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### On the Meaning and Impact of the Physician-Assisted Suicide Cases

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## On the Meaning and Impact of the Physician-Assisted Suicide Cases

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Yale Kamisar

I read every newspaper article I could find on the meaning and impact of the U.S. Supreme Court's June 1997 decisions in *Washington v Glucksberg*<sup>1</sup> and *Vacco v Quill*.<sup>2</sup> I came away with the impression that some proponents of physician-assisted suicide (PAS) were unable or unwilling publicly to recognize the magnitude of the setback they suffered when the Court handed down its rulings in the PAS cases.

### On Being Given "The Green Light"

The press reported that Barbara Coombs Lee, Executive Director of Compassion in Dying (an organization that counsels people considering PAS and one of the plaintiffs in the *Glucksberg* case), was "really thrilled" that the Supreme Court had given her organization and her allies "a green light" to seek legislation authorizing PAS.<sup>3</sup> But proponents of PAS have *always had* "the green light" to persuade state legislatures to legalize PAS. The issue presented by *Glucksberg* and *Quill* was whether the U.S. Constitution *required* or *compelled* the states to legalize PAS under certain circumstances, not whether the states were *permitted* to do so.

Early in the oral arguments before the Supreme Court, Justice Stevens asked the attorney representing Washington State whether it was his view that a legislature had "the constitutional authority to authorize assisted suicide" and the answer was an unequivocal "yes."<sup>4</sup> A short time later, Justice Ginsburg asked the attorney representing New York whether he agreed that a legislature was free to legalize PAS and he, too, left no doubt that he believed a legislature was so entitled.<sup>5</sup>

Nor did lawyers representing the plaintiffs in the PAS cases deny that they had always had the green light to seek legislation authorizing PAS. But they made it clear that they were *not* thrilled about pursuing such a course. Thus, when asked by Justice Breyer why a legislature was not "far more suited" to deal with end-of-life problems than a court interpreting a constitutional provision, Professor Laurence Tribe, the attorney for the respondents in *Quill*, responded that although "in a sense there are 50 laboratories out there," they "are now operating largely with the lights out."<sup>6</sup> And when

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asked a similar question by Justice O'Connor, Kathryn Tucker, the attorney for the respondents in *Glucksberg*, replied that because "ours is a culture of denial of death," she had "some concerns that the political process would not be expected to work in a usual fashion."<sup>7</sup>

That the lawyers for the states, not the lawyers for the respondents, urged the Court to let the state legislatures resolve the difficult issues involved in the PAS cases is hardly surprising. Proponents of PAS have not fared well in the political arena. They did achieve success in 1994 when Oregon voters passed a "death with dignity" act (a vote Oregon reaffirmed three years later), but so far Oregon has been a striking exception.

Washington and California ballot initiatives for "aid-in-dying" both failed in the early 1990s. Moreover, in the last decade bills to legalize PAS have been introduced in more than twenty states and none has passed.<sup>8</sup> Indeed, in 1997 alone seven state legislative attempts to legalize PAS "died outright or . . . languished in committee."<sup>9</sup> On the other hand, bills expressly prohibiting assisted suicide have fared much better. Since 1989, sixteen such bills have been enacted into law.<sup>10</sup>

Some have made much of the fact that five months after the Supreme Court handed down its decisions in the PAS cases, Oregon voters reaffirmed their support for assisted suicide by a much larger margin than the initial 1994 vote. The state legislature had put the initiative (which had initially passed by a 51–49% vote) back on the ballot for an unprecedented second vote. This time the initiative was reaffirmed overwhelmingly, 60–40%. Barbara Coombs Lee hailed the event as "a turning point for the death with dignity movement."<sup>11</sup> David Garrow called the landslide vote "a good indicator of where America may be headed."<sup>12</sup> Still another commentator viewed the lopsided vote as a demonstration of "[h]ow far, and how fast, public opinion is moving on this issue."<sup>13</sup>

I think not. I think the most plausible explanation for the large margin by which Oregon voters rebuffed efforts to repeal the initiative in favor of PAS was their resentment and anger over the fact that the state legislature had forced them to vote on the issue again—the first time in state history that the legislature had tried to repeal a voter-passed initiative. Those running pro-PAS advertisements, we are told by the press, "play[ed] on the perceived anger" generated by the repeal effort itself.<sup>14</sup> It is worth noting that a year after the second vote for assisted suicide in Oregon, a proposal to legalize physician assisted suicide in Michigan was defeated by almost a 3–1 vote.<sup>15</sup>

### **What, If Anything, Has Changed?**

Some consider the long-awaited Supreme Court opinions in the PAS cases anticlimactic.<sup>16</sup> Dr. Robert Brody, a well-known medical ethicist at San Francisco General Hospital and a co-author of recently published guidelines permitting PAS under certain narrow circumstances, has gone so far as to say that the Court's rulings "didn't change a thing."<sup>17</sup> I strongly disagree.

To put the Supreme Court's rulings in the PAS cases in some perspective, let us go back a couple of years. The U.S. Courts of Appeals for the Ninth and Second Circuits may have gladdened the hearts of PAS proponents when they ruled in the spring of 1996 that there was a constitutional right to assisted suicide under certain circumstances,<sup>18</sup> but these decisions stunned many others. Until the two federal courts of appeals had handed down their rulings, within the span of a single month, no American appellate court had ever held that there was a right to assisted suicide under any circumstances.

The decisions by the two courts generated a good deal of momentum in favor of physician-assisted suicide. The fact that the rulings came so close together, that there was no dissent in the Second Circuit case and that the decision of the Ninth Circuit was supported by a lopsided majority (8-3) all contributed to this momentum. So did the directness and forcefulness of the two majority opinions.

For example, the Ninth Circuit disparaged, almost ridiculed, two distinctions long relied on by opponents of PAS: (1) the distinction between "letting die" and actively intervening to promote or to bring about death; (2) the distinction between giving a patient a drug for the purpose of killing her and administering drugs for the purpose of relieving pain, albeit with the knowledge that such palliative care may hasten the patient's death. Observed the Ninth Circuit:

[W]e do not believe that the state's interest in preventing [PAS] is significantly greater than its interest in preventing the other forms of life-ending medical conduct that doctors now engage in regularly. More specifically, we see little, if any, difference for constitutional or ethical purposes between providing medication with a double effect and providing medication with a single effect, as long as one of the known effects in each case is to hasten the end of the patient's life. Similarly, we see no ethical or constitutionally cognizable difference between a doctors pulling the plug on a respirator and his prescribing drugs which will permit a terminally ill patient to end his own life. In fact, some might argue that pulling the plug is a more culpable and aggressive act on the doctor's part and provides more reason for criminal prosecution. To us, what matters most is that the death of the patient is the intended result as surely in one case as in the other.<sup>19</sup>

Moreover, the Ninth Circuit seemed unwilling to respect still another oft-made distinction, the one between assisted suicide (where the patient herself performs the last death-causing act) and active voluntary euthanasia (where a person other than the patient commits the death-causing act). Although the court noted that there was no need to decide whether there was a constitutional right to, or liberty interest in, active voluntary euthanasia, as well as in PAS, the Ninth Circuit could not resist indicating how it would answer that question if and when the occasion arose: "[F]or present purposes we view the critical line in right-to-die cases as the one between the volun-

tary and involuntary termination of an individual's life. . . . We consider it less important who administers the medication than who determines whether the terminally ill person's life shall end."<sup>20</sup>

In striking down, on equal protection grounds, New York's criminal prohibition against assisted suicide insofar as it prevented physicians from helping terminally ill, mentally competent patients commit suicide, the Second Circuit, if anything, was more outspoken than the Ninth:

[T]here is nothing "natural" about causing death by [withdrawing life support]. The withdrawal of nutrition brings on death by starvation, the withdrawal of hydration brings on death by dehydration, and the withdrawal of ventilation brings about respiratory failure. [Withdrawal of life support] is nothing more nor less than assisted suicide. . . .

A finding of unequal treatment does not, of course, end the inquiry, unless it is determined that the inequality is not rationally related to some legitimate state interest. . . . [But] what interest can the state possibly have in requiring the prolongation of a life that is all but ended? . . . [And] what business is it of the state to require the continuation of agony when the result is imminent and inevitable? What concern prompts the state to interfere with a mentally competent patient's "right to define [his] own concept of existence, or meaning, of the universe, and of the mystery of human life," when the patient seeks to have drugs prescribed to end life during the final stages of a terminal illness? The greatly reduced interest of the state in preserving life compels the answers to these questions: "None."<sup>21</sup>

As I hope I have made clear, both the Ninth and Second Circuits employed very strong and very quotable language—language that could be used quite effectively to advance the cause of PAS in editorials, op-ed pieces, talk shows, state legislatures and state courts. But then the U.S. Supreme Court entered the fray. It disagreed with the lower federal courts virtually point by point and, in effect, eradicated all the lower courts' forceful, felicitous, and stirring language (from the viewpoint of a PAS proponent at any rate).

Nor is that all. Now that the Supreme Court has rejected their main constitutional arguments, at least for the near future, I believe that proponents of PAS are in a weaker position than they were before these lawsuits ever commenced. For the constitutional arguments they made without success in the Supreme Court and the policy arguments they have been making, and will continue to make, in the state legislatures or state courts or on the op-ed pages of hundreds of newspapers greatly overlap.

I realize that, although the highest court in the land did not recognize (or is not yet ready to recognize) a constitutional right to PAS, even under narrow circumstances, one may still argue that there is a common law or state constitutional right or a "moral" or "political" right to PAS. Nevertheless, it will be a good deal harder to engage in any kind of "rights talk" after the Supreme Court decisions than before. There are only so many argu-

ments in favor of a “right” to PAS—and almost all of them were addressed by the Supreme Court in the *Glucksberg* and *Quill* cases. The Court, I think it fair to say, did not find any of them convincing. Thus those arguments have lost a considerable amount of credibility and will be easier to rebuff when made again, albeit in a different setting.<sup>22</sup>

### **Addressing and Rejecting Four Principal Arguments in Favor of a Right to PAS**

At this point it may be useful to summarize briefly (1) the main arguments the *Glucksberg* and *Quill* plaintiffs made in assailing a *total* prohibition against PAS and (2) the reasons Chief Justice Rehnquist gave for rejecting each of these arguments (using the Chief Justice’s own language wherever possible):

*Argument* Withdrawal of life support is nothing more nor less than assisted suicide; there is no significant moral or legal distinction between the two practices. The right to forgo unwanted life-sustaining medical treatment and the right to enlist a physician’s assistance in dying by suicide are merely *subcategories* of *the same* broad right or liberty interest—controlling the time and manner of one’s death or hastening one’s death.

*Response* The distinction between assisting suicide and terminating lifesaving treatment is “widely recognized and endorsed in the medical profession and in our legal traditions [and] is both important and logical.”<sup>23</sup> The decision to commit suicide with a physician’s assistance “may be just as personal and profound as the decision to refuse unwanted medical treatment, but it has never enjoyed similar legal protection. Indeed, the two acts are widely and reasonably regarded as quite distinct.”<sup>24</sup>

*Argument* There is no significant difference between administering palliative drugs with the knowledge that it is likely to hasten the patient’s death and prescribing a lethal dose of drugs for the very purpose of killing the patient. As the Ninth Circuit put it, there is no real distinction between providing medication with a double effect and providing it with a single effect “as long as one of the known effects in each case is to hasten the end of the patient’s life.”<sup>25</sup>

*Response* In some cases, to be sure, “painkilling drugs may hasten a patient’s death, but the physician’s purpose and intent is, or may be, only to ease his patient’s pain. . . . The law has long used actors’ intent or purpose to distinguish between two acts that may have the same result. . . . [T]he law distinguishes actions taken ‘because of’ a given end [dispensing drugs in order to bring about death] from actions taken ‘in spite of’ their unintended

but foreseen consequences [providing aggressive palliative care that may hasten death, or increase its risk.]”<sup>26</sup>

*Argument* The 1990 *Cruzan* case is not simply a case about the right to forgo unwanted medical treatment. Considering the facts, it is really a case about personal autonomy and the right to control the time and manner of one’s death. *Cruzan*’s extension of the right to refuse medical treatment to include the right to forgo life-sustaining nutrition and hydration was “influenced by the profound indignity that would be wrought upon an unconscious patient by the slow atrophy and disintegration of her body [and] can only be understood as a recognition of the liberty, at least in some circumstances, to physician assistance in ending one’s life.”<sup>27</sup>

*Response* *Cruzan* is not a suicide or an assisted suicide case. The Court’s assumption in that case was not based, as the Second Circuit supposed, “on the proposition that patients have a general and abstract ‘right to hasten death,’ but on well established, traditional rights to bodily integrity and freedom from unwanted touching.”<sup>28</sup> Indeed, “[i]n *Cruzan* itself, we recognized that most States outlawed assisted suicide—and even more do today—and we certainly gave no intimation that the right to refuse unwanted medical treatment could be somehow transmuted into a right to assistance in committing suicide.”<sup>29</sup>

*Argument* Fourteenth Amendment Due Process protects one’s right to make intimate and personal choices, such as those relating to marriage, procreation, child rearing—and the time and manner of one’s death. As the Ninth Circuit observed, quoting language from *Planned Parenthood v Casey*: “Like the decision of whether or not to have an abortion, the decision how and when to die is one of ‘the most intimate and personal choices a person may make in a lifetime,’ a choice ‘central to personal dignity and autonomy.’”<sup>30</sup>

*Response* The capacious, one might even say majestic, language in *Casey*—observing that “the right to define one’s own concept of existence . . . and of the mystery of human life” is “at the heart of liberty”<sup>31</sup> and noting that some important precedents in this area dealt with matters “involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy”<sup>32</sup>—simply “described, in a general way and in light of our prior cases, those personal activities and decisions that this Court has identified as so deeply rooted in our history and traditions, or so fundamental to our concept of constitutionally ordered liberty, that they are protected by the Fourteenth Amendment.”<sup>33</sup> However, the fact that many of the rights and liberties protected by due process “sound in personal autonomy does not warrant the sweeping conclusion that any and all important, intimate, and personal decisions are so protected, and *Casey* did not suggest otherwise.”<sup>34</sup>

## Justice O'Connor's Concurring Opinion

I am well aware that in both *Glucksberg* and *Quill* Justice O'Connor provided the fifth vote (along with Justices Scalia, Kennedy, and Thomas) to make the Chief Justice's opinions the opinions of the Court—by stating that she joined Rehnquist's opinion, yet writing separately. I am aware, too, that in large measure two other members of the Court, Justices Ginsburg and Breyer, joined O'Connor's opinion.

However, there is no indication in Justice O'Connor's brief concurring opinion that she found any of the principal arguments made by PAS proponents any more persuasive than the Chief Justice did. There is no suggestion, for example, that she reads the *Cruzan* opinion any more broadly than does the Chief Justice or that she interprets the stirring language in *Casey* any more expansively. Nor is there any suggestion that she has any more difficulty accepting the distinction between forgoing life-sustaining medical treatment and actively intervening to bring about death. Nor is there any reason to think that she has more trouble grasping the "double effect" principle (the principle that explains why a doctor forbidden to administer a lethal dose of drugs for the very purpose of killing a patient may increase the dosage of medication needed to relieve pain even though the increased dosage is likely to hasten death or increase its risk).

Indeed, in one respect at least Justice O'Connor may have gone a step further than the Chief Justice. I think she may be saying—she is certainly implying—that the "double effect" principle is not only plausible but *necessary*. Her position (and Justice Breyer's as well) seems to be that if, for example, a state were to prohibit the pain relief that a patient desperately needs when the increased dosage of medication is so likely to hasten death or cause unconsciousness that, according to the state, the procedure smacks of assisted suicide or euthanasia,<sup>35</sup> she (presumably along with Justices Breyer and Ginsburg) would want to revisit the question.

Professor Cass Sunstein reads Justice O'Connor's opinion differently than I do. He believes that O'Connor "signaled the possible existence of a right to physician-assisted suicide in compelling circumstances."<sup>36</sup> I think that is too broad a reading.

Early in her concurring opinion, Justice O'Connor does say that there is no need to address "the narrower question whether a mentally competent person who is experiencing great suffering has a constitutionally cognizable interest in *controlling the circumstances* of his or her imminent death."<sup>37</sup> That comment would provide some support for Professor Sunstein's view—if it were all Justice O'Connor had to say on the subject. But it is not. As her opinion continues, the general question about a constitutionally protected interest in controlling the circumstances of one's death is put aside and the opinion turns into a more narrow and more focused discussion about the liberty interest in obtaining needed pain relief or in preventing a state from erecting legal barriers preventing access to such relief.

This is why, I believe, Justice O'Connor deems it important that the parties and amici agree that the states of Washington and New York have imposed no legal barriers to pain relief.<sup>38</sup> *"In this light,"* she continues, "even assuming" that there is a constitutionally protected interest in controlling the circumstances of one's death, "the State's interests . . . are sufficiently weighty to justify a prohibition against physician-assisted suicide."<sup>39</sup> Moreover, at the end of her opinion, Justice O'Connor describes the "constitutionally cognizable interest" rather narrowly:

In sum, there is no need to address the question whether suffering patients have a constitutionally cognizable interest *in obtaining relief from the suffering that they may experience in the last days of their lives*. There is no dispute that dying patients in Washington and New York *can obtain palliative care, even when doing so would hasten their deaths*.<sup>40</sup>

In isolation, "obtaining relief from suffering" could mean assisted suicide or euthanasia. In context, however, I think it means only a liberty interest in obtaining pain relief. In light of her entire opinion, I believe Justice O'Connor's description of the constitutionally cognizable interest at the end of her opinion is more accurate than the one she refers to at the outset. Justice O'Connor's overall view appears to be that *so long as a state erects no legal barriers to obtaining pain relief* (even when the analgesics may hasten death or cause unconsciousness), the state's interests in protecting those who are not truly competent or whose wish to commit suicide is not truly voluntary (and the difficulties involved in defining "terminal illness" and ascertaining who fits that category) are sufficiently strong to uphold a total ban against PAS.<sup>41</sup>

As best as I can tell, Justice Breyer, who joined Justice O'Connor's opinion (except insofar as her opinion joined the majority) and also wrote separately, took essentially the same position as O'Connor. Even assuming that there is something like a "right to die with dignity," Justice Breyer saw no need to decide whether such a right is "fundamental."<sup>42</sup> Why not? Because, as he saw it, "the avoidance of severe physical pain (connected with death) would have to comprise an essential part of any successful claim"<sup>43</sup> and "as Justice O'Connor points out, the laws before us do not *force* a dying patient to undergo that kind of pain."<sup>44</sup>

"Rather," continued Breyer, the laws of New York and Washington allow physicians to provide patients with pain-relieving drugs "despite the risk that those drugs themselves will kill."<sup>45</sup> *So long as this is the case*, concluded Breyer, laws prohibiting PAS "would overcome any remaining significant interests" making up a "dying with dignity" claim and thus withstand constitutional challenge.<sup>46</sup>

Justice Breyer emphasized that the crucial question is not whether a patient is receiving adequate palliative care but whether *state laws* prevent

a patient from obtaining such care: “We [are] . . . told that there are many instances in which patients do not receive the palliative care that, in principle, is available, but that is so for institutional reasons or inadequacies or obstacles, which would seem possible to overcome, and which do not include a *prohibitive set of laws*.”<sup>47</sup>

I believe some passages in Solicitor General Dellinger’s amicus brief and some of his remarks during the oral arguments significantly illuminate the views of both Justice O’Connor and Justice Breyer.

Although the Solicitor General denied that “there is a broad liberty interest in deciding the timing and manner of one’s death,”<sup>48</sup> he went on to say that the term “liberty” in the Due Process Clause “is broad enough to encompass an interest on the part of terminally ill, mentally competent adults in obtaining relief from the kind of suffering experienced by the plaintiffs in this case.”<sup>49</sup> Not only is a liberty interest implicated when a state inflicts severe pain or suffering on someone, continued the Solicitor General, but also when a state “compels a person” to suffer severe pain caused by an illness by “prohibiting access to medication that would alleviate the condition.”<sup>50</sup>

During the oral arguments General Dellinger maintained:

[A] person states a cognizable liberty interest when he or she alleges that the state is imposing severe pain and suffering *or has adopted a rule which prevents someone from the only means of relieving that pain and suffering*. . . .

. . . [If] one alleges the kind of severe pain and agony that is being suffered here and that *the state is the cause of standing between you and the only method of relieving that*, you have stated a constitutionally cognizable liberty interest. . . .<sup>51</sup>

Kathryn Tucker, the lead lawyer for the plaintiffs in the *Glucksberg* case, addressed the Court immediately after General Dellinger. She was not pleased with the Solicitor General’s description of the liberty interest at stake: “[T]he Solicitor General’s comment that what were dealing with here is simply a liberty interest in avoiding pain and suffering . . . absolutely trivializes the claim. We have a constellation of interests [including decisional autonomy and the interest in bodily integrity], each of great Constitutional dimension.”<sup>52</sup>

It may well be that a liberty interest in obtaining pain relief or not being denied access to such relief is only a “trivialized” version of the liberty interest really at stake.<sup>53</sup> But Justices O’Connor and Breyer (and presumably Justice Ginsburg as well, for she concurred in the judgments in both cases “substantially for the reasons stated by Justice O’Connor”<sup>54</sup>) focused heavily, perhaps exclusively, on that trivialized or down-sized version.

Since Justices Stevens and Souter, who also concurred in the judgments, seem even more receptive than O’Connor, Ginsburg, and Breyer to arguments in favor of a right to PAS, at least in compelling cases,<sup>55</sup> there is reason to think

that at least five members of the Court are likely to resist state legislative efforts to reject or to modify the “double effect” principle if such action would force some dying people to endure severe pain.<sup>56</sup> Thus, although “Rehnquist’s opinions did not endorse a constitutional right to adequate palliative care but simply rejected the conclusion of the Ninth and Second Circuit Courts of Appeals,”<sup>57</sup> it may well be that “[a] Court majority” (the five concurring Justices in *Glucksberg* and *Quill*) did effectively endorse such a right.<sup>58</sup>

In a sense, the Court’s support for the “double effect” principle is a victory for everybody. For whatever position they may take on assisted suicide or euthanasia, surely most people want the dying and severely ill to suffer as little physical pain as possible. And as Howard Brody has observed:

Clinicians need to believe to some degree in some form of the principle of double effect in order to provide optimal symptom relief at the end of life. . . . A serious assault on the logic of the principle of double effect could do major violence to the (already reluctant and ill-informed) commitment of the mass of physicians to the goals of palliative care and hospice.<sup>59</sup>

In a way, however, the showing of support for the “double effect” principle by the highest court in the land was a special victory for opponents of assisted suicide and euthanasia. For they have long defended the principle. And they did so again in the *Glucksberg* and *Quill* cases.

For example, in an amicus brief supporting the states of New York and Washington, the American Medical Association (AMA), the American Nurses Association, the American Psychiatric Association, and some forty other medical and health care organizations emphasized that a physician’s obligation to relieve pain and suffering and to promote the dignity of dying patients “includes providing palliative treatment even though it may foreseeably hasten death.”<sup>60</sup> The AMA (and the many other medical organizations that joined it) told the Supreme Court: “[The] recognition that physicians should provide pain medication sufficient to ease their pain, even where that may serve to hasten death, is *vital* to ensuring that no patient suffer from physical pain.”<sup>61</sup>

A good number of those favoring the legalization (or constitutionalization) of PAS have sharply criticized the “double effect” principle. They have condemned the supposed hypocrisy in permitting the use of analgesics that hasten death while banning euthanasia. They have further maintained that killing to relieve suffering has already been sanctioned in the context of “risky pain relief.”<sup>62</sup>

Moreover, it is worth recalling that it was the 8–3 majority of the U.S. Court of Appeals for the Ninth Circuit that disparaged the “double effect” principle<sup>63</sup>—as Dr. Brody puts it, dismissing the principle as “moral hypocrisy.”<sup>64</sup>

A robust version of the “double effect” principle—the view that even when the level of medication is likely to cause death, the “double effect”

principle may be constitutionally required—helps *opponents* of PAS, *not* proponents of the practice. For one of the main arguments against the legalization of PAS is that “properly trained health care professionals can effectively meet their patients’ needs for compassionate end-of-life care without acceding to requests for suicide.”<sup>65</sup> The “double effect” principle eases the task of health care professionals—and eases the plight of their patients—and thus weakens the case for PAS.

### Some Final Thoughts on Justice O’Connor’s Concurring Opinion

Up to now, I have taken the position that if Justice O’Connor left the door open for future litigation in this area, she only left it open a small crack. But I must say that I find the reason she gave for joining the Chief Justice’s opinions quite baffling. At the outset of her concurring opinion she states that she is joining the Rehnquist opinions because she “agree[s] that there is no generalized right to ‘commit suicide.’”<sup>66</sup> But nobody claimed that there *was* a “generalized right to commit suicide” or a general right to obtain a physician’s assistance in doing so. *Nobody*.<sup>67</sup>

In their Supreme Court brief, the lawyers for the plaintiffs in the Washington case formulated the question presented as “[w]hether the Fourteenth Amendment’s guarantee of liberty protects the decision of a mentally competent, *terminally ill* adult to bring about impending death in a certain, humane, and dignified manner.”<sup>68</sup> Furthermore, Kathryn Tucker, the lead lawyer for the plaintiffs in the Washington case, *began* her oral argument by telling the Supreme Court that “this case presents the question whether *dying citizens* in full possession of their mental faculties *at the threshold of death due to terminal illness* have the liberty to choose to cross the threshold in a humane and dignified manner.”<sup>69</sup> It is hard to see how anyone could emphasize death, dying, and terminal illness any more than that.

Since one of the principal arguments made by opponents of PAS is that once established for terminally ill patients assisted suicide would not remain so limited for very long,<sup>70</sup> it was not surprising that several Justices voiced doubts about whether the claimed right or liberty interest would or could or should be limited to those on the threshold of death.<sup>71</sup> But Ms. Tucker stood her ground.

She told the Court that “we do draw the line at a patient who is confronting death” because, unlike other individuals who wish to die by suicide, one on the threshold of death *no longer* has a choice between living and dying, but “only the choice of *how* to die.”<sup>72</sup> She also recognized that a state may prevent a *nonterminally ill* person from choosing suicide because one day that person might “rejoice in that,” but the same could not be said for the person who is terminally ill—for his or her life is about to end anyhow.<sup>73</sup>

Moreover, when asked to define the liberty interest Dr. Quill and other plaintiffs in the New York case were claiming, Ms. Tucker's co-counsel, Professor Laurence Tribe, told the Court that it "is the liberty, *when facing imminent and inevitable death*, not to be forced by the government to endure . . . pain and suffering"; "the freedom, *at this threshold at the end of life*, not to be a creature of the state but to have some voice in the question of how much pain one is really going through."<sup>74</sup> This caused Justice Scalia to respond, "Why does the voice just [arise] when death is imminent?"<sup>75</sup>

From the outset of the litigation, the lawyers for the plaintiffs in the Washington and New York cases insisted that the right or liberty interest they claimed was limited to the terminally ill because, among other reasons, I think they knew there was no appreciable chance that the courts would establish a general right to assisted suicide. Or, to put it somewhat differently, I think they knew that *the only chance they had of prevailing* in the courts was to ask for a narrowly limited right to PAS, one confined to the terminally ill. They were well aware that such a narrowly limited right would cause less alarm and command more support than a general right to assisted suicide.

In short, if all that the Supreme Court decided last June is that there is no general right to commit suicide, the Court decided virtually nothing—because everybody agreed that there was no such right.

Justice O'Connor observes that "[t]he Court frames the issue in this case as whether the Due Process Clause . . . protects a 'right to commit suicide which itself includes a right to assistance in doing so,' and concludes that our [history and legal traditions] do not support the existence of such a right."<sup>76</sup> But this description of what "The Court" (or Chief Justice Rehnquist) did is incomplete.

In describing the claim at issue in *Glucksberg*, the Ninth Circuit had used such language as "a constitutionally recognized 'right to die,'" "a due process liberty interest in controlling the time and manner of one's death," "a liberty interest in hastening one's own death,"<sup>77</sup> "a strong liberty interest in choosing a dignified and humane death,"<sup>78</sup> and an issue "deeply affect[ing] individuals' right to determine their own destiny."<sup>79</sup> Apparently annoyed at what he apparently considered the Ninth Circuit's sloppy and emotive language, and perhaps displeased that in all its various descriptions of the claim at issue the Ninth Circuit had avoided the term "suicide" (a term that carries strongly negative associations), the Chief Justice maintained that a more careful statement of the question presented than any utilized by the Ninth Circuit would be "whether the 'liberty' specially protected by the Due Process Clause includes a right to commit suicide which itself includes a right to assistance in doing so."<sup>80</sup>

I readily admit that this passage caused a certain amount of confusion. But it should not be forgotten that the Chief Justice pointed out *at least three times* that the Ninth Circuit had held that the challenged law "was unconstitutional *as applied to terminally ill competent adults who wish to hasten their*

death with medication prescribed by their physicians.”<sup>81</sup> And in the penultimate paragraph of his opinion, the Chief Justice concluded: “We therefore hold that [the Washington law] does not violate the Fourteenth Amendment, either on its face or ‘as applied to competent, terminally ill adults who wish to hasten their deaths by obtaining medication prescribed by their doctors.’”<sup>82</sup>

The Washington statute was challenged by three terminally ill patients and four physicians who periodically treat terminally ill patients and who wished to help such patients die by suicide. Although the patients died during the pendency of the case, the physicians remained.

Justice O'Connor did not argue that the physician-plaintiffs “lacked standing” to challenge the constitutionality of the ban against PAS insofar as it applied to competent, terminally ill patients. In contrast, Justice Stevens, who wrote a separate concurring opinion, came close to saying just that. Although the Ninth Circuit considered the Washington law *as applied* to terminally ill, competent adult patients who wished to hasten their deaths, observed Stevens, all the patient-plaintiffs had died by then and therefore the court of appeals’ holding “was not limited to a particular set of plaintiffs before it.”<sup>83</sup> But Stevens’s statement is incomplete.

To be sure, the physician-plaintiffs were not threatened with prosecution for assisting in the suicide of *a particular* patient. As the Ninth Circuit pointed out, however, “they ran a severe risk of prosecution under the Washington statute, which proscribes the very conduct in which they seek to engage.”<sup>84</sup> Moreover, although Justice Stevens did not discuss this aspect of the case, both the district court and the court of appeals proceeded on the basis that the physician-plaintiffs had standing to sue on behalf of their terminally ill patients as well as on their own behalf.<sup>85</sup> This is hardly surprising; the U.S. Supreme Court has frequently permitted physicians to assert their patients’ rights in challenging abortion restrictions.<sup>86</sup> Moreover, it might be said that the Washington statute is aimed more directly at physicians than at their patients. It does not make *committing suicide* with the assistance of another a felony. It makes *aiding another* to commit suicide a felony.

If physicians lacked standing to challenge laws prohibiting assisted suicide, how could appellate courts *ever* consider an “as applied to terminally ill patients” challenge? All terminally ill patients *necessarily* will die prior to completion of the litigation. In fact, in the *Glucksberg* case all but one of the patient-plaintiffs had died by the time the district court issued its decision.

What is the most plausible explanation for Justice O'Connor’s odd statement that she is joining the Chief Justice’s opinions in *Glucksberg* and *Quill* because she “agree[s] that there is no generalized right to ‘commit suicide’”<sup>87</sup> (an odd statement, certainly, in light of the history of the case and against the background of the briefs and the oral arguments)? Although this is a conclusion that I am not eager to reach, I think the reason for Justice O'Connor’s statement is a reluctance to rule out the possibility of a right to PAS in every set of circumstances and a desire to “proceed with special caution” in this area.<sup>88</sup>

## The Next Time Around

I have to agree with the many Court watchers who say (especially those who were unhappy with the result in the assisted suicide cases) that *Glucksberg* and *Quill* will not be the Court's last word on the subject. But it hardly follows that the next time the Court confronts the issue it will establish a right to assisted suicide in some limited form. There were a number of factors at work when the Supreme Court decided the 1997 PAS cases and most of them will still be operating when the Court addresses the issue a second time.

For one thing, the issue has recently been the subject of intense discussion and vigorous debate and there is no indication this agitation will subside in the foreseeable future. As the Chief Justice observed (and concurring Justice O'Connor agreed), "[p]ublic concern and democratic action are . . . sharply focused on how best to protect dignity and independence at the end of life, with the result that there have been many significant changes in state laws and in the attitudes these laws reflect."<sup>89</sup>

For another thing, the rights of a politically vulnerable group are not at stake—as had been the situation when the Court intervened in prior cases.<sup>90</sup> After all, "[d]ying people are clearly not a discrete and insular minority in the same, sure way as are black people subject to race discrimination laws [or] women subject to abortion restrictions."<sup>91</sup> And when the issue is close and "there is no democratic defect in the underlying political process," courts "should not strike down reasonable legislative judgments."<sup>92</sup>

I think Justice O'Connor put it well when, reiterating a point she made during the oral arguments,<sup>93</sup> she commented:

Every one of us at some point may be affected by our own or a family member's terminal illness. There is no reason to think the democratic process will not strike the proper balance between the interests of terminally ill, mentally competent individuals who would seek to end their suffering and the State's interests in protecting those who might seek to end life mistakenly or under pressure.<sup>94</sup>

Another reason, quite likely, for the Court's reluctance to establish a constitutionally protected right to, or liberty interest in, assisted suicide, and one that will apply the next time around as well, is capsuled in the Solicitor General's amicus brief: once an exception to the general prohibition against PAS is mandated by the Court, however heavily circumscribed it might be at first, "there is no obvious stopping point."<sup>95</sup>

For example, the Ninth Circuit invalidated the state's assisted suicide ban "only 'as applied to competent, terminally ill adults who wish to hasten their deaths by obtaining medication prescribed by their doctors.'"<sup>96</sup> After noting Washington State's insistence that the impact of the Ninth Circuit's decision "will not and cannot be so limited,"<sup>97</sup> the Chief Justice observed:

The [Ninth Circuit's] decision, and its expansive reasoning, provide ample support for the State's concerns. The court noted, for example, that the "decision of a duly appointed surrogate decision maker is for all legal purposes the decision of the patient himself," that "in some instances, the patient may be unable to self-administer the drugs and . . . administration by the physician . . . may be the only way the patient may be able to receive them," and that not only physicians, but also family members and loved ones, will inevitably participate in assisting suicide. Thus, it turns out that what is couched as a limited right to "physician-assisted suicide" is likely, in effect, a much broader license, which could prove extremely difficult to solve and contain.<sup>98</sup>

Although concurring Justice Ginsburg neither joined the Chief Justice's opinion nor wrote an opinion of her own,<sup>99</sup> during the oral arguments she voiced skepticism that any right to PAS, no matter how narrowly limited initially, could or would be confined to the terminally ill or could or would stop short of active voluntary euthanasia.

When Kathryn Tucker, lead attorney for the plaintiffs in *Glucksberg*, urged the Court to recognize, or to establish, a constitutionally protected liberty interest "that involves bodily integrity, decisional autonomy, and the right to be free of unwanted pain and suffering,"<sup>100</sup> Justice Ginsburg retorted that "a lot of people would fit [this] category," not just the terminally ill.<sup>101</sup> How, she wondered, do you "leave out the rest of the world who would fit the same standards?"<sup>102</sup> At another point, Justice Ginsburg suggested that the patient who is so helpless or in so much agony that she "is not able to assist in her own suicide," but must have a health professional administer a lethal injection, is "in a more sympathetic situation" than one who is able to commit suicide with the preliminary assistance of a physician.<sup>103</sup>

Still another factor that must have had some impact on at least some members of the Court and is bound to influence at least some of the Justices in future cases, is the strong opposition of the AMA and other medical groups to the constitutionalization or legalization of PAS, regardless of how narrowly limited the constitutional right or the statutory authorization might be. As Linda Greenhouse has pointed out,<sup>104</sup> the amicus brief filed by the AMA in *Glucksberg* and *Quill* sharply contrasted with the one the same organization had filed seven years earlier in the *Cruzan* case.<sup>105</sup> In *Cruzan*, the AMA told the Court that under the circumstances, terminating life support was in keeping with "respecting the patient's autonomy and dignity."<sup>106</sup> In *Glucksberg* and *Quill*, however, the AMA (and more than forty other national and state medical and health care organizations) told the Court that "[t]he ethical prohibition against physician-assisted suicide is a cornerstone of medical ethics"; the AMA had repeatedly "reexamined and reaffirmed" that ethical prohibition, and had done so as recently as the summer of 1996; and that "[p]hysician-assisted suicide remains 'fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.'"<sup>107</sup>

Recent and continuing trends in medical practice may only heighten the AMA's resistance to PAS. The next time the issue is presented, the AMA and other medical groups might well tell the Court, as two commentators have recently argued, that new trends and developments make the need to maintain the absolute prohibition against PAS "more important than ever."<sup>108</sup> It would not be surprising if the next time around the AMA and other medical groups were to tell the Court something like this:

Given the great pressures threatening medical ethics today—including, among other factors, a more impersonal practice of medicine, the absence of a lifelong relationship with a physician, the push toward managed care, and the financially-based limitation of services—a bright line rule regarding medically-assisted death is a bulwark against disaster.<sup>109</sup>

Finally, another factor at work in the assisted suicide cases, and one that will operate as well the next time the Court confronts the issue, is the Justices' realization that if they were to establish a right to assisted suicide, however limited, the need to enact legislation implementing and regulating any such right would generate many problems—which inevitably would find their way back to the Court.

Whether a regulatory mechanism would be seen as providing patients and physicians with much-needed protection or viewed as unduly burdening the underlying right would be largely in the eye of the beholder.<sup>110</sup> Thus it is not surprising that proponents of PAS even disagree among themselves as to how a particular procedural requirement should be regarded.

For example, three of the nation's most respected proponents of PAS, Franklin Miller, Howard Brody, and Timothy Quill, have questioned the desirability of the fifteen-day waiting period required by the Oregon Death with Dignity Act, a provision designed to ensure that a patient's decision to elect assisted suicide is resolute.<sup>111</sup> According to Miller, Brody and Quill, such an "arbitrary time period . . . may be highly burdensome for patients who are suffering intolerably and may preclude access to assisted death for those who request it at the point when they are imminently dying."<sup>112</sup> The same three commentators also criticize a provision of a Model State Act requiring that the discussion between physician and patient concerning a request for assisted suicide be witnessed by two adults,<sup>113</sup> calling it "unduly intrusive and unlikely to be effective."<sup>114</sup> On the other hand, Miller, Brody, and Quill maintain that an Oregon provision requiring a second medical opinion on the assisted suicide decision is "not a reliable safeguard" because it "does not mandate that the consulting physician be genuinely independent."<sup>115</sup>

Perhaps the most rigorous condition on PAS to be found is the requirement of Compassion in Dying that the approval of all of the would-be suicide's immediate family members be obtained.<sup>116</sup> It is hard to believe that any group favoring PAS would retain such a requirement if the Court were to establish a constitutional right to assisted suicide. But one can be fairly

sure that if the Court were to establish such a right, opponents of PAS would fight hard to include a “family approval” provision in any legislation regulating assisted suicide—along with mandatory waiting periods, specified information and procedures to ensure that the decision to choose PAS is “truly informed,” and all sorts of notification requirements and bans on the use of public facilities, public employees, and public funds.<sup>117</sup>

Although not insubstantial, the differences among proponents of PAS over the requisite conditions and procedures for carrying out the practice pale compared to the differences likely to exist between those who disagree about legalizing PAS in the first place. In short, in many respects the legislative response to a Supreme Court decision establishing a right to assisted suicide is likely to be a replay of the response to *Roe v Wade*,<sup>118</sup> a specter that did not escape the attention of the Justices last year.

At one point in the oral arguments, the Chief Justice told the lead lawyer for the *Glucksberg* plaintiffs:

You're not asking that [this Court engage in legislation] now. But surely that's what the next couple of generations are going to have to deal with, what regulations are permissible and what not if we uphold your position here. . . . [Y]ou're going to find the same thing . . . that perhaps has happened with the abortion cases. There are people who are just totally opposed and people who are totally in favor of them. So you're going to have those 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.<sup>119</sup>

*Roe v Wade* ignited what has aptly been called a “domestic war,”<sup>120</sup> one that, after a quarter-century of tumult, seems finally to have come to an end in the courts. The Court that decided the assisted suicide cases in 1997 was not eager to set off a new domestic war. Neither, I venture to say, will the Court be the next time around.

#### NOTES

Although my views on assisted suicide and euthanasia are no secret to anyone who has dipped into the literature, I should point out that two days before the Supreme Court heard oral arguments in the physician-assisted suicide cases on January 8, 1997, I was one of nine lawyers and law professors who “moot courted” Dennis Vacco, the Attorney General of New York, who

argued for petitioners in *Vacco v Quill*.

1. 117 S Ct 2258 (1997).
2. 117 S Ct 2293 (1997).
3. See Richard Price & Tony Mauro, “Advocates Promise to Press the Fight,” *USA Today*, June 27, 1997, at 4A. Kathryn Tucker, the lead attorney for the plaintiffs in the *Glucksberg* case, also told the press that the Court

- had given the states "quite a green light to . . . proceed down the path" that Oregon had taken and enact laws permitting physicians to help their patients commit suicide. John Aloysius Farrell, "No Absolute 'Right to Die,' Supreme Court Rules; Bans Upheld on Assisted Suicide; Issue Is Left Open," *Boston Globe*, June 27, 1997, at A1; see also Tony Mauro, "But States Can Enact New Laws," *USA Today*, June 27, 1997, at 1A.
4. Transcript of Oral Argument, *Glucksberg* (No. 96-110), available in 1997 WL 13671, at \*12 (Jan. 8, 1997).
  5. Transcript of Oral Argument, *Quill* (No. 96-1858), available in 1997 WL 13672, at \*11 (Jan. 8, 1997).
  6. *Ibid.* at \*43.
  7. Transcript of Oral Argument, *Glucksberg* (No. 96-110), available in 1997 WL 13671, at \*40 (Jan. 8, 1997).
  8. See Timothy Egan, "Assisted Suicide Comes Full Circle, to Oregon," *New York Times*, Oct 26, 1997, § 1, at 1, Ezekiel J. Emanuel & Linda L. Emanuel, "Assisted Suicide? Not in My State," *New York Times*, July 24, 1997, at A15.
  9. See Price & Mauro, at 4A (cited in note 3).
  10. See Emanuel & Emanuel, at A15 (cited in note 8).
  11. Timothy Egan, "In Oregon, Opening a New Front in the World of Medicine," *New York Times*, Nov 6, 1997, at A26.
  12. David J. Garrow, "The Oregon Trail," *New York Times*, Nov 6, 1997, at A27.
  13. Winifred Gallagher, "Go With the Flow: What We Should Be Doing as We Prepare to Die," *New York Times*, Nov 30, 1997, Book Review, at 17 (reviewing MARILYN WEBB, *THE GOOD DEATH: THE NEW AMERICAN SEARCH TO RESHAPE THE END OF LIFE* (1997)).
  14. See Egan, at 1 (cited in note 8). See also Haya El Nasser & John Ritter, "Officials: Ore. Suicide Law in Effect," *USA Today*, Nov 6, 1997, at 3A.
  15. See the discussion in Yale Kamisar, "Devil in the Detail, Not Money, Defeated Assisted Suicide Plan," *Detroit News*, Nov. 5, 1998, at 12A.
  16. See, e.g., Ellen Goodman, "Guidelines for Assisted Suicide," *Boston Sunday Globe*, July 27, 1997, at E7.
  17. *Ibid.*
  18. See *Compassion in Dying v Washington*, 79 F 3d 790 (9th Cir 1996) (en banc), *rev'd sub nom.* *Washington v Glucksberg*, 117 S Ct 2258 (1997); *Quill v Vacco*, 80 F 3d 716 (2d Cir 1996), *rev'd*, 117 S Ct 2293 (1997). The Ninth Circuit relied on the Due Process Clause without considering the equal protection issue; the Second Circuit rejected the plaintiffs' due process argument, but found the basis for its decision in the Equal Protection Clause. For strong criticism of the majority opinions in these cases see, for example, John Arras, *Physician-Assisted Suicide: A Tragic View*, 13 *Journal of Contemporary Health Law & Policy* 361 (1997); Howard Brody, *Compassion in Dying v Washington: Promoting Dangerous Myths in Terminal Care*, *BioLaw*, July-Aug. 1996, Special Section, at S:154; Robert Burt, *Constitutionalizing Physician-Assisted Suicide: Will Lightning Strike Thrice?*, 35 *Duquesne Law Review* 159 (1996); Yale Kamisar, *The "Right to Die": On Drawing (And Erasing) Lines*, 35 *Duquesne Law Review* 481 (1996); Alexander Morgan Capron, *Liberty, Equality, Death!*, 26 *Hastings Center Report* 23 (May/June 1996).
  19. *Compassion in Dying*, 79 F 3d at 824.
  20. *Ibid.* at 832. In the case of voluntary euthanasia, of course, *as well as in* assisted suicide, the patient herself determines whether her life shall end.

21. *Quill*, 80 F 3d at 729–30 (quoting from the principal opinion in *Planned Parenthood v Casey*, 505 US 833, 851 (1992)).
22. See Charles H. Baron, *Pleading for Physician-Assisted Suicide in the Courts*, 19 *Western New England Law Review* 371 (1997) (arguing persuasively that proponents of PAS are likely to find a warmer reception in the state courts than in the state legislatures). But the decision in *Krischer v McIver*, 697 So 2d 97 (Fla 1997), indicates that in the post-*Glucksberg*, post-*Quill* era, PAS proponents may meet heavy resistance when they turn to the state courts for relief.

About six months before the U.S. Supreme Court rulings in *Glucksberg* and *Quill*, a Florida trial court held that a terminally ill AIDS patient was entitled, under the Privacy Amendment of the Florida Constitution, to determine the time and manner of his death and that, in order to do so, he had the right to seek and obtain the assistance of his physician in committing suicide. See the discussion in *Krischer v McIver*, 697 So 2d at 99–100. But a few short weeks after the Supreme Courts decisions in *Glucksberg* and *Quill*, the Florida Supreme Court reversed the trial court (6–1). See *ibid.* at 104.

Since Florida's Privacy Amendment establishes a right "much broader in scope than that of the Federal Constitution," *Winfield v Division of Pari-Mutuel Wagering*, 477 So 2d 544, 548 (Fla. 1985), the Florida Supreme Court could have distinguished *Glucksberg* and *Quill* without much difficulty. But the Florida Supreme Court did not do so. Instead, it quoted at length from Chief Justice Rehnquist's opinion in *Glucksberg* and the New York State

Task Force Report on assisted suicide and euthanasia, a report that recommended unanimously that New York's total ban against assisted suicide and euthanasia be maintained. (Chief Justice Rehnquist, too, had relied heavily on the New York report.) After discussing, and balking at, the arguments frequently made by proponents of PAS, Florida's highest court concluded:

[T]his case should not be decided on the basis of this Court's own assessment of the weight of the competing moral arguments. By broadly construing the privacy amendment to include the right to assisted suicide, we would run the risk of arrogating to ourselves those powers to make social policy that as a constitutional matter belong only to the legislature.

*Krischer*, 697 So 2d at 104.

23. *Quill*, 117 S Ct at 2298.
24. *Glucksberg*, 117 S Ct at 2270.
25. *Compassion in Dying v Washington*, 79 F 3d 790, 824 (9th Cir 1996) (en banc), *rev'd sub nom.* *Washington v Glucksberg*, 117 S Ct 2268 (1997).
26. *Quill*, 117 S Ct at 2298–99.
27. Brief for Respondents at 29, *Quill* (No. 95–1858), available in 1996 WL 708912.
28. *Quill*, 117 S Ct at 2301.
29. *Glucksberg*, 117 S Ct at 2270.
30. *Compassion in Dying*, 79 F 3d at 813–14 (quoting *Planned Parenthood v Casey*, 505 US 833, 851 (1992)).
31. *Casey*, 505 US at 851.
32. *Ibid.*
33. *Glucksberg*, 117 S Ct at 2271.
34. *Ibid.* (citation omitted).
35. Many physicians and bioethicists seem to believe that providing risky pain relief is always justifiable, regardless of how certain or probable

- the risk of death may be. Recently, however, two law professors have maintained that, as a matter of criminal law, the physician's motive or desire to relieve pain does not automatically or necessarily justify the administration of pain relief. See Norman L. Cantor & George C. Thomas III, *Pain Relief, Acceleration of Death, and Criminal Law*, 6 Kennedy Institute of Ethics Journal 107 (1996). They argue that if, for example, the situation were such that no analgesic dosage could provide pain relief without also causing prompt death (or if under the circumstances it was almost certain that the required analgesic dosage would cause death) the physician who administered the analgesic would be criminally liable for the resulting death even though death was not intended as a result. According to the authors, as defined by the Model Penal Code these deaths would be "knowing" homicides (acting with awareness that one's conduct is "practically certain" to bring about a particular result). See *ibid.* at 119. Moreover, according to the authors, if it were *highly likely* that the administration of an analgesic would cause prompt death (for example a 75–90% chance), the physician who used the painkillers that caused the death would also be criminally liable (for having acted "recklessly"). See *ibid.* at 111.
36. Cass R. Sunstein, "Supreme Caution: Once Again, the High Court Takes Only Small Steps," *Washington Post*, July 6, 1997, at C 1.
  37. *Glucksberg*, 117 S Ct at 2303 (O'Connor, J., concurring) (emphasis added).
  38. See *ibid.*
  39. *Ibid.* (emphasis added).
  40. *Ibid.* (emphasis added).
  41. See *ibid.*
  42. *Glucksberg*, 117 S Ct at 2311.
  43. *Ibid.*
  44. *Ibid.*
  45. *Ibid.*
  46. *Ibid.*
  47. *Ibid.* at 2312. (citations omitted).
  48. Brief for United States as Amicus Curiae Supporting Petitioners at 12, *Glucksberg* (No. 96–110), available in 1996 WL 663186.
  49. *Ibid.* at 13.
  50. *Ibid.* at 12–13.
  51. Transcript of Oral Argument, *Glucksberg* (No. 96–110), available in 1997 WL 13671, at \*18, \*20–21 (Jan. 8, 1997) (emphasis added).
  52. *Ibid.* at \*35–36.
  53. For the view that the O'Connor-Breyer-Ginsburg position that "any constitutional right [in this area] would be limited to relief from pain . . . seems arbitrary" for a number of reasons, see Ronald Dworkin, "Assisted Suicide: What the Court Really Said," *New York Review of Books*, Sept. 25, 1997, at 40, 42.
  54. *Glucksberg*, 117 S Ct at 2303.
  55. See Richard H. Fallon, Jr., *The Supreme Court, 1996 Term—Foreword: Implementing the Constitution*, 111 Harvard Law Review 54, 139 n.616 (1997).
  56. So far as I know, no state presently prohibits the use of palliative care when it is likely to hasten death. However, warns Dr. Howard Brody in this Symposium, "if it becomes widely known (or alleged) that palliative care techniques sometimes deliberately hasten death, we can expect new laws to be introduced that would hamstring palliative practice." Howard Brody, *Physician-Assisted Suicide in the Courts: Moral Equivalence, Double Effect, and Clinical Practice*, 82 Minnesota Law Review 939, 960 (1998) (citation omitted).

57. Robert A. Burt, *The Supreme Court Speaks—Not Assisted Suicide but a Constitutional Right to Palliative Care*, 337 *New England Journal of Medicine* 1234, 1234 (1997).
58. *Ibid.* I recently discovered that, acting independently of each other, Professor Burt and I had reached the same conclusion in this regard. Compare Yale Kamisar, *On the Meaning and Impact of the U.S. Supreme Court's Recent Rulings in the Physician-Assisted Suicide Cases*, Prepared Remarks for the Panel on Physician-Assisted Suicide at the American Bar Association Annual Meeting (Aug. 2, 1997) (transcript on file with the *Harvard Law Review*) with Burt (cited in note 57).
59. Brody, at 22 (cited in note 56); see also Burt at 1234 (cited in note 57), (noting that the Second Circuit's ruling in *Quill* had led some New York physicians "to fear the legal consequences of adequately managing symptoms through the use of opioids that are believed to carry a foreseeable risk of hastened death").
60. Brief of the American Medical Association, the American Nurses Association, and the American Psychiatric Association et al. as Amicus Curiae in Support of Petitioners at 4, *Glucksberg* (No. 96-110), available in 1996 WL 656263 (citation omitted).
61. *Ibid.* (emphasis added).
62. See the discussion in Cantor & Thomas, at 109 (cited in note 35). To cite one specific example, Dr. Thomas Preston, a well-known proponent of PAS, and one of the plaintiffs in the *Glucksberg* case, has asserted that "the morphine drip is undeniably euthanasia, hidden by the cosmetics of professional tradition and language." Thomas A. Preston, "Killing Pain, Ending Life," *New York Times*, Nov 1, 1994, at A27.
63. See *Compassion in Dying v Washington*, 79 F 3d 790, 824 (9th Cir 1996) (en banc), *rev'd sub nom. Washington v Glucksberg*, 117 S Ct 2258 (1997).
64. See Brody, at 13 (cited in note 56).
65. Brief of the American Medical Association, the American Nurses Association, and the American Psychiatric Association et al. as Amicus Curiae in Support of Petitioners at 3, *Glucksberg* (No. 96-110), available in 1996 WL 656263.
66. *Washington v Glucksberg*, 117 S Ct 2303 (1997) (O'Connor, J., concurring).
67. Puzzling, too, was Justice O'Connor's remark that, in the context of the facial challenge to the New York and Washington laws, she saw no need "to address the narrower question whether a mentally competent person who is experiencing great suffering has a constitutionally cognizable interest in controlling the circumstances of his or her imminent death." *Ibid.* The "narrower question" was the *only* question the parties addressed.
68. Brief for Respondents at i, *Glucksberg* (No. 95-1858), available in 1996 WL 708925.
69. Transcript of Oral Argument, *Glucksberg* (No. 96-110), available in 1997 WL 13671, at \*26-27 (Jan. 8, 1997) (emphasis added).
70. See, e.g., Kamisar, at 502-13 (cited in note 18).
71. See Transcript of Oral Argument, *Glucksberg* (No. 96-110), available in 1997 WL 13671, at \*27, \*29, \*33-35, \*50-51 (Jan. 8, 1997).
72. *Ibid.* at \*28 (emphasis added).
73. *Ibid.* at \*33-34.
74. Transcript of Oral Argument, *Quill* (No. 95-1858), available in 1997 WL 13672, at \*55-56 (Jan. 8, 1997).
75. *Ibid.* at \*56.

76. *Washington v Glucksberg*, 117 S Ct 2303 (1997) (O'Connor, J. concurring).
77. *Compassion in Dying v Washington*, 79 F 3d 790, 816 (9th Cir 1996) (en banc), *rev'd sub nom.* *Washington v Glucksberg*, 117 S Ct 2258 (1997); see also *ibid.* at 798–99.
78. *Ibid.* at 814.
79. *Ibid.* at 801.
80. *Glucksberg*, 117 S Ct at 2269 (footnote omitted).
81. *Ibid.* at 2262 & n.6, 2274, 2755 & n.24 (emphasis added).
82. *Ibid.* at 2275 (emphasis added).
83. *Ibid.* at 2304 (Stevens, J., concurring in the judgment).
84. *Compassion in Dying*, 79 F 3d at 795–96.
85. See *ibid.* at 795–96 & 795 n.3.
86. See *Singleton v Wulff*, 428 US 106, 112–13 (1976); *Planned Parenthood v Ashcroft*, 462 US 476, 478 (1983); *Planned Parenthood v Danforth*, 428 US 52, 62 (1976); *Doe v Bolton*, 410 US 179, 188 (1973).
87. *Glucksberg*, 117 S Ct at 2303.
88. Fallon, at 152 (cited in note 55); see also *The Supreme Court, 1996 Term—Leading Cases*, 111 Harvard Law Review 197, 248 (1997).
89. *Glucksberg*, 117 S Ct at 2265–66. See also concurring Justice O'Connor's comment: "As the Court recognizes, States are presently undertaking extensive and serious evaluation of physician-assisted suicide and other related issues." *Ibid.* at 2303.
90. At one point in the oral arguments, Justice Souter pointed out that in other cases in which the Court had intervened "[t]here were certain groups who simply did not get a representative fair shake," but "[t]hat's not what we've got here. . . . [In this case], everybody is in the same boat." Transcript of Oral Argument, *Glucksberg* (No. 96–110), available in 1997 WL 13671, at \*41 (Jan. 8, 1997).
91. Burt, at 179 (cited in note 18).
92. Cass R. Sunstein, *The Right to Die*, 106 Yale Law Journal 1123, 1146 (1997) (written before the *Glucksberg* and *Quill* cases).
93. Addressing Kathryn Tucker, attorney for the plaintiffs in *Glucksberg*, Justice O'Connor remarked:
- I wanted to ask you whether it should enter the balance of state interests versus the interests of the patient here, that this is an issue that every one of us faces, young or old, male or female, whatever it might be. And all of us who are citizens and authorized to vote can certainly participate through this process in the development of state law in this area.
- Does that cause the balance in any way to shift, do you think? We are not dealing perhaps with an unrepresented group, a group of children or a group of women who have no other means to protect themselves, some specific confined group. This is something that affects all of us.
- Transcript of Oral Argument, *Glucksberg* (No. 96–110), available in 1997 WL 13671, at \*39–40 (Jan. 8, 1997).
- A moment later Justice Ginsburg added that "most of us have parents or other loved ones and we've lived through a dying experience that forces us to think about these things." *Ibid.* at \*42. The reason age is not considered the same kind of suspect classification as race, continued Justice Ginsburg, is that "[w]e were all once young, we hope we will be old, it's universal." *Ibid.*

94. *Washington v Glucksberg*, 117 S Ct 2303, 2303 (1996). Some might argue that in a system formally prohibiting PAS the wealthy and the well connected will still obtain such assistance “underground.” But the counterargument is that in a system formally authorizing PAS, the risks of abuse are likely to fall most heavily against members of disadvantaged groups. See generally Yale Kamisar, *Physician-Assisted Suicide: The Problems Presented by the Compelling, Heartwrenching Case*, 88 *Journal Criminal Law & Criminology* 1121, 1127–33 (1998).
95. *Glucksberg*, 117 S Ct at 2274 n.23 (citation omitted). There is considerable literature on this point. See generally Kamisar, (cited in note 18, and the articles and books quoted or cited therein).
96. *Glucksberg*, 117 S Ct at 2274.
97. *Ibid.* (quoting *Compassion in Dying v Washington*, 79 F 3d 790, 838 (9th Cir 1996) (en banc), *rev’d sub nom.* *Washington v Glucksberg*, 117 S Ct 2258(1997)).
98. *Ibid.* (citations omitted). During the oral arguments, Justice Scalia repeatedly expressed doubts that any right to PAS should or could be limited to the terminally ill or to those undergoing physical pain, as opposed to those experiencing “emotional suffering” or “emotional pain.” See Transcript of Oral Argument, *Glucksberg* (No. 96-110), available in 1997 WL 13671, at \*27–28, \*31–34, \*55–56 (Jan. 8, 1997).
99. She said only that she “concur[red] in the Court’s judgments in [*Glucksberg* and *Quill*] substantially for the reasons stated by Justice O’Connor in her concurring opinion.” *Glucksberg*, 117 S Ct at 2310.
100. Transcript of Oral Argument, *Glucksberg* (No. 96–110), available in 1997 WL 13671, at \*49–50 (Jan. 8, 1997).
101. *Ibid.* at \*50.
102. *Ibid.*
103. *Ibid.* at \*29 (emphasis added).
104. See Linda Greenhouse, “An Issue for a Reluctant High Court,” *New York Times*, Oct. 6, 1996, at E3.
105. *Cruzan v Director, Missouri Department of Health*, 497 US 261 (1990).
106. See Greenhouse, at E3, cited in note 104.
107. Brief of the American Medical Association, the American Nurses Association, and the American Psychiatric Association et al. as Amicus Curiae in Support of Petitioners at 5, *Glucksberg* (No. 96–110), available in 1996 WL 656263 (citation omitted).
- I believe that the strong opposition to PAS by the AMA and many other medical groups is significant in itself. But I also believe that the AMA amicus brief makes a number of important points. To give some examples:
- (1) Demand for PAS among terminally ill persons is “best understood not as a necessary response to untreatable pain uniquely felt by the dying, but in the broader context of requests for suicide generally” (among all suicides only a small percentage are terminally ill and among all terminally or severely ill patients, only a small percentage attempt or commit suicide). *Ibid.* at 10.
  - (2) “[T]he fact that many patients do not receive adequate pain relief or suffer from undiagnosed and untreated depression puts undue pressure on them to seek physician-assisted suicide.” *Ibid.* at 13.

- (3) “[P]oor and minority individuals are at the greatest risk for receiving inadequate care and thus may feel the greatest pressure to request physician-assisted suicide.” *Ibid.*
- (4) “Were physician-assisted suicide to become a legitimate medical option, then a decision not to select that option would make many patients feel responsible for their own suffering and for the burden they impose on others.” *Ibid.* at 17.
- (5) “[T]he unprecedented intrusion into the physician-patient relationship needed independently to regulate [assisted suicide] decisions would be fundamentally inconsistent with the private nature of health care treatment, and all too likely to undermine what progress had been made in decisions to withdraw or withhold life-sustaining treatment and to use effective pain control.” *Ibid.*
108. Leon R. Kass & Nelson Lund, *Physician-Assisted Suicide, Medical Ethics and the Future of the Medical Profession*, 35 *Duquesne Law Review* 395, 423 (1996).
109. *Ibid.*
110. Although the drafters of a recently proposed “Model State Act” are convinced that a statute authorizing PAS must contain strong safeguards, they recognize that at a time which is likely to be extremely difficult for both patients and families, both patients and family members will “often quite reasonably view the procedures as a profound invasion of their privacy.” Charles H. Baron et al., *A Model State Act to Authorize and Regulate Physician-Assisted Suicide*, 33 *Harvard Journal on Legislation* 1, 13–14 (1996).
111. Franklin Miller et al., *Can Physician-Assisted Suicide Be Regulated Effectively?*, 24 *Journal of Law, Medicine, & Ethics* 225, 226 (1996).
112. *Ibid.* Consider, too, the recent observations of Thomas Preston, a well-known proponent of PAS and one of the plaintiffs in the *Glucksberg* case:
- Under the present legal climate, [any] future legislative or judicial allowance of dying by prescription of lethal drugs will be accompanied by a legal regulatory system so protracted and intrusive on the private decision of doctor and patient that it may render a legal request unworkable. . . . An eminent Seattle physician confided to me that he voted against Washington State Initiative 119 (this initiative, in 1991, would have legalized euthanasia and assisted suicide) because, “If I have a patient who is within days of dying and suffering greatly, I need to act quickly. If the initiative became law I’d have so many hoops to jump through every time I had a patient dying, I could never give the best treatment for the individual case.”
- Thomas A. Preston, *The Case for Privacy in Dying: A Solution from the Supreme Court*, *King County Medical Society Bulletin*, Nov 1997, at 9, 12.
113. See Baron et al., at 28 (cited in note 110).
114. Miller et al., at 226 (cited in note 111).
115. *Ibid.* Thus, this procedural safeguard could be satisfied by “a friend or close colleague of the treating physician, or even by a subordinate physician under the treating physician’s supervision.” *Ibid.*

116. See Sylvia A. Law, *Physician-Assisted Death: An Essay on Constitutional Rights and Remedies*, 55 Maryland Law Review 292, 297 n.13 (1996).
117. As noted in *Glucksberg*, two months before the Court decided the PAS cases, President Clinton signed the Federal Assisted Suicide Funding Restriction Act of 1997, Public Law 106-12, 111 Stat. 23 (codified as amended 42 U.S.C. §§ 14401 et seq.) prohibiting the use of federal funds in support of PAS. See *Washington v Glucksberg*, 117 S Ct 2258, 2266 (1997).
118. 410 US 113 (1973).
119. Transcript of Oral Argument, *Glucksberg* (No. 96-110), available in 1997 WL 13671, at \*38-39 (Jan. 8, 1997). Justice O'Connor added, "I think there is no doubt that [if those challenging the constitutionality of Washington's anti-assisted suicide law were to prevail] it would result in a flow of cases through the court system for heaven knows how long." *Ibid.* at \*39.
120. See David J. Garrow, "All Over but the Legislating: There Was a Genuine War over Abortion, These Writers Think, but the Armistice Appears to Be Durable," *New York Times*, Jan. 26, 1998, Book Review, at 14.