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HOT TOPIC: Too Costly to Live: The Moral Hazards of a Decision in Washington v. Glucksberg and Vacco v. Quill

Stephanie Graboyes-Russo

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Too Costly to Live: The Moral Hazards of a Decision in Washington v. Glucksberg and Vacco v. Quill

I. INTRODUCTION

On January 8, 1997, the United States Supreme Court heard oral argument in two cases that could prove to have as much resounding impact on American life as the Court's decision in Roe v. Wade. Washington v. Glucksberg and Vacco v. Quill present the Court with the question whether the Constitution affords a mentally competent, terminally ill adult the right to commit physician-assisted suicide.

Proponents of physician-assisted suicide contend that an individual


5. The Court is actually confronted with two constitutional questions. First, it has been asked to decide whether there is a constitutionally protected liberty interest in assisted suicide under the Due Process Clause. Second, it must determine whether state laws allowing patients to refuse life-sustaining medical treatment but prohibiting assisted suicide violate the Equal Protection Clause. See generally Petition for Writ of Certiorari, Washington v. Glucksberg, 79 F.3d 790 (9th Cir.), cert. granted sub nom. Compassion in Dying v. Washington, 117 S. Ct. 37 (1996) (No. 96-110); Petition for Writ of Certiorari, Vacco v. Quill, 80 F.3d 716 (2d Cir.), cert. granted, 117 S. Ct. 36 (1996) (No. 95-1858).

6. The proponents are represented, in both Glucksberg and Quill, by physicians and their now deceased patients who wished to commit physician-assisted suicide. They are joined by over thirty amici, including the American Civil Liberties Union. See Respondents' Brief at 2, Washington v. Glucksberg, 79 F.3d 790 (9th Cir.), cert. granted sub nom. Compassion in Dying v. Washington, 117 S. Ct. 37 (1996) (No. 96-110);
has a fundamental liberty interest in choosing the "timing and manner of one's death." As such, the right is protected by the Due Process Clause. Further, they argue that there is no rational basis for a state to distinguish between the status of terminally ill patients on life support, to which states give the choice of refusing life-sustaining treatment, and terminally ill patients not on life support who wish to procure the services of a physician to commit suicide. Proponents are asking the court to strike down state laws criminalizing assisted suicide, and to allow states to regulate physician-assisted suicide as they do the right to refuse medical treatment.

Opponents of physician-assisted suicide argue that the Constitution cannot recognize a right to commit suicide, much less a right to have another person aid in that suicide. Further, they argue that an inherent difference exists between refusing medical treatment and requesting lethal medication. Opponents have asked the Court to uphold state laws banning assisted suicide as not violative of substantive due process and as rationally related to legitimate state interests.

Jumping into the fray as amicus curiae, the United States has taken yet a third approach. The United States maintains that while the Due
Process Clause includes the right to "obtain relief from severe pain or suffering,"15 the states' interests are so significant that resolution of the issue should be left with them.16 Therefore, the United States argues, those legislatures that have done so are justified to impose an outright ban on physician-assisted suicide.17

Now that the briefs have been written and the arguments made, a final decision rests with the Supreme Court. The Court has a number of options. It can uphold outright prohibitions on physician-assisted suicide, by finding no such liberty interest in the Due Process Clause and recognizing the inherent difference between a patient's right to refuse medical treatment and a patient's desire to have a physician assist his suicide. Alternatively, the Court can strike down all prohibitions on assisted suicide, by finding that there is such a right and that no significant difference exists between refusing life sustaining treatment and seeking death by lethal medication. Finally, the Court can allow states to regulate the practice, by finding that legitimate state interests compel such regulation, regardless of whether any right to commit suicide exists under the constitution.18

15. United States Brief in Glucksberg, supra note 14, at 12.
17. As the Court acknowledged at oral argument, finding a Due Process liberty interest in physician-assisted suicide requires that bans on the practice be struck down. Upholding both the right and the prohibitions would be contradictory. See Oral Argument in Glucksberg, supra note 1, at 14-16 (the Court noting that "if we assume a liberty interest but nonetheless say that, even assuming a liberty interest, a state can prohibit it entirely, that would be rather a conundrum"). The United States is able to make the argument for a liberty interest and ban by redefining the right at stake as "a right to relief from pain and suffering," and not as a "liberty interest in dying." United States Brief in Glucksberg, supra note 14, at 12. Indeed, each of the groups—the states, physicians, and the United States—has offered a different formulation of the right at stake. The physicians claim that the right is "to determine the timing and manner of one's death" or more broadly, "to hasten one's own death." See supra text accompanying note 7. The states claim that the right is to "commit suicide." See supra note 11 and accompanying text. Constitutional analysis under the Due Process Clause begins with a careful exposition of the right at stake. See Reno v. Flores, 507 U.S. 292, 302 (1993). Thus, each group appreciates the importance of defining the right. See generally Oral Argument in Glucksberg, supra note 1; Oral Argument in Quill, supra note 1 (asking every party to attempt to define the right at stake).
18. Yet a fourth approach has been offered by at least one amicus curiae, which has asked the Court to reverse the lower courts by finding that the question is not ripe for constitutional adjudication. The theory relies on Justice Brandeis' classic admonition that the Court should not prematurely decide "novel, complex social problems," but rather should allow "deliberation and experimentation in . . . [the] laboratory of the states." See Brief of the Project on Death in America, Open Society Institute, as Amicus Curiae, for Reversal of the Judgments Below at 3, Washington v. Glucksberg, 79 F.3d 790 (9th Cir.), cert. granted sub nom. Compassion in Dying v. Washington, 117 S. Ct. 37 (1996) (No. 96-110) and Vacco v. Quill, 80 F.3d 716 (2d Cir.), cert.
This Article explores the high price of any decision in _Glucksberg_ and _Quill_. Part II explores potential consequences of continued societal and legal prohibitions on physician-assisted suicide. First, as proponents suggest, the "winks and nods" practice of covert and unregulated physician-assisted suicide may continue. Second, and conversely, a continued ban will force American medicine to focus on improving end-of-life health care. In doing so, patients' reasons for choosing physician-assisted suicide may disappear. Part III explores the opportunities for profiteering under a regime of legalized assisted suicide. Normalizing suicide as a reasonable medical treatment alternative will have devastating effects in a nation where health care choices are already dwindling. This section will identify potential opportunists in the insurance industry who have only recently discovered a lucrative new market in the terminally ill. This section will also identify those most likely to be victimized by legalized assisted suicide—the medically disenfranchised poor, elderly, minorities and disabled. Part IV explores the possibilities for state regulated physician-assisted suicide. It evaluates some of the proposed safeguards and concludes that those safeguards are

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*Note: Citations are not included in the plain text representation.*
inadequate at best. Part V examines the danger that legal challenges to regulation present—the very real threat of "doctrinal slippage." This section predicts the quagmire into which the legal and medical systems will inevitably fall in attempting to ensure that the right is not abused or expanded. More specifically, it argues that the analysis of *Cruzan v. Director, Missouri Department of Health*, together with a decision legalizing assisted suicide, will leave no principled means of limiting the right to the terminally ill capable of withstanding scrutiny. Voluntary euthanasia and eventually nonvoluntary euthanasia may be constitutionally mandated. Finally, this Article concludes that the Court, which must consider the foregoing in rendering its July decision, should ultimately decide to uphold the ban on physician-assisted suicide.

While there is much empirical evidence to suggest what the potential costs of any decision will be and much reason to suggest that this debate will continue long after the Court's July decision, what is clear at the outset is that none of the Court's options confront the real problem—the deplorable state of health care in the United States. As Professor Giles Scofield has declared: "The moral issue of our day is not whether to enable or prevent [physician-assisted suicide]. The moral issue of our day is whether to do something about our immoral system of care, in which treatment is dispensed according to a principle best characterized as that of economic apartheid." None of the available options requires universal or equitable access to health care as a prerequisite to recognition of any right to physician-assisted suicide. Yet, any chance of suicide remaining solely part of a patient's right "to define [his] own concept of existence, of meaning, of the universe, and of the mystery of human life," surely requires nondiscriminatory health care delivery. While no decision will end this debate, only one option, a continued ban on physician-assisted suicide, can prevent a "cheap and easy expedient" from becoming a perverse substitute for compassionate end-of-life care. This moral hazard compels a decision to uphold the ban on physician-assisted suicide.

23. See Kamisar, Against Assisted Suicide, supra note 19, at 749 (1995) (stating that a court cannot "responsibly resolve the constitutional issue . . . without considering the general implications of the asserted right").
26. See Tom Baker, On the Geneology of Moral Hazard, 75 TEX. L. REV. 237 (1996). Professor Baker explains that, "moral hazard signifies the perverse consequences of well-intentioned efforts to share the burdens of life, and it also helps to deny that refusing to share those burdens is mean-spirited or self-interested. . . . By 'proving' that helping people has harmful
II. SOME CONSEQUENCES OF MAINTAINING THE STATUS QUO

The Court's first option is to uphold state laws banning physician-assisted suicide.\(^{27}\) To do so, the Court must find that no right to commit suicide exists under the Constitution, or alternatively, regardless whether such a right exists, that states have compelling interests that render prohibitions on physician-assisted suicide constitutional.\(^{28}\) Should the Court decide to maintain the status quo, two consequences are likely to result. As proponents claim, physician-assisted suicide, already practiced with impunity by many health care providers, will continue. On the other hand, opponents assert that a continued prohibition will compel the health care system to seek legal alternatives to suicide, particularly more widespread use of hospice care and the improvement of palliative medicine. However, no one should discount the impact a Supreme Court decision upholding the ban will have on health care delivery in America. Such a decision would surely curtail the "winks and nods" practice of covert assisted suicide and provide the impetus for better end-of-life health care.

A. Covert Assisted Suicide

As the law stands today, assisted suicide in any form is criminal throughout the United States. Statutes in thirty-seven states and territories specifically prohibit it.\(^{29}\) Case law or negligent homicide statutes in

\(^{27}\) Physician-assisted suicide is a discrete act, meaning a doctor's provision of the means by which a person can commit suicide. This is the right advocated for in Quill and Glucksberg. Contrast that with "voluntary euthanasia," by which a doctor actually administers the lethal dose at the request of the patient. Physician-assisted suicide is also to be distinguished from "nonvoluntary euthanasia," where a doctor, without a patient's express consent, administers lethal medication for the purpose of causing death.

\(^{28}\) See, e.g., Cruzan v. Director, Missouri Dep't of Health, 497 U.S. at 278-79 (assuming, but not deciding, that a person has a right to refuse medical treatment, and upholding state statute requiring clear and convincing evidence of a patient's desire to end life-sustaining treatment). But see supra note 18 and accompanying text.

other states also punish assisted suicide. One state stands alone. Oregon, through popular vote, has legalized physician-assisted suicide.

Despite these laws, proponents and opponents alike acknowledge "widespread violation of the present legal prohibitions and a secret, unregulated underground practice" of physician-assisted suicide. Further, proponents are quick to point out that a physician has never been successfully prosecuted in the United States for assisted suicide, as evidence that Americans do not have the will to punish the act. From this, proponents conclude that a continued ban on the practice will have no impact on its use, except perhaps to send doctors further underground.

While data on current practice is limited, a Washington State Study indicates that physician-assisted suicide does occur with some frequency. In the study, 1,443 doctors were asked whether they had been

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

The statute was quickly enjoined one month after Oregon voters passed the initiative into law. See Lee v. Oregon, 891 F. Supp. 1439 (D. Or. 1995).


33. The unsuccessful prosecutions of Doctor Kevorkian, now implicated in thirty-six deaths, are cited as evidence that no jury will convict a doctor of assisted suicide. See David Margolick, Jury Acquits Dr. Kevorkian of Illegally Aiding a Suicide, N.Y. Times, May 3, 1994, at A1.

34. See Respondents' Brief in Glucksberg, supra note 6, at 38 (citation omitted) (stating that patients may be forced to seek the services of "a 'back alley' provider who may be a careless, unqualified charlatan").

requested to assist a suicide or perform euthanasia on terminally ill patients. Of the 828 doctors responding, 218 had received such requests. Forty-three doctors complied.

These results should not imply, however, that a Supreme Court decision upholding the ban on physician-assisted suicide will not influence physician behavior. Indeed, a significant number of responding doctors refused patient requests for assistance precisely because they “were worried about legal consequences.” Other surveys indicate that doctors consider legality the determinant in deciding whether to engage in the practice. For example, in a Colorado survey, fifty-nine percent of physicians indicated that they would use lethal medicine if the practice were legal. Similarly, forty-five percent of surveyed California doctors would engage in physician-assisted suicide, again, if it were legal. Interestingly, thirty-five percent would not do it regardless of its legal status.

Unsuccessful prosecution is not a legitimate reason to strike down prohibitions on assisted suicide, as proponents suggest. When confronted with the issue of nonenforcement, the New York State Task Force on Life and the Law stated that the continued prohibition “carries intense symbolic and practical significance, and ‘shores up the notion of limits in human relationships.’” Indeed, a lack of adequate enforcement mechanisms provides support for the contrary view that legitimating the practice could prove dangerous because legalization would only increase its prevalence while regulation of assisted suicide could never effectively control its practice.

In contrast, if the Supreme Court upholds state laws banning the practice, prosecutors may be instilled with a renewed resolve to more

36. See id. at 920.
37. See id. at 921.
38. Thirty-two doctors provided assistance in suicide. An additional eleven doctors performed euthanasia. See id. at 922.
39. Id. Twenty-six doctors or 12% refused for this reason.
41. See id.
42. See id. Fifty-one doctors in the Washington survey, refused to provide assistance in suicide or euthanasia because they felt that “[p]hysicians should never perform assisted suicide... [or] euthanasia.” See Back, supra note 35, at 922.
43. See Callahan & White, supra note 32, at 5.
44. Id. at 6 (quoting The New York State Task Force on Life and the Law, When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context (1994) (hereinafter New York State Task Force)). After years of study, the task force recommended to the New York legislature that prohibitions on assisted suicide remain in place. See id.
45. See discussion infra part IV.
TOO COSTLY TO LIVE

vigorously seek sanctions for those who would flout the law. For doctors currently ambivalent to the practice, a reaffirmed prohibition on assisted suicide will likely provide the impetus to forego assisted suicide as an option for treating the terminally ill.46 As one commentator has suggested, as long as physician-assisted suicide remains illegal:

as long as physicians know that in case of a complaint they will have to be able to justify their actions to their peers and to the legal system, the amount of such abuse will be limited. If a doctor chooses to break the law, he should do so with full knowledge of the seriousness of his action.47

Full knowledge of the consequences, via a Supreme Court decision banning the practice, will have an impact on many physicians in the United States.

Proponents also cite public opinion poll data suggesting that Americans are sympathetic to the plight of the terminally ill as evidence that the public condones covert assisted suicide.48 Americans have been polled extensively about their views on assisted suicide, but the question asked belies the limited utility of the answer. If asked whether the law should allow a person to "die with dignity" or to die in a "humane and dignified manner," only the most callous among us would say no.49 Yet, even when asked in those terms, Americans do not show anything approaching clear support for physician-assisted suicide. Indeed, the Oregon Death With Dignity Act50 passed by only a slim margin of fifty-

46. See Back, supra note 35, at 919 (stating that greater understanding of physician-assisted suicide and euthanasia "might influence medical and legal responses to an issue undergoing intense public scrutiny").


48. See Brief of the Coalition of Hospice Professionals as Amicus Curiae for Affirmance of the Judgments Below at 9-10 & n.4, Washington v. Glucksberg, 79 F.3d 790 (9th Cir.), cert. granted sub nom. Compassion in Dying v. Washington, 117 S. Ct. 37 (1996) (No. 96-110) and Vacco v. Quill. 80 F.3d 716 (2d Cir.), cert. granted, 117 S. Ct. 36 (1996) (No. 95-1858)[hereinafter Hospice Coalition Brief] (stating that "the fact that state legislatures have not repealed ancient statutory prohibitions against physician-assisted suicide is only the weakest kind of contrary evidence of public will, especially where such statutes have gone unenforced for generations").

49. See Callahan & White, supra note 32 at 20. This "kind of Orwellian doublespeak . . . has been acknowledged by at least one proponent as deliberate and politically motivated." Id. What's more, proponents of physician-assisted suicide readily admit that the language chosen for both public opinion polls and popular legislative enactments has practically determined the outcome. See id. Indeed, use of the terms "suicide" and "euthanasia" in the Washington state initiative helped defeat the legislation. See id. See generally Rita L. Marker & Wesley J. Smith, The Art of Verbal Engineering, 35 Duq. L. Rev. 81 (1996).

50. OR. REV. STAT. §§ 127.800-127.995 (1995). More than one commentator has queried whether the title to this act implies that dying a natural death is somehow undignified. While the question may sound rhetorical, one of the feared results of laws like these is that suicide may come to be regarded as the dignified choice, and as such a duty.
one percent.51 Reasons cited by Americans who support assisted suicide may have more to do with the sorry state of health care in the United States than with the belief that suicide is a constitutional right.52 It is entirely possible that open and frank discussion of the consequences of legalizing physician-assisted suicide would produce popular results different than those seen today. Moreover, health care reform emphasizing compassionate end-of-life care could quell the fears that today fuel support for physician-assisted suicide.

B. Legal Opportunities for Humane and Dignified Death

The present state of end-of-life health care in America explains much of the interest in physician-assisted suicide.53 Greater availability of compassionate hospice care and effective palliative medication could dissuade many terminally ill patients from opting for suicide.54 Equally likely, an opinion from the Supreme Court upholding state prohibitions on physician-assisted suicide could provide the impetus for improving end-of-life health care in the United States which, in turn, will make suicide less attractive. As the American Medical Association ("AMA") has said, "the prohibition on physician-assisted suicide provides health care professionals with a tremendous incentive to improve and expand the availability of palliative care."55

Indeed, both doctors and patients may be less inclined to consider suicide as an option if their reasons for doing so are addressed. From the patient's perspective, the fear that "pain may become intolerable,

51. See Callahan & White, supra note 32, at 18 (citation omitted).
52. Authorities cite "technological backlash," Americans' fears of being kept alive by machines, the medical profession's "lousy job of managing pain" and the rising costs of health care as the main reasons for support of suicide. See Dee Lane, Americans' Interest in Suicide Heightens, PORTLAND OREGONIAN, January 1, 1995, at B1. One has to wonder whether a Constitution that protects life, liberty and property should be turned on its head because advances in medical technology have outpaced our ability to figure out how to use it compassionately.
53. See id.
54. At oral argument, the states pointed out that "the fact that [many of the terminally ill] die in pain shows the task awaiting the medical profession, but it's not a task that calls for the cheap and easy expedient of lethal medication rather than the more expensive pain palliative." Oral Argument in Glucksberg, supra note 1, at 26. See also Brief Amicus Curiae for the National Hospice Organization in Support of Petitioners at 5, Washington v. Glucksberg, 79 F.3d 790 (9th Cir.), cert. granted sub nom. Compassion in Dying v. Washington, 117 S. Ct. 37 (1996) (No. 96-110) and Vacco v. Quill, 80 F.3d 716 (2d Cir.), cert. granted, 117 S. Ct. 36 (1996) (No. 95-1858) [hereinafter National Hospice Organization Brief]. The experience of members of the National Hospice Organization has shown that "[w]hen patients suffering from terminal illness are given proper palliative and supportive care, the desire for assistance with suicide generally disappears." Id.
55. AMA Brief in Quill, supra note 21, at 22. Moreover, the AMA fears that "abandoning the prohibition on physician-assisted suicide will undermine the provision of palliative care to those who need it." Id.
[he] may suffer a loss of dignity and become dependent on others or . . . will excessively burden [his] famil[y].” are the most frequently cited reasons for requesting assisted suicide. From the doctor’s perspective, the decision to assist a suicide usually comes after efforts to alleviate the patient’s pain have failed. Better alternatives to death may change both perspectives.

Opponents of physician-assisted suicide advocate two alternatives to suicide which must be explored and made universally available to prevent suicide from becoming an acceptable end-of-life treatment option for the terminally ill. First, compassionate hospice care must be made more readily available to those in need. The “provision of a humane, low technology environment in which to spend their final days can go far in alleviating patients’ fears of an undignified, lonely, technologically dependent death.” A continued prohibition on physician-assisted suicide may have a direct impact on the number and availability of hospices in the United States.

Additionally, improvements in palliative medicine should alleviate patients’ fears of agonizing and dependent death. The medical profession acknowledges that “the delivery of such care is ‘grossly inadequate’ today, and efforts to make such care universally available have not yet succeeded.” Removing the obstacles that currently leave palliative medicine unable to manage pain effectively, by forcing the health care

56. See AMA Brief in Glucksberg, supra note 21, at 8-10; see also Back, supra note 35, at 921. Accord Hendin, Seduced by Death, supra note 47, at 128. In the Netherlands, where assisted suicide and euthanasia are commonplace, doctors report that the fear of a “loss of dignity, pain, the wish not to die in an ‘unworthy way,’ dependence on others, and weariness with living” were patients most frequently given reasons for requesting suicide. Id.

57. See Hendin, Seduced by Death, supra note 47, at 155. Doctor’s feelings of failure and helplessness may influence the decision to assist a suicide, since the physician may gain the “illusion of mastery over the disease and the accompanying feelings of helplessness.” Id. at 129.

58. See National Hospice Organization Brief, supra note 54, at 17-18; see also Hendin, Seduced by Death, supra note 47, at 167 (stating that “[h]ospice care [in the United States] is in its infancy”).


60. As the Court noted at oral argument, the Netherlands has a grand total of three palliative care facilities to serve the terminally ill in its population. In contrast, England, which forbids physician-assisted suicide, has 185. Oral Argument in Quill, supra note 1, at 51-52.

61. AMA Brief in Quill, supra note 21, at 7.

62. Id. The AMA lists a number of current obstacles to effective palliative care, including: lack of professional training and knowledge, misconceptions about the risk of addiction and respiratory depression associated with pain medication, inadequate communication (reflecting both inadequate attention from health care professionals and undue reluctance of patients and their families to use pain relief medication), and concern over criminal or licensure actions against the prescribing physicians.

Id.
system to discount suicide and offer more legal treatment options, will serve both the medical profession's and patient interests better than death.63

III. LEGALIZATION'S NEW MARKET, NEW OPPORTUNISTS

If the Supreme Court elects to overturn the laws of nearly every state,64 nothing short of a wholesale use of physician-assisted suicide, and eventually euthanasia, is likely to result. “[L]ethal medication could be proposed as a treatment . . . to every competent, terminally ill person in the country.” 65 But while the ramifications of such a decision are obvious, what is not obvious is who the most likely victims and beneficiaries will be. In a perfect world, only those individuals with a well-reasoned and voluntary desire to commit suicide will choose the option. In a perfect world, no one benefits or profits from the decision, except perhaps the patient (if death can ever truly be a benefit). America, unfortunately, is not a perfect world.

63. The AMA recommends several options to medical professionals instead of the acceptance and practice of physician-assisted suicide:

1. [Acceptance of the statement that] physician-assisted suicide is fundamentally inconsistent with the physician’s professional role.
2. It is critical that the medical profession redouble its efforts to ensure that dying patients are provided optimal treatment for their pain and other discomfort. The use of more aggressive comfort care measures, including greater reliance on hospice care, can alleviate the physical and emotional suffering that dying patients experience. Evaluation and treatment by a health professional with expertise in the psychiatric aspects of terminal illness can often alleviate the suffering that leads a patient to desire assisted suicide.
3. Physicians must resist the natural tendency to withdraw physically and emotionally from their terminally ill patients. When the treatment goals for a patient in the end stages of a terminal illness shift from curative efforts to comfort care, the level of physician involvement in the patient’s care should in no way decrease.
4. Requests for physician-assisted suicide should be a signal to the physician that the patient’s needs are unmet and further evaluation to identify the elements contributing to the patient’s suffering is necessary. Multidisciplinary intervention, including specialty consultation, pastoral care, family counseling, and other modalities, should be sought as clinically indicated.
5. Further efforts to educate physicians about advanced pain management techniques, both at the undergraduate and graduate levels, are necessary to overcome any shortcomings in this area. Physicians should recognize that courts and regulatory bodies readily distinguish between use of narcotic drugs to relieve pain in dying patients and use in other situations.

Glasson, supra note 59, at 96-97.

64. At oral argument, the Court, asking counsel for the physicians to justify their position, stated “you are asking to overturn the laws of, now, all states but one.” Oral Argument in Glucksberg, supra note 1, at 46.

65. Oral Argument in Glucksberg, supra note 1, at 22.
TOO COSTLY TO LIVE

A. The Medically Disenfranchised

Proponents of the right to physician-assisted suicide insist they are asking only that mentally competent, terminally ill patients be given the right to choose suicide. What they do not acknowledge, however, is the threat of abuse and undue influence on those decisions. Those most likely to be victimized by the practice are patients whose choices are not truly voluntary, because no other realistic options are available to them. These are the same people currently victimized by America's inequitable health care system: the medically disenfranchised poor, minorities, elderly, and disabled.66

Among the many factors that influence Americans' health care decisions, money is the most invidious. Financial considerations may not make a patient's decision to commit suicide irrational. However, for certain groups, those financial considerations are so predominant as to be coercive, and therefore, inconsistent with true voluntariness. The disparity in medical care, both physical and mental, that the poor, elderly, and minorities receive is well-documented.67 For this reason, the AMA fears that:

Once established, the right to physician-assisted suicide would create profound danger for many ill persons with undiagnosed depression and inadequately treated pain, for whom physician-assisted suicide rather than good palliative care could become the norm. At greatest risk would be those with the least access to palliative care—the poor, the elderly, and members of minority groups.68

Those who must rely on Medicare and Medicaid are particularly at risk. Oregon Medicaid recipients, for example, face almost certain financial coercion in a state with legalized physician-assisted suicide and mandatory health care rationing. Oregon's Medicaid law, touted as a model for the rest of the country, denies coverage for life-sustaining treatments deemed not cost-effective, but covers the cost of physician-


67. See, e.g., Charles S. Cleeland et al., Pain and Its Treatment in Outpatients with Metastatic Cancer, 330 New Eng. J. Med. 592 (1994). In Cleeland's study, "patients seen at centers that treated predominantly minorities were three times more likely that those treated elsewhere to have inadequate pain management." Id. at 595.

68. AMA Brief in Quill, supra note 21, at 2.
assisted suicide.69 If the rest of the country follows Oregon’s example, financially coerced suicide may become the norm in a society facing the prospect of health care rationing.70

What’s more, once physician-assisted suicide becomes readily available, many patients will feel duty-bound to “die and get out of the way,” as Dick Lamm, former governor of Colorado, so eloquently put it.71 The reality is that many patients face an illusory choice of treatments at the end of life. One is prohibitively expensive or virtually inaccessible. The other is a “cheap and easy expedient.”72 Even patients who desperately wish to live for what ever time they have left may choose death rather than financial ruin for those who survive them.

B. The Beneficiaries

Compounding the financial influence on end-of-life treatment decisions is the role of insurance in American health care. As is readily apparent, “[t]he least costly treatment for any illness is lethal medication.”73 Insurance companies are poised to capitalize on America’s newest market, the terminally-ill. The prospects for profit are endless. As America has long recognized, however, there is something immoral, inhuman, in profiteering in human lives.74 In fact, the Dutch medical establishment, working in a society that openly advocates and practices

70. See Leonard M. Fleck, Just Caring: Assisted Suicide and Health Care Rationing, 72 U. DET. MERCY L. REV. 873 (1995) (footnote omitted). Professor Fleck characterizes the dilemma as follows:

[If] physician-assisted suicide were [a] socially permitted option[ ], . . . these individuals could be subtly cajoled into choosing this type of death. This would result in additional health care savings and provide society with a 'compassionate' response to the otherwise pointless suffering these individuals would endure. But, quite obviously, this is not compassion in any morally defensible sense. Rather, it is a clear compounding of injustices. It is the worst kind of discrimination hypocritically masked as compassion . . . . A more accurate label for this sort of practice would be nonvoluntary social euthanasia.

71. Alan Tonelson, A Look at the Lamm Candidacy: Or Is the Sky Really Falling?: Lamm is the Rare Pol Willing to Face Reality, WASH. POST, July 28, 1996, at C3. See also C. Everett Koop, Introduction to Special Issue: A Symposium on Physician-Assisted Suicide, 35 DUQ. L. REV. 1, 3 (1996) (stating that lethal medication may be used to “get [the patient] 'out of misery' and off of one’s hands by killing the patient as quickly as possible”).
73. Oral Argument in Glucksberg, supra note 1, at 25.
74. How ironic it will be if the Due Process Clause, adopted and ratified specifically to overrule Dred Scott, is used to once again set this nation on the path to bartering in human lives. See LAURENCE H. TRIBE, AMERICAN CONSTITUTIONAL LAW § 7-2, at 549 (2d ed. 1988) (discussing Dred Scott v. Sanford, 60 U.S. (19 How.) 393 (1857)).
physician-assisted suicide and euthanasia agrees. They strongly counsel against the United States legalizing physician-assisted suicide because the “difficulty of preventing the profit motive from making euthanasia and assisted suicide a lucrative business” would “contaminate[e] the process” in the United States.75

Unfortunately, the Dutch are right. The stage is already set for America’s insurance industry to exploit the legalization of physician-assisted suicide. The terminally ill comprise a currently exploding market for health and life insurers, as well as viatical settlement companies. Legalizing physician-assisted suicide creates potential profit for these businesses no matter which decision terminally ill patients might make at the end of life.76

While no one is certain that insurance companies will take advantage of suicide as a treatment option,77 the prospect that insurers will offer policies excluding expensive end-of-life treatment, but covering the cost of lethal medication is frightening enough. However, even without express exclusions, health care rationing is inherent in managed care plans, and that alone increases the odds of suicide becoming commonplace.78 “[Managed care] plans pervasively require utilization review in order to examine treatment prospectively, concurrently, or retrospectively and determine whether the [managed care organization] will pay for the treatment. This creates a mechanism for blocking treatment coverage,” that may leave patients with little alternative to suicide.79

75. Hendin, Seduced by Death, supra note 47, at 165. The Netherlands provides its citizens universal health care coverage, which, among other things, removes profit motive as an influence on decisions to commit suicide or perform euthanasia.

76. See Debra J. Saunders, Sharpened Pencils are Ready to Reduce High Cost of Dying, PORTLAND OREGONIAN, November 17, 1994, at D13. Saunders pictures “insurance and health maintenance organization executives . . . rubbing their hands in glee over the passage of the so-called Death With Dignity Act passed by Oregon voters.” Id.

77. See Oral Argument in Quill, supra note 1, at 29 (“We don’t know to what extent insurance companies, as they have indicated in Oregon, would quickly say ‘of course we will pay for this treatment while they are not paying for a hospitalization for palliative treatment.’”).


A recent article analyzed whether managed care plans can legally refuse to cover treatments that the plan deems experimental or futile. Particularly disturbing is the concept of legally denying benefits to patients on the basis of "futility." By definition, terminal illness implies that, to some extent, any treatment is futile. Yet, the courts have upheld such denials. An example is Barnett v. Kaiser Foundation Health Plan, Inc. Barnett considered whether a managed care plan could refuse to pay for a lifesaving liver transplant and held that "poor survival rate is an acceptable medical criterion" for determining whether to offer a treatment option. The court upheld the managed care plan's refusal to cover the treatment, rejecting the patient's contention that the decision was motivated by financial concerns for cost savings.

This inherent conflict between profit motive and patient care can only "heighten the risk of error and abuse" for managed care patients. Terminally ill patients denied coverage for treatments under the guise of utilization review will be forced to choose between the readily available, "cheap and easy" lethal dose or the prospect of an agonized death. This is no choice. Only the affluent, capable of financing the more costly treatments themselves, will truly have a choice.

Unfortunately, health insurers are not the only potential profiteers in the new market in the terminally ill. They have the company of life insurers. Able to avoid paying on the policies of terminally ill patients who opt for suicide, life insurance companies stand to profit from legalized physician-assisted suicide. A standard clause in nearly every life insurance policy issued in the United States is the suicide exclusion, which denies benefits if an insured commits suicide within two years of purchasing the policy. To address this concern, the Oregon Death With Dignity Act redefines suicide to prevent insurers from denying benefits. The legality of redefining such a traditional insurance term of art is debatable. Nevertheless, this new statutory definition of suicide may simply force insurance companies to shift their source of profit by

80. See Furrow, supra note 70.
81. 32 F.3d 413 (9th Cir. 1994).
82. Id. at 417.
83. Id.
84. Wolf, supra note 78, at 466. Wolf continues: "The elderly and poor 'account for a disproportionate share of health care expenditures and are, therefore, prime targets of cost containment. This suggests that those individuals would also have a heightened risk of being urged toward assisted suicide rather than toward the costly care they would otherwise merit.'" Id. (footnote omitted).
86. OR. REV. STAT. § 127.875 (1995) provides, in pertinent part: "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."
charging higher premiums. \(^8^7\)

Finally, new players in the terminally ill market are viatical settlement companies which currently enjoy huge profits. \(^8^8\) Viatical settlement allows terminally ill insureds to sell their policies at fifty to ninety percent of face value while still alive. On a half million dollar policy, that is up to $250,000.00 profit for the purchaser. Criticizing these companies for taking advantage of the terminally ill, \(^8^9\) states are just beginning to regulate viatical settlements with licensing requirements. \(^9^0\) Of course, if a patient is denied expensive treatment by his health insurance provider, viatical settlement companies are ready, willing and able to "fill the void left by insurers." \(^9^1\)

More frightening are the creative possibilities that may become reality if physician-assisted suicide is legalized. A modest proposal has been offered up by one advocate of physician-assisted suicide, K.K. Fung, a professor of economics at the University of Memphis. \(^9^2\) Fung has suggested that "insurance companies give rebates to terminally ill patients who agree to kill themselves," leaving "money [that] would be distributed to their heirs after their death." \(^9^3\) Giving prizes for taking the pill is among the most barbaric possibilities awaiting a society on which legalized suicide is unleashed.

Terminally ill patients confronted with inevitable death may become victims of big business as well as fate regardless of the choice they make. Patients with the desire to live as long as possible may face the prospect of being refused lifesaving treatment if an insurance provider determines that treatment is experimental or futile. In other words, patients may be told their lives are not worth the cost. Faced with this knowledge, patients might choose to "die with dignity," and take the

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\(^8^7\) See O'Neill, supra note 85. One insurance company spokesman noted that "[n]o insurance company would sell a policy to someone with a terminal illness." \(\text{Id.}\) Further, he noted that insurers are worried about Oregon's law, and "will be watching to see how much additional cost will be associated" with it. \(\text{Id.}\)

\(^8^8\) See Amey Stone, Easing the Economic Burdens of Terminal Illness, \(\text{BUSINESS WEEK, May 3, 1993, at 160; see also Pamela Sherrid, Enriching the Final Days, U.S. NEWS & WORLD REP., August 21, 1995, at 56 (viatical settlement companies purchased over $300 million worth of life insurance policies in 1994 alone); Jim Connelly, Viaticals Attract Institutional Money, \(\text{NAT. UNDERWRITERS, Nov. 21, 1994, at 3 (viatical industry expected to grow to 3 to 4 billion by turn of the century).}\)

\(^8^9\) See Anonymous, Buyer of AIDS Patients' Insurance Quitting, \(\text{N.Y. TIMES, July 18, 1996, at D5 (reporting that the country's first viatical settlement company pulled out of the business when the new drug therapy for AIDS patients causing increased life expectancy went on the market).}\)

\(^9^0\) \(\text{Id.}\)

\(^9^1\) \(\text{Id.}\)

\(^9^2\) See Lane, supra note 52.

\(^9^3\) \(\text{Id.}\) Fung estimates that "[i]f everybody who has a terminal illness chose to die early, the savings would be big . . . . I mean major league—$50 or $60 billion a year." \(\text{Id.}\)
lethal dose, which is likely to be covered by insurance. On the other hand, if some patients still refuse the "cheap and easy expedient," wanting instead to avail themselves to whatever treatments hold out hope of saving their lives, viatical settlement companies will come to the rescue to purchase their life insurance policies at a steep discount, giving patients the "opportunity" to finance their own treatments.

IV. THE VERITABLE QUICKSAND OF STATE REGULATION

Rather than simply strike down state prohibitions, the Court may recognize a right to physician-assisted suicide, but allow states to regulate much in the same way states regulate refusal of treatment. This approach may seem the most prudent way to balance conflicting patient and state interests. However, it's appeal is short-lived once one asks a simple question: is meaningful regulation possible? More importantly, can the regulations prevent what is most feared and what the available empirical evidence suggests is inevitable—the slow "gravitation out of physician-assisted suicide into euthanasia?" The short answer to these questions is no. Regulation will do little to hold the line. Indeed, it will most likely leave the states, the courts, the medical profession, and the public mired in veritable quicksand for generations.

Determining whether meaningful regulation of physician-assisted suicide is possible first requires ascertaining exactly what proponents would have the states regulate. As previously noted, proponents claim that the class of individuals entitled to commit assisted suicide is quite small. Proponents would have the right conferred only on those competent, terminally ill patients able to take life-ending medication.

94. Alternatively, the Court may assume the right exists, as it did in Cruzan v. Director, Missouri Dep't of Health, 497 U.S. 261, 278-79 (1990).
95. See id.
96. Because the proponent's argument rests almost entirely on the assumption that only those patients who make a voluntary and informed choice to commit suicide should have the opportunity to do so, at a minimum the right must be susceptible to regulation. See Mark Strasser, Assisted Suicide and the Competent Terminally Ill, 74 OR. L. REV. 539, 563-64 (1995).
97. Oral Argument in Glucksberg, supra note 1, at 7. At oral argument, the Court again and again queried the parties regarding this risk. See generally Oral Argument in Glucksberg, supra note 1; Oral Argument in Quill, supra note 1.
98. The inconsistency of recognizing a constitutional right and then allowing its exercise by so few individuals has been duly noted by the Court. See Oral Argument in Glucksberg, supra note 1, at 27-36. As the Court succinctly stated, "To say that as a matter of constitutional due process, you include the person who is able to take the pill herself but exclude the one [experiencing emotional or chronic suffering] whose mental state is the same? I don't understand how you get that line out of a grand due process clause." Id. at 31. See also Thomas J. Marzen, "Out, Out Brief Candle": Constitutionally Prescribed Suicide for the Terminally Ill, 21 HASTINGS CONST. L.Q. 799, 800 (1994).
themselves.99

To prevent abuse, proponents suggest that states impose strict guidelines patients must satisfy before they can exercise their right to physician-assisted suicide.100 Generally, the proposed guidelines require four safeguards before a patient can be assisted in his or her suicide:101 consent, mental competence, voluntariness, and terminal illness.102 However, the crucial question regarding these safeguards is whether any universal, and more importantly, objective, definition of these terms can be used to set clear limits on physician-assisted suicide.

First evaluate voluntariness. Proponents would ensure that the right to physician-assisted suicide will be adequately regulated by requiring patients to self-administer, i.e., voluntarily take the lethal drug.103 This notion of voluntariness is illusory. Voluntariness goes much deeper than mere physical dexterity. True voluntariness implies a decision free of inappropriate influence. Indeed, a choice is only as voluntary as the quality of viable alternatives to that choice. Unfortunately, many terminally ill patients simply will not have adequate alternatives under a regime of legalized physician-assisted suicide.104 "[I]n the context of

99. See supra note 28 and accompanying text. Some proponents of physician-assisted suicide would go further, and would limit the right to an even smaller class of terminally ill patients—those patients "whose suffering simply cannot be relieved, even with the best medical care (including terminal sedation)." Hospice Coalition Brief, supra note 48, at 4. Terminal sedation refers to the practice of putting a patient in a drug-induced coma to relieve or prevent severe pain. Id. at 10. The Hospice Coalition points to evidence suggesting that a small percentage of patients given terminal sedation continue to feel pain. See id. at 11. Thus, physician-assisted suicide is proffered as the only humane alternative remaining to this small group.

100. Model statutes have been drafted for states contemplating legalizing physician-assisted suicide. See Charles H. Baron et al., A Model State Act to Authorize and Regulate Physician-Assisted Suicide, 33 HARV. J. LEGIS. 1 (1996); see also Callahan & White, supra note 32, at 18-25 (discussing proposed state legislation).

101. See Callahan & White, supra note 32, at 25. The Netherland guidelines for physician-assisted suicide and euthanasia have facilitated much of the discussion and scrutiny of proposed legislation in the United States. The failure of the Netherlands guidelines to limit the now rampant use of both voluntary and involuntary euthanasia is well documented. See e.g., Herbert Hendin, The Slippery Slope: The Dutch Example, 35 DUQ. L. REV. 427 (1996) [hereinafter Hendin, The Slippery Slope] ("Virtually every guideline established by the Dutch . . . has failed to protect patients or has been modified or violated with impunity.").

102. Indeed, the Oregon statute, proposed as a model for other states, adopts similar guidelines. See OR. REV. STAT. § 127.805 (1995).

103. See supra note 28. As noted earlier, physician-assisted suicide is defined as an act of the patient, where the patient ingests the lethal medication prescribed by the physician. Necessarily, the patient must be able to take the drugs himself or herself. Proponents claim that, defined this way, the class of persons to whom the right will be extended is quite small. See Oral Argument in Quill, supra note 1, at 30 (proponents claim that self-administration will assure that the patient is committing suicide voluntarily); see also Baron et al., supra note 100, at 10 (limiting statute to physician-assisted suicide to assure patient responsibility and resolve to die, as well as to appease public, legislators and physicians).

104. John Pickering, Chair of the American Bar Association Commission on Legal Problems of the Elderly, noted:
cost containment and the millions of citizens who remain uninsured and underinsured and risk poverty from lengthy or chronic illness, voluntariness is an honorable ideal, although difficult to ensure or guarantee through legislative intent.105 Without greater equity in access to and delivery of health care, physical voluntariness as a safeguard against abuse will be a mere facade behind which a lack of real alternatives will remain as a hidden, but common influence on terminally ill patients’ choices to commit suicide.

Consent likewise falls far short of providing a meaningful limit on the use of physician-assisted suicide. Consent, as normally used in medical decision-making, has more to do with limiting caregiver liability than it does patient willingness. “In practice, consent has all too often become a tool of risk management for purposes of creating a liability-proof record of patient care in the event of lawsuits.”106 In the context of physician-assisted suicide, however, consent should be expected to operate differently than it does in typical medical treatment delivery.107 The level of proof necessary to establish consent to suicide ought to reflect the gravity of what the patient is consenting to.108 Unfortunately, it does not.109

The consent safeguard only insures against liability because it can do no more. Ultimately, patient consent is based on inherently subjec-

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Before there can be such truly voluntary choice to terminate life, there must be universal access to affordable health care. The lack of access to or the financial burdens of health care hardly permit voluntary choice for many. What may be voluntary in Beverly Hills is not likely to be voluntary in Watts.

Kamisar, Against Assisted Suicide, supra note 19, at 738-39 (quoting John H. Pickering, The Continuing Debate over Active Euthanasia, BIOETHICS BULLETIN (ABA), Summer 1994).

105. Callahan & White, supra note 32, at 42.
106. Id. at 27; see also OR. REV. STAT. § 127.885 (providing immunities from liability for assisting suicide where doctor acts in good faith).
107. In the typical consent process, the patient is required to sign documents listing the risks associated with their decision. The process sometimes includes conversation with the attending physician, though this is not required. See Callahan & White, supra note 32, at 27-28.
108. See id. at 36.
109. See Oregon Death With Dignity Act, supra note 31. The Oregon Death With Dignity Act defines “informed decision” as:
   a decision by a qualified patient, to request and obtain a prescription to end his or her life in a humane and dignified manner, that is based on an appreciation of the relevant facts and after being fully informed by the attending physician of:
   (a) His or her medical diagnosis;
   (b) His or her prognosis;
   (c) The potential risks associated with taking the medication to be prescribed;
   (d) The probable result of taking the medication to be prescribed;
   (e) The feasible alternatives, including, but not limited to, comfort care, hospice care and pain control.
As the court noted in *Lee v. Oregon*, consent under the Death With Dignity Act is "based on a person's own rational assessment of the quality and value of their life," not on objective proof. An individual's subjective assessment is a poor substitute for objective legal standards, and thus cannot provide a meaningful limit on physician-assisted suicide.

The competency safeguard presents its own problems. Competency assumes that the medical profession is always able to recognize and diagnose depression. A diagnosis of depression would preclude a finding of competency to decide whether to exercise the right to physician-assisted suicide. Nonrecognition of depression, which is common in terminally ill patients, makes determinations of competency unreliable. "Neither clinical medicine nor jurisprudence can entirely eliminate the inherent subjectivity of assessing someone to be of sound mind." This creates a substantial and unacceptable risk that patients with easily treatable depression may needlessly go to death.

Proponents respond to the potential inadequacies of voluntariness, consent, or competency by noting that the practice is available only to the terminally ill. While terminal illness would seem to offer a clear line beyond which the right to physician-assisted suicide could not extend, it does not. In reality, that line too is hard to determine. Aside from metaphysical questions, there seems to be little consensus on the definition of terminal illness. The great weakness in defining the term is the well documented medical fact that doctors can only guess at life expectancy. Studies suggest that physician determinations of length of survival have error rates of up to sixty percent. If a

110. See Strasser, *supra* note 96, at 550 & n.68 ("The individual must use her own values and preferences to make the decision.").
112. See Hendin, *The Slippery Slope*, *supra* note 101, at 428 (patients' subjective determinations explain why Dutch have been unsuccessful in preventing euthanasia of healthy, depressed patients).
114. Up to 42% of patients with serious illness are clinically depressed. See id.
115. Callahan & White, *supra* note 32, at 35. "[E]xperts underscore the inability of depressed persons to recognize the severity of their own symptoms and the failure of primary physicians to detect major depression." Kamisar, *Against Assisted Suicide, supra* note 19, at 760.
116. See Oral Argument in *Glucksberg, supra* note 1, at 28, the court noting that, in a sense, we are all terminal, "it's just a matter of time."
117. See Kamisar, *Against Assisted Suicide, supra* note 19, at 740 (noting that terminal illness is variously defined as "a condition that will produce death 'imminently' or 'within a short time' or in six months or a year").
118. See *Lee v. Oregon*, 891 F. Supp. 1429, 1435 (D. Or. 1995) (stating that "even for physicians who specialize in treating a terminal disease, no precise definition is medically or
diagnosis of terminal illness is going to be the basis for allowing a patient to commit suicide, error ridden determinations surely cannot provide adequate safeguards against needless death.

Beyond semantics and definitional ambiguity, one other obstacle leaves meaningful regulation of physician-assisted suicide in doubt. The flaw, which some suggest is fatal, is doctor-patient confidentiality.119 "The practice of physician-assisted suicide is in principle unregulatable, insofar as it will occur in the privacy of the doctor-patient relationship."120 Because "private medical matters become affairs of government when the state sanctions them,"121 the state must invade the doctor-patient relationship for adequate regulation to occur.122 Proponents only presume that such regulation can occur without destroying the sanctity of that relationship.123 Yet, any hope of regulating an act that occurs within a private and protected relationship, which also results in the death of the only witness, is unfounded, if not irrational.124

Given the inherently subjective and illusory nature of each proposed safeguard, the prospects for adequate regulation are dim. Each safeguard—voluntariness, consent, competency, and terminal illness—contains inherent flaws which simply do not reflect the grave and unique nature of the act of physician-assisted suicide. Given the extraordinary lengths to which our legal system goes to protect the lives of convicted criminals, shouldn’t the same standards apply to the innocent? Authorities maintain that any regulation of physician-assisted suicide will fail to hold the line and will fail to protect the innocent.125 The question really is not whether adequate safeguards can be established to prevent abuse, but whether the right to physician-assisted suicide can be regulated at all.

120. Id.
122. See Callahan & White, supra note 32, at 8-10.
123. See Strasser, supra note 96, at 609.
124. "Precisely the principle that allows doctors and patients to reach private agreements—doctor-patient confidentiality—no less assures them that [physician-assisted suicide] decisions can continue to be effectively hidden." See Callahan & White, supra note 32, at 9.
125. See generally Hendin, Seduced by Death, supra note 47; Kamisar, Against Assisted Suicide, supra note 19; see also Lee v. Oregon, 891 F. Supp. at 1438 (holding that Death With Dignity Act fails to protect against abuse). But see Compassion in Dying v. Washington, 850 F. Supp. 1454, 1465 (W.D. Wash. 1994) ("The court has no doubt that the legislature can devise regulations which will define the appropriate boundaries of physician-assisted suicide").
V. The Very Real Threat of Doctrinal Slippage

Proponents promise that any line drawn by state legislatures will be tested over and over. As noted at oral argument, "[O]ne can see a lawyer criticizing any line that the legislature would come up with . . . .
Any line would be subject to meaningful scrutiny." Thus, the fallacy of meaningful regulation will create more questions than answers, more opportunities to expand the right beyond the terminally ill, and forge the way for euthanasia.

Indeed, if the right to physician-assisted suicide is to be constitu-

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

Id. at 749-50.

127. The Court rightly anticipates continued judicial intervention, possibly as extensive as that following desegregation, in determining which regulations are permissible and which are not. The Court continued:

But surely that's what the next couple of generations are going to have to deal with, what regulations are permissible . . . [if the right is upheld] . . . . [Y]ou're going to have [ ] factions fighting it out in every session of the legislature, how far can we go in regulating this. And that will be a Constitutional decision in every case . . . . [T]here is no doubt that it would result if we upheld [physician-assisted suicide], it would result in a flow of cases through [the Court system] for heaven knows how long.

Oral Argument in Glucksberg, supra note 1, at 38-39. The Court is no doubt aware of the myriad cases that have followed the Brown v. Bd. of Education, 347 U.S. 483 (1954), decision. Courts have had to decide nearly every aspect of public education policy. See Jerald J. Director, Annotation, Federal Court Regulation of School Construction or Facility so as to Avoid School Segregation, 4 A.L.R. Fed. 979 (1970) (citing cases requiring courts to intervene in such activities as additions to school buildings, participation in athletic activities and school bands, architect's fees for school construction, bus routes, selection of sites for proposed schools, cafeterias, the right to participate in school clubs, faculty selection, selection of a name for a new school, quality of busses, libraries, use of school meeting rooms, overcrowding, discrimination in Parent-Teacher Association, access to school plays and theatrical activities, field trips, reading rooms, repairs of school buildings, and traffic conditions).

Extensive regulation of desegregation is beyond reproach, indeed it is necessary to effectuate a constitutional mandate. See Tribe, supra note 74, at 1477-78. Challenges to the regulation of a right as dubious as physician-assisted suicide, however necessary, have no laudable purpose. Rather, proponents of physician-assisted suicide promise protracted challenges to state regulation in order to extend the right to suicide beyond the terminally ill, and eventually to euthanasia. Indeed, "[a]dvocates . . . see [legalization of assisted suicide] as a first step, more likely to be accepted than euthanasia," their ultimate goal. Hendin, Sueded by Death, supra note 47, at 124. See also Lee v. Oregon, 891 F. Supp. 1249, 1432 & n.3 (D. Or. 1995) (supporters candidly admit that Oregon Death With Dignity Act candidly is first step to extending right to "others who consent"); Peter M. McGough, M.D., Medical Concerns About Physician-Assisted Suicide, 18 Seattle L. Rev. 521, 529 (1995). They may succeed.
tionally recognized at all, the Equal Protection clause demands that the right be expanded. The basic argument will go something like this: The Equal Protection Clause requires that similarly situated persons be treated alike. Legislation that distinguishes between similarly situated persons must be rationally related to a legitimate state interest to be upheld under Equal Protection scrutiny. The Constitution recognizes the right of patients, both competent and incompetent, to refuse medical treatment. After a decision in Quill and Glucksberg, the Constitution will also recognize the affirmative right of a mentally competent, terminally ill patient to commit physician-assisted suicide, presumably because no nonarbitrary difference exists between those patients and people on life support.

Proponents will then argue that no nonarbitrary difference exists between those two groups and myriad other groups that can justify limiting the right only to the competent terminally ill. Under rational basis review, the states will be required to offer meaningful differences between the competent, terminally ill and the challengers that promotes the state’s interests in protecting one, but not the other. Unless they do, the nation will surely witness the “slow gravitation out of physician-assisted suicide into euthanasia.” Sadly, the states stand little chance of finding such distinctions.

128. The Harvard model statute already extends the right beyond the terminally ill to any patient suffering from “intractable and unbearable suffering.” Baron, supra note 100, at 11. Extending the right to persons in chronic pain seems intuitively more logical than permitting suicide only by the terminally ill, because a person suffering from a chronic (but not terminal) illness will suffer more pain in the long run than a person with six months to live. “[T]he patient who has ten years of agony to look forward to has a more appealing case than the patient who is at the threshold of death.” Oral Argument in Glucksberg, supra note 1, at 27. As recommended and as logic would dictate, unbearable pain and suffering is a wholly subjective, and therefore, an unregulatable criterion for determining whether to allow a person to commit physician-assisted suicide. See Baron, supra note 100, at 11 (no objective standard should be imposed for unbearable suffering).

132. The court in Quill v. Vacco held that:
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.

133. See supra note 128.
134. Oral Argument in Glucksberg, supra note 1, at 7.
135. The Quill court continued:
[W]hat interest can the state possibly have in requiring the prolongation of a life that is all but ended? Surely, the state’s interest lessens as the potential for life...
Extending the right to physician-assisted suicide beyond the terminally ill follows necessarily from a decision recognizing the right in the first instance. Indeed, "the next case will argue . . . that [the right] should be extended . . . to the chronically ill,"136 among others. Proponents will use the Equal Protection argument outlined above to force the states to recognize the right of every mentally competent, chronically ill patient to commit physician-assisted suicide.

To prevent that, states will have to find meaningful differences between the terminally ill and chronically ill. Life expectancy is one possible difference. The ability of that line of demarcation to stand is, however, tenuous at best because, as discussed above, these determinations are little more than guesswork.137 Not only is such a distinction inaccurate, it is dangerous because "if proximity to death is the variable that governs when the [state's] interest in protecting life diminishes, then advanced age alone should warrant assisted suicide."138 The state cannot have much interest in a life whose quality is so diminished, as "[c]hronic, painful, and serious[ ] but not life-threatening conditions may impose burdens on the individual, the caregiver, or the State significantly greater than any which accompany terminal conditions."139 Hence, a state will be hard pressed to respond to the question of "what business is it of the state to require" a patient to live in "agony?"140 After all, a person in chronic pain is equally, if not more deserving of a right to suicide than the terminally ill patient since he will endure his agony longer. The states will be unable to answer the question after Glucksberg and Quill.

A subsequent case will argue that people suffering emotional pain deserve suicide no less than the terminally ill and chronically ill. Distinguishing between physical and mental pain is no less arbitrary that distinguishing between the pain of the terminally ill and chronically ill.141

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136. Oral argument in Glucksberg, supra note 1, at 8.
137. See supra notes 118-19 and accompanying text.
139. Id. at 13; see also note 128.
140. Quill v. Vaco, 80 F.3d at 730.
141. See Oral Argument in Glucksberg, supra note 1, at 32-35.
What right does a state have to require its citizens to endure unbearable emotional suffering, when it allows patients in unbearable physical suffering to end their pain with suicide? "What concern prompts the state to interfere with a . . . patient’s “right to define [his] own concept of existence, of meaning, of the universe, and of the mystery of human life?” If the Netherlands are any example, chronically depressed patients will win the right to suicide.

Proponents will also inevitably challenge as arbitrary state laws that require patients to self-administer the lethal dose. After all, what nonarbitrary difference exists between patients who can and cannot self-administer? This distinction is even more tenuous than the one between the withdrawal of life support and physician-assisted suicide. In fact, “it may be difficult to make a principled distinction between physician-assisted suicide and the provision to terminally ill patients of other forms of life-ending medical assistance, such as the administration of drugs by a physician.”

Although the Compassion in Dying court expressly limited its holding to “the critical line between voluntary and involuntary termination of an individual’s life,” it correctly noted that, under state law, the “decision of a duly appointed surrogate decision maker is for all legal purposes the decision of the patient himself.” If the general rule is that patients are entitled to execute advance directives listing their treatment choices, or alternatively, are entitled to delegate their treatment decisions to a surrogate, what justification can a state have for prohibiting a

142. Quill, 80 F.3d at 730 (quoting Planned Parenthood v. Casey, 505 U.S. 833, 851 (1992)).
143. See Hendin, Seduced by Death, supra note 47, at 145-153 (discussing the case of Netty Boomsma, a bereaved mother whose suicide was assisted by a doctor who determined that her chronic depression warranted such intervention).
144. See Kamisar, The “Right to Die,” supra note 135, at 486 n.27. Kamisar argues that the real counterpart to withdrawal of life support is not physician-assisted suicide, but voluntary euthanasia, because in both instances, the physician performs the act that ends the patient’s life.
146. Id. at 832.
147. Id. at n.120. See N.Y. Pub. Health Law § 2980-2994 (McKinney 1995 & Supp. 1997). Section 2981 provides in part that “[e]very adult shall be presumed competent to appoint a health care agent . . . .” Section 2982 provides in part that “[a]n agent shall have the authority to make any and all health care decisions on the principal’s behalf that the principal could make.” That section also lays out decision making standards for the agent:

[T]he agent shall make health care decisions: (a) in accordance with the principal’s wishes, including the principal’s religious and moral beliefs; or (b) if the principal’s wishes are not reasonably known and cannot with reasonable diligence be ascertained, in accordance with the principal’s best interests; provided, however, that if the principal’s wishes regarding [life sustaining treatment] are not reasonably known and cannot with reasonable diligence be ascertained, the agent shall not have the authority to make decisions regarding these measures.
patient from listing euthanasia as a permissible treatment or prohibiting a surrogate from making that decision?

For example, New York’s health care proxy law specifically prohibits a health care agent from making such a decision.\textsuperscript{148} However, the statute states that it only prohibits an agent from consenting to "any act or omission to which the principal could not consent under the law."\textsuperscript{149} Clearly, if a patient may himself legally request assisted suicide or voluntary euthanasia, so can his surrogate. America will have legalized euthanasia.

VI. CONCLUSION

Proponents of physician-assisted suicide usually dismiss opponents’ slippery slope arguments with claims that the slippery slope is no more than “Chicken Little” rhetoric.\textsuperscript{150} They claim that fears of state sanctioned euthanasia are unfounded.\textsuperscript{151} They are either deliriously optimistic\textsuperscript{152} or disingenuous.\textsuperscript{153} The proverbial writing is already on the wall. As C. Everett Koop warns:

This author does believe in the slippery slope, as must any student of German history from World War I through the Holocaust. . . . No competent individual would be safe from lethal injection if this theory is carried to its logical conclusion in the future climate of America[n] health care with an aging population, spiraling costs, and an unwary public.\textsuperscript{154}

\textsuperscript{148} Section 2989 provides, in part: “This article is not intended to permit or promote suicide, assisted suicide, or euthanasia.”

\textsuperscript{149} Id.

\textsuperscript{150} “[T]he opponents of assisted-suicide conjure up a parade of horribles and insist that the only way to halt the downward spiral is to stop it before it starts.” Compassion in Dying v. Washington, 79 F.3d at 830.

\textsuperscript{151} “There is no reason to believe that legalizing assisted suicide will lead to the horrific consequences its opponents suggest.” Id. at 831.

\textsuperscript{152} See id. at 833 (noting that “[w]hile there is always room for error in any human endeavor, we believe that sufficient protections can and will be developed by the various states.”).

\textsuperscript{153} See supra notes 49, 128 and accompanying text.

\textsuperscript{154} Koop, supra note 71, at 4. Koop’s reference to the Holocaust is by no means an unwarranted comparison. Jewish groups have reminded the Court that they represent: “a people whose numbers were decimated little more than half-a-century ago by a society that ‘progressed’ from its ‘enlightened’ practices of ‘mercy killing’ to the mass slaughter of millions of human beings deemed physically or racially ‘inferior’. . . .” Brief of Agudath Israel of America as Amicus Curiae in Support of the Petition at 3, Washington v. Glucksberg, 79 F.3d 790 (9th Cir.), cert. granted sub nom. Compassion in Dying v. Washington, 117 S. Ct. 37 (1996) (No. 96-110) and Vacco v. Quill, 80 F.3d 716 (2d Cir.), cert. granted, 117 S. Ct. 36 (1996) (No. 95-1858).

We have witnessed too much history to disregard how easily a society may devalue the lives of the ‘unproductive.’ The ‘‘angel of mercy’ can become the fanatic, bringing the ‘comfort’ of death to some who do not clearly want it, then to others who ‘would be better off dead,’ and finally, to classes of ‘undesirable persons,’ . . . . In the current environment, it may well prove convenient—and all too easy—to
There can be little doubt that "[t]he risks of killing people who shouldn't be killed are great."\textsuperscript{155} Thus, there is both a legal and moral imperative to avoid the risk of needless death a regime of legal suicide and a system of discriminatory healthcare delivery creates. The Court should be at pains to avoid a decision which may be "fraught with serious consequences for the nation."\textsuperscript{156} The risks simply outweigh any benefit that legalized suicide might achieve.\textsuperscript{157} Americans need equitable access to healthcare, not the right to suicide. Yet, "[i]t is one of the great paradoxes of contemporary America that... we... would rather give patients the 'right to die' than medical care to help them live."\textsuperscript{158} Calls for suicide are symptoms of a failing system, not solutions.

\textbf{Stephanie Graboyes-Russo}