

# Annotated Legal Cases on Physician-Assisted Suicide in the USA

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## Keywords

assisted, assisting, Baxter, compassion, case, cases, death, die, Donaldson, dying, euthanasia, Glucksberg, Kevorkian, law, laws, legal, life, McIver, mercy killing, Oregon, physician, physician-assisted suicide, Quill, Sanderson, suicide, United States, U.S., U.S.A., Vacco

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## Introduction

This essay contains annotated quotations from the major reported cases in the USA on the alleged legal right of an adult patient with a terminal illness to receive a lethal dose of drugs from his/her physician. I list the cases in chronological order in this essay, so the reader can easily follow the historical development of a national phenomenon.

I have an earlier collection of annotated court cases on the legal right of a mentally competent adult to refuse medical care, even if that refusal would cause the patient's death — the so-called right-to-die — which is posted on the Internet at <http://www.rbs2.com/rtd.pdf> . That essay includes a discussion of seven cases:

1. *Matter of Quinlan*, 355 A.2d 647 (N.J. 1976).
2. *Eichner v. Dillon*, 426 N.Y.S.2d 517 (N.Y.A.D. 2 Dept. 1980), *mod. sub nom. Matter of Storar*, 420 N.E.2d 64, 438 N.Y.S.2d 266 (N.Y. 1981) (case of Brother Fox).
3. *Matter of Welfare of Colyer*, 660 P.2d 738 (Wash. 1983).
4. *Matter of Conroy*, 486 A.2d 1209 (N.J. 1985).
5. *Bouvia v. Superior Court*, 225 Cal.Rptr. 297 (Cal.App. 2 Dist. 1986).
6. *Cruzan v. Harmon* 760 S.W.2d 408 (Mo. 1988), *aff'd*, 497 U.S. 261 (1990).
7. Matter of Theresa Schiavo in Florida state courts and U.S. federal courts.

The problem of withdrawal of life-support machinery (e.g., ventilator or feeding tube) from patients in a persistent vegetative state was solved in a series of cases, beginning with *Quinlan* and ending with *Cruzan*. Furthermore, courts have had no difficulty in allowing conscious adult quadriplegics to refuse food or to request disconnection of their ventilator, see *Bouvia* and similar cases cited in my right-to-die essay.

In contrast with the “right-to-die” cases in the previous paragraph, this essay considers physician-assisted suicide, where the physician either (1) prescribes a lethal dose of medication, knowing that the patient will use that medication to commit suicide, or (2) personally administers a lethal dose of medication.

I am interested in this subject for two different reasons. First, I am interested in constitutional privacy law,<sup>1</sup> which sets limits on the power of governments to intrude in personal choices and Second, I am interested in the relationship between technology and change in the law. Prior to the 1960s, people tended to die quickly. Modern medical technology can prolong life, even when the quality of life (according to the affected individual) is not worth living. People with a terminal illness can suffer great pain during the last year of their life, have no reasonable hope of recovery, and consume large amounts of money in health-care expenses. The legal and religious rules that worked well prior to the 1960s are suddenly not only inadequate, but also harsh and cruel.

This essay is difficult to organize, because there are a number of different issues involved in why assisted suicide is currently a felony in most states in the USA, and there are more issues involved in why physician-assisted suicide should be lawful. I begin by explaining why some mentally competent people want to die. Beginning at page 13, I list the state statutes that prohibit assisted suicide. I then list some of the court cases that apply these statutes, and explain why consent of the victim is *not* a defense to the crime of assisting a suicide. The bulk of this essay is quotations from, and a discussion of, various court cases in which plaintiffs have sought the judicial declaration of a new legal right for physician-assisted suicide. I have arranged these cases in approximately historical order, so readers can follow the historical development of the law in this area. As discussed beginning at page 31 below, federal courts in Washington state (i.e., *Glucksberg*) and in New York state (i.e., *Quill*) found a legal right in the U.S. Constitution to physician-assisted suicide, but the U.S. Supreme Court unanimously rejected that alleged right. Beginning at page 80 below, I tersely discuss the cases involving Dr. Kevorkian.

I wrote the first drafts of this essay in May 2005. In May 2012, I added a current list of state statutes on assisted suicide, and added a discussion of five cases.

#### definitions

Physicians, attorneys, and judges commonly use words like “euthanasia”, “mercy killing”, and “physician-assisted suicide” without defining precisely what these words mean.

*Euthanasia* (from the Greek words for “good death”) is a general term that indicates any lethal act that ends a suffering person’s life in a quick, painless way.

*Physician-assisted suicide* means that a physician prescribes a lethal dose of medicine, knowing that the patient will use it to commit suicide. To be a suicide, the victim (patient) himself must do the lethal act of taking the lethal dose of medicine. Technically, this is *not* a suicide, because the legal cause of death is the underlying disease or condition.

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<sup>1</sup> Ronald B. Standler, *Fundamental Rights Under Privacy in the USA*, <http://www.rbs2.com/priv2.pdf> (Aug 1998).

When a physician personally injects a lethal dose of drugs into a patient, with the intent on ending the patient's life, terms such as "mercy killing", "active euthanasia", or "physician-assisted death" are commonly used. Such acts are *not* discussed in this essay. In the situation where the physician injects a lethal dose of drugs, none of the conventional terms indicates the critically important distinction between (1) a patient who rationally and repeatedly requests to die and (2) a physician who decides that the patient is better off dead, but the patient's wish is unknown. While mercy killing is considered murder, the killer often does *not* flee from the crime scene, unlike a conventional murderer.

Below, at page 114, I suggest that the phrase "physician-assisted suicide" is a misnomer. I use "physician-assisted suicide" because it is the conventional label used in the medical journals and court cases.

#### disclaimer

This essay is intended only to present general information about an interesting topic in law and is *not* legal advice for your specific problem. See my disclaimer at <http://www.rbs2.com/disclaim.htm> . Furthermore, the reader is cautioned that the law on this topic varies from state to state, and also changes with time. Therefore, reading the excerpts from court cases in this essay does *not* necessarily tell you the current law in your state.

## Patients Who Want to Die

It makes sense to present here, collected from various court cases, some examples of specific patients who desired and requested physician-assisted suicide. These examples show the real need for humane and merciful termination of life. These examples are *not* a parade of hypothetical horrible possibilities, they are *real* situations taken from court cases.

In the case of *Washington v. Glucksberg*, the three patient-plaintiffs who were suffering from terminal illnesses were described by the trial court in the following words:

FN2. To preserve their privacy, the patient plaintiffs have chosen to use pseudonyms. The court also notes that plaintiffs Jane Roe and John Doe have died since this case began. However, for purposes of examining the legal issue raised, the court will set forth their circumstances as they existed at the time the complaint was filed.

Jane Roe is a 69-year-old retired pediatrician who has suffered since 1988 from cancer which has now metastasized throughout her skeleton. Although she tried and benefitted temporarily from various treatments including chemotherapy and radiation, she is now in the terminal phase of her disease. In November of 1993, her doctor referred her to hospice care. Only patients with a life expectancy of less than six months are eligible for such care.

Jane Roe has been almost completely bedridden since June of 1993 and experiences constant pain, which becomes especially sharp and severe when she moves. The only medical treatment available to her at this time is medication, which cannot fully alleviate her pain. In addition, she suffers from swollen legs, bed sores, poor appetite, nausea and vomiting, impaired vision, incontinence of bowel, and general weakness.

Jane Roe is mentally competent and wishes to hasten her death by taking prescribed drugs with the help of plaintiff Compassion in Dying. In keeping with the requirements of that organization, she has made three requests for its members to provide her and her family with counseling, emotional support and any necessary ancillary assistance at the time she takes the drugs.

John Doe is a 44-year-old artist dying of AIDS. Since his diagnosis in 1991, he has experienced two bouts of pneumonia, chronic, severe skin and sinus infections, grand mal seizures and extreme fatigue. He has already lost 70% of his vision to cytomegalovirus retinitis, a degenerative disease which will result in blindness and rob him of his ability to paint. His doctor has indicated that he is in the terminal phase of his illness.

John Doe is especially cognizant of the suffering imposed by a lingering terminal illness because he was the primary caregiver for his long-term companion who died of AIDS in June of 1991. He also observed his grandfather's death from diabetes preceded by multiple amputations as well as loss of vision and hearing. Mr. Doe is mentally competent, understands there is no cure for AIDS, and wants his physician to prescribe drugs which he can use to hasten his death.

James Poe is a 69-year-old retired sales representative who suffers from emphysema, which causes him a constant sensation of suffocating. He is connected to an oxygen tank at all times, and takes morphine regularly to calm the panic reaction associated with his feeling of suffocation. Mr. Poe also suffers from heart failure related to his pulmonary disease which obstructs the flow of blood to his extremities and causes severe leg pain. There are no

cures for his pulmonary and cardiac conditions, and he is in the terminal phase of his illness. Mr. Poe is mentally competent and wishes to commit suicide by taking physician-prescribed drugs.

*Compassion in Dying v. State of Washington*, 850 F.Supp. 1454, 1456-1457 (W.D.Wash. 1994). quoted in *Compassion in Dying*, 79 F.3d at 794-795 (9thCir. 1996).

The en banc opinion of the U.S. Court of Appeals in *Compassion in Dying* mentions some additional testimony about patients.

The plaintiffs offered considerable specific testimony involving individual patients that strongly supports their claims that the Washington statute frequently presents an insuperable obstacle to terminally ill persons who wish to hasten their deaths by peaceful means. The testimony produced by the plaintiffs shows that many terminally ill patients who wish to die with dignity are forced to resort to gruesome alternatives because of the unavailability of physician assistance. One such patient, a 34-year-old man dying from AIDS and lymphoma, asked his physician for drugs to hasten his inevitable death after enduring four excruciatingly painful months because he did not wish to die in a hospital in a drug-induced stupor. His doctor, Dr. Harold Glucksberg, one of the physician plaintiffs in this case, refused because he feared prosecution under Washington Statute RCW 9A.36.060. Denied medical assistance, the patient ended his life by jumping from the West Seattle bridge and plummeting to his death. [FN125] Fortunately, he did not survive the plunge and require permanent hospitalization in an even more exacerbated state of pain.

FN125. *Compassion In Dying*, 850 F.Supp. at 1458, and Declaration of Harold Glucksberg, M.D., at 5-6.

Deprived of physician assistance, another terminally ill patient took his own life by withholding his insulin and letting himself die of insulin shock. [Brief of Amicus Curiae of Ten Surviving Family Members in Support of Physician-Assisted "Suicide" at 4-5.] Like many terminally ill patients, one individual killed himself in a secretive and lonely fashion, in order to spare his family from possible criminal charges; as a result he was deprived of a chance to die in a dignified manner with his loved ones at his side. The man's daughter described her father's death this way:

When he realized that my family was going to be away for a day, he wrote us a beautiful letter, went down to his basement, and shot himself with his 12 gauge shot gun. He was 84.... My son-in-law then had the unfortunate and unpleasant task of cleaning my father's splattered brains off the basement walls. *Id.* at 7

*Compassion in Dying v. State of Wash.*, 79 F.3d 790, 834-835 (9th Cir. 1996).

In the case of *Quill v. Vacco*, the three named patient-plaintiffs who were suffering from terminal illnesses were described by the U.S. Court of Appeals in the following words.

In her declaration, Jane Doe ["76-year-old retired physical education instructor who was dying of thyroid cancer"<sup>2</sup>] stated:

I have a large cancerous tumor which is wrapped around the right carotid artery in my neck and is collapsing my esophagus and invading my voice box. The tumor has significantly reduced my ability to swallow and prevents me from eating anything but very thin liquids in extremely small amounts. The cancer has metastasized to my plural

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<sup>2</sup> *Quill v. Vacco*, 80 F.3d at 719.

[sic] cavity and it is painful to yawn or cough.... In early July 1994 I had the [feeding] tube implanted and have suffered serious problems as a result.... I take a variety of medications to manage the pain.... It is not possible for me to reduce my pain to an acceptable level of comfort and to retain an alert state.... At this time, it is clear to me, based on the advice of my doctors, that I am in the terminal phase of this disease.... At the point at which I can no longer endure the pain and suffering associated with my cancer, I want to have drugs available for the purpose of hastening my death in a humane and certain manner. I want to be able to discuss freely with my treating physician my intention of hastening my death through the consumption of drugs prescribed for that purpose.

Mr. Kingsley [“a 48- year-old publishing executive suffering from AIDS”<sup>3</sup>] subscribed to a declaration that included the following:

At this time I have almost no immune system function.... My first major illness associated with AIDS was cryptosporidiosis, a parasitic infection which caused me severe fevers and diarrhea and associated pain, suffering and exhaustion.... I also suffer from cytomegalovirus ("CMV") retinitis, an AIDS-related virus which attacks the retina and causes blindness. To date I have become almost completely blind in my left eye. I am at risk of losing my sight altogether from this condition.... I also suffer from toxoplasmosis, a parasitic infection which has caused lesions to develop on my brain.... I ... take daily infusions of cytovene for the ... retinitis condition. This medication, administered for an hour through a Hickman tube which is connected to an artery in my chest, prevents me from ever taking showers and makes simple routine functions burdensome. In addition, I inject my leg daily with neupogen to combat the deficient white cell count in my blood. The daily injection of this medication is extremely painful.... At this point it is clear to me, based on the advice of my doctors, that I am in the terminal phase of [AIDS].... It is my desire that my physician prescribe suitable drugs for me to consume for the purpose of hastening my death when and if my suffering becomes intolerable.

In his declaration, Mr. Barth [“a 28- year-old former fashion editor under treatment for AIDS”<sup>4</sup>] stated:

In May 1992, I developed a Kaposi's sarcoma skin lesion. This was my first major illness associated with AIDS. I underwent radiation and chemotherapy to treat this cancer.... In September 1993, I was diagnosed with cytomegalovirus ("CMV") in my stomach and colon which caused severe diarrhea, fevers and wasting.... In February 1994, I was diagnosed with microsporidiosis, a parasitic infection for which there is effectively no treatment.... At approximately the same time, I contracted AIDS-related pneumonia. The pneumonia's infusion therapy treatment was so extremely toxic that I vomited with each infusion.... In March 1994, I was diagnosed with cryptosporidiosis, a parasitic infection which has caused severe diarrhea, sometimes producing 20 stools a day, extreme abdominal pain, nausea and additional significant wasting. I have begun to lose bowel control.... For each of these conditions I have undergone a variety of medical treatments, each of which has had significant adverse side effects.... While I have tolerated some [nightly intravenous] feedings, I am unwilling to accept this for an extended period of time.... I understand that there are no cures.... I can no longer endure

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<sup>3</sup> *Ibid.*

<sup>4</sup> *Ibid.*



the pain and suffering ... and I want to have drugs available for the purpose of hastening my death.

*Quill v. Vacco*, 80 F.3d 716, 720-721 (2nd Cir. 1996).

All three of these patient-plaintiffs in *Quill* died between the initial filing of the complaint on 20 July 1994 and the trial court's opinion on 15 Dec 1994. *Quill*, 870 F.Supp. at 79.

reason we need physician-assisted suicide

A U.S. Court of Appeal in 1996 explained that modern medical technology is the reason that we need physician-assisted suicide.

The debate over whether terminally ill patients should have a right to reject medical treatment or to receive aid from their physicians in hastening their deaths has taken on a new prominence as a result of a number of developments. Two hundred years ago when America was founded and more than one hundred years ago when the Fourteenth Amendment was adopted, Americans died from a slew of illness and infirmities that killed their victims quickly but today are almost never fatal in this nation — scarlet fever, cholera, measles, diarrhea, influenza, pneumonia, gastritis, to name a few. Other diseases that have not been conquered can now often be controlled for years, if not decades — diseases such as diabetes, muscular dystrophy, Parkinson's disease, cardiovascular disease, and certain types of cancer. As a result, Americans are living longer, and when they finally succumb to illness, lingering longer, either in great pain or in a stuporous, semi-comatose condition that results from the infusion of vast amounts of pain killing medications. [FN60] Despite the marvels of technology, Americans frequently die with less dignity than they did in the days when ravaging diseases typically ended their lives quickly. AIDS, which often subjects its victims to a horrifying and drawn-out demise, has also contributed to the growing number of terminally ill patients who die protracted and painful deaths.

FN60. As a result of medical advances, most Americans now die from slow acting ailments such as heart disease, cancer, and cerebrovascular disease. One in every two Americans dies of a disease diagnosed at least 29 months in advance; chronic conditions were the cause of more than 87% of the deaths in 1978. G. Steven Neeley, *Chaos In the "Laboratory" of the States": The Mounting Urgency in The Call for Judicial Recognition of a Constitutional Right to Self-Directed Death*, 26 U.Tol.L.Rev. 81, \* 3 (1994).

One result has been a growing movement to restore humanity and dignity to the process by which Americans die. [FN61] The now recognized right to refuse or terminate treatment and the emergent right to receive medical assistance in hastening one's death are inevitable consequences of changes in the causes of death, advances in medical science, and the development of new technologies. Both the need and the capability to assist individuals end their lives in peace and dignity have increased exponentially. [footnote about French President Mitterrand omitted]

FN61. Most Americans used to die at home, in the comfort of familiar surroundings, with their loved ones around them. No longer. In 1939, only 37 percent of Americans died in hospitals or nursing homes. Cathaleen A. Roach, *Paradox and Pandora's Box: The Tragedy of Current Right-To-Die Jurisprudence*, 25 U.Mich.J.L.Ref. 133, 154 (1991). Today, by contrast, between 80 and 85 percent of Americans die in institutions. *Id.* citing President's Comm'n for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Deciding to Forego Life-Sustaining Treatment* 17-18 (1983). About 70 percent of those who die in institutions do so after a decision to hasten their death by withholding or withdrawing medical treatment or technology. *Id.*

citing Lisa Belkin, As Family Protests, Hospital Seeks an End to Woman's Life Support, N.Y. Times, Jan. 10, 1991, at A1.

*Compassion in Dying v. State of Wash.*, 79 F.3d 790, 811-812 (9th Cir. 1996).

A mentally competent adult's decision to end his/her life is an intimate, personal decision that should not be subject to approval by other people. But the above examples show that such decisions can be reasonable and humane. Modern medicine often prolongs dying and can make terminally ill patients suffer meaninglessly and needlessly, given that these terminally ill patients will never again either enjoy their life and will never again be productive people.

### "It's Over, Debbie"

Although the topic of euthanasia and physician-assisted suicide had been discussed earlier in medical journals,<sup>5</sup> a terse case report from an anonymous resident published in January 1988 really ignited discussion in the medical community over such end-of-life issues.<sup>6</sup>

This resident was awakened in the middle of the night by a telephone call from a nurse in an oncology ward, asking him to come see a patient. The resident described the patient:

... a 20-year-old girl named Debbie was dying of ovarian cancer. She was having unrelenting vomiting apparently as the result of an alcohol drip administered for sedation. ....

As I approached the room I could hear loud, labored breathing. .... She was receiving nasal oxygen, had an IV, and was sitting in bed suffering from what was obviously severe air hunger. The chart noted her weight at 80 pounds. .... She had not eaten or slept in two days. .... Her only words to me were, "Let's get this over with."

anonymous, "It's Over, Debbie," 259 *Journal of the American Medical Association* 272

(8 Jan 1988). The resident administered 20 mg of morphine sulfate intravenously and she died four minutes later.

In looking back to "It's over, Debbie", the physician's error was his hasty, superficial approach to a complicated and serious topic. "Let's get this over with" is *not* an explicit, legally

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<sup>5</sup> See, e.g., James Rachels, "Active and Passive Euthanasia," 292 *New England Journal of Medicine* 78 (9 Jan 1975); S.H. Wanzer, S.J. Adelstein, R.E. Cranford, D.D. Federman, E.D. Hook, C.G. Moertel, P. Safar, A. Stone, H.B. Taussig, J. van Eys, "The Physician's Responsibility Toward Hopelessly Ill Patients," 310 *New England Journal of Medicine* 955 (12 Apr 1984).

<sup>6</sup> "Ignited" is hardly hyperbole — the *Journal of the American Medical Association* published 13 pages of letters from readers in response to this half-page case report. See 259 *JAMA* at pages 2094-2098 and 2139-2143 (8 Apr 1988) and 260 *JAMA* at pages 787-789 (12 Aug 1988). During the less than three months after publication of the case report, the editor of *JAMA* "received more than 150 letters" about this case report. 259 *JAMA* 2142 (8 Apr 1988).

acceptable request to die.<sup>7</sup> In applying the thoughtful criteria<sup>8</sup> for physician-assisted suicide proposed almost five years later, there was no exploration of whether nonlethal doses of morphine could control her pain, there was no established physician-patient relationship (this resident had never seen Debbie before), there was no consultation with another experienced physician, and there was no documentation. In this case, a young *inexperienced* physician (a resident who was still in training) did something impulsive that seemed right, but without thinking formally about ethics and law. He *may* have done the right thing (i.e., kill Debbie) for the wrong reason (i.e., because she was burdensome to the resident, or because the resident believed further medical treatment was futile). Later the resident apparently felt guilty and wrote the confession to JAMA.

Instead of focusing only on the sleepy resident's bad decision, one should also ask why Debbie's attending physician permitted her to suffer like this.<sup>9</sup>

There is the possibility that the case report about Debbie is a hoax: (1) the dose of morphine should not have killed her so quickly; (2) alcohol drips were common before 1963, but obsolete in 1988; and (3) and surely the resident would not commit murder in the presence of two witnesses, a nurse and an unidentified woman in the room who was holding Debbie's hand.<sup>10</sup> If it were a hoax, the case report was at least a plausible occurrence in a hospital in the USA during the years 1950-1990.

There are probably at least many hundreds of cases like Debbie every day in hospitals in the USA, where the patient is suffering and the patient has no reasonable hope of recovery. In my opinion, these patients deserve a legal right to end their suffering with a lethal dose of medicine, but *only if* the patient desires such an end. These patients *also* deserve more thought and more effort (similar to what attorneys and judges call "due process of law") from physicians than what Debbie received.

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<sup>7</sup> Maybe Debbie was referring to her "unrelenting vomiting". Frances H. Miller and George J. Annas, Letter, 259 JAMA 2095 (8 Apr 1988). Or maybe Debbie was referring to an unwelcome visit by a resident who was unknown to her.

<sup>8</sup> Timothy E. Quill, Christine K. Cassel, and Diane E. Meier, "Proposed Clinical Criteria for Physician-Assisted Suicide," 327 New England Journal of Medicine 1380 (5 Nov 1992). See my discussion at page 117, below.

<sup>9</sup> Bernadine Z. Paulshock, Letter, 259 JAMA 2094 (8 Apr 1988).

<sup>10</sup> Verne M. Marshall, Letter, 260 JAMA 787 (12 Aug 1988); Sheldon T. Berkowitz, Letter, 260 JAMA 788 (12 Aug 1988).

## Suicide Was a Crime

Many years ago, it was a crime in both England and the USA to commit suicide. It was a stupid law: the perpetrator of a suicide was dead and therefore beyond the reach of the courts for a trial, and also unavailable for punishment. Forfeiting a suicide's property to the state only punished innocent heirs, which might include a spouse and minor children.

Some states formerly made it a crime for a person to *attempt* to commit suicide.<sup>11</sup>

When suicide was a crime, assisting a suicide was aiding and abetting the crime of suicide. See *North Carolina v. Willis*, 121 S.E.2d 854, 856-857 (N.C. 1961). North Carolina abolished the common-law crime of suicide in 1973. North Carolina General Statutes § 14-17.1.

Many judicial opinions on physician-assisted suicide include a section on the history of society's attitudes toward suicide, at least back to the year 1600. Later in this essay, I have quoted several of these histories, including the one in *Compassion in Dying v. State of Washington* by the U.S. Court of Appeals for the Ninth Circuit, beginning at page 32 below. More history is in Judge Calabresi's concurring opinion in *Quill*, quoted below, beginning at page 71.

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<sup>11</sup> "Research indicates that the last prosecution in the U.S. for attempted suicide probably occurred in 1961. The North Carolina Supreme Court relied on the English common law to determine that attempted suicide was punishable as a misdemeanor. *State v. Willis*, 255 N.C. 473, 121 S.E.2d 854 (1961)." *Compassion in Dying v. Washington*, 79 F.3d at 847, n. 14 (Beezer, J., dissenting).

## Assisting a Suicide Is a Crime

### statutes

The strongest legal argument against physician-assisted suicide is that statutes in most states in the USA make it a crime to assist a person committing suicide. In June 1997, the concurring opinion of Justice Souter in *Washington v. Glucksberg*, 521 U.S. 702, 775, n.14 (1997) cited state statutes that prohibit assisting a suicide. On 29 May 2012, I checked each statute in Westlaw and updated Justice Souter's list, which now includes 40 states:

- Alaska Stat. Ann. § 11.41.120(a)(2) (manslaughter);
- Arizona Rev. Stat. Ann. § 13-1103(A)(3) (manslaughter);
- Arkansas Code Ann. § 5-10-104(a)(2) (manslaughter);
- California Penal Code Ann. § 401 (felony) (enacted 1873);
- Colorado Rev.Stat. § 18-3-104(1)(b) (manslaughter);
- Connecticut Gen.Stat. § 53a-56(a)(2) (manslaughter in second degree);
- Delaware Code Ann., Tit. 11, § 645 (felony);
- Florida Stat. § 782.08 (manslaughter) (enacted 1868);
- Georgia Code Ann. § 16-5-5(c) (undue influence that intentionally causes suicide is felony);
- Hawaii Rev.Stat. § 707-702(1)(b) (manslaughter);
- Idaho Code § 18-4017 (felony) (enacted 2011);
- Illinois Comp. Stat., ch. 720, § 5/12-34.5 (a)(2) (felony) (statute renumbered in 2011);
- Indiana Code §§ 35-42-1-2 to 35-42-1-2.5 (felony);
- Iowa Code Ann. § 707A.2 (felony);
- Kansas Criminal Code § 21-5407(a)(2) (felony) (statute recodified in 2010);
- Kentucky Rev. Stat. Ann. § 216.302(2) (felony);
- Louisiana Rev. Stat. Ann. § 14:32.12 (enacted 1995);
- Maine Rev. Stat. Ann., Tit. 17-A, § 204 (crime);
- Maryland Criminal Law, § 3-102 (felony) (enacted 2002);
- Michigan Compiled Laws Ann. § 752.1027 (felony) (enacted 1992);
- Minnesota Stat. § 609.215;
- Mississippi Code Ann. § 97-3-49 (felony) (enacted 1930);
- Missouri Stat. § 565.023.1(2) (manslaughter);
- Montana Code Ann. § 45-5-105 (felony) (enacted 1895);<sup>12</sup>
- Nebraska Rev.Stat. § 28-307 (felony) (enacted 1977);
- New Hampshire Revised Stat. Ann. § 630:4 (felony) (enacted 1971);
- New Jersey Stat. Ann. § 2C:11-6 (crime) (enacted 1978);
- New Mexico Stat. Ann. § 30-2-4 (felony) (enacted 1953);
- New York Penal Law § 120.30 (felony) (enacted 1881);
- North Dakota Century Code § 12.1-16-04 (felony);

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<sup>12</sup> But Montana has a statute that permits assisted suicide with the consent of the victim. *Baxter v. Montana*, 224 P.3d 1211 (Mont. 2009). See page 98, below.

- Oklahoma Stat., Tit. 21, §§ 813-818 (felony) (enacted 1887);
- Oregon Rev.Stat. § 163.125(1)(b) (manslaughter);
- Pennsylvania Consolidated Stat. Ann., Tit. 18, § 2505 (felony) (enacted 1972);
- Rhode Island Gen. Laws §§ 11-60-1 through 11-60-5 (felony);
- South Carolina Code 1976 § 16-3-1090(B) (felony) (enacted 1998);
- South Dakota Codified Laws § 22-16-37 (felony) (enacted 1883, revised 1939);
- Tennessee Code Ann. § 39-13-216 (felony) (enacted 1993);
- Texas Penal Code Ann. § 22.08 (felony) (enacted 1973);
- Washington Revised Code § 9A.36.060 (felony) (enacted 1854);
- Wisconsin Stat. § 940.12 (felony) (enacted 1849).

See also Model Penal Code § 210.5 (published 1962).

In my research in May 2012, the following 10 states appear to have *no* statute that criminalizes assisting a suicide:

- Alabama;
- Massachusetts;
- Nevada;
- North Carolina;
- Ohio<sup>13</sup>;
- Utah;
- Vermont;
- Virginia;
- West Virginia;
- Wyoming.

Some of the states that do not criminalize assisted suicide nonetheless condemn assisted suicide in other statutes:

- Alabama Code 1975 § 22-8A-10 (Termination of Life-Support Procedures: "Nothing in this chapter shall be construed to condone, authorize or approve mercy killing or physician assisted suicide or to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying as provided in this chapter.") (enacted 1981, amended 1997);
- Massachusetts General Laws, Chapter 201D § 12 (Health-Care Proxy: "Nothing in this chapter shall be construed to constitute, condone, authorize, or approve suicide or mercy killing, or to permit any affirmative or deliberate act to end one's own life other than to permit the natural process of dying.") (enacted 1990).

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<sup>13</sup> Under Ohio law, aiding and abetting a suicide is *not* a crime. *Ohio v. Sage*, 510 N.E.2d 343, 346-347 (Ohio 1987).

- Nevada Revised Statutes 449.670 (Withholding or Withdrawal of Life-Sustaining Treatment: "NRS 449.535 to 449.690, inclusive, do not condone, authorize or approve mercy-killing, assisted suicide or euthanasia.");
- Ohio Code Revised § 2133.12 (Do-Not-Resuscitate Order Law: "Nothing in sections 2133.01 to 2133.15 of the Revised Code condones, authorizes, or approves of mercy killing, assisted suicide, or euthanasia.");
- Ohio Revised Code § 3795.02(A) ("Assisting suicide is ... against the public policy of the state.") (enacted 2002);
- Utah Code 1953 § 75-2a-122 ("The Advance Health Care Directive Act created in this chapter does not ... authorize mercy killing, assisted suicide, or euthanasia; ...") (enacted 2007);
- Virginia Code § 8.01-622.1 (statute provides for injunction against person "who is reasonably expected to assist or attempt to assist a suicide", and "A licensed health care provider who assists or attempts to assist a suicide shall be considered to have engaged in unprofessional conduct for which his certificate or license to provide health care services in the Commonwealth shall be suspended or revoked by the licensing authority.") (enacted 1998);
- West Virginia Code § 16-30-2 (West Virginia Health Care Decisions Act: "It is not the intent of the Legislature to legalize, condone, authorize or approve mercy killing or assisted suicide.") (enacted 2000);
- Wyoming Statutes 1977 § 35-22-414 (Wyoming Health Care Decisions Act: "This act does not authorize mercy killing, assisted suicide, euthanasia ....") (enacted 2005).

#### case law

The two leading cases are *Washington v. Glucksberg*<sup>14</sup> and *Vacco v. Quill*,<sup>15</sup> each of which generated opinions at the U.S. Supreme Court.

In April 1996, the U.S. Court of Appeals in New York state wrote in *Vacco*:

Although neither suicide nor attempted suicide is any longer a crime in the United States, 32 states, including New York, continue to make assisted suicide an offense. The New York State Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context*, 55 (1994) ("*When Death Is Sought*"). Clearly, no "right" to assisted suicide ever has been recognized in any state in the United States. See generally Mark E. Chopko & Michael F. Moses, *Assisted Suicide: Still a Wonderful*

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<sup>14</sup> See page 31, below.

<sup>15</sup> See page 65, below.

*Life?*, 70 Notre Dame L.Rev. 519, 561 (1995); Yale Kamisar, *Are Laws against Assisted Suicide Unconstitutional?*, 23 Hastings Center Rep., May-June 1993, at 32.  
*Quill v. Vacco*, 80 F.3d 716, 724 (2nd Cir. 1996).

In 1997, the U.S. Supreme Court summarized the law:

Similarly, the overwhelming majority of state legislatures have drawn a clear line between assisting suicide and withdrawing or permitting the refusal of unwanted lifesaving medical treatment by prohibiting the former and permitting the latter. *Glucksberg*, [521 U.S. 702, 117 S.Ct. 2258 (1997)] at 708-711, 713-720, 117 S.Ct., at 2262-2263, 2264-2267. And “nearly all states expressly disapprove of suicide and assisted suicide either in statutes dealing with durable powers of attorney in health-care situations, or in ‘living will’ statutes.” *Kevorkian*, [527 N.W.2d 714 (Mich. 1994)] at 731-732, and nn. 53-54. [footnote omitted] Thus, even as the States move to protect and promote patients' dignity at the end of life, they remain opposed to physician-assisted suicide.

*Vacco v. Quill*, 521 U.S. 793, 804-806 (1997) (U.S. Supreme Court upheld New York State statute that prohibited assisted suicide.). The U.S. Supreme Court noted:

It has always been a crime, either by statute or under the common law, to assist a suicide in New York. See Marzen, O'Dowd, Crone, & Balch, *Suicide: A Constitutional Right?*, 24 Duquesne L.Rev. 1, 205-210 (1985) (App.).

*Vacco v. Quill*, 521 U.S. 793, 807, n.10 (1997).

See also:

- *Ohio v. Sage*, 510 N.E.2d 343, 347, n.3 (Ohio 1987) (citing statutes in 20 other states that “criminalized assisting suicide”);
- *Michigan v. Kevorkian*, 527 N.W.2d 714, 731-733 (Mich. 1994) (no legal right to assisted suicide: “We would hold that the Due Process Clause of the federal constitution does not encompass a fundamental right to commit suicide, with or without assistance, and regardless of whether the would-be assistant is a physician.”), *cert. den. sub nom., Hobbins v. Kelley*, 514 U.S. 1083 (1995);
- *Compassion in Dying v. Washington*, 79 F.3d 790, 847, nn. 10-13 (9th Cir. 1996) (Beezer, J., dissenting) (citing statutes and cases in 44 states, the District of Columbia, and the territories of Puerto Rico and Virgin Islands that “prohibit or condemn assisted suicide”), *rev'd sub nom. Washington v. Glucksberg*, 521 U.S. 702 (1997) (Declining to recognize physician-assisted suicide as a fundamental right of privacy. At 710 and n.8, citing Beezer's list and adding three more states that prohibit assisted suicide. At 725-726: “In *Cruzan* itself, we recognized that most States outlawed assisted suicide — and even more do today — and we certainly gave no intimation that the right to refuse unwanted medical treatment could be somehow transmuted into a right to assistance in committing suicide. 497 U.S. [261], at 280 [(1990)].” At 728: “The history of the law's treatment of assisted suicide in this country has been and continues to be one of the rejection of nearly all efforts to permit it.”);



- *Vacco v. Quill*, 521 U.S. 793 (1997) (U.S. Supreme Court upheld New York State statute that prohibited assisted suicide. Footnote 9 cites statutes in 48 states and the District of Columbia that reject assisted suicide.);
- *Sampson v. Alaska*, 31 P.3d 88, 96 (Alaska 2001) (“There can be little doubt that substantial state interests underlie the manslaughter statute’s general ban of assisted suicide. [citing six cases]”);
- *Woods v. Kentucky*, 142 S.W.3d 24, 31, n.9 (Ky. 2004) (“The so-called ‘right to die’ does not extend to euthanasia or mercy killing, *DeGrella*, 858 S.W.2d [698] at 707 [(Ky. 1993)], or to suicide or assisted suicide. *Vacco v. Quill*, 521 U.S. 793, 807–09, 117 S.Ct. 2293, 2301–02, 138 L.Ed.2d 834 (1997); *Washington v. Glucksberg*, 521 U.S. 702, 735, 117 S.Ct. 2258, 2275, 138 L.Ed.2d 772 (1997).”);
- *Commissioner of Correction v. Coleman*, 38 A.3d 84, 99-100 (Conn. 2012) (Inmate of prison on hunger strike. “The legislature has made clear the state’s interest in preventing suicide by determining that assisting in a suicide is a criminal offense. .... In fact, the legislature has resisted several attempts to amend [Connecticut Statutes] to decriminalize physician assisted suicide, even for terminally ill patients.”).

#### my comments

The absolute rule of law shown by the above-cited cases is beginning to crumble. Since 1994, Oregon has a “death with dignity” statute that permits physician-assisted suicide. In 2009, Washington adopted a statute similar to Oregon’s statute. The Montana Supreme Court has affirmed the legal right of people to have physician-assisted suicide. *Baxter v. Montana*, 224 P.3d 1211 (Mont. 2009).

As pointed out by Judge Calabresi, *Quill v. Vacco*, 80 F.3d 716, 732-735 (2nd Cir. 1996) (Calabresi, J., concurring),<sup>16</sup> criminalizing assisting a suicide made sense when suicide (i.e., self-murder) was a crime, so assisting a suicide was being an accessory to self-murder. However, now that suicide is no longer a crime, the best justification for criminalizing *all* assisted suicides has evaporated.

I find it exasperating when attorneys and judges cite a long history of laws prohibiting assisting a suicide. The history is interesting for understanding *how* and *why* we got into the present predicament in which physician-assisted suicide is a crime. But citing a long legal history does *not* justify these ancient statutes. If we *always* followed old law, then the law would never change and our civilization would stagnate. For example, in the 1600s, society burned witches. We stopped burning witches when we realized that the justification was only religious superstition.

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<sup>16</sup> Quoted below, beginning at page 71.

Similarly, prior to 1967 some states in the USA had statutes prohibiting mixed-race marriages, so-called anti-miscegenation statutes. The U.S. Supreme Court rejected the long historical basis for these statutes, and invalidated these anti-miscegenation statutes in 1967, because they improperly intruded on the privacy rights of mixed-race couples.<sup>17</sup> Since the 1960s, modern medicine has greatly prolonged the time that some patients die, and physician-assisted suicide would be a compassionate way to end suffering by those patients who wish to hasten their death.

#### possibility of criminal prosecution of physicians

There is at least the possibility of criminal prosecution of physicians who act in a compassionate way and prescribe a lethal dose of drugs for their terminally ill patient.

A declaration by Quill also describes the following incident. In 1990 he treated a terminally ill patient, who feared a lingering death and who apprised Quill that she would act on her own to hasten death if he refused to assist her to do so. Quill made barbiturates available to the patient, which she could use to induce sleep, but which she could also take to end her life by an overdose at the point she desired to do so. She agreed to meet with Quill prior to taking any overdose. The patient reached the point where she desired to end her life. She met with Quill "to insure that all alternatives had been explored," after which she took the overdose and died. Quill was not present at the time of death. Subsequently, Quill wrote an article in the *New England Journal of Medicine*<sup>18</sup> describing these events. This led to what Quill describes as a "very public criminal investigation" in New York State, and presentation to a grand jury. Quill testified before the grand jury, as did other witnesses. The grand jury did not indict.

*Quill v. Koppell*, 870 F.Supp. 78, 80 (S.D.N.Y. 1994).

Later in the same case, Judge Calabresi said:

And the prohibition of assisting suicide also remained on the books. But we have found no case in which a physician aiding a person who wished to commit suicide was, in fact, penalized in New York after 1919.

*Quill v. Vacco*, 80 F.3d 716, 733 (2dCir. 1996) (Calabresi, J., concurring).

About one month before Judge Calabresi's concurring opinion, another U.S. Court of Appeals also noted the absence of punishing physicians.

Just as the mere absence of criminal statutes prohibiting suicide or attempted suicide does not indicate societal approval so the mere presence of statutes criminalizing assisting in a suicide does not necessarily indicate societal disapproval. That is especially true when such laws are seldom, if ever, enforced. There is no reported American case of criminal punishment being meted out to a doctor for helping a patient hasten his own death. [FN54] ....

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<sup>17</sup> See the discussion in *Compassion in Dying v. State of Washington*, 79 F.3d 790, 805-806 (9th Cir. 1996) ("... historical evidence alone is not a sufficient basis for rejecting a claimed liberty interest.")

<sup>18</sup> Timothy E. Quill, "Death and Dignity, A Case of Individualized Decision Making," 324 *New England Journal of Medicine* 691 (7 Mar 1991). In addition to assisting in her suicide, Dr. Quill admits that he lied to the medical examiner about the cause of her death, to avoid an autopsy, coroner's investigation, and possible criminal prosecution. Dr. Quill said she died of "acute myelomonocytic leukemia", instead of suicide by overdose of barbiturates.

FN54. Franklin G. Miller et al, *Regulating Physician-Assisted Death*, 331 N.Eng.J.Med. 119, 119 (1994). Dr. Jack Kevorkian is currently facing criminal charges for helping several patients hasten their deaths. His case presents a number of peculiar factors that prevent us from drawing any particular inferences from the fact that local authorities in Michigan have made a number of efforts to obtain a conviction.

In a celebrated, though less complicated, recent example, a grand jury decided against indicting Dr. Timothy Quill, who admitted in the pages of the *New England Journal of Medicine* that he had intentionally prescribed the barbiturates that a terminally ill patient used to end her life. [Julia] Pugliese, [ Note, *Don't Ask--Don't Tell: The Secret Practice of Physician-Assisted Suicide*, 44 Hastings L.J. 1291,] 1298, n. 47 [(1993)].

Quill's case was not exceptional. In 1973, a New York physician who administered a lethal injection to a comatose patient was acquitted of assisted suicide. In 1950, another doctor was acquitted after injecting a "fatal air embolism into the blood vessels of a carcinoma patient, who had repeatedly urged him to end her misery." *Id.* at 1298 nn. 45-46.

*Compassion in Dying v. State of Wash.*, 79 F.3d 790, 810-811 (9th Cir. 1996).

Several law review articles have also recognized the apparent absence of criminal convictions for a physician who assisted the death of a patient:

- William H. Baughman, John C. Bruha, and Francis J. Gould, "Euthanasia: Criminal, Tort, Constitutional and Legislative Considerations, 48 Notre Dame Lawyer 1202, 1206-07 (June 1973) ("Prosecution for aiding and abetting a suicide, however, is rare." On the "question of euthanasia by omission ... there has never been a case dealing with this issue ....").
- Leonard H. Glantz, "Withholding and Withdrawing Treatment: the Role of the Criminal Law," 15 Law, Medicine and Health Care 231, 232 (Winter 1987) ("No physician has ever been successfully prosecuted for an act of either omission or commission that led to the death of a seriously ill patient.").
- Lawrence O. Gostin, "Drawing a Line Between Killing and Letting Die: The Law, and Law Reform, on Medically Assisted Dying," 21 The Journal of Law, Medicine & Ethics 94, 97 (Spring 1993) ("In a search of reported decisions, no case was found in which a health care professional was convicted of causing, inducing, or assisting in the death of her patient.").
- Julia Pugliese, Note, "Don't Ask — Don't Tell: The Secret Practice of Physician-Assisted Suicide," 44 Hastings Law Journal 1291, 1297-1299 (Aug 1993).

But see

- David R. Schanker, Note, "Of Suicide Machines, Euthanasia Legislation, and the Health Care Crisis," 68 Indiana Law Journal 977, 986, n. 41 (Summer 1993) ("Of the eleven physicians who have been charged in connection with the killing of a patient or an ill or incapacitated member of the physician's family, none has been imprisoned." citing the book, *EUTHANASIA*, by Derek Humphrey, pp. 129-135 (1991). Schanker mentions two physicians who were acquitted at trial, two physicians who received probation, and one physician who committed suicide before his trial.)

Despite this alleged lack of convictions, physicians would be properly hesitant to assist a suicide, given that criminal prosecution would damage their reputation, and criminal conviction could end their professional career. And my searches of Westlaw hint that prosecution of assisted suicides by nonphysicians became more common in the USA after the mid-1980s, so these assurances in old law review articles may no longer be valid. And, as discussed below, I have found some

recent cases involving criminal convictions of physicians, as well as several cases of suspending a physician's license to practice medicine.

Two commentators have noted the dearth of reported appellate cases involving assisted suicide, so that information on criminal prosecutions must come from newspapers and books on euthanasia.

Indeed, from 1930 to 1985, not one state court decision on an actual prosecution for suicide assistance appears in an official state reporter. Newspaper and wire services furnish the only located record of those who have actually been charged under the statutes on assisting suicide. Catherine D. Shaffer, Note, "Criminal Liability for Assisting Suicide," 86 Columbia Law Review 348, 358 (March 1986). Shaffer does not mention physician-assisted suicide, as her note was written before physician-assisted suicides became widely discussed.

Most of the documented reports of assisted suicides do not come from case law, but from newspaper articles and personal accounts, .... [three footnotes omitted] Julia Pugliese, Note, "Don't Ask — Don't Tell: The Secret Practice of Physician-Assisted Suicide," 44 Hastings Law Journal 1291, 1297 (Aug 1993). There are several possible reasons that would explain the dearth of reported appellate cases involving assisted suicide or mercy killings:

1. In other areas of law, only a few percent of trial court decisions are appealed, so — assuming that fewer than twenty people were found guilty of assisting a suicide — zero reported appellate decisions would be statistically reasonable.
2. People who are prosecuted for assisting a suicide, found guilty, and received a lenient sentence (e.g., probation, community service, etc.) may be reluctant to appeal, because of their desire to avoid more embarrassing publicity about their case and their desire to avoid additional attorney's fees.
3. It is common in a plea bargain that, in exchange for a guilty plea and a reduced sentence, the defendant waives his right to appeal.
4. Certainly, people who were found "not guilty" would refuse to appeal.

I emphasize that my suggested reasons for the dearth of reported cases are only speculation. However, my searches of Westlaw databases have found some reported cases since the mid-1980s on either euthanasia or assisted suicide, which are tersely listed below.

#### cases involving physicians

*Barber v. Superior Court*, 195 Cal.Rptr. 484 (Cal.App. 2 Dist. 1983) prohibited the Superior court from proceeding to trial of two physicians for murder, because they disconnected life-support machinery from a patient in a persistent vegetative state at the request of the patient's family. The existence of *Barber* reminds us of the dangers of overzealous prosecutors.

A physician in Kansas was indicted and convicted for attempted murder in connection with giving large doses of narcotics to a terminally ill patient with cancer. The conviction was reversed on appeal. *Kansas v. Naramore*, 965 P.2d 211 (Kan.App. 1998).

A physician in Oregon was disciplined for the euthanasia of a 78-y-old patient who “had suffered a severe brain hemorrhage that would soon end her life.” The patient’s daughter, who was a nurse, said that the patient did not want artificial life support. After a ventilator was disconnected, the patient unexpectedly continued to breathe, but appeared to be suffering, despite diazepam and morphine. The physician then ordered an injection of succinylcholine to kill the patient. The Board of Medical Examiners suspended the physician’s license to practice medicine for 60 days as punishment for “unprofessional conduct” in performing active euthanasia. The Oregon Appellate court affirmed the punishment. *Gallant v. Board of Medical Examiners*, 974 P.2d 814 (Or.App. 1999). Incidentally, “this case in no way concerns Oregon’s Death with Dignity Act” that is discussed below, beginning at page 90.

In March 1999, Dr. Jack Kevorkian was convicted in Michigan of murder in the second degree, in a case involving euthanasia of a person with amyotrophic lateral sclerosis (ALS). *Michigan v. Kevorkian*, 639 N.W.2d 291 (Mich.App. 2001). Dr. Kevorkian may be distinguishable from typical physicians, in that Kevorkian was specializing in killing people, instead of treating people in a typical physician-patient relationship. Indeed, Dr. Kevorkian’s license to practice medicine was revoked in Michigan in 1991, *before* he committed the murder for which he was convicted. See the discussion of Kevorkian’s cases below, beginning at page 80.

A physician in Illinois was disciplined for euthanasia. The patient was 69 y old, suffering from end-stage renal disease, and who was acutely suffocating because of a blood clot that occluded the superior vena cava. The physician gave the patient a large dose (either 10 or 20 mg) of morphine intravenously, followed by a lethal dose of undiluted potassium chloride. The physician’s license to practice medicine was suspended for five years. A circuit court reversed and vacated the license suspension because of procedural errors. An appellate court affirmed one error found by the district court and remanded the case for an administrative hearing. *Wilson v. Illinois Department of Professional Regulation*, 801 N.E.2d 36 (Ill.App. 1 Dist. 2003), *rehearing denied* (Ill.App. 26 Dec 2003), *appeal denied*, 809 N.E.2d 1293 (Ill. 2004), *cert. den.*, 543 U.S. 869 (2004). There is nothing further on this case in the Westlaw database.

A physician in Utah was charged with first-degree murder in the deaths of five elderly psychiatric patients, but the jury found him guilty of two counts of manslaughter and three counts of negligent homicide. The physician was granted a new trial, because of prosecution’s failure to disclose to the defense a better qualified expert witness who was exculpatory. *Utah v. Weitzel*, Not Reported in P.3d, 2001 WL 34048225 (Utah Dist.Ct. 9 Jan 2001). There is nothing further in the Westlaw database on this case. This physician-defendant has a website at <http://www.weitzelcharts.com>, which says he was found not guilty at the second trial in Nov 2002.

cases involving *nonphysicians*

There are more than one dozen reported appellate cases involving criminal prosecutions and convictions for *nonphysicians* who killed a seriously ill patient, either at the request of the patient or for a humanitarian reason. My searches of Westlaw indicate that reported (i.e., appellate) legal cases on assisting suicides is a modern legal phenomena, which seems to begin in the mid-1980s.

- *Massachusetts v. Noxon*, 66 N.E.2d 814 (Mass. 1946) (Father killed his six-month-old baby, who was a Mongoloid (i.e., Down's Syndrome). The father was convicted of first-degree murder, which was affirmed on appeal.). The father was paroled after serving approximately four years in prison.<sup>19</sup>
- *Repouille v. United States*, 165 F.2d 152 (2dCir. 1947) (Father had a 13-y-old boy who "suffered from birth from a brain injury which destined him to be an idiot and a physical monstrosity malformed in all four limbs. The child was blind, mute, and deformed. He had to be fed; the movements of his bladder and bowels were involuntary, and his entire life was spent in a small crib." In 1939, the father killed this son with chloroform. The federal court summarized the proceedings in state court: "He was indicted for manslaughter in the first degree; but the jury brought in a verdict of manslaughter in the second degree with a recommendation of the 'utmost clemency'; and the judge sentenced him to not less than five years nor more than ten, execution to be stayed, and the defendant to be placed on probation, from which he was discharged in December, 1945.");
- *California v. Gibson*, 101 Cal.Rptr. 620 (Cal.App.2 Dist. Mar 1972) (Affirmed first-degree murder conviction of father who killed his 12-year-old autistic son.);
- *Kansas v. Cobb*, 625 P.2d 1133, 1136 (Kan. 1981) (Defendant twice injected victim with cocaine, then shot him in the head. Victim wanted to die, and victim obtained the cocaine and pistol. Defendant convicted of first-degree murder.);
- *Gilbert v. Florida*, 487 So.2d 1185 (Fla.App. 4 Dist. Apr 1986), *review denied*, 494 So.2d 1150 (Fla. 1986) (Affirmed minimum 25-year prison sentence for a 75-year-old man who killed his wife, who was suffering from Alzheimer's disease, painful arthritis, and osteoporosis. The court held: "Euthanasia is not a defense to first degree murder in Florida ....");
- *North Carolina v. Forrest*, 362 S.E.2d 252 (N.C. Dec 1987) (Affirmed life imprisonment for defendant, who shot his critically ill father in a hospital. No mention of whether father requested to die.);

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<sup>19</sup> Joseph Sanders, "Euthanasia: None Dare Call It Murder," 60 *The Journal of Criminal Law, Criminology and Police Science* 351, 356, n. 36 (Sep 1969). The fruits of Mr. Sander's research in the *New York Times* was copied and expanded by two later authors: William H. Baughman, John C. Bruha, and Francis J. Gould, "Euthanasia: Criminal, Tort, Constitutional and Legislative Considerations, 48 *Notre Dame Lawyer* 1202, 1213-1214 (June 1973); Leonard H. Glantz, "Withholding and Withdrawing Treatment: the Role of the Criminal Law," 15 *Law, Medicine and Health Care* 231, 232 (Winter 1987).

- *Griffith v. Florida*, 548 So.2d 244 (Fla.App. 3 Dist. Mar 1989), *quashed in part*, 561 So.2d 528 (Fla. 1990) (Affirmed that “mercy killing” of daughter in persistent vegetative state was first-degree murder; sentence of “life imprisonment without the possibility of parole for twenty-five years.”);
- *California v. Cleaves*, 229 Cal.App.3d 367, 280 Cal.Rptr. 146 (Cal.App. 4 Dist. Apr 1991), *review denied* (Cal. 17 Jul 1991) (Affirmed second-degree murder conviction for person who helped an AIDS victim commit suicide.);
- *Ragan v. Florida*, 599 So.2d 276 (Fla.App. 2 Dist. May 1992) (Tersely affirmed second-degree murder conviction “for the death of his friend”, without stating facts of case. “... euthanasia is not a defense to murder.”);
- *Maine v. Michaud*, 611 A.2d 61 (Me. July 1992) (Affirmed first-degree murder conviction for son who shot his terminally ill father. A week before the death, the father apparently told defendant’s sister that he wanted to die. On the day of the death, father apparently told defendant that father wanted to die. “... a doctor testified that although the father's death had been caused by bullet wounds, there was a reasonable possibility that he would have died that day even without being shot.”);
- *Gentry v. Indiana*, 625 N.E.2d 1268 (Ind.App. 1 Dist. Dec 1993) (Defendant’s 58 y old mother “suffered from multiple sclerosis and a benign brain tumor and who was confined to a wheelchair or scooter.” She attempted suicide with an overdose of thioridazine, but she did not die. Her son then suffocated her. Affirmed murder conviction and 30 year prison sentence for son.);
- *Illinois v. Williams*, 638 N.E.2d 345 (Ill.App. 1 Dist. Jul 1994) (Wife had “multiple sclerosis which had confined her to a wheelchair and had rendered her unable to feed herself.” Husband said she had been “screaming in pain for most of the day” and then he shot and killed her. No mention of whether wife requested to die. Affirmed second-degree murder conviction with 10 year prison sentence.);
- *Edinburgh v. Oklahoma*, 896 P.2d 1176, 1995 OK CR 16 (Okla.Crim.App. Feb 1995) (Affirmed first-degree murder conviction with life imprisonment for defendant who killed his terminally ill father at the request of his father.);
- *Hislop v. Texas*, 64 S.W.3d 544 (Tex.App.-Texarkana Nov 2001) (Affirmed 75 year imprisonment for murder. Son killed his 80 y old mother, who “had bone cancer, and her prognosis was extremely poor.” He stabbed her 39 times, then did not report the murder “for at least three days.”);
- *California v. Journey*, 2003 WL 22079543 (Cal.App.3 Dist. Sep 2003), *review denied* (Calif. Nov 2003) (Affirmed 50 years to life prison sentence for defendant who killed her 79-year-old husband, who had been suffering for ten years from emphysema and cancer.);

- *South Dakota v. Goulding*, 799 N.W.2d 412 (S.D. 2011) (The victim “wanted to die because he was likely returning to prison, he was addicted to drugs, and he was in chronic, terminal pain.” The victim asked defendant, Goulding, to kill him. Defendant shot victim in head, killing the victim instantly. Defendant was guilty of first-degree murder, *not* assisted suicide.).

Needless to say, killing a person without their permission is homicide, although doing it for a humanitarian reason *might* justify a lesser punishment than doing it for a malicious reason.<sup>20</sup>

consent of victim is *not* a defense

And we now come to a very important point. As a matter of law, it is not possible for a victim to give valid consent to a homicide. Therefore, killing a person who desires to die is homicide.

- *Turner v. Tennessee*, 108 S.W. 1139, 1141 (Tenn. 1908) (“Murder is no less murder because the homicide is committed at the desire of the victim. He who kills another upon his desire or command is, in the judgment of the law, as much a murderer as if he had done it merely of his own head. 1 Hawk. Pleas of the Crown, c. 27, § 6; 1 Russell on Crimes, 670, citing Sawyer's Case (1815) Old Bailey MS., all cited in 8 Am. & Eng. Encyc. of Law, p. 294, text, and note 5.”);
- *Martin v. Virginia*, 37 S.E.2d 43, 47 (Va. 1946) (“Invitation and consent to the perpetration of a crime do not constitute defenses, adequate excuses, or provocations.”);
- *California v. Conley*, 411 P.2d 911, 918 (Cal. 1966) (“Thus, one who commits euthanasia bears no ill will toward his victim and believes his act is morally justified, but he nonetheless acts with malice if he is able to comprehend that society prohibits his act regardless of his personal belief.”);
- *Gentry v. Indiana*, 625 N.E.2d 1268, 1273 (Ind.App. 1 Dist. Dec 1993) (“... consent is not a defense to conduct causing another human being’s death.”);
- *Iowa v. Couser*, 567 N.W.2d 657, 660 (Iowa 1997) (“A substantial number of cases from other jurisdictions hold that one who actually performs or actively assists in performing an overt act resulting in the death of another person is guilty of homicide, irrespective of the victim's desire to die.” [citing eight cases]);
- *New York v. Jovanovic*, 700 N.Y.S.2d 156, 168 , n.5 (N.Y.A.D. 1999)(“... just as a person cannot consent to his or her own murder (see, *People v. Duffy*, 79 N.Y.2d 611, 584 N.Y.S.2d 739, 595 N.E.2d 814 [(N.Y. 1992)]), as a matter of public policy, a person cannot avoid criminal responsibility for an assault that causes injury or carries a risk of serious harm, even if the victim asked for or consented to the act ....”);

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<sup>20</sup> See, e.g., *Devis v. Texas*, 18 S.W.3d 777, 782 (Tex.App.-San Antonio 2000) (“The judge then goes on to explain [to the jury] that in a mercy killing you may want to consider probation; however, in a murder involving torture you should probably give him the maximum [sentence].”). But see the more than a dozen cases cited above where perpetrators of mercy killings of family members received long prison sentences.



- *Sanders v. Wyoming*, 7 P.3d 891, 894 (Wyo. 2000) (“... a victim's consent to be killed is not a defense to a homicide charge ....” Cites *Gentry* in Indiana, *Couser* in Iowa, and 40 Am.Jur.2d Homicide § 105 (1999).);
- *Kansas v. Sophophone*, 19 P.3d 70, 75 (Kan. 2001) (“It is true that it is no defense to intentional homicide crimes that the victim voluntarily placed himself in danger of death at the hands of the defendant, or even that he consented to his own death: a mercy killing constitutes murder; and aiding suicide is murder unless special legislation reduces it to manslaughter.” quoting LaFave & Scott, *SUBSTANTIVE CRIMINAL LAW*, § 7.5(d), Vol. 2, pp. 217-18 (1986));
- *Michigan v. Kevorkian*, 639 N.W.2d 291, 331 (Mich.App. 2001) (affirming second-degree murder conviction: “Simply put, consent and euthanasia are not recognized defenses to murder.”), *appeal denied*, 642 N.W.2d 681 (Mich. 2002);
- *New York v. Minor*, 898 N.Y.S.2d 440, 442 (N.Y.Sup. 2010) (“Because the consent of the victim is not a defense to murder, euthanasia is therefore prosecutable as murder in the second degree.” Task Force on Life & the Law, *Where Death is Sought: Assisted Suicide and Euthanasia in the Medical Context*, Chapter 4 at p. 63 (May 1994)).

As authors of several law review articles have recognized, this rule of law means that a physician commits a homicide when the physician kills a patient (i.e. by injecting a lethal dose of drugs) at the request of the patient:

- William H. Baughman, John C. Bruha, and Francis J. Gould, “Euthanasia: Criminal, Tort, Constitutional and Legislative Considerations, 48 *Notre Dame Lawyer* 1202, 1205 (June 1973) (“... those special factors which may be said to distinguish euthanasia from more reprehensible forms of killing — a humanitarian motive, possible consent of the victim, the victim’s hopeless condition — are irrelevant in the eyes of the law.”)
- Percy Foreman, “The Physician’s Criminal Liability for the Practice of Euthanasia,” 27 *Baylor Law Review* 54, 54-55, 59 (Winter 1975) (“In Texas, euthanasia is a euphemism for criminal homicide. .... ... the fact that the physician obtains the consent of the relatives of the victim is no defense. .... Although evidence of the physician’s motive would be admissible and could mitigate punishment, it is not a defense to the crime of murder. Common law has never recognized consent of the victim as a defense to criminal homicide.”).
- Sue Wolf Brenner, “Undue Influence in the Criminal Law: A Proposed Analysis of the Offense of ‘Causing Suicide’,” 47 *Albany Law Review* 62, 76-77 (Fall 1982).
- George C. Garbesi, “The Law of Assisted Suicide,” 3 *Issues in Law and Medicine* 93, 95 (Fall 1987) (“It is important to note that the consent of the victim of a homicide is not of itself a defense to the charge of murder.”).
- Leonard H. Glantz, “Withholding and Withdrawing Treatment: The Role of the Criminal Law,” 15 *Law, Medicine and Health Care* 231, 232 (Winter 1987) (“... killing someone out of a good motive, such as to relieve pain, is not a defense to homicide. It is not the *motive* of the killer but, rather, the *intent* to kill that is the key element in unlawful homicide. Furthermore, the consent of the victim is not a defense against a charge of murder.”).

- Lawrence O. Gostin, “Drawing a Line Between Killing and Letting Die: The Law, and Law Reform, on Medically Assisted Dying,” 21 *The Journal of Law, Medicine & Ethics* 94, 96 (Spring 1993) (“A physician who directly takes the life of a patient commits a criminal offense even if the patient desires to die. .... Neither the consent of the victim nor the absence of malice reduced the crime of murder.” And at page 95: “The fact that a physician is motivated by the desire to end unendurable pain and suffering is irrelevant to criminal liability.”)

A voluntary request to die by a patient is *not* a defense to criminal prosecution of a physician, either for murder or for assisting a suicide. That such a legal rule will be shocking to nonattorneys is *not* a reason to change the rule about consent to a crime being *invalid*,<sup>21</sup> but it *is* a reason to decriminalize assisting a suicide, or even decriminalize homicide,<sup>22</sup> under some conditions.<sup>23</sup>

As one commentator said about people who were active participants in a suicide: “No defendant displayed real ill will toward the suicidal individual, nor do any of the court opinions reveal any substantive murder motive. These are unusual murderers.”<sup>24</sup>

The following pages discuss the major cases in which plaintiffs sought judicial recognition of legal physician-assisted suicide.

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<sup>21</sup> The legal invalidity of consent to a crime is a reasonable rule, because the intent of the criminal law is to protect public interests, *not* private interests. See e.g., Lawrence O. Gostin, “Drawing a Line Between Killing and Letting Die: The Law, and Law Reform, on Medically Assisted Dying,” 21 *The Journal of Law, Medicine & Ethics* 94, 96 (Spring 1993).

<sup>22</sup> I am contemplating a paralyzed patient who desires to end his life, but who is physically unable to commit suicide.

<sup>23</sup> My proposal is sketched below, beginning at page 116.

<sup>24</sup> Catherine D. Shaffer, Note, “Criminal Liability for Assisting Suicide,” 86 *Columbia Law Review* 348, 363 (March 1986).

## Donaldson (Cal.App. 1992)

*Donaldson* is a weird, obscure case from Santa Barbara, California. Readers in a hurry should skip to *Glucksberg*, on page 31. The appellate court summarized the case and presented the following facts:

Plaintiff Thomas Donaldson wishes to die in order to live. He suffers from an incurable brain disease. He wishes to commit suicide with the assistance of plaintiff Carlos Mondragon so that his body may be cryogenically preserved. It is Donaldson's hope that sometime in the future, when a cure for his disease is found, his body may be brought back to life.

He and Mondragon appeal a judgment dismissing their action for declaratory and injunctive relief. Despite our sympathy for Donaldson, we must affirm and hold he has no constitutional right to either premortem cryogenic suspension or an assisted suicide. We also decide Mondragon has no constitutional right to aid, advise or encourage Donaldson's suicide.

### FACTS

Donaldson and Carlos Mondragon brought an action for declaratory and injunctive relief against the State Attorney General [Lungren], the Santa Barbara District Attorney, and the Santa Barbara County Coroner. Plaintiffs' first amended complaint seeks a declaration that Donaldson has a constitutional right to premortem cryogenic suspension of his body and the assistance of others in achieving that state. The first amended complaint also seeks an injunction against criminal prosecution of Mondragon and others for participating in the premortem cryogenic suspension and an injunction against the coroner performing an autopsy on Donaldson's body after death. Plaintiffs allege the following:

Plaintiff Thomas Donaldson, a mathematician and computer software scientist, suffers from a malignant brain tumor, diagnosed by physicians as a grade 2 astrocytoma. The astrocytoma, a "space occupying lesion," is inoperable and continues to grow and invade brain tissue. The tumor has caused Donaldson weakness, speech impediments and seizures. Ultimately, continued growth of the tumor will result in Donaldson's persistent vegetative state and death. Physicians have predicted his probable death by August 1993, five years from initial diagnosis.

Donaldson desires to be cryogenically suspended, premortem, with the assistance of Mondragon and others. This procedure would freeze Donaldson's body to be later reanimated when curative treatment exists for his brain cancer. Following cryogenic suspension, Donaldson will suffer irreversible cessation of circulatory and respiratory function and irreversible cessation of all brain function.

He will be dead according to the definition of death set forth in Health and Safety Code section 7180. That section provides: "(a) An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead...."

Donaldson seeks a judicial declaration that he has a constitutional right to cryogenic suspension premortem with the assistance of others. Alternatively, he asserts he will end his life by a lethal dose of drugs. Mondragon will "advise and encourage" Donaldson through suicide "to minimize the time between his legal death and the onset of the cryonic suspension process."

Recognizing that Mondragon will be committing a homicide, or alternatively, aiding and advising a suicide, Donaldson and Mondragon seek an injunction protecting Mondragon from criminal prosecution. In order not to destroy his chance of reanimation, they also seek a court

order to prevent the county coroner from examining Donaldson's remains. Donaldson and Mondragon base their action upon asserted constitutional rights of privacy and free expression.

Defendants demurred to plaintiffs' first amended complaint, contending Donaldson had no constitutional right to an assisted suicide and could not consent to his murder. Defendants also raised procedural challenges to plaintiffs' action. The trial judge ruled plaintiffs failed to state a cause of action, sustained the demurrer, and dismissed the action. Plaintiffs' appeal followed. On appeal they contend: 1) Donaldson has a constitutional right to premortem cryogenic suspension, and 2) Donaldson has a constitutional right to receive and Mondragon has a constitutional right to give advice and encouragement concerning Donaldson's suicide. *Donaldson v. Lungren*, 4 Cal.Rptr.2d 59, 60-61 (Cal.App. 1992).

The appellate court found the following state interests in plaintiff's continued life:

Pertinent state interests include preserving human life, preventing suicide, protecting innocent third parties such as children, and maintaining the ethical integrity of the medical profession. *People v. Adams*, [216 Cal.App.3d 1431] at 1438, 265 Cal.Rptr. 568 [572 (Cal.App. 1990)]; *Alexander, Death by Directive* (1988) 28 SANTA CLARA L.REV. 67, 78 (hereafter *Death by Directive*). The state may also decline to assess the quality of a particular human life and assert an unqualified general interest in the preservation of human life<sup>25</sup> to be balanced against the individual's constitutional rights. *Cruzan*, 497 U.S. 261 at 282, 110 S.Ct. 2841 at 2853 (1990).

*Donaldson v. Lungren*, 4 Cal.Rptr.2d at 62.

The Plaintiff cited right-to-die cases in support of his desire for assisted suicide.

Donaldson acknowledges these decisions concern patients in persistent vegetative states ..., but argues a refusal of further medical treatment is a legal fiction for suicide: "As is often true in times of social transition, case law has created fictions to avoid affronting previously accepted norms. [footnote omitted.] In life support termination, there is a fiction of medical determinism. Patients are seen as passive victims of their illness. They do not choose to die; death overtakes them. Their physicians do nothing to help them die. Death overwhelms them, too." *Death by Directive*, supra, at p. 82.

*Donaldson v. Lungren*, 4 Cal.Rptr.2d at 62-63.

The appellate court then disposed of Donaldson's claim to assisted suicide:

There may be an apparent similarity between the patient and doctor, and Donaldson and Mondragon, but in fact there is a significant difference. The patient, for example, who is being kept alive by a life-support system has taken a detour that usually postpones an immediate encounter with death. In short, the medical treatment has prolonged life and prevented death from overtaking the patient. Stopping the treatment allows the delayed meeting with death to take place.

Donaldson is asking that we sanction something quite different. Here there are no life-prolonging measures to be discontinued. Instead, a third person will simply kill Donaldson and hasten the encounter with death. No statute or judicial opinion countenances Donaldson's decision to consent to be murdered or to commit suicide with the assistance of others. *Von Holden v. Chapman*, 450 N.Y.S.2d 623, 627 (N.Y.A.D. 1982) ("essential dissimilarity" between right to decline medical treatment and any right to end one's life.).

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<sup>25</sup> Note by Standler: See page 110 below for a discussion of quality of life.

Donaldson, however, may take his own life. He makes a persuasive argument that his specific interest in ending his life is more compelling than the state's abstract interest in preserving life in general. No state interest is compromised by allowing Donaldson to experience a dignified death rather than an excruciatingly painful life.

Nevertheless, even if we were to characterize Donaldson's taking his own life as the exercise of a fundamental right, it does not follow that he may implement the right in the manner he wishes here. It is one thing to take one's own life, but quite another to allow a third person assisting in that suicide to be immune from investigation by the coroner or law enforcement agencies.

In such a case, the state has a legitimate competing interest in protecting society against abuses. This interest is more significant than merely the abstract interest in preserving life no matter what the quality of that life is. Instead, it is the interest of the state to maintain social order through enforcement of the criminal law and to protect the lives of those who wish to live no matter what their circumstances. This interest overrides any interest Donaldson possesses in ending his life through the assistance of a third person in violation of the state's penal laws. We cannot expand the nature of Donaldson's right of privacy to provide a protective shield for third persons who end his life.

Donaldson argues that his right to die is like a citizen's right to vote. An invalid, for example, may need the assistance of a third person to get to the polling booth. Donaldson argues that in similar fashion his claimed right to take his life carries with it the right to assistance in exercising that right.

In the example of the invalid voter, the state has no competing interest to prevent assistance. Quite the contrary, the state's interest is to encourage its citizens to vote. In the case of assisted suicides, however, the state has an important interest to ensure that people are not influenced to kill themselves. The state's interest must prevail over the individual because of the difficulty, if not the impossibility, of evaluating the motives of the assister or determining the presence of undue influence.<sup>26</sup>

To this, Donaldson argues, constitutional rights do not depend on there being a fail-safe scheme, nor may they be deferred because of the difficulty in devising a procedure to implement them. We agree with the general proposition that the difficulty in effecting a solution to a legal problem is not sufficient grounds for a court to deny relief. However cumbersome, it is conceivable to devise a judicial procedure to supervise Donaldson's assisted death.

We do not embark on such an enterprise because we hold Donaldson has no constitutional right to a state-assisted death. Moreover, the court may not enjoin public officers from performing official acts that they are required by law to perform. (See Civ.Code, § 3423 and Code Civ.Proc., § 526, which provide that injunctions may not be granted to prevent officers of the law acting for the benefit of the public pursuant to statute; see also *Manchel v. County of Los Angeles* (1966) 245 Cal.App.2d 501, 505–506, 54 Cal.Rptr. 53, disallowing injunctions to stay criminal proceedings.) The coroner is required to inquire into deaths involving suicide or homicide (Gov.Code, § 27491) and to carry out his or her inquiry, may take custody of the remains and examine the body of a homicide or suicide victim. (See Gov.Code, § 27491.2; Health & Saf.Code, § 7102.)

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<sup>26</sup> Note by Standler: The notion of freedom is that people are free to make their own choices, but if they choose to commit a crime (e.g., undue influence) then they will be punished by a court. It is certainly possible to evaluate motives, or presence of undue influence, as these are routine issues in courts.

It is unfortunate for Donaldson that the courts cannot always accommodate the special needs of an individual. We realize that time is critical to Donaldson, but the legal and philosophical problems posed by his predicament are a legislative matter rather than a judicial one.

*Donaldson v. Lungren*, 4 Cal.Rptr.2d at 63-64.

Despite the reputation of California for being on the forefront of social change, the three-judge panel reached a unanimous conclusion that there was no legal right to assisted suicide.

The appellate court made an important incidental remark:

Suicide or attempted suicide is not a crime under the criminal statutes of California or any state. [citation omitted] The absence of a criminal penalty for these acts is explained by the prevailing thought, to which Donaldson and others would disagree, that suicide or attempted suicide is an expression of mental illness that punishment cannot remedy. *In re Joseph G.*, 194 Cal.Rptr. 163 at 165-166, 667 P.2d 1176 at 1178-1179 (Cal. 1983).

*Donaldson v. Lungren*, 4 Cal.Rptr.2d at 64.

This view is simply wrong. Not all people who attempt suicide are mentally ill. Terminally ill people — people with no hope of recovery — who are suffering may wish suicide as a rational way to end their suffering, and — while some may disagree with their desire for suicide — those terminally ill people are neither mentally ill nor irrational. A soldier who covers a grenade with his body to protect his comrades is a hero, not someone who is mentally ill.<sup>27</sup>

*In re Joseph G.*, cited for the proposition that people who commit suicide are mentally ill, involved two 16 y old children who were in a car driven off a cliff in a suicide pact. I agree that Joseph G., who survived the car crash, was not making rational choices when he deliberately drove the car off the cliff. But I strongly reject the conclusion that all (or most) people who seek physician-assisted suicide are mentally ill. It is wrong to mix irrational reasons for suicide with suffering patients who have a rational reason for suicide. *Donaldson v. Lungren* should not have mentioned that most people who desire suicide are mentally ill.

*Donaldson* is an obscure case that is often ignored in subsequent cases involving physician-assisted suicide. *Donaldson* was cited in *Michigan v. Kevorkian*, 527 N.W.2d 714, 754, n.5, 758 (Mich. 1994) (Mallett, J., concurring in part); *Vacco v. Quill*, 521 U.S. 793, 804, n.8 (1997) (long string cite); *Krischer v. McIver*, 697 So.2d 97, 101 (Fla. 1997) (quoting four sentences from *Donaldson*); *Sampson v. Alaska*, 31 P.3d 88, 94, n.48 (Alaska 2001). Perhaps the cryogenics was too weird. Perhaps the fact that Donaldson did *not* want a physician involved in his death and preservation distinguishes this case from physician-assisted suicide cases. Having a licensed physician involved in suicide helps assure that the patient makes a rational choice in ending his life, and helps assure that the suicide will be accomplished quickly and painlessly.

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<sup>27</sup> *Baxter v. Montana*, 224 P.3d 1211, 1226, ¶70 (Mont. 2009) (Nelson, J., specially concurring).

### Washington State v. Glucksberg (1994-97)

- *Compassion in Dying v. State of Wash.*, 850 F.Supp. 1454 (W.D.Wash. 3 May 1994), *rev'd*, 49 F.3d 586 (9th Cir. 9 Mar 1995), *aff'd en banc*, 79 F.3d 790 (9th Cir. 6 Mar 1996), *rev'd sub nom. Washington v. Glucksberg*, 521 U.S. 702 (1997), *on remand*, 122 F.3d 1262 (9th Cir. 25 Aug 1997).

The state of Washington had a statute making assisting suicide a felony. The constitutionality of this statute was challenged by “four physicians who treat terminally ill patients, three terminally ill patients, and a Washington non-profit organization called Compassion In Dying.”<sup>28</sup> The U.S. District Court granted summary judgment for the patient-plaintiffs, but did *not* decide the issues raised by the Compassion in Dying organization. 850 F.Supp. at 1467-68, *aff'd*, 79 F.3d at 796-97. One of the physician-plaintiffs was Dr. Harold Glucksberg, who became the named appellee when the case was appealed to the U.S. Supreme Court.

The plaintiffs challenged the validity of a Washington state statute only as applied to physicians who prescribed a lethal dose of medicine for a mentally competent, terminally ill, adult patient who wanted to commit suicide.

Washington has no law prohibiting suicide or attempted suicide. However, Washington bans aiding or causing the suicide of another:

A person is guilty of promoting a suicide attempt when he knowingly causes or aids another person to attempt suicide.

RCW 9A.36.060(1).

Promoting a suicide attempt is a class C felony punishable by imprisonment for a maximum of five years and a fine of up to ten thousand dollars. RCW 9A.36.060(2) and 9A.20.020(1)(c).

*Compassion in Dying v. State of Washington*, 850 F.Supp. 1454, 1458-59 (W.D.Wash. 1994).

The U.S. District Court found the state statute violated the due process clause of the 14<sup>th</sup> Amendment to the U.S. Constitution. The three-judge panel of the U.S. Court of Appeals for the Ninth Circuit upheld the statute. The en banc<sup>29</sup> U.S. Court of Appeals for the Ninth Circuit found the state statute violated the due process clause of the U.S. Constitution. The U.S. Supreme Court upheld the state statute, and held that there is *no* constitutional right-to-die in the USA.

The U.S. District Court also found that the state statute violated the equal protection of laws clause of the U.S. Constitution. 850 F.Supp. at 1467. The en banc majority opinion of the

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<sup>28</sup> 79 F.3d at 794.

<sup>29</sup> Technically, a limited en banc decision: there were 23 judges on the Ninth Circuit, but only eleven of them participated in this limited en banc decision. Eight judges joined the majority opinion, while three judges dissented.

U.S. Court of Appeals did not consider the equal protection argument, because they agreed with the District Judge's other reason: that the statute violated due process. "One constitutional violation is enough to support the judgment that we reach here." 79 F.3d at 838. (For a detailed consideration of the equal protection argument, see the *Quill* case in New York state, below, beginning at page 65.)

en banc opinion of U.S. Court of Appeals

The en banc majority opinion is rather lengthy (i.e., 47 pages in the Federal Reporter). While some paragraphs are eloquent, much of the opinion is simply tediously lengthy. The length of the opinion obscures the fact that there is very little legal precedent that justifies physician-assisted suicide.

The en banc majority opinion has a long review of the history of society's attitude toward suicide. In quoting the court, I have omitted the remarks about ancient Greek and Roman societies, and begin by quoting the court's history of the Christian, English, and American societies.

The early Christians saw death as an escape from the tribulations of a fallen existence and as the doorway to heaven. [FN25] "In other words, the more powerfully the Church instilled in believers the idea that this world was a vale of tears and sin and temptation, where they waited uneasily until death released them into eternal glory, the more irresistible the temptation to suicide became." *Id.* at 25. The Christian impulse to martyrdom reached its height with the Donatists, who were so eager to enter into martyrdom that they were eventually declared heretics. Gibbon, in the *Decline and Fall of the Roman Empire*, described them this way:

They sometimes forced their way into courts of justice and compelled the affrighted judge to give orders for their execution. They frequently stopped travellers on the public highways and obliged them to inflict the stroke of martyrdom by promise of a reward, if they consented — and by the threat of instant death, if they refused to grant so singular a favour. [FN26]

FN25. The stories of four suicides are noted in the Old Testament — Samson, Saul, Abimelech, and Achitophel — and none is treated as an act worthy of censure. In the New Testament, the suicide of Judas Iscariot is not treated as a further sin, rather as an act of repentance.

FN26. Edward Gibbon, *I Decline and Fall of the Roman Empire* 721 (Oliphant Smeaton ed.).

St. Augustine said of the Donatists, "to kill themselves out of respect for martyrdom is their daily sport." *Id.* at 27. Prompted in large part by the utilitarian concern that the rage for suicide would deplete the ranks of Christians, St. Augustine argued that committing suicide was a "detestable and damnable wickedness" and was able to help turn the tide of public opinion. *Id.* Even staunch opponents of a constitutional right to suicide acknowledge that "there were many examples of Christian martyrs whose deaths bordered on suicide, and confusion regarding the distinction between suicide and martyrdom existed up until the time of St. Augustine (354-430 A.D.)." [FN27]

FN27. Marzen, [O'Dowd, Crone, & Balch, *Suicide: A Constitutional Right?*, 24 *Duquesne Law Rev.* 1,] 26 [(1985)].



In 562 A.D., the Council of Braga denied funeral rites to anyone who killed himself. A little more than a century later, in 693 A.D., the Council of Toledo declared that anyone who attempted suicide should be excommunicated. *Id.* at 27-28. Once established, the Christian view that suicide was in all cases a sin and crime held sway for 1,000 years until philosophers, poets, and even some clergymen — Montesquieu, Voltaire, Diderot, Francis Bacon, David Hume, John Donne, Sir Thomas More, among others [FN28] — began to challenge the all-encompassing nature of the dominant ideology. In his book *Utopia*, Sir Thomas More, who was later canonized by the Roman Catholic Church, strongly supported the right of the terminally ill to commit suicide and also expressed approval of the practice of assisting those who wished to hasten their deaths. [FN29] Hume argued that a decision by a terminally ill patient to end his life was often laudable. [FN30] France even enacted a statute legalizing suicide in 1790, primarily as a result of the influence of the nation's leading philosophers. [FN31]

FN28. Thane Josef Messinger, *A Gentle and Easy Death: From Ancient Greece to Beyond Cruzan Toward a Reasoned Legal Response to the Societal Dilemma of Euthanasia*, 71 *Denv.U.L.Rev.* 175, 185-188 (1993).

FN29. *Id.* at 185, *citing* St. Thomas More, *Utopia* 55-56 (Edward Surtz ed., 1964).

FN30. *Id. citing* David Hume, *Dialogues Concerning Natural Religion and the Posthumous Essays of the Immortality of the Soul and of Suicide* 103-104 (Richard H. Popkin ed., 1980); Tom L. Beauchamp, *Suicide in the Age of Reason* 184 in *Suicide and Euthanasia: Historical and Contemporary Themes* (Barough A. Brody ed., 1989).

FN31. Messinger, *supra* note 28, at 188.

Suicide was a crime under the English common law, at least in limited circumstances, probably as early as the thirteenth century. [FN32] Bracton, incorporating Roman Law as set forth in Justinian's *Digest*, declared that if someone commits suicide to avoid conviction of a felony, his property escheats to his lords. [FN33] Bracton said "[i]t ought to be otherwise if he kills himself through madness or unwillingness to endure suffering." [FN34] Despite his general fidelity to Roman law, Bracton did introduce a key innovation: "[I]f a man slays himself in weariness of life or because he is unwilling to endure further bodily pain ... he may have a successor, but his movable goods [personal property] are confiscated. He does not lose his inheritance [real property], only his movable goods." [FN35] Bracton's innovation was incorporated into English common law, which has thus treated suicides resulting from the inability to "endure further bodily pain" with compassion and understanding ever since a common law scheme was firmly established.

FN32. 2 H. de Bracton (c. 1250) *reprinted in On the Laws and Customs of England* 423 (S. Thorne trans., 1968).

FN33. Marzen, *supra* [note 27], at 58-59.

FN34. *Id.*

FN35. *Id.*

Sir Edward Coke, in his *Third Institute* published in 1644, held that killing oneself was an offense and that someone who committed suicide should forfeit his movable property.

But Coke listed an exception for someone who "by the rage of sickness or infirmity or otherwise," kills himself "while he is not of compos mentia," or sound mind. [FN36] In eighteenth century England, many and perhaps most juries compensated for the perceived unfairness of the law by concluding that anyone who killed himself was necessarily *not* of sound mind. [FN37] Thus, although, formally, suicide was long considered a crime under English common law, in practice it was a crime that was punished leniently, if at all, because juries frequently used their power to nullify the law.

FN36. *Id.* at 61.

FN37. *Id.*

The traditional English experience was also shaped by the taboos that have long colored our views of suicide and perhaps still do today. English common law reflected the ancient fear that the spirit of someone who ended his own life would return to haunt the living. Accordingly, the traditional practice was to bury the body at a crossroads — either so the suicide could not find his way home or so that the frequency of travelers would keep his spirit from rising. [FN38] As added insurance, a stake was driven through the body.

FN38. 4 William Blackstone, *Commentaries* 190 (noting that people who committed suicide were subject to "an ignominious burial in the highway, with a stake driven through the body").

English attitudes toward suicide, including the tradition of ignominious burial, carried over to America [FN39] where they subsequently underwent a transformation. By 1798, six of the 13 original colonies had abolished all penalties for suicide either by statute or state constitution. [FN40] There is no evidence that any court ever imposed a punishment for suicide or attempted suicide under common law in post-revolutionary America. [FN41] By the time the Fourteenth Amendment was adopted in 1868, suicide was generally not punishable, and in only nine of the 37 states is it clear that there were statutes prohibiting assisting suicide. [FN42]

FN39. This practice was continued in seventeenth century Virginia. In 1661, for instance, a jury found a man guilty of suicide and "caused him to be buried at the next cross path as the Law Requires with a stake driven though the middle of him in his grave." Marzen, *supra* [note 27], at 64-65, citing A. Scott, *Criminal Law in Colonial Virginia* at 198-199 & n. 16 (1930).

FN40. Marzen, *supra* [note 27], at 67.

FN41. Catherine D. Shaffer, Note, *Criminal Liability for Assisting Suicide*, 86 Colum.L.Rev. 348, 350 (1986).

FN42. Marzen, *supra* [note 27], at 75. Nevertheless, extrapolating from incomplete historical evidence and drawing inferences from states' treatment of suicide and from later historical evidence, Marzen hypothesized that in 1868, "twenty-one of the thirty-seven states, and eighteen of the thirty ratifying states prohibited assisting suicide." *Id.* at 76.

The majority of states have not criminalized suicide or attempted suicide since the turn of the century. [FN43] The New Jersey Supreme Court declared in 1901 that since suicide was not punishable it should not be considered a crime. "[A]ll will admit that in some cases it is ethically defensible," the court said, as when a woman kills herself to escape being raped or "when a man curtails weeks or months of agony of an incurable disease." *Campbell v.*

*Supreme Conclave Improved Order Heptasophs*, 66 N.J.L. 274, 49 A. 550, 553 (1901). [FN44] Today, no state has a statute prohibiting suicide or attempted suicide; nor has any state had such a statute for at least 10 years. [FN45] A majority of states do, however, still have laws on the books against assisting suicide. [FN46]

FN43. Marzen, *supra* [note 27], at 85.

FN44. Cited by Marzen, *supra* [note 27], at 84.

FN45. *Id.* at 350 (noting in 1986 that no state prohibits suicide or attempted suicide by statute).

FN46. Julia Pugliese, Note, *Don't Ask--Don't Tell: The Secret Practice of Physician-Assisted Suicide*, 44 Hastings L.J. 1291, 1295 (1993).

*Compassion in Dying v. State of Wash.*, 79 F.3d 790, 808-810 (9th Cir. 1996).

The en banc majority opinion then has a section on current attitudes in the USA toward suicide. I am not quoting this section for two reasons: (1) opinion polls are a matter for legislators, *not* judges, to consider and (2) constitutional rights should not be decided by a majority — indeed, it is the minority that usually needs protection from the majority.

The key holding of the en banc majority opinion was the recognition of a new constitutional right of privacy in end of life decisions, into which the state may intrude only if the state has a compelling interest.

Next we examine previous Court decisions that delineate the boundaries of substantive due process. We believe that a careful examination of these decisions demonstrates that there is a strong liberty interest in determining how and when one's life shall end, and that an explicit recognition of that interest follows naturally, indeed inevitably, from their reasoning.

The essence of the substantive component of the Due Process Clause is to limit the ability of the state to intrude into the most important matters of our lives, at least without substantial justification. [FN63] In a long line of cases, the Court has carved out certain key moments and decisions in individuals' lives and placed them beyond the general prohibitory authority of the state.<sup>30</sup> The Court has recognized that the Fourteenth Amendment affords constitutional protection to personal decisions relating to marriage, *Loving v. Virginia*, 388 U.S. 1, 87 S.Ct. 1817, 18 L.Ed.2d 1010 (1967), procreation, *Skinner v. Oklahoma*, 316 U.S. 535, 62 S.Ct. 1110, 86 L.Ed. 1655 (1942), family relationships, *Prince v. Massachusetts*, 321 U.S. 158, 64 S.Ct. 438, 88 L.Ed. 645 (1944), child rearing and education, *Pierce v. Society of Sisters*, 268 U.S. 510, 534-535, 45 S.Ct. 571, 573-574, 69 L.Ed. 1070 (1925), and intercourse for purposes other than procreation, *Griswold v. Connecticut*, 381 U.S. 479, 85 S.Ct. 1678, 14 L.Ed.2d 510 (1965). The Court has recognized the right of individuals to be free from government interference in deciding matters as personal as whether to bear or beget a child, *Eisenstadt v. Baird*, 405 U.S. 438, 92 S.Ct. 1029, 31 L.Ed.2d 349 (1972), and whether to continue an unwanted pregnancy to term, *Roe v. Wade*, 410 U.S. 113, 93 S.Ct. 705, 35 L.Ed.2d 147 (1973). [FN64]

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<sup>30</sup> For a more detailed review of constitutional privacy cases, see Ronald B. Standler, *Fundamental Rights Under Privacy in the USA*, <http://www.rbs2.com/priv2.pdf> (Aug 1998).

FN63. When we refer to the Due Process Clause in this opinion, we refer to the due process clause of the Fourteenth Amendment, whether or not we include the reference to the specific numbered amendment. The due process clause of the Fifth Amendment, of course, provides *inter alia*, similar protection against comparable invasions by the federal government.

FN64. The dissent points to language in *Palko v. Connecticut*, 302 U.S. 319, 325, 58 S.Ct. 149, 152, 82 L.Ed. 288 (1937), referring to liberty interests that are such that "neither liberty nor justice would exist if they were sacrificed." That language, however, has never been applied literally. It would be difficult, if not impossible, for any fundamental right or liberty interest to meet such a standard. One could hardly argue for example that neither liberty nor justice would survive if contraceptives were banned, as they were for most of our history. Nor, indubitably, would even the most vigorous proponent of abortion rights argue that neither liberty nor justice existed in this nation prior to *Roe*.

A common thread running through these cases is that they involve decisions that are highly personal and intimate, as well as of great importance to the individual. [FN65] Certainly, few decisions are more personal, intimate or important than the decision to end one's life, especially when the reason for doing so is to avoid excessive and protracted pain. Accordingly, we believe the cases from *Pierce* through *Roe* provide strong general support for our conclusion that a liberty interest in controlling the time and manner of one's death is protected by the Due Process Clause of the Fourteenth Amendment.

FN65. In this respect, *Bowers v. Hardwick*, 478 U.S. 186, 106 S.Ct. 2841, 92 L.Ed.2d 140 (1986), would appear to be aberrant and to turn on the specific sexual act at issue.<sup>31</sup> In *Bowers*, the Court held that the Constitution does not "confer[ ] a fundamental right upon homosexuals to engage in [homosexual] sodomy." 478 U.S. at 190, 106 S.Ct. at 2843. We do not believe that the *Bowers* holding controls the outcome here or is in any way inconsistent with our conclusion that there is a liberty interest in dying peacefully and with dignity. We also note, without surprise, that in the decade since *Bowers* was handed down the Court has never cited its central holding approvingly.

*Compassion in Dying v. State of Wash.*, 79 F.3d 790, 812-813 (9th Cir. 1996).

The preceding paragraphs make a strong argument for the need to recognize a new constitutional privacy right.

Earlier, the en banc majority opinion recognized the similarity of abortion and right-to-die cases.

.... Equally important, both types of cases raise issues of life and death, and both arouse similar religious and moral concerns. Both also present basic questions about an individual's right of choice.

Historical evidence shows that both abortion and assisted suicide were for many years condemned, but that the efforts to prevent people from engaging in the condemned conduct were always at most only partially successful. Even when prohibited, abortions and assisted-suicides flourished in back alleys, in small street-side clinics, and in the privacy of the bedroom. Deprived of the right to medical assistance, many pregnant women and terminally ill adults ultimately took matters into their own hands, often with tragic consequences.

Because they present issues of such profound spiritual importance and because they so deeply affect individuals' right to determine their own destiny, the abortion and right-to-die cases have given rise to a highly emotional and divisive debate. In many respects, the legal arguments on both sides are similar, as are the constitutional principles at issue.

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<sup>31</sup> The U.S. Court of Appeals was correct that *Bowers* was "aberrant". In fact, the U.S. Supreme Court later overruled *Bowers*. *Lawrence v. Texas*, 539 U.S. 558 (2003).

*Compassion in Dying v. State of Wash.*, 79 F.3d 790, 800-801 (9th Cir. 1996).

The en banc majority opinion concentrates on only two U.S. Supreme Court cases, *Casey*, a case involving abortion, and *Cruzan*, a case involving removal of a feeding tube from a patient in a persistent vegetative state.

While the cases we have adverted to lend general support to our conclusion, we believe that two relatively recent decisions of the Court, *Planned Parenthood v. Casey*, 505 U.S. 833, 112 S.Ct. 2791, 120 L.Ed.2d 674 (1992) and *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 110 S.Ct. 2841, 111 L.Ed.2d 224 (1990), are fully persuasive, and leave little doubt as to the proper result.

#### Liberty Interest under *Casey*

In *Casey*, the Court surveyed its prior decisions affording "constitutional protection to personal decisions relating to marriage, procreation, contraception, family relationships, child rearing, and education", *id.* at 851, 112 S.Ct. at 2807 and then said:

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.

*Id.* at 851, 112 S.Ct. at 2807. The district judge in this case found the Court's reasoning in *Casey* "highly instructive" and "almost prescriptive" for determining "what liberty interest may inhere in a terminally ill person's choice to commit suicide." *Compassion In Dying*, 850 F.Supp. at 1459. We agree.

Like the decision of whether or not to have an abortion, the decision how and when to die is one of "the most intimate and personal choices a person may make in a lifetime," a choice "central to personal dignity and autonomy." A competent terminally ill adult, having lived nearly the full measure of his life, has a strong liberty interest in choosing a dignified and humane death rather than being reduced at the end of his existence to a childlike state of helplessness, diapered, sedated, incontinent. How a person dies not only determines the nature of the final period of his existence, but in many cases, the enduring memories held by those who love him.

Prohibiting a terminally ill patient from hastening his death may have an even more profound impact on that person's life than forcing a woman to carry a pregnancy to term. The case of an AIDS patient treated by Dr. Peter Shalit, one of the physician-plaintiffs in this case, provides a compelling illustration. In his declaration, Dr. Shalit described his patient's death this way:

One patient of mine, whom I will call Smith, a fictitious name, lingered in the hospital for weeks, his lower body so swollen from oozing Kaposi's lesions that he could not walk, his genitals so swollen that he required a catheter to drain his bladder, his fingers gangrenous from clotted arteries. Patient Smith's friends stopped visiting him because it gave them nightmares. Patient Smith's agonies could not be relieved by medication or by the excellent nursing care he received. Patient Smith begged for assistance in hastening his death. As his treating doctor, it was my professional opinion that patient Smith was mentally competent to make a choice with respect to shortening his period of suffering before inevitable death. I felt that I should accommodate his request.

However, because of the statute, I was unable to assist him and he died after having been tortured for weeks by the end-phase of his disease. [FN66]

FN66. Declaration of Peter Shalit, M.D., at 5-6.

For such patients, wracked by pain and deprived of all pleasure, a state-enforced prohibition on hastening their deaths condemns them to unrelieved misery or torture. Surely, a person's decision whether to endure or avoid such an existence constitutes one of the most, if not the most, "intimate and personal choices a person may make in a life-time," a choice that is "central to personal dignity and autonomy." *Casey*, 505 U.S. at 851, 112 S.Ct. at 2807. Surely such a decision implicates a most vital liberty interest.

### Liberty Interest under *Cruzan*

In *Cruzan*, the Court considered whether or not there is a constitutionally-protected, due process liberty interest in terminating unwanted medical treatment. The Court said that an affirmative answer followed almost inevitably from its prior decisions holding that patients have a liberty interest in refusing to submit to specific medical procedures. Those cases include *Jacobson v. Massachusetts*, 197 U.S. 11, 24-30, 25 S.Ct. 358, 360- 363, 49 L.Ed. 643 (1905), in which the Court balanced an individual's liberty interest in declining an unwanted smallpox vaccine against the State's interest in preventing disease; *Washington v. Harper*, 494 U.S. 210, 229, 110 S.Ct. 1028, 1041, 108 L.Ed.2d 178 (1990), in which the Court said: "The forcible injection of medication into a nonconsenting person's body represents a substantial interference with that person's liberty"; and *Parham v. J.R.*, 442 U.S. 584, 600, 99 S.Ct. 2493, 2503, 61 L.Ed.2d 101 (1979), in which it said: "[A] child, in common with adults, has a substantial liberty interest in not being confined unnecessarily for medical treatment". Writing for a majority that included Justices O'Connor and Scalia, Chief Justice Rehnquist said that those cases helped answer the first critical question at issue in *Cruzan*, stating: "The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be *inferred* from our prior decisions." *Cruzan*, 497 U.S. at 278, 110 S.Ct. at 2851 (emphasis added). [FN67]

FN67. In a passage that has caused confusion among commentators, the Chief Justice later said that the Court would assume the existence of a constitutionally protected *right* to reject life-sustaining delivery of food and water for purposes of deciding the controversy presented in *Cruzan*. The Court stated:

Although we think the logic of the cases discussed above would embrace such a liberty interest, the dramatic consequences involved in refusal of such treatment would inform the inquiry as to whether the deprivation of that interest is constitutionally permissible. But for purposes of this case, we *assume* that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition.

*Cruzan*, 497 U.S. at 279, 110 S.Ct. at 2852 (emphasis added). The passage is not inconsistent with, nor does it undermine, the Court's earlier statement that a due process liberty *interest* may be inferred from its prior holdings. Rather, the Court found a liberty *interest* and assumed a liberty *right*. That is, the Court recognized that an overall deprivation of the liberty interest would not be permissible and then assumed for purposes of deciding the ultimate issue before it that in the circumstances presented by *Cruzan* the interest resulted in a constitutional right and the state could not prohibit its exercise. *Cruzan*, 497 U.S. at 279, 110 S.Ct. at 2851. The ultimate question before the Court was whether or not Missouri could constitutionally require clear and convincing evidence of a comatose patient's previously stated wish not to be kept alive by artificial provision of food and water. The Court answered that question in the affirmative.

In her concurrence, Justice O'Connor explained that the majority opinion held (implicitly or otherwise) that a liberty interest in refusing medical treatment extends to all types of medical treatment from dialysis or artificial respirators to the provision of food and water by tube or other artificial means. As Justice O'Connor said: "I agree that a protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions, and that the refusal of artificial delivery of food and water is encompassed in that liberty interest." *Cruzan*, 497 U.S. 261, 287, 287, 110 S.Ct. 2841, 2856 (O'Connor, J., concurring) (emphasis added).

Justice O'Connor further concluded that under the majority's opinion, "[r]equiring a competent adult to endure such procedures against her will burdens the patient's liberty, dignity, and freedom to determine the course of her own treatment." *Id.* at 289, 110 S.Ct. at 2857 (O'Connor, J., concurring). In the majority opinion itself, Chief Justice Rehnquist made a similar assertion, writing:

*The choice between life and death is a deeply personal decision of obvious and overwhelming finality. We believe Missouri may legitimately seek to safeguard the personal element of this choice through the imposition of heightened evidentiary requirements. It cannot be disputed that the Due Process Clause protects an interest in life as well as an interest in refusing life-sustaining medical treatment.* *Cruzan*, 497 U.S. at 281, 110 S.Ct. at 2852-53 (emphasis added).

These passages make it clear that *Cruzan* stands for the proposition that there is a due process liberty interest in rejecting unwanted medical treatment, including the provision of food and water by artificial means. [footnote omitted] Moreover, the Court majority clearly recognized that granting the request to remove the tubes through which *Cruzan* received artificial nutrition and hydration would lead inexorably to her death. *Cruzan*, 497 U.S. at 267-68, 283, 110 S.Ct. at 2846, 2853. [footnote omitted] Accordingly, we conclude that *Cruzan*, by recognizing a liberty interest that includes the refusal of artificial provision of life-sustaining food and water, necessarily recognizes a liberty interest in hastening one's own death

*Compassion in Dying v. State of Wash.*, 79 F.3d 790, 813-816 (9th Cir. 1996).

This last sentence is where the en banc majority opinion went wrong. When the state of Washington subsequently appealed to the U.S. Supreme Court, the U.S. Supreme Court rejected this interpretation of *Cruzan* and refused to find a new constitutional right of privacy about the right-to-die.

#### six state interests

Having found a new privacy right, the en banc majority of the U.S. Court of Appeals then considered whether the state had a compelling interest in prohibiting physician-assisted suicide. The cases involving refusal of medical treatment (e.g., right-to-die for patients in a persistent vegetative state) had identified *four* important state interests. Without explanation, the en banc majority considered *six* state interests. Numbers three and six seem to be new.

We analyze the factors in turn, and begin by considering the first: the importance of the state's interests. We identify six related state interests involved in the controversy before us: 1) the state's general interest in preserving life; 2) the state's more specific interest in preventing suicide; 3) the state's interest in avoiding the involvement of third parties and in precluding the use of arbitrary, unfair, or undue influence; 4) the state's interest in protecting

family members and loved ones; 5) the state's interest in protecting the integrity of the medical profession; and, 6) the state's interest in avoiding adverse consequences that might ensue if the statutory provision at issue is declared unconstitutional. [FN71]

FN71. The majority of the three-judge panel identified five state interests. First, "[t]he interest in not having physicians in the role of killers of their patients." Second, "[t]he interest in not subjecting the elderly and even the not-elderly but infirm to psychological pressure to consent to their own deaths." Third, "[t]he interest in protecting the poor and minorities from exploitation." Fourth, "[t]he interest in protecting all of the handicapped from societal indifference and apathy." Fifth, "[a]n interest in preventing abuse similar to what has occurred in the Netherlands where, since 1984, legal guidelines have tacitly allowed assisted suicide or euthanasia in response to a repeated request from a suffering, competent patient." *Compassion In Dying*, 49 F.3d at 592-93. The district court, by contrast, employing more dispassionate and traditional terms, identified two somewhat broader state interests: preventing suicide and preventing undue influence and abuse. *Compassion In Dying*, 850 F.Supp. at 1464-65. In two substituted judgment cases about halting the life-sustaining treatment of patients who were in or almost in a vegetative state, the Washington Supreme Court listed four possible countervailing state interests: 1) the preservation of life; 2) the protection of the interests of innocent third parties; 3) the prevention of suicide; and 4) the maintenance of the integrity of the medical profession. *In re Guardianship of Grant*, 109 Wash.2d 545, 747 P.2d 445, 451 (Wash. 1987); *In re Colyer*, 99 Wash.2d 114, 660 P.2d 738, 743 (Wash. 1983).

In *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977), one of several state supreme court cases discussed in *Cruzan*, the state court found four state interests: preservation of life, protection of the interests of innocent third parties, the prevention of suicide, and the maintenance of the ethical integrity of the medical profession. *Cruzan*, 497 U.S. at 271, 110 S.Ct. at 2847.

*Compassion in Dying v. State of Wash.*, 79 F.3d 790, 816-817 (9th Cir. 1996).

In June 1997, the U.S. Supreme Court issued its opinion in this case, and discussed the six so-called state interests in preventing physician-assisted suicide. *Washington v. Glucksberg*, 521 U.S. 702, 728, n.20 (1997). So it is important to understand what the U.S. Court of Appeals for the Ninth Circuit said.

### 1. preserving life

Most tellingly, the state of Washington has already decided that its interest in preserving life should ordinarily give way — at least in the case of competent, terminally ill adults who are dependent on medical treatment — to the wishes of the patients. In its Natural Death Act, RCW 70.122.020 *et seq.*, Washington permits adults to have "life-sustaining treatment withheld or withdrawn in instances of a terminal condition or permanent unconsciousness." RCW 70.122.010. [footnote omitted] In adopting the statute, the Washington legislature necessarily determined that the state's interest in preserving life is not so weighty that it ought to thwart the informed desire of a terminally ill, competent adult to refuse medical treatment.

Not only does Washington law acknowledge that terminally ill and permanently unconscious adults have a right to refuse life-sustaining treatment, the statute includes specific legislative findings that appear to recognize that a due process liberty interest underlies that right. The statute states:

The legislature finds that adult persons have the fundamental right to control the decisions relating to the rendering of their own medical care, including the decision to have life-sustaining procedures withheld or withdrawn in instances of terminal condition.



The legislature further finds that modern medical technology has made possible the artificial prolongation of human life beyond natural limits.

The legislature further finds that, in the interest of protecting individual autonomy, 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.

RCW 70.122.010 [1979]. [footnote omitted]

The Washington statute permits competent adults to reject life-sustaining medical treatment in advance by means of living wills and durable powers of attorney. RCW 70.122.010-030. Even in cases in which the Washington Natural Death Act does not authorize surrogate decision-making, the Washington Supreme Court has found that legal guardians may sometimes have life-sustaining treatment discontinued. *In re Guardianship of Grant*, 109 Wash.2d 545, 747 P.2d 445 (Wash. 1987); *In re Colyer*, 99 Wash.2d 114, 660 P.2d 738 (Wash. 1983). [footnote omitted]

There is nothing unusual about Washington's recognition that the state's interest in preserving life is not always of the same force and that in some cases at least other considerations may outweigh the state's. [FN76] More than 40 other states have adopted living will statutes that permit competent adults to declare by advance directive that they do not wish to be kept alive by medical treatment in the latter stages of a terminal illness. [footnote omitted] Like Washington, many states also permit competent adults to determine in advance that they do not wish any medical treatment should they become permanently and irreversibly unconscious. [footnote omitted] Also, like Washington, many states allow patients to delegate decision-making power to a surrogate through a durable power of attorney, health care proxy, or similar device, or permit courts to appoint surrogate decision-makers. [footnote omitted] Finally, Congress favors permitting adult patients to refuse life-sustaining treatment by advance directive and requires hospitals receiving federal financial support to notify adult patients of their rights to execute such instruments upon admission. [FN80]

FN76. In *Grant*, the Washington Supreme Court said that the state's interest in preserving life "weakens considerably, however, if treatment will merely postpone death for a person with a terminal and incurable condition." 747 P.2d at 451; In *Colyer*, the Washington Supreme Court held that the state's interest in preserving life "weakens, however, in situations where continued treatment only serves to prolong a life inflicted with an incurable condition." 660 P.2d at 743.

FN80. The Federal Patient Self-Determination Act, passed in 1990, requires all health care providers receiving Medicaid or Medicare to inform all competent adult patients, even those admitted for the simplest of procedures, about state laws on advance directives and to record any advance directives the patient might have. Omnibus Budget Reconciliation Act of 1990, Pub.L. No. 101-508, 4206, 104 Stat. 1388-115 (codified at 42 U.S.C.A. § 1395cc(f)) (West 1992 & Supp. 1995)).

As the laws in state after state demonstrate, even though the protection of life is one of the state's most important functions, the state's interest is dramatically diminished if the person it seeks to protect is terminally ill or permanently comatose and has expressed a wish that he be permitted to die without further medical treatment (or if a duly appointed representative has done so on his behalf). When patients are no longer able to pursue liberty or happiness and do not wish to pursue life, the state's interest in forcing them to remain alive is clearly less compelling. Thus, while the state may still seek to prolong the lives of terminally ill or comatose patients or, more likely, to enact regulations that will safeguard the manner in which

decisions to hasten death are made, the strength of the state's interest is substantially reduced in such circumstances.

*Compassion in Dying v. State of Wash.*, 79 F.3d 790, 817-820 (9th Cir. 1996).

My comments on the state interest in preserving life are given below, beginning at page 107. This state interest goes back hundreds of years and comes from both religious dogma (page 102) and medieval law (page 108).

## 2. preventing suicide

The en banc majority distinguished suicides that should be prevented (e.g., people who are temporarily depressed or anguished)<sup>32</sup> from terminally ill patients, whose remainder of their lives would be filled with only pain and suffering.

While the state has a legitimate interest in preventing suicides in general, that interest, like the state's interest in preserving life, is substantially diminished in the case of terminally ill, competent adults who wish to die. [footnote omitted] One of the heartaches of suicide is the senseless loss of a life ended prematurely. In the case of a terminally ill adult who ends his life in the final stages of an incurable and painful degenerative disease, in order to avoid debilitating pain and a humiliating death, the decision to commit suicide is not senseless, and death does not come too early. [footnote omitted] Unlike "the depressed twenty-one year old, the romantically devastated twenty-eight year old, the alcoholic forty-year old," *Compassion In Dying*, 49 F.3d at 590-91, or many others who may be inclined to commit suicide, a terminally ill competent adult cannot be cured. While some people who contemplate suicide can be restored to a state of physical and mental well-being, terminally ill adults who wish to die can only be maintained in a debilitated and deteriorating state, unable to enjoy the presence of family or friends. Not only is the state's interest in preventing such individuals from hastening their deaths of comparatively little weight, but its insistence on frustrating their wishes seems cruel indeed. [FN86] ....

FN86. While recognizing the state's general interest in preventing suicide, the district court in this case said that it did not apply in the case of terminally ill, competent adults who wished to hasten their deaths. The court said:

As to them, preventing suicide simply means prolonging a dying person's suffering, an aim in which the State can have no interest. In other words, the State's legitimate interest in preventing suicide is not abrogated by allowing mentally competent terminally ill patients to freely and voluntarily commit physician-assisted suicide.

*Compassion In Dying*, 850 F.Supp. at 1464.

*Compassion in Dying v. State of Wash.*, 79 F.3d 790, 820-821 (9th Cir. 1996).

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<sup>32</sup> "... the state has a clear interest in preventing anyone, no matter what age, from taking his own life in a fit of desperation, depression, or loneliness or as a result of any other problem, physical or psychological, which can be significantly ameliorated. Studies show that many suicides are committed by people who are suffering from treatable mental disorders. Most if not all states provide for the involuntary commitment of such persons if they are likely to physically harm themselves." 79 F.3d at 820.

Moreover, we are doubtful that deaths resulting from terminally ill patients taking medication prescribed by their doctors should be classified as "suicide." Certainly, we see little basis for such a classification when deaths that result from patients' decisions to terminate life support systems or to refuse life-sustaining food and water, for example, are not. We believe that there is a strong argument that a decision by a terminally ill patient to hasten by medical means a death that is already in process, should not be classified as suicide. Thus, notwithstanding the generally accepted use of the term "physician-assisted suicide," we have serious doubt that the state's interest in preventing suicide is even implicated in this case.

In addition to the state's purported interest in preventing suicide, it has an additional interest in preventing deaths that occur as a result of errors in medical or legal judgment. We acknowledge that it is sometimes impossible to predict with certainty the duration of a terminally ill patient's remaining existence, just as it is sometimes impossible to say for certain whether a borderline individual is or is not mentally competent. [footnote omitted] However, we believe that sufficient safeguards can and will be developed by the state and medical profession, *see infra* p. 833, to ensure that the possibility of error will ordinarily be remote. Finally, although life and death decisions are of the gravest order, should an error actually occur it is likely to benefit the individual by permitting a victim of unmanageable pain and suffering to end his life peacefully and with dignity at the time he deems most desirable. [FN98]

FN98. There is some evidence that the state's efforts to prohibit assisted suicide in hopes of deterring suicide is at least partially counter-productive. As a result of the state's ban, some terminally ill adults probably commit suicide although they otherwise might not have done so and others probably commit suicide sooner than they would have done so.

In his recent book, Judge Richard Posner suggests that "permitting physician-assisted suicide ... [in] cases of physical incapacity might actually *reduce* the number of suicides and *postpone* the suicides that occur." [Richard] Posner, [*Age and Old Age*,] 224 [1995]. Judge Posner concludes that assuring such individuals that they would be able to end their lives later if they wished to, even if they became totally physically incapacitated, would deter them from committing suicide now and would also give such people a renewed peace of mind. He says that some of those individuals would eventually commit suicide but others would decide never to do so. *Id.* 243-253.

The suicide of Nobel Prize winning physicist Percy Bridgman, recounted in one of the amicus briefs, graphically illustrates the point. Dr. Bridgman, 79, was in the final stages of cancer when he shot himself on August 20, 1961, leaving a suicide note that said: "It is not decent for society to make a man do this to himself. Probably this is the last day I will be able to do it myself."

Sherman B. Nuland, *How We Die*, 152-53 (1993).

*Compassion in Dying v. State of Wash.*, 79 F.3d 790, 824 (9th Cir. 1996).

My comments on the state interest in preventing suicide are given below, beginning at page 107. This state interest goes back hundreds of years and comes from both religious dogma (page 102) and medieval law (page 108).

### 3. preventing undue influence

The en banc majority was concerned that heirs of terminally ill patients might encourage the patients to die sooner (i.e., via physician-assisted suicide), thus maximizing the size of the inheritance to the heirs.

There is a far more serious concern regarding third parties that we must consider — one not even mentioned by the majority in the panel opinion. That concern is the fear that infirm, elderly persons will come under undue pressure to end their lives from callous, financially burdened, or self-interested relatives, or others who have influence over them. The risk of undue influence is real — and it exists today. Persons with a stake in the outcome may now pressure the terminally ill to reject or decline life-saving treatment or take other steps likely to hasten their demise. Surrogates may make unfeeling life and death decisions for their incompetent relatives. This concern deserves serious consideration, as it did when the decision was made some time ago to permit the termination of life-support systems and the withdrawal or withholding of other forms of medical treatment, and when it was decided to recognize living wills, durable powers of attorney, and the right of courts to appoint substitute decision-makers. While we do not minimize the concern, the temptation to exert undue pressure is ordinarily tempered to a substantial degree in the case of the terminally ill by the knowledge that the person will die shortly in any event. Given the possibility of undue influence that already exists, the recognition of the right to physician-assisted suicide would not increase that risk unduly. In fact, the direct involvement of an impartial and professional third party in the decision-making process would more likely provide an important safeguard against such abuse.

We also realize that terminally ill patients may well feel pressured to hasten their deaths, not because of improper conduct by their loved ones, but rather for an opposite reason — out of concern for the economic welfare of their loved ones. Faced with the prospect of astronomical medical bills, terminally ill patients might decide that it is better for them to die before their health care expenses consume the life savings they planned to leave for their families, or, worse yet, burden their families with debts they may never be able to satisfy. While state regulations can help ensure that patients do not make rash, uninformed, or ill considered decisions, we are reluctant 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.

.... .. we are certainly not obligated to pile injury upon injury by holding that all of our citizens may be subjected to the prospect of needless pain, suffering, and degradation at the end of their lives, either because of our concern over Congress' failure to provide government-insured health care or alternatively in order to satisfy the moral or religious precepts of a portion of the population.

*Compassion in Dying v. State of Wash.*, 79 F.3d 790, 826 (9th Cir. 1996).

The conflict of interest problem could be solved simply by requiring a surrogate who hold a proxy to make health-care decisions for an incompetent person to *not* be a beneficiary of the incompetent person's will. On the other hand, the people who best know the incompetent person's values and wishes are his/her spouse and children, and they would be likely beneficiaries of the will. This is a difficult problem, but it is a problem for surrogates in right-to-die cases, *not* a problem in

physician-assisted suicide cases. In physician-assisted suicide cases, the patient himself can communicate his wish to die to the physician.

#### 4. preventing injury to innocent third-parties

In the case of a parent who refuses a blood transfusion that is necessary to save his/her life, there is an obvious adverse effect on minor children. This kind of concern is not important for patients who are terminally ill, because they are expected to die within six months anyway.

The state clearly has a legitimate interest in safeguarding the interests of innocent third parties such as minor children and other family members dependent on persons who wish to commit suicide. That state interest, however, is of almost negligible weight when the patient is terminally ill and his death is imminent and inevitable. The state cannot help a minor child or any other innocent third party by forcing a terminally ill patient to die a more protracted and painful death. In fact, witnessing a loved one suffer a slow and agonizing death as a result of state compulsion is more likely to harm than further the interests of innocent third parties.

[footnote omitted]

*Compassion in Dying v. State of Wash.*, 79 F.3d 790, 827 (9th Cir. 1996).

#### 5. protecting integrity of medical profession

Recognizing the right to "assisted-suicide" would not require doctors to do anything contrary to their individual principles. A physician whose moral or religious beliefs would prevent him from assisting a patient to hasten his death would be free to follow the dictates of his conscience. Those doctors who believe that terminally ill, competent, adult patients should be permitted to choose the time and manner of their death would be able to help them do so. We believe that extending a choice to doctors as well as to patients would help protect the integrity of the medical profession without compromising the rights or principles of individual doctors and without sacrificing the welfare of their patients. [FN112]

FN112. Patients who are concerned about the possibility that they will suffer an unwanted agonizing death because of a doctor's unwillingness to provide them with the medication they need would have the opportunity to select a doctor whose view of the physician's role comports with theirs. See Michigan Commission on Death and Dying, Final Report (June 1994), which reprints Model Statute Supporting Aid-In-Dying, including § 1.11, providing mechanism for the transfer of patients in case a physician refuses to provide aid-in-dying.

*Compassion in Dying v. State of Wash.*, 79 F.3d 790, 830 (9th Cir. 1996).

There is a simple reason why the integrity of the medical profession is consistent with assisting suicides in some patients. Medical progress, especially since the 1960s, has allowed physicians to prolong life. In many cases, this only prolongs the dying process, with months or years of suffering. When the patient has no reasonable hope of improvement, the medical profession ought to be legally permitted to provide a quick, painless end to those patients who desire it.

Physicians who personally oppose euthanasia should *not* be required to participate in physician-assisted suicide. This alone is enough to protect the ethics of the medical profession. Physician-assisted suicide should be reserved for patients who sincerely desire a quick, painless end to their suffering *and* for physicians who agree such an end is a rational choice.

#### 6. fear of adverse consequences

Attorneys and judges who oppose physician-assisted suicide see it as the beginning of a “slippery slope” that will inevitably progress to *involuntarily* terminating lives of people who are a burden on society. It is a ridiculous argument, but since they raise it, it must be refuted.

This same nihilistic argument can be offered against any constitutionally-protected right or interest. Both before and after women were found to have a right to have an abortion, critics contended that legalizing that medical procedure would lead to its widespread use as a substitute for other forms of birth control or as a means of racial genocide. Inflammatory contentions regarding ways in which the recognition of the right would lead to the ruination of the country did not, however, deter the Supreme Court from first recognizing and then two decades later reaffirming a constitutionally-protected liberty interest in terminating an unwanted pregnancy. In fact, the Court has *never* refused to recognize a substantive due process liberty right or interest merely because there were difficulties in determining when and how to limit its exercise or because others might someday attempt to use it improperly.

*Compassion in Dying v. State of Wash.*, 79 F.3d 790, 830-831 (9th Cir. 1996).

In my opinion, there is an old Latin legal maxim that is appropriate here: “*abusus non tollit usum.*” This translates to “abuses do not prohibit uses” — the possibility of abuse should not prevent us from doing something appropriate. By enacting broad prohibitions and by refusing to trust professionals to make appropriate discretionary decisions, the legislature has adopted a rigid, paternalistic prohibition in the name of protecting society. In reality, such rigid, paternalistic “protections” infringe the personal autonomy of individuals to make important decisions about *their* lives.

the en banc majority opinion continues ....

The en banc majority opinion suggests some safeguards that the legislature could enact to prevent misuse of physician-assisted suicide.

By adopting appropriate, reasonable, and properly drawn safeguards Washington could ensure that people who choose to have their doctors prescribe lethal doses of medication are truly competent and meet all of the requisite standards. Without endorsing the constitutionality of any particular procedural safeguards, we note that the state might, for example, require: witnesses to ensure voluntariness; reasonable, though short, waiting periods to prevent rash decisions; second medical opinions to confirm a patient's terminal status and also to confirm that the patient has been receiving proper treatment, including adequate comfort care; psychological examinations to ensure that the patient is not suffering from momentary or treatable depression; reporting procedures that will aid in the avoidance of abuse. Alternatively, such safeguards could be adopted by interested medical associations

and other organizations involved in the provision of health care, so long as they meet the state's needs and concerns. [FN123]

FN123. We do not suggest that all of these safeguards are either necessary or desirable singularly or collectively. That is essentially a matter for the states to determine. In doing so, they would of course consider the practical implications of the various potential procedural safeguards before deciding which, if any, to adopt.

*Compassion in Dying v. State of Wash.*, 79 F.3d 790, 833 (9th Cir. 1996).

The Oregon statute has some of these safeguards, see above, beginning at page 90.

The clearest statement of the holding in this case was in the introduction to the U.S. Court of Appeals' en banc majority opinion:

We now affirm the District Court's decision and clarify the scope of the relief. We hold that the "or aids" provision of Washington statute RCW 9A.36.060, as applied to the prescription of life-ending medication for use by terminally ill, competent adult patients who wish to hasten their deaths, violates the Due Process Clause of the Fourteenth Amendment. [footnote omitted]

*Compassion in Dying v. State of Wash.*, 79 F.3d 790, 798 (9th Cir. 1996).

Finally, the en banc majority opinion concludes with:

There is one final point we must emphasize. Some argue strongly that decisions regarding matters affecting life or death should not be made by the courts. Essentially, we agree with that proposition. In this case, by permitting the *individual* to exercise the right to *choose* we are following the constitutional mandate to take such decisions out of the hands of the government, both state and federal, and to put them where they rightly belong, in the hands of the people. We are allowing individuals to make the decisions that so profoundly affect their very existence — and precluding the state from intruding excessively into that critical realm. The Constitution and the courts stand as a bulwark between individual freedom and arbitrary and intrusive governmental power. Under our constitutional system, neither the state nor the majority of the people in a state can impose its will upon the individual in a matter so highly "central to personal dignity and autonomy," *Casey*, 505 U.S. at 851, 112 S.Ct. at 2807. Those who believe strongly that death must come without physician assistance are free to follow that creed, be they doctors or patients. They are not free, however, to force their views, their religious convictions, or their philosophies on all the other members of a democratic society, and to compel those whose values differ with theirs to die painful, protracted, and agonizing deaths.

*Compassion in Dying v. State of Wash.*, 79 F.3d 790, 798 (9th Cir. 1996).

## U.S. Supreme Court

The U.S. Supreme Court unanimously reversed the en banc opinion of the U.S. Court of Appeals for the Ninth Circuit. The Court began with a long review of the legal history of prohibiting assisting a suicide.

We begin, as we do in all due process cases, by examining our Nation's history, legal traditions, and practices. See, e.g., *Casey*, *supra*, at 849- 850, 112 S.Ct., at 2805-2806; *Cruzan*, *supra*, at 269-279, 110 S.Ct., at 2846-2842; *Moore v. East Cleveland*, 431 U.S. 494, 503, 97 S.Ct. 1932, 1937- 1938, 52 L.Ed.2d 531 (1977) (plurality opinion) (noting importance of "careful 'respect for the teachings of history' "). In almost every State — indeed, in almost every western democracy — it is a crime to assist a suicide. [FN8] The States' assisted-suicide bans are not innovations. Rather, they are longstanding expressions of the States' commitment to the protection and preservation of all human life. *Cruzan*, *supra*, at 280, 110 S.Ct., at 2852 ("[T]he States — indeed, all civilized nations — demonstrate their commitment to life by treating homicide as a serious crime. Moreover, the majority of States in this country have laws imposing criminal penalties on one who assists another to commit suicide"); see *Stanford v. Kentucky*, 492 U.S. 361, 373, 109 S.Ct. 2969, 2977, 106 L.Ed.2d 306 (1989) ("[T]he primary and most reliable indication of [a national] consensus is ... the pattern of enacted laws"). Indeed, opposition to and condemnation of suicide — and, therefore, of assisting suicide — are consistent and enduring themes of our philosophical, legal, and cultural heritages. See generally Marzen 17-56; New York State Task Force on Life and the Law, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context* 77-82 (May 1994) (hereinafter New York Task Force).

FN8. See *Compassion in Dying v. Washington*, 79 F.3d 790, 847, and nn. 10-13 (C.A.9 1996) (Beezer, J., dissenting) ("In total, forty-four states, the District of Columbia and two territories prohibit or condemn assisted suicide") (citing statutes and cases); *Rodriguez v. British Columbia (Attorney General)*, 107 D.L.R. (4th) 342, 404 (Can. 1993) ("[A] blanket prohibition on assisted suicide ... is the norm among western democracies") (discussing assisted-suicide provisions in Austria, Spain, Italy, the United Kingdom, the Netherlands, Denmark, Switzerland, and France). Since the Ninth Circuit's decision, Louisiana, Rhode Island, and Iowa have enacted statutory assisted-suicide bans. La.Rev.Stat. Ann. 14:32.12 (West Supp. 1997); R.I. Gen. Laws 11-60-1, 11-60-3 (Supp. 1996); Iowa Code Ann. 707A.2, 707A.3 (Supp.1997). For a detailed history of the States' statutes, see Marzen, O'Dowd, Crone, & Balch, *Suicide: A Constitutional Right?*, 24 *Duquesne L.Rev.* 1, 148-242 (1985) (App.) (hereinafter Marzen).

More specifically, for over 700 years, the Anglo-American common-law tradition has punished or otherwise disapproved of both suicide and assisting suicide. [FN9] *Cruzan*, 497 U.S., at 294-295, 110 S.Ct., at 2859-2860 (SCALIA, J., concurring). In the 13th century, Henry de Bracton, one of the first legal-treatise writers, observed that "[j]ust as a man may commit felony by slaying another so may he do so by slaying himself." 2 *Bracton on Laws and Customs of England* 423 (f.150) (G. Woodbine ed., S. Thorne transl., 1968). The real and personal property of one who killed himself to avoid conviction and punishment for a crime were forfeit to the King; however, thought Bracton, "if a man slays himself in weariness of life or because he is unwilling to endure further bodily pain ... [only] his movable goods [were] confiscated." *Id.*, at 423-424 (f.150). Thus, "[t]he principle that suicide of a sane person, for whatever reason, was a punishable felony was ... introduced into English common law." [FN10] Centuries later, Sir William Blackstone, whose *Commentaries on the Laws of England* not only provided a definitive summary of the



common law but was also a primary legal authority for 18th- and 19th-century American lawyers, referred to suicide as "self-murder" and "the pretended heroism, but real cowardice, of the Stoic philosophers, who destroyed themselves to avoid those ills which they had not the fortitude to endure...." 4 W. Blackstone, Commentaries \*189. Blackstone emphasized that "the law has ... ranked [suicide] among the highest crimes," *ibid.*, although, anticipating later developments, he conceded that the harsh and shameful punishments imposed for suicide "borde[r] a little upon severity." *Id.*, at \*190.

FN9. The common law is thought to have emerged through the expansion of pre-Norman institutions sometime in the 12th century. J. Baker, *An Introduction to English Legal History* 11 (2d ed. 1979). England adopted the ecclesiastical prohibition on suicide five centuries earlier, in the year 673 at the Council of Hereford, and this prohibition was reaffirmed by King Edgar in 967. See G. Williams, *The Sanctity of Life and the Criminal Law* 257 (1957).

FN10. Marzen 59. Other late-medieval treatise writers followed and restated Bracton; one observed that "man-slaughter" may be "[o]f [one]self; as in case, when people hang themselves or hurt themselves, or otherwise kill themselves of their own felony" or "[o]f others; as by beating, famine, or other punishment; in like cases, all are man-slayers." A. Horne, *The Mirrour of Justices*, ch. 1, 9, pp. 41-42 (W. Robinson ed. 1903). By the mid-16th century, the Court at Common Bench could observe that "[suicide] is an Offence against Nature, against God, and against the King... [T]o destroy one's self is contrary to Nature, and a Thing most horrible." *Hales v. Petit*, 1 Plowd. Com. 253, 261, 75 Eng. Rep. 387, 400 (1561-1562). In 1644, Sir Edward Coke published his *Third Institute*, a lodestar for later common lawyers. See T. Plucknett, *A Concise History of the Common Law* 281-284 (5th ed. 1956). Coke regarded suicide as a category of murder, and agreed with Bracton that the goods and chattels--but not, for Coke, the lands--of a sane suicide were forfeit. 3 E. Coke, *Institutes* \*54. William Hawkins, in his 1716 *Treatise of the Pleas of the Crown*, followed Coke, observing that "our laws have always had ... an abhorrence of this crime." 1 W. Hawkins, *Pleas of the Crown*, ch. 27, 4, p. 164 (T. Leach ed. 1795).

For the most part, the early American Colonies adopted the common-law approach. For example, the legislators of the Providence Plantations, which would later become Rhode Island, declared, in 1647, that "[s]elf-murder is by all agreed to be the most unnatural, and it is by this present Assembly declared, to be that, wherein he that doth it, kills himself out of a premeditated hatred against his own life or other humor: ... his goods and chattels are the king's custom, but not his debts nor lands; but in case he be an infant, a lunatic, mad or distracted man, he forfeits nothing." *The Earliest Acts and Laws of the Colony of Rhode Island and Providence Plantations 1647-1719*, p. 19 (J. Cushing ed. 1977). Virginia also required ignominious burial for suicides, and their estates were forfeit to the Crown. A. Scott, *Criminal Law in Colonial Virginia* 108, and n. 93, 198, and n. 15 (1930).

Over time, however, the American Colonies abolished these harsh common-law penalties. William Penn abandoned the criminal-forfeiture sanction in Pennsylvania in 1701, and the other Colonies (and later, the other States) eventually followed this example. *Cruzan, supra*, at 294, 110 S.Ct., at 2859-2860 (SCALIA, J., concurring). Zephaniah Swift, who would later become Chief Justice of Connecticut, wrote in 1796:

There can be no act more contemptible, than to attempt to punish an offender for a crime, by exercising a mean act of revenge upon lifeless clay, that is insensible of the punishment. There can be no greater cruelty, than the inflicting [of] a punishment, as the forfeiture of goods, which must fall solely on the innocent offspring of the offender.... [Suicide] is so abhorrent to the feelings of mankind, and that strong love of life which is implanted in the human heart, that it cannot be so frequently committed, as to become dangerous to society. There can of course be no necessity of any punishment.

2 Z. Swift, *A System of the Laws of the State of Connecticut* 304 (1796).

This statement makes it clear, however, that the movement away from the common law's harsh sanctions did not represent an acceptance of suicide; rather, as Chief Justice Swift observed, this change reflected the growing consensus that it was unfair to punish the suicide's family for his wrongdoing. *Cruzan, supra*, at 294, 110 S.Ct., at 2859 (SCALIA, J., concurring). Nonetheless, although States moved away from Blackstone's treatment of suicide, courts continued to condemn it as a grave public wrong. See, e.g., *Bigelow v. Berkshire Life Ins. Co.*, 93 U.S. 284, 286, 23 L.Ed. 918 (1876) (suicide is "an act of criminal self-destruction"); *Von Holden v. Chapman*, 87 A.D.2d 66, 70-71, 450 N.Y.S.2d 623, 626-627 (1982); *Blackwood v. Jones*, 111 Fla. 528, 532, 149 So. 600, 601 (1933) ("No sophistry is tolerated ... which seek[s] to justify self-destruction as commendable or even a matter of personal right").

That suicide remained a grievous, though nonfelonious, wrong is confirmed by the fact that colonial and early state legislatures and courts did not retreat from prohibiting assisting suicide. Swift, in his early 19th-century treatise on the laws of Connecticut, stated that "[i]f one counsels another to commit suicide, and the other by reason of the advice kills himself, the advisor is guilty of murder as principal." 2 Z. Swift, *A Digest of the Laws of the State of Connecticut* 270 (1823). This was the well-established common-law view, see *In re Joseph G.*, 34 Cal.3d 429, 434-435, 194 Cal.Rptr. 163, 166, 667 P.2d 1176, 1179 (1983); *Commonwealth v. Mink*, 123 Mass. 422, 428 (1877) (" 'Now if the murder of one's self is felony, the accessory is equally guilty as if he had aided and abetted in the murder' ") (quoting Chief Justice Parker's charge to the jury in *Commonwealth v. Bowen*, 13 Mass. 356 (1816)), as was the similar principle that the consent of a homicide victim is "wholly immaterial to the guilt of the person who cause[d] [his death]," 3 J. Stephen, *A History of the Criminal Law of England* 16 (1883); see 1 F. Wharton, *Criminal Law* 451-452 (9th ed. 1885); *Martin v. Commonwealth*, 184 Va. 1009, 1018-1019, 37 S.E.2d 43, 47 (1946) (" 'The right to life and to personal security is not only sacred in the estimation of the common law, but it is inalienable' "). And the prohibitions against assisting suicide never contained exceptions for those who were near death. Rather, "[t]he life of those to whom life ha[d] become a burden — of those who [were] hopelessly diseased or fatally wounded — nay, even the lives of criminals condemned to death, [were] under the protection of the law, equally as the lives of those who [were] in the full tide of life's enjoyment, and anxious to continue to live." *Blackburn v. State*, 23 Ohio St. 146, 163 (1872); see *Bowen, supra*, at 360 (prisoner who persuaded another to commit suicide could be tried for murder, even though victim was scheduled shortly to be executed).

The earliest American statute explicitly to outlaw assisting suicide was enacted in New York in 1828, Act of Dec. 10, 1828, ch. 20, § 4, 1828 N.Y. Laws 19 (codified at 2 N.Y.Rev.Stat. pt. 4, ch. 1, Tit. 2, Art. 1, § 7, p. 661 (1829)), and many of the new States and Territories followed New York's example. Marzen 73-74. Between 1857 and 1865, a New York commission led by Dudley Field drafted a criminal code that prohibited "aiding" a suicide and, specifically, "furnish[ing] another person with any deadly weapon or poisonous drug, knowing that such person intends to use such weapon or drug in taking his own life." *Id.*, at 76-77. By the time the Fourteenth Amendment was ratified, it was a crime in most States to assist a suicide. See *Cruzan*, 497 U.S. at 294-295, 110 S.Ct., at 2859-2860 (SCALIA, J., concurring). The Field Penal Code was adopted in the Dakota Territory in 1877 and in New York in 1881, and its language served as a model for several other western States' statutes in the late 19th and early 20th centuries. Marzen 76-77, 205-206, 212-213. California, for example, codified its assisted-suicide prohibition in 1874, using language similar to the Field Code's. [FN11] In this century, the Model Penal Code also prohibited "aiding" suicide, prompting many States to enact or revise their assisted-suicide bans. [FN12]

The code's drafters observed that "the interests in the sanctity of life that are represented by the criminal homicide laws are threatened by one who expresses a willingness to participate in taking the life of another, even though the act may be accomplished with the consent, or at the request, of the suicide victim." American Law Institute, Model Penal Code 210.5, Comment 5, p. 100 (Official Draft and Revised Comments 1980).

FN11. In 1850, the California Legislature adopted the English common law, under which assisting suicide was, of course, a crime. Act of Apr. 13, 1850, ch. 95, 1850 Cal. Stats. 219. The provision adopted in 1874 provided that "[e]very person who deliberately aids or advises, or encourages another to commit suicide, is guilty of a felony." Act of Mar. 30, 1874, ch. 614, § 13,400 (codified at Cal.Penal Code § 400 (T. Hittel ed. 1876)).

FN12. "A person who purposely aids or solicits another to commit suicide is guilty of a felony in the second degree if his conduct causes such suicide or an attempted suicide, and otherwise of a misdemeanor." American Law Institute, Model Penal Code § 210.5(2) (Official Draft and Revised Comments 1980).

Though deeply rooted, the States' assisted-suicide bans have in recent years been reexamined and, generally, reaffirmed. Because of advances in medicine and technology, Americans today are increasingly likely to die in institutions, from chronic illnesses. President's Comm'n for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Deciding to Forego Life-Sustaining Treatment* 16-18 (1983). Public concern and democratic action are therefore sharply focused on how best to protect dignity and independence at the end of life, with the result that there have been many significant changes in state laws and in the attitudes these laws reflect. Many States, for example, now permit "living wills," surrogate health-care decisionmaking, and the withdrawal or refusal of life-sustaining medical treatment. See *Vacco v. Quill*, 521 U.S. 793, 804-806, 117 S.Ct. 2293, 2299-2301, 138 L.Ed.2d 834; 79 F.3d, at 818-820; *People v. Kevorkian*, 447 Mich. 436, 478-480, and nn. 53-56, 527 N.W.2d 714, 731-732, and nn. 53-56 (1994). At the same time, however, voters and legislators continue for the most part to reaffirm their States' prohibitions on assisting suicide.

The Washington statute at issue in this case, Wash. Rev.Code 9A.36.060 (1994), was enacted in 1975 as part of a revision of that State's criminal code. Four years later, Washington passed its Natural Death Act, which specifically stated that the "withholding or withdrawal of life-sustaining treatment ... shall not, for any purpose, constitute a suicide" and that "[n]othing in this chapter shall be construed to condone, authorize, or approve mercy killing...." Natural Death Act, 1979 Wash. Laws, ch. 112, § 8(1), p. 11 (codified at Wash. Rev.Code § 70.122.070(1), 70.122.100 (1994)). In 1991, Washington voters rejected a ballot initiative which, had it passed, would have permitted a form of physician-assisted suicide. [FN13] Washington then added a provision to the Natural Death Act expressly excluding physician-assisted suicide. 1992 Wash. Laws, ch. 98, 10; Wash. Rev.Code 70.122.100 (1994).

FN13. Initiative 119 would have amended Washington's Natural Death Act, Wash. Rev.Code § 70.122.010 *et seq.* (1994), to permit "aid-in-dying," defined as "aid in the form of a medical service provided in person by a physician that will end the life of a conscious and mentally competent qualified patient in a dignified, painless and humane manner, when requested voluntarily by the patient through a written directive in accordance with this chapter at the time the medical service is to be provided." App. H to Pet. for Cert. 3-4.

California voters rejected an assisted-suicide initiative similar to Washington's in 1993. On the other hand, in 1994, voters in Oregon enacted, also through ballot initiative, that State's

"Death With Dignity Act," which legalized physician-assisted suicide for competent, terminally ill adults. [FN14] Since the Oregon vote, many proposals to legalize assisted-suicide have been and continue to be introduced in the States' legislatures, but none has been enacted. [FN15] And just last year, Iowa and Rhode Island joined the overwhelming majority of States explicitly prohibiting assisted suicide. See Iowa Code Ann. §§ 707A.2, 707A.3 (Supp.1997); R.I. Gen. Laws §§ 11-60-1, 11-60-3 (Supp. 1996). Also, on April 30, 1997, President Clinton signed the Federal Assisted Suicide Funding Restriction Act of 1997, which prohibits the use of federal funds in support of physician-assisted suicide. Pub.L. 105-12, 111 Stat. 23 (codified at 42 U.S.C. § 14401 *et seq.*). [FN16]

FN14. Ore.Rev.Stat. § 127.800 *et seq.* (1996); *Lee v. Oregon*, 891 F.Supp. 1429 (Ore. 1995) (Oregon Act does not provide sufficient safeguards for terminally ill persons and therefore violates the Equal Protection Clause), vacated, *Lee v. Oregon*, 107 F.3d 1382 (C.A.9 1997).

FN15. See, *e.g.*, Alaska H.B. 371 (1996); Ariz. S.B. 1007 (1996); Cal. A.B. 1080, A.B. 1310 (1995); Colo. H.B. 1185 (1996); Colo. H.B. 1308 (1995); Conn. H.B. 6298 (1995); Ill. H.B. 691, S.B. 948 (1997); Me. H.P. 663 (1997); Me. H.P. 552 (1995); Md. H.B. 474 (1996); Md. H.B. 933 (1995); Mass. H.B. 3173 (1995); Mich. H.B. 6205, S.B. 556 (1996); Mich. H.B. 4134 (1995); Miss. H.B. 1023 (1996); N.H.H.B. 339 (1995); N.M.S.B. 446 (1995); N.Y.S.B. 5024, A.B. 6333 (1995); Neb. L.B. 406 (1997); Neb. L.B. 1259 (1996); R.I.S. 2985 (1996); Vt. H.B. 109 (1997); Vt. H.B. 335 (1995); Wash. S.B. 5596 (1995); Wis. A.B. 174, S.B. 90 (1995); Senate of Canada, *Of Life and Death*, Report of the Special Senate Committee on Euthanasia and Assisted Suicide A-56 (June 1995) (describing unsuccessful proposals, between 1991-1994, to legalize assisted suicide).

FN16. Other countries are embroiled in similar debates: The Supreme Court of Canada recently rejected a claim that the Canadian Charter of Rights and Freedoms establishes a fundamental right to assisted suicide, *Rodriguez v. British Columbia (Attorney General)*, 107 D.L.R. (4th) 342 (1993); the British House of Lords Select Committee on Medical Ethics refused to recommend any change in Great Britain's assisted-suicide prohibition, House of Lords, Session 1993-94 Report of the Select Committee on Medical Ethics, 12 *Issues in Law & Med.* 193, 202 (1996) ("We identify no circumstances in which assisted suicide should be permitted"); New Zealand's Parliament rejected a proposed "Death With Dignity Bill" that would have legalized physician-assisted suicide in August 1995, Graeme, MPs Throw out Euthanasia Bill, *The Dominion (Wellington)*, Aug. 17, 1995, p. 1; and the Northern Territory of Australia legalized assisted suicide and voluntary euthanasia in 1995, see Shenon, *Australian Doctors Get Right to Assist Suicide*, *N.Y. Times*, July 28, 1995, p. A8. As of February 1997, three persons had ended their lives with physician assistance in the Northern Territory. Mydans, *Assisted Suicide: Australia Faces a Grim Reality*, *N.Y. Times*, Feb. 2, 1997, p. A3. On March 24, 1997, however, the Australian Senate voted to overturn the Northern Territory's law. Thornhill, *Australia Repeals Euthanasia Law*, *Washington Post*, Mar. 25, 1997, p. A14; see *Euthanasia Laws Act 1997*, No. 17, 1997 (Austl.). On the other hand, on May 20, 1997, Colombia's Constitutional Court legalized voluntary euthanasia for terminally ill people. *Sentencia No. C-239/97 (Corte Constitucional, Mayo 20, 1997)*; see *Colombia's Top Court Legalizes Euthanasia*, *Orlando Sentinel*, May 22, 1997, p. A18.

Thus, the States are currently engaged in serious, thoughtful examinations of physician-assisted suicide and other similar issues. For example, New York State's Task Force on Life and the Law — an ongoing, blue-ribbon commission composed of doctors, ethicists, lawyers, religious leaders, and interested laymen — was convened in 1984 and commissioned with "a broad mandate to recommend public policy on issues raised by medical advances." *New York Task Force* vii. Over the past decade, the Task Force has recommended laws relating to end-of-life decisions, surrogate pregnancy, and organ donation. *Id.*, at 118-119. After studying physician-assisted suicide, however, the Task Force unanimously concluded that "[l]egalizing assisted suicide and euthanasia would pose profound risks to many individuals

who are ill and vulnerable.... [T]he potential dangers of this dramatic change in public policy would outweigh any benefit that might be achieved." *Id.*, at 120.

Attitudes toward suicide itself have changed since Bracton, but our laws have consistently condemned, and continue to prohibit, assisting suicide. Despite changes in medical technology and notwithstanding an increased emphasis on the importance of end-of-life decisionmaking, we have not retreated from this prohibition. Against this backdrop of history, tradition, and practice, we now turn to respondents' constitutional claim. *Washington v. Glucksberg*, 521 U.S. 702, 710-719 (1997).

The Court addressed the specific issues in this case.

Turning to the claim at issue here, the Court of Appeals stated that "[p]roperly analyzed, the first issue to be resolved is whether there is a liberty interest in determining the time and manner of one's death," 79 F.3d, at 801, or, in other words, "[i]s there a right to die?," *id.*, at 799. Similarly, respondents assert a "liberty to choose how to die" and a right to "control of one's final days," Brief for Respondents 7, and describe the asserted liberty as "the right to choose a humane, dignified death," *id.*, at 15, and "the liberty to shape death," *id.*, at 18. As noted above, we have a tradition of carefully formulating the interest at stake in substantive-due-process cases. For example, although *Cruzan* is often described as a "right to die" case, see 79 F.3d, at 799; 521 U.S., at 745, 117 S.Ct., at 2307 (STEVENS, J., concurring in judgments) (*Cruzan* recognized "the more specific interest in making decisions about how to confront an imminent death"), we were, in fact, more precise: We assumed that the Constitution granted competent persons a "constitutionally protected right to refuse lifesaving hydration and nutrition." *Cruzan*, 497 U.S., at 279, 110 S.Ct., at 2843; *id.*, at 287, 110 S.Ct., at 2856 (O'CONNOR, J., concurring) ("[A] liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions").<sup>33</sup> The Washington statute at issue in this case prohibits "aid[ing] another person to attempt suicide," Wash. Rev.Code 9A.36.060(1) (1994), and, thus, the question before us is whether the "liberty" specially protected by the Due Process Clause includes a right to commit suicide which itself includes a right to assistance in doing so. [FN18]

FN18. See, e.g., *Quill v. Vacco*, 80 F.3d 716, 724 (C.A.2 1996) ("right to assisted suicide finds no cognizable basis in the Constitution's language or design"); *Compassion in Dying v. Washington*, 49 F.3d 586, 591 (C.A.9 1995) (referring to alleged "right to suicide," "right to assistance in suicide," and "right to aid in killing oneself"); *People v. Kevorkian*, 447 Mich. 436, 476, n. 47, 527 N.W.2d 714, 730, n. 47 (1994) ("[T]he question that we must decide is whether the [C]onstitution encompasses a right to commit suicide and, if so, whether it includes a right to assistance").

We now inquire whether this asserted right has any place in our Nation's traditions. Here, as discussed *supra*, at 2262-2267, we are confronted with a consistent and almost universal tradition that has long rejected the asserted right, and continues explicitly to reject it today, even for terminally ill, mentally competent adults. To hold for respondents, we would

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<sup>33</sup> The Court's citation is *wrong*. The sentence "The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions." actually occurs in the majority opinion in *Cruzan*, 497 U.S. at 278, 110 S.Ct. at 2851. Justice O'Connor began her concurring opinion by saying: "I agree that a protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions, see *ante*, [110 S.Ct.] at 2850-2851, and that the refusal of artificially delivered food and water is encompassed within that liberty interest. See *ante*, at 2852." *Cruzan*, 497 U.S. at 287, 110 S.Ct. at 2856 (O'Connor, J., concurring).

have to reverse centuries of legal doctrine and practice, and strike down the considered policy choice of almost every State. See *Jackman v. Rosenbaum Co.*, 260 U.S. 22, 31, 43 S.Ct. 9, 9-10, 67 L.Ed. 107 (1922) ("If a thing has been practised for two hundred years by common consent, it will need a strong case for the Fourteenth Amendment to affect it"); *Flores*, 507 U.S., at 303, 113 S.Ct., at 1447 ("The mere novelty of such a claim is reason enough to doubt that 'substantive due process' sustains it").

Respondents contend, however, that the liberty interest they assert *is* consistent with this Court's substantive-due-process line of cases, if not with this Nation's history and practice. Pointing to *Casey* and *Cruzan*, respondents read our jurisprudence in this area as reflecting a general tradition of "self-sovereignty," Brief for Respondents 12, and as teaching that the "liberty" protected by the Due Process Clause includes "basic and intimate exercises of personal autonomy," *id.*, at 10; see *Casey*, 505 U.S., at 847, 112 S.Ct., at 2804-2805 ("It is a promise of the Constitution that there is a realm of personal liberty which the government may not enter"). According to respondents, our liberty jurisprudence, and the broad, individualistic principles it reflects, protects the "liberty of competent, terminally ill adults to make end-of-life decisions free of undue government interference." Brief for Respondents 10. The question presented in this case, however, is whether the protections of the Due Process Clause include a right to commit suicide with another's assistance. With this "careful description" of respondents' claim in mind, we turn to *Casey* and *Cruzan*.

In *Cruzan*, we considered whether Nancy Beth Cruzan, who had been severely injured in an automobile accident and was in a persistent vegetative state, "ha[d] a right under the United States Constitution which would require the hospital to withdraw life-sustaining treatment" at her parents' request. 497 U.S., at 269, 110 S.Ct., at 2846-2847. We began with the observation that "[a]t common law, even the touching of one person by another without consent and without legal justification was a battery." *Ibid.* We then discussed the related rule that "informed consent is generally required for medical treatment." *Ibid.* After reviewing a long line of relevant state cases, we concluded that "the common-law doctrine of informed consent is viewed as generally encompassing the right of a competent individual to refuse medical treatment." *Id.*, at 277, 110 S.Ct., at 2851. Next, we reviewed our own cases on the subject, and stated that "[t]he principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions." *Id.*, at 278, 110 S.Ct., at 2851. Therefore, "for purposes of [that] case, we assume[d] that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition." *Id.*, at 279, 110 S.Ct., at 2852; see *id.*, at 287, 110 S.Ct., at 2856 (O'CONNOR, J., concurring). We concluded that, notwithstanding this right, the Constitution permitted Missouri to require clear and convincing evidence of an incompetent patient's wishes concerning the withdrawal of life-sustaining treatment. *Id.*, at 280-281, 110 S.Ct., at 2852-2853.

Respondents contend that in *Cruzan* we "acknowledged that competent, dying persons have the right to direct the removal of life-sustaining medical treatment and thus hasten death," Brief for Respondents 23, and that "the constitutional principle behind recognizing the patient's liberty to direct the withdrawal of artificial life support applies at least as strongly to the choice to hasten impending death by consuming lethal medication," *id.*, at 26. Similarly, the Court of Appeals concluded that "*Cruzan*, by recognizing a liberty interest that includes the refusal of artificial provision of life-sustaining food and water, necessarily recognize[d] a liberty interest in hastening one's own death." 79 F.3d, at 816.

The right assumed in *Cruzan*, however, was not simply deduced from abstract concepts of personal autonomy. Given the common-law rule that forced medication was a battery, and the long legal tradition protecting the decision to refuse unwanted medical treatment, our assumption was entirely consistent with this Nation's history and constitutional traditions.

The decision to commit suicide with the assistance of another may be just as personal and profound as the decision to refuse unwanted medical treatment, but it has never enjoyed similar legal protection. Indeed, the two acts are widely and reasonably regarded as quite distinct. See *Vacco v. Quill*, 521 U.S., at 800-808, 117 S.Ct., at 2298-2302. In *Cruzan* itself, we recognized that most States outlawed assisted suicide — and even more do today — and we certainly gave no intimation that the right to refuse unwanted medical treatment could be somehow transmuted into a right to assistance in committing suicide. 497 U.S., at 280, 110 S.Ct., at 2852.

Respondents also rely on *Casey*. There, the Court's opinion concluded that "the essential holding of *Roe v. Wade*[, 410 U.S. 113, 93 S.Ct. 705, 35 L.Ed.2d 147 (1973),] should be retained and once again reaffirmed." 505 U.S., at 846, 112 S.Ct., at 2804. We held, first, that a woman has a right, before her fetus is viable, to an abortion "without undue interference from the State"; second, that States may restrict post viability abortions, so long as exceptions are made to protect a woman's life and health; and third, that the State has legitimate interests throughout a pregnancy in protecting the health of the woman and the life of the unborn child. *Ibid*. In reaching this conclusion, the opinion discussed in some detail this Court's substantive-due-process tradition of interpreting the Due Process Clause to protect certain fundamental rights and "personal decisions relating to marriage, procreation, contraception, family relationships, child rearing, and education," and noted that many of those rights and liberties "involv[e] the most intimate and personal choices a person may make in a lifetime." *Id.*, at 851, 112 S.Ct., at 2807.

The Court of Appeals, like the District Court, found *Casey* "highly instructive" and "almost prescriptive" for determining "what liberty interest may inhere in a terminally ill person's choice to commit suicide":

Like the decision of whether or not to have an abortion, the decision how and when to die is one of 'the most intimate and personal choices a person may make in a lifetime,' a choice 'central to personal dignity and autonomy.'

79 F.3d, at 813-814.

Similarly, respondents emphasize the statement in *Casey* that:

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." *Casey*, 505 U.S., at 851, 112 S.Ct., at 2807.

Brief for Respondents 12. By choosing this language, the Court's opinion in *Casey* described, in a general way and in light of our prior cases, those personal activities and decisions that this Court has identified as so deeply rooted in our history and traditions, or so fundamental to our concept of constitutionally ordered liberty, that they are protected by the Fourteenth Amendment. [FN19] The opinion moved from the recognition that liberty necessarily includes freedom of conscience and belief about ultimate considerations to the observation that "though the abortion decision may originate within the zone of conscience and belief, it is *more than a philosophic exercise*." *Casey*, 505 U.S., at 852, 112 S.Ct., at 2807 (emphasis added). That many of the rights and liberties protected by the Due Process Clause sound in personal autonomy does not warrant the sweeping conclusion that any and all important, intimate, and personal decisions are so protected, *San Antonio Independent School Dist. v. Rodriguez*, 411 U.S. 1, 33-35, 93 S.Ct. 1278, 1296-1298, 36 L.Ed.2d 16 (1973), and *Casey* did not suggest otherwise.

FN19 See *Moore v. East Cleveland*, 431 U.S. 494, 503, 97 S.Ct. 1932, 1937-1938, 52 L.Ed.2d 531 (1977) ("[T]he Constitution protects the sanctity of the family *precisely because* the institution of the family is deeply rooted in this Nation's history and tradition" (emphasis added)); *Griswold v.*

*Connecticut*, 381 U.S. 479, 485-486, 85 S.Ct. 1678, 1682- 1683, 14 L.Ed.2d 510 (1965) (intrusions into the "sacred precincts of marital bedrooms" offend rights "older than the Bill of Rights"); *id.*, at 495-496, 85 S.Ct., at 1687-1688 (Goldberg, J., concurring) (the law in question "disrupt[ed] the traditional relation of the family — a relation as old and as fundamental as our entire civilization"); *Loving v. Virginia*, 388 U.S. 1, 12, 87 S.Ct. 1817, 1823-1824, 18 L.Ed.2d 1010 (1967) ("The freedom to marry has long been recognized as one of the vital personal rights essential to the orderly pursuit of happiness"); *Turner v. Safley*, 482 U.S. 78, 95, 107 S.Ct. 2254, 2265, 96 L.Ed.2d 64 (1987) ("[T]he decision to marry is a fundamental right"); *Roe v. Wade*, 410 U.S. 113, 140, 93 S.Ct. 705, 720-721, 35 L.Ed.2d 147 (1973) (stating that at the founding and throughout the 19th century, "a woman enjoyed a substantially broader right to terminate a pregnancy"); *Skinner v. Oklahoma ex rel. Williamson*, 316 U.S. 535, 541, 62 S.Ct. 1110, 1113, 86 L.Ed. 1655 (1942) ("Marriage and procreation are fundamental"); *Pierce v. Society of Sisters*, 268 U.S. 510, 535, 45 S.Ct. 571, 573-574, 69 L.Ed. 1070 (1925); *Meyer v. Nebraska*, 262 U.S. 390, 399, 43 S.Ct. 625, 626- 627, 67 L.Ed. 1042 (1923) (liberty includes "those privileges long recognized at common law as essential to the orderly pursuit of happiness by free men").

The history of the law's treatment of assisted suicide in this country has been and continues to be one of the rejection of nearly all efforts to permit it. That being the case, our decisions lead us to conclude that the asserted "right" to assistance in committing suicide is not a fundamental liberty interest protected by the Due Process Clause. The Constitution also requires, however, that Washington's assisted-suicide ban be rationally related to legitimate government interests. See *Heller v. Doe*, 509 U.S. 312, 319- 320, 113 S.Ct. 2637, 2642-2643, 125 L.Ed.2d 257 (1993); *Flores*, 507 U.S., at 305, 113 S.Ct., at 1448-1449. This requirement is unquestionably met here. As the court below recognized, 79 F.3d, at 816-817, [FN20] Washington's assisted-suicide ban implicates a number of state interests. [FN21] See 49 F.3d, at 592-593; Brief for State of California et al. as *Amici Curiae* 26-29; Brief for United States as *Amicus Curiae* 16-27.

FN20. The court identified and discussed six state interests: (1) preserving life; (2) preventing suicide; (3) avoiding the involvement of third parties and use of arbitrary, unfair, or undue influence; (4) protecting family members and loved ones; (5) protecting the integrity of the medical profession; and (6) avoiding future movement toward euthanasia and other abuses. 79 F.3d, at 816-832.

FN21. Respondents also admit the existence of these interests, Brief for Respondents 28-39, but contend that Washington could better promote and protect them through regulation, rather than prohibition, of physician-assisted suicide. Our inquiry, however, is limited to the question whether the State's prohibition is rationally related to legitimate state interests.

First, Washington has an "unqualified interest in the preservation of human life." *Cruzan*, 497 U.S., at 282, 110 S.Ct., at 2853. The State's prohibition on assisted suicide, like all homicide laws, both reflects and advances its commitment to this interest. See *id.*, at 280, 110 S.Ct., at 2852; Model Penal Code 210.5, Comment 5, at 100 ("[T]he interests in the sanctity of life that are represented by the criminal homicide laws are threatened by one who expresses a willingness to participate in taking the life of another"). [FN22] This interest is symbolic and aspirational as well as practical:

FN22. The States express this commitment by other means as well:

[N]early all states expressly disapprove of suicide and assisted suicide either in statutes dealing with durable powers of attorney in health-care situations, or in 'living will' statutes. In addition, all states provide for the involuntary commitment of persons who may harm themselves as the result of mental illness, and a number of states allow the use of nondeadly force to thwart suicide attempts.



*People v. Kevorkian*, 447 Mich., at 478-479, and nn. 53-56, 527 N.W.2d, at 731-732, and nn. 53-56.

"While suicide is no longer prohibited or penalized, the ban against assisted suicide and euthanasia shores up the notion of limits in human relationships. It reflects the gravity with which we view the decision to take one's own life or the life of another, and our reluctance to encourage or promote these decisions." New York Task Force 131-132.

Respondents admit that "[t]he State has a real interest in preserving the lives of those who can still contribute to society and have the potential to enjoy life." Brief for Respondents 35, n. 23. The Court of Appeals also recognized Washington's interest in protecting life, but held that the "weight" of this interest depends on the "medical condition and the wishes of the person whose life is at stake." 79 F.3d, at 817. Washington, however, has rejected this sliding-scale approach and, through its assisted-suicide ban, insists that all persons' lives, from beginning to end, regardless of physical or mental condition, are under the full protection of the law. See *United States v. Rutherford*, 442 U.S. 544, 558, 99 S.Ct. 2470, 2478-2479, 61 L.Ed.2d 68 (1979) ("... Congress could reasonably have determined to protect the terminally ill, no less than other patients, from the vast range of self-styled panaceas that inventive minds can devise"). As we have previously affirmed, the States "may properly decline to make judgments about the 'quality' of life that a particular individual may enjoy," *Cruzan, supra*, at 282, 110 S.Ct., at 2853. This remains true, as *Cruzan* makes clear, even for those who are near death.<sup>34</sup>

Relatedly, all admit that suicide is a serious public-health problem, especially among persons in otherwise vulnerable groups. See Washington State Dept. of Health, Annual Summary of Vital Statistics 1991, pp. 29-30 (Oct. 1992) (suicide is a leading cause of death in Washington of those between the ages of 14 and 54); New York Task Force 10, 23-33 (suicide rate in the general population is about one percent, and suicide is especially prevalent among the young and the elderly). The State has an interest in preventing suicide, and in studying, identifying, and treating its causes. See 79 F.3d, at 820; *id.*, at 854 (Beezer, J., dissenting) ("The state recognizes suicide as a manifestation of medical and psychological anguish"); Marzen 107-146.

Those who attempt suicide — terminally ill or not — often suffer from depression or other mental disorders. See New York Task Force 13-22, 126-128 (more than 95% of those who commit suicide had a major psychiatric illness at the time of death; among the terminally ill, uncontrolled pain is a "risk factor" because it contributes to depression); Physician-Assisted Suicide and Euthanasia in the Netherlands: A Report of Chairman Charles T. Canady to the Subcommittee on the Constitution of the House Committee on the Judiciary, 104th Cong., 2d Sess., 10-11 (Comm. Print 1996); cf. Back, Wallace, Starks, & Pearlman, Physician-Assisted Suicide and Euthanasia in Washington State, 275 JAMA 919, 924 (1996) ("[I]ntolerable physical symptoms are not the reason most patients request physician-assisted suicide or euthanasia"). Research indicates, however, that many people who request physician-assisted suicide withdraw that request if their depression and pain are treated. H. Hendin, *Seduced by Death: Doctors, Patients and the Dutch Cure* 24-25 (1997) (suicidal, terminally ill patients "usually respond well to treatment for depressive illness and pain medication and are then grateful to be alive"); New York Task Force 177-178. The New York Task Force, however, expressed its concern that, because depression is difficult to diagnose, physicians and medical professionals often fail to respond adequately to seriously ill patients' needs. *Id.*, at 175. Thus, legal physician-assisted suicide could make it more

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<sup>34</sup> Note by Standler: See page 110 below for a discussion of quality of life.

difficult for the State to protect depressed or mentally ill persons, or those who are suffering from untreated pain, from suicidal impulses.

The State also has an interest in protecting the integrity and ethics of the medical profession. In contrast to the Court of Appeals' conclusion that "the integrity of the medical profession would [not] be threatened in any way by [physician-assisted suicide]," 79 F.3d, at 827, the American Medical Association, like many other medical and physicians' groups, has concluded that "[p]hysician-assisted suicide is fundamentally incompatible with the physician's role as healer." American Medical Association, Code of Ethics 2.211 (1994); see Council on Ethical and Judicial Affairs, Decisions Near the End of Life, 267 JAMA 2229, 2233 (1992) ("[T]he societal risks of involving physicians in medical interventions to cause patients' deaths is too great")<sup>35</sup>; New York Task Force 103-109 (discussing physicians' views). And physician-assisted suicide could, it is argued, undermine the trust that is essential to the doctor-patient relationship by blurring the time-honored line between healing and harming. Assisted Suicide in the United States, Hearing before the Subcommittee on the Constitution of the House Committee on the Judiciary, 104th Cong., 2d Sess., 355-356 (1996) (testimony of Dr. Leon R. Kass) ("The patient's trust in the doctor's whole-hearted devotion to his best interests will be hard to sustain").

Next, the State has an interest in protecting vulnerable groups — including the poor, the elderly, and disabled persons — from abuse, neglect, and mistakes. The Court of Appeals dismissed the State's concern that disadvantaged persons might be pressured into physician-assisted suicide as "ludicrous on its face." 79 F.3d, at 825. We have recognized, however, the real risk of subtle coercion and undue influence in end-of-life situations. *Cruzan*, 497 U.S., at 281, 110 S.Ct., at 2852. Similarly, the New York Task Force warned that "[l]egalizing physician-assisted suicide would pose profound risks to many individuals who are ill and vulnerable.... The risk of harm is greatest for the many individuals in our society whose autonomy and well-being are already compromised by poverty, lack of access to good medical care, advanced age, or membership in a stigmatized social group." New York Task Force 120; see *Compassion in Dying*, 49 F.3d, at 593 ("An insidious bias against the handicapped — again coupled with a cost-saving mentality — makes them especially in need of Washington's statutory protection"). If physician-assisted suicide were permitted, many might resort to it to spare their families the substantial financial burden of end-of-life health-care costs.

The State's interest here goes beyond protecting the vulnerable from coercion; it extends to protecting disabled and terminally ill people from prejudice, negative and inaccurate stereotypes, and "societal indifference." 49 F.3d, at 592. The State's assisted-suicide ban reflects and reinforces its policy that the lives of terminally ill, disabled, and elderly people must be no less valued than the lives of the young and healthy, and that a seriously disabled person's suicidal impulses should be interpreted and treated the same way as anyone else's. See New York Task Force 101-102; Physician-Assisted Suicide and Euthanasia in the Netherlands: A Report of Chairman Charles T. Canady, *supra*, at 9, 20 (discussing prejudice toward the disabled and the negative messages euthanasia and assisted suicide send to handicapped patients).

Finally, the State may fear that permitting assisted suicide will start it down the path to voluntary and perhaps even involuntary euthanasia. The Court of Appeals struck down Washington's assisted-suicide ban only "as applied to competent, terminally ill adults who wish to hasten their deaths by obtaining medication prescribed by their doctors." 79 F.3d, at

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<sup>35</sup> While pronouncements by the American Medical Association carry great weight, it should be recognized that the AMA does *not* speak for *all* physicians. Indeed, many physicians disagree with the political, ethical, and philosophical positions of the AMA.

838. Washington insists, however, that the impact of the court's decision will not and cannot be so limited. Brief for Petitioners 44-47. If suicide is protected as a matter of constitutional right, it is argued, "every man and woman in the United States must enjoy it." *Compassion in Dying*, 49 F.3d, at 591; see *Kevorkian*, 447 Mich., at 470, n. 41, 527 N.W.2d, at 727-728, n. 41. The Court of Appeals' decision, and its expansive reasoning, provide ample support for the State's concerns. The court noted, for example, that the "decision of a duly appointed surrogate decision maker is for all legal purposes the decision of the patient himself," 79 F.3d, at 832, n. 120; that "in some instances, the patient may be unable to self-administer the drugs and ... administration by the physician ... may be the only way the patient may be able to receive them," *id.*, at 831; and that not only physicians, but also family members and loved ones, will inevitably participate in assisting suicide, *id.*, at 838, n. 140. Thus, it turns out that what is couched as a limited right to "physician-assisted suicide" is likely, in effect, a much broader license, which could prove extremely difficult to police and contain. [FN23] Washington's ban on assisting suicide prevents such erosion.

FN23. Justice SOUTER concludes that "[t]he case for the slippery slope is fairly made out here, not because recognizing one due process right would leave a court with no principled basis to avoid recognizing another, but because there is a plausible case that the right claimed would not be readily containable by reference to facts about the mind that are matters of difficult judgment, or by gatekeepers who are subject to temptation, noble or not." *Post*, at 2291 (opinion concurring in judgment). We agree that the case for a slippery slope has been made out, but — bearing in mind Justice Cardozo's observation of "[t]he tendency of a principle to expand itself to the limit of its logic," *The Nature of the Judicial Process* 51 (1932) — we also recognize the reasonableness of the widely expressed skepticism about the lack of a principled basis for confining the right. See Brief for United States as *Amicus Curiae* 26 ("Once a legislature abandons a categorical prohibition against physician assisted suicide, there is no obvious stopping point"); Brief for Not Dead Yet et al. as *Amici Curiae* 21-29; Brief for Bioethics Professors as *Amici Curiae* 23-26; Report of the Council on Ethical and Judicial Affairs, App. 133, 140 ("[I]f assisted suicide is permitted, then there is a strong argument for allowing euthanasia"); New York Task Force 132; Kamisar, *The "Right to Die": On Drawing (and Erasing) Lines*, 35 *Duquesne L.Rev.* 481 (1996); Kamisar, *Against Assisted Suicide--Even in a Very Limited Form*, 72 *U. Det. Mercy L.Rev.* 735 (1995).

This concern is further supported by evidence about the practice of euthanasia in the Netherlands. The Dutch government's own study revealed that in 1990, there were 2,300 cases of voluntary euthanasia (defined as "the deliberate termination of another's life at his request"), 400 cases of assisted suicide, and more than 1,000 cases of euthanasia without an explicit request. In addition to these latter 1,000 cases, the study found an additional 4,941 cases where physicians administered lethal morphine overdoses without the patients' explicit consent. *Physician-Assisted Suicide and Euthanasia in the Netherlands: A Report of Chairman Charles T. Canady, supra*, at 12-13 (citing Dutch study). This study suggests that, despite the existence of various reporting procedures, euthanasia in the Netherlands has not been limited to competent, terminally ill adults who are enduring physical suffering, and that regulation of the practice may not have prevented abuses in cases involving vulnerable persons, including severely disabled neonates and elderly persons suffering from dementia. *Id.*, at 16-21; see generally C. Gomez, *Regulating Death: Euthanasia and the Case of the Netherlands* (1991); H. Hendin, *Seduced By Death: Doctors, Patients, and the Dutch Cure* (1997). The New York Task Force, citing the Dutch experience, observed that "assisted suicide and euthanasia are closely linked," New York Task Force 145, and concluded that the "risk of ... abuse is neither speculative nor distant," *id.*, at 134. Washington, like most other States, reasonably ensures against this risk by banning, rather than regulating, assisting suicide. See *United States v. 12 200-ft. Reels of Super 8MM. Film*, 413 U.S. 123, 127, 93 S.Ct. 2665, 2668, 37 L.Ed.2d 500 (1973) ("Each step, when taken, appear[s] a reasonable

step in relation to that which preceded it, although the aggregate or end result is one that would never have been seriously considered in the first instance").

We need not weigh exactly the relative strengths of these various interests. They are unquestionably important and legitimate, and Washington's ban on assisted suicide is at least reasonably related to their promotion and protection. We therefore hold that Wash. Rev. Code § 9A.36.060(1) (1994) does not violate the Fourteenth Amendment, either on its face or "as applied to competent, terminally ill adults who wish to hasten their deaths by obtaining medication prescribed by their doctors." 79 F.3d, at 838. [FN24]

FN24. Justice STEVENS states that "the Court does conceive of respondents' claim as a facial challenge — addressing not the application of the statute to a particular set of plaintiffs before it, but the constitutionality of the statute's categorical prohibition...." 521 U.S., at 740, 117 S.Ct., at 2305 (opinion concurring in judgments). We emphasize that we today reject the Court of Appeals' specific holding that the statute is unconstitutional "as applied" to a particular class. See n. 6, *supra*. Justice STEVENS agrees with this holding, see 521 U.S., at 750, 117 S.Ct., at 2309, but would not "foreclose the possibility that an individual plaintiff seeking to hasten her death, or a doctor whose assistance was sought, could prevail in a more particularized challenge," *ibid*. Our opinion does not absolutely foreclose such a claim. However, given our holding that the Due Process Clause of the Fourteenth Amendment does not provide heightened protection to the asserted liberty interest in ending one's life with a physician's assistance, such a claim would have to be quite different from the ones advanced by respondents here.

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.<sup>36</sup> The decision of the en banc Court of Appeals is reversed, and the case is remanded for further proceedings consistent with this opinion.

*It is so ordered.*

*Washington v. Glucksberg*, 521 U.S. 702, 722-736 (1997).

Justice Stevens was the only one of the four dissenters in *Cruzan* who was still a justice of the U.S. Supreme Court when *Glucksberg* was decided. One might expect Justice Stevens to dissent in *Glucksberg* and urge affirmance of the en banc opinion of the U.S. Court of Appeals for the Ninth Circuit. Instead, Justice Stevens concurred with the unanimous Court in *Glucksberg* that the state should generally prohibit assisting suicides, even amongst terminally ill patients.

History and tradition provide ample support for refusing to recognize an open-ended constitutional right to commit suicide. Much more than the State's paternalistic interest in protecting the individual from the irrevocable consequences of an ill-advised decision motivated by temporary concerns is at stake. There is truth in John Donne's observation that "No man is an island." [footnote omitted] The State has an interest in preserving and fostering the benefits that every human being may provide to the community — a community that thrives on the exchange of ideas, expressions of affection, shared memories, and humorous incidents, as well as on the material contributions that its members create and support. The value to others of a person's life is far too precious to allow the individual to claim a constitutional entitlement to complete autonomy in making a decision to end that life. Thus, I fully agree with the Court that the "liberty" protected by the Due Process Clause does

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<sup>36</sup> The first two sentences of this paragraph are consistent with the "laboratory of the states", discussed below, beginning at page 94.

not include a categorical "right to commit suicide which itself includes a right to assistance in doing so."

*Washington v. Glucksberg*, 521 U.S. at 740-741 (Stevens, J., concurring).

One wonders how many benefits can be contributed to the community by a terminally ill patient who is wracked with pain and who wants to die quicker than the state law permits.

But then Justice Stevens states that there *might be some* specific instances where a terminally ill patient had a legal right to physician-assisted suicide.

A State, like Washington, that has authorized the death penalty, and thereby has concluded that the sanctity of human life does not require that it always be preserved, must acknowledge that there are situations in which an interest in hastening death is legitimate. Indeed, not only is that interest sometimes legitimate, I am also convinced that there are times when it is entitled to constitutional protection.

*Washington v. Glucksberg*, 521 U.S. at 741-742 (Stevens, J., concurring).

Justice Stevens recalled his dissent in *Cruzan*.

... I insist that the source of Nancy Cruzan's right to refuse treatment was not just a common-law rule. Rather, this right is an aspect of a far broader and more basic concept of freedom that is even older than the common law. [footnote omitted] This freedom embraces not merely a person's right to refuse a particular kind of unwanted treatment, but also her interest in dignity, and in determining the character of the memories that will survive long after her death. [FN11] In recognizing that the State's interests did not outweigh Nancy Cruzan's liberty interest in refusing medical treatment, *Cruzan* rested not simply on the common-law right to refuse medical treatment, but — at least implicitly — on the even more fundamental right to make this "deeply personal decision," *id.*, at 289, 110 S.Ct., at 2857 (O'CONNOR, J., concurring).

FN11.

[But] Nancy Cruzan's interest in life, no less than that of any other person, includes an interest in how she will be thought of after her death by those whose opinions mattered to her. There can be no doubt that her life made her dear to her family and to others. How she dies will affect how that life is remembered.

*Cruzan v. Director, Mo. Dept. of Health*, 497 U.S. 261, 344, 110 S.Ct. 2841, 2885[-86], 111 L.Ed.2d 224 (1990) (STEVENS, J., dissenting).

Each of us has an interest in the kind of memories that will survive after death. To that end, individual decisions are often motivated by their impact on others. A member of the kind of family identified in the trial court's findings in this case would likely have not only a normal interest in minimizing the burden that her own illness imposes on others, but also an interest in having their memories of her filled predominantly with thoughts about her past vitality rather than her current condition. [The meaning and completion of her life should be controlled by persons who have her best interests at heart — not by a state legislature concerned only with the "preservation of human life."]

*Id.*, at 356, 110 S.Ct., at 2892.

Thus, the common-law right to protection from battery, which included the right to refuse medical treatment in most circumstances, did not mark "the outer limits of the substantive sphere of liberty" that supported the Cruzan family's decision to hasten Nancy's death.

*Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833, 848, 112 S.Ct. 2791, 2805, 120 L.Ed.2d 674 (1992). Those limits have never been precisely defined. They are generally identified by the importance and character of the decision confronted by the individual, *Whalen v. Roe*, 429 U.S. 589, 599-600, n. 26, 97 S.Ct. 869, 876-877, n. 26, 51

L.Ed.2d 64 (1977). Whatever the outer limits of the concept may be, it definitely includes protection for matters "central to personal dignity and autonomy." *Casey*, 505 U.S., at 851, 112 S.Ct., at 2807. It includes

[...] the individual's right to make certain unusually important decisions that will affect his own, or his family's, destiny. The Court has referred to such decisions as implicating "basic values," as being "fundamental," and as being dignified by history and tradition. The character of the Court's language in these cases brings to mind the origins of the American heritage of freedom the abiding interest in individual liberty that makes certain state intrusions on the citizen's right to decide how he will live his own life intolerable. [Guided by history, our tradition of respect for the dignity of individual choice in matters of conscience and the restraints implicit in the federal system, federal judges have accepted the responsibility for recognition and protection of these rights in appropriate cases.]

*Fitzgerald v. Porter Memorial Hospital*, 523 F.2d 716, 719- 720 (C.A.7 1975) (footnotes omitted), cert. denied, 425 U.S. 916, 96 S.Ct. 1518, 47 L.Ed.2d 768 (1976).

The *Cruzan* case demonstrated that some state intrusions on the right to decide how death will be encountered are also intolerable. The now-deceased plaintiffs in this action may in fact have had a liberty interest even stronger than Nancy Cruzan's because, not only were they terminally ill, they were suffering constant and severe pain. Avoiding intolerable pain and the indignity of living one's final days incapacitated and in agony is certainly "[a]t the heart of [the] liberty ... to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life." *Casey*, 505 U.S., at 851, 112 S.Ct., at 2807.

While I agree with the Court that *Cruzan* does not decide the issue presented by these cases, *Cruzan* did give recognition, not just to vague, unbridled notions of autonomy, but to the more specific interest in making decisions about how to confront an imminent death. Although there is no absolute right to physician-assisted suicide, *Cruzan* 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.

*Washington v. Glucksberg*, 521 U.S. at 743-745 (Stevens, J., concurring).

Justice Stevens recognized that all terminally ill patients are not the same, and that some terminally ill patients "might make a rational choice for assisted suicide."

Many terminally ill people find their lives meaningful even if filled with pain or dependence on others. Some find value in living through suffering; some have an abiding desire to witness particular events in their families' lives; many believe it a sin to hasten death. Individuals of different religious faiths make different judgments and choices about whether to live on under such circumstances. There are those who will want to continue aggressive treatment; those who would prefer terminal sedation; and those who will seek withdrawal from life-support systems and death by gradual starvation and dehydration. Although as a general matter the State's interest in the contributions each person may make to society outweighs the person's interest in ending her life, this interest does not have the same force for a terminally ill patient faced not with the choice of whether to live, only of how to die. Allowing the individual, rather than the State, to make judgments " 'about the "quality" of life that a particular individual may enjoy," 521 U.S., at 729, 117 S.Ct., at 2272 (quoting *Cruzan*, 497 U.S., at 282, 110 S.Ct., at 2853), does not mean that the lives of terminally ill, disabled

people have less value than the lives of those who are healthy, see 521 U.S., at 732, 117 S.Ct., at 2273. Rather, it gives proper recognition to the individual's interest in choosing a final chapter that accords with her life story, rather than one that demeans her values and poisons memories of her. See Brief for Bioethicists as *Amici Curiae* 11; see also R. Dworkin, *Life's Dominion* 213 (1993) ("Whether it is in someone's best interests that his life end in one way rather than another depends on so much else that is special about him — about the shape and character of his life and his own sense of his integrity and critical interests — that no uniform collective decision can possibly hope to serve everyone even decently").

Similarly, the State's legitimate interests in preventing suicide, protecting the vulnerable from coercion and abuse, and preventing euthanasia are less significant in this context. I agree that the State has a compelling interest in preventing persons from committing suicide because of depression or coercion by third parties. But the State's legitimate interest in preventing abuse does not apply to an individual who is not victimized by abuse, who is not suffering from depression, and who makes a rational and voluntary decision to seek assistance in dying.

....

Relatedly, the State and *amici* express the concern that patients whose physical pain is inadequately treated will be more likely to request assisted suicide. Encouraging the development and ensuring the availability of adequate pain treatment is of utmost importance; palliative care, however, cannot alleviate all pain and suffering. .... An individual adequately informed of the care alternatives thus might make a rational choice for assisted suicide. For such an individual, the State's interest in preventing potential abuse and mistake is only minimally implicated.

*Washington v. Glucksberg*, 521 U.S. at 746-748 (Stevens, J., concurring).

Although, as the Court concludes today, these *potential* harms are sufficient to support the State's general public policy against assisted suicide, they will not always outweigh the individual liberty interest of a particular patient. Unlike the Court of Appeals, I would not say as a categorical matter that these state interests are invalid as to the entire class of terminally ill, mentally competent patients. I do not, however, foreclose the possibility that an individual plaintiff seeking to hasten her death, or a doctor whose assistance was sought, could prevail in a more particularized challenge. Future cases will determine whether such a challenge may succeed.

*Washington v. Glucksberg*, 521 U.S. at 749-750 (Stevens, J., concurring).

Justice Stevens concludes:

There remains room for vigorous debate about the outcome of particular cases that are not necessarily resolved by the opinions announced today. How such cases may be decided will depend on their specific facts. In my judgment, however, it is clear that the so-called "unqualified interest in the preservation of human life," *Cruzan*, 497 U.S., at 282, 110 S.Ct., at 2853; 521 U.S., at 728, 117 S.Ct., at 2272, 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 alleviating her intolerable suffering.

*Washington v. Glucksberg*, 521 U.S. at 751-752 (Stevens, J., concurring).

After reading Justice Stevens concurring opinion that hints at a constitutional right for *some* terminally ill patients ("with specific facts") to receive physician-assisted suicide, I realized that the majority opinion of the U.S. Supreme Court does *not* mention *any* facts about the three patients (Jane Roe, John Doe, James Poe — see above, beginning at page 6) in this case who were

amongst the plaintiffs when the case was filed in the U.S. District Court.<sup>37</sup> The U.S. Supreme Court appears to have decided the case based on concerns about protecting hypothetical patients from assisted suicide, *not* real patients.

The concurring opinion of Justice Souter in *Washington v. Glucksberg* cites state statutes that prohibit assisting a suicide.

The dominant western legal codes long condemned suicide and treated either its attempt or successful accomplishment as a crime, the one subjecting the individual to penalties, the other penalizing his survivors by designating the suicide's property as forfeited to the government. See 4 W. Blackstone, COMMENTARIES \*188-\*189 (commenting that English law considered suicide to be "ranked ... among the highest crimes" and deemed persuading another to commit suicide to be murder); see generally Marzen, O'Dowd, Crone, & Balch, *Suicide: A Constitutional Right?*, 24 *Duquesne L.Rev.* 1, 56-63 (1985). While suicide itself has generally not been considered a punishable crime in the United States, largely because the common-law punishment of forfeiture was rejected as improperly penalizing an innocent family, see *id.*, at 98-99, most States have consistently punished the act of assisting a suicide as either a common-law or statutory crime and some continue to view suicide as an unpunishable crime. See generally *id.*, at 67-100, 148-242. [FN13] Criminal prohibitions on such assistance remain widespread, as exemplified in the Washington statute in question here. [footnote citing statutes deleted here, a current list is at page 13 of this essay]

FN13. Washington and New York are among the minority of States to have criminalized attempted suicide, though neither State still does so. See Brief for Members of the New York and Washington State Legislatures as *Amicus Curiae* 15, n. 8 (listing state statutes). The common law governed New York as a Colony and the New York Constitution of 1777 recognized the common law, N.Y. Const. of 1777, Art. XXXV, and the state legislature recognized common-law crimes by statute in 1788. See Act of Feb. 21, 1788, ch. 37, § 2, 1788 N.Y. Laws 664 (codified at 2 N.Y. Laws 73 (Greenleaf 1792)). In 1828, New York changed the common-law offense of assisting suicide from murder to manslaughter in the first degree. See 2 N.Y.Rev.Stat. pt. 4, ch. 1, tit. 2, art. 1, § 7, p. 661 (1829). In 1881, New York adopted a new penal code making attempted suicide a crime punishable by two years in prison, a fine, or both, and retaining the criminal prohibition against assisting suicide as manslaughter in the first degree. Act of July 26, 1881, ch. 676, §§ 172-178, 1881 N.Y. Laws (3 Penal Code), pp. 42-43 (codified at 4 N.Y. Consolidated Laws, Penal Law §§ 2300-2306, pp. 2809-2810 (1909)). In 1919, New York repealed the statutory provision making attempted suicide a crime. See Act of May 5, 1919, ch. 414, § 1, 1919 N.Y. Laws 1193. The 1937 New York Report of the Law Revision Commission found that the history of the ban on assisting suicide was "traceable into the ancient common law when a suicide or *felo de se* was guilty of crime punishable by forfeiture of his goods and chattels." State of New York, report of the Law Revision Commission for 1937, p. 830. The report stated that since New York had removed "all stigma [of suicide] as a crime" and that "[s]ince liability as an accessory could no longer hinge upon the crime of a principal, it was necessary to define it as a substantive offense." *Id.*, at 831. In 1965, New York revised its penal law, providing that a "person is guilty of manslaughter in the second degree when ... he intentionally causes or aids another person to commit suicide." Penal Law, ch. 1030, 1965 N.Y. Laws 2387 (codified at N.Y. Penal Law § 125.15(3) (McKinney 1975)).

Washington's first territorial legislature designated assisting another "in the commission of self-murder" to be manslaughter, see Act of Apr. 28, 1854, § 17, 1854 Wash. Laws 78, and re-enacted the provision in 1869 and 1873, see Act of Dec. 2, 1869, § 17, 1869 Wash. Laws 201; Act of Nov. 10, 1873, § 19, 1873 Wash. Laws 184 (codified at Wash.Code § 794 (1881)). In 1909,

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<sup>37</sup> These three patients are relegated to a terse footnote: "John Doe, Jane Roe, and James Poe, plaintiffs in the District Court, were then in the terminal phases of serious and painful illnesses. They declared that they were mentally competent and desired assistance in ending their lives." *Glucksberg*, 521 U.S. at 708, n. 4.



the state legislature enacted a law based on the 1881 New York law and a similar one enacted in Minnesota, see Marzen, O'Dowd, Crone, & Balch, 24 Duquesne L.Rev., at 206, making attempted suicide a crime punishable by two years in prison or a fine, and retaining the criminal prohibition against assisting suicide, designating it manslaughter. See Criminal Code, ch. 249, §§ 133-137, 1909 Wash. Laws, 11th Sess., 890, 929 (codified at Remington & Ballinger's Wash.Code §§ 2385-2389 (1910)). In 1975, the Washington Legislature repealed these provisions, see Wash.Crim. Code, 1975, ch. 260, § 9A.92.010 (213-217), 1975 Wash. Laws 817, 858, 866, and enacted the ban on assisting suicide at issue in this case, see Wash.Crim. Code, 1975, ch. 260, § 9A.36.060, 1975 Wash. Laws 817, 836, codified at Rev. Wash. Code § 9A.36.060 (1977). The decriminalization of attempted suicide reflected the view that a person compelled to attempt it should not be punished if the attempt proved unsuccessful. See *Compassion in Dying v. Washington*, 850 F.Supp. 1454, 1464, n. 9 (W.D.Wash. 1994) (citing Legislative Council Judiciary Committee, Report on the Revised Washington Criminal Code 153 (Dec. 3, 1970)).

*Washington v. Glucksberg*, 521 U.S. 702, 774-775 (1997) (Souter, J., concurring).

### **Quill v. Vacco (1994-1997)**

- ***Quill v. Koppell*, 870 F.Supp. 78 (S.D.N.Y. 15 Dec 1994),  
rev'd sub nom. *Quill v. Vacco*, 80 F.3d 716 (2nd Cir. 2 Apr 1996),  
rev'd, 521 U.S. 793 (26 June 1997).**

Plaintiffs sought an injunction against the enforcement of two New York statutes, as applied to physicians who prescribe a lethal dose of drugs for their mentally competent patients who want to commit suicide. These two statutes said:

A person is guilty of manslaughter in the second degree when:

1. He recklessly causes the death of another person; or
2. He commits upon a female an abortifacient act which causes her death, unless such abortifacient act is justifiable pursuant to subdivision three of section 125.05; or
3. He intentionally causes or aids another person to commit suicide.

Manslaughter in the second degree is a class C felony.

New York Penal Law § 125.15 (enacted 1965, still current May 2005).

A person is guilty of promoting a suicide attempt when he intentionally causes or aids another person to attempt suicide. Promoting a suicide attempt is a class E felony.

New York Penal Law § 120.30 (enacted 1965, still current May 2005).

See *Quill*, 870 F.Supp. at 79, 80 F.3d at 719.

Judge Calabresi traced the history of these statutes<sup>38</sup> back to the year 1828. The sentences for a Class C felony include imprisonment for between 1 and 15 years, and for a class E felony imprisonment for between 1 and 4 years. New York Penal Law § 70.00.

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<sup>38</sup> *Quill*, 80 F.3d at 732-34, quoted below, beginning at page 71.

## U.S. Court of Appeals

The three judge panel of the U.S. Court of Appeals in New York declined to find a constitutional right of privacy that would permit physician-assisted suicide.

The right of privacy has been held to encompass personal decisions relating to marriage, procreation, family relationships, child rearing and education, contraception and abortion. *See Carey v. Population Servs. Int'l*, 431 U.S. 678, 684-85, 97 S.Ct. 2010, 2015- 16, 52 L.Ed.2d 675 (1977). While the Constitution does not, of course, include any explicit mention of the right of privacy, this right has been recognized as encompassed by the Fourteenth Amendment's Due Process Clause. *Id.* at 684, 97 S.Ct. at 2015-16. Nevertheless, the Supreme Court has been reluctant to further expand this particular list of federal rights, and it would be most speculative for a lower court to do so. *See Rotunda & Nowak, Treatise on Constitutional Law, supra*, 15.7, at 433-37.

In any event, the Supreme Court has drawn a line, albeit a shaky one, on the expansion of fundamental rights that are without support in the text of the Constitution. In *Bowers*, the Supreme Court framed the issue as "whether the Federal Constitution confers a fundamental right upon homosexuals to engage in sodomy and hence invalidates the laws of the many States that still make such conduct illegal and have done so for a very long time." 478 U.S. at 190, 106 S.Ct. at 2843. Holding that there was no fundamental right to engage in consensual sodomy, the Court noted that the statutes proscribing such conduct had "ancient roots." *Id.* at 192, 106 S.Ct. at 2844-45. The Court noted that sodomy was a common law criminal offense, forbidden by the laws of the original 13 states when they ratified the Bill of Rights, and that 25 states and the District of Columbia still penalize sodomy performed in private by consenting adults. *Id.* at 192-93, 106 S.Ct. at 2844-46.<sup>39</sup>

As in *Bowers*, the statutes plaintiffs seek to declare unconstitutional here cannot be said to infringe upon any fundamental right or liberty. As in *Bowers*, the right contended for here cannot be considered so implicit in our understanding of ordered liberty that neither justice nor liberty would exist if it were sacrificed. Nor can it be said that the right to assisted suicide claimed by plaintiffs is deeply rooted in the nation's traditions and history. Indeed, the very opposite is true. The Common Law of England, as received by the American colonies, prohibited suicide and attempted suicide. *See Thomas J. Marzen et al., Suicide: A Constitutional Right?*, 24 Duq. L.Rev. 1, 56-67 (1985). Although neither suicide nor attempted suicide is any longer a crime in the United States, 32 states, including New York, continue to make assisted suicide an offense. The New York State Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context*, 55 (1994) ("*When Death Is Sought*"). Clearly, no "right" to assisted suicide ever has been recognized in any state in the United States. *See generally* Mark E. Chopko & Michael F. Moses, *Assisted Suicide: Still a Wonderful Life?*, 70 Notre Dame L.Rev. 519, 561 (1995); Yale Kamisar, *Are Laws against Assisted Suicide Unconstitutional?*, 23 Hastings Center Rep., May-June 1993, at 32.

In rejecting the due process-fundamental rights argument of the plaintiffs, we are mindful of the admonition of the Supreme Court:

Nor are we inclined to take a more expansive view of our authority to discover new fundamental rights imbedded in the Due Process Clause. The Court is most vulnerable

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<sup>39</sup> Note that *Bowers* was later overruled in *Lawrence v. Texas*, 539 U.S. 558 (2003). However, it remains true that constitutional privacy rights are quite limited in scope, see my separate essay at <http://www.rbs2.com/priv2.pdf>.

and comes nearest to illegitimacy when it deals with judge-made constitutional law having little or no cognizable roots in the language or design of the Constitution. *Bowers*, 478 U.S. at 194, 106 S.Ct. at 2846. The right to assisted suicide finds no cognizable basis in the Constitution's language or design, even in the very limited cases of those competent persons who, in the final stages of terminal illness, seek the right to hasten death. We therefore decline the plaintiffs' invitation to identify a new fundamental right, in the absence of a clear direction from the Court whose precedents we are bound to follow. The limited room for expansion of substantive due process rights and the reasons therefor have been clearly stated: "As a general matter, the Court has always been reluctant to expand the concept of substantive due process because guideposts for responsible decisionmaking in this unchartered area are scarce and open-ended." *Collins v. City of Harker Heights*, 503 U.S. 115, 125, 112 S.Ct. 1061, 1068, 117 L.Ed.2d 261 (1992). Our position in the judicial hierarchy constrains us to be even more reluctant than the Court to undertake an expansive approach in this unchartered area.

*Quill v. Vacco*, 80 F.3d 716, 724-725 (2nd Cir. 1996).

But the U.S. Court of Appeals did find that New York state's prohibition of physician-assisted suicide was a violation of equal protection of laws in the Fourteenth Amendment to the U.S. Constitution. On one hand, patients in a persistent vegetative state have the legal right to have their ventilator or feeding tube disconnected, which will terminate their biological life within a few minutes to days. But, on the other hand, terminally ill patients are not able to receive a lethal dose of prescription drugs that would humanely and quickly end their life.

Applying the foregoing principles to the New York statutes criminalizing assisted suicide, it seems clear that:

- 1) the statutes in question fall within the category of social welfare legislation and therefore are subject to rational basis scrutiny upon judicial review;
- 2) New York law does not treat equally all competent persons who are in the final stages of fatal illness and wish to hasten their deaths;
- 3) the distinctions made by New York law with regard to such persons do not further any legitimate state purpose; and
- 4) accordingly, to the extent that the statutes in question prohibit persons in the final stages of terminal illness from having assistance in ending their lives by the use of self-administered, prescribed drugs, the statutes lack any rational basis and are violative of the Equal Protection Clause.

The right to refuse medical treatment long has been recognized in New York. In 1914 Judge Cardozo wrote that, under New York law, "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body." *Schloendorff v. Society of New York Hosp.*, 211 N.Y. 125, 129, 105 N.E. 92 (1914). In 1981, the New York Court of Appeals held that this right extended to the withdrawal of life-support systems. *In re Eichner* (decided with *In re Storar*), 52 N.Y.2d 363, 438 N.Y.S.2d 266, 420 N.E.2d 64, *cert. denied*, 454 U.S. 858, 102 S.Ct. 309, 70 L.Ed.2d 153 (1981). The *Eichner* case involved a terminally-ill, 83-year-old patient whose guardian ultimately was authorized to withdraw the patient's respirator. The Court of Appeals determined that the guardian had proved by clear and convincing evidence that the patient, prior to becoming incompetent due to illness, had consistently expressed his view that life should not be prolonged if there was no hope of recovery. *Id.* at 379-80, 438 N.Y.S.2d 266, 420 N.E.2d 64. In *Storar*, the companion case to *Eichner*, the Court of Appeals determined that a profoundly retarded,

terminally-ill patient was incapable of making a decision to terminate blood transfusions. There, the patient was incapable of making a reasoned decision, having never been competent at any time in his life. *Id.* at 380, 438 N.Y.S.2d 266, 420 N.E.2d 64. In both these cases, the New York Court of Appeals recognized the right of a competent, terminally-ill patient to hasten his death upon proper proof of his desire to do so.

The Court of Appeals revisited the issue in *Rivers v. Katz*, 67 N.Y.2d 485, 504 N.Y.S.2d 74, 495 N.E.2d 337 (1986) (establishing the right of mentally incompetent persons to refuse certain drugs). In that case, the Court recognized the right to bring on death by refusing medical treatment not only as a "fundamental common-law right" but also as "coextensive with [a] patient's liberty interest protected by the due process clause of our State Constitution." *Id.* at 493, 504 N.Y.S.2d 74, 495 N.E.2d 337. The following language was included in the opinion:

In our system of a free government, where notions of individual autonomy and free choice are cherished, it is the individual who must have the final say in respect to decisions regarding his medical treatment in order to insure that the greatest possible protection is accorded his autonomy and freedom from unwanted interference with the furtherance of his own desires.

*Id.*

After these cases were decided, the New York legislature placed its imprimatur upon the right of competent citizens to hasten death by refusing medical treatment and by directing physicians to remove life-support systems already in place. In 1987, the legislature enacted Article 29-B of the New York Public Health Law, entitled "Orders Not to Resuscitate." N.Y. Pub. Health Law §§ 2960-79 (McKinney 1993). The Article provides that an "adult with capacity" may direct the issuance of an order not to resuscitate. § 2964. "Order not to resuscitate" is defined as "an order not to attempt cardiopulmonary resuscitation in the event a patient suffers cardiac or respiratory arrest." § 2961(17). "Cardiopulmonary resuscitation" is defined as "measures ... to restore cardiac function or to support ventilation in the event of a cardiac or respiratory arrest." § 2961(4). An elaborate statutory scheme is in place, and it provides, among other things, for surrogate decision-making, § 2965, revocation of consent, § 2969, physician review, § 2970, dispute mediation, § 2972, and judicial review, § 2973.

In 1990, the New York legislature enacted Article 29-C of the Public Health Law, entitled "Health Care Agents and Proxies." N.Y. Pub. Health Law §§ 2980-94 (McKinney 1993). This statute allows for a person to sign a health care proxy, § 2981, for the purpose of appointing an agent with "authority to make any and all health care decisions on the principal's behalf that the principal could make." § 2982(1). These decisions include those relating to the administration of artificial nutrition and hydration, provided the wishes of the principal are known to the agent. § 2982(2). The agent's decision is made "[a]fter consultation with a licensed physician, registered nurse, licensed clinical psychologist or certified social worker." *Id.* Accordingly, a patient has the right to hasten death by empowering an agent to require a physician to withdraw life-support systems. The proxy statute also presents a detailed scheme, with provisions for a determination that the principal lacks capacity to make health care decisions, for such a determination to be made only by the attending physician in consultation with another physician "[f]or a decision to withdraw or withhold life-sustaining treatment," § 2983, for provider's obligations, § 2984, for revocation, § 2985, and for special proceedings, § 2992, among other matters.

The concept that a competent person may order the removal of life-support systems found Supreme Court approval in *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 110 S.Ct. 2841, 111 L.Ed.2d 224 (1990). There the Court upheld a determination of the Missouri Supreme Court that required proof by clear and convincing evidence of a patient's desire for the withdrawal of life-sustaining equipment. The patient in that case, Nancy

Cruzan, was in a persistent vegetative state as the result of injuries sustained in an automobile accident. Her parents sought court approval in the State of Missouri to terminate the artificial nutrition and hydration with which she was supplied at the state hospital where she was confined. The hospital employees refused to withdraw the life-support systems, without which Cruzan would suffer certain death. The trial court authorized the withdrawal after finding that Cruzan had expressed some years before to a housemate friend some thoughts that suggested she would not wish to live on a life-support system. The trial court also found that one in Cruzan's condition had a fundamental right to refuse death-prolonging procedures.

The Missouri Supreme Court, in reversing the trial court, refused to find a broad right of privacy in the state constitution that would support a right to refuse treatment. Moreover, that court doubted that such a right existed under the United States Constitution. It did identify a state policy in the Missouri Living Will Statute favoring the preservation of life and concluded that, in the absence of compliance with the statute's formalities or clear and convincing evidence of the patient's choice, no person could order the withdrawal of medical life-support services.

In affirming the Missouri Supreme Court, the United States Supreme Court stated: "The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions." *Id.* at 278, 110 S.Ct. at 2851. The Court noted that the inquiry is not ended by the identification of a liberty interest, because there also must be a balancing of the state interests and the individual's liberty interests before there can be a determination that constitutional rights have been violated. *Id.* at 279, 110 S.Ct. at 2851- 52. The Court all but made that determination in the course of the following analysis:

Petitioners insist that under the general holdings of our cases, the forced administration of life-sustaining medical treatment, and even of artificially-delivered food and water essential to life, would implicate a competent person's liberty interest. Although we think the logic of the cases discussed above would embrace such a liberty interest, the dramatic consequences involved in refusal of such treatment would inform the inquiry as to whether the deprivation of that interest is constitutionally permissible. But for purposes of this case, we assume that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition.

*Id.*

The Court went on to find that Missouri allowed a surrogate to "act for the patient in electing to have hydration and nutrition withdrawn in such a way as to cause death," subject to "a procedural safeguard to assure that the action of the surrogate conforms as best it may to the wishes expressed by the patient while competent." *Id.* at 280, 110 S.Ct. at 2852. The Court then held that the procedural safeguard or requirement imposed by Missouri — the heightened evidentiary requirement that the incompetent's wishes be proved by clear and convincing evidence — was not forbidden by the United States Constitution. *Id.* at 280-82, 110 S.Ct. at 2852-53.

In view of the foregoing, it seems clear that New York does not treat similarly circumstanced persons alike: those in the final stages of terminal illness who are on life-support systems are allowed to hasten their deaths by directing the removal of such systems; but those who are similarly situated, except for the previous attachment of life-sustaining equipment, are not allowed to hasten death by self-administering prescribed drugs. The district judge has identified "a difference between allowing nature to take its course, even in the most severe situations, and intentionally using an artificial death-producing device." *Quill*, 870 F.Supp. at 84. But Justice Scalia, for one, has remarked upon "the irrelevance of the action-inaction distinction," noting that "the cause of death in both cases is the suicide's

conscious decision to 'pu[t] an end to his own existence.' " *Cruzan*, 497 U.S. at 296-297, 110 S.Ct. at 2861 (citations omitted and alteration in original) (Scalia, J., concurring); *see also* Note, *Physician-Assisted Suicide and the Right to Die with Assistance*, 105 Harv. L.Rev. 2021, 2028-31 (1992) (arguing that there is no distinction between assisted suicide and the withholding or withdrawal of treatment).

Indeed, there is nothing "natural" about causing death by means other than the original illness or its complications. The withdrawal of nutrition brings on death by starvation, the withdrawal of hydration brings on death by dehydration, and the withdrawal of ventilation brings about respiratory failure. By ordering the discontinuance of these artificial life-sustaining processes or refusing to accept them in the first place, a patient hastens his death by means that are not natural in any sense. It certainly cannot be said that the death that immediately ensues is the natural result of the progression of the disease or condition from which the patient suffers.

Moreover, the writing of a prescription to hasten death, after consultation with a patient, involves a far less active role for the physician than is required in bringing about death through asphyxiation, starvation and/or dehydration. Withdrawal of life support requires physicians or those acting at their direction physically to remove equipment and, often, to administer palliative drugs which may themselves contribute to death. The ending of life by these means is nothing more nor less than assisted suicide. It simply cannot be said that those mentally competent, terminally-ill persons who seek to hasten death but whose treatment does not include life support are treated equally.

*Quill v. Vacco*, 80 F.3d 716, 727-729 (2nd Cir. 1996).

The U.S. Court of Appeals then held that there was no rational basis for the denial of equal protection of law to patients who want to commit suicide.

#### my comments on *Quill*

It may appear that the U.S. Court of Appeals reasoning in *Quill* fails because there is a valid distinction between the legal right of a patient to *refuse* a particular medical treatment (including the right to withdrawal of life-support machinery or the right to a "do not resuscitate" order) and the alleged right of a patient to demand a lethal dose of some prescription drug. It is obvious that a patient can refuse to have a prescription filled at a pharmacy or that a patient can refuse to take the prescribed medication. However, there is no legal right for a patient to demand that a physician prescribe a lethal dose of drugs. Some physicians might consider it unethical or immoral to write such a prescription, in addition to legal issues. It is often illusory to make a distinction between *one* person who either (1) does an act or (2) refuses to act, as both are choices. However, in this specific instance, the distinction is valid, because it is the *patient* who can refuse treatment and the *physician* who can refuse to prescribe lethal drugs. On the other hand, this case is actually about prohibiting criminal prosecution of physicians who do prescribe lethal drugs at the request of a terminally ill, mentally competent, adult patient. And the U.S. Court of Appeals may be correct that there is no valid distinction between refusing to prosecute physicians who (1) disconnect life-support machinery at the request of a patient or at the request of the patient's surrogate and (2) prescribe a lethal dose of drugs at the request of a terminally ill patient.

There is another reason why the court's argument in *Quill* fails. The U.S. Court of Appeals says that withdrawal of life-support machinery (e.g., feeding tube or ventilator) causes death. As I explain in my previous essay, at <http://www.rbs2.com/rtd.pdf> in the section on Overview of the Law, the proximate (i.e., legal) cause of death is widely held by courts to be the initial illness or injury, *not* the removal of life support. This is a very subtle philosophical point: disconnection of life-support machinery may be the *actual* cause of death, but that disconnection is *not* the *legal* cause of death. If you believe that only the legal cause of death matters, then the U.S. Court of Appeals argument collapses. In my personal opinion, the equal protection of laws approach is *not* a convincing reason to permit physician-assisted suicide. I would prefer to see the U.S. Supreme Court declare a new constitutional right of privacy that protects personal choices in the area of suicide, as an extension of personal autonomy.

#### Calabresi's concurring opinion

Judge Guido Calabresi, an emeritus professor at the Yale Law School as well as the dean of the Yale Law School during 1985-1994, and one of the most intellectual judges in the USA, wrote an interesting dissent in this case. Judge Calabresi discussed the archaic origins of the law. When suicide was a crime (i.e., self-murder), then assisting a suicide was properly also a crime, as an accessory to self-murder. However, Judge Calabresi recognized the now-abolished prohibition against suicide leaves no good justification for the continuing prohibition against assisted suicide.

#### *A Bit of History*

There once was a time when the law and its judges were not called upon to make choices for human beings lying in the twilight between life and death. In the past, many of these decisions were left to individual doctors and their patients. Sometimes, easing of pain melded, not quite imperceptibly, into more. While doctors did not advertise their availability, there often was an understanding (perhaps unspoken), as patients entered into what usually were long-term relationships with physicians, that when the time came doctors would do what was expected of them. Laws prohibiting assisted suicide were on the books. But whether they were ever meant to apply to a treating physician, or whether such doctors were even slightly concerned about them, is unclear and lost in the shadows of time. [FN1] And despite a web of statutes, and doctors who, understandably, have become increasingly averse to taking risks and responsibilities, that tradition undoubtedly continues today. As the majority demonstrates, however, this fact is not a prescription for judicial silence. *Ante* at 722-23. We must, therefore, address petitioners' claim that New York's laws are invalid.

FN1. See NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT 57 (1994) ("No person has been convicted in New York State of manslaughter for intentionally aiding or causing a suicide.... The reluctance to bring such cases no doubt rests in part on the degree of public sympathy [such cases] often arouse, and the resulting difficulty of securing an indictment and conviction."); *Compassion in Dying*, 79 F.3d at 811 (footnotes omitted) ("[T]he mere presence of statutes criminalizing assisting in a suicide does not necessarily indicate societal disapproval. That is especially true when such laws are seldom, if ever, enforced. There is no reported American case of criminal punishment being meted out to a doctor for helping a patient hasten his own death.... Running beneath the official history of legal condemnation of physician-assisted suicide is

a strong undercurrent of a time-honored but hidden practice of physicians helping terminally ill patients to hasten their deaths.").

The statutes at issue were born in another age. New York enacted its first prohibition of assisted suicide in 1828. The statute punished any individual who assisted another in committing "self-murder" for first-degree manslaughter. Act of Dec. 10, 1828, ch. 20, 4 1828 N.Y. Laws 19 (codified at N.Y.Rev.Stat. pt. 4, ch. 1, tit. 2, art. 1, § 7 (1829)). This prohibition was tied to the crime of suicide, described by one contemporary New York Court as a "criminal act of self-destruction." *Breasted v. Farmers' Loan & Trust Co.*, 4 Hill 73, 75 (Sup.Ct. 1843), *aff'd*, 8 N.Y. 299 (1853).

English authorities had long declared suicide to be murder. See 3 EDWARD COKE, INSTITUTES OF THE LAWS OF ENGLAND 54 (London, E. & R. Brooke 1797) (1644); 1 MATTHEW HALE, PLEAS OF THE CROWN 411-18 (London, E. & R. Nutt 1736) (1680); 4 WILLIAM BLACKSTONE, COMMENTARIES ON THE LAWS OF ENGLAND \*189 (1769); 3 JAMES FITZJAMES STEPHEN, HISTORY OF THE CRIMINAL LAW OF ENGLAND 104 (1869); William E. Mikell, *Is Suicide Murder?*, 3 COLUM. L. REV. 379, 391 (1903) ("[W]hatever may have been the law before Bracton's time ... suicide is murder in English law."). And the leading American case echoed these English authorities. See *Commonwealth v. Bowen*, 13 Mass. 356 (1816). In that case, Chief Justice Parker instructed the jury: "Self-destruction is doubtless a crime of awful turpitude; it is considered in the eye of the law of equal heinousness with the murder of one by another. In this offence, it is true the actual murderer escapes punishment; for the very commission of the crime, which the the [sic] law would otherwise punish with its utmost rigor, puts the offender beyond the reach of its infliction. And in this he is distinguished from other murderers. But his punishment is as severe as the nature of the case will admit; his body is buried in infamy, and in England his property is forfeited to the King." *Commonwealth v. Mink*, 123 Mass. 422, 428 (1877) (reprinting Parker's jury instructions in *Bowen*). *Mink* itself, written by Chief Justice Gray, found that "any attempt to commit" suicide is "unlawful and criminal." *Id.* at 429.

Four years after *Mink*, however, the New York Legislature revised the Penal Code. The new code provided that an intentional *attempt* to commit suicide was a felony with a maximum penalty of two years' imprisonment. Act of July 26, 1881, ch. 676, §§ 174, 178, 3 1881 N.Y. Laws 42-43. But while the Code declared suicide itself to be "a grave public wrong," it imposed no forfeiture because of "the impossibility of reaching the successful perpetrator." *Id.* § 173. The 1881 statute, echoing the earlier 1828 provision, punished assisting a successful suicide as manslaughter in the first degree. *Id.* § 175. The Code also punished assistance in attempted suicide as an unspecified felony. *Id.* § 176.

Whatever may have been the case in other jurisdictions, [FN2] the 1828 and 1881 statutes prohibited all attempts to assist in a suicide on the theory that such behavior created accessory liability. Thus, because attempted suicide was a crime, assisting in the commission of suicide was also a crime. And the titles of the sections of the 1881 statute manifest these derivative origins; section 175 prohibited "*Aiding* suicide" and section 176 prohibited "*Abetting* an attempt at suicide." *Id.* (emphasis added). [FN3] Whether these laws applied to a doctor who eased or hastened the death of a terminally ill patient is, of course, quite another matter, and one on which the evidence is scant. [FN4]

FN2. See *Compassion in Dying*, 79 F.3d at 846-47 (Beezer, J., dissenting).

FN3. The 1937 New York Report of the Law Revision Commission explicitly found that "[t]he history of the [abetting and advising suicide] provision is traceable into the ancient common law



when a suicide or *felo de se* was guilty of a crime punishable by forfeiture of his goods and chattels. One who encouraged or aided him was guilty as an accessory to the crime of 'self-murder'...." STATE OF NEW YORK, REPORT OF THE LAW REVISION COMMISSION FOR 1937, at 830 (1937).

FN4. See *supra* note 1.

The 1881 scheme was altered in 1919 when the prohibition against attempted suicide (originally found in sections 174 and 178) was removed. Act of May 5, 1919, ch. 414, § 1, 2 1919 N.Y. Laws 1193. The Legislature, nevertheless, left in place the declaration of suicide as a "grave public wrong." See *Hundert v. Commercial Travelers' Mut. Accident Ass'n of Am.*, 244 A.D. 459, 460, 279 N.Y.S. 555, 556 (1st Dep't 1935) (per curiam) ("[S]uicide, although recognized as a grave public wrong, is not a crime."). And the prohibition of assisting suicide also remained on the books. But we have found no case in which a physician aiding a person who wished to commit suicide was, in fact, penalized in New York after 1919.

In 1965, the Legislature took the next step and deleted the declaration that suicide was a "grave public wrong." [FN5] It, however, left in place redrafted versions of sections 175 and 176 of the 1881 Code, stating: "A person is guilty of manslaughter in the second degree when ... [h]e intentionally causes or aids another person to commit suicide," § 125.15(3), and, "[a] person is guilty of promoting a suicide attempt when he intentionally causes or aids another person to attempt suicide," § 120.30. [FN6]

FN5. The 1965 Act did provide that "[a] person acting under a reasonable belief that another person is about to commit suicide or to inflict serious physical injury upon himself may use physical force upon such person to the extent that he reasonably believes it necessary to thwart such result." Act of July 20, 1965, ch. 1030, 1965 N.Y. Laws 2355 (codified at N.Y. Penal Law § 35.10(4)). See *Von Holden v. Chapman*, 87 A.D.2d 66, 68, 450 N.Y.S.2d 623, 626 (4th Dep't 1982) (upholding order authorizing forced feeding of John Lennon's murderer, Mark David Chapman, to prevent Chapman from starving himself to death because "[t]he preservation of life has a high social value in our culture").

FN6. Why the legislature left the prohibition of assisted suicide in the law, and whether it thought about the issue at all is hard to say. The 1937 Law Revision Report had, in a sense, presaged the event when it said that since New York had removed "all stigma [of suicide] as a crime" and that "[s]ince liability as an accessory could no longer hinge upon the crime of a principal, it was necessary to define it as a substantive offense." REPORT OF THE LAW REVISION COMMISSION, *supra* note 3, at 831. The Commission seemed to have been concerned primarily with those who talked others into killing themselves. It noted the important difference between aiding someone who had a mind-set to commit suicide and the "more dangerous" person "working upon the mind of a susceptible person to induce suicide," *id.* at 832.

The years since 1965 have brought further erosion in the bases for prohibiting assisted suicide with respect to terminally ill persons. Thus, in 1981, the New York Court of Appeals declared that "a doctor cannot be held to have violated his legal or professional responsibilities when he honors the right of a competent adult patient to decline medical treatment." *In re Storar*, 52 N.Y.2d 363, 377, 420 N.E.2d 64, 71, 438 N.Y.S.2d 266, 273, *cert. denied*, 454 U.S. 858, 102 S.Ct. 309, 70 L.Ed.2d 153 (1981). The court applied this principle both to the withdrawal of life-support and to the refusal of blood transfusions. *Id.* at 379-80, 438 N.Y.S.2d 266, 420 N.E.2d 64. Furthermore, in 1986, the court stated: "In our system of a free government, where notions of individual autonomy and free choice are cherished, it is the individual who must have the final say in respect to decisions regarding his medical treatment...." *Rivers v. Katz*, 67 N.Y.2d 485, 493, 495 N.E.2d 337, 341, 504 N.Y.S.2d 74,

78 (1986). Lower courts, understandably, followed suit. *See Delio v. Westchester County Medical Ctr.*, 129 A.D.2d 1, 516 N.Y.S.2d 677 (2d Dep't 1987) ("[T]he common-law right of self determination with respect to one's body also forms the foundation for a competent adult patient's right to refuse life-sustaining treatment even if the effect is to hasten death....").

The New York Legislature itself acted accordingly. In the 1987 Orders Not to Resuscitate Act, it provided that an "adult with capacity" may create an "order not to resuscitate" in the event the patient "suffers cardiac or respiratory arrest." Act of Aug. 7, 1987, ch. 818, § 1, 1987 N.Y. Laws 3140 (codified as amended at N.Y. Pub. Health Law, §§ 2960-2979 (McKinney 1993 & Supp. 1996)). In the 1990 Health Care Agents and Proxies Act, it went further and permitted a competent person to designate an agent who has "authority to make any and all health care decisions on the principal's behalf that the principal could make." Act of July 22, 1990, ch. 752, § 2, 1990 N.Y. Laws 1538 (codified as amended at N.Y. Pub. Health Law § 2982(1) (McKinney 1993)). The statute explicitly stated that choices regarding the withdrawal of artificial nutrition and hydration are within the purview of a health care agent when the wishes of the principal are reasonably known to the agent. N.Y. Pub. Health Law § 2982(2). [FN7]

FN7. The 1990 Act provided the following caution: "This article is not intended to permit or promote suicide, assisted suicide, or euthanasia; accordingly, nothing herein shall be construed to permit an agent to consent to any act or omission to which the principal could not consent under law." N.Y. Pub. Health Law § 2989(3). The full significance of this section is not clear. It understandably limited the agent to doing those acts to which the principal, on whose behalf the agent is acting, could consent. It also seemed to leave in place the *status quo* both as to those acts, like suicide, which were no longer crimes and those, like assisted suicide, which nominally were. But the section did not go further, as New York claims in a letter brief where it says, citing § 2989(3), that "New York's legislature expressly rejected permitting physician assisted suicide." Section 2989(3) did not speak to this any more than it spoke to the legality of suicide.

Later, in 1994, the New York Task Force on Life and the Law, a group organized in 1985 at the request of Governor Cuomo and composed of doctors, bioethicists, and religious leaders, among others, prepared a report on the question. The report, in effect, said leave things as they are: permit suicide and attempted suicide, recognize the right of competent terminally ill patients — either on their own or through agents — to order the ceasing of nutrition and hydration and the withdrawal of life support systems, but do not alter the law to permit what petitioners seek today. **NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT** 142-46 (1994). The Legislature received the report and, not surprisingly, took no action, then or since.

From this historical survey, I conclude that

- 1) what petitioners seek is nominally still forbidden by New York statutes;
- 2) the bases of these statutes have been deeply eroded over the last hundred and fifty years; and
- 3) few of their foundations remain in place today.

Specifically:

- The original reason for the statutes — criminalizing conduct that aided or abetted other crimes — is long since gone.
- The distinction that has evolved over the years between conduct currently permitted (suicide, and aiding someone who wishes to die to do so by removing hydration, feeding,

and life support systems) and conduct still prohibited (giving a competent, terminally ill patient lethal drugs, which he or she can self-administer) is tenuous at best. [FN8]

FN8. *See ante* at 728-31 (the majority opinion's powerful discussion of the weakness of the distinction).

- The Legislature — for many, many years — has not taken any recognizably affirmative step reaffirming the prohibition of what petitioners seek.
- The enforcement of the laws themselves has fallen into virtual desuetude — not so much as to render the case before us nonjusticiable, but enough to cast doubt on whether, in a case like that which the petitioners present, a prosecutor would prosecute or a jury would convict. And this fact by itself inevitably raises doubts about the current support for these laws. [FN9]

FN9. We note in passing that a jury in Michigan recently acquitted Dr. Jack Kevorkian after he argued (despite his earlier, quite explicit, publicity and statements) that all he was doing was ending pain. *See* Todd Nissen, *Kevorkian Found Not Guilty in Assisted Suicide Trial*, Reuters, Mar. 8, 1996. We note also that Iowa has just enacted a law forbidding assisted suicide and that this law does not prohibit "the responsible actions of a licensed health professional to administer pain medication to a patient with a terminal illness." *See Gov. Branstad Signs Bill Outlawing Assisted Suicide*, BNA Health Care Daily, Mar. 5, 1996.

*Quill v. Vacco*, 80 F.3d 716, 732-735 (2nd Cir. 1996) (Calabresi, J., concurring).

Judge Calabresi —optimistically in my view — urges that the court do nothing and let the New York legislature reflect on the wisdom in the judicial opinions and then modernize the statutes. Of course, the New York legislature did nothing. Incidentally, given the recent hysterical propaganda by demagogues about liberal “activist judges”, Judge Calabresi is the very model of judicial restraint: he wanted to discuss the law, not decide the case on the merits, and then send the statute to the legislature for reconsideration and revisions, rather than find the current law unconstitutional.

Judge Calabresi, despite his judicial reluctance, made it very clear that he regarded the New York statute to be *unconstitutional*.

There can be no doubt 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. While differing in emphasis, the various opinions of the Supreme Court in *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261, 110 S.Ct. 2841, 111 L.Ed.2d 224 (1990), and in *Planned Parenthood v. Casey*, 505 U.S. 833, 112 S.Ct. 2791, 120 L.Ed.2d 674 (1992), as well as the *en banc* opinion of the Ninth Circuit in *Companion in Dying*, and the strongly argued majority opinion in this case, make that abundantly clear.

*Quill v. Vacco*, 80 F.3d at 735-736 (Calabresi, J., concurring).

Today's majority and the Ninth Circuit, *en banc*, in *Compassion in Dying*, go further than the Supreme Court did in *Cruzan* and *Casey*. These circuits — the first to rule on the matter — hold that laws prohibiting physicians from assisting suicide in some circumstances actually violate the Constitution. The majority does so because it can see no valid Equal Protection

difference between the so-called "passive" assistance that New York allows and the "active" assistance that New York purports to forbid. The Ninth Circuit, instead, finds a violation of a fundamental Due Process right. [FN11]

FN11. And some distinguished scholars agree. See, e.g., Jed Rubenfeld, *The Right of Privacy*, 102 HARV. L. REV. 737, 794-95 (1989) ("If the decision to live or die is said to be so fundamental to a person that the state may not make it for him, then it is difficult to see on what plausible ground the right to make this decision could be granted to those on life support but denied to all other individuals."). There are, of course, distinguished scholars who disagree. See, e.g., Yale Kamisar, *Against Assisted Suicide — Even a Very Limited Form*, 72 DETROIT MERCY L. REV. 735, 753-60 (1995).

In light of these opinions, I believe that it cannot be denied that the laws here involved, whether tested by Due Process or by Equal Protection, are highly suspect. It is also the case, however, that neither *Cruzan*, nor *Casey*, nor the language of our Constitution, nor our constitutional tradition clearly makes these laws invalid. ....

*Quill v. Vacco*, 80 F.3d at 738 (Calabresi, J., concurring).

Judge Calabresi concluded his separate opinion with the following paragraph:

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

*Quill v. Vacco*, 80 F.3d at 743 (Calabresi, J., concurring).

The U.S. Supreme Court did not agree with the U.S. Court of Appeals decision, as explained in the following paragraphs.

#### U.S. Supreme Court

The U.S. Supreme Court decided *Glucksberg* and *Quill* on the same day, as companion cases. Just as the Court found no constitutional right to physician-assisted suicide in *Glucksberg*, the Court unanimously found no denial of equal protection of laws by the New York statute in *Quill*. The key issue in *Quill* is whether there is a significant difference between:

(1) so-called passive euthanasia (i.e., disconnecting life-support machinery (e.g., ventilator or feeding tube))

and

(2) so-called active euthanasia (e.g., deliberately using a lethal dose of prescription drugs to kill a patient, regardless of whether the drugs are taken by the patient or injected by the physician).

This question is sometimes postured as the difference between (1) "letting die" and (2) "killing", the latter word choice favors the conclusion that there *is* a significant difference between these two acts, because "killing" is *wrong*. However, not only is the patient just as dead in both passive and

active euthanasia, but also the death of the patient is both slower and more gruesome in passive euthanasia. A fair and genuine discussion would be facilitated by choosing a different word than “killing”, perhaps “hasten death” or “euthanasia”.

After reviewing the history of the case, the Court said:

Unlike the Court of Appeals, we think the distinction between assisting suicide and withdrawing life-sustaining treatment, a distinction widely recognized and endorsed in the medical profession [footnote omitted] and in our legal traditions, is both important and logical; it is certainly rational.

*Vacco v. Quill*, 521 U.S. 793, 800-801 (1997).

As the Court considered the issues, the Court said:

The distinction comports with fundamental legal principles of causation and intent. First,<sup>40</sup> 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. See, e.g., *People v. Kevorkian*, 447 Mich. 436, 470-472, 527 N.W.2d 714, 728 (1994), cert. denied, 514 U.S. 1083, 115 S.Ct. 1795, 131 L.Ed.2d 723 (1995); *Matter of Conroy*, 98 N.J. 321, 355, 486 A.2d 1209, 1226 (1985) (when feeding tube is removed, death "result[s] ... from [the patient's] underlying medical condition"); *In re Colyer*, 99 Wash.2d 114, 123, 660 P.2d 738, 743 (1983) ("[D]eath which occurs after the removal of life sustaining systems is from natural causes"); American Medical Association, Council on Ethical and Judicial Affairs, *Physician-Assisted Suicide*, 10 *Issues in Law & Medicine* 91, 93 (1994) ("When a life-sustaining treatment is declined, the patient dies primarily because of an underlying disease").

Furthermore, a physician who withdraws, or honors a patient's refusal to begin, life-sustaining medical treatment purposefully intends, or may so intend, only to respect his patient's wishes and "to cease doing useless and futile or degrading things to the patient when [the patient] no longer stands to benefit from them." *Assisted Suicide in the United States*, Hearing before the Subcommittee on the Constitution of the House Committee on the Judiciary, 104th Cong., 2d Sess., 368 (1996) (testimony of Dr. Leon R. Kass). The same is true when a doctor provides aggressive palliative care; in some cases, painkilling drugs may hasten a patient's death, but the physician's purpose and intent is, or may be, only to ease his patient's pain. A doctor who assists a suicide, however, "must, necessarily and indubitably, intend primarily that the patient be made dead." *Id.*, at 367. Similarly, a patient who commits suicide with a doctor's aid necessarily has the specific intent to end his or her own life, while a patient who refuses or discontinues treatment might not. See, e.g., *Matter of Conroy*, *supra*, at 351, 486 A.2d, at 1224 (patients who refuse life-sustaining treatment "may not harbor a specific intent to die" and may instead "fervently wish to live, but to do so free of unwanted medical technology, surgery, or drugs"); *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 743, n. 11, 370 N.E.2d 417, 426, n. 11 (1977) ("[I]n refusing treatment the patient may not have the specific intent to die").

The law has long used actors' intent or purpose to distinguish between two acts that may have the same result. See, e.g., *United States v. Bailey*, 444 U.S. 394, 403-406, 100 S.Ct. 624, 631-633, 62 L.Ed.2d 575 (1980) ("[T]he ... common law of homicide often distinguishes ... between a person who knows that another person will be killed as the result of his conduct and a person who acts with the specific purpose of taking another's life");

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<sup>40</sup> Despite the implied promise, the U.S. Supreme Court does *not* provide a “second” reason.

*Morrisette v. United States*, 342 U.S. 246, 250, 72 S.Ct. 240, 243, 96 L.Ed. 288 (1952) (distinctions based on intent are "universal and persistent in mature systems of law"); M. Hale, 1 Pleas of the Crown 412 (1847) ("If A. with an intent to prevent a gangrene beginning in his hand doth without any advice cut off his hand, by which he dies, he is not thereby *felo de se* for tho it was a voluntary act, yet it was not with an intent to kill himself"). Put differently, the law distinguishes actions taken "because of" a given end from actions taken "in spite of" their unintended but foreseen consequences. *Feeney*, 442 U.S., at 279, 99 S.Ct., at 2296; *Compassion in Dying v. Washington*, 79 F.3d 790, 858 (C.A.9 1996) (Kleinfeld, J., dissenting) ("When General Eisenhower ordered American soldiers onto the beaches of Normandy, he knew that he was sending many American soldiers to certain death.... His purpose, though, was to ... liberate Europe from the Nazis").

*Vacco v. Quill*, 521 U.S. 793, 801-803 (1997).

While the Court is correct about the consensus amongst judges in the USA, it is also true that judges could declare that the *legal* cause of death in physician-assisted suicide is the patient's underlying disease, and *not* the lethal drugs prescribed for suicide. As the Court recognizes, judges have recognized such a legal fiction in cases involving removal of feeding tubes or disconnecting a ventilator from patients in a persistent vegetative state.<sup>41</sup> This would be an easy way of using the common law to legalize so-called physician-assisted suicide. See my proposal on page 113, below.

It is *not* obvious that the Court is correct in maintaining a significant difference between passive euthanasia and active euthanasia. Back in 1975, the New England Journal of Medicine published a landmark article by a philosophy professor that argued there was no significant difference.<sup>42</sup> Approximately simultaneously with the U.S. Supreme Court's decision in *Quill*, a law professor also argued that there was no significant difference.<sup>43</sup>

The U.S. Supreme Court criticized the U.S. Court of Appeals for asserting a legal right to assisted suicide.

Given these general principles, it is not surprising that many courts, including New York courts, have carefully distinguished refusing life-sustaining treatment from suicide. See, e.g., *Fosmire v. Nicoleau*, 75 N.Y.2d 218, 227, and n. 2, 551 N.Y.S.2d 876, 881, and n. 2, 551 N.E.2d 77, 82, and n. 2 (1990) ("[M]erely declining medical care ... is not considered a suicidal act"). [FN7] In fact, the first state-court decision explicitly to authorize withdrawing lifesaving treatment noted the "real distinction between the self-infliction of deadly harm and a

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<sup>41</sup> Ronald B. Standler, *Annotated Legal Cases Involving Right-to-Die in the USA*, <http://www.rbs2.com/rtd.pdf> (April 2005), particularly the long list of citations in the "Overview of the Law" section.

<sup>42</sup> James Rachels, "Active and Passive Euthanasia," 292 *New England Journal of Medicine* 78 (9 Jan 1975).

<sup>43</sup> Alan Meisel, "Physician-Assisted Suicide: A Common Law Roadmap for State Courts," 24 *Fordham Urban Law Journal* 817, 824 (Summer 1997) ("... for two decades courts created and maintained the fiction, with little, if any, in-depth analysis, that there is a difference, a determinative difference, between passively and actively hastening death." [footnote omitted]).

self-determination against artificial life support." *In re Quinlan*, 70 N.J. 10, 43, 52, and n. 9, 355 A.2d 647, 665, 670, and n. 9, cert. denied *sub nom. Garger v. New Jersey*, 429 U.S. 922, 97 S.Ct. 319, 50 L.Ed.2d 289 (1976). And recently, the Michigan Supreme Court also rejected the argument that the distinction "between acts that artificially sustain life and acts that artificially curtail life" is merely a "distinction without constitutional significance — a meaningless exercise in semantic gymnastics," insisting that "the *Cruzan* majority disagreed and so do we." *Kevorkian*, 447 Mich., at 471, 527 N.W.2d, at 728. [footnote omitted]

FN7. Thus, the Second Circuit erred in reading New York law as creating a "right to hasten death"; instead, the authorities cited by the court recognize a right to refuse treatment, and nowhere equate the exercise of this right with suicide. *Schloendorff v. Society of New York Hospital*, 211 N.Y. 125, 129-130, 105 N.E. 92, 93 (1914), which contains Justice Cardozo's famous statement that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body," was simply an informed-consent case. See also *Rivers v. Katz*, 67 N.Y.2d 485, 495, 504 N.Y.S.2d 74, 80, 495 N.E.2d 337, 343 (1986) (right to refuse antipsychotic medication is not absolute, and may be limited when "the patient presents a danger to himself"); *Matter of Storar*, 52 N.Y.2d 363, 377, n. 6, 438 N.Y.S.2d 266, 273, n. 6, 420 N.E.2d 64, 71, n. 6, cert. denied, 454 U.S. 858, 102 S.Ct. 309, 70 L.Ed.2d 153 (1981).

*Vacco v. Quill*, 521 U.S. 793, 803-804 (1997).

The Court simply ignored the obvious: when a patient, or the patient's surrogate decision maker, refuses to continue life-supporting machinery (e.g., a feeding tube or a mechanical ventilator), then the patient dies. If that death is the logical result of the patient's decision, then it is clearly a form of suicide,<sup>44</sup> regardless of whatever legal fictions and declarations that judges may create.

The U.S. Supreme Court concluded:

By permitting everyone to refuse unwanted medical treatment while prohibiting anyone from assisting a suicide, New York law follows a longstanding and rational distinction.

New York's reasons for recognizing and acting on this distinction — including prohibiting intentional killing and preserving life; preventing suicide; maintaining physicians' role as their patients' healers; protecting vulnerable people from indifference, prejudice, and psychological and financial pressure to end their lives; and avoiding a possible slide towards euthanasia — are discussed in greater detail in our opinion in *Glucksberg, ante*. These valid and important public interests easily satisfy the constitutional requirement that a legislative classification bear a rational relation to some legitimate end

*Vacco v. Quill*, 521 U.S. 793, 808-809 (1997).

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<sup>44</sup> See, e.g., *Krischer v. McIver*, 697 So.2d 97, 110 (Fla. 1997) (Kogan, C.J., dissenting) ("*In re Guardianship of Browning*, 568 So.2d 4, 17 (Fla. 1990), we found that the right to refuse treatment could be asserted by a surrogate on behalf of a woman who was vegetative but not terminally ill, but who previously had indicated she wanted life support removed in such circumstances. All of these acts would have been suicide at common law, and the assistance provided by physicians would have been homicide. Today they are not.")

### **Kevorkian (Mich. 1993-2002)**

Jack Kevorkian was a physician in Michigan who, in 1989, invented a machine for committing suicide. The victim activated a switch that began the flow of intravenous fluids containing sodium thiopental, a barbiturate that would cause unconsciousness, followed by flow of intravenous fluids containing a lethal dose of potassium chloride. During the next nine years, Kevorkian reportedly helped kill more than one hundred people: some with his suicide machine, some with inhalations of carbon monoxide gas, and some with injections of lethal doses of a drug.

As an initial skirmish, seven health care professionals and two terminally ill patients filed litigation against the Michigan attorney general, seeking a declaration that the statute prohibiting assisted suicide was unconstitutional.

- *Hobbins v. Attorney General*, 1993 WL 276833 (Mich.Cir.Ct. 20 May 1993) (declaratory judgment: held unconstitutional Michigan statute prohibiting assisting suicide), *rev'd in part*, 518 N.W.2d 487 (Mich.App. 10 May 1994) (no constitutional right to commit suicide).  
*aff'd in part*, 527 N.W.2d 714 (Mich. 13 Dec 1994),  
*cert. den. sub nom. Hobbins v. Kelley*, 514 U.S. 1083 (1995).

Similarly, Kevorkian and a terminally ill patient also filed litigation challenging California's prohibition of assisted suicide. The U.S. Supreme Court's decisions in *Glucksberg* and *Quill* killed Kevorkian's opportunity to make new law at the U.S. Court of Appeals for the Ninth Circuit.

- *Kevorkian v. Arnett*, 939 F.Supp. 725 (C.D.Cal. 11 Sep 1996) (statute is constitutional), *vacated and appeal dismissed*, 136 F.3d 1360 (9th Cir. 31 Mar 1998).

Represented by a skillful attorney, Kevorkian consistently managed to avoid criminal convictions in several prosecutions. In some cases, judges dismissed the charges against Kevorkian; in other cases the jury refused to convict Kevorkian. The following is a list of all of the judicial opinions in the Westlaw database in the various criminal cases against Kevorkian, in chronological order:

- *People v. Kevorkian*, Not Reported in N.W.2d, 1993 WL 603212 (Mich.Cir.Ct. 13 Dec 1993) (Motion to dismiss criminal prosecution denied), *rev'd*, 518 N.W.2d 487 (Mich.App. May 10, 1994), *aff'd in part*, 527 N.W.2d 714 (Mich. 13 Dec 1994), *cert. den.*, 514 U.S. 1083 (24 Apr 1995).
- *People v. Kevorkian*, 517 N.W.2d 293 (Mich.App. 10 May 1994), *judgment vacated*, 527 N.W.2d 714 (Mich. 13 Dec 1994), *cert. den.*, 514 U.S. 1083 (24 Apr 1995).



- *People ex rel. Oakland County Prosecuting Attorney v. Kevorkian*, 534 N.W.2d 172 (Mich.App. 12 May 1995) (affirming injunction against Dr. Kevorkian assisting more suicides),  
*appeal denied*, 549 N.W.2d 566 (Mich. 26 Apr 1996),  
*cert. den.*, 519 U.S. 928 (15 Oct 1996).

In the most recent criminal prosecution, Dr. Kevorkian arrogantly defended himself, instead of using an attorney. Kevorkian was convicted and sentenced to prison for 10 to 25 years.

- *People v. Kevorkian*, 639 N.W.2d 291 (Mich.App. 20 Nov 2001) (affirming second-degree murder conviction),  
*appeal denied*, 642 N.W.2d 681 (Mich. 9 Apr 2002),  
*cert. den.*, 537 U.S. 881 (7 Oct 2002).

Dr. Kevorkian may be distinguishable from typical physicians, in that Kevorkian was specializing in killing people, instead of treating people in a typical physician-patient relationship. Indeed, Dr. Kevorkian's license to practice medicine was revoked in Michigan in November 1991, *before* he committed a murder in September 1998 for which he was convicted.

The majority opinions of the Michigan appellate courts are predictable, boring, and conventional in that they refuse to recognize a constitutional right to euthanasia. The Michigan Supreme Court opinion at 524 N.W.2d 714 (1994) is a consolidation of appeals in *five* cases involving assisted suicide. That opinion is difficult to read, because there are five opinions by the seven justices: (1) a terse memorandum opinion that summarizes the majority holdings, (2) the opinion of the chief justice, joined by two other justices, and (3-5) three separate opinions that dissent in part, each of which is joined by one other justice. A note in a law review does a good job of sorting through the facts and issues in these cases.<sup>45</sup> Kevorkian's appeal of his criminal conviction, 639 N.W.2d 291, is discussed in another legal journal.<sup>46</sup>

Dr. Kevorkian was released on parole in June 2007, after serving eight years in prison. He died in June 2011. Dr. Kevorkian was eccentric and iconoclastic, but he did inspire many Americans to confront end-of-life issues.

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<sup>45</sup> Janet M. Branigan, Note, "Michigan's Struggle with Assisted Suicide and Related Issues as Illuminated by Current Case Law: An Overview of *People v. Kevorkian*," 72 University of Detroit Mercy Law Review 959 (Summer 1995).

<sup>46</sup> Barry A. Bostrom, "In the Michigan Court of Appeals: *People vs. Jack Kevorkian*," 18 Issues in Law and Medicine 57 (Summer 2002).

***Krischer v. McIver (Fla. 1997)***

The Florida Supreme Court tersely summarized the litigation in the trial court:

Charles E. Hall and his physician, Cecil McIver, M.D., filed suit for a declaratory judgment that section 782.08, Florida Statutes (1995), which prohibits assisted suicide, violated the Privacy Clause of the Florida Constitution [Art. I, § 23, “Every natural person has the right to be let alone and free from governmental intrusion into the person's private life except as otherwise provided herein.”] and the Due Process and Equal Protection Clauses of the Fourteenth Amendment to the United States Constitution.[footnote: “Three patient-plaintiffs originally joined in the action but two died before the trial.”] They sought an injunction against the state attorney from prosecuting the physician for giving deliberate assistance to Mr. Hall in committing suicide. After a six-day bench trial, the trial court issued a final declaratory judgment and injunctive decree responding to the “question of whether a competent adult, who is terminally ill, immediately dying and acting under no undue influence, has a constitutional right to hasten his own death by seeking and obtaining from his physician a fatal dose of prescription drugs and then subsequently administering such drugs to himself.” The court concluded that §782.08 could not be constitutionally enforced against the appellees and enjoined the state attorney from enforcing it against Dr. McIver should he assist Mr. Hall in committing suicide. The court based its conclusion on Florida’s privacy provision and the federal Equal Protection Clause but held that there was no federal liberty interest in assisted suicide guaranteed by the federal Due Process Clause.

Mr. Hall is thirty-five years old and suffers from acquired immune deficiency syndrome (AIDS) which he contracted from a blood transfusion. The court found that Mr. Hall was mentally competent and that he was in obviously deteriorating health, clearly suffering, and terminally ill. The court also found that it was Dr. McIver’s professional judgment that it was medically appropriate and ethical to provide Mr. Hall with the assistance he requests at some time in the future.

*Krischer v. McIver*, 697 So.2d 97, 99 (Fla. 1997).

The defendant in this case, Krischer, was the Palm Beach County State Attorney. The trial court’s opinion was not published.

After the plaintiff’s victory in the trial court, the state attorney appealed directly to the Florida Supreme Court, which reversed the decision of the trial court. In overruling the trial court, the Florida Supreme Court noted:

1. *Washington v. Glucksberg*, 521 U.S. 702 (1997). “... assistance in committing suicide was not a fundamental liberty interest protected by the Due Process Clause.” *McIver*, 697 So.2d at 100.
2. *Vacco v. Quill*, 521 U.S. 793 (1997) (no violation of Equal Protection clause). “... the Court’s decision in *Vacco* rejected one of the two bases for the trial court’s ruling in the instant case.” *McIver*, 697 So.2d at 100.

3. “Florida imposes criminal responsibility on those who assist others in committing suicide. Section 782.08, Florida Statutes (1995), which was first enacted in 1868, provides in pertinent part that “every person deliberately assisting another in the commission of self murder shall be guilty of manslaughter.” See also §§ 765.309, 458.326(4), Fla. Stat. (1995) (disapproving mercy killing and euthanasia). Thus, it is clear that the public policy of this state as expressed by the legislature is opposed to assisted suicide.” *McIver*, 697 So.2d at 100.
4. Cited *Donaldson v. Lungren*, 4 Cal.Rptr.2d 59, 63 (1992) as “the only case in the nation in which a court has considered whether assisted suicide is a protected right under the privacy provision of its state’s constitution”. *McIver*, 697 So.2d at 100-101. In that case, California rejected assisted suicide.
5. Discussed a 1984 report by the New York State Task Force on Life and the Law — as well as amicus briefs filed by advocates for the disabled — that presented the horror that physician-assisted suicide would become genocide against mentally disabled, physically disabled, impoverished, mentally-ill, or “socially marginalized groups”. *McIver*, 697 So.2d at 101-102.
6. “... recognized the state's legitimate interest in (1) the preservation of life, (2) the protection of innocent third parties, (3) the prevention of suicide, and (4) the maintenance of the ethical integrity of the medical profession. However, we held that these interests were not sufficiently compelling to override the patient's right of self-determination to forego life-sustaining medical treatment.” *McIver*, 697 So.2d at 102-104.
7. Quoted *Washington v. Glucksberg*, 521 U.S. 702, 730 (1997) (“Those who attempt suicide — terminally ill or not — often suffer from depression or other mental disorders.”). *McIver*, 697 So.2d at 103.
8. Disclaimed responsibility of court for making social policy, which allegedly belongs to legislature. *McIver*, 697 So.2d at 104. My retort is that this is akin to a paternalistic father telling his child “Go ask your mother.”
9. But the Florida Supreme Court admits: “We do not hold that a carefully crafted statute authorizing assisted suicide would be unconstitutional.” *McIver*, 697 So.2d at 104.

These reasons can be condensed into one reason that no other state is permitting physician-assisted suicide, so neither will Florida. The horror about genocide is irrelevant in this case, because the Florida Supreme Court cites no evidence that any of the plaintiffs in this case were disabled, impoverished, or otherwise vulnerable. Similarly, there is no evidence that any of the plaintiffs in this case suffered from “depression or other mental disorders”, as claimed in *Glucksberg*, a so-called fact that deprives sane people of their autonomy, in order to protect insane people.

Chief Justice Kogan wrote a dissenting opinion. *McIver*, 697 So.2d at 109-115.

### **Sanderson v. Colorado (2000)**

- *Sanderson v. Colorado*, 12 P.3d 851, 2000 CJ C.A.R. 3169 (Colo.App. 8 Jun 2000), *certiorari denied* (Colo. 23 Oct 2000).

In contrast to *Compassion in Dying/Glucksberg* and *Quill*, which cases were decided by the U.S. Supreme Court, and in contrast to the saga of Dr. Kevorkian, which was repeatedly mentioned in nationwide news reports during the 1990s, there is an obscure case of *Sanderson* in Colorado. Robert Sanderson, the plaintiff, was an elderly man who sought a declaratory judgment that neither his physician nor his wife would be criminally prosecuted for providing euthanasia to him. The Colorado statute at issue in this case says:

- (1) A person commits the crime of manslaughter if:
  - (a) Such person recklessly causes the death of another person; or
  - (b) Such person intentionally causes or aids another person to commit suicide.

- (2) Manslaughter is a class 4 felony.<sup>47</sup>

- (3) This section shall not apply to a person, including a proxy decision-maker as such person is described in section § 15-18.5-103, C.R.S., who complies with any advance medical directive in accordance with the provisions of title 15, C.R.S., including a medical durable power of attorney, a living will, or a cardiopulmonary resuscitation (CPR) directive.

Colorado Statutes § 18-3-104. Manslaughter (as revised 1 June 1996, current 13 May 2005).

In an unpublished decision, the trial court rejected his claim without allowing Sanderson to present testimony in court. Sanderson then appealed. The intermediate court of appeal in Colorado wrote a short opinion that disposed of Sanderson's case. The entire appellate opinion follows:

Plaintiff, Robert Sanderson, appeals the judgment dismissing his claim for declaratory relief against defendant, the People of the State of Colorado. The sole issue on appeal is whether § 18-3-104(1)(b), C.R.S.1999, which criminalizes assisted suicide, violates Sanderson's rights under the Free Exercise Clause of the First Amendment to the United States Constitution. Because we conclude it does not, we affirm.

Sanderson is over eighty years old, and wishes to provide his wife with a durable medical power of attorney authorizing her to end his life by euthanasia, provided that two physicians agree his medical condition is hopeless. He filed this action seeking a declaratory judgment that neither his wife, nor the physician administering euthanasia, would be subject to criminal liability for homicide under § 18-3-104(1)(b). The statute provides that: "A person commits the crime of manslaughter if: Such person intentionally causes or aids another person to commit suicide."

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<sup>47</sup> A class four felony is punishable by imprisonment for between two and six years, followed by at least three years of parole. Colorado Statutes § 18-1.3-401(V)(A) (effective 1 July 1993, current 13 May 2005).

Sanderson asserted claims under the First, Fourth, Fifth, Sixth, Ninth, and Fourteenth Amendments to the United States Constitution. The trial court dismissed the action for failure to state a claim upon which relief could be granted, and on appeal, Sanderson raises only his First Amendment claim. He has not pressed his claims under other portions of the United States Constitution, or raised any issues under the Colorado Constitution.

Sanderson contends the trial court erred in dismissing his complaint for failure to state a claim. He maintains that Colorado's assisted suicide law interferes with his religious beliefs, and therefore violates his rights under the Free Exercise Clause of the First Amendment to the United States Constitution. We are not persuaded.

A complaint should not be dismissed for failure to state a claim unless it appears beyond doubt that the plaintiff can prove no set of facts in support of the claim which would entitle him or her to relief. *Burke v. Greene*, 963 P.2d 1119 (Colo.App. 1998).

In reviewing a motion to dismiss, we must accept as true all allegations of material fact contained in the complaint, and view such allegations in the light most favorable to the plaintiff. *Burke v. Greene, supra*. Review of a motion to dismiss is *de novo*. *Fluid Technology, Inc. v. CVJ Axles, Inc.*, 964 P.2d 614 (Colo.App. 1998).

Statutes are presumed to be constitutional, and the burden of establishing unconstitutionality is on the party challenging the statute's validity. *People v. Bielecki*, 964 P.2d 598 (Colo.App. 1998).

In his complaint, Sanderson described his personal religious beliefs as follows:

[Sanderson] believes that God or nature endowed human kind with a "free will" and that [Sanderson's] "free will" is the predominant and driving force in his life, as well as in human life generally, within the confines of man's physical and mental limitations and within the limitations of [the] earthly environment.

[Sanderson] believes that God, or nature, intended that the free will of man be exercised in all circumstances according to his own best judgment with due consideration for others.

Such belief includes man's right to delegate power to another person to authorize euthanasia, or to directly authorize euthanasia by an attending Physician when [Sanderson] predetermines the reasonable medical conditions under which it is to be exercised.

[Sanderson] does not believe in the sanctity of human life as such, therefore he is not bound by any particular religious or church doctrine which opposes euthanasia under any circumstances, including a situation which is atrocious and intolerable to him.

There have been other constitutional challenges to laws that criminalize assisted suicide, all of which have been unsuccessful. See *Vacco v. Quill*, 521 U.S. 793, 117 S.Ct. 2293, 138 L.Ed.2d 834 (1997)(concluding there is no right to assisted suicide under the Equal Protection Clause); *Washington v. Glucksberg*, 521 U.S. 702, 117 S.Ct. 2258, 138 L.Ed.2d 772 (1997)(concluding there is no right to assisted suicide under the Due Process Clause). However, we are unaware of any published opinion that has addressed a First Amendment freedom of religion challenge to an assisted suicide statute, nor have counsel referred us to such authority.

The Free Exercise Clause of the First Amendment provides that: "Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof...." U.S. Const. amend I. The First Amendment is binding on the states through incorporation into the Fourteenth Amendment. See *Cantwell v. Connecticut*, 310 U.S. 296, 60 S.Ct. 900, 84 L.Ed. 1213 (1940).

Under the Free Exercise Clause, religious belief and the profession of that belief are absolutely protected, and religious practices also are protected to a lesser extent. However, neutral laws of general applicability that have an incidental effect on religious practices do not offend the Free Exercise Clause. *See Employment Division, Department of Human Resources v. Smith*, 494 U.S. 872, 110 S.Ct. 1595, 108 L.Ed.2d 876 (1990). In other words, an individual's religious beliefs do not excuse the individual from "compliance with an otherwise valid law prohibiting conduct that the State is free to regulate." *Employment Division, Department of Human Resources v. Smith, supra*, 494 U.S. at 878-79, 110 S.Ct. at 1600, 108 L.Ed.2d at 885.

In *Smith*, two Native Americans were denied unemployment benefits after they were fired for ingesting peyote during a religious ceremony. It was undisputed that their religious beliefs were sincere, that they only ingested peyote for sacramental purposes, and that the use of peyote was "vital to [their] ability to practice their religion." *Employment Division, Department of Human Resources v. Smith, supra* 494 U.S. at 903, 110 S.Ct. at 1613, 108 L.Ed.2d at 902 (O'Connor, J., concurring in the judgment).

The Court held that the Free Exercise Clause did not exempt the *Smith* plaintiffs from an Oregon law criminalizing their consumption of peyote. In its analysis, the Court refused to apply the compelling state interest test, *see Sherbert v. Verner*, 374 U.S. 398, 83 S.Ct. 1790, 10 L.Ed.2d 965 (1963), emphasizing that the test was inapplicable to "across-the-board" criminal prohibitions on a particular form of conduct. *Employment Division, Department of Human Resources v. Smith, supra*, 494 U.S. at 884-85, 110 S.Ct. at 1603, 108 L.Ed.2d at 889-90 ("The government's ability to enforce generally applicable prohibitions of socially harmful conduct ... cannot depend on measuring the effects of a governmental action on a religious objector's spiritual development.").

The Court in *Smith* also distinguished its earlier cases barring the application of a neutral, generally applicable law to religious conduct, observing that the previous cases had "involved not the Free Exercise Clause alone, but the Free Exercise Clause in conjunction with other constitutional protections, such as freedom of speech and of the press...." *Employment Division, Department of Human Resources v. Smith*, 494 U.S. at 881, 110 S.Ct. at 1601, 108 L.Ed.2d at 887. That distinction has been criticized. *See Church of the Lukumi Babalu Aye, Inc. v. City of Hialeah*, 508 U.S. 520, 567, 113 S.Ct. 2217, 2245, 124 L.Ed.2d 472, 512 (1993)(Souter, J., concurring in part and concurring in the judgment, criticizing the "hybrid" distinction made in *Smith* as "ultimately untenable," and as creating an exception "so vast as to swallow the *Smith* rule").

However, here, as in *Smith*, the sole issue presented by Sanderson in this appeal is his Free Exercise claim, unsupported by any other alleged constitutional violation.

Sanderson's claim is less compelling than that presented in *Smith* because he does not just seek a limited exemption from the assisted suicide statute for himself so that he may freely practice his religion without fear of criminal prosecution. He also seeks exemptions for third parties — his wife and his physician — based on his personal religious beliefs, which may or may not be shared by the others. Even assuming that Sanderson had standing to raise such claims on behalf of third persons, an issue not raised by the parties on appeal, we have found no precedent for such a broad application of the Free Exercise Clause in First Amendment jurisprudence.

In summary, we conclude § 18-3-104(1)(b) is a valid, religiously-neutral, and generally-applicable criminal statute that prohibits conduct a state is free to regulate. *Employment Division, Department of Human Resources v. Smith, supra*. Thus, while we do not question the sincerity of Sanderson's religious beliefs, we agree with the trial court that there was no evidence Sanderson could have proffered regarding the importance of assisted suicide to his

belief system which would exempt him, or his designated third persons, on First Amendment grounds from the provisions of the statute.

Because Sanderson could not as a matter of law provide any facts to support his claim for relief under the First Amendment, we conclude the trial court did not err in dismissing the claim under C.R.C.P. 12(b)(5).

Judgment affirmed.

*Sanderson v. Colorado*, 12 P.3d 851, 852-854 (Colo.App. 8 Jun 2000).

The Colorado Supreme Court refused to hear the case and Sanderson did not appeal to the U.S. Supreme Court.<sup>48</sup>

#### my comments

The Colorado appellate court said there had “been other constitutional challenges to laws that criminalize assisted suicide, all of which have been unsuccessful.”<sup>49</sup> That sentence makes it appear that the issue in this case had been repeatedly litigated and the validity of the statutes thoroughly established. In fact, there were *only four* previously reported cases involving constitutional challenges to these statutes: *Donaldson* in California, *McIver* in Florida, *Glucksberg* in Washington state, and *Vacco* in New York state. And *none* of those four cases involved a challenge under the First Amendment.

I am troubled that the Colorado appellate court cited only one U.S. Supreme Court case (*Smith*, 494 U.S. 872 (1990)) to support the court’s holding. In April 2004, I wrote a legal memorandum on abortion restrictions as infringing religious freedom, and at that time I realized that this issue was extraordinarily complex. There have been more than 35 cases on religious freedom decided by the U.S. Supreme Court during the years 1944-2001. I conclude that the Colorado appellate court’s treatment of this issue was superficial.

There is no support for the Colorado appellate court’s conclusion that “Sanderson could not as a matter of law provide any facts to support his claim for relief under the First Amendment, ....”<sup>50</sup> Because the trial court dismissed his case for failure to state a claim upon which relief could be granted, Sanderson never had an opportunity to present facts to the court. Would Sanderson, who was a former judge in a Colorado state court, really file bogus litigation for which a court could not grant relief? I think it is more likely that the trial judge dismissed this extraordinarily complex case on a highly controversial topic, because the judge did not want to be bothered with this case, and the appellate court affirmed the dismissal for similar reasons.

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<sup>48</sup> According to Prof. Valerie J. Vollmar, “Sanderson decided not to appeal to the U.S. Supreme Court after the national board of the Hemlock Society decided to withdraw its financial support for the litigation.” [http://www.willamette.edu/wucl/pas/2001\\_reports/062001.html](http://www.willamette.edu/wucl/pas/2001_reports/062001.html) (29 March 2004).

<sup>49</sup> *Sanderson*, 12 P.3d at 853.

<sup>50</sup> *Sanderson*, 12 P.3d at 854.

### ***Sampson v. Alaska (2001)***

The Alaska Supreme Court summarized this case:

Kevin Sampson and Jane Doe were mentally competent, terminally ill adults who sued for an order declaring their physicians exempt from Alaska's manslaughter statute for the purpose of assisting them to commit suicide. The superior court entered summary judgment against Sampson and Doe, and they appealed. We affirm the judgment, concluding that the Alaska Constitution's guarantees of privacy and liberty do not afford terminally ill patients the right to a physician's assistance in committing suicide and that Alaska's manslaughter statute did not violate Sampson and Doe's right to equal protection.

Sampson was an accountant who was diagnosed as carrying human immunodeficiency virus (HIV) in 1985. [footnote: "Sampson died while this case was pending."] In 1992 doctors diagnosed Sampson as having acquired immune deficiency syndrome (AIDS) due to an AIDS-defining opportunistic infection. By 1998 Sampson's doctors had advised him that he was in the terminal phase of AIDS. Sampson asserted that he wanted his physician's assistance to end his life.

Doe was a physician. [footnote: "Doe is a pseudonym used to protect the physician's privacy. Doe also died while this case was pending."] She was diagnosed as having breast cancer in 1977 and later retired from her practice of medicine as a result of the disease. Doe underwent a mastectomy, but the cancer metastasized and was rediscovered in 1989 in her ribs and then later in her skin. Despite radiation and chemotherapy, the cancer had spread to Doe's bones and liver by 1998. Doe's doctors informed her that she was in the terminal stages of her cancer. Doe asserted that she wanted to have the option of physician assistance in ending her life.

Sampson and Doe filed suit, asking the superior court to declare Alaska's manslaughter statute invalid to the extent that it prevents mentally competent, terminally ill individuals from obtaining prescribed medication to self-administer for the purpose of hastening death. The state answered, and both sides moved for summary judgment. Superior Court Judge Eric T. Sanders denied Sampson and Doe's motion for summary judgment and granted the state's cross-motion. Sampson and Doe appeal.

*Sampson v. Alaska*, 31 P.3d 88, 90 (Alaska 2001).

The Alaska Supreme Court unanimously affirmed the trial court's summary judgment for the state.

1. "Alaska is among the vast majority of states that criminalize assisted suicide. [footnote: "See *Washington v. Glucksberg*, 521 U.S. 702, 710-11 & n. 8, 117 S.Ct. 2258, 138 L.Ed.2d 772 (1997) (stating that forty-four states criminalize assisted suicide)."] Alaska Statute 11.41.120(a)(2) provides: 'A person commits the crime of manslaughter if the person intentionally aids another person to commit suicide.' " *Sampson*, 31 P.3d at 91.
2. "The approach of the Alaska Statutes toward assisted suicide has been consistent since statehood: Alaska law has prohibited all forms of assisted suicide and has never recognized an exception for physicians assisting their patients." *Sampson*, 31 P.3d at 92.



3. The court was concerned about the possibility that “vulnerable Alaskans, including terminally ill persons,” might be the subject of undue influence, if physician-assisted suicide were permitted. *Sampson*, 31 P.3d at 96-97.

The Alaska Supreme Court held that the prohibition on all assisted suicide was constitutional, despite the fact it “substantially interferes with Sampson and Doe’s general privacy and liberty interests”. *Sampson*, 31 P.3d at 95.

There can be little doubt that substantial state interests underlie the manslaughter statute's general ban of assisted suicide. Other courts have recognized state interests in preserving human life,[FN56] protecting vulnerable persons,[FN57] protecting the integrity of the medical profession,[FN58] regulating dangerous substances and activities in the state,[FN59] and preventing suicide.[FN60]

**FN56.** See *Washington v. Glucksberg*, 521 U.S. 702, 728, 117 S.Ct. 2258 (1997); *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 282, 110 S.Ct. 2841, 111 L.Ed.2d 224 (1990); *Donaldson v. Van de Kamp*, 2 Cal.App.4th 1614, 4 Cal.Rptr.2d 59, 62 (1992); *Krischer v. McIver*, 697 So.2d 97, 103 (Fla. 1997).

**FN57.** Cf. *Glucksberg*, 521 U.S. at 731-32, 117 S.Ct. 2258.

**FN58.** Cf. *Glucksberg*, 521 U.S. at 731, 117 S.Ct. 2258; American Medical Assoc., CODE OF ETHICS § 2.211 (1994).

**FN59.** See *State v. Erickson*, 574 P.2d 1, 18 (Alaska 1978).

**FN60.** See Alaska Criminal Code Revision Part I, at 33 (Tent. Draft 1977). The comments to the Model Penal Code summarize some of a state's interests in preventing assisted suicide:

Self-destruction is surely not conduct to be encouraged or taken lightly. The fact that penal sanctions will prove ineffective to deter the suicide itself does not mean that the criminal law is equally powerless to influence the behavior of those who would aid or induce another to take his own life. Moreover, in principle it would seem that the interests in the sanctity of life that are represented by the criminal homicide laws are threatened by one who expresses a willingness to participate in taking the life of another, even though the act may be accomplished with the consent, or at the request of the suicide victim.

Model Penal Code § 210.5(2) cmt. 5 (1980) (revised commentary on the Model Penal Code as adopted in 1962). We note that Alaska does not allow the death penalty as criminal punishment or otherwise sanction death in any context.

*Sampson*, 31 P.3d at 96.

The Alaska Supreme Court took ten pages to effectively say “physician-assisted suicide has always been, and still is, a crime in the state of Alaska.” This is a very *unsatisfying* opinion.

### Oregon "Death With Dignity" Statute (1995-2006)

In 1995, the Oregon legislature enacted the following "Death With Dignity Act", which allows physician-assisted suicide under certain conditions. The first section of the safeguards in this Act states the responsibilities of the attending physician.

- (1) The attending physician shall:
  - (a) Make the initial determination of whether a patient has a terminal disease,<sup>51</sup> is capable, and has made the request voluntarily;
  - (b) Request that the patient demonstrate Oregon residency pursuant to ORS 127.860;
  - (c) To ensure that the patient is making an informed decision, 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; and
    - (E) The feasible alternatives, including, but not limited to, comfort care, hospice care and pain control;
  - (d) Refer the patient to a consulting physician for medical confirmation of the diagnosis, and for a determination that the patient is capable and acting voluntarily;
  - (e) Refer the patient for counseling if appropriate pursuant to ORS 127.825;
  - (f) Recommend that the patient notify next of kin;
  - (g) Counsel the patient about the importance of having another person present when the patient takes the medication prescribed pursuant to ORS 127.800 to 127.897 and of not taking the medication in a public place;
  - (h) 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 ORS 127.840;
  - (i) Verify, immediately prior to writing the prescription for medication under ORS 127.800 to 127.897, that the patient is making an informed decision;
  - (j) Fulfill the medical record documentation requirements of ORS 127.855;
  - (k) Ensure that all appropriate steps are carried out in accordance with ORS 127.800 to 127.897 prior to writing a prescription for medication to enable a qualified patient to end his or her life in a humane and dignified manner; and
  - (ℓ)
    - (A) Dispense medications directly, including ancillary medications intended to facilitate the desired effect to minimize the patient's discomfort, provided the attending physician is registered as a dispensing physician with the Board of Medical Examiners, has a current Drug Enforcement Administration certificate and complies with any applicable administrative rule; or
    - (B) With the patient's written consent:
      - (i) Contact a pharmacist and inform the pharmacist of the prescription; and
      - (ii) Deliver the written prescription personally or by mail to the pharmacist, who will dispense the medications to either the patient, the attending physician or an expressly identified agent of the patient.

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<sup>51</sup> "'Terminal disease' means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months." Oregon Statutes, Title 13, Chapter 127.800, § 1.01(12) (current 3 May 2005).

(2) Notwithstanding any other provision of law, the attending physician may sign the patient's death certificate.

Oregon Statutes, Title 13, Chapter 127.815, § 3.01 (current 3 May 2005).

The second section states the duties of the consulting physician.

Before a patient is qualified under ORS 127.800 to 127.897, 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.

Oregon Statutes, Title 13, Chapter 127.820, § 3.02 (current 3 May 2005).

The third section is designed to prevent assisting depressed patients commit suicide.

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 patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.

Oregon Statutes, Title 13, Chapter 127.825, § 3.03 (current 3 May 2005).

The fourth section requires an 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 ORS 127.800 (7). Immediately prior to writing a prescription for medication under ORS 127.800 to 127.897, the attending physician shall verify that the patient is making an informed decision.

Oregon Statutes, Title 13, Chapter 127.830, § 3.04 (current 3 May 2005).

The definitions in ORS 127.800(7) say:

The following words and phrases, whenever used in ORS 127.800 to 127.897, have the following meanings:

....

(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; and
- (e) The feasible alternatives, including, but not limited to, comfort care, hospice care and pain control.

Oregon Statutes, Title 13, Chapter 127.800, § 1.01 (current 3 May 2005).

The fifth section recommends notification of the patient's family.

The attending physician shall recommend that the patient notify the next of kin of his or her request for medication pursuant to ORS 127.800 to 127.897. A patient who declines or is unable to notify next of kin shall not have his or her request denied for that reason.

Oregon Statutes, Title 13, Chapter 127.835, § 3.05 (current 3 May 2005).

The Oregon legislature modified this statute in 1999 to make notification of the family optional.

The original 1995 version of the statute required that the physician "shall ask the patient to notify" the patient's family, and the original § 3.01(f) stated that the attending physician's responsibilities included "Request that the patient notify next of kin".

The sixth section contains a time delay to prevent hasty decisions.

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.

Oregon Statutes, Title 13, Chapter 127.840, § 3.06 (current 3 May 2005).

The seventh section contains an explicit right for the patient to rescind the 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 ORS 127.800 to 127.897 may be written without the attending physician offering the qualified patient an opportunity to rescind the request.

Oregon Statutes, Title 13, Chapter 127.845, § 3.07 (current 3 May 2005).

The eighth section contains an additional time delay, to work together with the sixth section.

No less than fifteen (15) days shall elapse between the patient's initial oral request and the writing of a prescription under ORS 127.800 to 127.897. No less than 48 hours shall elapse between the patient's written request and the writing of a prescription under ORS 127.800 to 127.897.

Oregon Statutes, Title 13, Chapter 127.850, § 3.08 (current 3 May 2005).

Other sections of this statute require the physician to keep written documentation, and require that only residents of Oregon can receive physician-assisted suicide under this statute (obviously to prevent a flood of terminally ill patients from the other 49 states into Oregon).

The thirteenth section prevents health insurance contracts from requiring an early death by physician-assisted suicide, in order to reduce medical expenses paid by the insurance company. Similarly, an annuity contract can not give any incentive for an early death via physician-assisted suicide.

The sale, procurement, or issuance of any life, health, or accident insurance or annuity policy or the rate charged 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.

Oregon Statutes, Title 13, Chapter 127.875, § 3.013 (current 3 May 2005).

The fourteenth, and final, section says:

Nothing in ORS 127.800 to 127.897 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 ORS 127.800 to 127.897 shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law.

Oregon Statutes, Title 13, Chapter 127.880, Laws 1995 § 3.014 (current 1 June 2012).

Notice that this statute allows a physician to prescribe a lethal dose of medicine that the *patient* will knowingly take to commit suicide. This statute does *not* authorize a physician or nurse to administer a lethal dose of medicine. The second sentence prevents criminal prosecution of the physician(s) and other people involved in physician-assisted suicide under the conditions of this statute. The second sentence apparently also makes the underlying disease the legal cause of death, because the statute declares the legal fiction that the death is *not* a suicide.

The Oregon statute went into effect in October 1997.<sup>52</sup> My search of the Oregon annotated statutes and Oregon cases on Westlaw on 1 June 2012 found no cases in state court, so apparently there have been no local problems with the implementation of this statute. During 14 years, 1998 to 2011, a total of 596 residents of Oregon had died using a prescription obtained under the Death With Dignity Act, according to information released by the Oregon state government. In the 2010 census, Oregon had a total population of 3.8 million people, so the 71 deaths in 2011 were less than 0.002% of the state's population.

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<sup>52</sup> Previously, there were challenges to the constitutionality of this statute. See, *Lee v. State of Oregon*, 107 F.3d 1382 (9th Cir. 1997), *cert. den.*, *sub nom. Lee v. Harclerod*, 522 U.S. 927 (14 Oct 1997); *Hamilton v. Myers*, 943 P.2d 214 (Or. 2 Sep 1997).

## laboratory of the states

I suggest the right way to approach the novel Oregon statute that permits physician-assisted suicide is to give freedom to Oregon to experiment, under a doctrine known as “laboratory of the states”. Individual states may offer more freedom or more liberties to their citizens than the minimum required by the U.S. Constitution. Back in 1932, Justice Brandeis wrote:

To stay experimentation in things social and economic is a grave responsibility. Denial of the right to experiment may be fraught with serious consequences to the nation. 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. This Court has the power to prevent an experiment. [footnote omitted] We may strike down the statute which embodies it on the ground that, in our opinion, the measure is arbitrary, capricious, or unreasonable. We have power to do this, because the due process clause has been held by the Court applicable to matters of substantive law as well as to matters of procedure. But, in the exercise of this high power, we must be ever on our guard, lest we erect our prejudices into legal principles. If we would guide by the light of reason, we must let our minds be bold.

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

This is the origin of the phrase “laboratory of the states”, which is now a common buzzword in constitutional law, to indicate the freedom of states to experiment with different policies, instead of requiring a uniform, nationwide policy. See, for example:

Courts and commentators frequently have recognized that the 50 States serve as laboratories for the development of new social, economic, and political ideas. [FN20] This state innovation is no judicial myth. When Wyoming became a State in 1890, it was the only State permitting women to vote. [footnote omitted] That novel idea did not bear national fruit for another 30 years. [footnote omitted] Wisconsin pioneered unemployment insurance, [footnote omitted] while Massachusetts initiated minimum wage laws for women and minors. [footnote omitted] After decades of academic debate, state experimentation finally provided an opportunity to observe no-fault automobile insurance in operation. [footnote omitted] Even in the field of environmental protection, an area subject to heavy federal regulation, the States have supplemented national standards with innovative and far-reaching statutes. [footnote omitted] Utility regulation itself is a field marked by valuable state invention. [footnote omitted] ....

FN20. See, e.g., *Chandler v. Florida*, 449 U.S. 560, 579, 101 S.Ct. 802, 812, 66 L.Ed.2d 740 (1981); *Reeves, Inc. v. Stake*, 447 U.S. 429, 441, 100 S.Ct. 2271, 2279, 65 L.Ed.2d 244 (1980); *Whalen v. Roe*, 429 U.S. 589, 597, and n.20, 97 S.Ct. 869, 875, and n.20, 51 L.Ed.2d 64 (1977); *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311, 52 S.Ct. 371, 386, 76 L.Ed. 747 (1932) (Brandeis, J., dissenting); Hart, *supra* n.13, at 540, 542; A. Macmahon, *The Problems of Federalism: A Survey*, in *Federalism: Mature and Emergent* 3, 10-11 (A. Macmahon ed., 1955); N. Rockefeller, *The Future of Federalism* 8-9 (1962); Stewart, [Pyramids of Sacrifice? Problems of Federalism in Mandating State Implementation of National Environmental Policy, 86 Yale L.J. 1196, 1210 (1977)]; [L.] White, [The States and the Nation 12 (1953)].

*F. E. R. C. v. Mississippi*, 456 U.S. 742, 788-789 (1982) (O'Connor, J., dissenting in part, joined by Chief Justice Burger and Justice Rhenquist).

Justice O'Connor mentioned "laboratory of the states" again in her concurring opinion in *Cruzan*, a case involving disconnection of a feeding tube from a patient in a persistent vegetative state.

Today we decide only that one State's practice does not violate the Constitution; the more challenging task of crafting appropriate procedures for safeguarding incompetents' liberty interests is entrusted to the "laboratory" of the States, *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311, 52 S.Ct. 371, 386-87, 76 L.Ed. 747 (1932) (Brandeis, J., dissenting), in the first instance.

*Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 292 (1990) (O'Connor, J., concurring), part quoted with approval by the majority opinion in *Smith v. Robbins*, 528 U.S. 259, 275 (2000).

Justice O'Connor made the point that regulation of medicine was a matter for state governments.

As the Court recognizes, States are presently undertaking extensive and serious evaluation of physician-assisted suicide and other related issues. [citation omitted] In such circumstances, "the ... challenging task of crafting appropriate procedures for safeguarding ... liberty interests is entrusted to the 'laboratory' of the States ... in the first instance." *Cruzan v. Director, Mo. Dept. of Health*, 497 U.S. 261, 292, 110 S.Ct. 2841, 2859, 111 L.Ed.2d 224 (1990) (O'CONNOR, J., concurring) (citing *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311, 52 S.Ct. 371, 386-387, 76 L.Ed. 747 (1932)).

*Glucksberg v. Washington*, 521 U.S. 702 at 737, 117 S.Ct. 2302 at 2303 (1997) (O'Connor, J., concurring).

#### Ashcroft's Regulation rejected

Despite the *promise* of freedom for states to experiment with various social policies, when Oregon actually experimented by enacting the Death with Dignity Act, Oregon's experiment was nullified by the U.S. Attorney General. On 6 Nov 2001, Daniel Ashcroft, the U.S. Attorney General, effectively nullified this Oregon statute by threatening to revoke the license to prescribe federally controlled substances<sup>53</sup> from any physician who prescribed a federally controlled substance during physician-assisted suicide. 66 F.R. 56607. In my view, Attorney General Ashcroft sought to impose his personal religious opinion on the state of Oregon, as well as any other state that dared legalize physician-assisted suicide. The state of Oregon then sued the Attorney General in his official capacity. Ashcroft's regulation was rejected by all three federal courts that considered the matter:

1. *Oregon v. Ashcroft*, 192 F.Supp.2d 1077 (D.Or. 2002),
2. *aff'd*, 368 F.3d 1118 (9thCir. 2004),
3. *aff'd sub nom. Gonzales v. Oregon*, 546 U.S. 243 (2006).

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<sup>53</sup> 21 U.S.C. § 801, et seq., particularly § 812. Controlled substances include opiates such as morphine, and synthetic narcotic drugs such as dihydrocodeine, fentanyl, and methadone.

Aside from the litigation, several physicians were concerned about the U.S. Attorney General's "intrusion into medical practice", a matter that is usually left to regulation by state governments.<sup>54</sup>

The U.S. District Court in Oregon noted the narrow issue in considering the validity of Ashcroft's regulation:

Despite the enormity of the debate over physician-assisted suicide, the issues in this case are legal ones and, as pertain to my disposition, are fairly narrowly drawn. My resolution of the legal issues does not require any delving into the complex religious, moral, ethical, medical, emotional or psychological controversies that surround physician-assisted suicide or "hastened death" (as the parties sometimes describe it), because in Oregon, those controversies have been-for now-put to rest.

*Oregon v. Ashcroft*, 192 F.Supp.2d 1077, 1080 (D.Or. 2002).

The U.S. Court of Appeals in Oregon wrote:

However, we do note the argument by the plaintiff patients that the Ashcroft Directive, if followed, will achieve the *in terrorem* effect intended. Doctors will be afraid to write prescriptions sufficient to painlessly hasten death. Pharmacists will fear filling the prescriptions. Patients will be consigned to continued suffering and, according to the declarations of record, may die slow and agonizing deaths. Should patients attempt suicide without the assistance of their doctors and pharmacists, they may fail or leave loved ones with the trauma of dealing with the aftermath of certain forms of suicide too unpleasant to describe in this opinion.

*Oregon v. Ashcroft*, 368 F.3d 1118, 1121, n.2 (9thCir. 2004).

Later in its opinion, the Court of Appeals wrote:

To be perfectly clear, we take no position on the merits or morality of physician assisted suicide. We express no opinion on whether the practice is inconsistent with the public interest or constitutes illegitimate medical care. This case is simply about who gets to decide. All parties agree that the question before us is whether Congress authorized the Attorney General to determine that physician assisted suicide violates the [Controlled Substances Act] CSA. We hold that the Attorney General lacked Congress' requisite authorization. The Ashcroft Directive violates the "clear statement" rule, contradicts the plain language of the CSA, and contravenes the express intent of Congress.

*Oregon v. Ashcroft*, 368 F.3d 1118, 1123 (9thCir. 2004).

The U.S. Supreme Court opinion is a tediously lengthy (28 pages for the majority opinion in U.S. Reports) discussion of the appropriateness of an Attorney General issuing a regulation about medical practice. The focus is on administrative procedure. The key paragraph in the majority opinion says:

The Attorney General has rulemaking power to fulfill his duties under the CSA [Controlled Substances Act]. The specific respects in which he is authorized to make rules,

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<sup>54</sup> See, e.g., Edward Lowenstein and Sidney H. Wanzer, 346 NEW ENGLAND JOURNAL OF MEDICINE 447 (7 Feb 2002).



however, instruct us that he is not authorized to make a rule declaring illegitimate a medical standard for care and treatment of patients that is specifically authorized under state law. *Gonzales v. Oregon*, 546 U.S. 243, 258 (2006).

The U.S. Supreme Court did *not* mention the “laboratory of the states” argument that I suggested above, but the Court did remark:

Beyond this, however, the [federal Controlled Substances Act] manifests no intent to regulate the practice of medicine generally. The silence is understandable given the structure and limitations of federalism, which allow the States “ ‘great latitude under their police powers to legislate as to the protection of the lives, limbs, health, comfort, and quiet of all persons.’ ” *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 475, 116 S.Ct. 2240, 135 L.Ed.2d 700 (1996) (quoting *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 756, 105 S.Ct. 2380, 85 L.Ed.2d 728 (1985)).

*Gonzales v. Oregon*, 546 U.S. at 270 (2006).

Physician-assisted suicide is hardly mentioned in the majority opinion, but makes a brief appearance in Justice Scalia’s dissenting opinion.

The fact that many in Oregon believe that the boundaries of “legitimate medicine” *should be* extended to include assisted suicide does not change the fact that the overwhelming weight of authority (including the 47 States that condemn physician-assisted suicide) confirms that they have not yet been so extended. Not even those of our Eighth Amendment cases most generous in discerning an “evolution” of national standards would have found, on this record, that the concept of “legitimate medicine” has evolved so far. See *Roper v. Simmons*, 543 U.S. 551, 564–567, 125 S.Ct. 1183, 161 L.Ed.2d 1 (2005).

*Gonzales v. Oregon*, 546 U.S. at 287 (Scalia, J., dissenting). In *Roper v. Simmons*, the Court held it was unconstitutional to execute criminals who were under 18 years of age at the time of their crime. The issue cited here was about a developing “national consensus” to change the law. Scalia’s fact about 47 states comes from *Glucksberg*, 521 U.S. at 710, n.8 — a fact that was nine years old and probably slightly wrong.

This was one of Justice O’Connor’s last cases. She voted with the majority. Her replacement, Justice Alito, would probably have dissented with Justices Scalia, Thomas, and Roberts.

### **Washington (2009)**

In June 1997, the U.S. Supreme Court in *Washington v. Glucksberg* unanimously declared that citizens had no constitutional right to physician-assisted suicide. Advocates of physician-assisted suicide then placed a proposal (Washington Initiative Measure No. 1000) on the 4 Nov 2008 ballot. In the election, 57.8% of voters approved the initiative to direct the legislature to legalize physician-assisted suicide.

The Washington Death with Dignity Act, Revised Code of Washington § 70.245, became effective on 5 March 2009. This statute only applies to terminally ill patients who are capable of self-administering the lethal dose of medicine.

Part of this statute avoids labeling the death as suicide: "... the patient's death certificate which shall list the underlying terminal disease as the cause of death." RCW § 70.245.040(2). That means it is **not** accurate to call this process (and the similar one in Oregon) "physician-assisted suicide", because the official cause of death is the underlying disease.

Washington state's Natural Death Act previously said:

Nothing in this chapter shall be construed to condone, authorize, or approve mercy killing or physician-assisted suicide, or to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying.

RCW § 70.122.100 (enacted 1979, amended 1992). This was changed to read:

Nothing in this chapter shall be construed to condone, authorize, or approve mercy killing, lethal injection, or active euthanasia.

RCW § 70.122.100 (amended 2008).

As of 1 June 2012, there are no reported court cases involving this statute.

### **Montana (2009)**

The Montana Supreme Court summarized the facts and the decision of the court below:

¶ 5 This appeal originated with Robert Baxter, a retired truck driver from Billings who was terminally ill with lymphocytic leukemia with diffuse lymphadenopathy. At the time of the District Court's decision, Mr. Baxter was being treated with multiple rounds of chemotherapy, which typically become less effective over time. As a result of the disease and treatment, Mr. Baxter suffered from a variety of debilitating symptoms, including infections, chronic fatigue and weakness, anemia, night sweats, nausea, massively swollen glands, significant ongoing digestive problems and generalized pain and discomfort. The symptoms were expected to increase in frequency and intensity as the chemotherapy lost its effectiveness. There was no cure for Mr. Baxter's disease and no prospect of recovery. Mr. Baxter wanted the option of ingesting a lethal dose of medication prescribed by his physician and self-administered at the time of Mr. Baxter's own choosing.

¶ 6 Mr. Baxter, four physicians, and Compassion & Choices, brought an action in District Court challenging the constitutionality of the application of Montana homicide statutes to physicians who provide aid in dying to mentally competent, terminally ill patients. The complaint alleged that patients have a right to die with dignity under the Montana Constitution Article II, Sections 4 and 10, which address individual dignity and privacy.

¶ 7 In December 2008, the District Court issued its Order and Decision [2008 WL 6627324], holding that the Montana constitutional rights of individual privacy and human dignity, together, encompass the right of a competent, terminally ill patient to die with dignity. The District Court held that a patient may use the assistance of his physician to obtain a prescription for a lethal dose of medication. The patient would then decide whether to self-administer the dose and cause his own death. The District Court further held that the patient's right to die with dignity includes protection of the patient's physician from prosecution under

the State's homicide statutes. Lastly, the District Court awarded Mr. Baxter attorney fees. The State appeals.

*Baxter v. Montana*, 224 P.3d 1211, 1213-1214 (Mont. 2009).

The Supreme Court affirmed the decision, except for denying attorney's fees to Plaintiff.

Montana has an unusual consent statute that says:

- (1) The consent of the victim to conduct charged ... is a defense.
- (2) Consent is ineffective if:
  - (a) it is given by a person who is legally incompetent to authorize the conduct charged to constitute the offense;
  - (b) it is given by a person who by reason of youth, mental disease or defect, or intoxication is unable to make a reasonable judgment as to the nature or harmfulness of the conduct charged to constitute the offense;
  - (c) it is induced by force, duress, or deception; or
  - (d) it is against public policy to permit the conduct or the resulting harm, even though consented to.

Montana Code § 45-2-211 (enacted 1973).

The Montana Supreme Court ignored the first three factors, (a) through (c), because they “require case-by-case factual determinations.” *Baxter*, 224 P.3d at 1215, ¶4.

After a review of cases in Montana and Washington state, and one case in each of two other states, the Montana Supreme Court concluded:

¶ 18 A survey of courts that have considered this issue yields unanimous understanding that consent is rendered ineffective as “against public policy” in assault cases characterized by aggressive and combative acts that breach public peace and physically endanger others.

....

¶ 21 The above acts — including the *Mackrill* [191 P.3d 451 (Mont. 2008)] brawl — illustrate that sheer physical aggression that breaches public peace and endangers others is against public policy. In contrast, the act of a physician handing medicine to a terminally ill patient, and the patient's subsequent peaceful and private act of taking the medicine, are not comparable to the violent, peace-breaching conduct that this Court and others have found to violate public policy.

¶ 22 The above cases address assaults in which the defendant alone performs a direct and violent act that causes harm. The bar brawler, prison fighter, BB gun-shooter, and domestic violence aggressor all committed violent acts that directly caused harm and breached the public peace. It is clear from these cases that courts deem consent ineffective when defendants directly commit blatantly aggressive, peace-breaching acts against another party.

¶ 23 In contrast, a physician who aids a terminally ill patient in dying is not directly involved in the final decision or the final act. He or she only provides a means by which a terminally ill patient himself can give effect to his life-ending decision, or not, as the case may be. Each stage of the physician-patient interaction is private, civil, and compassionate. The physician

and terminally ill patient work together to create a means by which the patient can be in control of his own mortality. The patient's subsequent private decision whether to take the medicine does not breach public peace or endanger others.

*Baxter*, 224 P.3d at 1216-1217.

The Montana Supreme Court discussed The Montana Rights of the Terminally Ill Act, Montana Code § 50-9-201 to 206 (enacted 1985), which covers withdrawal of life-sustaining treatment, but found nothing to prevent a physician from prescribing lethal dose of drugs to a patient who wished to commit suicide. *Baxter*, 224 P.3d at 1217-1220, ¶¶27-38.

The Montana Supreme Court then wrote a paragraph that seems wrong to me:

¶ 36 The provision also lists behaviors not supported by the statute. Notably, physician aid in dying is not listed. Section 50-9-205(7), MCA, reads: “This chapter does not condone, authorize, or approve mercy killing or euthanasia.” Physician aid in dying is, by definition, neither of these. Euthanasia is the “intentional putting to death of a person with an incurable or painful disease intended as an act of mercy.” *STEDMAN'S MEDICAL DICTIONARY* 678 (28<sup>th</sup> ed., Lippincott Williams & Wilkins 2006). The phrase “mercy killing” is the active term for euthanasia defined as “a mode of ending life in which the intent is to cause the patient's death in a single act.” *STEDMAN'S MEDICAL DICTIONARY* at 678. Neither of these definitions is consent-based, and neither involves a patient's autonomous decision to self-administer drugs that will cause his own death.

*Baxter*, 224 P.3d at 1219, ¶36.

It seems to me that when a physician prescribes a lethal dose of drugs, knowing that the patient will take those drugs to commit suicide in a neat and painless way, the physician is plainly engaged in a form of euthanasia. Anything else is dishonest, and playing games with words — something that should be anathema to judges involved in criminal law. The legislature's condemnation of euthanasia or “mercy killing” is an indication that physician-assisted suicide is contrary to public policy. The Montana Rights of the Terminally Ill Act explicitly says:

This chapter does not condone, authorize, or approve mercy killing or euthanasia. Montana Code 50-9-205 (7) (enacted 1985, amended 1991 to conform to the Uniform Rights of the Terminally Ill Act). Many other states have similar statutes, and the Florida Supreme Court held that such a clause shows that physician-assisted suicide is against public policy. *Krischer v. McIver*, 697 So.2d 97, 100 (Fla. 1997) (citing Florida Statutes § 765.309 (“Nothing in this chapter shall be construed to condone, authorize, or approve mercy killing or euthanasia, or ....”) and holding: “Thus, it is clear that the public policy of this state as expressed by the legislature is opposed to assisted suicide.”).

As I write this in May 2012, it has been 29 months since the opinion in *Baxter* was released, but the Montana legislature has not revised the statutes to reject *Baxter*. Furthermore, it was poor practice for the Montana Supreme Court to rely on the definitions of “euthanasia” or “mercy killing” in a medical dictionary. They should have looked at the definitions in the legislative history of the statute. If the legislative history is not helpful, they should consult a variety of dictionaries, including legal dictionaries, to see the ambiguity in these words. There are legal

issues involved in these words, such as consent of the patient, who makes the determination(s), who does the lethal act, etc.

The Court then asserts:

¶ 38 There is no indication in the Rights of the Terminally Ill Act that physician aid in dying is against public policy. Indeed, the Act reflects legislative respect for the wishes of a patient facing incurable illness. The Act also indicates legislative regard and protection for a physician who honors his legal obligation to the patient. The Act immunizes a physician for following the patient's declaration even if it requires the physician to directly unplug the patient's ventilator or withhold medicine or medical treatment that is keeping the patient alive. Physician aid in dying, on the other hand, does not require such direct involvement by a physician. Rather, in physician aid in dying, the final death-causing act lies in the patient's hands. In light of the long-standing, evolving and unequivocal recognition of the terminally ill patient's right to self-determination at the end of life in Title 50, chapter 9, MCA, it would be incongruous to conclude that a physician's indirect aid in dying is contrary to public policy.

*Baxter*, 224 P.3d at 1219-1220, ¶38.

This distinction is going to cause problems when a quadriplegic who is physically unable to commit suicide sues Montana under an equal protection of law theory. But that is another case for another day.

The Montana Supreme Court concluded:

¶ 49 In conclusion, we find nothing in Montana Supreme Court precedent or Montana statutes indicating that physician aid in dying is against public policy. The “against public policy” exception to consent has been interpreted by this Court as applicable to violent breaches of the public peace. Physician aid in dying does not satisfy that definition. We also find nothing in the plain language of Montana statutes indicating that physician aid in dying is against public policy. In physician aid in dying, the patient-not the physician-commits the final death-causing act by self-administering a lethal dose of medicine.

¶ 50 Furthermore, the Montana Rights of the Terminally Ill Act indicates legislative respect for a patient's autonomous right to decide if and how he will receive medical treatment at the end of his life. The Terminally Ill Act explicitly shields physicians from liability for acting in accordance with a patient's end-of-life wishes, even if the physician must actively pull the plug on a patient's ventilator or withhold treatment that will keep him alive. There is no statutory indication that lesser end-of-life physician involvement, in which the patient himself commits the final act, is against public policy. We therefore hold that under § 45-2-211, MCA, a terminally ill patient's consent to physician aid in dying constitutes a statutory defense to a charge of homicide against the aiding physician when no other consent exceptions apply.

*Baxter*, 224 P.3d at 1222, ¶49-50.

This victory for physician-assisted suicide in Montana is probably applicable to few other states, because of the unusual consent statute in Montana. In most states, consent of a victim is *not* a defense to a crime, see cases cited at page 24, above.

## Religious Origins

While everyone knows that the criminal prohibition against suicide had its origin in Christian religious dogma that suicide was a sin, few attorneys in the USA have explicitly accused the Christian majority of imposing their religious beliefs on everyone via the criminal law. Here are a few quotations from court cases that make the connection between prohibiting suicide and religious dogma.

The venerable Blackstone said in 1778:

Self-Murder, the pretended heroism, but real cowardice, of the Stoic philosophers, who destroyed themselves to avoid those ills which they had not the fortitude to endure, though the attempting it seems to be countenanced by the civil law, yet was punished by the Athenian law with cutting off the hand, which committed the desperate deed. And also the law of England wisely and religiously considers, that **no man hath a power to destroy life, but by commission from God, the author of it: and, as the suicide is guilty of a double offense; one spiritual, in invading the prerogative of the Almighty,** [emphasis added] and rushing into his immediate presence uncalled for; the other temporal, against the king, who hath an interest in the preservation of all his subjects; the law has therefore ranked this among the highest crimes, making it a peculiar species of felony, a felony committed on one's self. And this admits of accessories before the fact, as well as other felonies; for if one persuades another to kill himself, and he does so, the adviser is guilty of murder. \* \* \* The party must be of years of discretion, and in his senses, else it is no crime. But this excuse ought not to be restrained to that length, to which our coroner's juries are apt to carry it, viz. that the very act of suicide is an evidence of insanity; as if every man, who acts contrary to reason, had no reason at all: for the same argument would prove every other criminal non compos, as well as to self-murderer. The law very rationally judges, that every melancholy or hypochondriac fit does not deprive a man of the capacity of discerning right from wrong; which is necessary, as was observed in a former chapter, to form a legal excuse. And therefore if a real lunatic kills himself in a lucid interval, he is a *felo de se* as much as another man.

Blackstone, *Commentaries on the Laws of England*, ch. 14 at p. 189 (8th ed. 1778).

quoted in *Kentucky v. Hicks*, 82 S.W. 265, 266 (Ky. 1904);

*Tate v. Canonica*, 5 Cal.Rptr. 28, 31-32 (Cal.App. 1 Dist. 1960);

*North Carolina v. Willis*, 121 S.E.2d 854, 855 (N.C. 1961);

*Clift v. Narragansett Television L.P.*, 688 A.2d 805, 807-808 (R.I. 1996).

In 1877, some 135 years ago, the Massachusetts Supreme Court said:

By the common law of England, suicide was considered a crime against the laws of God and man, the goods and chattels of the criminal were forfeited to the King, his body had an ignominious burial in the highway, and he was deemed a murderer of himself and a felon, *felo de se*. *Hales v. Petit*, Plowd. 253, 261. 3 Inst. 54. 1 Hale P. C. 411-417. 2 Hale P. C. 62. 1 Hawk. c. 27. 4 Bl. Com. 95, 189, 190.

*Massachusetts v. Mink*, 123 Mass. 422, 425, 1877 WL 10314, 25 Am.Rep. 109 (Mass. 1877).

In 1903, a concurring opinion in the highest court in New York State mentioned in passing the Christian theology that suicide was a sin.

But the Christian religion declared that suicide was a ‘mortal’ sin, and there can be no doubt that it is due to belief in that religion that a practice once common has substantially ceased, though sporadic instances still occur. See 1 Lecky, *EUROPEAN MORALS*, 233 et seq. *Brink v. Stratton*, 68 N.E. 148, 152 (N.Y. 1903) (Cullen, J., concurring).

In a terse opinion that affirmed a murder conviction for a man who killed a woman who was trying to prevent the man’s suicide, the Indiana Supreme Court declared that:

Self-destruction is against the law of God and man.  
*Wallace v. Indiana*, 116 N.E.2d 100, 101 (Ind. 1953).  
cited in *Von Holden v. Chapman*, 450 N.Y.S.2d 623, 626 (N.Y.A.D. 4 Dept. 1982).

A comment in the Model Penal Code mentions:

... the interests in the sanctity of life that are represented by the criminal homicide laws are threatened by one who expresses a willingness to participate in taking the life of another, even though the act may be accomplished with the consent, or at the request, of the suicide victim. Model Penal Code, § 210.5, comment 5 (1980).

Cited in *In re Joseph G.*, 667 P.2d 1176, 1181 (Cal. 1983); *Michigan v. Kevorkian*, 527 N.W.2d 714, 736, n.68 (Mich. 1994); *Washington v. Glucksberg*, 521 U.S. 702, 716 (1997); and *Sampson v. Alaska*, 31 P.3d 88, 96, n.60 (Alaska 2001). I believe *sanctity* is a religious term that has no place in the law of a secular nation.

In a right-to-die case in Kentucky in 2004, there are brief mentions of the religious prohibition against all suicides:

The reference by the majority opinion [p. 49] that the afterlife is somehow better than impaired life is founded only on sincere religious faith. These religions generally assert that euthanasia and suicide are wrong because the end of life is in God’s hands, not man’s. *Woods v. Kentucky*, 142 S.W.3d 24, 62 (Ky. 2004) (Wintersheimer, J., dissenting.).

In 2008, a Washington State Supreme Court case involved an inmate in a state prison who refused to eat food, and who had been brutally force fed through a nasogastric tube to coerce him to eat “voluntarily”. Judge Sanders dissented from the majority decision to allow force feeding to prevent death by starvation.

¶78 .... Likewise, since the State's interest in preventing suicide is based on theological doctrine, its constitutional validity is questionable.FN13

FN13. Our culture's prohibition of suicide is founded in St. Augustine’s City of God and the early church’s concern of Christian extremists seeking suicide as a means to achieve life everlasting. G. Steven Neeley, *THE CONSTITUTIONAL RIGHT TO SUICIDE: A LEGAL & PHILOSOPHICAL EXAMINATION* 48, 52 (Peter Lang Publ’g 1996); see also Glanville Williams, *THE SANCTITY OF LIFE AND THE CRIMINAL LAW* 255 (1957).

¶ 79 Properly stated, the State's prevention of suicide interest is concerned with preventing irrational acts of self-destruction, the impulsive act of irreparable consequence. See *Superintendent of Belchertown State Sch. v. Saikewicz*, 373 Mass. 728, 744 n. 11, 370 N.E.2d 417 (1977). Fasting, however, is not an impulsive act of irreparable consequence but a daily commitment and affirmation of belief.[footnote omitted] As Judge Benjamin Cardozo eloquently stated, "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body." *Schloendorff v. Soc'y of N.Y. Hosp.*, 211 N.Y. 125, 129, 105 N.E. 92 (1914). This includes fasting for whatever reason. *McNabb v. Department of Corrections*, 180 P.3d 1257, 1274, ¶¶78-79 (Wash. 2008) (Sanders, J., dissenting).

The current law that criminalizes *all* assisted suicides endorses the religious dogma of the churches who believe in sanctity of *all* human life, while infringing the religious beliefs of atheists and liberal Protestant Christians who desire physician-assisted suicide. Decriminalizing physician-assisted suicide would not harm anyone, because every individual would remain free to refuse physician-assisted suicide. As explained below, government statutes that endorse one religion are prohibited by the First Amendment to the U.S. Constitution.

#### sketch of the law

Many valid criminal statutes have their origin in religion. For example, the Ten Commandments say: "Thou shalt not kill. .... Thou shalt not steal. .... Thou shalt bear no false witness against thy neighbor." And clearly valid criminal statutes punish homicide, larceny, and perjury.

The Ten Commandments also require keeping the sabbath day holy, and the U.S. Supreme Court upheld state statutes that prohibited stores from being open on Sunday,<sup>55</sup> but only because those statutes *also* had a secular purpose, such as giving employees at least one day of rest each week.

But the Ten Commandments also prohibit adultery. While adultery, like suicide, was formerly a crime, modern state statutes in most of the USA do not punish adultery.

And some religions are strongly opposed to abortion and sodomy, but the U.S. Supreme Court in 1973 invalidated state statutes that prohibited abortions in the first trimester of pregnancy,<sup>56</sup> and the U.S. Supreme Court in 2003 invalidated state statutes that prohibited sodomy between consenting adults.<sup>57</sup>

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<sup>55</sup> See, e.g., *McGowan v. Maryland*, 366 U.S. 420 (1961).

<sup>56</sup> *Roe v. Wade*, 410 U.S. 113 (1973).

<sup>57</sup> *Lawrence v. Texas*, 539 U.S. 558 (2003).



So it is clear that some religious prohibitions (e.g., homicide, larceny, and perjury) are reflected in valid criminal laws, and other religious prohibitions are *not* reflected in valid laws. Currently, the Christian religion's prohibition against suicide is strongly reflected in the criminal laws and public policy of the USA.

The precise test adopted by the U.S. Supreme Court for deciding establishment clause cases is:

Every analysis in this area must begin with consideration of the cumulative criteria developed by the Court over many years. Three such tests may be gleaned from our cases. First, the statute must have a secular legislative purpose; second, its principal or primary effect must be one that neither advances nor inhibits religion, *Board of Education v. Allen*, 392 U.S. 236, 243, 88 S.Ct. 1923, 1926, 20 L.Ed.2d 1060 (1968); finally, the statute must not foster 'an excessive government entanglement with religion.' *Walz*, [397 U.S.] at 674, 90 S.Ct., at 1414.

*Lemon v. Kurtzman*, 403 U.S. 602, 612-613 (U.S. 1971).

For more recent cases, see *Zelman v. Simmons-Harris*, 536 U.S. 639, 668-69 (U.S. 2002) (O'Connor, J., concurring).

I have quickly traced legal arguments on First Amendment grounds against criminalizing euthanasia back to a law review article<sup>58</sup> in the year 1970 and such arguments may be even older.

A dissenting opinion by Justice Stevens in a U.S. Supreme Court case involving disconnecting life-support machinery from a patient in a persistent vegetative state notes the relationship of religion to death.

The more precise constitutional significance of death is difficult to describe; not much may be said with confidence about death unless it is said from faith, and that alone is reason enough to protect the freedom to conform choices about death to individual conscience. We may also, however, justly assume that death is not life's simple opposite, or its necessary terminus, [FN15] but rather its completion. Our ethical tradition has long regarded an appreciation of mortality as essential to understanding life's significance. It may, in fact, be impossible to live for anything without being prepared to die for something.

FN15. Many philosophies and religions have, for example, long venerated the idea that there is a "life after death," and that the human soul endures even after the human body has perished. Surely Missouri would not wish to define its interest in life in a way antithetical to this tradition. *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 343 (1990) (Steven, J., dissenting).

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<sup>58</sup> Arval A. Morris, "Voluntary Euthanasia," 45 *Washington Law Review* 239, 250-251 (April 1970). Morris cited a book by Prof. Glanville Williams, *THE SANCTITY OF LIFE AND THE CRIMINAL LAW*, pp. 311-318 (1957).

And the majority opinion of the U.S. Supreme Court in a case involving allegations of misrepresentations in religious publications says:

Freedom of thought, which includes freedom of religious belief, is basic in a society of free men. [citation omitted] It embraces the right to maintain theories of life and of death and of the hereafter which are rank heresy to followers of the orthodox faiths.

*U.S. v. Ballard*, 322 U.S. 78, 86 (1944).

In my opinion, the criminal prohibition against *all* assisted suicides is an invalid attempt by the Christian majority to use the criminal law to impose<sup>59</sup> on everyone their religious belief that suicide is a sin and therefore death is *always* an *unacceptable* choice. In my opinion, it is particularly important to end this criminal prohibition against assisting suicide, since modern medical technology can prolong dying for months, and even years, without any reasonable hope of recovery of a life that is enjoyable and meaningful to an individual. Ending the criminal prohibition against assisting suicide in no way forces Christians to commit suicide, in violation of their religious beliefs. But ending the criminal prohibition against assisting suicide would allow non-Christians (or Christians who disagree that suicide is *always* a sin) to have lawful assistance with their suicides. I emphasize that legalizing assisted suicides does *not* force anyone to choose such a suicide, just as legalizing abortion does *not* force anyone to have an abortion.

The U.S. Court of Appeals for the Ninth Circuit concluded in a physician-assisted suicide case:

Given the nature of the judicial process and the complexity of the task of determining the rights and interests comprehended by the Constitution, good faith disagreements within the judiciary should not surprise or disturb anyone who follows the development of the law. For these reasons, we express our hope that whatever debate may accompany the future exploration of the issues we have touched on today will be conducted in an objective, rational, and constructive manner that will increase, not diminish, respect for the Constitution.

There is one final point we must emphasize. Some argue strongly that decisions regarding matters affecting life or death should not be made by the courts. Essentially, we agree with that proposition. In this case, by permitting the *individual* to exercise the right to *choose* we are following the constitutional mandate to take such decisions out of the hands of the government, both state and federal, and to put them where they rightly belong, in the hands of the people. We are allowing individuals to make the decisions that so profoundly affect their very existence — and precluding the state from intruding excessively into that critical realm. The Constitution and the courts stand as a bulwark between individual freedom and arbitrary and intrusive governmental power. Under our constitutional system, neither the state nor the majority of the people in a state can impose its will upon the individual in a matter so highly “central to personal dignity and autonomy,” *Casey*, 505 U.S. at 851, 112 S.Ct. at 2807. Those who believe strongly that death must come without physician assistance are free to follow that creed, be they doctors or patients. They are not free, however, to force their views, their religious convictions, or their philosophies on all the other members of a democratic society, and to compel those whose values differ with theirs to die painful, protracted, and agonizing deaths.

*Compassion in Dying v. State of Washington*, 79 F.3d 790, 838-839 (9th Cir. 1996) (en banc),

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<sup>59</sup> The inclusion of Christian religious values into the criminal law was originally done in England, where there is an official state religion.

*rev'd on other grounds sub nom. Washington v. Glucksberg*, 521 U.S. 702 (1997). Italics are in the original document.

In a separate essay, I review the U.S Supreme Court jurisprudence that prohibits the majority from forcing its [religious] values on everyone via the law. Standler, Freedom from the Majority in the USA, <http://www.rbs2.com/majority.pdf> (Nov 2005).

### **Does Government "own" our lives?**

Does Government "own" our lives? This sounds like a silly question. People in the USA are *not* slaves to the government. In 1972, the District of Columbia Court of Appeals tersely wrote:

The notion that the individual exists for the good of the state is, of course, quite antithetical to our fundamental thesis that the role of the state is to ensure a maximum of individual freedom of choice and conduct.

*In re Osborne*, 294 A.2d 372, 375, n.5 (D.C. 1972) (refused to order blood transfusion for adult Jehovah's Witness). Quoted with approval in *Thor v. Superior Court*, 855 P.2d 375, 384 (Cal. 1993). Similar principles were stated by the highest court in New York state:

In our system of a free government, where notions of individual autonomy and free choice are cherished, it is the individual who must have the final say in respect to decisions regarding his medical treatment in order to insure that the greatest possible protection is accorded his autonomy and freedom from unwanted interference with the furtherance of his own desires. [citations omitted]

*Rivers v. Katz*, 495 N.E.2d 337, 341 (N.Y. 1986).

However, during 1992-2005 judges in the USA repeatedly *refused* to allow legal physician-assisted suicide to a mentally competent adult who has a rational reason for wanting to die: not only do individuals need to ask permission of the government, but also the government says "no". As explained below, the state government is declared to have a legal interest in both preserving life and preventing suicide.

## four state interests

Judicial opinions in cases involving the right to refuse medical treatment (including so-called “right-to-die” cases) have held that a person has an absolute right to refuse medical treatment, except for the four state interests. See my essay at <http://www.rbs2.com/rrmt.pdf> . Two of these state interests are relevant to physician-assisted suicide: “preserving life” and “avoiding suicide”.

In 1985, the New Jersey Supreme Court, in *Matter of Conroy*, 486 A.2d 1209, 1224 (N.J. 1985), appears to have destroyed “preventing suicide” as a state interest, as explained in my essay cited in the previous paragraph.

State statutes and regulations on physician-assisted suicide should include adequate protections for state interests (e.g., requiring an independent diagnosis by a second physician, requiring a waiting period to make certain that the patient will not change his desire, etc.). To protect the integrity of the medical profession, no physician should be required to prescribe drugs or give treatment that offends the physician’s ethics or morality.

## medieval law

*Why* does the state assert an interest in preserving life and preventing suicide? The answers to this question go back hundreds of years:

1. religious dogma that suicide is a sin and religious dogma about sanctity of life, as explained above, beginning at page 102.
2. medieval law that seeks to preserve citizens so they can fight for the King, as explained in the following paragraphs.

The clearest expression of the medieval law in this context was in the crime of mayhem. A perpetrator who permanently injured (i.e., maimed) a citizen had deprived the King of that citizen’s military service. The perpetrator was prosecuted for mayhem.

- *U.S. v. Cook*, 462 F.2d 301, 302-303 (C.A.D.C. 1972) (“To be sure, mayhem in the early common law was committable only by infliction of an injury which substantially reduced the victim's formidability in combat. As a crime jeopardizing the King's prerogative to the aid and assistance of its subjects in battle, .... [¶] That body of ancient doctrine can hardly afford reliable guidance in the interpretation of a statute promulgated in an age and milieu in which individual and social values are vastly different.”);
- *Goodman v. Superior Court*, 148 Cal.Rptr. 799, 800 (Cal.App. 1978) (citing *Cook*);
- *Perkins v. U. S.*, 446 A.2d 19, 23 (D.C. 1982) (“[Mayhem] preserved the king’s right to the able military services of any of his subjects. Thus, mayhem was a crime against the king, limited to injuries rendering the victim a less efficient warrior.”);

- *Hammond v. Maryland*, 588 A.2d 345, 347-348 (Md. 1991);
- *California v. Sekona*, 32 Cal.Rptr.2d 606, 612-613 (Cal.App. 1994) (citing *Goodman*).

Similarly, the crime of kidnapping was explained as depriving the King. “[Kidnapping] is unquestionably a very heinous crime, as it robs the king of his subjects, ... ; and therefore the common law of England has punished it with fine, imprisonment and pillory.” Blackstone, COMMENTARIES ON THE LAWS OF ENGLAND, Vol. 4, p. 219. Also see *California v. Ordonez*, 277 Cal.Rptr. 382, 391, n.7 (Cal.App. 1991) (quoting Blackstone).

The venerable Blackstone explained why suicide — which Blackstone calls “self-murder” — was a crime:

And also the law of England wisely and religiously considers, that no man hath a power to destroy life, but by commission from God, the author of it: and, as the suicide is guilty of a double offense; one spiritual, in invading the prerogative of the Almighty, and rushing into his immediate presence uncalled for; the other temporal, against the King, who hath an interest in the preservation of all his subjects; the law has therefore ranked this among the highest crimes, making it a peculiar species of felony, a felony committed on one's self.

Blackstone's COMMENTARIES ON THE LAWS OF ENGLAND, Vol. 4, ch. 14, p. 189 (1778). See, e.g., *Kentucky v. Hicks*, 82 S.W. 265, 266 (Ky.App. 1904) (quoting Blackstone); *Tate v. Canonica*, 5 Cal.Rptr. 28, 32 (Cal.App. 1960) (quoting Blackstone); *North Carolina v. Willis*, 121 S.E.2d 854, 855 (N.C. 1961) (quoting Blackstone).

Notice the dual justification that (1) suicide is a sin and (2) the King has an interest in the preservation of life.

Allowing a government to tell citizens under what conditions they can end their lives is an anachronistic continuation of medieval law that has no place in modern society. The paternalistic interest of governments in preserving life and preventing suicides is in conflict with the autonomy of individual citizens, who should be able to decide when to die.

I think the en banc U.S. Court of Appeals decision in *Compassion in Dying* gives the correct reason why physician-assisted suicide should be legal: the right of an individual, mentally competent, adult person to control when and how he/she dies trumps the general state interest in both preserving the life of its citizens and preventing suicides. A religious freedom argument, under the First Amendment, adds additional support to this personal autonomy reason.

## Is “Quality of Life” Relevant?

The U.S. Supreme Court has twice refused to consider “quality of life” issues faced by patients who want die.

As we have previously affirmed, the States “may properly decline to make judgments about the ‘quality’ of life that a particular individual may enjoy,” *Cruzan*, [497 U.S. 261] at 282, 110 S.Ct., at 2853. This remains true, as *Cruzan* makes clear, even for those who are near death.

*Washington v. Glucksberg*, 521 U.S. 702, 729-730 (1997) (majority opinion).

Such a refusal to consider quality of life is consistent with the states’ absolute prohibition on *all* assisted suicides. *Cruzan*, a right-to-die case involving a patient in a persistent vegetative state, said:

Finally, we think a State may properly decline to make judgments about the “quality” of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life to be weighed against the constitutionally protected interests of the individual.

*Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 282 (1990). Such an “unqualified interest in preservation of human life” ignores the facts of the case, and effectively imposes religious dogma about sanctity of life.

Justice Stevens in his separate decision, concurring in the judgments (but not the reasons), in *Glucksberg v. Washington*, said:

Many terminally ill people find their lives meaningful even if filled with pain or dependence on others. Some find value in living through suffering; some have an abiding desire to witness particular events in their families' lives; many believe it a sin to hasten death. Individuals of different religious faiths make different judgments and choices about whether to live on under such circumstances. There are those who will want to continue aggressive treatment; those who would prefer terminal sedation; and those who will seek withdrawal from life-support systems and death by gradual starvation and dehydration. Although as a general matter the State's interest in the contributions each person may make to society outweighs the person's interest in ending her life, this interest does not have the same force for a terminally ill patient faced not with the choice of whether to live, only of how to die. Allowing the individual, rather than the State, to make judgments “about the “quality” of life that a particular individual may enjoy,” 521 U.S., at 729, 117 S.Ct., at 2272 (quoting *Cruzan*, 497 U.S., at 282, 110 S.Ct., at 2853), does not mean that the lives of terminally ill, disabled people have less value than the lives of those who are healthy, see 521 U.S., at 732, 117 S.Ct., at 2273. Rather, it gives proper recognition to the individual's interest in choosing a final chapter that accords with her life story, rather than one that demeans her values and poisons memories of her. See Brief for Bioethicists as Amici Curiae 11; see also R. Dworkin, *LIFE'S DOMINION* 213 (1993) (“Whether it is in someone's best interests that his life end in one way rather than another depends on so much else that is special about him—about the shape and character of his life and his own sense of his integrity and critical interests—that no uniform collective decision can possibly hope to serve everyone even decently”).

Similarly, the State's legitimate interests in preventing suicide, protecting the vulnerable from coercion and abuse, and preventing euthanasia are less significant in this context. I agree that the State has a compelling interest in preventing persons from committing suicide because of depression or coercion by third parties. But the State's legitimate interest in preventing abuse does not apply to an individual who is not victimized by abuse, who is not suffering from depression, and who makes a rational and voluntary decision to seek assistance in dying. Although, as the New York Task Force report discusses, diagnosing depression and other mental illness is not always easy, mental health workers and other professionals expert in working with dying patients can help patients cope with depression and pain, and help patients assess their options. See Brief for Washington State Psychological Association et al. as Amici Curiae 8-10.

*Washington v. Glucksberg*, 521 U.S. 702, 746-747 (1997) (Stevens, J., concurring in the judgments).

An earlier paragraph in *Cruzan* made the point that the decision about acceptable quality of life must be made according to the *patient's* values:

While continuing to recognize a common-law right to refuse treatment, the court [in New York State] rejected the substituted judgment approach for asserting it "because it is inconsistent with our fundamental commitment to the notion that no person or court should substitute its judgment as to what would be an acceptable quality of life for another. Consequently, we adhere to the view that, despite its pitfalls and inevitable uncertainties, the inquiry must always be narrowed to the patient's expressed intent, with every effort made to minimize the opportunity for error." [*Matter of Westchester County Medical Center on Behalf of O'Connor*, 72 N.Y.2d 517] at 530, 534 N.Y.S.2d [886] at 892, 531 N.E.2d [607] at 613 (citation omitted) [(N.Y. 1988)].

*Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 275 (1990).

A few state courts have recognized quality of life as a relevant issue in right-to-die cases:

- *Superintendent of Belchertown State School v. Saikewicz*, 370 N.E.2d 417, 425-426 (Mass. 1977) ("The interest of the State in prolonging a life must be reconciled with the interest of an individual to reject the traumatic cost of that prolongation. There is a substantial distinction in the State's insistence that human life be saved where the affliction is curable, as opposed to the State interest where, as here, the issue is not whether but when, for how long, and at what cost to the individual that life may be briefly extended.");
- *McKay v. Bergstedt*, 801 P.2d 617, 622 (Nev. 1990) ("Moreover, as the quality of life diminishes because of physical deterioration, the State's interest in preserving life may correspondingly decrease.");
- *Polk County Sheriff v. Iowa District Court for Polk County*, 594 N.W.2d 421, 426 (Iowa 1999) ("It is also commonly understood that as the quality of life diminishes because of physical deterioration, a state's interest in preserving life correspondingly reduces.");

- *In re D.L.H.*, 967 A.2d 971, 985 (Pa.Super. 2009) ("A state's interest in preserving life, however, decreases proportionality when the quality of life diminishes as a result of physical deterioration. *Polk County Sheriff v. Iowa Dist. Court*, 594 N.W.2d 421, 426 (Iowa 1999).").

my opinion on "quality of life"

It would be repugnant for the government to decide that a group of people are life unworthy of living, and kill them.<sup>60</sup> But that is not what the "quality of life" consideration represents. In my opinion, the decision of when to end a person's life belongs solely to that individual person, as part of their autonomy and personal liberty. As part of a rational person's decisionmaking process, they should evaluate their quality of life, according to their personal values. If their quality of life is so poor that life is not worth living, and there is no reasonable hope of improvement in their condition, then suicide is a logical conclusion. (There are other reasonable conclusions, such as deciding that suicide is wrong, to postpone the decision, or to pursue a small chance of improvement after aggressive treatment, etc.)

In my opinion, the evaluation of quality of life is a two-part test:

1. Consider the patient's values, desires, and goals, as well as the patient's realistic ability to do any of the things that the patient considers enjoyable, significant, or desirable — in short, evaluate the patient's quality of life, according to the patient's values.
2. Consider whether there is reasonable hope of improvement in their condition.

Before a physician decides to prescribe drugs to end a patient's life, the physician needs to evaluate whether the patient's request to die is a rational request of a sane mind. That evaluation should use the same two-part test, with emphasis on the *patient's* values — *not* whether the physician would make the same choice as the patient.

Advocates of physician-assisted suicide often suggest that suicide be permitted only when the patient is terminally ill (i.e., less than six months of expected life). Being terminally ill and suffering is only one example of an *unacceptably* poor quality of life. Other examples might include patients in persistent vegetative states, quadriplegic patients, and patients with various incurable diseases or progressive neurological disorders (e.g., ALS, Alzheimer's), each of whom can continue living for years.

I suggest that the choice of when life is unacceptable should be made by the patient *alone*, and others — including judges — should respect that choice, even if they disagree with it. To reduce the risk of undue influence, other people should *not* suggest what the patient should do, because the decision is uniquely that of the patient.

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<sup>60</sup> I ignore the role of courts in applying the death penalty to vicious criminals, because each of those criminals made a deliberate decision to do Evil. In contrast, people who suffer from some disease, injury, or condition are innocent victims.



## My Opinion

The reality is that any physically able adult *can* commit suicide. Common methods for suicide, such as shooting one's self in the head, are gruesome and messy. A compassionate society would permit neat, quick, painless way(s) to commit suicide — the obvious being an overdose of prescription drugs, e.g., narcotics, barbiturates, or sophisticated sequences of lethal drugs used in modern executions of criminals.<sup>61</sup>

As an advocate for privacy of adults, I can not think of any choice that is more private, and more essential to individual autonomy, than the choice of when to end one's life. But I am *not* going to write rhetoric about liberty, autonomy, and self-determination — because these values are obvious.

Advocates of physician-assisted suicide often suggest that the patient — *not* the physician — do the lethal act of swallowing the drugs that will kill the patient. The problem is that some patients may be physically unable to commit suicide, because they are either unconscious or paralyzed. If physicians are permitted to prescribe lethal doses of drugs, knowing that the drugs will be used in a suicide, then physicians should also be allowed to personally administer those drugs.

There is a long line of court cases that declare the initial injury or underlying disease as the legal cause of death when life-support machinery (e.g., feeding tube or ventilator) is withdrawn from patients in a persistent vegetative state or from patients who are quadriplegic.<sup>62</sup> I suggest that the same legal finding be used for voluntary termination of a mentally competent adult patient who has either a terminal illness or a progressive neurological disease (e.g., ALS). Regardless of whether a physician prescribes drugs that the patient voluntarily takes (i.e., physician-assisted suicide) or the physician administers a lethal dose of a drug to a paralyzed patient, the legal cause of death should be the underlying disease. There are four advantages to this legal fiction:

1. The legal cause of the patient's death is the initial illness or injury that gave the patient an *unacceptable* quality of life, according to the patient's values.
2. There is nothing criminal about such termination of life with a lethal dose of drugs. From a legal perspective, there is no suicide. From a legal perspective, there is no murder by the physician, since this death was a consequence of some illness or injury.

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<sup>61</sup> Execution of criminals is discussed below, beginning at page 120.

<sup>62</sup> Ronald B. Standler, *Annotated Legal Cases Involving Right-to-Die in the USA*, <http://www.rbs2.com/rtd.pdf> (April 2005), see particularly the long list of citations in the section: "Overview of the Law — initial injury or disease is proximate cause of death".

3. It corrects what some attorneys and judges believe is a denial of equal protection of law: allowing a patient the legal right to refuse life-sustaining medical care (e.g., disconnecting a ventilator or discontinuing food and water), but criminalizing a physician who prescribes a lethal dose of drugs with intent to help a patient kill him/herself.<sup>63</sup>
4. Because the legal cause of death is *not* suicide, life insurance policies (which exclude benefits for suicide) will pay the beneficiaries, typically a spouse and children.

Incidentally, labels can inhibit thinking. By choosing the phrase “physician-assisted suicide,” advocates of that practice may have avoided finding an easy way of legalizing what they advocated. While calling it a “suicide” correctly emphasizes the patient’s choice, it also makes it appear that the *legal* cause of death was the patient’s act, instead of the underlying illness or condition. And, most importantly, calling it a “suicide” invokes the criminal statutes that punish assisting a suicide.<sup>64</sup> Therefore, I suggested in May 2005 that the widely accepted nomenclature, “physician-assisted suicide”, is a misnomer. I suggest that the way out of this nomenclature problem is to declare a legal fiction in statutes: when a patient uses drugs prescribed by a physician to hasten death, the legal cause of death is the underlying terminal illness — or condition that caused the unacceptable quality of life — *not* suicide.

In June 2012, during a revision of this essay, about seven years after I wrote the first drafts, it occurred to me that there was a different way of viewing the topic of physician-assisted suicide. First, consider examples of “bad death”, a patient who:

- (1) suffers chronic pain as a result of an incurable condition that persists for years, waiting for a natural death;
- (2) who lives for months in a morphine-induced stupor, waiting for his terminal disease to kill him; or
- (3) a patient who puts a shotgun in his mouth, creating a mess for someone else to clean up.

These examples are all legal and common. Because the decision about what is an *unacceptable* quality of life is a personal decision, some people may be willing to tolerate chronic pain or a morphine-induced stupor. And because the decision about *unacceptable* quality of life is a personal decision, there will be other examples of a “bad death”.

Second, consider examples of “good death” — any death that is quick, painless, and neat. For example, the method currently used to execute criminals (see page 120 of this essay) is a “good death”. However, under current law in the USA, if a physician did this to a patient, it

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<sup>63</sup> *Compassion in Dying v. Washington*, 850 F.Supp. 1454, 1467 (W.D.Wash. 1994); *Quill v. Vacco*, 80 F.3d 716 (2dCir. 1996). As explained above, both of these cases were reversed by the U.S. Supreme Court.

<sup>64</sup> Alan Meisel, “Physician-Assisted Suicide: A Common Law Roadmap for State Courts,” 24 *Fordham Urban Law Journal* 817, n.1 (Summer 1997) (“The problem with this terminology is that it prejudices the conclusion and makes the practice illicit because of the long-standing pejorative connotations associated with the word ‘suicide’.”).

would be murder. It seems illogical to treat convicted criminals better than innocent citizens who are suffering and want to die, but that is the state of the current law. Worse, “bad death” is legal and common, while “good death” is illegal and rarely admitted — society and law has its values reversed.

Third, note that discontinuing medical treatment in the right-to-die cases generally does *not* produce a “good death”. For example,

1. Theresa Schiavo lived for 13 days after her feeding tube was disconnected, as she slowly dehydrated. While she did *not* suffer (she was in a persistent vegetative state and most of her brain had atrophied), her parents and her husband suffered while waiting for her to die. Such suffering could be eliminated by allowing physicians to inject an unconscious patient with drugs that would quickly kill the patient.
2. Quadriplegic patients who want to die, currently die of asphyxia when their ventilator is turned off. Asphyxia takes a few minutes to kill, and is terrifying for the patient. Significantly, at least two judicial opinions ordered sedatives for quadriplegic patients whose ventilator would be disconnected.<sup>65</sup> These are landmark decisions in that the judges incidentally ordered a “good death” for those patients.

If someone is going to die soon, I believe they should have a “good death” if they choose that option. The law should not force a suffering person to wait for a death from natural causes.

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<sup>65</sup> *Georgia v. McAfee*, 385 S.E.2d 651, 652 (Ga. 1989) (“We further hold that Mr. McAfee's right to be free from pain at the time the ventilator is disconnected is inseparable from his right to refuse medical treatment. .... His right to have a sedative (a medication that in no way causes or accelerates death) administered before the ventilator is disconnected is a part of his right to control his medical treatment.”); *McKay v. Bergstedt*, 801 P.2d 617, 631 (Nev. 1990) (“... we agree with the court in *State v. McAfee* that a patient's ‘right to be free from pain at the time the ventilator [or other life support system] is disconnected is inseparable from his right to refuse medical treatment.’ *State v. McAfee*, 385 S.E.2d at 652.”).

## suggested statute

State legislatures need to amend statutes that criminalize assisting a suicide to permit a person to have assistance in ending his/her life under certain conditions. The conditions should include all five conditions of the following:

- (1) the seven criteria of Dr. Quill, et al., which are mentioned at page 117 of this essay;
  - (2) a rational reason — all of the following three findings:
    - (a) a serious condition, including, but not limited to, a patient with: any terminal illness, a progressive neurological disease, a persistent vegetative state, quadriplegic, etc.;
    - (b) an unacceptable quality of life according to the patient's values;and
    - (c) no reasonable hope of improvement in the patient's condition;
  - (3) clear and convincing evidence of consent is required: either
    - (a) if the patient is mentally competent, the patient must sign a written consent form<sup>66</sup> in the presence of witnesses, that says the patient voluntarily requests to die;or
    - (b) in the case of a permanently unconscious patient, the consent form must be signed by the guardian of the patient, using clear and convincing evidence that the patient himself/herself would have made the same decision as the guardian;
  - (4) reiterate the request to the physician at least two weeks<sup>67</sup> after the initial request, to avoid hasty decisions or poorly considered requests.
- and
- (5) the motive for the deadly act is either:
    - (a) a good-faith effort to permanently end the suffering of the patient,
    - (b) or recognition that the patient has no reasonable hope of recovery of a life that would be acceptable to the patient (i.e., further medical treatment is futile).

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<sup>66</sup> An advance directive (e.g., living will) is adequate if it is sufficiently detailed about either the minimum acceptable quality of life or conditions where death would be preferable to life.

<sup>67</sup> In cases where the patient is not terminally ill or otherwise facing imminent death, perhaps the interval between the initial request and second request should be two months, to obtain more certainty that the patient has a consistent desire to die.

When all of the above four conditions are satisfied, there should be immunity from both criminal prosecution and civil prosecution for:

- (a) the patient's physician, the patient's family members, and/or the patient's friends,<sup>68</sup> who provide assistance with the patient's suicide;
- (b) a physician who administers a lethal dose of drugs to a patient who is physically unable to commit suicide, but who otherwise qualifies; and
- (c) a health care professional who disconnects life-support machinery (e.g., ventilator or feeding tube) on the order of a physician.

An example is Oregon's statute, which was quoted above, beginning at page 90. However, the Oregon statute *only* permits physicians to prescribe a lethal dose of medicine for a terminally ill patient to use to commit suicide.

### Views of Physicians

In 1992, Drs. Quill, Cassel, and Meier wrote a very thoughtful article that suggests seven clinical criteria for physician-assisted suicide.<sup>69</sup>

1. "the patient must have a condition that is incurable and associated with severe, unrelenting suffering." This includes both terminally ill patients and patients "with incurable, but not imminently terminal, progressive illnesses" such as amyotrophic lateral sclerosis (ALS).
2. physician must make an attempt to provide adequate "comfort care" *before* resorting to physician-assisted suicide.
3. patient must voluntarily and repeatedly request an end to his/her life, without ambivalence.
4. physician must verify that the patient is mentally competent to make this decision.
5. there must be "a meaningful doctor-patient relationship" in which "the physician must get to know the patient personally in order to understand fully the reasons for the request."

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<sup>68</sup> A more conservative proposal would extend immunity *only* to licensed physicians, to insist on the involvement of a learned professional, and to avoid conflicts of interest of family members who may also be heirs under the patient's will.

<sup>69</sup> Timothy E. Quill, Christine K. Cassel, and Diane E. Meier, "Proposed Clinical Criteria for Physician-Assisted Suicide," 327 *New England Journal of Medicine* 1380 (5 Nov 1992).

6. “consulting with another<sup>70</sup> experienced physician is required to ensure that the patient’s request is voluntary and rational, the diagnosis and prognosis accurate, and the exploration of comfort-oriented alternatives thorough.”
7. “clear documentation” is required for each of the above six criteria, as well as a written consent form signed by “the patient, the primary physician, and the consultant”.<sup>71</sup> Making such decisions openly provides protection against “abuse and idiosyncratic decision making with ... secret practices”.

no discrimination against paralyzed patients

Drs. Quill, Cassel, and Meier initially restricted their proposal only to a physician prescribing a lethal dose of tablets, which tablets were consumed by the patient.<sup>72</sup> However, there are some patients (e.g., quadriplegics or otherwise suffering from paralysis) who are physically unable to commit suicide. For these patients to have the same right to end their lives as normal people have, then someone else will need to administer a lethal drug. In the context of patients in a persistent vegetative state, it was decided that a patient did not lose the right to refuse medical treatment just because the patient was unconscious. I argue, by analogy, that patients should not lose the right to end their life just because they are physically paralyzed.

Drs. Quill and Meier later recognized that restricting “legalized physician-assisted death to assisted suicide unfairly discriminates against patients with unrelievable suffering who resolve to end their lives but are physically unable to do so.”<sup>73</sup>

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<sup>70</sup> However, my legal research shows that it is common for court cases to require *two* consulting physicians to make independent evaluations that concur with the primary physician. See, e.g., *Matter of Welfare of Colyer*, 660 P.2d 738, 751 (Wash. 1983); *Foody v. Manchester Memorial Hosp.*, 482 A.2d 713, 721 (Conn.Super. 1984); *Matter of Farrell*, 529 A.2d 404, 415 (N.J. 1987); *In re Estate of Longeway*, 549 N.E.2d 292, 299 (Ill. 1989); *In re Guardianship of Browning*, 543 So.2d 258, 271 (Fla.App. 2 Dist. 1989), *aff’d*, 568 So.2d 4, 16 (Fla. 1990); *In re Fiori*, 673 A.2d 905, 912-913 (Pa. 1996).

<sup>71</sup> I suggest that there would be more protection for everyone if the consent form was a formal legal document that was signed in the presence of a Notary Public and with three witnesses who are *neither* heirs under the will of the patient *nor* involved in the patient’s assisted death (i.e., truly disinterested witnesses). However, as the consent becomes more formal, there is also more expense and less privacy for the patient.

<sup>72</sup> Quill, Cassel, and Meier, *loc. cit.*, at 1381.

<sup>73</sup> Franklin G. Miller, Timothy E. Quill, Howard Brody, John C. Fletcher, Lawrence O. Gostin, and Diane E. Meier, “Regulating Physician-Assisted Death,” 331 *New England Journal of Medicine* 119, 120 (14 July 1994).

## other considerations

In patients who are physically capable of taking and swallowing tablets, I suggest that the patient personally do that to end their life, as additional evidence that this is truly a voluntary choice by the patient. Furthermore, Dr. Brody compared (1) a physician prescribing a lethal dose of tablets for a patient to knowingly and voluntarily take and (2) a physician injecting a patient with a lethal dose of some drug:

The first is preferred over the second for reasons stressed by Quill but sometimes lost sight of. [footnote to 324 NEJM 691] It is not preferable because the physician is less directly involved as a casual agent; letting the patient do the dirty work can be an abrogation of responsibility rather than an exercise in professional integrity. Instead, the preference lies in the potentially therapeutic effect of both having the means to end one's life and having personal control of the time and setting of their use. ....

There are psychological reasons to prefer patient control over physician-administered lethal injection whenever possible. The normal human response to facing the final moment before death, when one has control over the choice, ought to be ambivalence. The bottle of pills allows full recognition and expression of that ambivalence: I, the patient, can sleep on it, and the pills will still be there in the morning; I do not lose my means of escape through the delay. ....

Howard Brody, "Assisted Death — A Compassionate Response to a Medical Failure," 327 *New England Journal of Medicine* 1384, 1386 (5 Nov 1992).

By making physician-assisted suicide illegal, the law harms society in two ways. First, physicians who respect the law must deny their suffering patient's request, thus increasing the amount of suffering in the world. Second, physicians who grant their suffering patient's request must do so secretly to avoid possible criminal prosecution. And such secrecy frustrates monitoring to detect and punish abuse.<sup>74</sup> And, Dr. Brody recognized,

If the law forces already suffering patients to die alone — for fear that seeking the supportive presence of others might implicated them in an illegal act — then the law undermines important social values of family and community.

Howard Brody, "Assisted Death — A Compassionate Response to a Medical Failure," 327 *New England Journal of Medicine* 1384, 1387 (5 Nov 1992).

Finally, terminating the life of someone without their specific, voluntarily request (or — for a permanently unconscious patient or a permanently incompetent patient — without the request of a surrogate decisionmaker who uses the patient's values) is homicide. Such homicides should be condemned as going down the slippery slope of killing people who are burdensome to society.

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<sup>74</sup> Such monitoring is particularly important given the pressures from health insurance companies and HMOs to reduce costs of treating patients. See, e.e., Timothy E. Quill, Christine K. Cassel, and Diane E. Meier, "Proposed Clinical Criteria for Physician-Assisted Suicide," 327 *New England Journal of Medicine* 1380, 1383 (5 Nov 1992); Franklin G. Miller, Timothy E. Quill, Howard Brody, John C. Fletcher, Lawrence O. Gostin, and Diane E. Meier, "Regulating Physician-Assisted Death," 331 *New England Journal of Medicine* 119, 120 (14 July 1994).

The punishment for such homicides might range from suspension of a physician's license for a few months to imprisonment, depending on the facts of the case, including the physician's motives. This topic is beyond the scope of this essay, except to suggest that there is a firm line separating such homicides from ending the life of patients who rationally and voluntarily decide that, according to their own values, life is no longer worth living.

some physicians oppose aiding suicide

Reading medical journals shows that a substantial number of physicians in the USA believe that it is unethical or immoral to kill patients who wish to die. Those physicians are entitled to have their opinion respected and they should not be involved in physician-assisted suicide or euthanasia. I am not trying to change anyone's personal opinion about the desirability of physician-assisted suicide or euthanasia. I am only arguing that such end-of-life decisions should be legal under some conditions, so that patients and physicians who personally agree with euthanasia can chose such a death.

### Executions of Criminals

Traditionally, criminals executed in the USA were either hanged, shot by firing squad, electrocuted, or breathed cyanide gas. In 1977, intravenous injection of lethal drugs was designed and adopted as "a more humane alternative" to previous execution methods.<sup>75</sup> By 2010, the procedure for execution of criminals involved intravenous administration of a sequence of lethal doses of three drugs:

1. large dose (5 grams)<sup>76</sup> of sodium thiopental, a barbiturate
2. after unconscious by the barbiturate, 120 mg pancuronium bromide, to paralyze muscles and stop breathing
3. 240 mEq potassium chloride, to stop the heart

*Pavatt v. Jones*, 627 F.3d 1336, 1339 (10thCir. 2010); *West v. Brewer*, 652 F.3d 1060, 1063 (9thCir. 2011). The three-drug execution is really a form of euthanasia.

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<sup>75</sup> *Baze v. Rees*, 553 U.S. 35, 42 (2008) ("In 1977, legislators in Oklahoma, after consulting with the head of the anesthesiology department at the University of Oklahoma College of Medicine, introduced the first bill proposing lethal injection as the State's method of execution. .... A total of 36 States have now adopted lethal injection as the exclusive or primary means of implementing the death penalty, making it by far the most prevalent method of execution in the United States." At 43: "... in moving to lethal injection, the States were motivated by a desire to find a more humane alternative to then-existing methods.").

<sup>76</sup> *Beardslee v. Woodford*, 395 F.3d 1064, 1075 (9thCir. 2005) ("... five grams of sodium pentothal [i.e., thiopental] — which is 12.5 times the normal surgical dosage — and would render most people unconscious for a period in excess of 13 hours."); *Pavatt v. Jones*, 627 F.3d 1336, 1339 (10thCir. Dec 2010) (Quoting physician: "a 5,000 milligram dose of pentobarbital as 'an enormous overdose' that would be lethal").



## Eighth Amendment

In mid-2010, sodium thiopental became unavailable in the USA, and states switched to using pentobarbital. *Pavatt v. Jones*, 627 F.3d at 1337. As a result, opponents of the death penalty filed litigation in federal courts that argued that using untested pentobarbital would be “cruel and unusual punishment” in violation of the Eighth Amendment. My search of Westlaw on 3 June 2012 showed that such litigation was nearly always unsuccessful:

- *Wackerly v. Jones*, 398 Fed.Appx. 360 (10thCir. Oct 2010);
- *Pavatt v. Jones*, 627 F.3d 1336 (10thCir. Dec 2010), cert. den., 131 S.Ct. 974 (2011);
- *Powell v. Thomas*, 641 F.3d 1255 (11thCir. May 2011), cert. den., 131 S.Ct. 2487 (2011);
- *Beaty v. Brewer*, 649 F.3d 1071 (9thCir. May 2011), cert. den., 131 S.Ct. 2929 (2011);
- *Powell v. Thomas*, 643 F.3d 1300 (11thCir. June 2011), cert. den., 131 S.Ct. 3018 (2011);
- *West v. Brewer*, 652 F.3d 1060 (9thCir. July 2011);
- *DeYoung v. Owens*, 646 F.3d 1319 (11thCir. July 2011), cert. den., 132 S.Ct. 46 (2011);
- *Jackson v. Danberg*, 656 F.3d 157 (3dCir. Sep 2011);
- *Valle v. Singer*, 655 F.3d 1223 (11thCir. Sep 2011), cert. den., 132 S.Ct. 73 (2011);
- *Towery v. Brewer*, 672 F.3d 650 (9thCir. Feb 2012) (lethal dose of pentobarbital alone), cert. den., 132 S.Ct. 1656 (2012).

I find it ironic that the lawyers would object to a few minutes of alleged suffering by a convicted criminal, yet ignore months — or even years — of suffering by an innocent citizen who wants to die. **Comparing convicted criminals to candidates for physician-assisted suicide fails as a legal argument, because criminals have the constitutional right to be free from “cruel ... punishment”, while innocent citizens have no such legal right.**<sup>77</sup> I have taken the time to write this essay, because I believe legislatures or courts should give innocent citizens the legal right to the same euthanasia as used for criminals who face the death penalty. It is ironic that governments in the USA *require* euthanasia for criminals sentenced to death, but do *not permit* euthanasia for innocent victims of disease or injury.

In cases involving the method of applying the death penalty, a court considers the following factors to avoid cruel punishment, forbidden by the Eighth Amendment:

In *Weems v. United States*, 217 U.S. 349 ... (1910), the Court articulated a framework for addressing the constitutionality of a method of execution: (1) whether the method of execution comported with the contemporary norms and standards of society; (2) whether it offends the dignity of the prisoner and society; (3) whether it inflicted unnecessary physical pain; and (4) whether it inflicted unnecessary psychological suffering.

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<sup>77</sup> I put this sentence in boldface to emphasize its importance — a judge will ignore any Eighth Amendment argument about physician-assisted suicide, because the Eighth Amendment *only* applies to punishment of convicted criminals. Nonetheless, it is ironic that a quick, painless method of euthanasia used in the death penalty is *not* available to citizens suffering from a terminal illness who want to die.

*Connecticut v. Webb*, 750 A.2d 448, 454 (Conn. 2000), *cert. den.*, 531 U.S. 835 (2000). See also *Abdur'Rahman v. Bredesen*, 181 S.W.3d 292, 306 (Tenn. 2005) (citing *Weems*, 217 U.S. at 373 and *Webb*).

Despite the Connecticut court citing *Weems*,

1. the first test comes from *Woodson v. North Carolina*, 428 U.S. 280, 288 (1976) (“Central to the application of the Amendment is a determination of contemporary standards regarding the infliction of punishment.”),
2. the second test comes from *Trop v. Dulles*, 356 U.S. 86, 100 (1958) (“The basic concept underlying the Eighth Amendment is nothing less than the dignity of man.”),
3. the third test comes from *State of La. ex rel. Francis v. Resweber*, 329 U.S. 459, 463 (1947) (“The traditional humanity of modern Anglo-American law forbids the infliction of unnecessary pain in the execution of the death sentence.”); *In re Kemmler*, 136 U.S. 436, 447 (1890) (“Punishments are cruel when they involve torture or a lingering death; ....”), and
4. I am unable to find the fourth test in the U.S. Supreme Court opinions, but psychological suffering is found to be cruel in *Jordan v. Gardner*, 986 F.2d 1521, 1525-1526 (9th Cir. 1993).

In a death penalty case, the state has already decided the prisoner deserves to die, so preservation of life is *not* an appropriate issue. In a physician-assisted suicide case, I argue<sup>78</sup> that the patient alone should make the decision to die because of an unacceptable quality of life and no reasonable hope of improvement, so preservation of life is also *not* an appropriate issue.

Denying the three-drug euthanasia to terminally ill people who are suffering (or to victims of progressive neurological diseases who wish to die) both “offends the dignity” of the victim, “inflicts unnecessary physical pain” on the victim, *and* “inflicts unnecessary psychological suffering” on the victim — each a violation of the constitutional standards we use to evaluate methods of punishment for criminals.

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<sup>78</sup> See page 112, above.

## Conclusion

Given that mentally competent adults have a legal right to commit suicide, it is desirable to allow such people to die a neat, quick, and painless death by using prescription drugs, the way we execute criminals or euthanize animals. Bluntly stated, a person has a legal right to put a shotgun in their mouth and blow their brains out in a messy and gruesome end, and a person has a legal right to slowly dehydrate or starve himself to death, but a person in the USA currently does *not* have the legal right to receive prescription drugs for a neat, quick, and painless death. The law in the USA *should* be changed to permit physician-assisted suicide, which is compassionate and humane (i.e., quick, neat, and painless).

Aside from asserting the right of mentally competent adults to humanely end their suffering, there is also a need to legalize physician-assisted suicide, to permit monitoring of such suicides, so that any abuses can be detected and punished. Currently, most physician-assisted suicides are kept secret, because they are illegal in most states.

The real difficulty with this issue in the courts is that American judges depend on precedent, and there is a long history in the USA of criminalizing assisting a suicide, which long history prevents change by courts. Furthermore, the U.S. Supreme Court has been reluctant since about 1980 to declare any new constitutional right of privacy,<sup>79</sup> which right would prevent government from intruding on personal choices without a compelling reason. So attorneys and judges who try to justify physician-assisted suicide have their hands tied: legal precedent is solidly against physician-assisted suicide and the U.S. Supreme Court is *unwilling* to make new law in this area.

If a judge were to decide that there is no significant difference between (1) so-called passive euthanasia (i.e., disconnecting life-support machinery (e.g., ventilator or feeding tube)) and (2) so-called active euthanasia (e.g., deliberately using a lethal dose of prescription drugs to kill a patient, regardless of whether taken by the patient or injected by the physician),<sup>80</sup> then the door would be open to declare that the legal cause of death in both situations is the initial injury or underlying illness. This would be an easy way of using the common law to legalize so-called physician-assisted suicide. See page 113, above.

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<sup>79</sup> Ronald B. Standler, Fundamental Rights Under Privacy in the USA, <http://www.rbs2.com/priv2.pdf> (first posted Aug 1998).

<sup>80</sup> Prof. Meisel, author of a treatise on right-to-die law, argues that there is no significant difference between passive and active euthanasia. Alan Meisel, "Physician-Assisted Suicide: A Common Law Roadmap for State Courts," 24 Fordham Urban Law Journal 817, 824 (Summer 1997) ("... for two decades courts created and maintained the fiction, with little, if any, in-depth analysis, that there is a difference, a determinative difference, between passively and actively hastening death." [footnote omitted]).

I would prefer to see the U.S. Supreme Court declare a new constitutional right of privacy that protects personal choices in the area of suicide, as an extension of personal autonomy. But, given the reluctance of the current justices on the U.S. Supreme Court to expand privacy rights, the most practical way to get legal access to physician-assisted suicide may be for state legislatures to enact statutes. On the other hand, Prof. Alan Meisel said “Physician-assisted suicide, like abortion, is just too controversial a subject for legislatures to vote to approve regardless of individual legislators’ views on the subject.”<sup>81</sup> Prof. Meisel sees hope for legalizing physician-assisted suicide in state courts on grounds of state constitutional law and state common law. However, citizens’ initiatives to vote on the matter and direct legislatures to legalize physician-assisted suicide have been successful in Oregon and Washington states.

Issues in right-to-die cases span the disciplines of medicine, philosophy, religion, and law. There is little hope of reaching a consensus between pro-life Christians and those who favor euthanasia. However, one can hope that everyone would respect each individual’s right to make his/her own personal choices, according to his/her religion and philosophy.

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This document is at **www.rbs2.com/pas.pdf**

My most recent searches for court cases on this topic were in May 2005 and May 2012.  
first posted 9 May 2005, revised 29 Jul 2012

my webpage of links to other resources on euthanasia: <http://www.rbs2.com/euthlink.htm>

return to my homepage at <http://www.rbs2.com/>

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<sup>81</sup> Meisel, “Physician-Assisted Suicide: A Common Law Roadmap for State Courts,”  
24 Fordham Urban Law Journal 817, 819-820 (Summer 1997).