Physician-assisted suicide: The courts leave it to the states

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ABSTRACT

Physician-Assisted Suicide:
The Courts Leave It
To The States

by

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In Vacco v. Quill and Washington v. Glucksberg, the Supreme Court ruled that laws in New York and Washington prohibiting physician-assisted suicide violated neither the Due Process nor the Equal Protection Clauses of the Fourteenth Amendment. The Court overturned decisions from the Second and Ninth Circuit Courts of Appeal. The Court stated these decisions do not prevent a state from enacting legislation approving assisted suicide, but there is no protection of such under the Constitution. This thesis examines the legal reasoning used by the two Courts of Appeal in their decisions and the Supreme Court in its decision. There is a review of the three critical precedent-establishing cases and some of the *amicus* briefs submitted. The final section will focus on the States, primarily Oregon, where after two elections and a lengthy legal battle citizens legalized physician-assisted suicide, as well as various proposals for state control of physician-assisted suicide.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABSTRACT</td>
<td>iii</td>
</tr>
<tr>
<td>ACKNOWLEDGMENTS</td>
<td>v</td>
</tr>
<tr>
<td>CHAPTER 1 INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>CHAPTER 2 PRECEDENTS</td>
<td>5</td>
</tr>
<tr>
<td>CHAPTER 3 APPEALS COURTS DECISIONS</td>
<td>16</td>
</tr>
<tr>
<td>CHAPTER 4 SUPREME COURT DECISIONS</td>
<td>38</td>
</tr>
<tr>
<td>Amicus Briefs</td>
<td>38</td>
</tr>
<tr>
<td>Supreme Court Opinions</td>
<td>49</td>
</tr>
<tr>
<td>CHAPTER 5 STATE ACTIONS</td>
<td>59</td>
</tr>
<tr>
<td>CHAPTER 6 CONCLUSION</td>
<td>72</td>
</tr>
<tr>
<td>APPENDIX A THE OREGON DEATH WITH DIGNITY ACT</td>
<td>82</td>
</tr>
<tr>
<td>BIBILOGRAPHY</td>
<td>89</td>
</tr>
<tr>
<td>VITA</td>
<td>97</td>
</tr>
</tbody>
</table>

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The biggest help with this project, and in life in general, came from my wife Sarah. She edited each chapter, continually amazed at my lack of understanding when dealing with possessives. She also listened to the vast majority of this paper as the ideas came to me a little at a time, always acting interested. My brother Brian also deserves some mention here, as he was very understanding of canceled golf dates (sorry, got that damn thesis to finish), as well as listening to draft sections of this paper while playing golf or at the movies (no, really there is a tie-in between this movie and physician-assisted suicide. Isn’t it apparent to you?).

V
CHAPTER 1

INTRODUCTION

A young family physician in New York decided to help a young female patient suffering from AIDS to commit suicide. "She asked me for pills, morphine basically. She was intelligent and engaged me on this issue. She even said, 'Let's sit down and read "Final Exit" together.'" After a lengthy discussion, the physician agreed to help but admitted he was unsure of exactly what drugs and what dosages would be necessary. He promised to ask around. Finding the necessary information from a hospice nurse, he provided the prescription to his patient. She survived the initial attempt after becoming unconscious and having her breathing slowed. The physician described this as a "devastating" experience for him, the patient and her family. "What I learned was there is hubris in deciding when someone should die," he said. She asked for another prescription weeks later and he complied. She again took the pills, lapsed into a coma and died a few days later.¹

Physician-assisted suicide, of which the above example was just one of many, has come to the forefront of legal and social debate over the last several years. The moral and ethical issues involved tend to create the same sort of polarization as is present in the debate over abortion since the Supreme Court's decision in Roe v. Wade (1973). This thesis will examine this debate over physician-assisted suicide, focusing on federal court decisions and statutes passed by various states attempting to grapple with the issues presented. There is little solid data on how prevalent physician-assisted suicide currently is within our

society. Very few physicians, aside from Dr. Jack Kevorkian, are willing to discuss the number of patients who have requested or received assistance. A 1991 survey by the *Boston Globe* and the Harvard Medical School found that 64 percent of the public supports some form of legalized euthanasia. A recent survey of oncologists, physicians who specialize in the treatment of cancer, found that 57 percent had received requests for physician-assisted suicide and 13.5 percent had furnished prescriptions for this purpose. There are several statements from physicians in national newspapers and journals in which they admitted providing such prescriptions, including that of Dr. Timothy Quill, one of the physicians involved in the New York case, in an article in the *New England Journal of Medicine* in 1991. However, the American Geriatrics Society, in a brief filed in the Supreme Court cases, argues that these numbers are high, as nearly "three-quarters of all deaths happen in institutions where a regularized endeavor would require the collusion of a large number of persons, which seems implausible." The remainder of this section will outline the chapters that follow and provide some definitions that will be helpful in attempting to understand fully the issues presented.

Chapter Two examines a set of four documents that establish critical precedents upon which the federal courts based each of their decisions. There are three court cases and a report of a state agency dealing with assisted suicide and euthanasia. Chapter Three reviews in detail the decisions of two U.S. Courts of Appeal, each of which overturned existing state laws prohibiting physician-assisted suicide. These cases represent the first entries of the federal judiciary into physician-assisted suicide. Chapter Four examines the U.S. Supreme Court decisions that found no constitutional right to physician-assisted suicide and therefore overturned the Appeals Courts’ decisions. Included in this section is

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3 Ibid., A15.

a sampling of the various briefs filed in favor of and opposition to physician-assisted suicide. Chapter Five looks at the actions taken by the various state governments regarding physician-assisted suicide, including the recently enacted law in Oregon legalizing this practice, as well as other suggestions for statutory regulation in this area. The final chapter discusses whether or not the decision of the Supreme Court was proper in terms of judicial activism versus judicial restraint and in terms of the democratic process as a whole. It also examines the question of whether it is possible for the states to regulate physician-assisted suicide in a satisfactory manner.

What is physician-assisted suicide? It falls under the general category of euthanasia, which comes from the Greek term for 'good death.' There are several categorical distinctions, or grades, involved in the current debate about euthanasia ranging from physician-assisted suicide to involuntary euthanasia. Physician-assisted suicide occurs when a physician provides a patient with the medical means necessary to commit suicide. It is at one end of the spectrum. The means normally include a prescription for the drugs necessary, but there is no direct involvement by the physician in the performance of the act itself. The drugs are to be self-administered by the patient. Next is physician-aid-in-dying, which is similar to physician-assisted suicide except the physician is present and aids in the administration of the drugs necessary, including possible intravenous administration. This is sometimes called voluntary euthanasia. Non-voluntary euthanasia represents the other end of the spectrum where a patient, who is incompetent and has not requested suicide, is given the drugs necessary to bring about death. There is a great deal of debate as to whether one of these procedures can be legalized without all becoming legal over time.

These are all separate and distinct, at least in a legal sense, from the right of a competent person to refuse or to terminate life-supporting or sustaining medical treatment, a right which has been legally recognized since the Supreme Court's decision in *Cruzan v. Director, Missouri Department of Health* (1990). Individuals can use a "living will" or a
“durable power of attorney for health care” to avail themselves of this right should they become incompetent. A living will is a statement written in advance that indicates what types of medical care an individual wants and does not want. A durable power of attorney for health care is a signed and dated declaration in which an individual names another person to be an authorized spokesperson for medical decisions should the individual become incompetent.\(^5\) Forty-six states recognize both living wills and the durable power of attorney, while Alaska recognizes only the living will and Massachusetts, Michigan and New York allow only the durable power of attorney.\(^6\) The effectiveness of these documents can be questioned, however. A survey in 1991 found that while 87 percent of the public supported the legality of these health care proxies, only 17 percent had actually filed such an affidavit.\(^7\)

In the end, much of what is involved in this debate boils down to a matter of personal preference or opinion. Questions of this type are often better decided by the legislative process rather than the judiciary. Keep this distinction in mind as you read the various expert opinions on the different aspect of this issue, as this topic may appear “on a ballot near you” in the future.


CHAPTER 2

PRECEDENTS

There are several documents that are important to understanding the precedents used by both the courts of appeals and the Supreme Court in their decisions. This review is done in an attempt to give the reader a better idea of the full context of these precedents, rather than just one or two sentences of a seventy page opinion. Three of these are previous court decisions, starting with *in re Quinlan* (1976). In this case, the Supreme Court of New Jersey was presented with the first case dealing with a right to die or a right to refuse unwanted medical treatment. The second case is *Cruzan v. Director, Missouri Department of Health* (1990), where the Supreme Court addressed the question of the right to refuse such treatment. The third case is *Planned Parenthood of Southeastern Pennsylvania v. Casey* (1992), in which the Court dealt with abortion and right to privacy. The final document is the report of The New York State Task Force on Life and the Law, "When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context" (1994). The *Quinlan* and *Cruzan* decisions are the most important in terms of physician-assisted suicide and will therefore be given the most attention.

The case of Karen Quinlan received national attention. In April, 1975, she stopped breathing while at a party with some friends. She was taken to a hospital where she was diagnosed as comatose and placed on life-support equipment. Tests indicated that she had some brain activity but remained in a "chronic persistent vegetative state." Her father wanted to be appointed her legal guardian in order to have the life support equipment
removed. The physicians agreed that she could never be restored to her previous mental
capacity but would not disconnect the life support.¹

Chief Justice Hughes delivered the opinion of the New Jersey Court. The first matter
the Court addressed was the general suitability of Joseph Quinlan as a guardian under
normal circumstances. There was a high degree of familial love evidenced in the record.
Mr. Quinlan was a communicant of the Roman Catholic Church and had gained the support
of the New Jersey Catholic Conference in his effort. The Conference issued a written
opinion stating that the request “would not involve euthanasia” and was therefore a morally
correct decision.² Thus, he would have been a suitable guardian if appointed by the court
or Karen, if she were competent. The Court then turned to the constitutional questions
present in this case, especially the right to privacy.

The Court stated there would be little doubt that if Karen became lucid and aware of
her condition, she would decide to discontinue the life support and that no interest of the
state could compel her to continue in a vegetative state without hope of recovery. The right
to privacy found in several Supreme Court decisions, particularly Griswold v. Connecticut
(1965) was presumed by the Court to be “broad enough to encompass a patient’s decision
to decline medical treatment under certain circumstances, ...” Such a right is also found in
the New Jersey Constitution. The State claimed an interest in preservation and sanctity of
human life, but the Court argued that this interest weakens as the degree of medical
invasion grows and the prognosis dims, and that there is a point where the individual’s
rights become greater than the state interest. The problem for the Court was that Karen was
unable to exercise her right due to her condition.³ The court then states “the only practical
way to prevent destruction of the right is to permit the guardian and family of Karen to

¹ In the Matter of Karen Quinlan (Arlington, VA: University Publications of America,
² Ibid., 296-8.
³ Ibid., 304-5.

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render their best judgment, ..., as to whether she would exercise it in these circumstances."^4 This decision allowed for the life support to be discontinued.

Karen Quinlan lived for another ten years after the life support machines were disconnected. Her feeding and hydration tubes were left in place. Her parents did not ask the Court for permission to remove these, as her father stated that these were her nourishment.\(^5\) This case established a right of a patient or his guardians to remove life support, thereby allowing nature to take its course, without this act being considered suicide. This distinction between allowing someone to die and actively assisting someone to die is critical in the physician-assisted suicide cases and subject to a great deal of debate. Some argue that there is little if any real difference between the two practices. They argue that the providing of a prescription to hasten death is a less active role for a physician than overseeing the withdrawal of life support equipment\(^6\) and could be seen as more humane than allowing a patient to suffocate or starve to death.\(^7\) Justice Scalia seemed to take a similar position in the \textit{Cruzan} decision, reviewed below. However, the American Medical Association (AMA), along with many others, sees a clear distinction between the two practices. The AMA argued that the "withholding or withdrawing [of] medical treatment may lead to death, [but] the intent of the physician so acting is not to cause death" and the ultimate cause of death is the underlying disease. In cases of physician-assisted suicide, the only role of the physician is to help the patient in the taking of his own life.\(^8\)

\(^4\) Ibid., 306.
Supreme Court would be faced with a case dealing with feeding and hydration thirteen years later.

Nancy Cruzan was in a persistent vegetative state as a result of an automobile accident. Her parents wanted to terminate the artificial nutrition and hydration that was keeping their daughter alive, but hospital employees refused. A state court authorized the termination, based in part on testimony of family and friends about conversations with Nancy about her wishes should she become incapacitated. The State Supreme Court overturned that decision citing the lack of a living will or other documented proof of Nancy's wishes. In a 5-4 decision, the United States Supreme Court affirmed the State Supreme Court. Chief Justice Rehnquist delivered the opinion of the Court, joined by Justices White, O'Connor, Scalia and Kennedy. 9

The Chief Justice began by reviewing several cases, including *Quinlan*, which demonstrated that competent individuals have the right to refuse medical treatment. He wrote that the main question for the Court is whether the Constitution “prohibits Missouri from choosing the rule of decision which it did.” 10 While he noted that “the principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior discussions,” this liberty interest must be weighed against the relevant state interests such as the interest in preserving life and is therefore not an absolute. The majority agreed that in this case there would be “a constitutionally protected right to refuse lifesaving hydration and nutrition” for a competent patient. 11 However, Nancy Cruzan was incompetent, and Missouri law requires clear and convincing evidence as to the wishes of an incompetent patient prior to authorizing the withdrawal of treatment. The majority held that this requirement did not violate the

10 Ibid., 277.
11 Ibid., 278-9.
Constitution. The Due Process Clause protects interests in continuing life support as well as in the withdrawal of such support, and the state was entitled to guard against potential abuse.\textsuperscript{12}

Justice O'Connor filed a concurring opinion, arguing that "artificial feeding cannot readily be distinguished from other forms of medical treatment. ... the liberty guaranteed by the Due Process Clause must protect, if it protects anything, an individual's deeply personal decision to reject medical treatment, including the artificial delivery of food and water."\textsuperscript{13} She also wanted to state clearly that this case did not preclude a future decision which would require States to allow surrogates to make decisions for patients in similar circumstances.\textsuperscript{14}

Justice Scalia also filed a concurring opinion which began by stating that the Court is not the proper place for questions of this type, as the

point at which life becomes "worthless," and the point at which the means necessary to preserve it become "extraordinary" or "inappropriate," are neither set forth in the Constitution nor known to the nine Justices of this Court any better than they are known to nine people picked at random from the Kansas City telephone directory.\textsuperscript{15}

Scalia stated that there is no difference between starving oneself to death and shooting oneself in the head, as far as the common law is concerned. There is no difference between refusing life-sustaining medical treatment and refusing to obtain nourishment or intentionally killing oneself.\textsuperscript{16}

Justice Brennan, joined by Justices Marshall and Blackmun, wrote a dissenting opinion arguing that if a competent person has a liberty interest in refusing medical

\textsuperscript{12} Ibid., 280-1.

\textsuperscript{13} Ibid., 288-9.

\textsuperscript{14} Ibid., 292.

\textsuperscript{15} Ibid., 292-3.

\textsuperscript{16} Ibid., 299.
treatment, that interest must be treated as fundamental by the court. In order for a right or liberty to be considered fundamental by the Court under the Due Process Clause of the Fourteenth Amendment, it must be "implicit in the concept of ordered liberty" (Palko v. Connecticut, 1937) or "so rooted in the traditions and conscience of our people as to be ranked as fundamental." (Snyder v. Massachusetts, 1934). Brennan argued that the only way for these rights to have any meaning for people who are medically incompetent, or for others deemed incompetent such as children, is for those rights to be exercised by an agent acting with the best interests of the individual in mind. Brennan criticized the majority's stance that only a living will or other legal document can provide the necessary evidence for the wishes of an incompetent person to be carried out, as too few people execute those documents and "no general conclusion about a patient's choice can be drawn from the absence of formalities. The probability of becoming irreversibly vegetative is so low that many people may not feel an urgency to marshal formal evidence of their preferences."

Justice Stevens also dissented, arguing that the decision allowed the "State's abstract, undifferentiated interest in the preservation of life to overwhelm the best interests of Nancy Beth Cruzan, interests that would ... be served by allowing her guardians to exercise her constitutional right to discontinue medical treatment." He objected that Missouri is attempting to define life rather than protect it, which is not a legitimate end of state legislation.

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17 Ibid., 304.
19 Ibid., 309.
20 Ibid., 323.
21 Ibid., 331.
22 Ibid., 344.
Planned Parenthood v. Casey dealt with the legality of abortion statutes in the state of Pennsylvania, and therefore the particulars of the case have little bearing on the legality of physician-assisted suicide. Justice O'Connor, joined by Justices Kennedy and Souter and joined in part by Justices Stevens and Blackmun, delivered the opinion of the Court.

Rather than reviewing the opinion in its entirety, most of which is not germane to physician-assisted suicide, only the passage to which the Ninth Circuit refers in its decision is included. The key statement for our purposes comes from the following paragraph (internal citations omitted):

Our law affords Constitutional protections 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 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.**

The portion of the above quotation in bold was understood by the Ninth Circuit to provide a precedent for physician-assisted suicide. Courts frequently pull sections such as this from older opinions to provide a foundation for opinions, but this is not done without opposition from other judges and some legal scholars. In fact, the majority opinion of the three-judge panel of the Ninth Circuit that originally heard the Compassion in Dying v. State of Washington case overturned the lower court's decision in favor of physician-assisted suicide and criticized the lower court's use of this section, stating that it is a common error "to lift sentences or even paragraphs out of one context and insert the abstracted thought into a wholly different context. To take three sentences out of an

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opinion over thirty pages in length dealing with the highly charged subject of abortion and to find these sentences ‘almost prescriptive’ in ruling on a statute proscribing the promotion of suicide is to make an enormous leap.”*24 Whether or not the use of this section as a precedent in dealing with physician-assisted suicide was proper depends on the philosophical outlook of the individual being asked. However, in terms of constitutional law, this is the normal method in which precedent is cited. Rarely does the reader get the full context of a previous decision, but just the two or three sentences that are germane to the case in question.

The final key document to be reviewed is the report of The New York State Task Force on Life and Law titled “When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context.”. This Task Force was created by then-Governor Mario M. Cuomo in 1984 to recommend public policy on issues raised by continuing medical advances. Members of the Task Force represent the fields of medicine, philosophy, and nursing as well as medical school and law school faculty, leaders of various religious faiths and members of advocacy groups.25 The Task Force defines active euthanasia as “actions that intentionally cause death” and voluntary euthanasia is that act performed at the explicit request of an individual.26 Assisted suicide is when “one person contributes to the death of another, but the person who dies directly takes his or her own life.”27 Both of these are


27 Ibid., 7.
separate from the withdrawal of life support, including hydration and nutrition. For all intents and purposes, the report treats assisted suicide as one and the same as voluntary euthanasia, despite the differences in definition. It could be argued that this decision to treat assisted suicide and voluntary euthanasia as the same is a weakness of this report, as many argue that there is a distinct difference between the two, and legislation could be enacted to differentiate between them.

The first part of the report dealt with suicide in general and the factors that place an individual at higher risk to make this choice. The authors identify depression and chronic pain as the two primary risk factors associated with "suicide ideation," or thoughts about suicide. The two medical conditions most likely to produce requests for physician-assisted suicide are cancer and acquired immunodeficiency syndrome (AIDS), due in large part to the above two factors and the accompanying loss of control often associated with these conditions. The Task Force believes that current medical practices are not satisfactory in terms of the diagnosis and treatment of depression or in the providing of palliative care, which is the management of symptoms, including pain, associated with severe illness.

The report states that "the failure to provide pain relief is a pervasive fault of current clinical practice." This is due in part to a failure on the part of the physician to communicate early in the process of the treatment as to what options are available to the

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patient. Another factor is a medical community and general population that do not understand and therefore fear the process of addiction. This fear makes physicians less likely to diagnose properly and prescribe the correct amounts of pain medication, and patients are often unwilling to notify a physician of increasing pain or discomfort. A related problem is the fear of health care professionals that high doses of pain medications may hasten a patient’s death, a fear that is unfounded according to the report, as “the provision of pain medication is ethically and professionally acceptable even when the treatment may hasten the patient's death, if the medication is intended to alleviate pain and severe discomfort, not to cause death.” This is known as the principle of ‘double effect,’ a principle which has the support of the AMA. The AMA argues that this could be in wider use in palliative care if not for the lack of express support by state legislatures, which would remove the threat of criminal prosecution for physicians.

A second major problem identified by the Task Force is that physicians and other health care professionals are currently unable to diagnose depression in those suffering from a chronic or terminal illness. This diagnosis should be accomplished not only when there is some dramatic shift in the patient’s overall condition or morale or when there is a request for assisted suicide, but also as part of regular medical visits. Physicians also need to be willing to discuss suicidal thoughts should they arise, including assisted suicide. This can actually lessen the likelihood of a suicide attempt, as the patient may feel less isolated.

After lengthy deliberations, the Task Force unanimously concluded that the dangers of such a dramatic change in public policy would far outweigh any possible benefits. In light of the pervasive

31 Ibid., 8-10.
32 Ibid., 11.
34 Ibid., 25-9.
failure of our health care system to treat pain and diagnose and treat depression, legalizing assisted suicide and euthanasia would be profoundly dangerous for many individuals who are... vulnerable. The risks would be most severe for those who are elderly, poor, socially disadvantaged, or without access to good medical care.\textsuperscript{35}

The Task force found that any set of guidelines established for the practice of assisted suicide would still be open to inequality and bias, and therefore it could not recommend legalizing such a practice.\textsuperscript{36}

These four documents are the primary precedent sources for the decisions by the Second and Ninth Circuit Courts of Appeals and the decisions of the Supreme Court. It is interesting to see how the weight given to these documents will differ from the Appeals Courts to the Supreme Court.


\textsuperscript{36} Ibid., 5.
CHAPTER 3

APPEALS COURTS DECISIONS

Two United States Courts of Appeal decisions have supported the existence of a constitutional right to physician-assisted suicide. These two decisions are the first ever by a federal appeals court on this issue. The Ninth Circuit Court decided the case Compassion in Dying v. State of Washington on March 6, 1996 finding a Washington statute which prohibited causing or aiding someone to commit suicide to be unconstitutional under the Due Process Clause of the Fourteenth Amendment. In Quill v. Vacco, which was decided on April 2, 1996, the Second Circuit Court found a similar statute in the state of New York unconstitutional based on the Equal Protection Clause of the Fourteenth Amendment.

There are several things that make these cases interesting, including the controversial nature and uniqueness of the subject matter and the close timing of the two decisions. In analyzing the two cases, it seems natural to look at the Compassion decision first as it was the first announced.

The decision of the Ninth Circuit Court, known as one of the most liberal courts in the country,\(^1\) affirmed a decision of a United States District Court of Washington which had granted summary judgment for the plaintiffs, a group consisting of three terminally ill patients, four physicians and a Washington-based non-profit corporation known as Compassion in Dying.\(^2\) A three-judge panel of the Ninth Circuit had originally overturned the District Court, but the court voted to hear the case \textit{en banc} and overturned the earlier


decision. The Washington statute in question made it a crime to knowingly cause or aid another person in a suicide attempt, which constituted a felony punishable by up to five years in prison and up to a $10,000 fine. The court carefully pointed out that this case did not deal with what it calls "physician-aid-in-dying," where the physician would actually administer the lethal drugs to the patient, but with physician-assisted suicide where the physician would simply write a prescription for the necessary drugs to be administered by the patient themselves.

Circuit Judge Stephen Reinhardt, viewed by some as the court's most liberal member, wrote the majority opinion. He stated that the doctors met the standing requirement because they ran a severe risk of prosecution under the statute as the state had never indicated it would not prosecute physicians who violated the law. He also ruled the case was not moot because of the death of the named patients prior to the case reaching this court. Both of these decisions were based on prior Supreme Court precedents (see Babbit v. United Farm Workers National Union [1979] and Singleton v. Wulff [1976]). The appeals court had therefore settled the threshold questions as to whether it had jurisdiction to hear and decide this case. It could now move forward into the questions of the case itself.

The first question that the court addressed was whether an individual has a liberty interest in choosing the time and manner of his death, i.e. is there a right to die? The court found that there was. To reach this decision, the court was guided by the Supreme Court's

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3 Ibid., 794.

4 Ibid., 802 [Footnote 15].


7 Ibid., 798-9.
various abortion opinions, especially Planned Parenthood v. Casey[1992]. The fundamental message from Casey in terms of this case came down to the statement that:

> 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 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.

Through the use of this as a precedent for deciding this case, the court linked the liberty interest in the ability to obtain an abortion to the liberty interest in obtaining physicians’ assistance in terminating one’s life. The court stated that a competent, terminally ill patient should be allowed to choose a dignified and humane death and be able to avoid being reduced to a “childlike state” of helplessness, and that prohibiting such a choice could have “an even more profound impact on that person’s life than forcing a woman to carry a pregnancy to term.”

The court also linked this case to the Cruzan decision, particularly the parts of that decision stating that a person has a liberty interest in refusing medical treatment and that “... the Due Process Clause protects an interest in life as well as an interest in refusing life-sustaining medical treatment.” The removal of feeding tubes and other means of support, which the Supreme Court upheld, would result in the death of the individual, and therefore the majority believed that the Supreme Court had “necessarily recognized a liberty interest in hastening one’s own death.” The Appeals Court, while recognizing the liberty interest here, points out that the state should still have the right to regulate this activity and this regulation “is fully consistent with constitutional principles.”

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8 Ibid., 813.
9 Ibid., 814.
10 Ibid., 814-5.
11 Ibid., 816.
12 Ibid., 816.
The court surveyed both historical and contemporary attitudes towards suicide, similar to what the Supreme Court had done in *Roe v. Wade* with attitudes towards abortion. The court noted that the Greeks and Romans often viewed suicide as a commendable practice, and magistrates often kept hemlock on hand for those who wanted to commit suicide. Plato believed that suicide was justifiable if one suffered from a painful disease. The early Christians saw death as an escape and this attitude held until St. Augustine's time, when he wrote that "committing suicide was a 'detestable and damnable wickedness,'" an attitude that changed the outlook of the church as a whole. English common law made suicide a crime, and one who killed himself often forfeited his property to his lord. In time, the criminalization of suicide declined, and the law began to look on those who would consider it as not of sound mind. In America, there is no evidence of any punishment ever being imposed for suicide in post-revolutionary America, and only seven of the original thirteen colonies still had penalties for suicide by 1798. By the beginning of the twentieth century the majority of states had completely de-criminalized suicide. Recently polls have indicated that 64-73% of Americans believe that the terminally ill should have access to physician-assisted suicide. Voters in Oregon approved a referendum in the 1994 election legalizing physician-assisted suicide. This demonstrates a mixed historical record on this question in the majority's opinion, but a growing support in the general population for this idea.

Next, the court had to balance the liberty interest of the individual against the state's interest in preserving life. This type of balancing test is common when dealing with substantive due process and has been used by the Supreme Court in a number of

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13 Ibid., 807.
14 Ibid., 808.
15 Ibid., 809.
16 Ibid., 810.
instances, beginning with *Jacobson v. Massachusetts* [1905] and including the *Cruzan* decision. The court identified six areas of state interest: a general interest in preserving life; an interest in preventing suicide; an interest in avoiding the involvement of third parties and in precluding the use of arbitrary, unfair or undue influence; an interest in protecting the family and loved ones of a potential suicide; an interest in protecting the integrity of the medical profession; and an interest in avoiding adverse consequences possible by having the statute in question declared unconstitutional.\(^{17}\) The court discussed each of these on an individual basis.

The court acknowledged a strong state interest in preserving life, but held that the strength of that interest is not always the same and varies depending on the relevant circumstances of the individual case in question. The state of Washington has laws giving its citizens the ability to decline life-sustaining treatment in cases of terminal illness, in part because "such prolongation of life for persons with a terminal condition may cause loss of patient dignity, and unnecessary pain and suffering, while providing nothing medically necessary or beneficial to the patient."\(^{18}\) More than forty other states have adopted similar measures, normally in the form of living will statutes. Congress has passed legislation that requires hospitals receiving federal funding to notify patients as to their right to execute such documents upon admission.\(^{19}\) The interest of the state in protecting life is clearly less compelling and the strength of the state’s interest reduced “when patients are no longer able to pursue liberty or happiness and do not wish to pursue life.”\(^{20}\)

The interest of the state in preventing suicide is also reduced in the case of a terminally ill patient who wishes to die, according to the court.\(^{21}\) Over the last 20 years, the state’s

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\(^{17}\) Ibid., 816-7.

\(^{18}\) Ibid., 817-8.

\(^{19}\) Ibid., 818-9.

\(^{20}\) Ibid., 820.

\(^{21}\) Ibid., 820.
interests have been subordinated to those of the individual in terms of the ability to reject or terminate unwanted medical treatments. There were those who argued that to withdraw life support was the same as suicide or murder, but the courts slowly moved in the other direction. The state of Washington argued that this type of procedure is different from physician-assisted suicide for three reasons: physician-assisted suicide would require physicians to play an active role, the death would not result from the patient's underlying disease, and the physician is required to provide the causal agents of the patient's death.

The court did not agree, arguing that when physicians disconnect a life support system, they "take an active role in bringing about the patient's death." In terms of the argument that the physician will have to provide medication to cause a patient's death, it is common practice today for physicians to prescribe medications that have a "double effect," in that it reduces the level of pain of a patient and hastens the death of that patient. The American Medical Association, which is opposed to physician-assisted suicide, states that this practice of using medication with double effects is both ethical and good. The court did not see any real difference, in constitutional or ethical terms, between the use of double effect medication and prescribing medicine with the single effect of allowing a patient to end his own life. It acknowledged that there is a need for state regulation in this area in order to limit the possibility of error in terms of the terminal diagnosis of a patient.

The court turned next to the interest concerning third parties and arbitrary or undue influence. The court agreed that the state has a proper interest in this area, stating that joint action is generally considered more serious than that of a single individual. However, this

22 Ibid., 821-2.
23 Ibid., 822.
24 Ibid., 822.
25 Ibid., 823 [text and Footnote 95].
26 Ibid., 824.
risk remains minimal because of the fact that a trained physician has control of the situation in terms of if and when medical assistance will be provided for a suicide.\textsuperscript{27} The court also recognized that there could be a problem in terms of an elderly or infirm person succumbing to family pressure, and that this is not a hypothetical situation but one that exists today. It is the very fact that this pressure exists in the current culture, without legalized physician-assisted suicide, that the court cites as the mitigating reason in this area. The addition of this form of health care would not increase that risk unduly. The court believed that the addition of a physician as an impartial and professional third party could provide a safeguard in this situation. The court also stated its reluctance "to say that, in a society in which the costs of protracted health care can be so exorbitant, it is improper for competent, terminally ill adults to take the economic welfare of their families and loved ones into consideration."\textsuperscript{28}

In the opinion dealing with the effects on children and other family members, the court noted that although the state has a legitimate interest in this area, there is little to be gained by the state’s forcing the family of a terminally ill individual to watch a long and protracted death. In fact, this could do more harm than good to the interests of these third parties.\textsuperscript{29} There is also the problem of a family member or loved one being asked by the terminally ill individual to end his pain and suffering, placing that family member in a terrible position of aiding his loved one and breaking the law, or declining the request and having to live with that for the rest of his life. "This burden would be substantially alleviated if physicians were authorized to assist terminally ill persons to end their lives..."\textsuperscript{30}

The court stated that the legalization of physician-assisted suicide will not harm the integrity of the medical profession. Rather, it is the existence of statutes that criminalize the

\textsuperscript{27} Ibid., 825.

\textsuperscript{28} Ibid., 826.

\textsuperscript{29} Ibid., 827.

\textsuperscript{30} Ibid., 836.
providing of needed medical care which could create conflicts and threaten the medical establishment. The court again discussed the irrational position of the AMA that while physician-assisted suicide should remain illegal, the administration of drugs with “double effects” should be allowed to continue and not be viewed as contrary to the statute in question, stating that “given the similarity between what physicians are now permitted to do and what the plaintiffs assert they should be permitted to do, we see no risk at all to the integrity of the profession.” The court also pointed out that recognizing a right to physician-assisted suicide would not force a physician to perform any services which ran contrary to their individual principles or to their moral or religious beliefs. Physicians would still be free to choose how to practice medicine and how best to serve their patients.

The final area of state interest is the adverse consequences of having the statute declared unconstitutional and thereby legalizing physician-assisted suicide. Opponents of physician-assisted suicide have argued that allowing this practice to become legal is a “slippery slope” because of problems in defining and limiting the scope of the new right. The court dismissed this argument, stating that with every new right there is the potential for abuse and that the Supreme Court has never refused to recognize substantive due process liberty rights or interests because of this potential. A second argument discussed by the court is that the new right will undoubtedly expand due to the problematic nature of defining exactly what is a “terminal illness.” The court acknowledged that a definition of this type is not easy, but the experience of the states has proven that the class of the

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31 Ibid., 827.
32 Ibid., 828.
33 Ibid., 830.
34 Ibid., 830.
35 Ibid., 831.
terminally ill is neither indefinable nor undefined. The court again states that the case under consideration deals only with physician-assisted suicide, leaving for a future court to determine the constitutionality of physician-aid-in-dying.36

The court then moved to a discussion of the various means by which the state has chosen to further its interests, another necessity in performing the balancing test of substantive due process. The first of these means is prohibition, which is the method the state has employed under the statute in question. The second method available is regulation, which the court favored. It based this choice on the Cruzan decision, where the Supreme Court recognized the state's legitimate role in regulating the process of refusing or terminating life support but not the right to prohibit these decisions.37 The court also answered those who argue that courts are not the proper vehicle for this type of decision, believing the matter should be left to the individual states: "... where important liberty interests are at stake it is not the proper role of the state to adopt statutes totally prohibiting their exercise. Rather, the state should enact regulatory measures that ensure ... all necessary safeguards have been provided."38 This could be viewed as one of the weaker arguments in the opinion. If the elected representatives of a state enact a piece of legislation and the voters of that state do not force its change through the election process, the legislature can make the argument that it has acted in the interest of public good and with a majority of public support. In this type of situation, a court that rules against the legislature would be acting contrary to the spirit of self-government, states rights and the Tenth Amendment.

In this case, the court concluded "unhesitatingly that the balance favors the individual's liberty interest"39 and therefore the statute in question is unconstitutional

36 Ibid., 831.
37 Ibid., 833.
38 Ibid., 833.
39 Ibid., 799.
because it violates the Due Process Clause of the Fourteenth Amendment. The District Court had also found a Equal Protection Clause violation, but the Appeals Court did not address this matter, as "one constitutional violation is enough to support the judgment that we reach here."

Circuit Judge Beezer dissented in this case, finding that the statute rationally addressed four legitimate government concerns: "preserving life, protecting the interests of innocent third parties, preventing suicide and maintaining the ethical integrity of the medical profession." Beezer also argued that the plaintiffs in this case were not similarly situated to patients who requested the removal of life support systems or treatments. "The proper place to draw the line is between withdrawing life-sustaining treatment (which is based on the right to be free from unwanted intrusion) and physician-assisted suicide and euthanasia (which implicate the assistance of others in controlling the timing and manner of death)." He discussed each of the four state interests in some detail.

Beezer argued that the state's interest in the preservation of life is not weakened when dealing with a terminally ill patient who wishes to end his life, as the patient is "essentially viable. The patient may be inexorably approaching the line of nonviability. But the patient is still on the viable side of that line and enjoys the full protection of the state's interest in preserving life." This is also the case in terms of the state's interest in preventing suicide, which runs "directly contrary to any claimed right to physician-assisted suicide." Beezer also argued that people who request physician-assisted suicide normally do so because of some sort of unalleviated pain or suffering. He believed increasing the effectiveness and

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40 Ibid., 838.
41 Ibid., 839.
42 Ibid., 840.
43 Ibid., 851.
44 Ibid., 854.
availability of palliative care should be the focus rather than attempting through the courts to allow these individuals to commit suicide.⁴⁵ Beezer noted that a right to suicide could create legal problems in the area of wills, trusts, life insurance and other items of a person's estate, and these are some of the interests protected by the state's interest in innocent third parties.⁴⁶ In terms of the state interest in the maintenance of the integrity of the medical profession, allowing physician-assisted suicide "is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks."⁴⁷ 

Beezer's historical analysis contrasts sharply with that of the majority. He argues that both Plato and Aristotle were opposed to suicide.⁴⁸ In terms of American thought, he discussed Thomas Jefferson's opposition to the criminalization of suicide. Jefferson believed that if someone was so inclined as to take his own life, there was very little that legal restrictions could do to prevent it.⁴⁹ In terms of the contemporary attitudes towards assisted suicide, he noted that forty-four states either have laws that criminalize or condemn this act.⁵⁰ This would seem at odds with the public support that the majority cited in its opinion.

Beezer agrees with the majority that terminally ill adults do have a right to physician-assisted suicide, but this is an "autonomy-based, non-fundamental liberty interest in committing physician-assisted suicide" rather than a fundamental right. He pointed out that the Supreme Court has indicated a reluctance to expand the list of fundamental rights, and

⁴⁵ Ibid., 852.
⁴⁶ Ibid., 853.
⁴⁷ Ibid., 855.
⁴⁸ Ibid., 845.
⁴⁹ Ibid., 846.
⁵⁰ Ibid., 847.
he is not willing to attempt to add to this list in this case. 51 In order for a right to be deemed “fundamental,” it must be shown to be central to personal autonomy or it must be rooted in the nation’s history. Beezer is of the opinion that the idea of a right to physician-assisted suicide fails in both parts. The *Cruzan* decision is based on a “nonfundamental liberty interest in refusing unwanted medical treatment.” 52 Because the right to physician-assisted suicide is deemed non-fundamental, the statute in question must pass only a rational relationship test in order to be valid. Beezer attempted to demonstrate that the statute is rationally related to four distinct state interests; therefore the statute is valid. 53

Circuit Judges Fernandez and Kleinfeld joined Beezer’s dissent with minor additions. Fernandez argued that “no one has an even nonfundamental constitutional right” to physician-assisted suicide. He thought this issue is better left to the people, as “our Constitution leaves it to them; it is they and their representatives who must grapple with the riddle and solve it.” 54 Kleinfeld agreed with the AMA’s position that there is a difference between physician-assisted suicide and a physician prescribing drugs with a “double effect,” as one is intended to kill and the other is intended to relieve pain with the “knowledge that as the necessary dosage rises, it will produce the undesired consequence of death.” 55 He agreed with Fernandez that this is an issue best left to the people, who are at least as effective as judges in dealing with “complex and conflicting considerations.” 56

This is a very interesting opinion, but there are some problems. The first is the reliance on a link between abortion and physician-assisted suicide. The linkage here could require quite a leap of faith, and could easily be denied by the Supreme Court, which

51 Ibid., 848.
52 Ibid., 849.
53 Ibid., 855.
54 Ibid., 857.
55 Ibid., 858.
56 Ibid., 859.
would be fatal to the holding in this case. The Supreme Court has stated that one reason for the abortion rulings is the unique societal situation of pregnant women as the vast array of impacts and unwanted child can have on a women. There is no guarantee that the Court will see terminally ill patients in the same light, as this would require a broad reading of the Casey precedent. The Court has attempted to limit the scope of privacy interests protected to those involving “marriage, procreation, contraception, family relationships, child rearing, and education.”

Another problem is the historical analysis, which does not seem to be fairly weighted, given the dominance of anti-suicide thought in Western civilization, and especially in the history of the United States. The majority opinion does not even mention John Locke, the English philosopher whose writings had a great influence on the Framers of the Constitution. Locke was clearly against suicide, stating in his Second Treatise that man “has no liberty to destroy himself” and is “bound to preserve himself, and not to quit his station wilfully.” Historical writings from the Hebrews, the Romans, Plato, Aristotle, St. Augustine and many others throughout history demonstrate a general pattern of contempt for the idea of suicide, contrary to the majority’s opinion. In Beezer’s dissent, the legal problems he discussed in terms of estates and life insurance posed by physician-assisted suicide seem overstated, as the insurance companies and others affected by changes in the legal structure would adapt, as they have in the past when laws were changed. Some parts of the opinions are very sound. The majority pointed out that recognizing a right to physician-assisted suicide would not force a physician to perform any procedure he did not feel was ethical or one that conflicted with his moral or religious beliefs. This situation is similar to what has happened with abortion, as physicians in that


59 Ibid., 185-95.
area of medicine have remained free to exercise their personal beliefs. The discussion of the lack of difference between physician-assisted suicide and the termination of life support systems is another strength. The distinction between the two practices is hard to discern. Beezer is correct in his assertion that this should be viewed as a non-fundamental right, and his analysis of why this is so is clear and logical.

In *Quill v. Vacco*, the Second Circuit Court of Appeals, a court which is considered far more moderate than the Ninth Circuit, held that a physician may prescribe drugs to a mentally competent patient for the purpose of ending that patient’s life under the Equal Protection Clause of the Fourteenth Amendment, thereby reversing part of a District Court ruling which had determined that physician-assisted suicide was not a fundamental right under the Constitution, and that the State’s interests protected by the New York law were both reasonable and rational. In the process, a section of the New York penal law that made it a felony to aid someone in the commission of a suicide was declared unconstitutional. The plaintiffs in the case were three physicians who contended that the statute prohibited them from acting on the requests from terminally ill, mentally competent patients for assistance in hastening death, violating both the Due Process Clause and the Equal Protection Clause of the Fourteenth Amendment.

The first item for the court to establish was that the case presented a justiciable case or controversy. To accomplish this, the court relied in part on the Supreme Court ruling in *Babbitt v. United Farm Workers National Union* [1979], which stated that it is not

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61 Quill v. Vacco, 80 F. 3d 716, United States Court of Appeals, Second Circuit, 1996, 718.

62 Ibid., 722.

63 Ibid., 719.

64 Ibid., 718.
necessary for someone to expose himself to arrest and prosecution in order to contest the constitutionality of a state criminal statute.\textsuperscript{65} Dr. Quill had been the object of a criminal proceeding previously, and the state had made no promises against future prosecution against him in terms of assisted suicide. This decision gave the plaintiffs further grounds on which to sue.\textsuperscript{66} The court ruled the case to be justiciable.

The court then turned to the Due Process part of the argument. The court states that rights that have no textual support in the language of the Constitution but qualify for heightened judicial protection include fundamental liberties so “implicit in the concept of ordered liberty” that “neither liberty nor justice would exist if they were sacrificed.” ...Fundamental liberties also have been described as those that are “deeply rooted in this Nation’s history and tradition.”\textsuperscript{67}

Based on these precedents, the court rejected the physicians’ claim that the New York statute is a violation of the Due Process Clause as the statute does not infringe upon any fundamental right or liberty. The right contended is not so important that neither liberty nor justice would survive without it, and there is little if any history to support such a right in our nation.\textsuperscript{68} The court also mentioned that its position in the judicial hierarchy forces it “to be even more reluctant than the (Supreme) Court to undertake an expansive approach in this uncharted area.”\textsuperscript{69} In this regard, the Appeals Court agreed with the findings of the District Court.

The Equal Protection question is somewhat different. The court opined that this clause requires that states treat individuals in similar situations in a similar manner. If the states are going to treat groups differently, the state legislature will be granted wide latitude as

\textsuperscript{65} Ibid., 722.
\textsuperscript{66} Ibid., 723.
\textsuperscript{67} Ibid., 723.
\textsuperscript{68} Ibid., 724.
\textsuperscript{69} Ibid., 725.
long as the statutory classifications are "rationally related to a legitimate state interest." The court noted that the New York law does not treat all people with a terminal illness who wish to hasten their deaths in a similar manner, and that the distinctions in the New York law do not further a legitimate state interest. Therefore the statute in question violates the Equal Protection Clause of the Fourteenth Amendment. New York has long recognized the right to refuse medical treatment. In 1914 a judge wrote that under state law individuals of a sound mind have a right to determine what will be done to or with their bodies. In 1981, the state court of appeals held that this right extended to the withdrawal of life-support systems. In 1987, the state legislature passed a law giving citizens the ability to issue medical orders that they not be resuscitated and also set up a process for surrogate decision-making. In 1990, the legislature passed a law allowing health care proxies, allowing people to appoint an agent who would speak for them should they become incapacitated. All of this occurred prior to the Supreme Court's approval of the right of competent persons to remove life support systems in *Cruzan*, which the court also cites as supporting the idea of a lack of equal protection.

In view of this evidence, the court held that New York does not treat people in similar circumstances in a similar fashion: "those 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." There is no distinction between the two in the court's view. "Physicians do not fulfill the role of 'killer' by prescribing drugs to hasten death any more than they do by disconnecting life-support systems," according to

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70 Ibid., 725.
71 Ibid., 727.
72 Ibid., 727-8.
73 Ibid., 729.
the court. In fact, the court said that there is a far more active outside role for a physician when he or she disconnects life-support systems to bring about a death through asphyxiation, starvation and/or dehydration than in writing a prescription to hasten someone's death. The court also quoted Justice Scalia's opinion in the *Cruzan* case that there is an "irrelevance in the action-inaction distinction, ...the cause of death in both cases is the suicide’s conscious decision to 'put an end to his own existence.'" The court stated that a finding of unequal treatment does not end the inquiry, as that treatment might still be reasonably related to some legitimate state interest. However, as the court stated: "what interest can the state possibly have in requiring the prolongation of a life that is all but ended?" The court also asked how the state's interests can be served by mandating the continued agony of a terminally ill patient when that patient attempts to obtain drugs to end his suffering or life? The court provided a simple one word answer to these questions: "None." The court did acknowledge the state's legitimate right to regulate physician-assisted suicide, including the right to establish guidelines in terms of what defines a terminal illness and at what stage of that illness physician-assisted suicide would be an option but drew a line at the prohibition of this procedure. The court also pointed out that this case pertains only to physician-assisted suicide, and not to euthanasia in general. This means that the drugs must be self-administered.

Circuit Judge Calabresi concurred in the opinion. He did not think that New York had violated either the Due Process or Equal Protection Clauses of the Fourteenth Amendment.

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74 Ibid., 730.
75 Ibid., 729.
76 Ibid., 729.
77 Ibid., 729.
78 Ibid., 730.
79 Ibid., 731.
80 Ibid., 730.
and would open the question of whether a state can restrict or prohibit physician-assisted suicide. He concurred with the decision because “the statutes at issue were born in another age. New York enacted its first prohibition of assisted suicide in 1828.”

When this law was originally passed, suicide was a crime and therefore assisted suicide would have to be a crime as well. Calabresi conceded that “the statutes at issue come close—at the very least—to infringing fundamental due process rights and to doing so in ways that are also suspect under the antidiscrimination principles of the Equal Protection Clause.”

Times have changed, and Calabresi would like to leave the door open for current or future legislatures to pass a similar piece of legislation, supposedly based on the concerns of their constituents, and have cases arising under that legislation come before the court. Absent such current information from the legislature and the people of the state, the court has the right to strike down such laws.

Calabresi argued that the distinction between the removal of life supporting systems and physician-assisted suicide “is tenuous at best,” agreeing with the court. Even if such a distinction exists, “New York has never enacted a law based on a reasoned defense” of that distinction. Although *Cruzan* did not specifically decide whether a patient has a right to die, Calabresi wrote that the majority opinion in that case “clearly recognized that any infringement of such a liberty interest was at least constitutionally suspect” under the Due Process Clause.

Finally, he argued that “no court need or ought to make ultimate and

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81 Ibid., 732.
82 Ibid., 733.
83 Ibid., 735-6.
84 Ibid., 738.
85 Ibid., 735.
86 Ibid., 735.
87 Ibid., 737.
immensely difficult constitutional decisions unless it knows that the state’s elected representatives and executives—having been made to go, as it were, before the people—assert through their actions (not their inaction) that they really want and are prepared to defend laws that are constitutionally suspect."

The major strength of this opinion is the discussion of the pattern of New York law in dealing with the rights of patients to disconnect or refuse life-support systems. It is especially important that this legislation was enacted prior to the *Cruzan* decision. The timing of this legislative activity begs the question as to why someone who is attached to life-support should have more of a right to determine the time and nature of his death than someone who has a terminal condition but does not require life-support? There does seem to be a basic inequity in this situation, which adds a great deal of strength to the findings of the court. Judge Calabresi’s concurring opinion is somewhat puzzling, as he seems to base his willingness to overturn the law on the time of enactment. There are very few instances where the age of a law is the grounds for its dismissal, and one could argue that by not attempting to have the law removed, the voters of New York have granted it at least tacit approval.

There are some interesting similarities between these two cases, outside of the obvious one that each found a way to allow physician-assisted suicide based on part of the Fourteenth Amendment. Each court discussed the idea that these decisions did not infringe on the state’s right to regulate this service or industry, but only kept the states from being able to prohibit physicians from being able to provide said service. Both agreed that state regulation was necessary in order to ensure the overall quality of the medical services offered and to provide some sort of uniform code in terms of the definition of ‘terminal,’ as well as to protect the members of society from pressure or poor judgment. Each court was also careful to point out the fact that its decisions only affected physician-assisted suicide, and did not deal with the larger issue of euthanasia in general. This is an important

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88 Ibid., 742.
limitation, especially in terms of attempting to allow some sort of uniform state regulation of this service. The two courts were also careful to point out that allowing physicians to perform this service does not make them "killers," or at least not any more than the currently accepted practice of prescribing medications with 'double effects' or allowing physicians to disconnect life-support equipment at the patient's request. One commentator argued that the two opinions offered the same argument, but that the Ninth Circuit was more open about the that argument, while the Second Circuit attempted to veil or blunt the point of its argument, eventually ending up with the same basic premise as the Ninth Circuit. Each court addressed the idea that this is a question better left to the voters and their elected representatives because of the complexity of the questions and the lack of constitutional foundation in this area. Allowing the electorate to decide this matter is probably the most practical and least controversial manner in which physician-assisted suicide could become accepted in the United States.

There has been a significant amount of criticism of these two decisions. The fact that the two courts used different clauses of the Fourteenth Amendment demonstrates that there may not be a definitive, irrefutable constitutional basis for right to physician-assisted suicide. Some have argued that the decision in Compassion in Dying was based on narrow, speculative, highly contested constitutional law theories, which, if left intact by the Supreme Court, will have the effect of allowing eight federal judges to usher "in an era of state-sanctioned suicide in nine Western states, including the populous and politically influential state of California. A social and legal shift of this magnitude, done in this


manner, teeters on the edge of illegitimacy." The same author criticized the use of the Planned Parenthood v. Casey and Cruzan precedents, as "each of these earlier opinions was tailored to cover a distinctly different set of circumstances," those being contraception and the right to refuse life-prolonging treatment. Questions have also been raised about the wisdom of federal judges substituting their judgment for that of elected officials who have balanced and weighed both sides of a question prior to passing legislation. In areas where there is limited history upon which the courts can rely, deference should be given to legislative judgments. This is a common complaint against judicial activism.

Others have argued that the appeals court has gone too far from the original "right to die," as promulgated in the Quinlan case. They argue there is a distinct difference between the ending of artificial life support, or the "passive withdrawal of life support," and physician-assisted suicide. Some critics agree that the line between these two ideas is not always clear, but they contend that the logic of this separation is "vastly more tenable and legally enforceable" than the one suggested by these decisions. They argue that by adding concepts such as "voluntary", "terminally ill", "suffering intolerable pain" and "competent" to the equation, the prospects for uniform enforcement of and compliance with laws dims, as these are all subjective terms. Some have suggested that the liberty interest in determining the manner of one's death cannot be limited to the terminally ill, but must


92 Moskowitz, A20.


extend to the non-terminally ill as well. The HIV-positive individual or the person in the
early stages of Alzheimer's might also want to avail himself of this right, which would be
denied by these decisions. The appeals court is guilty here of placing a higher value on
the life of the nonterminally ill, which one author calls “privileging the productive citizen,”
and denies this group due process protection. There is a judgment made by the appeals
court about the value of life of the type that the Supreme Court was unwilling to make in
_Cruzan._

The decisions also garnered support. Some argued that they presented an opportunity
to establish a legal as well as a clinical framework for physician-assisted suicide, which is
already a widespread practice, as well as a national committee on issues pertaining to the
end of life. Supporters cited an article in _The Journal of the American Medical Association_
that shows 24% of those patients who request aid in dying obtain prescriptions for that
purpose.

The decisions in these cases were appealed to the Supreme Court. Kathryn L. Sisk
Tucker, the attorney who represented the advocacy group Compassion in Dying in both
cases, predicted a 6-3 vote in favor of physician-assisted suicide with Chief Justice
Rehnquist and Justices Thomas and Scalia the minority opposition. She may have
miscalculated.

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Suicide Cases,” _Harvard Civil Rights-Civil Liberties Law Review,_ 32, no. 1 (winter

97 Ibid., 210-11.

98 “Dead Right,” editorial, _The Nation,_ 29 April 1996, 4-5.

CHAPTER 4

SUPREME COURT DECISIONS

The Supreme Court heard arguments in the cases of Washington v. Glucksberg and Vacco v. Quill on 8 January 1997 and issued its opinion on 26 June 1997, finding no constitutionally protected right to physician-assisted suicide, thereby overturning the Appeals Courts' decisions. In order to gain a fuller understanding of what entered into these decisions, it seems appropriate to review briefly a select few of the more than sixty amicus curiae or “friends of the court” briefs filed in support of and opposition to physician-assisted suicide. These briefs are of interest as different groups often use the same evidence to reach different conclusions about aspects of this question. These differences demonstrates the diversity of opinion and understanding on this subject through which the Court was obligated to cut in reaching its decision. Once that examination is completed, the decisions themselves will be examined.

Amicus Briefs

The Solicitor General of the United States filed separate briefs for each case, arguing against the Appeals Courts' rulings. The brief in the Washington case argued that the United States had a substantial interest in these cases because of the numerous health care facilities that it owns and operates as well as the medical funding provided through

1 A complete list of the amicus briefs filed in these cases is available from http://www.med.upenn.edu/~bioethic/PAS.

numerous governmental programs. The brief stated that the previous decisions of the Court do not support the “conclusion that there is a broad liberty interest in deciding the timing and manner of one’s death.” The brief attacked the use of the abortion cases as precedent for physician-assisted suicide, arguing the fundamental right to obtain an abortion is grounded in a combination of constitutionally protected interests and at the intersection of “constitutional liberty and constitutional equality.” This is due to the long-term obligations involved in childbirth and parenting. The same conditions were not present with the question of physician-assisted suicide.

The brief argued that lawmakers may legitimately question whether physician-assisted suicide could be legalized without “endangering the lives of many other persons who do not satisfy the criteria specified by the court of appeals” and therefore “lead to the deaths of many persons who are not competent, who are not terminally ill, and who do not make truly voluntary requests for assistance... There is little doubt that a legislature may responsibly decide that making lethal medication available for some would create widespread and unjustified risks for many others.” The brief also cited the dangers of the ‘slippery slope,’ including the possibility that voluntary and involuntary euthanasia could become legal.

The Solicitor General’s brief in the Vacco case began by stating that the Equal Protection Clause does not require “things which are different in fact or opinion to be treated in law as though they were the same... and a legislature must have some latitude in creating classifications that respond to perceived problems and accommodate competing

4 Ibid., 9.
5 Ibid., 10.
6 Ibid., 12.
7 Ibid., 16.
concerns both public and private."\textsuperscript{8} The Solicitor General argued that there is a distinction between termination and physician-assisted suicide based on the fatal pathology of patients in the two cases. One dies of the underlying disease and the other as a result of an ingested prescription. He stated that prohibition of physician-assisted suicide provides "an important psychological barrier for the physician who might be tempted to resort to a quick exit for the patient whose illness he cannot cure."\textsuperscript{9} The brief argued that the privacy of the physician-patient relationship, while necessary and appropriate, could interfere with the legislative attempt to provide adequate procedural safeguards in this area.\textsuperscript{10} The brief criticized Judge Calabresi for opining that the New York law was "born in another age" and had not been revisited. As recently as 1990 the legislature enacted laws allowing for health care proxies and the use of health care agents and stated clearly in that legislation that "this article is not intended to permit or promote suicide, assisted suicide, or euthanasia."\textsuperscript{11}

The American Civil Liberties Union [ACLU], a group dedicated to preserving the principles of liberty and equality embodied in the Constitution, along with eleven other groups, filed a brief arguing that the Appeals Courts' decisions should be upheld.\textsuperscript{12} The ACLU argued that physician-assisted suicide should be considered a fundamental right. The group argued that the history of suicide is irrelevant to these cases, and the focus instead should be placed on whether history supports the right of a competent, terminally ill individual to end a painful existence by hastening an inevitable death, which the ACLU


\textsuperscript{9} Ibid., 9.

\textsuperscript{10} Ibid., 10.

\textsuperscript{11} Ibid., 12.

believed it did. They also cited the reluctance to prosecute or punish individuals who have aided another to commit suicide as proof that society in general believes "it has no right to insist on the continued suffering of the terminally ill and no right to punish those who honor the request of the terminally ill by assisting them in ending their agony."13

The brief refuted the argument that there was a difference between physician-assisted suicide and the removal of life support. It also countered various claims of state interest in preventing the practice of physician-assisted suicide such as the argument that legalizing this practice would erode public confidence in the medical profession or that attempting to define a terminal illness would be impossible. In terms of the distinction between termination and assistance, the brief stated that both sets of patients are seeking medical assistance to die, and that the level of assistance necessary is greater in termination and that often medication is administered to ease the pain during this procedure in doses that precipitate an early death.14 The ACLU argued that the opposite would be true, as the decriminalization of this act and the enactment of state regulations of its practice would free physicians to discuss all available options with a patient, thereby raising patient confidence in their physician. The brief also pointed out that there is an existing definition of terminally ill in at least the forty states that have enacted 'living will' statutes which are based in part on the individual being terminally ill, thereby refuting one of the 'slippery slope' arguments against physician-assisted suicide.15

"The Philosophers' Brief" was submitted by a group of six moral and political philosophers, led by Ronald Dworkin. They argued that physician-assisted suicide should be viewed as a fundamental right based on prior Court decisions, especially the 

13 Ibid., 4-5.
14 Ibid., 13.
15 Ibid., 12.
and *Casey* precedents.** "A person’s interest in following his own convictions at the end of life is so central a part of the more general right to make ‘intimate and personal choices’ for himself that a failure to protect that particular interest would undermine the general right altogether,” according to the brief.** The group argued that there is no moral distinction between termination of life support and physician-assisted suicide, as in either case the physician is acting “with the same intention: to help the patient die.” The same is true from a patient perspective, as in either case the physician is helping him to end his life.** The brief also observed that the potential for mistake and abuse is greater with termination than with assistance. The advance directives often used in termination may have been made under pressure from a family member or by a patient who is incompetent, and there is no impartial professional representation in this process as there would be in most regulatory mechanisms for physician-assisted suicide. Also, the living will may have been made years ago and no longer represent the patient’s wishes.**

The brief claimed that there is a need for the states to regulate physician-assisted suicide, taking all reasonable measures to insure that a patient requesting such assistance has made an “informed, competent, stable and uncoerced decision,” and mentions that several regulatory schemes have been proposed. These are necessary to promote uniformity in the delivery of this service. The group also stated that doctors who feel a moral or ethical objection to this practice should not be compelled to offer it to their patients.**


** Ibid., 44.

** Ibid., 45.

** Ibid., 45.

** Ibid., 47.

** Ibid., 47.

** Ibid., 45.
The American Geriatrics Society, a group of “professional health care providers focused on serving the health care needs of elderly persons,” filed a brief arguing for a reversal of the Appeals Courts’ decisions.\(^2\) It argued that the Appeals Courts misunderstood the end-of-life process. The Society stated that most people die quietly in their sleep due in large part to hospice and palliative care programs and that these programs can and will get better with time.\(^3\) The brief contended that the lower courts also were mistaken in finding no substantial difference between termination and assistance, as one is a matter of leaving a patient alone while the other requires physician intervention. When life support is terminated, the underlying disease causes the patient’s death, not the actions of the medical personnel who removed the support. In physician-assisted suicide, the patient dies from a drug overdose and not from natural causes. This group of patients could be giving up on years of life while those on support are normally very sick and close to death.\(^4\)

The brief argued that the categories of “terminal illness” and “competence,” upon which rely most regulatory mechanisms suggested for physician-assisted suicide, could be impossible to delineate. Another problem involved the reliance on physicians to provide the prescriptions for ending a patient’s life, as “there is no drug approved as safe and effective ... for PAS, no instructions given in medical texts, ...”\(^5\) The brief contended that the scope of physician assistance would grow if this practice were legalized, as pressure would increase to allow the use of intravenous administration of drugs for this purpose because of the increased efficiency of that delivery mechanism, thereby legalizing voluntary

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\(^3\) Ibid., 4.

\(^4\) Ibid., 6.

\(^5\) Ibid., 10.
euthanasia. The group closed its argument by urging the Court to vacate the lower courts' opinions and leave the matter to the various state legislatures for further debate and study, based in part on the Tenth Amendment.

The Project on Death in America, a group formed in 1994 to "understand and transform the culture and experience of dying in the United States" and taking no position on whether physician-assisted suicide should ultimately be legalized, filed a brief urging that the Supreme Court overturn the lower court's decisions. The basis of its argument comes from a quote of Justice Brandeis's in *New State Ice Co. v. Liebmann* [1932], that "it is one of the happy incidents of the federal system that a single courageous state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country." The group cited a number of issues dealing with the Fourteenth and the Eighth amendments where the Court had allowed a state or group of states to act as this type of laboratory, and urged the Court to take the same approach with regard to physician-assisted suicide. The brief argued that there is not enough empirical information available for the Court to make an informed decision, and therefore the Court should reverse due to a lack of ripeness on this question.

The National Hospice Organization, "a non-profit, public-benefit, charitable organization dedicated to promoting and maintaining quality care for the needs of terminally

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26 Ibid., 11.
27 Ibid., 12.
29 Ibid., 4.
30 Ibid., 5-11.
ill persons,” filed a brief arguing that the lower court decisions should be overturned.31 The organization wanted the Court to be “fully aware of a middle ground available between the two extremes of physician-assisted suicide and a death devoid of peace and dignity. In that middle group is hospice.”32 The brief argued that the primary function of hospice is the provision of palliative and supportive care, and when the proper level of this type of care is available, the desire for suicide generally subsides. Its brief charged that the Appeals Courts failed to recognize that the final days of a person's life may contain profound opportunities for him and his family that could be lost if physician-assisted suicide were legal, as often this time is when outstanding issues are resolved between family members.33

The brief also attacked the idea that there is no distinction between termination of life support and physician-assisted suicide, stating that termination is based on the right to refuse unwanted and unwarranted invasions of bodily integrity while assistance involves the aid of a physician for purposes “inimical to the physician’s purpose and creed.”34 The brief contended that if the general public were aware of the services provided by hospices, the support for physician-assisted suicide would decrease. However, if physician-assisted suicide were to be legalized, the advances made in palliative care recently would slow and the existence of hospices in general would be threatened.35

The American Medical Students Association, “an independent, non-profit organization representing nearly 30,000 physicians-in-training,” along with a group of medical

32 Ibid., 7.
33 Ibid., 7-9.
34 Ibid., 11.
35 Ibid., 12.
professionals submitted a brief supporting the holdings of the Appeals Courts. It argued that there is no 'bright-line' legal distinction between the refusal of life support and the request for physician-assisted suicide. When a patient "chooses to hasten his death, his ultimate goal is no different from that Petitioners ascribe to those who reject life sustaining treatment: to avoid a prolonged and dehumanizing process of dying," according to the group. It contends that often when an individual requests a lethal dosage of medication, it is often not with the intent of using the prescription but rather a way to gain some control in a situation that is out of his control. The group contended that when a physician disconnects a respirator or halts the provision of food and hydration, they are the cause of death just as much as suffocation and dehydration, and that if a physician "performed either of these actions without the patient's consent, she would be legally responsible for causing the patient's death just as surely as if she had shot her patient." The brief also attacked the doctrine of "double effect" as being far more dangerous in terms of evolving into voluntary or involuntary euthanasia than physician-assisted suicide.

A group of fifty professors who teach medical ethics to medical students filed a brief asking the Court to overturn the Appeals Courts' decisions. The group claimed that the lower courts were in error when they concluded there was no difference between physician-assisted suicide and the termination of life support. They stated all courts that have dealt with refusal of treatment issues have pointed out that states may have a legitimate interest that would allow for the abridgment of the right to refuse, and one of the primary

37 Ibid., 4.
38 Ibid., 5.
39 Ibid., 7.
interests cited as an example of a legitimate interest has been suicide. This indicates that
courts have distinguished between the patient’s right of refusal and suicide.\textsuperscript{41} A person
does not have to be terminal in order to refuse treatment but would have to be in order to
receive physician-assisted suicide, which offers further evidence that these two groups are
not similarly situated. In terms of the argument about the cause of death resulting from a
termination, the brief points out that a person placed on artificial nutrition and hydration is
unable to take nourishment in a normal fashion due to the underlying disease. Therefore, if
the artificial sustenance is removed and the patient dies, it is still a result of the symptoms
of the underlying disease. If one accepts that the termination of life support becomes the
cause of death, “one would also have to accept the conclusion that when physicians stop
attempting cardiopulmonary resuscitation on a patient in cardiac arrest, what kills the patient
is not the cardiac arrest but rather the physician who intentionally stops compressing the
heart.”\textsuperscript{42}

The brief argued that the Ninth Circuit Court’s use of the \textit{Casey} precedent was
inappropriate as it dealt specifically with “enabling a woman to make choices she believes
further her health, and continued participation in society, whereas assisted suicide leads
only to death.”\textsuperscript{43} The group believed that the abortion cases present a unique set of
circumstances, such as attempting to allow women to shape their role in society and ensure
that they are treated equally in society and by government, which circumstances do not
apply to the question of physician-assisted suicide.\textsuperscript{44} They argued that the linkage is
further weakened by the fact that abortion is a medical procedure performed by licensed

\begin{itemize}
  \item \textsuperscript{40} George Annas et al., “Brief for Bioethics Professors Amicus Curiae Supporting
        Petitioners.” 12 November 1996, 5, available from
  \item \textsuperscript{41} Ibid., 9.
  \item \textsuperscript{42} Ibid., 10.
  \item \textsuperscript{43} Ibid., 5
  \item \textsuperscript{44} Ibid., 12.
\end{itemize}
physicians using techniques taught in formal schooling, whereas assisted suicide is not taught in medical schools nor the methods used tested by any medical board of examiners.\(^{45}\)

The final *amicus* brief to be reviewed was submitted by a different group of bioethicists comprised of “professors, lawyers, and medical doctors who have written and lectured extensively, and are considered among the nation’s pre-eminent experts on the narrow issue before the Court”\(^{46}\) arguing in favor of upholding the Appeals Courts’ rulings. This group argued that the use of long-standing traditions against suicide cannot be used to decide the constitutionality of physician-assisted suicide because the fundamental nature of death has changed dramatically in the past few decades as people live longer and the process of death is often slow and painful. By finding in favor of physician-assisted suicide, the Court “would not be judicially mandating social change; it would be applying constitutional doctrines of protected individual rights to a new factual situation.”\(^{47}\)

The brief attacked the idea that a physician would be violating the Hippocratic Oath if he provided drugs for the purpose of assisted suicide. The ancient version of the Oath, which prohibited the providing of poison, also prohibits surgery, the charging of fees for the teaching of medicine, and the practice of abortion. The contemporary Oath does not prohibit any of these procedures, stating only that doctors should “do no harm.”\(^{48}\) The group acknowledged the need for guidelines for physician-assisted suicide, but argued that the formulation of these guidelines would not be as problematic as some had suggested and

\(^{45}\) Ibid., 14.


\(^{47}\) Ibid., 5.

\(^{48}\) Ibid., 6-7.
stated that the opportunity for abuse in this area would be no greater than in the area of termination of treatment.49

These briefs clearly demonstrate the lack of consensus about the issues involved in physician-assisted suicide, especially in terms of the question of difference between termination and assistance. The discussion of the dangers of abuse in the area of termination was enlightening, if for no other reason than to point out the success of the regulatory system involved with termination. There have been few, if any, cases dealing with the wrongful termination of someone whose advance directive did not represent their true wishes. However, there have been eight cases in state courts which have dealt with whether a guardian can choose to withdraw the support of a patient who was never competent, and in seven of those cases the courts have allowed the termination. These cases clearly represented courts allowing involuntary euthanasia based at least in part on the Cruzan precedent, not on the right to physician-assisted suicide as some fear.50 The lack of consensus about the difference between these two procedures existed not only in the professional communities involved in this dispute, but in the society as a whole. It was also very interesting that the AMA argued against physician-assisted suicide while the American Medical Students Association argued in favor. The decisions and opinions of the members of the Supreme Court should be viewed with this in mind.

Supreme Court Opinions

The Supreme Court in Washington v. Glucksberg overturned the Ninth Circuit by a vote of 9-0, finding no constitutional right to assisted suicide. Chief Justice Rehnquist, joined by Justices O'Connor, Scalia, Kennedy and Thomas, delivered the opinion of the Court. The Chief Justice began by reviewing the nation's history, a common beginning in

49 Ibid., 9-10.
questions of due process, stating that it is a crime in almost every state, and nearly all western democracies, to assist in a suicide. These bans are "longstanding expressions of the states' commitment to the protection and preservation of all human life," and for over seven hundred years the common law has "punished or otherwise disapproved of both suicide and assisting suicide." The majority stated that at the time of the ratification of the Fourteenth Amendment, assisted suicide was a crime in most states. The majority pointed out that the Washington statute in question was enacted in 1975 and in 1991 voters in that state rejected a ballot initiative to legalize a form of physician-assisted suicide. The States Natural Death Act (1979), which allows for the termination of life support at the request of a patient, specifically stated that physician-assisted suicide would not be considered suicide under the law and was later amended to expressly exclude this procedure.

The majority argued that the Court has always been hesitant to expand the area covered by substantive due process, as such expansion removes matters from public and legislative debate. With this in mind, they began to examine whether physician-assisted suicide could be considered a fundamental right and therefore subject to special protection under the Due Process Clause by first reviewing the *Cruzan* decision. They argued that the precedent established in that case grants competent persons a "constitutionally protected right to refuse lifesaving hydration and nutrition." This right was drawn from the common law provision that forced medication was battery and therefore illegal, rather than from some

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52 Ibid., 4.

53 Ibid., 4.

54 Ibid., 6.
concept of personal autonomy as the Appeals Courts had ruled. The Court also recognized in *Cruzan* that most states outlawed assisted suicide, and the decision gave no indication that those laws were in danger of being overturned. Therefore, the precedent from the *Cruzan* case was of no relevance to the question of assisted suicide. The *Casey* decision was found to be irrelevant in this case as well, as the Court stated that just because "many of the rights and liberties protected by the Due Process Clause sound in personal autonomy does not warrant the sweeping conclusion that any and all important, intimate and personal decisions are so protected" and there was nothing in the *Casey* opinion to suggest otherwise. Thus the Court had established that there was no fundamental right to assisted suicide.

"The Constitution also requires, however, that Washington's assisted suicide ban be rationally related to legitimate government interests;" otherwise the statute could still be found to violate the Due Process Clause. The majority found this condition to be met in this case, citing a number of legitimate state interests to be served by this statute. The Court noted that Washington had an "unqualified interest in the preservation of human life" and may exercise this interest without consideration of the quality of that life. This allows the state to protect the patients who suffer from depression or untreated pain, who, the Court believes, would be at great risk if physician-assisted suicide were legal. The state has a recognized interest to protect the integrity of the medical industry which could be endangered by physician-assisted suicide, according to testimony from the AMA and the report of the New York Task Force on Assisted Suicide. The state has an interest in protecting vulnerable groups that could be compromised by the legalization of this

55 Ibid., 7.
56 Ibid., 8.
57 Ibid., 8.
58 Ibid., 8-9.
procedure. Individuals might feel pressure to request physician-assisted suicide to spare their families the financial expense of end-of-life health care, and there could be prejudice against the terminally ill who refuse to take this path. The final state interest discussed was a fear that legalizing physician-assisted suicide would start a process whereby euthanasia in general would become legal. 59

The majority closed by observing that “throughout the Nation, Americans are engaged in an earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a democratic society.” 60

Justice O’Connor, joined by Justices Ginsburg and Breyer, filed a concurring opinion stating that there is no “generalized right to commit suicide” 61 but also arguing that the question of “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” is not addressed in these facial challenges to statutes of New York and Washington. These states have not erected legal barriers to obtaining medication to relieve pain and suffering, “even to the point of causing unconsciousness and hastening death.” 62 Justice O’Connor argued that the difficulty of defining terminal illness and the need to protect individuals from being pressured to request physician-assisted suicide justified the Supreme Court’s decision, and “there is no reason to think the democratic process will not strike the proper balance between the interest of terminally ill, mentally competent

59 Ibid., 9-10.

60 Ibid., 10.


62 Ibid., 1.
individuals who would seek to end their suffering and the State's interest in protecting those who might seek to end life mistakenly or under pressure.\textsuperscript{63}

Justice Stevens filed a concurring opinion arguing that "there is no absolute requirement for states to treat all human life as having an equal right to protection," a precedent established by capital punishment.\textsuperscript{64} Thus, in a state like Washington which has the death penalty, there may be times when an individual has an interest in hastening his death that would be entitled to constitutional protection.\textsuperscript{65} Stevens argued that \textit{Cruzan} was based on more than a common law rule as the majority suggested, "but also her interest in dignity, and in determining the character of the memories that will survive long after her death," and that some of the plaintiffs in this case may have a stronger interest than that of Nancy Cruzan as they were terminally ill and suffering constant pain.\textsuperscript{66} The \textit{Cruzan} decision also makes it clear that some individuals who no longer have the option of deciding whether to live or to die because they are already on the threshold of death have a constitutionally protected interest that may outweigh the State's interest in preserving life at all costs. The liberty interest at stake in a case like this differs from, and is stronger than, both the common law right to refuse medical treatment and the unbridled interest in deciding whether to live or die. It is an interest in deciding how, rather than whether, a critical threshold shall be crossed.\textsuperscript{67}

Justice Stevens suggested that the refusal of, or legal prevention of, a physician to dispense medication to assist in a suicide could do just as much harm to the integrity of the medical profession as physician-assisted suicide, especially in cases where there is a long-standing relationship between the patient and his doctor. He identified a tension between

\textsuperscript{63} Ibid., 1-2.


\textsuperscript{65} Ibid., 2.

\textsuperscript{66} Ibid., 3.

\textsuperscript{67} Ibid., 3.
the traditional role of physicians and the roles required of them today, which include the
termination of life support, withholding of medical treatment and terminal sedation.68

Justice Souter, concurring, wrote that:

Legislatures, ..., have superior opportunities to obtain the facts necessary for a judgment about the present controversy. Not only do they have more flexible mechanisms for factfinding than the Judiciary, but their mechanisms include the power to experiment, moving forward and pulling back as facts emerge within their own jurisdictions. There is, indeed, good reason to suppose that in the absence of a judgment for respondents here, just such experimentation will be attempted in some of the States.69

Justice Breyer argued in his concurring opinion that the Court should not decide the question of whether there is a fundamental right to physician-assisted suicide based on these cases, as the laws of New York and Washington do not "force a dying person" to suffer severe physical pain.70 He cited the discussion of the New York Task Force report regarding prescribing with a double effect. If a state law prevented the provision of such extreme palliative care, the question of fundamental rights would be more in focus. He closes by stating that this is an issue the Court may have to revisit.71

In Vacco v. Quill, the Supreme Court rejected by a 9-0 majority the idea that physician-assisted suicide must be legalized under the Equal Protection Clause of the Fourteenth Amendment because of its similarity to the termination of life support. Chief Justice Rehnquist, joined by Justices O'Connor, Scalia, Kennedy, and Thomas, delivered the opinion of the Court stating that there was no difference in treatment under the law allowing for termination of treatment, as everyone was entitled to refuse unwanted lifesaving medical treatment, provided they were competent. The same was true in regard

68 Ibid., 5.


71 Ibid., 2.
to the law prohibiting assisted suicide, as no one was permitted to assist a suicide. In each case, individuals were treated equally. The majority argued that “the distinction between assisting suicide and withdrawing life sustaining treatment, a distinction widely recognized and endorsed in the medical profession and our legal traditions, is both important and logical; it is certainly rational.”

The majority offered several reasons for this distinction. “First, when a patient refuses life sustaining medical treatment, he dies from an underlying fatal disease or pathology; but if a patient ingests lethal medication prescribed by a physician, he is killed by that medication.” Second, when a physician removes life support he is responding to a patient’s request and honoring his wishes. Also, when prescribing aggressive palliative care, the physicians’ intent was only to alleviate the patient’s pain and suffering. In contrast, a doctor who assisted with a suicide “must, necessarily and indubitable, intend primarily that the patient be made dead.” The Court noted that intent has long been used to distinguish between two acts that may have similar results. The majority granted that the line between the two types of treatment may not always been clear, “but certainty is not required, even were it possible. 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.”

The concurring opinions of Justices O’Connor, joined by Justices Ginsburg and Breyer, of Justice Souter, and of Justice Breyer were identical to the concurring opinion in Washington discussed above.

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73 Ibid., 2.

74 Ibid., 3.

75 Ibid., 4.
Justice Stevens also authored a concurring opinion, stating that there was little if any difference between the intent of a patient who refused life support or asked that it be withdrawn and that of a patient who requests physician-assisted suicide; “in both situations the patient is seeking to hasten a certain, impending death.” He agreed that in this particular case the law in question did not violate the Equal Protection Clause, but asserted that this holding “does not foreclose the possibility that some applications of the New York statute may impose an intolerable intrusion on the patient’s freedom.” Stevens closed by writing, “In my judgment, ..., it is clear that the so called ‘unqualified interest in the preservation of human life’ is not itself sufficient to outweigh the interest in liberty that may justify the only possible means of preserving a dying patient’s dignity and alleviation of her intolerable suffering.”

There were several interesting facets to these decisions. First, the Court rejected the Ninth Circuit’s interpretation of history in terms of suicide. This rejection was predictable, as discussed in the earlier review of that decision. The members of the Court, with one exception, also saw a clear distinction between physician-assisted suicide and the termination of life support, finding that one is a request for a service while the other is based on the avoidance of unwanted bodily intrusion (in Washington), or that one was based on respecting the patient’s wishes while the other is based on helping the patient die (in Vacco). This also was predictable if for no other reason than there was a clear precedent finding termination constitutionally permissible while there was no direct precedent in support of assisted suicide. This is a relatively conservative Court, and as such has been and will be unwilling to expand the limits of what previous decisions would allow. Rehnquist has never been known as a ground-breaker.

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77 Ibid., 6.
Several of the Justices based their concurrence in part on the idea of state support for terminal sedation and prescribing with a double effect as discussed in the New York Task Force report. The acceptance of these options ensures that patients are not forced to suffer from pain. However, the Task Force also reported that the laws of New York “pose obstacles to the availability of medication to relieve pain or severe discomfort,” including the inability of physicians to prescribe long-term supplies of medically necessary narcotics, the lack of access to these drugs on a trial basis, and the use of a triplicate prescription system for controlled substances which monitors the frequency with which physicians prescribe these medications. These obstacles lead to a perception on the part of physicians that they are being watched and could be sanctioned for their use of these substances.\textsuperscript{78}

The Court did not comment directly on this portion of the report and these types of laws are not unique to New York. Dr. Stan Naramore, a physician in Kansas, has been convicted of murder and attempted murder for two separate instances in 1992 where patients died due to palliative care with a double effect.\textsuperscript{79} The Court’s decision seemed to indicate that a State could not prosecute a doctor for causing the death of a patient which resulted from aggressive palliative care without violating the Constitution,\textsuperscript{80} which may help the appeal of Dr. Naramore and others prosecuted in the past.

All the Justices seemed to agree, at least for the present, that this is a better question for the state legislatures to consider. However, five of the six justices who wrote opinions left the question open to future consideration and did not reject such a right in principle.\textsuperscript{81}


This was probably the most important part of the decisions, as it placed this question back in the realm controlled by the states, some of which had been working on this question prior to the courts' becoming involved.

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CHAPTER 5

STATE ACTIONS

Several states had already begun the process of examining the issues involved in physician-assisted suicide prior to the Supreme Court's rulings in Washington and Vacco. Since 1991, voters in Washington, California and Oregon have voiced their opinions on this question through ballot initiatives. Oregon was the only state to approve of this practice and therefore will serve as the starting point for an overview of state actions in this area. Questions have been raised as to whether states can effectively regulate this area of medical service. There have been several proposed models for the regulation of physician-assisted suicide, each with some interesting ideas and each generating a new set of questions and criticisms. The complexity of issues presented by physician-assisted suicide often results in clear and strong feelings by those on each side, making this a political issue to be handled with extreme care.

Currently, thirty-six states¹ criminalize assisted suicide through statutes and another nine² through common law.³ The legality of physician-assisted suicide was not clear in the

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² The states are: Alabama, Idaho, Maryland, Massachusetts, Michigan, Nevada, South Carolina, Vermont, and West Virginia.

states of Utah, North Carolina, Wyoming, Ohio and Virginia. Several of these states have been active on this front recently. In 1996, Iowa and Rhode Island passed laws allowing for aggressive palliative care by physicians, even if the dosages of necessary medication hastened death, without these deaths being considered assisted suicide. In 1997, twenty-four state legislatures considered legislation dealing with different aspects of physician-assisted suicide, but only four enacted proposals. The Michigan House of Representatives recently passed a bill that would make physician-assisted suicide a felony, but would exempt aggressive palliative care. The law was expected to pass the state senate and be signed by the governor. This legislation was due in part to the unsuccessful prosecutions of Dr. Jack Kevorkian under current state laws. There is also a movement in Michigan to place an initiative on the ballot in the 1998 general election that would legalize physician-assisted suicide.

South Dakota and Virginia enacted legislation allowing for aggressive palliative care and the withholding of life support while protecting the physician from liability in these instances. Arizona’s Commission on Aging and End of Life Issues recently issued a report recommending that the “prohibition in state law against assisted suicide should be maintained.” They called for greater training of the state’s physicians in effective palliative care, public education on the right to refuse treatment and the use of legal means to control medical treatment such as a durable medical power of attorney or living will.

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5 Maria Rothouse, “Physician-Assisted Suicide,” Health Policy Tracking Service, 4, 31 December 1997, Denver, CO.


7 Maria Rothouse, “Physician-Assisted Suicide,” Health Policy Tracking Service, 4, 31 December 1997, Denver, CO.


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In Washington, a proposed initiative that would have legalized physician-assisted suicide and physician-aid-in-dying was defeated 54 percent to 46 percent. In California a similar law was defeated by the same percentage.\(^9\) The proposal in Oregon was targeted only at approval of physician-assisted suicide. On 8 November 1994 Oregon voters approved Question 16, the Oregon Death With Dignity Act, 52 percent to 48 percent.\(^10\) (See Appendix A for full text of the act.) The electoral victory ended up being the beginning of the question of physician-assisted suicide in Oregon rather than the end. The act was broken into several sections, the first of which gave a series of definitions for terminology used in the legislation, including that a terminal illness is defined as the patient having less than six months life expectancy. The second section established that only an individual over the age of eighteen who is a resident of Oregon and is suffering from a terminal illness can make a written request for this medical service, and that this written request must be witnessed by two people, one of whom cannot be related to the individual or stand to benefit from his death.\(^11\)

Section Three outlined the safeguards established, including the steps to ensure informed consent, require a second medical opinion regarding the terminal diagnosis, and possible psychiatric or psychological counseling for depression, requests that the patient notify his next of kin of his decision, inform the patient of the right to rescind such a request at any time, and require a waiting period of at least fifteen days between the oral and written requests and a forty-eight hour waiting period between the time of the written request and the provision of a prescription for physician-assisted suicide. A patient's use


of physician-assisted suicide shall have no effect on his life, health, or accident insurance as this act cannot be considered suicide. This section clearly stated this act is not authorizing any individual to "end a patient’s life by lethal injection, mercy killing or active euthanasia." Section Four dealt with immunities and liabilities and established that no civil or criminal liability can result from good faith compliance with this act. It also established that a physician has the right not to provide this service for his patients but must forward the medical records of a patient who wishes to see another physician. This section also established that a person who alters or forges a request for a prescription under this act, or who coerces or attempts to force a patient to request this service, would be guilty of a Class A felony under Oregon law.13

Passage of this law drew a great deal of criticism, even from some supporters of physician-assisted suicide. Dr. Timothy Quill, one of the defendants in the New York case reviewed earlier, argued that the requirement of a second medical opinion in the manner stated in this act would not necessarily protect against abuse in physician-assisted suicide. The reason for this was the lack of requirement that the second opinion be from a genuinely independent physician, leaving the possibility open that the attending physician could have a partner in his practice or a subordinate sign off as the second physician. The attending physician could also move from doctor to doctor until one was willing to sign off on the assisted suicide. Dr. Quill also stated that the “safeguard of witnesses brought to the bedside is unduly intrusive and unlikely to be effective in ensuring that the criteria of PAS have been met,” arguing that a trained palliative care consultant would be a much more effective witness.14 A second, and arguably more important, criticism of the act revolved

12 Ibid., 3-4.

13 Ibid., 5.

around the question of limiting physician-assisted suicide to only those suffering from a terminal illness. Many commentators sounded arguments similar to this: "it is inherently indefensible to limit the right to assisted suicide, if there is such a right, to the terminally ill with six months or less to live." This was the question raised in the lawsuit seeking to prevent this act from taking effect.

In *Lee v. Oregon* (1996), Judge Michael Hogan found that,

> since 'treating' physicians under Measure 16 are solely responsible for evaluating mental conditions of their patients which, under the civil commitment procedure, were required to be evaluated by licensed or certified mental health professionals, then Measure 16 discriminates against the terminally ill by favoring their suicidal deaths in a manner that is irrational. The fact that a terminally ill patient is required to be evaluated by a second 'consulting' physician who may be equally unqualified to evaluate the terminally ill patient's mental status does little to add sense to this situation.

Judge Hogan went on to question whether a physician who is not trained in diagnosing mental health could realistically determine the voluntariness of a patient's request for an assisted suicide. He stated that Measure 16 requires physicians to provide a "good faith" standard of care which releases some of the physicians from liability for negligence, while physicians are required to provide non-terminally ill patients with a 'reasonable' standard of care with full liability for negligence. "Because of this and the fact that death is the result, Measure 16 subjects terminally ill patients to irrational prejudice and violates the basic idea of equal protection, according to Judge Hogan. He argued that Measure 16 suffers from a lack of adequate safeguards against erroneous decisions on the

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17 Ibid., 5.

18 Ibid., 6.
part of physicians and therefore sustained an injunction preventing its implementation.\textsuperscript{19} This decision was appealed to the Ninth Circuit Court of Appeals.

Judge Brunetti wrote the opinion in \textit{Lee v. State of Oregon} (1997), in which the Circuit Court vacated the judgment of the district court for lack of Article III jurisdiction.\textsuperscript{20} Brunetti stated that the district court relied on a chain of “speculative contingencies,” and found a threat of injury to be “actual and imminent rather than conjectural or hypothetical,”\textsuperscript{21} and that the Ninth Circuit has “repeatedly found a lack of standing where the litigant’s claim relies upon a chain of speculative contingencies.”\textsuperscript{22}

Richard Coleson, one of the attorneys challenging Measure 16, filed an appeal of this decision with the Supreme Court and stated that “there are very strong constitutional arguments against Measure 16 ... [and] those arguments were not considered by the 9th Circuit.”\textsuperscript{23} However, in October, 1997, the Supreme Court refused to hear the case.\textsuperscript{24} This decision had the effect of placing the matter back in the hands of the Oregon legislature, which had already decided in May, 1997 to hold a special mail-only election on Measure 16. The ballots were to be counted as part of the general election in November, 1997.\textsuperscript{25} Oregon voters reaffirmed Measure 16 by a larger margin than the original vote, 60

\textsuperscript{19} Ibid., 7-8.


\textsuperscript{21} Ibid., 5.

\textsuperscript{22} Ibid., 6.


\textsuperscript{24} “Supreme Court Clears Way for Assisted Suicide Measure,” \textit{Las Vegas Review-Journal}, 15 October 1997, A5.

percent for and 40 percent against with voter turnout as large as had been seen in the last 34 years.

Another hurdle to Measure 16 finally being enacted came from an unlikely source. Senator Orrin Hatch (R-Utah) and Representative Henry Hyde (R-Illinois) wrote to the Drug Enforcement Administration (DEA) asking for an investigation into the possibility of suspending the DEA license of any physician who wrote a prescription under the Oregon law. The DEA has not approved any drugs for physician-assisted suicide and therefore such prescriptions would be for an illegal purpose. DEA Chief Thomas A. Constantine sent a letter to Oregon doctors warning against prescribing lethal medications. However, a full review by the Justice Department found that the DEA lacked the authority to sanction doctors who issued prescriptions under Measure 16. The law approved by voters in 1994 finally will take effect in at the beginning of 1998.

In a final twist, Oregon’s Health Services Commission voted 10-1 to cover the expenses of physician-assisted suicide under the state’s health plan for low-income residents, which gives some 270,000 people access to this service. This meant that the taxes collected from people who are opposed to physician-assisted suicide will help pay for


low-income individuals to obtain this service.\textsuperscript{32} There is some question as to the final result of the Health Services Commission decision, as Oregon's health plan receives federal matching Medicaid funds and Congress passed the Assisted Suicide Funding Restriction Act of 1997 which bans the use of federal funds "to provide any health care item or service furnished for the purpose of causing, or for the purpose of assisting in causing the death of any individuals, such as by assisted suicide, euthanasia, or mercy killing."\textsuperscript{33}

Florida has also visited this issue recently. Florida Circuit Judge S. Joseph Davis ruled in early 1997 that Dr. Cecil McLver could assist with the suicide of Charles Hall, an AIDS patient, under the Privacy Amendment of the Florida Constitution and the Due Process and Equal Protection Clauses of the Fourteenth Amendment of the U.S. Constitution. Judge Davis stated in his opinion that it would apply only to this particular case. McLver and Hall had never met prior to the filing of the lawsuit.\textsuperscript{34} This decision prompted the Florida Board of Medicine, by a vote of 9-6, to threaten to revoke the license of any physician who assists a patient to commit suicide.\textsuperscript{35} The decision was appealed to the Supreme Court of Florida.

Justice Grimes, writing for the court, dismissed the Due Process and Equal Protection questions based on the Supreme Court decisions in \textit{Washington} and \textit{Vacco}. This left only the question of the Privacy Amendment, and Grimes stated that "once a privacy right has been implicated, the state must establish a compelling interest to justify intruding into the

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privacy rights of an individual." The court identified four areas in which previous
decisions dealing with the privacy right had articulated legitimate state interests: "the
preservation of life, the protection of innocent third parties, the prevention of suicide, and
the maintenance of the ethical integrity of the medical profession." The court held that at
least three of the four recognized state interests, including the preservation of life,
preserving the integrity of the medical profession, and the prevention of suicide are
compelling enough to outweigh the privacy claims asserted here. Grimes argued that the
trial court had agreed with the patient that there was no "meaningful difference" between
physician-assisted suicide and the termination of medical treatment. The Supreme Court
did not agree, based on the distinction between the active role of the physician in physician-
assisted suicide versus the passive role in termination or treatment withdrawal.

Justice Kogan dissented, stating that "dying no longer falls into the neat categories our
ancestors knew. In today's world, we demean the hard reality of terminal illness to say
otherwise." He argued there is little difference between assistance and termination.
"What possible interest does society have in saving life when there is nothing of life to save
but a final convulsion of agony? The state has no business in this arena. Terminal illness
is not a portrait in blacks and whites, but unending shades of gray."

There have been several other regulatory schemes suggested for states to follow in
implementing physician-assisted suicide, two of which will be examined here. The first is
"A Model State Act to Authorize and Regulate Physician-Assisted Suicide," developed by a
group of lawyers, physicians, academics and Hemlock Society members in the Boston

37 Ibid., 4.
38 Ibid., 11.
39 Ibid., 12.
This act was not based only on terminal illness, but on "intractable and unbearable illness," defined as an illness that "cannot be cured or successfully palliated and ... that causes such severe suffering that a patient prefers death." The act also allows the physician or another individual to "be present and assist the patient at the time that the patient makes use of such means, provided that the actual use of such means is knowing, intentional and voluntary physical act of the patient."

The act required the physician to ensure the patient's decision is based on informed consent, and that the patient be made aware of all available support services available such as hospice care or palliative care, and undergo a consultation with a social worker if necessary. The act required that the above conversation be audio or video taped and witnessed by two individuals, at least one of whom is not involved with the care of the patient and does not stand to benefit in any way from the patient's death. The act stipulated the necessity for a second opinion from a consulting physician and a psychiatric or psychological examination of the patient. This act allows for those physicians who are "conscientiously opposed" to assisted suicide to refuse to provide such a service, and any health care facility that gives reasonable notice of a policy against assisted suicide can also refuse.

The second set of guidelines was created by the Bay Area Network of Ethics Committees (BANEQ). The guidelines stressed the importance of either hospice programs or specially-trained physicians in the implementation of physician-assisted suicide, as many

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Ibid., 2.

Ibid., 3-5.

Ibid., 3-4.

Ibid., 5.
primary care physicians do not have the skills necessary for helping patients cope with “difficult deaths.” The guidelines stated that no physician or other health care worker is required to participate in an assisted suicide. The patient must have had a terminal diagnosis with “a reasonable certainty of death within six months” with a second opinion to confirm the diagnosis, preferably from a physician with experience in palliative care. The patient must be assessed to be mentally competent by the physician or other practitioner in the psychological or social services community if the physician does not feel qualified to make such a determination. The patient’s consent must be witnessed by two people, one of whom is not related to the patient nor will benefit from the patient’s death. A second signature, again witnessed, needed to be obtained at least 48 hours after the first.

“These guidelines emphasize that the physician may aid the patient in the process of hastening death (i.e. by provision of oral or injectable medication, or the starting and maintaining of intravenous access,) but it should be the patient’s own physical effort that initiates and completes the process,” and the physician should remain “immediately and continuously available to the patient and family until death has occurred,” according to the guidelines. The cause of death listed on the death certificate should be the underlying disease and not physician-assisted suicide.

There were a couple of critical distinctions between these two proposals and the one adopted in Oregon. Each of these acts allowed ‘physician-aid-in-dying,’ where the attending physician remains with the patient and can help to administer the drugs intravenously. Both proponents and opponents of physician-assisted suicide have argued


48 Ibid., 43.
that the distinction between the two practices is textual rather than actual.49 This was important as intravenously administered drugs are a much more effective manner in which to induce death. Pills alone, "the 60 to 100 you must keep in your body to induce death—fail in up to 25 percent of the cases."50 The question of the constitutionality of this distinction has also been raised, as some argue that this imposes an undue burden on patients who meet the other criteria for physician-assisted suicide but are unable to swallow due to the symptoms of their illness.51 The "Model Act" did not require a terminal diagnosis, important because this would allow patients suffering from AIDS and other degenerative diseases such as Alzheimer's to obtain physician-assisted suicide. These groups were excluded under the Oregon law.

Opponents of physician-assisted suicide have argued that regulation by state governments could prove impossible, but it could be argued that the similarities among the three plans demonstrate otherwise. Each relied on a foundation of a terminal diagnosis (at least in part) confirmed by a second opinion with approximately six months of life remaining, patient competence, psychological screening for depression or other mental disorders, informed consent, voluntary request for physician-assisted suicide, counseling of other options including palliative and hospice care, independent witnesses, legal immunity for physicians operating under the acts, and the allowance for 'conscientious objectors' within the medical community. The six-month window has some precedence in federal law, as a patient must have six months or less to live to qualify for Medicare


coverage of hospice care. Some have suggested that rather than an independent physician providing a second opinion, a group of independent palliative care specialists could be formed to provide this second opinion on a regional basis, which would address the problems of a lack of specialized training on the part of the physician in palliative care and the question of independence on the part of the consulting physician.

The states have been active on the question of physician-assisted suicide for some time. Oregon has become the first state to legalize it, and other states have made aggressive palliative care easier to provide and obtain. There are several solid models with which states and other interested parties can work if they are interested in changing this area of their state laws. Consensus definitions on terms have begun to emerge and will continue to do so as the 'experiment' in Oregon and elsewhere continues.

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CHAPTER 6

CONCLUSION

Physician-assisted suicide should be legalized. However, the Supreme Court was absolutely correct in holding that physician-assisted suicide is not a fundamentally protected right under the Constitution, and held that the question would be better left to the voters of each state to decide. The many-faceted arguments for and against physician-assisted suicide are compelling and will be examined, including what is arguably the most interesting ethical dilemma presented by these cases: the question of whether there is a difference between the withdrawal/termination of life support and physician-assisted suicide. The discussion will then turn to why the Court was correct in exercising judicial restraint in these cases, and I will offer a new formula for use of judicial authority in the activism/restraint debate. The final section of this chapter will deal with the possibility of effective regulation of physician-assisted suicide by the states.

Is there a difference between withdrawal/termination of life support and physician-assisted suicide? This question seems to be at the core of the question about assisted suicide in general and a matter of personal opinion rather than an argument based on solid evidence. Legally, there is no doubt that there is a difference. The Supreme Court held in the Cruzan decision and in the two physician-assisted suicide cases that termination was protected by the Constitution as a prevention of medical battery, while physician-assisted suicide enjoys no such constitutional protection. However, the Court was not unanimous regarding this difference. Justice Scalia argued that the distinction between the two has little creditability. Ronald Dworkin, in his book Life’s Dominion, writes that this distinction “produces the apparently irrational result that people can choose to die lingering
deaths by refusing to eat, by refusing treatment that keeps them alive, or by being disconnected from respirators and suffocating, but they cannot choose a quick, painless death that their doctors could easily provide."

The argument in general centers on two points, one based on the distinction between an ‘active’ versus a ‘passive’ role for the physician, or what some have called a ‘positive’ vs. ‘negative’ right, and the second dealing with the cause of death in each case. Those who favor the distinction believe the physician takes an active role in causing death in physician-assisted suicide while he has a passive role in the death resulting from termination. This group believes that the underlying disease causes death in instances of termination, while the prescribed drugs are the cause of death in assisted suicide. "The distinction between ‘killing’ and ‘letting die’ may not be perfectly logical, but, unlike assisted suicide or euthanasia, ‘letting die’ is a practical condition upon the successful operation of medicine," according to Yale Kamisar, a law professor at the University of Michigan and a leading opponent of physician-assisted suicide.

Those who believe that the distinction has no merit argue that the role of the physician in termination is greater than that in physician-assisted suicide, as the physician often will wean the patient off a respirator rather than abruptly shut it off or will administer some sort of sedative to make the patient as comfortable as possible during the process. In terms of the cause of death, this group argues that it is the same in both cases: the actions of a physician respecting the wishes of a terminally ill patient. In each case, the interests of the patient are the same: “both have a common interest in choosing how to die.”

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before, this is a matter of personal choice. For me, there is little, if any, difference between
the two requests.

There are many other levels on which the debate about physician-assisted suicide takes
place. The strongest arguments in favor of physician-assisted suicide find their source in
personal autonomy and self-respect, arguing that people should have the right to control the
time and manner of their own death, especially in cases of terminal or debilitating illness.
“Decisions about life and death are the most important, the most crucial for forming and
expressing personality, that anyone makes; we think it crucial to get these decisions right,
but also crucial to make them in character, and for ourselves,” according to Dworkin.4
Unrelieved pain is not the only reason that might motivate a person to seek physician-
assisted suicide. Others are rooted in self-respect. The loss of dignity brought on by
terminal illness is often a far greater burden than any physical pain. This loss can result in
a quality of life that is so low that an individual decides he or she no longer wishes to live.
This is probably the area most overlooked by those who argue against physician-assisted
suicide because of the availability of palliative care. Aggressive pain management cannot
always return a person’s dignity.

The most common argument against physician-assisted suicide is that it represents a
‘slippery slope,’ and that once one form of euthanasia is legalized there is no stopping other
forms from being legalized.

Suppose a right to physician-assisted suicide for the terminally ill
were established? Is there any doubt that lawyers would soon appear
in court arguing that (a) the new right could not be limited to the
terminally ill, but had to apply as well to others who would
experience unacceptable suffering for many years; and (b) the new
right could not be limited to assisted suicide, but had to include active
euthanasia, at least for those severely ill patients who were unable to
perform the ‘final act’ themselves?5

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5 Congress, House, Committee on the Judiciary, Subcommittee on the Constitution,
Against Assisted Suicide—Even a Very Limited Form by Yale Kamisar, 7, 110th
Congress, 1st session, 29 April 1996, available from
Another argument against physician-assisted suicide is based on the lack of access to quality medical care across the country which could result in some failing to receive aggressive palliative care or mental health evaluations necessary when dealing with terminal illness. Related to this problem is the lack of long-standing physician-patient relationships, which are seen as necessary for the physician to make an accurate diagnosis of depression and are often absent in the current managed-care environment. The New York medical board cited this type of relationship when it refused to sanction Dr. Quill for his assisting a suicide in 1991. With the current trend towards managed health care, some fear that legalization of physician-assisted suicide could lead to insurance companies refusing to pay for hospice care or long-term hospitalization for the terminally ill.

It was stated earlier that the Supreme Court’s decisions in the physician-assisted suicide cases demonstrated restraint on the part of the Court. The debate about the proper role of the courts in this country is almost as old as the nation itself and has centered around the question of which is proper: activism or restraint. Often the sides are linked ideologically as well, with activists being seen as liberal and restraintists as conservatives. This may be true for current circumstances, but has not always been the case. During the first part of the New Deal, it was conservatives who favored an active judiciary while liberals urged more restraint.

There are several characteristics included in judicial activism: relative unconcern with the intentions of the framers; a lessened emphasis on precedent in deciding current cases; lessened enforcement of procedural principles such as standing or ripeness; reduced deference to decisions by the legislative and executive branches of government; broad holdings and opinions based on broad constitutional interpretations; and greater judicial remedial powers. Judicial restraint is primarily based on the idea that judges should not

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confuse their own ideas and beliefs with the law and should attempt to ignore the former and apply the latter. Another main tenet is that of deference to the political branches of government. Actions of these branches should be overturned only if they clearly violate the Constitution. Bradley Cannon has identified six dimensions upon which a particular decision can be evaluated to determine if it demonstrates activism or restraint:

1. Majoritarianism - the degree to which policies adopted through democratic processes are judicially negated.
2. Interpretive Stability - the degree to which earlier court decisions, doctrines, or interpretations are altered.
3. Interpretive Fidelity - the degree to which constitutional provisions are interpreted contrary to the clear intentions of their drafters or the clear implications of the language used.
4. Substance/Democratic Process Distinction - the degree to which judicial decisions make substantive policy rather than affect the preservation of democratic political processes.
5. Specificity of Policy - the degree to which a judicial decision establishes policy itself as opposed to leaving discretion to other agencies or individuals.
6. Availability of an Alternative Policymaker - the degree to which a judicial decision supersedes serious consideration of the same problem by other governmental agencies.

Neither judicial activism nor judicial restraint can be considered entirely correct in terms of establishing a "determinative horizon" for constitutional law. John Hart Ely, in his book *Democracy and Distrust*, suggests another role for the courts, which he calls a "representation-reinforcing approach." In this approach, the judiciary becomes involved only when the process of government breaks down, rather than when a legislative outcome seems disagreeable. He argues that the process can break down only when those in power

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control and curtail the channels of political change to prevent such change, or when representatives are "systematically disadvantaging some minority out of simple hostility or a prejudiced refusal to recognize commonalities of interest, and thereby denying that minority the protection afforded other groups by a representative system." Ely argues that judges are well-suited to fill this role.

I have a different role in mind for judges, especially in cases arising under the Fourteenth Amendment. Justice Scalia is an ardent supporter of judicial restraint, and this seems to be the proper guideline for the Court to follow in the vast majority of cases. The only way for there to be some sort of recognizable stability and consistency to judicial decisions is to base them on some sort of foundation accessible to everyone. The Constitution provides just such a foundation. However, there are times when the Court needs to be willing to step outside this formula and be willing to fill a void left by the other branches of government, federal or state. There are several examples in which the Court has done just that, in cases such as Brown v. Board of Education (1954), Griswold v. Connecticut (1965), and Roe v. Wade (1973), to name just a few. In cases such as these, where an equal protection or substantive due process question is involved, I believe the courts should invoke a sliding scale based on two criteria: (1) the size of the segment of the population whose rights are affected and the percentage of that segment likely to benefit from judicial action, and (2) the chances for a democratic solution to the problem in question. This is not radically different from Ely's proposal, as each calls for judicial intervention when there is a problem within the system. The sliding scale system allows more room for judges to use their discretion. The three cases mentioned above can help illustrate this idea, under which two decisions would be considered correct and one flawed.

In Brown, the Supreme Court ended the idea of 'separate but equal' in terms of public education, allowing black children to go to school with white children. Under the sliding scale...

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scale theory this decision would be considered a just and proper use of judicial activism, as the entire black race in the South and elsewhere benefited from the increased educational opportunities this ruling would afford. The chance of a democratic solution within the various state governments in the South or by the elected branches of the federal government was extremely unlikely, giving further sanction to this activism. In *Griswold*, the Court overturned a Connecticut ban on the use of contraceptives "by any person," due mainly to its interference with marital relations.  

This decision would also be considered a just use of activism under the proposed scheme, as the law affected every married person within the state, and the chances for a democratic reversal were limited as several attempts to repeal the measure in the state legislature had failed. In both of these cases, the population segment whose rights were in question was substantial and the portion of that group who stood to use and benefit from the new right was significant.

The decision in *Roe* was different and would not be considered just under the sliding scale. The segment of the population whose rights were in question was certainly significant, that being women in general, but the percentage of this segment standing to benefit or make use of the proposed change was very small. More importantly, there had been some movement in the various state legislatures toward a relaxing of the anti-abortion statutes. If this movement had been allowed to continue, there is a good chance that we

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would have had abortion legalized in some states, and would have been able to avoid the bitter conflicts and violence between the two sides on this question. There has been a great deal of violence surrounding the aborting debate, including the shooting of several abortion clinic workers, the bombing of thirty-two clinics and another thirty-eight being destroyed by arson.¹⁷ There is something almost magical about the democratic process in this country. Even on very contentious proposals, if people are allowed the chance to vote (or have someone vote on their behalf in Congress), they are more willing to accept the outcome even if they end up on the losing side. The first example of this phenomenon in this country was the ratification of the Constitution, which had been preceded by a heated and articulate debate. However, once the document was ratified, everyone accepted it and those who had problems worked through the newly adopted system to effect change and thereby legitimize the processes established.¹⁸ Justice Scalia criticized the holding in Roe in his dissent in Casey, stating that "by foreclosing all democratic outlet for the deep passions this issue arouses, by banishing the issue from the political forum that gives all participants, even the losers, the satisfaction of a fair hearing and an honest fight, by continuing the imposition of a rigid national rule instead of allowing for regional differences, the Court merely prolongs and intensifies the anguish."¹⁹

It is based on these same potential problems that I find the Court’s action on the question of physician-assisted suicide to be valid. The segment of the population possibly affected by the right in question is vast, as everyone is going to die and a large percentage of those deaths will occur as the result of some sort of terminal illness. However, the number of people in that group who would avail themselves of that right would be small.

probably no more than five percent. More importantly, the political process is beginning to move in this area, as many states are addressing issues related to physician-assisted suicide and Oregon has legalized this procedure. The country will be better served by allowing this process to continue, even to the point of there being a ‘checkerboard’ pattern of states having legalized assisted suicide in different forms. This will allow the residents of the states to make these decisions, either through the initiative process or through legislative actions. There are several issues where a ‘checkerboard’ pattern already exists among the states, such as gambling, state income taxes, inheritance taxes, prostitution, and many others. There is no compelling reason, given the number of people likely to choose physician-assisted suicide and the movement on the issue in the states, for the Court to issue a national decree.

The sliding scale theory would have two fundamental results. One, it places discretionary power in the hands of federal judges. This is intentional and done in an attempt to help the courts address one of the most consistent problems under our structure of government, that of tyranny of the majority. This was a concern of the founders and continues to be of concern today. The courts are often the last protection against this tyranny and need to have the flexibility this theory affords in order to deal with problems that the federal and state governments are unable or unwilling to solve. The fact that judges are not elected and therefore insulated (at least to a certain degree) from political pressure is a positive in terms of dealing with problems such as these. It is political pressure that often paralyzes the elected branches of federal and state government. The second outcome is to place a premium on the democratic process, especially where there is the probability of a remedy through this process. People are much more willing to accept an unsatisfactory outcome if they had a voice in that outcome. This scheme would require a great deal of judges, but they are in a unique position to do what is correct rather than what is politically

expedient. This theory opens the possibility of abuse on the part of the judiciary, but no more than the current system.

Can the states effectively regulate physician-assisted suicide? At this time there is no quantitative or qualitative data with which to answer this question, only opinions. As one set of authors put it, there are "no a priori reasons for assuming that regulating PAS will necessarily fail." Others have argued that it will prove impossible to control and the possibility of abuse is so great that it should not be legalized. The only way to answer this question is to observe the results of legalized physician-assisted suicide in Oregon, and those of any other state that may legalize this procedure. The Oregon statute was used for the first time in March, 1998 by a woman suffering from terminal breast cancer, so the data pool is being established. There have been problems as well, as the Oregon Medical Board has sued the Oregon Board of Pharmacy over pharmacies requiring doctors to identify prescriptions intended for physician-assisted suicide. Pharmacists want the identification so that those who do not approve of physician-assisted suicide are able to decline filling the prescriptions under the "conscience clause" of the Oregon law. This demonstrates the difficulty in attempting to introduce legislation of this type and the necessity for a slow course at the individual state level rather than a nation one. However, the possible benefits to society in general, especially those faced with a long and debilitating illness and a death devoid of their definition of dignity, justify the experiment.

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APPENDIX A

THE OREGON DEATH WITH DIGNITY ACT

SECTION 1

GENERAL PROVISIONS

1.01 Definitions The following words and phrases, whenever used in this Act, shall have the following meanings:

(1) “Adult” means an individual 18 years of age or older.
(2) “Attending physician” means the physician who has primary responsibility for the care of the patient and treatment of the patient’s disease.
(3) “Consulting physician” means the physician who is qualified by specialty or experience to make a professional diagnoses and prognosis regarding the patient’s disease.
(4) “Counseling” means a consultation between a state licensed psychiatrist or psychologist and a patient for the purpose of determining whether the patient is suffering from a psychiatric or psychological disorder, or depression causing impaired judgment.
(5) “Health care provider” means a person licensed, certified, or otherwise authorized or permitted by the law of this state to administer health care in the ordinary course of business or practice or a profession, and includes a health care facility.
(6) “Incapable” means that in the opinion of a court or in the opinion of the patient’s attending physician or consulting physician, a patient lacks the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the patient’s manner or communication if those persons are available. Capable means not incapable.
(7) “Informed decision” means a decision by a qualified patient, to request and obtain a prescription to end his or her life in a humane and dignified manner, that is based on an appreciation of the relevant facts and after being fully informed by the attending physician of:
(a) his or her medical diagnosis;
(b) his or her prognosis;
(c) the potential risks associated with taking the medication to be prescribed;
(d) the probable result of taking the medication to be prescribed;
(e) the feasible alternatives, including, but not limited to, comfort care, hospice care and pain control.
(8) “Medically confirmed” means the medical opinion of the attending physician has been confirmed by a consulting physician who has examined the patient and the patient’s relevant medical records.
(9) “Patient” means a person who is under the care of a physician.
(10) “Physician” means a doctor of medicine or osteopathy licensed to practice medicine by the Board of Medical Examiners for the State of Oregon.
(11) "Qualified patient" means a capable adult who is a resident of Oregon and has satisfied the requirements of this Act in order to obtain a prescription for medication to end his or her life in a humane and dignified manner.
(12) "Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six (6) months.

SECTION 2

WRITTEN REQUEST FOR MEDICATION TO END ONE'S LIFE IN A HUMANE AND DIGNIFIED MANNER

2.01 Who may initiate a written request for medication

An adult who is capable, is a resident of Oregon, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner in accordance with this Act.

2.02 Form of the written request

(1) A valid request for medication under this Act shall be in substantially the form described in Section 6 of this Act, signed and dated by the patient and witnessed by at least two individuals who, in the presence of the patient, attest that to the best of their knowledge and belief the patient is capable, acting voluntarily, and is not being coerced to sign the request.
(2) One of the witnesses shall be a person who is not:
   (a) A relative of the patient by blood, marriage or adoption;
   (b) A person who at the time the request is signed would be entitled to any portion of the estate of the qualified patient upon death under any will or by operation of law; or
   (c) An owner, operator or employee of a health care facility where the qualified patient is receiving medical treatment or is a resident.
(3) The patient's attending physician at the time the request is signed shall not be a witness.
(4) If the patient is a patient in a long term care facility at the time the written request is made, one of the witnesses shall be an individual designated by the facility and having the qualifications specified by the Department of Human Resources by rule.

SECTION 3

SAFEGUARDS

3.01 attending physician responsibilities

The attending physician shall:
(1) Make the initial determination of whether a patient has a terminal disease, is capable, and has made the request voluntarily;
(2) Inform the patient of;
   (a) his or her medical diagnosis;
   (b) his or her prognosis;
(c) the potential risks associated with taking the medication to be prescribed;
(d) the probable result of taking the medication to be prescribed;
(e) the feasible alternatives, including, but not limited to, comfort care, hospice care and pain control.
(3) Refer the patient to a consulting physician for medical confirmation of the diagnosis, and for determination that the patient is capable and acting voluntarily;
(4) Refer the patient for counseling if appropriate pursuant to Section 3.03;
(5) Request that the patient notify next of kin;
(6) Inform the patient that he or she has an opportunity to rescind the request at any time and in any manner, and offer the patient an opportunity to rescind at the end of the 15 day waiting period pursuant to Section 3.06;
(7) Verify, immediately prior to writing the prescription for medications under this Act, that the patient is making an informed decision;
(8) Fulfill the medical record documentation requirements of Section 3.09;
(9) Ensure that all appropriate steps are carried out in accordance with this Act prior to writing a prescription for medication to enable a qualified patient to end his or her life in a humane and dignified manner.

3.02 Consulting Physician Confirmation

Before a patient is qualified under this Act, a consulting physician shall examine the patient and his or her relevant medical records and confirm, in writing, the attending physician’s diagnosis that the patient is suffering from a terminal disease, and verify that the patient is capable, is acting voluntarily and has made an informed decision.

3.03 Counseling Referral

If in the opinion of the attending physician or the consulting physician a patient may be suffering from a psychiatric or psychological disorder, or depression causing impaired judgment, either physician shall refer the patient for counseling. No medication to end a patient’s life in a humane and dignified manner shall be prescribed until the person performing the counseling determines that the person is not suffering from a psychiatric or psychological disorder, or depression causing impaired judgment.

3.04 Informed Decision

No person shall receive a prescription for medication to end his or her life in a humane and dignified manner unless he or she has made an informed decision as defined in Section 1.01(7). Immediately prior to writing a prescription for medication under this Act, the attending physician shall verify that the patient is making an informed decision.

3.05 Family Notification

The attending physician shall ask the patient to notify next of kin of his or her request for medication pursuant to this Act. A patient who declines or is unable to notify next of kin shall not have his or her request denied for that reason.

3.06 Written and Oral Requests

In order to receive a prescription for medication to end his or her life in a humane and dignified manner, a qualified patient shall have made an oral request and a written request, and reiterate the oral request to his or her attending physician no less than fifteen (15) days after making the initial oral request. At the time the qualified patient makes his or her
second oral request, the attending physician shall offer the patient an opportunity to rescind the request.

3.07 Right to Rescind Request

A patient may rescind his or her request at any time and in any manner without regard to his or her mental state. No prescription for medication under this Act may be written without the attending physician offering the qualified patient an opportunity to rescind the request.

3.08 Waiting Periods

No less than fifteen (15) days shall elapse between the patient’s initial and oral request and the writing of a prescription under this Act. No less than 48 hours shall elapse between the patient’s written request and the writing of a prescription under this Act.

3.09 Medical Record Documentation Requirements

The following shall be documented or filed in the patient’s medical record:
(1) All oral requests by a patient for medication to end his or her life in a humane and dignified manner;
(2) All written requests by a patient for medication to end his or her life in a humane and dignified manner;
(3) The attending physician’s diagnosis and prognosis, determination that the patient is capable, acting voluntarily and has made an informed decision;
(4) The consulting physician’s diagnosis and prognosis, and verification that the patient is capable, acting voluntarily and has made an informed decision;
(5) A report of the outcome and determinations made during counseling, of performed;
(6) The attending physician’s offer to the patient to rescind his or her request at the time of the patient’s second oral request pursuant to Section 3.06; and
(7) A note by the attending physician indicating that all requirements under this Act have been met and indicating the steps taken to carry out the request, including a notation of the medication prescribed.

3.10 Residency Requirements

Only requests made by Oregon resident, under this Act, shall be granted.

3.11 Reporting Requirements

(1) The Health Division shall annually review a sample of records maintained pursuant to this Act;
(2) The Health Division shall make rules to facilitate the collection of information regarding compliance with this Act. The information collected shall not be a public record and may not be made available for inspection by the public;
(3) The Health Division shall generate and make available to the public an annual statistical report of information collected under Section 3.11 (2) of this Act.

3.12 Effect on Construction of Wills, Contracts and Statutes

(1) No provision in a contract, will or other agreement, whether written or oral, to the extent the provision would affect whether a person may make or rescind a request for medication to end his or her life in a humane and dignified manner, shall be valid;
(2) No obligation owing under any currently existing contract shall be conditioned or affected by the making or rescinding of a request, by a person, for medication to end his or her life in a humane and dignified manner.

3.13 Insurance or Annuity Policies

The sale, procurement, or issuance of any life, health, or accident insurance or annuity policy or the rate charge for any policy shall not be conditioned upon or affected by the making or rescinding of a request, by a person, for medication to end his or her life in a humane and dignified manner. Neither shall a qualified patient's act of ingesting medication to end his or her life in a humane and dignified manner have an effect upon a life, health, or accident insurance or annuity policy.

3.14 Construction of Act

Nothing in this Act shall be construed to authorize a physician or any other person to end a patient's life by lethal injection, mercy killing or active euthanasia. Actions taken in accordance with this Act shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law.

SECTION 4

IMMUNITIES AND LIABILITIES

4.01 Immunities

Except as provided in Section 4.02:
(1) No person shall be subject to civil or criminal liability or professional disciplinary action for participation in good faith compliance with this Act. This includes being present when a qualified patient takes the prescribed medication to end his or her life in a humane and dignified manner;
(2) No professional organization or association, or health care provider, may subject a person to censure, discipline, suspension, loss of license, loss of privileges, loss of membership or other penalty for participation or refusing to participate in good faith compliance with this Act;
(3) No request by a patient for or provision by an attending physician of medication in good faith compliance with the provisions of this Act shall constitute neglect for any purpose of law or provide the sole basis for the appointment of a guardian or conservator;
(4) No health care provider shall be under any duty, whether by contract, by statute or by any other legal requirement to participate in the provision to a qualified patient of medication to end his or her life in a humane and dignified manner. If a health care provider is unable or unwilling to carry out a patient's health care provider shall transfer, upon request, a copy of the patient's relevant medical records to the new health care provider.

4.02 Liabilities

(1) A person who without authorization of the patient willfully alters or forges a request for medication or conceals or destroys a rescission of that request with the intent or effect of causing the patient’s death shall be guilty of a Class A felony;
(2) A person who coerces or exerts undue influence on a patient to request medication for the purpose of ending the patient's life, or to destroy a rescission of such a request, shall be guilty of a Class A felony;
(3) Nothing in this Act limits further liability for civil damages resulting from other negligent conduct or intentional misconduct by any persons;
(4) The penalties in this Act do not preclude criminal penalties applicable under other law for conduct which is inconsistent with the provisions of this Act.

SECTION 5
SEVERABILITY

5.01 Severability

Any section of this Act being held invalid as to any person or circumstance shall not affect the application of any other section of this Act which can be given full effect without the invalid section or application.

SECTION 6
FORM OF THE REQUEST

6.01 Form of the Request

A request for a medication as authorized by this Act shall be in substantially the following form:

REQUEST FOR MEDICATION TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER

I, ______________________________, am an adult of sound mind.

I am suffering from ______________________________, which my attending physician has determined is a terminal disease and which has been medically confirmed by a consulting physician.

I have been fully informed of my diagnosis, prognosis, the nature of medication to be prescribed and potential associated risks, the expected result, and the feasible alternatives, including comfort care, hospice care and pain control.

I request that my attending physician prescribe medication that will end my life in a humane and dignified manner.

INITIAL ONE:

_____ I have informed my family of my decision and taken their opinions into consideration.

_____ I have decided not to inform my family of my decision.

_____ I have no family to inform of my decision.
I understand that I have the right to rescind this request at any time.

I understand the full import of this request and I expect to die when I take the medication to be prescribed.

I make this request voluntarily and without reservation, and I accept full moral responsibility for my actions.

Signed: __________________________________________
Dated: __________________________________________

DECLARATION OF WITNESSES
We declare that the person signing this request:
(a) Is personally known to us or has provide proof of identity;
(b) Signed this request in our presence;
(c) Appears to be of sound mind and not under duress, fraud or undue influence;
(d) Is not a patient or whom either of us is attending physician.

_____________________________________________ Witness 1/
Date

_____________________________________________ Witness 2/
Date

Note: One witness shall not be a relative (by blood, marriage or adoption) of the person signing this request, shall not be entitled to any portion of the person's estate upon death and shall not own, operate or be employed at a health care facility where the person is a patient or resident. If the patient is an inpatient at a health care facility, one of the witnesses shall be an individual designated by the facility.
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