HOT TOPIC: The Constitutionality of Statutes Prohibiting and Permitting Physician-Assisted Suicide

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HOT TOPIC

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I. INTRODUCTION

Whether the act of suicide is morally justifiable has long been the subject of debate. Over many centuries, the positions on the issue have ranged from absolute condemnation\(^1\) to absolute approval.\(^2\) Where a particular society's attitude toward suicide falls upon a continuum, and more importantly, how its laws treat the act of suicide, appear to depend, at least in part, on how that society conceives of death. Suicide is a very different act for one who believes in the existence of an afterlife, than

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1. In response to the argument that suicide is a morally valid act if committed to avoid sin, St. Augustine wrote: "To say this would be monstrous; it follows that suicide is monstrous. If there could be a valid reason for suicide one could not find one more valid than this; and since this is not valid, a valid reason does not exist." St. Augustine, The City of God 38-39 (David Knowles ed. & Henry Bettenson trans., Pelican Books 1972).

2. See GEORGE HOWE COLT, THE ENIGMA OF SUICIDE 171-182 (1991). Many of the eighteenth-century rationalists espoused views of this nature. In his essay, On Suicide, David Hume, the predominant member among them, refuted arguments that suicide was a crime against nature, against the state, and against God. Id. at 173-75.
for one who believes only in the existence of this world. Yet, even among those who believe in life after death, much disagreement exists regarding the moral justifiability of suicide.

In ancient Egypt, for example, where one's earthly existence was thought to be a mere precursor to the afterworld, suicide was considered neither tragic nor shameful. Similarly, early Christians viewed suicide through martyrdom as a means of ensuring their place in the kingdom of heaven. If avoiding sin was the only way to arrive in paradise, then self-sacrifice in the name of God seemed a practical and sensible step towards that goal, especially when the temptations on earth for sinning were greater than many could bear. Interestingly, the present-day Catholic prohibition against suicide was not part of original Christian doctrine, and cannot be found in either the Old or New Testament. Rather, scholars can trace it back to the writings of fourth and fifth-century authors, such as St. Augustine, who wrote in response to the large numbers of Christians who killed themselves in the name of God. St. Augustine explained the Catholic Church's designation of sainthood for certain people who took their own lives by proposing that God most likely instructed those people to kill themselves. While obedience to God is never a sin, suicide without express divine authority is a detestable and damnable one.

Although the present-day prohibition against suicide may have its roots in religious doctrine, the debate regarding the moral justifiability of suicide extends well beyond the realm of theology. For example, there are utilitarian arguments suggesting that suicide is morally superior to life in certain circumstances. Some societies have approved, and even encouraged, the act of suicide by individuals who constituted a burden on that society. Conversely, utilitarian arguments discouraging suicide include the idea that every suicide results in a loss of that individual's contribution to society, an injury to the individual's family and friends, and a promotion of lawlessness.

3. See id. at 130.
4. See id. at 154, 156-57.
5. See id. at 154.
7. See id. at 36-38.
8. See id. at 37.
9. See id. at 36.
11. See BATTIN, supra note 10, at 76-106. For a thorough exposition and critique of these arguments, see id. at 106-11.
In the United States today, suicide is less a topic of discussion for moralists and theologians than it is for the medical community. The central issue of debate is not so much whether the desire to kill oneself is morally wrong, but whether it is always a symptom of mental illness.12

This shifting of the problem of suicide from the realm of religion to medicine has produced a change in its treatment by legislatures. Puritans in seventeenth and early eighteenth-century England and America believed that depression or other mental illnesses should not be considered a defense to the crime of suicide, and that such mental conditions were merely an indication of diabolical temptation.13 Early in U.S. history, in accordance with the common law tradition inherited from England, the suicide victim was denied a Christian burial and his bodily remains were mutilated.14 Gradually, mental illness became recognized first as a legitimate defense for the crime of suicide, and eventually as its leading cause.15 Because people who commit suicide are now viewed as victims of mental illness rather than criminals, today, there are no laws against suicide in any state in the United States.16

Laws do exist in a majority of states, however, that explicitly make assisted suicide a crime.17 In those states that do not explicitly criminalize assisted suicide, such conduct may, nonetheless, be prohibited by murder or manslaughter statutes.18

Oregon is a notable exception. In November 1994, its legislature enacted a law that decriminalizes assisted suicide under certain conditions. The Oregon Death With Dignity Act creates a right for mentally competent, terminally ill patients to request physician-assisted suicide, and contains a number of safeguards designed to protect against coercion.19

Both types of statutes—the one in Oregon that permits assisted suicide and the many that prohibit it—encountered constitutional challenges. A federal district court enjoined the Oregon statute from enforcement, and declared it unconstitutional.20 In addition, two chal-

12. See id. at 131-53.
15. See Kushner, supra note 13, at 27-34.
18. See id. at 776-77.
Challenges to the constitutionality of statutes prohibiting assisted suicide have succeeded at the appellate level. The Ninth Circuit for the U.S. Court of Appeals, after granting a petition to rehear the case en banc, recently found a Washington law prohibiting assisted suicide violative of substantive due process.\textsuperscript{21} Similarly, the Second Circuit for the U.S. Court of Appeals, while choosing not to identify a new substantive due process right, held New York laws criminalizing physician-assisted suicide unconstitutional on equal protection grounds.\textsuperscript{22} Currently, both cases are pending before the U.S. Supreme Court.\textsuperscript{23}

In either type of case, the legal issue is inextricably linked to one medical, ethical, and philosophical question: Is it truly possible for a mentally competent individual ever to choose to commit suicide? The existence of a right to assisted suicide, whether a constitutional or a state-created right, must be predicated upon a belief that suicide can be a rational act. If it is rational, the legislature might still prohibit the act as immoral. But if suicide is always irrational, then it would seem extremely improbable that a court might identify the act as a right.

II. The Necessary Predicate for a Right: Can There Be a Rational Basis for Suicide?

Some philosophers argue that a desire to commit suicide is never rational, and is always the product of depression or other mental illness.\textsuperscript{24} Such a view, however, fails to take into account the various situations that may arise in which a mentally competent person may wish to enlist the aid of a physician in ending her own life.

The following hypotheticals suggest rational suicides: 1) A father has a son who will die unless he gets a heart transplant. Time is of the essence, and no compatible hearts are available. The father decides to sacrifice himself by donating his heart to his son.

2) A killer, faced with a life sentence, elects to die painlessly by lethal injection.

3) A patient with a chronic illness wishes to end her life, not because of

\textsuperscript{21} See Compassion in Dying v. Washington, 79 F.3d 790 (9th Cir. 1996).

\textsuperscript{22} See Quill v. Vacco, 80 F.3d 716 (2d Cir. 1996).


\textsuperscript{24} See John Donnelly, Suicide: Some Epistemological Considerations, in Analysis and Metaphysics 283 (Keith Lehrer et al eds., 1975). A similar view is shared by Dr. Carol Gill, whose affidavit was submitted by plaintiffs in Lee v. Oregon, 869 F. Supp. 1491, 1498 (D. Or. 1994) (opinion granting preliminary injunction). Gill claims that up to ninety-five percent of the people wishing to commit suicide suffer from mental illnesses or emotional disorders. See id. at 1498. n.2.
physical pain or suffering, but because of the financial burden her costly treatment places upon her family.

4) A terminally ill patient suffering from an extremely painful disease decides to end her life in order to escape the pain.

In his article, *Suicide: Some Epistemological Considerations*, John Donnelly argues against the existence of rational suicide. Donnelly considers an individual's religious beliefs, as well as the many possible reasons for wanting to end one's own life, in determining the rationality of the decision to do so. For purposes of analysis of the hypotheticals above, however, we are not concerned with people whose religious beliefs dictate that they will be eternally damned if they commit suicide. Such a person probably would not be able to do so rationally if she sincerely believed the result would be eternal damnation.

In the case of the first hypothetical, Donnelly would argue that regardless of the father's belief in an afterworld, his decision to sacrifice himself for his daughter is irrational because the guilt his daughter would experience outweighs the benefit of a prolonged life. Such a view is speculative, at best. Certainly, the father is in a better position than the government to determine whether his act will result in his daughter feeling guilty. Moreover, even if one can somehow balance the daughter's guilt feelings and the loss of her father against the daughter's prolonged life, an action based upon poor judgment may, nonetheless, be perfectly rational.

In the case of the serial killer, Donnelly would argue that, if he were committing suicide because he believed he would be better off dead than incarcerated for a lifetime, the decision would be irrational because, under a materialistic view of death, a cadaver is incapable of experiencing psychological states. In other words, Donnelly believes that one can only rationally choose a particular state of existence over another. For one who does not believe in an afterlife, death is non-existence, and cannot rationally be chosen. If the killer believes in an afterlife but not hell, the decision is likewise irrational because of the metaphysical difficulties in the notion of disembodied existence and individuation.

Donnelly's arguments against the existence of rational suicide are easily dismissed. First, a cadaver's inability to experience psychological states does not render a person's decision to choose oblivion over pro-

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25. See Donnelly, supra note 24.
26. See id. at 286-89.
27. See id. at 294, 296.
28. See id. at 290-92.
29. See id.
30. See id. at 293.
longed confinement irrational. It is not irrational to choose non-existence over an extremely unpleasant existence. Second, the mystery that surrounds the possibility of existence after death does not preclude a rational decision to terminate life. Choosing an unknown alternative, in certain circumstances, may be entirely reasonable.\textsuperscript{31}

If, on the other hand, the killer is motivated to end his own life by a sense of altruism, namely that he wishes no longer to have society subjected to his evil deeds, then Donnelly suggests that his act, though rational, is not suicide, but an act of heroism.\textsuperscript{32} This view is more of a semantic game than an argument. Actions that are profoundly moral are probably more likely to be rational than irrational. Moreover, the morality and the rationality of an act are two different issues. Murder, for example, may be calculated, rational, and entirely immoral. Thus, although a rational basis for deciding to end one's life is a necessary foundation for a hypothesized right to die, an act's rationality, by itself, does not render it a right.

The four previously mentioned hypotheticals are all examples of rational decisions to end one’s life. If the United States Supreme Court declared that a constitutionally protected right to physician-assisted suicide extended to all mentally competent adults, irrespective of a state’s interest in preserving life, the father would be free to sacrifice his life to save his daughter, the serial killer could choose a death sentence, the patient with a chronic illness requiring costly treatment could commit suicide for economic reasons, and the suffering patient could end her pain. Important policy reasons exist, however, for limiting the right to die, and perhaps denying it in each of the hypotheticals. Before examining the policy implications for a hypothesized right to die, however, we must consider the various possibilities for the legal treatment of assisted suicide.

\textbf{III. The Possibilities for the Legal Treatment of Physician-Assisted Suicide}

Five possible ways of treating the issue of assisted suicide are possible.\textsuperscript{33} First, the Court could find that implicit in the Constitution is a fundamental, unqualified right to die, as long as the person is mentally

\textsuperscript{31} For a more complete discussion of the rationality of suicide, and the issue of “calculative rationality” and suicide, see Fred Feldman, Confrontations with the Reaper, 217-223 (1992).

\textsuperscript{32} See Donnelly, supra note 24, at 294-95.

\textsuperscript{33} It is certainly possible to imagine many more than five possible rulings by the United States Supreme Court, including variations on the scope of a fundamental right, if identified, and limits upon to whom such right may extend. For purposes of analytical and organizational clarity, however, I have outlined five basic types of outcomes.
competent. Laws prohibiting assisted suicide would be constitutional only as applied to those who used undue influence to manipulate another into committing suicide.

Second, the Court could conclude that the Constitution contains a fundamental right to die only in very specific circumstances. Most likely, the right would extend only to the terminally ill who suffer from uncontrorollable pain. Legislation prohibiting assisted suicide would violate the Constitution only as applied to those whose situations match specific criteria.

Third, the Court could declare that while the right to die is not a fundamental constitutional right, existing laws that prohibit assisted suicide violate the right to equal protection. Depending upon the particular class of people deemed to have been denied equal protection, the state legislatures could respond either by creating an expansive right to die, or by prohibiting assisted suicide and/or suicide in any form, for everyone.

Fourth, the Court could maintain that laws prohibiting assisted suicide are constitutional, that there is no fundamental, constitutional right to die implicit in the Constitution, but that states are free to create such a right. Under this reading of the Constitution, both statutes permitting and those prohibiting assisted suicide would be constitutional.

Finally, the Court could find a right to life implicit in the Constitution, and strike down any statute permitting suicide or physician-assisted suicide. If the Court held that a right to assisted suicide impinged upon a right to life irrespective of any procedural safeguards the legislature could attach to such a right, this would effectively outlaw assisted suicide throughout the country. Alternatively, the Court might hold that in order to survive constitutional scrutiny, a statute creating a right to assisted suicide must contain certain procedural safeguards. Such a holding might leave room for a state-created right to assisted suicide, although more limited than the one delineated in the Oregon statute.

IV. THE COMPETING RIGHTS

A. The Right to Physician-Assisted Suicide

1. COMPETING POLICY CONSIDERATIONS THAT ARISE IN RECOGNITION OF A RIGHT TO PHYSICIAN-ASSISTED SUICIDE

The policy interests served by a limited right to physician-assisted suicide generally tend to outweigh those that support an absolute ban on the act. The scale tips in favor of a right to die, however, only when it is limited. How to limit the right is a difficult and complex problem. Thus, the problem of legalizing physician-assisted suicide in light of the policy concerns involved becomes not only a question of whether the
legislature should legalize the act, but a question of how the legislature could regulate it so as to maximize the goals of legalization and minimize its potentially negative effects.

There are at least four major policy considerations in support of the recognition of a right to physician-assisted suicide, whether constitutionally protected or state-created. The first, and arguably most important, is the interest in ending needless pain and suffering for those with diseases that offer no chance of recovery. If the elimination of extreme pain is the principal objective of physician-assisted suicide, however, extending the right only to the terminally ill appears unsatisfactory. In some cases, such an interest would be served by extending the right beyond the terminally ill to those with chronic, excruciatingly painful, non-fatal, but incurable, diseases.\textsuperscript{34} Conversely, an extension of the right may not be desirable for those with terminal but relatively painless illnesses. Perhaps if doctors developed a means of eliminating or significantly reducing pain without impairing a patient's quality of life, most patients' desire to die would disappear. Nonetheless, in the absence of such a drug or technique, the elimination of extreme pain is an interest that would be well served by a right to physician-assisted suicide.

Second, the act of suicide is more precise and humane when assisted by a physician. Some of those who attempt suicide on their own inevitably fail, often seriously injuring themselves and rendering their quality of life inferior to what it was before. Even more problematic are those who wish to commit suicide, but are physically unable to do so. Many feel compelled to ask relatives or friends to assist them in dying. Such people are most likely ill-equipped to honor the suicide's wishes, both technically and psychologically. Moreover, if they comply, they may be convicted of manslaughter in most states, even though the act they committed was arguably less morally culpable than those acts normally categorized as manslaughter.

Third, society has an interest in distributing scarce and costly medical resources to people who want to live and have a reasonable chance of recovering from illness. While, ideally, one should never have to balance human life against economic interests, only in an imaginary society will resources be unlimited. Thus, in spite of the lack of consensus in the medical community regarding what is "appropriate treatment,"\textsuperscript{35} doctors must decide whether it is worthwhile to use extremely expensive, high-tech medical procedures for patients whose chances of

\textsuperscript{34} Such illnesses are not mere conjecture. One example is \textit{tic doloreaux}, an extremely painful condition of the trigeminal nerve which, while not fatal, is frequently untreatable. \textit{See Tom L. Beauchamp & James F. Childress, Principles of Biomedical Ethics} 96 (2nd ed. 1983).

\textsuperscript{35} \textit{Derek Humphry & Ann Wickett, The Right to Die} 208 (1986).
recovery are minimal. A right to physician-assisted suicide, especially if extended to the terminally ill, would provide another option for those who would needlessly consume precious resources in a futile attempt at recovery. The preservation of these resources, in turn, would allow their distribution to people who may truly benefit from them.

Finally, a person suffering from a disease that requires costly treatment may have a legitimate interest in preserving her resources and those of her family. Given the inaccessibility of high-tech treatment for the average person, patients may be put in the position of choosing between a chance for life and the prevention of their family’s impending bankruptcy. Depending upon the person’s chances for a cure and the cost of treatment, the preservation of the family’s financial resources may be a legitimate concern. If the concern is legitimate, the need for a right to assisted suicide becomes compelling when the person suffers from a disease that is especially painful. Although, in the absence of a right to assisted suicide, the patient may still refuse the costly treatment and await a “natural” death, forcing a patient with a painful disease to choose this route seems cruel; the patient has no hope for recovery and may have to wait in extreme pain for months before natural death arrives.

Just as the elimination of pain is only a relevant concern when the right to assisted suicide is extended to those who suffer from painful, incurable diseases, some of the policy concerns for opposing the recognition of a right to physician-assisted suicide tend to disappear when the right is extended only to a group such as the terminally ill, or is couched in procedural safeguards. The first concern is that a right to physician-assisted suicide may facilitate murder under the guise of suicide. Physicians, and other people who would profit financially from a person’s death, could conspire to murder the person, asserting the statute as an affirmative defense to any action brought against them. Such a possibility is practically non-existent if the state requires multiple manifestations of the person’s consent in the presence of witnesses, along with certification by two or more physicians that the person is terminally ill.

A second argument for opposing the legalization of physician-assisted suicide is that it is contrary to the very purpose of the medical profession to cast doctors in the role of killers, even at their patient’s request. The Hippocratic Oath, that all medical doctors promise to uphold, contains such a prohibition, as the physician vows to “never do harm to anyone” or “prescribe a deadly drug” to anyone if asked for it.  

While protecting and preserving human life may be the primary

purpose of the medical profession, doctors must balance such a goal against countervailing considerations. An equally important principle for doctors is respecting patient autonomy. The legal doctrine of informed consent, which emerged from common law battery, has undoubtedly helped shape this principle. Currently, the importance of patient autonomy appears to outweigh the goal of preserving life only when a patient refuses treatment, while the reverse is true when the patient asks for a physician’s assistance in dying. If one discards the distinction between active and passive dying as legally and morally irrelevant, however, then such balancing needs reformulation. Also, considering that terminally ill patients are often given pain killers that both hasten their death and mitigate their suffering, one can see that current medical practice does not reflect a literal reading of the Hippocratic Oath. The elimination of suffering is an objective for doctors that may conflict with, and at times, outweigh the prolongation of life.

A third, more troubling concern is that a right to assisted suicide would put patients whose medical treatment consumes their family’s resources under undue pressure to elect to end their own lives. Herein lies the difficulty in ensuring that the decision to die remains truly voluntary. One could characterize a patient’s decision to relieve his family of an economic burden, for example, as a response to coercive economic pressures, rather than as a voluntary desire to die.

Notwithstanding the persuasiveness of such a characterization, whether a decision is voluntary depends upon how broadly one defines the word. A person’s decision to seek employment, for example, is most likely prompted, at least in part, by economic pressures or incentives, and yet few would find such a decision morally objectionable. Merely applying conclusory labels does not help us determine which motivations for committing a particular act are legitimate. Thus, characterizing a person’s decision to end her life for economic reasons as “involuntary” amounts to no more than a simple assertion that, as a matter of morality, financial motivations should not enter into a decision to commit suicide. Conversely, a decision motivated by economic concerns may be charac-

37. See Beauchamp & Childress, supra note 34, at 59-102.
39. See Beauchamp & Childress, supra note 34, at 66-70.
41. See id. at 202.
42. How much weight the medical community should give a literal reading of the Hippocratic Oath is debatable, especially considering that the teachings of Hippocrates are wholly inconsistent with the doctrine of informed consent. Hippocrates taught that the physician should conceal the patient’s condition from him. See Terrion, supra note 38, at 496.
terized as voluntary by analogizing it to a sale; the patient might relinquish her life for the preservation of her family’s resources, just as she might sell a house or car for the same reason.

Margaret Radin, in her article *Market-Inalienability*, discusses the legal and ethical problems in determining which goods or services should be bought and sold on the market. Radin takes the position that in an ideal world, certain things too closely connected with personhood, such as sexuality, children, and genetic material, should not be bought and sold on the market. The sale of such personal goods is harmful to the seller because it strips her of things that are essential to personhood, and makes fungible, and hence inferior, that which, if not commodified, would be unique and personal.

Radin, however, does not confine her discussion to the ideal. She recognizes that in a world plagued by poverty, racism and sexism, prohibiting the sale of those goods and services too closely connected with personhood may exacerbate, rather than ameliorate, the plight of the seller. Radin labels such a situation “the double bind.” Unless the seller is provided with the resources for which she is willing to exchange a particular aspect of her personhood, prohibiting its sale adds only insult to injury. Without an effective welfare system, for example, a legal prohibition on prostitution has at least two likely results. First, poor women who would otherwise become prostitutes forego essential goods and services or engage in labor that they consider more oppressive than selling sexual services. Second, poor women prostitute themselves illegally, in spite of the adverse conditions imposed by a black market.

For Radin, the existence of the double bind does not automatically result in the conclusion that the sale should be legal. Rather, Radin concludes that in determining whether the sale of a particular aspect of personhood should be prohibited, the legislature should weigh the harm to the sellers and society caused by commodification and its accompanying market rhetoric, against the deleterious effects of the double bind.

Comparing a legal prohibition on prostitution in the absence of an effective welfare system to a legal prohibition on physician-assisted sui-

44. See id. at 1905-06, 1910.
45. See id. at 1905-06.
46. See id. at 1915-17.
47. See id. at 1915, 1921-22.
48. Id. at 1915-17.
49. See id. at 1916-17, 1921-22.
50. See id. at 1925-28.
51. See id.
cide in the absence of an effective health care system yields fruitful results. Admittedly, the analogy is in some ways imperfect. Characterizing assisted suicide as a sale when the act is done for economic reasons may appear strained, especially given the conspicuous absence of a buyer. Yet, in more important ways, the situation is analogous. First, nothing could be more harmful to personhood than the alienation of life itself. Second, a poor patient who would otherwise want to live, but contemplates suicide because of the cost of medical treatment to her family is in a double bind. Assuming the patient is physically unable to take her own life, a legal prohibition on assisted suicide in the absence of an adequate health care system serves only to aggravate her dilemma; she can either watch helplessly as her family's scant resources are quickly consumed, refuse treatment and await her death, possibly in agonizing pain, or she can try to persuade another to commit the act despite its illegality, and the accompanying risk of potentially long-term imprisonment. Just as conditions for prostitutes are worsened in a black market, a patient seeking to commit assisted suicide despite its illegality confronts numerous difficulties. Given the high risks involved in committing a felony, the chances are slim that the person who agrees to help the patient will be a neutral, disinterested party, such as a physician. Instead, the patient is more likely to seek and obtain the help of family members who may be unable to end her life in a humane, painless fashion. Even more disturbing and undesirable is the likelihood that those who assist the patient in taking her life are the ones whose resources are being consumed, and who are exerting pressure, whether consciously or unconsciously, upon the patient to die.\textsuperscript{52}

2. \textbf{IS THERE A FUNDAMENTAL CONSTITUTIONALLY PROTECTED RIGHT TO PHYSICIAN-ASSISTED SUICIDE?}

Arguments that support identifying a fundamental constitutionally protected right in physician-assisted suicide are both numerous and persuasive. Nonetheless, conceptual difficulties abound when one attempts to delineate the contours of this right. Given the extreme unlikelihood that a constitutional right to assisted suicide exists for all mentally competent adults, and the complexities involved in determining to whom

\textsuperscript{52} The question of how to amend our health care system so that people would not be forced to choose between assisted suicide and the depletion of their resources is, of course, an extremely complex problem. These complexities are further compounded by the emergence of expensive, new technologies and the lack of consensus in the medical community regarding what is appropriate treatment, especially for the terminally ill. For a discussion on the impact that the costs of health care have on the quality of care for the terminally ill, see Humphry, supra note 35, at 204-17.
such a right should extend, any attempt by the Court to identify such a
liberty interest would most likely resemble judicial legislation.

There are at least two possible avenues through which a fundamen-
tal right to assisted suicide may be found implicitly in the Constitution.
The first is a substantive due process right in personal autonomy or pri-
vacy. The second is a logical extension of the substantive due process
right to refuse medical treatment as discussed in *Cruzan v. Director,
Missouri Department of Health.*

When supporting a substantive due process right, one can argue
that the right to assisted suicide is part of a broader liberty interest and
right to privacy. In this context, this right is analogous to the right to
abortion, as well as other rights involving personal choices. The district
court in *Compassion in Dying v. Washington,* in finding a right to die
implicit in the Due Process Clause, quoted the following from *Planned
Parenthood v. Casey:*

> [T]hese 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 attrib-
> utes of personhood were they formed under compulsion of the
> State.

The Ninth Circuit, in affirming the district court's opinion and
identifying a substantive due process liberty interest, also defined the
interest broadly as a right to determine the time and manner of one's
death, as opposed to a right to receive aid in killing oneself. The Ninth
Circuit concluded that a decision of a terminally ill person to end his
own life is so intimate and personal, that the power to choose or refuse
such an option should be removed from the hands of the government,
and placed in the hands of the people.

Just as the due process liberty interests in right-to-die and abortion
cases bear similarities, the competing state interests also invite compari-
sion. Notably, the state's interests, both in abortion and right-to-die
cases, fluctuate in accordance with varying physical and medical cir-
cumstances. Even more importantly, however, one can cogently argue

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   F.3d 790 (9th Cir. 1996).
55. Id. at 1459.
56. Compassion in Dying v. Washington, 79 F.3d 790, 801 (9th Cir. 1996).
57. See id. at 839.
58. See id. at 800. The Ninth Circuit also found that the constitutional right to an abortion
that in instances where the right to die is extended only to the terminally ill, the state’s interest in abortion cases in preserving the life of the fetus at any stage is more compelling than the state’s interest in preserving the lives of those with no hope of recovery who wish to live no longer.

The second avenue through which one could find a right to assisted suicide implicit in the Constitution is in the logical extension of the constitutionally protected right to refuse medical treatment identified in *Cruzan v. Director, Missouri Department of Health.* 59 The Court first acknowledged that various lower state and federal courts had found support for the right, both as a corollary to the common law doctrine of informed consent and as a right to privacy. 60 The Court then stated that the right is a due process liberty interest that can be traced to prior U.S. Supreme Court decisions. 61 Such decisions included cases in which the Court held that a person has a liberty interest in refusing a smallpox vaccine; that prisoners have an interest in refusing unwanted antipsychotic drugs; and that children have a liberty interest in not being confined unnecessarily for medical treatment. 62

As the Court in *Cruzan* explained, however, identifying a liberty interest does not end the Court’s inquiry. 63 One must balance the individual’s interest against the state’s interest to determine whether the state has unconstitutionally impinged upon that right. Thus, in order to declare prohibitions on assisted suicide unconstitutional, one must maintain that the right to refuse treatment, even when such refusal results in death, would outweigh any compelling state interest in preserving life. 64

and a possible right to die were similar in that both liberty interests are not static, but fluctuate in strength as medical and physical circumstances change. Such reasoning is problematic, as the balancing process in determining whether a statute sufficiently impinges upon a liberty interests so as to be unconstitutional would be even more complicated were both the liberty interests and the state interests deemed to fluctuate. Furthermore, the argument that the state interest in preserving life weakens when one becomes terminally ill, while not invulnerable to criticism, is more conceptually sound than the argument that one has a stronger liberty interest in self-determination when one becomes terminally ill.

60. See id. at 270-75.
61. See id. at 278.
62. See id.
63. Id. at 279.
64. See Lee v. Oregon, 869 F. Supp. 1491, 1498 (D. Or. 1994) (granting an order for a preliminary injunction on December 27th, 1994). Judge Hogan misstates the limitation of the right outlined in *Cruzan*: “The Supreme Court held that a competent person has a liberty interest in refusing unwanted medical treatment, but stopped short of deciding that such a person had a constitutionally protected right when death was the likely result.” Id. The Court assumed the right exists for the sake of argument. Nonetheless, the hypothesized right exists even if the refusal of treatment will result in death. The unanswered question is whether the Supreme Court, in balancing the right against a State’s interest in preserving life, would find that the right prevailed. See *Cruzan*, 497 U.S. at 278.
Although *Cruzan* involved the right to die of an unconscious woman on life support systems, the issue before the Court was the constitutionality of a Missouri statute requiring a standard of clear and convincing evidence of a person's desire to be withdrawn from life support before that person's family could request such withdrawal.\(^{65}\) Thus, the Missouri statute acted as a procedural limitation on a constitutionally protected substantive right to refuse medical treatment. Although the cases that Chief Justice Rehnquist cites in identifying the right to refuse treatment involved situations in which such refusal would not necessarily result in death, the Court assumed, for the purposes of the case, that the right exists even when the person would certainly die without treatment.\(^{66}\) The issue left unresolved by the Court, however, was when such a right could be outweighed by a sufficiently compelling state interest.\(^{67}\)

The variability of a state's interest in preserving life is problematic. The case law fails to clarify if the state's interest diminishes as the quality of life decreases. *Cruzan* suggests that it does not,\(^{68}\) as the ruling required that the hospital keep Nancy Cruzan alive although she had virtually no chance of ever regaining consciousness.\(^{69}\) Some have suggested that the state interest diminishes as proximity to natural death increases.\(^{70}\) Proximity to death by itself, however, should not be enough

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66. *See id.* at 279. Chief Justice Rehnquist states:

> 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.*

67. *See id.* at 279. Chief Justice Rehnquist further asserts: "But determining that a person has a 'liberty interest' under the Due Process Clause does not end the inquiry; 'whether respondent's constitutional rights have been violated must be determined by balancing his liberty interests against the relevant state interests.'" *Id.* (quoting *Youngberg v. Romero*, 457 U.S. 307, 321 (1982)).

68. Chief Justice Rehnquist's reasoning in *Cruzan* regarding this point has faced criticism. Ronald Dworkin proposes that the state has absolutely no interest in preserving the life of a human being in an irreversibly insensate, vegetative state. Such a life, according to Dworkin, has no value to anyone. *See Ronald Dworkin, The Right to Death, in Modern Constitutional Theory: A Reader* 685-88 (John H. Garvey & T. Alexander Aleinikoff eds., 1994).

Although Dworkin's viewpoint suggests that the state's interest in preserving life fluctuates as a person's quality of life increases or decreases, perhaps the *Cruzan* dilemma is better conceptualized as a problem in defining where life ends. If brain death is the equivalent of death, and the ability for consciousness remains a necessary part of life, then one could argue that the state has an equal interest in protecting the lives of all those who are "alive." For a brief discussion on the problems in determining death, see Daniel Maguire, *The Freedom to Die, in Bioethics* 211-12 (Thomas A. Shannon ed., 1981).

70. *See Compassion in Dying v. Washington*, 79 F.3d 790, 837 (9th Cir. 1996); *see also In Re Quinlan*, 355 A.2d 647, 664 (N.J. 1976).
to weaken the state's interest in protecting life. Such an approach would suggest that the state has a lessened interest in protecting the lives of the elderly as compared to the rest of the population. Nonetheless, if the case can be made that a state's interest in preserving life fluctuates, one could argue persuasively that the interest is significantly weakened when those whom the law seeks to protect no longer wish to live.

Putting aside the issue of balancing the individual's liberty interest against the state's interest, constructing an argument for a constitutional right to assisted suicide requires consideration of whether the distinction between acts and omissions is meaningful in this context. To assert that a constitutionally protected right to assisted suicide is a logical extension of the right to refuse medical treatment, one must maintain that for constitutional purposes, there should be no difference between dying by refusing treatment and dying by drugs prescribed by a physician.

A strong case may be made for the proposition that the act/omission distinction should be discarded here. First, modern case law suggests that the right to refuse unwanted medical treatment is part of a broader right to be free from governmental interference in making fundamental personal decisions. The decision to end one's own life is no less personal or fundamental solely because of the means by which one chooses to die. "Patients request physician-assisted suicide for the same reasons that they refuse life-saving treatment: they want control over when and how they die." If the right to refuse medical treatment is based upon a right to personal autonomy and self-determination, it is only logical that such a right be extended to include a right to die by active, as well as by passive, means.

Moreover, distinguishing between acts and omissions often becomes a matter of semantics. A patient's decision to die by not eating or drinking may be characterized as actively starving or passively refusing food and water. Turning off a respirator may similarly be characterized as an act or an omission.

Next, the law in many instances imposes the same degree of liability for omissions, as for acts. Under the criminal law, for example, a parent who intentionally causes the death of his or her child by failing to seek medical treatment, or through suffocation, may be held liable for murder. Justice Scalia, who vehemently rejects the existence of a constitutional right to suicide, also rejects the active/passive distinction

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72. Id. at 2026.
73. See id. at 2028.
between refusing treatment and requesting aid in committing suicide.  

Scalia notes that at common law, the necessary element to the crime of suicide was not actively causing one’s death, but the conscious decision to put an end to one’s life, whether through active or passive means. Although Justice Scalia opposes the identification of a constitutionally-protected right to end one’s life either by active or by passive means, he recognizes that the focus should not be on how the individual chooses to die, but on the individual’s intent and desire to die.

Although the moral justifiability of an act does not render it a constitutionally-protected liberty interest, an act or an omission’s moral justifiability is relevant to the issue of whether it should or should not be legal. Again, the reasons for choosing to die, rather than the means by which one chooses to die, are essential in determining the moral justifiability of a decision to end one’s own life. One can imagine situations in which refusing medical treatment is less morally justifiable than requesting the aid of a physician in dying. One who refuses lifesaving treatment because he believes life is not worth living, for example, is arguably less morally justified in choosing to die than a patient with no chance of recovery who requests lethal drugs in order to avoid excruciating pain.

Finally, finding a distinction of constitutional significance between acts and omissions regarding a right to die makes little sense if one considers that many of the policy arguments opponents raise against physician-assisted suicide apply with equal force to a right to withdraw from life support systems. In both cases, patients may experience pressure to end their lives from family members bearing the economic burden of their treatment. Also, both the right to refuse medical treatment and the right to physician-assisted suicide could conceivably facilitate murder under the guise of suicide. Finally, the poor are more vulnerable than the wealthy to economic pressures to end their lives, whether they are able to do so by withdrawing from life support systems or by actively ingesting lethal dosages of barbiturates.

One could raise two legal arguments for distinguishing between the right to refuse medical treatment and the hypothesized right to assisted suicide. The first is that the right to refuse medical treatment has its origins in the Fourth and Fifth Amendments, which do not support a right to assisted suicide. More precisely, the right to refuse medical treatment is part of a more general right to be left alone, i.e., a right to be

74. See Cruzan v. Director, Mo. Dep’t of Health, 497 U.S. 261, 296-97 (Scalia, J., concurring).
75. See id.
76. See id. at 296-98.
free from physical intrusions from the government, and not be compelled by the government to do anything. Such an argument finds some support in the Court’s reasoning in *Cruzan*, and in Supreme Court cases allowing prisoners to refuse mind altering drugs.\textsuperscript{77} Moreover, evidence of the Court’s view toward assisted suicide can be found in *Cruzan*, as the opinion mentions laws against assisted suicide in support of the proposition that the state has a legitimate interest in protecting and preserving human life.\textsuperscript{78}

Although the right to refuse medical treatment may have its origins in the Fourth and Fifth Amendments’ right to privacy, the right to privacy has been held to encompass more than merely a right to be left alone. Cases such as *Planned Parenthood v. Casey*\textsuperscript{79} and *Eisenstadt v. Baird*\textsuperscript{80} establish that the right of privacy includes the right to make certain fundamental, personal decisions free from governmental interference.\textsuperscript{81} Thus, both a right to assisted suicide and the right to refuse unwanted medical treatment, can be viewed properly as protected privacy interests implicit in the Due Process clause of the Fourteenth Amendment.

The second problem in arguing that a right to assisted suicide is implicit in the Constitution is found in Justice Scalia’s concurring opinion in *Cruzan*, where he argues that substantive due process rights are implicit in the Constitution only if they have traditionally or historically been protected. Because both suicide and assisted suicide were prohibited early in U.S. history, one could argue that no protected liberty interest could possibly exist.

Justice Scalia’s position, nonetheless, does not foreclose the possibility of a right to physician-assisted suicide. First, there appears to be some dispute regarding the legal treatment of suicide under common law. In *Cruzan*, Justice Scalia, quoting from Blackstone, maintained that suicide was always considered a crime, even in cases where the victim was “hopelessly diseased.”\textsuperscript{82} Authority exists, however, for the proposition that even under English law, the taking of one’s own life under certain circumstances was non-culpable.\textsuperscript{83} The first exception to culpability occurred when the act was committed in an “abnormal emotional state.” While it is not clear whether an abnormal emotional state

\textsuperscript{77} Id. at 278.
\textsuperscript{78} Id. at 280.
\textsuperscript{81} See Planned Parenthood, 505 U.S. at 858; Eisenstadt, 405 U.S. at 453.
\textsuperscript{82} 497 U.S. at 294 (Scalia, J., concurring).
\textsuperscript{83} Keith Burgess-Jackson, *The Legal Status of Suicide in Early America: A Comparison With the English Experience*, 29 WAYNE L. REV. 57,75 (1983).
in this context is the equivalent of mental illness, such “an emotional state could be induced by extreme old age, a physical infirmity or disabi-
ability, or severe and prolonged pain.”

Thus, if suicide was not considered a crime at common law under certain circumstances, one cannot utilize the prohibition of suicide under the common law as evidence that the framers never intended to provide a fundamental constitutional right to die.

More importantly, however, even some of the more conservative justices on the Supreme Court do not accept Scalia’s methodology for finding substantive rights implicit in the Due Process Clause of the Fourteenth Amendment. In Cruzan, Chief Justice Rehnquist assumed arguendo that a right to refuse medical treatment exists, even when such refusal results in death, despite the common law tradition criminalizing the act of suicide both through active and passive means. The opinion of Justice O’Connor, in Michael H. v. Gerald D. explicitly rejects Scalia’s method of historical analysis when identifying liberty interests, asserting its inconsistency with the Court’s past decisions.

Even more persuasive, however, is Justice Brennan’s dissent in Michael H. v. Gerald D. Justice Scalia refused to find that a biological father had a constitutionally protected liberty interest in asserting his right to visit his child when the mother of the child was married to another man. Justice Scalia reached this decision because of the lack of historical traditions supporting such a right. In contrast, Justice Brennan noted that using tradition to find support, or the lack of support, for the existence of protected liberty interests is neither an effective nor objective means of limiting the meaning of “liberty” under the Due Process Clause. Justice Brennan explained that tradition “can be as malle-
able and as elusive as ‘liberty’ itself,” and that people cannot always agree as to which traditions are deeply rooted in our history, and which traditions are related to hypothesized liberty interests.

84. Id.
85. See Michael H. v. Gerald D., 491 U.S. 110, 132 (1989) (O’Connor, J., concurring) (noting that Justice Scalia “sketches a mode of historical analysis to be used when identifying liberty interests protected by the Due Process Clause of the Fourteenth Amendment that may be somewhat inconsistent with our past decisions in this area.”).
86. Cruzan, 497 U.S. at 279.
87. See id. at 296-97.
89. Id. at 132 (O’Connor, J., concurring).
90. Id. at 136-41.
91. Id. at 127.
92. See id.
93. See id. at 173 (Brennan, J., dissenting).
94. Id.
95. See id.
3. IF THERE IS A FUNDAMENTAL RIGHT TO PHYSICIAN-ASSISTED SUICIDE, TO WHOM DOES IT EXTEND?

The scope of an alleged fundamental right to assisted suicide depends on the different theories of its origin. If the right extends only to terminally ill patients, then it is best viewed as a broader right to self-determination or personal liberty, which then must be balanced against the state's interest in preserving life. More precisely, every mentally competent person possesses a fundamental liberty interest in self-determination; however, when an individual seeks to engage in self-determination by ending her life, this liberty interest outweighs the state's interest in preserving life only when she becomes terminally ill. Although logic suggests that a person's right to self-determination should remain constant from adulthood until death, the conception of a right to die emerging when one becomes terminally ill suggests that the state's interest in preserving life weakens as a person's proximity to death increases.

This view is unsatisfactory for the following reasons. If taken to an extreme, this proposition would support the position that the state has a more compelling interest in protecting the lives of the young than the lives of the elderly. Although one could argue that the state's interest in protecting life weakens only when a person becomes seriously ill, and not continuously from birth to death, the fact that a person's days are numbered should not, by itself, indicate that her life merits diminished protection from the law. Some may feel legitimately that their last few days, especially if spent free of significant pain, are especially valuable and perhaps deserving of heightened protection by the state.

Moreover, the most important purpose in finding a fundamental right to die is to prevent the government from subjecting people to needless pain and suffering when there is no hope of recovery. Perhaps this right is more accurately analogized to a right to be free from torture than to a liberty interest in refusing medical treatment. In any case, the category of "terminally ill" is both over and underinclusive. Some terminal illnesses may not be particularly painful. Thus, a terminally ill patient may have no legitimate reason for wishing to accelerate her death. Alternatively, certain untreatable chronic illnesses that do not threaten an individual's life are excruciatingly painful. One could argue effectively that a chronically ill person in excruciating pain should be afforded the choice of ending her life free from governmental interference.

96. As previously noted, one such example is tic doloreaux, a sometimes untreatable and extremely painful condition of the trigeminal nerve. See supra note 34.
Finally, the argument that a fundamental right to assisted suicide extends only to the terminally ill is flawed if that right is viewed as an extension of the right to refuse medical treatment. The absence of any limitations on the assumed right to refuse medical treatment that the Court outlines in *Cruzan* is a good indication that all mentally competent adults possess a liberty interest in refusing medical treatment, regardless of their reason for refusal. If requesting to die with the aid of a physician is no different from refusing unwanted treatment, then why should the right to such a request be limited to the terminally ill?

If the existence of pain and suffering rather than proximity to death is the necessary element to weaken the state’s interest in preserving life, then it would appear that the liberty interest of self-determination possessed by those suffering from incurable, excruciatingly painful illnesses, would outweigh the state’s interest. Even more problematic than determining when an individual is terminally ill, however, is determining when that individual is suffering from pain so severe to allow death as an alternate choice.

Making the degree of pain and suffering a criteria for the creation of a right to die also places the courts and the legislatures in the position of making judgments about the quality of life. As evidenced by *Cruzan*, the Supreme Court is unwilling to make such judgments, and with good reason. Making judgments about the quality of life could lead the state to place a higher value on the lives of certain individuals than on others. If the state’s interest in protecting the lives of those in severe pain is diminished, it might follow that the lives of the deaf and the blind should also be afforded a lesser degree of protection. Such reasoning would be consistent with that of the Nazis in their goals to “improve” the quality of human beings through eugenics.

A third option for the Court would be to expand the right to die to all mentally competent adults. More precisely, the right to end one’s own life, as part of a broader liberty interest in self-determination, would outweigh any State interest in the preservation of life, as long as the decision to commit suicide was made voluntarily, free from undue influence, by a mentally competent adult.

Although a broadly defined right to die may be more conceptually sound than one limited to the terminally ill, one might think of very few instances in which a person who is not terminally ill or suffering from an extremely painful disease would have a rational reason for needing the aid of another to end her life. The requirement that the act be rational, however, is an essential predicate for the recognition of a constitution-

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ally-protected or state-created right to assisted suicide. Thus, although the question of when suicide is rational may appear better answered by psychologists or metaphysicians than by the legislature or the judiciary, it is a question that must be answered in order to identify the contours of a hypothesized right to assisted suicide.

4. **Do Existing Prohibitions on Physician-Assisted Suicide Violate the Right to Equal Protection?**

At least two equal protection arguments suggest that the present state law prohibitions against assisted suicide may be unconstitutional, even in the absence of a constitutionally protected right to die. The first argument follows necessarily, but could exist independently, of an extension of the hypothesized due process right identified in *Cruzan*: if one accepts the proposition that there is no legally significant distinction between actively choosing to die and choosing to die passively, then the legislature cannot permit those who are able to end their lives by refusing life-saving medical treatment to do so without also allowing those who can die only with the assistance of a physician to carry out their final wish. Proponents of the second equal protection argument contend that the legislature, by criminalizing physician-assisted suicide while permitting suicide and attempted suicide, is denying equal protection of the laws to those who are physically unable to take their own lives. If a person is free to commit suicide or to attempt to commit suicide with impunity, then in prohibiting assisted suicide, the legislature is denying such freedom to those who must enlist the aid of another to die.

The standard of review the U.S. Supreme Court has developed for statutes challenged as denying equal protection varies. First, statutes that classify on the basis of a suspect class, i.e., race and alienage, trigger strict scrutiny. Thus, in order for a statute containing a racial classification to withstand constitutional scrutiny, the statute must serve a compelling state interest and the classification must be narrowly tailored to serve that interest. Second, statutes impinging upon funda-

98. More precisely, an extension of the right in *Cruzan*, and an identification of the right as one that is fundamental for equal protection purposes, would heighten the level of scrutiny to strict scrutiny under an equal protection analysis.
99. Without an extension of the right, the statute is subject only to rational basis review.
100. Such is the position taken by the Second Circuit in *Quill v. Vacco*, 80 F.3d 716, 731 (2d Cir. 1996).
mental rights also trigger strict scrutiny. Again, the statute's disparate treatment of one group of people must serve a compelling state interest, and the classification must be closely tailored to the purpose of the statute. Third, gender-based classifications trigger intermediate scrutiny, and, therefore, must be substantially related to an important governmental interest to pass constitutional muster. Finally, laws that neither impinge upon fundamental rights, nor classify on the basis of a suspect or quasi-suspect class, must be only rationally related to a legitimate state interest. Thus, in defense of either equal protection attack, proponents of laws that prohibit assisted suicide would have to assert a rational basis for the disparate treatment.

In opposition to the first equal protection argument, one could assert several reasons for allowing people to refuse life-saving medical treatment while preventing others from dying with the aid of a physician. While these distinctions may not be persuasive, they need be only rational. As noted earlier, allowing physicians to prescribe lethal medication puts them in the role of killers, thus creating a position inconsistent and irreconcilable with their duty to heal. While one could argue that a physician who disconnects an artificial respirator is as much of a killer as one who prescribes lethal medication, the difference is that in the former case, the underlying illness, having deprived the patient of his ability to breathe on his own, is the actual cause of death. Perhaps this distinction can be more accurately described as a moral stance that physicians can intervene in nature's course only to preserve life, and never to cause death.

Other rational reasons for making a distinction between killing and letting die include the risk that someone with an excellent chance of recovery would elect to die because of a misdiagnosis, the view that patients on life support have a greater interest in autonomy due to the invasive nature of the life support, and the considerable increased difficulty in regulating a right to die once it is extended beyond a right to

106. See Williamson v. Lee Optical of Okla., 348 U.S. 483 (1955); but see Schweiker v. Wilson, 450 U.S. 221, 235 (1981) (upholding the statute but finding that the classification must advance a reasonable governmental objective).
108. See Williamson, 398 U.S. at 486-88.
109. Although patients temporarily attached to artificial life support systems could also recover after being misdiagnosed with a terminal illness, the legislature could rationally, and even reasonably, conclude that patients who require the aid of a physician to die are more likely to fall victim to such misdiagnosis.

Similarly, the states could generate multiple defenses against the second equal protection attack. One possible reason for treating physically debilitated people differently from those physically capable of taking their own lives is the numerous policy concerns implicated when another person is involved in taking a life. Some of these policy concerns, such as the fear that legalizing assisted suicide would facilitate murder under the guise of suicide, could be eliminated. For example, the legislature could allow people who are physically unable to take their own lives to do so with restrictions—only through the aid of a physician and with sufficient procedural safeguards to ensure the person’s mental competence and consent.

States could also defend laws that prohibit assisted suicide, in the absence of laws that prohibit suicide or attempted suicide, by arguing that there is no other effective way of preventing suicide. The absence of a criminal penalty for taking one’s own life does not so much represent a freedom to commit suicide, but rather the legislature’s view that suicide prevention is not furthered by criminal penalties for the act. Prohibitions on suicide and attempted suicide do not deter an individual from taking or attempting to take her own life. Criminal penalties for assisted suicide, however, do effectively deter people from helping those who wish to die, but cannot do so by themselves.

5. THE RIGHT TO PHYSICIAN-ASSISTED SUICIDE WHEN CREATED BY A STATE STATUTE

Even if no constitutionally protected right to assisted suicide exists, state legislatures may be free to pass laws creating such a right, thereby effectively regulating physician-assisted suicide, provided the state created right does not impinge upon other constitutionally protected interests. In November of 1994, Oregon passed the first law creating a right to physician-assisted suicide by enacting the Death With Dignity Act (“DWDA”).

The DWDA permits mentally competent adults diagnosed as suffering from a terminal illness, and who have voluntarily expressed a desire to die, to request medication from a physician for the purposes of ending their lives. For the purposes of the statute, “terminally ill” is

110. Once again, this last argument suggests the difficulty in delineating the scope of a right to physician-assisted suicide, whether state-created or constitutionally protected. A right to refuse treatment, even if such refusal results in death, is less problematic. This is primarily because the class to which the right adheres to is more easily identifiable, i.e., it consists of those who cannot survive without medical treatment.

111. Oregon Death with Dignity Act §§ 1.01-6.01 (1994).

112. Id. at § 2.01.
defined as "an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six (6) months."\textsuperscript{113}

The DWDA contains a number of safeguards designed to ensure both that the patient's request to die with assistance is voluntary and that the patient is mentally competent. The DWDA requires three requests by the patient, two oral and one written, for a physician to prescribe the medication.\textsuperscript{114} A minimum of fifteen days must elapse between the initial and the final oral request, whereupon the physician must offer the patient an opportunity to rescind.\textsuperscript{115} The written request must be signed in the presence of two witnesses who declare that to the best of their knowledge the patient is mentally competent and acting voluntarily.\textsuperscript{116} Notably, one of the witnesses must be a person unrelated to the patient, and at the time of the request, not be entitled to any portion of the patient's estate.\textsuperscript{117} Finally, under the DWDA, a consulting physician must confirm the attending physician's diagnosis that the patient is terminally ill, and that the patient is both mentally competent and acting voluntarily.\textsuperscript{118}

A state-created right to assisted suicide poses interesting constitutional problems. First, if there is a due process liberty interest in assisted suicide implicit in the Constitution, a state statute that narrowly delineates the right may, like the statutes prohibiting assisted suicide in all forms, be an unconstitutional infringement upon such a right. However, if a constitutional right to assisted suicide does not exist implicitly in the Constitution, then the state statute may unconstitutionally impinge upon other rights, such as equal protection, due process life and liberty interests, and freedom of religion.

\textbf{B. \textit{Does a State-Created Right to Physician-Assisted Suicide Impinge Upon Other Fundamental Rights?}}

Shortly after the DWDA was passed, a group of terminally ill patients, a residential care facility, and operators of residential care facilities succeeded in persuading a federal district court in Oregon to declare the law unconstitutional,\textsuperscript{119} and permanently enjoin its enforcement.\textsuperscript{120}

\begin{itemize}
\item \textsuperscript{113} Id. at § 1.01 (12).
\item \textsuperscript{114} Id. at § 3.06.
\item \textsuperscript{115} See id. at § 3.08.
\item \textsuperscript{116} See id. at § 2.02.
\item \textsuperscript{117} See id. at § 2.02(2)(a), (b).
\item \textsuperscript{118} See id. at § 3.02.
\item \textsuperscript{119} See Lee v. Oregon, 891 F. Supp. 1429, 1438 (D. Or. 1995).
\item \textsuperscript{120} See Lee v. Oregon, 891 F. Supp. 1439 (court granting declaratory and permanent injunction).
\end{itemize}
They claimed that the DWDA violated the right to equal protection and due process life and liberty interests of the terminally ill, as well as the residential care plaintiffs' First Amendment right to free exercise of religion.\footnote{121}

1. THE RIGHT TO EQUAL PROTECTION OF THE LAWS

The plaintiffs' first claim was that the DWDA deprived the terminally ill of equal protection of the Oregon criminal law.\footnote{122} Because the statute exempted from criminal liability those who assisted the terminally ill in committing suicide, the terminally ill plaintiffs claimed that the law did not offer them the same protection from assisted suicide as those who were not terminally ill.\footnote{123} More specifically, they claimed that they might become depressed or subject to undue influence, and ultimately choose physician-assisted suicide despite their unwillingness to do so at the time they brought the action.\footnote{124}

The court, in striking down the DWDA, began its equal protection analysis by declaring the level of scrutiny it used in reviewing the statute. The court articulated accurately the standard for minimal, rational basis scrutiny. The opinion stated: “Legislation is presumed valid if a classification drawn by a statute is rationally related to a legitimate state interest.”\footnote{125} The court further explained that it must uphold the statute provided “there is any reasonably conceivable state of facts that could provide a rational basis for the classification.”\footnote{126} Since the remainder of the opinion fails to state that the law impinges upon a fundamental right or involves a suspect classification, one would expect the court to uphold the statute, provided it found that the classification of “terminally ill” was rationally related to a legitimate state interest.

The state defendants asserted that the statute served several legitimate state interests. These included avoiding unnecessary pain and suffering, preserving and enhancing the right of competent adults to make their own critical health care decisions, preventing less humane and dignified suicides and attempted suicides, protecting the terminally ill from financial hardships, and protecting the terminally ill from unwanted intrusions into their personal affairs.\footnote{127} Avoiding unnecessary pain and suffering is, undoubtedly, a legitimate state interest. Thus, the issue under equal protection analysis should have been whether it was rational

\footnote{121. See Lee v. Oregon, 891 F. Supp. at 1431.}
\footnote{122. See id.}
\footnote{123. See id. at 1433.}
\footnote{124. See id. at 1433-34.}
\footnote{125. Id. at 1432 (citing Schweiker v. Wilson, 450 U.S. 221, (1981)).}
\footnote{126. Id. (citing F.C.C. v. Beach Communications, Inc., 508 U.S. 307, 308 (1993)).}
\footnote{127. See id. at 1434.}
for the Oregon legislature to presume that the terminally ill, as a class, are more likely than others to experience pain and suffering, and whether giving the terminally ill the option of seeking the aid of a physician in ending their lives would help to eliminate such pain and suffering. Under this kind of analysis, the statute was rationally related to a legitimate state interest and should have survived judicial review.

Curiously, the court chose to frame the equal protection issue differently. It asserted that for the statute to be rational, it must have sufficient safeguards to justify treating the terminally ill differently from others. The court then went on to conclude that the DWDA did not have sufficient procedures to distinguish the mentally competent from the incompetent, thus ensuring that those expressing a desire to die were capable of giving their consent.

While the court's concern for adequate safeguards was legitimate, its analysis resembled one of procedural due process rather than equal protection. The court did not really question whether the statute's classification was rationally related to a legitimate purpose, but whether the state could authorize a physician to take a terminally ill patient's life without sufficiently establishing that person's consent. If the statute's procedural safeguards were inadequate, then the statute should have been declared unconstitutional not because the classification of terminally ill was unrelated to a legitimate state interest, but because it deprived the terminally ill of life without adequate due process.

2. DUE PROCESS LIFE AND LIBERTY INTERESTS

The district court, in its final opinion, chose not to reach plaintiffs' Due Process and First Amendment claims. The following discussion expounds the issues insofar as they were discussed in the court's opinion granting a preliminary injunction. Plaintiffs' second claim had two prongs. First, they argued that the Oregon statute unconstitutionally deprived the terminally ill of procedural protections for their right to live. Second, plaintiffs asserted that the statute deprived them of a liberty interest in self-determination and personal autonomy in its failure to ensure that the choice to end life would be informed and voluntary. The constitutional rights asserted were derived from the Due Process Clause of the Fourteenth Amendment.

The plaintiffs correctly pointed out that the statute may not have

128. See id. at 1434-37.
129. See id.
131. See id.
possessed sufficient procedural safeguards to ensure that a patient's choice to end life was not the product of judgment-impairing depression. Section 3.03 of the statute provides that if the attending physician or the consulting physician suspect the patient is suffering from depression or another mental illness, they must refer the patient to psychiatric counseling. The attending or consulting physicians, however, may not possess sufficient expertise to identify such a condition. Thus, requiring a patient who wishes to end her life with the aid of a physician to first undergo a psychiatric examination would help to ensure that she is mentally competent to make such a choice.

Again, plaintiffs' due process life and liberty claim raised the problem of determining mental competence and identifying depression. Unfortunately, as psychologists possess different views on the rationality of suicide, with some adopting the view that a desire to commit suicide is almost always the product of depression, the ability to exercise one's right to die under a statute may be dependent upon the particular philosophy of a psychologist.

A possible weakness, however, in the plaintiffs' Due Process claim was the lack of state action. If the DWDA had been enforced and the plaintiffs lost their lives, they would have done so at the hands of private, as opposed to state actors. Although the doctors' actions would have been subject to regulation by the state, that fact alone, does not convert their action into state action. Thus, the relatives of the deceased could not have successfully brought suit against the doctors for depriving their patients of life without due process.

Whether or not the DWDA itself violated the procedural due process rights of the terminally ill, however, is another matter. If one characterized the DWDA as a mere repeal of the law that "protected" the terminally ill from those willing to help them commit suicide, then such a repeal would arguably not constitute state action. As Chief Justice Rehnquist stated in DeShaney v. Winnebago City Department of Social Services:

\[\text{[N]othing in the language of the Due Process Clause itself requires the State to protect the life, liberty, and property of its citizens against invasion by private actors. The Clause is phrased as a limitation on the State's power to act, not as a guarantee of certain minimal levels of safety and security. It forbids the State itself to deprive individuals of life, liberty, or property without `due process of law,' but its language cannot fairly be extended to impose an affirmative obligation}\]

132. See Oregon Death with Dignity Act § 3.03 (1994).
133. See Lee v. Oregon, 869 F. Supp. at 1498 n.2.
on the State to ensure that those interests do not come to harm through other means.  

On the other hand, the United States Supreme Court has found statutory or constitutional authorization of private activity to constitute state action. In Reitman v. Mulkey, the Court held that a constitutional amendment prohibiting fair housing legislation and authorizing private discrimination in the sale of homes constituted state action. In this case, the legislature appears even more entangled with private conduct than in Reitman. The Oregon legislature is not merely legalizing physician-assisted suicide for anyone who may choose it, but rather it is regulating and extending it only to the terminally ill under limited circumstances.

Whether the legislature in Lee was a state actor for purposes of due process may depend in part upon the characterization of the freedom to commit physician-assisted suicide as a right or a deprivation. In many ways, the problem of characterizing the DWDA as employing either state action or inaction is similar to the act/omission distinction discussed earlier. Although the consequences are the same, the constitutionality of the statute hinges upon the distinction. Assuming that the DWDA lacks sufficient safeguards to ensure that patients’ decision to opt for suicide will be voluntary and not the product of depression, it would appear that the legislature is in effect depriving certain individuals of life without sufficient due process.

3. THE RIGHT TO FREE EXERCISE OF RELIGION

The residential care plaintiffs asserted the final constitutional challenge to the DWDA. These health care workers claimed that the DWDA requires complicity on their part that is inconsistent with their religious beliefs, thereby violating their right to free exercise of religion under the First Amendment. The drafters of the DWDA, however, apparently foresaw such a problem. In Section 4.01(2), the legislature provided: “No professional organization or association, or health care provider, may subject a person to censure, discipline, suspension, loss of license, loss of privileges, loss of membership or other penalty for participating or refusing to participate in good faith compliance with [this Act].” Plaintiffs contend, however, that the Oregon law, nevertheless, requires health care providers to transfer records at a patient’s request if

136. Id. at 195.
140. See id. at 1500.
the facility is unwilling to comply with the patient’s request, and requires, in conjunction with Oregon’s informed consent law, discussion of physician-assisted suicide as an available treatment option for patients. Such requirements, however, do not seriously interfere with health care workers’ ability to practice their religion, especially when such minimal interference is weighed against the state’s interest in eliminating needless pain and suffering.

V. CONCLUSION

The recognition of a fundamental, constitutionally protected interest in physician-assisted suicide, while not wholly untenable, is fraught with difficulties. If a fundamental right to assisted suicide exists implicitly in the Constitution, how can the Court justify extending the right only to the terminally ill? The Court could assert that the right exists for all mentally competent adults, but this right is outweighed by the state’s interest in preserving life until a person becomes terminally ill, as the state’s interest in preserving life weakens upon proximity to death. Nonetheless, the implications of such a path are such that the Court would undoubtedly steer clear of it.

As an extension of the right to refuse medical treatment identified in Cruzan, the right to physician-assisted suicide suffers from conceptual flaws. If a right to assisted suicide is truly an extension of the right to refuse treatment, then it would follow logically that both rights be similar in scope and available to all mentally competent adults. Important policy concerns, however, dictate that the Court avoid such a finding. Also, in Cruzan, Chief Justice Rehnquist identified the assisted suicide laws as an example of the State demonstrating its interest in preserving life. Finally, the right to refuse medical treatment may be distinguished from a hypothesized right to assisted suicide in that the former has its origins in the Fourth and Fifth Amendments’ guarantee of privacy, or a right to be left alone, and not be compelled by the government to do anything.

Recognition of a state-created right, on the other hand, poses fewer conceptual difficulties and would allow the states individually to construct procedural safeguards ensuring that a right to die would not impinge upon fundamental rights. Given the importance of the policy concerns that such a right implicates, and the uncertainty and unpredictability of results that state-regulated, physician-assisted suicide would

144. See supra note 79 and accompanying text.
produce, allowing the states to create and limit the right as they see fit is the most sensible alternative.

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