

[111] Lawrence H. Tribe, American Constitutional Law 1370–1371 (2d ed. 1988).

Circuit's view that potential risks to vulnerable classes of patient could be better handled by procedural safeguards than a statutory ban on assisted suicide, the government argues that a state could reasonably decide that procedural safeguards would not be effective.

The United States also seeks to distinguish these cases from the abortion cases. It contends that the right to abortion allows women to participate more equally in the life of the nation, and that there is thus an equal protection aspect of the right to an abortion that has no counterpart in the assisted-suicide cases. This argument finds support in Justice O'Connor's *Casey* opinion and echoes views expressed by Justice Ginsburg.[112] However, this equal protection approach finds scant support in the Court's abortion opinions.

While it is always difficult to predict exactly how the Court will decide such a controversial issue, the present membership of the Court and its recent precedents make it highly unlikely that the Court will hold that denial of physician-assisted suicide to patients who are not on life support violates the equal protection clause.

New York and Washington both argued that there is no constitutional right at stake. By contrast, the United States argued that such patients do have a liberty interest in not having the state prevent their relief from "severe pain and suffering." However, the government argued, this interest is outweighed by the states' interest in affirming the value of life and protecting vulnerable patients.[113] From a pragmatic viewpoint, the states' argument is more likely to appeal to the Court, as acceptance of the administration's argument would almost certainly involve the Court in ongoing monitoring of state statutes, similar to the abortion cases.

Accordingly, it appears likely that the Court, quite possibly in multiple opinions (as in *Casey*), will hold the following:

- The assisted-suicide issue is quite different from that of abortion, so the abortion decisions are not controlling precedents.
- There is no constitutionally protected liberty interest that invokes the due process clause.
- There is no constitutional prohibition preventing the states from legislating either to permit assisted suicide, or to regulate it, or to ban it altogether.

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[112] Ginsburg, "Some Thought on Autonomy and Equality in Relation to Roe v. Wade," 63 NC L. Rev. 375 (1985).

[113] Linda Greenhouse, "High Court Hears 2 Cases Involving Assisted Suicide," New York Times, Jan. 9, 1997, at A1.

If this is the outcome, attention will focus directly on Oregon. Opponents are already pressing for repeal of the Oregon statute. If that fails, the other immediate battleground is likely to be whether Medicaid or Medicare will cover medical expenses related to physician-assisted suicide.