

A Line Already Drawn: The Case for Voluntary Euthanasia After the Withdrawal of Life-Sustaining Hydration and Nutrition

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When life-sustaining hydration and nutrition is withheld from an incompetent and immobile patient like Terri Schiavo, death comes to the patient by dehydration within about two weeks. Americans should be permitted to arrange for euthanasia at that point, as opposed to merely dehydrating to death, and should be able to incorporate their desire for euthanasia into an advance directive. A state constitutional right of privacy could provide the legal avenue permitting effectuation of such a choice.

I. INTRODUCTION

President Ronald Reagan once exclaimed that “[t]he nine most terrifying words in the English language are ‘I’m from the government and I’m here to help.’”¹ Considering the events that have transpired since Terri Schiavo’s heart attack in 1990, she would likely agree. Mrs. Schiavo has survived in a permanent vegetative state² since her heart attack, and, like most Ameri-

* The Author wishes to thank Professor Robert Levy and Lisa Ells for their invaluable efforts and advice in the production of this Note.

1. President Ronald Reagan, Statement at a Chicago Press Conference (Aug. 12, 1986).

2. A permanent vegetative state is a product of technological advance in the field of medicine. See *In re Eichner*, 73 A.D.2d 431, 447 (N.Y. App. Div. 1980). Commentators have described the vegetative state as follows:

When the eyes open after a coma but the person remains unconscious, the individual is said to be in a vegetative state — defined as not having an awareness of oneself, or of the environment, and having no evidence of language compre-

cans, never executed an advance directive or living will.³ Following a three-week trial to determine what Mrs. Schiavo's wishes would have been under the circumstances, the feeding tube that had kept her alive for thirteen years was removed on October 15, 2003.⁴ Six days later, however, the public drama began, as the Florida Legislature substituted its judgment for Mrs. Schiavo's — or at least what the courts had determined was her judgment — and passed legislation ordering the tube to be reinserted.⁵ As of this writing, Mrs. Schiavo continues to be maintained alive, awaiting the outcome of the ensuing litigation.⁶

Normally, withdrawing life-sustaining hydration and nutrition from a perpetually incompetent and immobile patient like Terri Schiavo leads to death by dehydration within about two weeks.⁷ The patient is left to slowly wither away. It is impossible to know whether the patient "feels" this dehydration as it occurs.

This Note argues for allowing citizens, in creating an advance directive, to order voluntary euthanasia⁸ after life-sustaining hy-

hension. If there's no progress within a month, the person is considered to be in a "persistent vegetative state." Next is the "permanent vegetative state," which is declared between three months and a year, depending on the nature of the injury.

Dawn MacKeen & Roni Rabin, *States of Awareness, Defining, Debating What Constitutes a Vegetative State*, NEWSDAY (New York), Oct. 26, 2003, at A05.

3. The "overwhelming majority of Americans have not executed such written instructions." *Cruzan v. Mo. Dep't of Health*, 497 U.S. 261, 323 n.21 (1990) (Brennan, J., dissenting). Justice Brennan cites three polls finding that twenty-three percent, fifteen percent, and nine percent, respectively, of Americans have executed advance treatment instructions.

4. William R. Levesque & Craig Pittman, *Food Tube Back In, Schiavo at Hospice*, ST. PETERSBURG TIMES, Oct. 23, 2003, at 1A.

5. William R. Levesque, *Judge Calls Terri's Law Intrusive*, ST. PETERSBURG TIMES, Nov. 15, 2003, at B1.

6. The Florida Supreme Court recently held the legislation unconstitutional, setting the stage for the removal, again, of Mrs. Schiavo's life support. See Press Release, Voice of America, U.S. State Court Strikes Down Law Keeping Brain-Dead Woman Alive (Sept. 24, 2004), available at 2004 WL 92188293. For more information about Terri Schiavo generally, see Terri Schindler-Schiavo Foundation, at <http://www.terrisfight.org> (last updated Oct. 5, 2004).

7. There is some range, however, from three to thirty days. See, e.g., *In re Conroy*, 486 A.2d 1209, 1217 (N.J. 1985) ("Both doctors testified that if the nasogastric tube were removed, Ms. Conroy would die of dehydration in about a week.").

8. In the debate about physician-assisted suicide and the right to remove life-sustaining treatment, different authors use different terms to convey specific ideas. As used in this Note, "assisted suicide" or "physician-assisted suicide" refers to assistance provided by a doctor or third party to a patient who desires to end his or her own life, where the patient commits the final death-causing act themselves. The assistance could be in the form of prescribing medication (as in Oregon's Death with Dignity Act, see OR.

dration and nutrition is withdrawn. Part II outlines the bleak state of the law relating to physician-assisted suicide, beginning with its precursor, the right to refuse life-sustaining treatment. Part III criticizes the Supreme Court's intense focus on tradition and refusal to recognize any constitutionally protected liberty interest in suicide. Part IV argues that a privacy interest in suicide should be established under a right of privacy found in state constitutional law. Establishing such a privacy interest need not entail significant alteration of the status quo. Typically, the state can put forth significant countervailing interests so as to justify its attempts to prevent suicides. Part V explores the ways in which the law and our conceptual framework have changed to allow for the refusal and withdrawal of life-sustaining treatment and argues that the existing conceptual framework can change to encompass greater degrees of physician assistance in suicide, including voluntary euthanasia. Part VI explores the possibility that when life-sustaining hydration and nutrition is withdrawn from an immobile, incompetent patient, his or her privacy interest in suicide may overcome the countervailing state interests, thus vesting in the patient a "right" to suicide. Analogous to physician assistance with abortion, the patient's right to suicide may be construed with sufficient breadth so as to immunize a physician who acts to effectuate the patient's right in those cases where the patient's desire for voluntary euthanasia under these circumstances was previously made clear.⁹

REV. STAT. § 127.805(1) (2001)), providing information, or otherwise. "Euthanasia" refers to such assistance in situations where the patient cannot or does not perform the final death-causing act themselves. Euthanasia can be "voluntary," in which case it is often referred to simply as "euthanasia," or "non-voluntary/ involuntary," according to whether the patient desired and instructed the assistance. "Non-voluntary/ involuntary" euthanasia is the kind typically balked at and feared, conjuring up images of Nazi Germany and the Eugenics Movement. John Glasson, *Reports of the Council on Ethical and Judicial Affairs of the American Medical Association*, 10 ISSUES L. & MED. 91, 92 (1994).

The literature further categorizes the form of assistance that is provided into "active" or "passive" assistance. "Active" assistance refers to assisted suicide and euthanasia, whereas "passive" assistance refers to the removal or termination of life-sustaining treatment or nutrition and hydration. See, e.g., Victoria L. Helms, *Assisted Suicide: Giving Meaning to the Right to Die*, 6 ST. THOMAS L. REV. 173, 176 (1993).

9. What the required standard of proof of the patient's intent should be is beyond the scope of this Note. As a baseline, this Note assumes that such prior-expressed intent takes the form of an advance directive.

II. BACKGROUND

A. THE REFUSAL OF LIFE-SUSTAINING TREATMENT AND *CRUZAN V. MISSOURI DEPARTMENT OF HEALTH*

The precursor to the physician-assisted suicide debate was the debate about the right to remove life-sustaining treatment,¹⁰ commonly known as the “right to die.” By the time the Supreme Court addressed the question as to whether there was a constitutionally protected right to refuse life-saving medical treatment, several state supreme courts had already held that there was such a right, either in the common law doctrine of informed consent or in the Constitution.¹¹

In *Cruzan v. Missouri Department of Health*,¹² the question came to the Supreme Court in a roundabout way. The issue was not directly whether there was a constitutionally protected “right to die,” but whether Missouri could constitutionally continue forced hydration and nutrition of an incompetent, immobile patient, legally permitting the treatment to be abandoned only where clear and convincing proof of the patient’s prior-expressed desire not to be kept alive in that manner was presented. Writing for the majority, Justice Rehnquist acknowledged that the “principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions.”¹³ With regard to

10. Marker and Smith have expressed concern over the “verbal engineering” that has sometimes left the term “removal of treatment” encompassing the removal of nutrition and hydration. See Rita L. Marker & Wesley J. Smith, *The Art of Verbal Engineering*, 35 DUQ. L. REV. 81, 94–102 (1996).

11. See, e.g., *In re Conservatorship of Drabick*, 200 Cal. App. 3d 185 (1988) (noting that right to refuse life-sustaining treatment was grounded in common law and constitutional right of privacy); *In re Estate of Longeway*, 549 N.E.2d 292 (Ill. 1989) (holding that the doctrine of informed consent allowed for right to refuse life-sustaining hydration and nutrition); *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417 (Mass. 1977) (holding that the right of privacy and the right of informed consent allowed for the refusal of life-sustaining medical treatment); *In re Conroy*, 486 A.2d 1209 (N.J. 1985) (holding that the common law doctrine of informed consent and self-determination allowed for removal of life-sustaining medical treatment); *In re Quinlan*, 355 A.2d 647 (N.J. 1976) (holding that the federal constitutional right of privacy entailed a right to refuse life-sustaining medical treatment); *In re Eichner*, 420 N.E.2d 64 (N.Y. 1981) (holding that the doctrine of informed consent allowed withdrawal of life-sustaining treatment).

12. 497 U.S. 261 (1990).

13. *Id.* at 278.

treatment that would result in the death of the patient if withheld, however, the Court vacillated, noting that although “the logic of the cases discussed . . . 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.”¹⁴ Instead of deciding whether there was a constitutionally protected liberty interest in refusing such life-sustaining treatment, the Court assumed, “for the purposes of [the] case,” that “the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition.”¹⁵ The Court went on to hold that even if such a substantive liberty interest existed, Missouri’s procedural “rule of decision” regarding incompetent patients was constitutional.¹⁶

Although the majority opinion assumed the existence of a protected liberty interest in refusing life-sustaining treatment, five of the justices addressed the liberty interest at stake. For Justice O’Connor, the liberty interest recognized by the Court’s prior decisions encompassed “artificially delivered food and water,”¹⁷ since “[a]rtificial feeding cannot readily be distinguished from other forms of medical treatment.”¹⁸ Under her analysis, then, the protected liberty interest in refusing treatment implicitly includes the right to refuse those forms of treatment — like food and water — that are necessary to sustain life.

Justice Stevens’s dissent similarly indicated a protected liberty interest in removing life-sustaining treatment. He would have required that Nancy Cruzan’s feeding tube be removed, suggesting that the “Constitution requires the State to care for [patients’] li[ves] in a way that gives appropriate respect to [their] own best interests.”¹⁹ Although a patient’s prior-expressed intent may not coincide in marginal cases with what is deemed to be in the patient’s “best interests,” it is clear that Justice Stevens’s best interests standard applies only to cases where the patient “did

14. *Id.* at 279.

15. *Id.*

16. The state rule of decision required clear and convincing evidence of an incompetent patient’s wish to have life-sustaining treatment withdrawn. *Id.* at 284.

17. *Id.* at 287 (O’Connor, J., concurring).

18. *Id.* at 288.

19. *Id.* at 331 (Stevens, J., dissenting).

not have the foresight to preserve [his/her] constitutional right in a living will, or some comparable . . . alternative.”²⁰ He clearly acknowledged a constitutionally protected right to remove life-sustaining treatment, complaining that the majority’s “waiver rationale” leaves “[a]n innocent person’s constitutional right to be free from unwanted medical treatment . . . categorically limited to those patients who had the foresight to make an unambiguous statement of their wishes while competent.”²¹

Similarly, Justice Brennan in his dissent (joined by Justices Marshall and Blackmun) argued that the right to refuse life-sustaining treatment should be a fundamental right.²² With five Justices agreeing that a competent patient has at least a constitutionally protected liberty interest, the constitutional liberty interest in refusing life-sustaining treatment was presumptively established. The majority’s holding — that the state may require clear and convincing evidence of a patient’s prior-expressed desire to refuse such treatment before permitting the withdrawal — is in no way inconsistent with this secondary holding that there indeed exists a protected liberty interest in refusing life-sustaining treatment.

B. THE SUPREME COURT REJECTS PHYSICIAN-ASSISTED SUICIDE IN *WASHINGTON V. GLUCKSBERG*

In *Washington v. Glucksberg*,²³ challengers to a statute criminalizing assisted suicide heavily relied upon the *Cruzan* case and the “right” to refuse life-sustaining treatment. The Supreme Court nevertheless unanimously held that there is no right to physician-assisted suicide for terminally ill, mentally competent patients in the Fourteenth Amendment Due Process Clause.²⁴ In

20. *Id.* at 339.

21. *Id.* at 338–39.

22. *Id.* at 304 (Brennan, J., dissenting).

23. 521 U.S. 702 (1997). In the companion case to *Glucksberg* the Supreme Court held that statutes barring assisted suicide do not violate the Equal Protection Clause. *See Vacco v. Quill*, 521 U.S. 793 (1997).

24. Unlike several of the concurring opinions which treated the constitutional attack as a facial challenge, Chief Justice Rehnquist’s majority opinion treated the attack as a challenge to the statute as it applied to terminally ill, mentally competent patients. *See Glucksberg*, 521 U.S. at 709 n.6 (1997) (“It is . . . the [lower] court’s holding that Washington’s physician-assisted suicide statute is unconstitutional as applied to the ‘class of ter-

so holding, the majority heavily relied on the fact that, “for over 700 years, the Anglo-American tradition has punished or otherwise disapproved of both suicide and assisted suicide.”²⁵ Although no state currently criminalizes suicide, prohibitions against assisted suicide remain, and “the prohibitions against assisted suicide [have] never contained exceptions for those who were near death.”²⁶ Chief Justice Rehnquist, again writing for the Court, followed what he considered the “established approach”²⁷ to substantive due process, insisting upon “a threshold requirement — that a challenged state action implicate a fundamental right — before requiring more than a reasonable relation to a legitimate state interest.”²⁸ The Court found that “the asserted ‘right’ to assistance in committing suicide is not a fundamental liberty interest protected by the Due Process Clause.”²⁹ Failing the threshold inquiry, then, the Court’s rational basis review of the statute was easily satisfied.³⁰

Of the five concurrences, Justice Souter’s was the only one to treat — as the majority did — the constitutional attack as an “as-applied” challenge, narrowed to whether the statute was constitutional as it applied to the specific group of terminally ill, mentally competent patients.³¹ Characterizing the substantive due process inquiry as “whether the statute sets up one of those ‘arbitrary impositions’ or ‘purposeless restraints’ at odds with the Due Process Clause,”³² Justice Souter rejected the majority’s fundamental liberty threshold analysis as the “opposite pole” from the “absolutist failings of many older cases.”³³ Although Justice Souter accepted the necessity of a “threshold requirement,”³⁴ his

minally ill, mentally competent patients,’ that is before us today.”) (internal citations omitted).

25. *Id.* at 711.

26. *Id.* at 714.

27. *Id.* at 722 n.17.

28. *Id.* at 722.

29. *Id.* at 728.

30. *Id.* (“The Constitution also requires, however, that Washington’s assisted-suicide ban be rationally related to legitimate government interests. This requirement is unquestionably met here.”) (internal citations omitted).

31. *Id.* at 753 n.2 (Souter, J., concurring) (“I see the challenge to the statute not as facial but as-applied . . .”).

32. *Id.* at 752.

33. *Id.* at 765.

34. *Id.* at 767 n.9.

was much looser than the majority's,³⁵ allowing for more to pass through to the second-level balancing of interests.³⁶ At this second stage, according to Justice Souter, the Court "assess[es] the relative 'weights' or dignities of the contending interests,"³⁷ requiring the state to put forth an "interest sufficiently compelling"³⁸ in order for the statute to be upheld.³⁹ Although he found the liberty interest of terminally ill, competent patients to be considerable,⁴⁰ Souter nevertheless concluded that the state's interest in avoiding coerced or otherwise non-voluntary decisions by patients outweighed that liberty interest,⁴¹ at least for now. Justice Souter entertained the argument that this controlling state interest might be feasibly accommodated by simply policing physicians through implementation of "regulation with teeth."⁴² But given that such regulatory attempts in the Netherlands have produced inconclusive results,⁴³ and since legislatures have "superior" fact-finding ability to determine how best to police that line,⁴⁴ it was appropriate that the judiciary "stay its hand."⁴⁵ As a parting note, though, Justice Souter intimated that "legislative foot dragging in ascertaining the facts going to the state's argu-

35. Justice Souter's idea of substantive due process is a "continuum of rights to be free from 'arbitrary impositions and purposeless restraints.'" *Id.* at 765 (citing *Poe v. Ullman*, 367 U.S. 497, 543 (1961) (Harlan, J., dissenting)). Anywhere along the continuum where a "protected" liberty interest exists, it passes the threshold. For Justice Souter, the term "fundamental" describes the situation when the liberty interest prevails in the subsequent balancing. *Id.* at 782. The lack of distinction that Justice Souter perceives between "fundamental" liberties and other protected liberties is apparent in a footnote listing "various terms" that the Court has used to refer to fundamental liberty interests, including inter alia, "protected liberty" and "constitutionally protected liberty interest." *Id.* at 768 n.10.

36. *Id.* at 767.

37. *Id.*

38. *Id.* at 766.

39. For Justice Souter, the statute will stand if "reasonable." Reasonableness implies that it is not arbitrarily or pointlessly applied, taking into consideration the individual interest and the justifying principle behind the statute. *Id.* at 768.

40. *Id.* at 782 ("In my judgment, the importance of the individual interest here, as within that class of 'certain interests' demanding careful scrutiny of the State's contrary claim, cannot be gainsaid." (internal quotation marks omitted)).

41. *See id.* ("It is not necessary to discuss the exact strengths of the first two claims of justification . . . for the third is dispositive for me.")

42. *Id.* at 785.

43. *Id.* at 786.

44. *Id.* at 788.

45. *Id.* at 789.

ment that the right in question could not be confined as claimed⁴⁶ might lead to a different outcome in the future.

Justices O'Connor's,⁴⁷ Stevens's, and Breyer's concurrences all treated the constitutional challenge as a facial one, thereby largely skirting the issue.⁴⁸ Justice O'Connor went further, however, asserting that "there is no generalized right to commit suicide,"⁴⁹ and that even if this were a particularized challenge, the "difficulty in defining terminal illness and the risk that a dying patient's request for assistance in ending his or her life might not be truly voluntary justifies the prohibitions on assisted suicide."⁵⁰

For Justice Breyer, the fact that the state does not interfere with the availability of pain medication, even when it hastens death, controlled the inquiry. Although willing to consider alternative formulations of potentially protected liberty interests — such as the "right to die with dignity" — Justice Breyer insisted that the core of such a protected interest would have to encompass the "avoidance of unnecessary and severe physical suffering."⁵¹ Since "severe physical pain" would have to "constitute an essential part of any successful claim,"⁵² the current absence of any "prohibitive set of laws"⁵³ on this issue was dispositive for him. If the "legal circumstances" surrounding the administration

46. *Id.* at 788.

47. Justice O'Connor was joined in her concurrence by Justice Ginsburg, and by Justice Breyer except insofar as her concurrence joined the opinions of the Court. *Id.* at 736 (O'Connor, J., concurring).

48. Although "[t]he appropriate standard to be applied in cases making facial challenges to state statutes has been the subject of debate," *id.* at 739 (Stevens, J., concurring), as a general rule it is much more difficult to attack a statute facially. Under the strictest standard, the Justice must merely "identify situations in which the . . . statute could be validly enforced" in order to uphold it. *Id.* at 740 n.6. Even under the most lenient standard that has been applied, the challenger must "establish that the invalid applications of a statute [are] not only . . . real, but substantial as well, judged in relation to the statute's plainly legitimate sweep." *Id.* at 740 n.7 (internal quotation marks omitted). Affirming the "plainly legitimate sweep" of assisted suicide statutes is much easier and less controversial than affirming the legitimacy of such statutes as applied to doctors attempting to aid terminally ill, competent patients.

49. *Id.* at 736 (O'Connor, J., concurring) (internal quotation marks omitted).

50. *Id.* at 738. Justice O'Connor's concern over *voluntary* decision-making is one face on the prism reflecting concern over a decision-maker's *competence*. For patients creating an advance directive or living will, such concern is greatly diminished.

51. *Id.* at 790 (Breyer, J., concurring).

52. *Id.* at 791.

53. *Id.* at 792 (emphasis omitted).

of pain medication were altered in the future, though, Breyer suggested the Court “might have to revisit its conclusions.”⁵⁴

Justice Stevens’s concurrence was the most liberal of the five, emphasizing that there is room for further debate with respect to the “limits that the Constitution places on the power of the states to punish the practice,”⁵⁵ and heavily relying on the “facial challenge” versus “applied challenge” distinction. Although finding no “categorical right to commit suicide which itself includes a right to assistance in doing so,”⁵⁶ Justice Stevens noted,

[J]ust as our conclusion that capital punishment is not always unconstitutional did not preclude later decisions holding that it is sometimes impermissibly cruel, so it is equally clear that a decision upholding a general statutory prohibition on assisted suicide does not mean that every possible application of the statute would be valid.⁵⁷

Justice Stevens also read *Cruzan* rather broadly, claiming that it gave recognition to the “specific interest in making decisions about how to confront an imminent death,”⁵⁸ and that it “demonstrated that some state intrusions on the right to decide how death will be encountered are . . . intolerable.”⁵⁹ Although the statute in *Glucksberg* passed the facial challenge, Justice Stevens explicitly refused to “foreclose the possibility that an individual plaintiff seeking to hasten her death, or a doctor whose assistance was sought, could prevail in a more particularized challenge.”⁶⁰

Glucksberg thus delimited at least the outer parameters of any liberty interest implicitly acknowledged in *Cruzan*. Whereas *Cruzan* suggested that the Constitution may demand that patients be permitted to refuse or discontinue life-sustaining treatment, *Glucksberg* made it clear that states may legally prohibit physicians from assisting suicide — or at least from engaging in any proactive means of assistance greater than that necessary to terminate life-sustaining treatment.

54. *Id.*

55. *Id.* at 738 (Stevens, J., concurring).

56. *Id.* at 741 (citations omitted) (internal quotation marks omitted).

57. *Id.*

58. *Id.* at 745.

59. *Id.*

60. *Id.* at 750.

C. LEGISLATURES UNIFORMLY REJECT PHYSICIAN-ASSISTED
SUICIDE, DESPITE THE AMERICAN PEOPLE'S STATED
PREFERENCES

Despite the repeated emphasis in the *Glucksberg* opinions that legislatures may adopt statutes to experiment with methods of providing assisted suicide,⁶¹ state legislatures have uniformly rejected attempts to legalize any form of "active" assisted suicide. Currently, the only state that allows physician-assisted suicide is Oregon, whose Measure 16 was adopted by ballot initiative.⁶² When *Glucksberg* was decided, "forty-four states, the District of Columbia and two territories prohibit[ed] or condemn[ed] asisted suicide."⁶³ Subsequent legislative consideration of the issue has reaffirmed this unanimity in legislative condemnation.

The universal rejection of liberty-enhancing law in this area is not a failure of democracy, at least not in the narrow sense. Majority vote has vindicated these legislative outcomes on several occasions.⁶⁴ Such rejection seems to not, however, coincide with Americans' *stated* preferences. From 1990 to 1994, polls related that sixty-four to seventy-three percent of Americans believe terminally ill people should be able to ask for and receive help from a doctor in order to die.⁶⁵ Similarly, of doctors polled, the majority favor some form of legalized physician-assisted suicide⁶⁶

61. See *Glucksberg*, 521 U.S. at 735.

62. Scott Gast, *Who Defines "Legitimate Medical Practice?" Lessons Learned From the Controlled Substances Act, Physician-Assisted Suicide, & Oregon v. Ashcroft*, 10 VA. J. SOC. POL'Y & L. 261, 261 (2002).

63. *Glucksberg*, 521 U.S. at 711 n.8.

64. In Washington, for example, voters rejected a ballot proposal that would have allowed for physician-assisted suicide. *Id.* at 717. In 1993, California voters rejected a similar ballot proposal. *Id.* In 1998, Michigan voters overwhelmingly rejected such a proposal. See National Conference of State Legislatures, Ballot Measures Database: Statewide Initiatives and Referenda, at <http://www.ncsl.org/programs/legman/elect/dbintro.htm> (last visited Jan. 31, 2004). In 2000, Maine voters barely rejected, by a vote of fifty-one percent, a similar proposal. See *id.*

65. Melvin I. Urofsky, *Leaving The Door Ajar: The Supreme Court And Assisted Suicide*, 32 U. RICH. L. REV. 313, 331 (1998); see also *Compassion in Dying v. State of Washington*, 79 F.3d 790, 810 n.50 (1996) ("A Field poll conducted in California in March 1995 found that 70% of Californians agreed that the terminally ill should be able to obtain medication from their doctors to end their lives."), *rev'd sub nom.* *Washington v. Glucksberg*, 521 U.S. 702 (1997).

66. Various polls have concluded that a majority of doctors favor some form of legalized physician-assisted suicide over an explicit ban. See *Glucksberg*, 521 U.S. at 749 n.12 (Stevens, J., concurring).

in spite of the formally-adopted conservative position of the American Medical Association.⁶⁷

The disparity between poll results and ballot results is provocative, but could be explained in at least three ways. First, the safeguards or procedures incorporated in these ballot proposals may have been insufficient in the view of voters, and given the nature of a ballot proposal, no alterations of the safeguards or procedures were possible. Second, not all Americans vote. It may be that the group of Americans that regularly vote is more disposed against physician-assisted suicide than the general population. Third, Americans may like the idea in theory, but refuse to put their votes where their mouths are, so to speak.⁶⁸ For whatever reason, aside from Oregon's measure, the results of such ballot initiatives have not corresponded with the stated preferences of the American public as related through polling. For patients seeking physician assistance in terminating what has become an objectively unbearable life, the law is inexplicable. Most people seem to agree that they *should* be allowed to obtain assistance, yet only Oregon will give it to them.

D. STATE SUPREME COURTS REJECT PHYSICIAN-ASSISTED SUICIDE

Especially with the expansion of what has been termed "New Federalism,"⁶⁹ the activity of state supreme courts is another area of legal importance. In interpreting their own constitutions, however, state supreme courts have followed the lead of the United States Supreme Court. Although several state supreme

67. As noted in *Krischer v. McIver*, "[T]he American Medical Association, which represents 290,000 physicians . . . overwhelmingly endorsed a recommendation to reaffirm the ethical ban on physician-assisted suicide." 697 So. 2d 97, 103-04 (Fla. 1997) The AMA, however, is a conservative association that also staunchly supported the ban on abortion, and that an assertion that the AMA "represents 290,000 physicians" may be misleading. It is widely acknowledged that a large number of physicians subscribe to the AMA mainly for the periodicals and continuing-education literature.

68. As suggested by members of the Law and Economics movement, preferences should perhaps be understood in terms of what people *do*, as opposed to what people *report* as their preferences.

69. "Proponents of the new judicial federalism envision vigorous state constitutional protection for individual rights implicating an increase in the scope of judicial power among state courts." Michael D. Blanchard, *The New Judicial Federalism: Deference Masquerading as Discourse and the Tyranny of the Locality in State Judicial Review of Education Finance*, 60 U. PITT. L. REV. 231, 232 (1998).

courts have considered the issue under various forms of state constitutional challenges, none has found any right to physician-assisted suicide or euthanasia within the bounds of its state constitution.⁷⁰

E. OREGON: THE LONE EXCEPTION

Oregon is the only state functioning as a “laboratory”⁷¹ on the issue of physician-assisted suicide, and only after much controversy. In November of 1994, Oregon barely approved by ballot initiative its Measure 16, known as the Death with Dignity Act.⁷² Soon after its passage, however, a federal judge enjoined the law, later ruling it unconstitutional and issuing a permanent injunction.⁷³ After the Ninth Circuit reversed⁷⁴ and the Supreme Court denied certiorari, Oregon held a second voter referendum, one which would have repealed the Act.⁷⁵ Voters rejected this second referendum by a more significant margin, allowing the Act to go into effect.⁷⁶

Various federal actors have attempted to prevent the Oregon statute from being fully utilized. Attorney General John Ashcroft tried to stymie the Act, for example, by issuing an interpretive

70. See *Sampson v. State*, 31 P.3d 88 (Alaska 2001) (holding that the Alaskan privacy clause does not protect physician-assisted suicide); *Sanderson v. People*, 12 P.3d 851 (Colo. App. 2000) (rejecting free exercise of religion argument for protecting physician-assisted suicide); *Krischer v. McIver*, 697 So. 2d 97 (Fla. 1997) (holding that the Florida privacy clause does not protect physician-assisted suicide); *People v. Kevorkian*, 639 N.W.2d 291 (Mich. App. 2001) (holding that the Michigan constitution does not protect physician-assisted suicide), *appeal denied*, 642 N.W.2d 681 (Mich. 2002).

71. As noted by Justice Brandeis, “It is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.” *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting).

72. See *Gast*, *supra* note 62, at 261. The Death with Dignity Act is codified at OR. REV. STAT. § 127.800–.897 (2001). The entire text of the statute is available as an appendix to *Lee v. Oregon*, 107 F.3d 1382, 1392–97 (9th Cir. 1997).

73. *Lee v. Oregon*, 891 F. Supp. 1439 (D. Or. 1995), *vacated by* 107 F.3d 1382, 1386 (9th Cir. 1997).

74. *Lee*, 107 F.3d at 1386.

75. See Brian H. Bix, *Physician-Assisted Suicide And Federalism*, 17 NOTRE DAME J.L. ETHICS & PUB. POL’Y 53, 62 (2003).

76. Oregon voters approved Measure 16 by a vote of fifty-one percent to forty-nine percent and rejected the second referendum with a vote of sixty percent to forty percent. Joseph Cordaro, *Who Defers To Whom? The Attorney General Targets Oregon’s Death With Dignity Act*, 70 FORDHAM L. REV. 2477, 2483–84 (2002).

rule with respect to the Controlled Substances Act (“CSA”).⁷⁷ The interpretive rule declared that any physician who prescribed a lethal dose of a drug would be considered in violation of the CSA⁷⁸ and face suspension or revocation of his or her medical license.⁷⁹ The State of Oregon, however, sought and received an injunction against the Attorney General in enforcing, applying, or otherwise giving any legal effect to this interpretive rule.⁸⁰ For its part, United States Congressional opposition to Oregon’s law has taken the form of attempts to pragmatically hamper the law’s application. For example, the Federal Assisted Suicide Funding Restriction Act of 1997, 42 U.S.C. § 14402, prohibits the use of federal funds in support of physician-assisted suicide.⁸¹ At least one other bill that would prohibit using federally controlled substances in physician-assisted suicide has died in Congress.⁸² Despite the multitude of attacks and challenges, it seems that Oregon’s law will continue to function.⁸³ Oregon thus remains the sole exception to nation-wide legal hostility toward physician-assisted suicide.

F. SUMMARY OF NEGATIVE PRECEDENT

Against this background of opposition, there appears to be little hope for liberalizing the rules governing physician-assisted suicide. Although the Supreme Court in *Cruzan* did recognize a federal constitutional liberty interest in refusing life-sustaining

77. 21 U.S.C. § 829 (2004); 21 C.F.R. § 1306.04 (2001) (section that of the regulation that Ashcroft’s interpretive rule was based upon); Attorney General Order No. 2534-2001, 66 Fed. Reg. 56607 (Nov. 9, 2001) (interpretive rule).

78. The Controlled Substances Act regulates drugs like pentobarbital and secobarbital that are used in physician-assisted suicide, providing the federal government a round-about manner of controlling physicians who would assist in suicides. See generally Cordaro, *supra* note 76, at 2486–88.

79. See generally Gast, *supra* note 62, at 267–68.

80. Oregon v. Ashcroft, 192 F. Supp. 2d 1077, 1079–80 (D. Or. 2002).

81. See Bix, *supra* note 75, at 62.

82. “In 1999, Senator Nickles and Representative Hyde launched a second attack on the Death With Dignity Act with the Pain Relief Promotion Act.” Cordaro, *supra* note 76, at 2485–86. The House of Representatives passed the Act by a wide margin, but the bill never reached the floor in the Senate. *Id.* at 2486.

83. In 2002, thirty-eight patients procured life-terminating medication under Oregon’s Death With Dignity Act, moving the total number who have utilized the Act since 1998 to 129. See Deaths Under Oregon’s Physician Assisted Suicide Act, at <http://www.euthanasia.com/deaths2003.html> (last visited Nov. 15, 2004).

treatment, the Court in *Glucksberg* strictly limited the growth prospects for that interest by reaffirming the legal line between active and passive assistance in suicide. State supreme courts and legislatures — aside from Oregon's — have followed suit, leaving active physician-assisted suicide uniformly prohibited in forty-nine states.

In a situation like Terri Schiavo's, however, where a patient has previously made clear his or her desire in an advance directive or living will, all of this negative precedent might effectively be distinguished to allow a doctor to administer euthanasia at the point where life-sustaining hydration and nutrition is terminated. In order for the law to allow euthanasia under such circumstances, the first required step is to establish a liberty interest in suicide.

III. NO INTEREST IN SUICIDE

The fact that the “[n]ation’s history, legal traditions, and practices”⁸⁴ condone no right to suicide led the Supreme Court in *Washington v. Glucksberg* to find no constitutional right to suicide, or at least not one that would “itself include[] a right to assistance in doing so.”⁸⁵ Following the fundamental rights threshold analysis, the Court’s historical survey began with English common law, under which suicide was plainly forbidden. “The real and personal property of one who killed himself to avoid conviction and punishment were forfeit to the king.”⁸⁶ Even for non-convicts, under English law the “movable goods [were] confiscated.”⁸⁷ Along with other common law treatise writers, Blackstone’s view was that “the law has . . . ranked [suicide] among its highest crimes.”⁸⁸

84. *Washington v. Glucksberg*, 521 U.S. 702, 721 (1997).

85. *Id.* at 723. Three years earlier the Michigan Supreme Court, interpreting the federal Constitution, similarly had held that there was not even a constitutionally protected liberty interest to commit suicide, let alone a right. *People v. Kevorkian*, 527 N.W.2d 714, 727 n.37 (Mich. 1994) (“We find it unnecessary to consider the proper reach of the state’s regulatory interest because we disagree with the foundational premise that there exists a constitutionally protected liberty interest to commit suicide.”).

86. *Glucksberg*, 521 U.S. at 711.

87. *Id.* (internal quotation marks omitted).

88. *Id.* at 712 (internal quotation marks omitted).

In the early American colonies, Virginia “required ignominious burial for suicides, and their estates were forfeit to the crown.”⁸⁹ Although American states did later move away from punishment of suicide, the “courts continued to condemn it as a grave public wrong.”⁹⁰ Movement away from the common law’s “harsh sanctions,” Justice Rehnquist argued, “did not represent an acceptance of suicide; rather, . . . this change reflected the growing consensus that it was unfair to punish the suicide’s family for his wrongdoing.”⁹¹

Conceding that suicide has not traditionally received protection throughout American history, it is unclear whether tradition should be such a conclusive factor for determining constitutional rights.⁹² Recourse to tradition functions as a method of grounding the courts, a way to “rein in the subjective elements that are necessarily present in due-process judicial review.”⁹³ As society changes, though, newly developed areas of science and law are automatically controlled by the legislature. Over time, then, excessive reliance on tradition will leave the sphere of individual liberty smaller in relationship to the sphere of activity controlled by majoritarian will as expressed through legislation. As noted by Justice Mallett of the Michigan Supreme Court, “[T]o recognize only fundamental rights according to such a test is unsuitable for the vast and fast-moving progressions of the modern world.”⁹⁴

The Court’s other fundamental rights principle — that an individual choice seeking protection must be one “implicit in the concept of ordered liberty” such that “neither liberty nor justice would exist if [the choice] were sacrificed”⁹⁵ — is so narrow that if

89. *Id.* at 713.

90. *Id.* at 714.

91. *Id.* at 713.

92. “Anglo-American traditions, so understood, include a great deal of good but also significant confusion and injustice (consider, for example, bans on racial intermarriage); it is appropriate for courts to engage in at least a degree of critical scrutiny of intrusions on liberty even if those intrusions do not offend tradition.” Cass R. Sunstein, *The Right to Die*, 106 YALE L.J. 1123, 1135 (1997). As Justice Souter suggests, the Court’s exclusive focus on “past practice described at a very specific level” is merely the “opposite pole” from the “absolutist failing” of the *Lochner* era. *Glucksberg*, 521 U.S. at 765 (Souter, J., concurring).

93. *Id.* at 722.

94. *People v. Kevorkian*, 527 N.W.2d 714, 753 (Mich. 1994) (Mallett, J., concurring in part and dissenting in part).

95. *Palko v. Connecticut*, 302 U.S. 319, 325–26 (1937).

taken literally, it fails to encompass anything at all. Although doctrine shows that this is not the actual test that the Court has applied,⁹⁶ to accept the Court's test at face value would suggest progression over time toward a veritable "tyranny of the majority."⁹⁷

The Court's refusal to find even a liberty *interest* in suicide highlights the questionable nature of an overpowering focus on tradition. Chief Justice Rehnquist reports that "England adopted the ecclesiastical prohibition on suicide . . . in the year 673 at the Council of Hereford, and this prohibition was reaffirmed by King Edgar in 967."⁹⁸ Pertinent to understanding the context of the 673 adoption, however, is the fact that "secular authorities in the middle ages recognized canon law as binding in *any* area related to church teaching."⁹⁹ King Edgar's 967 reaffirmation, it should also be noted, was a move to justify an alteration of the law regarding a suicide's possessions, which caused them to escheat to the King as opposed to the feudal lord.¹⁰⁰ Making suicide a felony brought this change of law into conceptual alignment, as felons' possessions customarily escheated to the King. At the root of the prohibition on suicide, then, we find religious tradition functioning as law, later bolstered in its severity by monarchical greed. Yet, since tradition has allowed such arbitrary control over this area of law, so does due process while beheld to tradition.

96. As stated by Judge Reinhardt, "That language, however, has never been applied literally. It would be difficult, if not impossible, for any fundamental right or liberty interest to meet such a standard. One could hardly argue for example that neither liberty nor justice would survive if contraceptives were banned, as they were for most of our history. Nor, indubitably, would even the most vigorous proponent of abortion rights argue that neither liberty nor justice existed in this nation prior to *Roe*." *Compassion in Dying v. Washington*, 79 F.3d 790, 813 n.64 (9th Cir. 1996), *rev'd sub nom. Washington v. Glucksberg*, 521 U.S. 702 (1997).

97. Tyranny of the majority was a concern for the Framers. *See, e.g., PAUL BREST ET AL., PROCESSES OF CONSTITUTIONAL DECISIONMAKING, CASES AND MATERIALS* 80 (4th ed. 2000) ("[I]n the years following the Revolutionary War, as state legislatures authorized the issuance of worthless paper money, enacted sweeping debtor relief legislation, and directed oppressive measures against British loyalists, the possibility of legislative abuse — of tyranny of the majority — became increasingly apparent. One remedy was bicameralism Judicial review emerged as another remedy").

98. *Glucksberg*, 521 U.S. at 712 n.9.

99. Urofsky, *supra* note 65, at 327 (emphasis added). This understanding has direct relevance to the discussion of issues upon which religion has a powerful influence. *See infra* Part IV.B.

100. *Id.* at 329.

The example of suicide also illustrates that it is often difficult to decide which aspects of tradition the law should acknowledge. Chief Justice Rehnquist took note, for example, of the ignominious burials that were given to suicides,¹⁰¹ but did not mention one of the rationales that lay behind such burials. In the lower court, Judge Reinhardt had pointed out that

English common law reflected the ancient fear that the spirit of someone who ended his own life would return to haunt the living. Accordingly, the traditional practice was to bury the body at a crossroads — either so the suicide could not find his way home or so that the frequency of travelers would keep his spirit from rising. As added insurance, a stake was driven through the body.¹⁰²

Justice Rehnquist did provide explanations for historical practice, though, when they served his argument. For instance, Justice Rehnquist's single rationale for why no state criminally prohibits suicide was that it is "unfair to punish the suicide's family for his wrongdoing."¹⁰³ Even though this *was* one of the major factors leading to suicide's decriminalization, one might ask how this rationale accounts for the states' decriminalization of *attempted* suicide. On that matter, Justice Souter argued that decriminalization "reflected the view that a person compelled to attempt [suicide] should not be punished if the attempt proved unsuccessful."¹⁰⁴ Contrasted with Justice Rehnquist's selective historical depiction, Justice Souter's account of history connotes much more sympathy for those who would attempt suicide, as opposed to merely a concern about overly broad retribution.

Justice Souter's historical account, and its connotation of sympathy towards potential suicides, detracts from Justice Rehnquist's assertion that "the movement away from the common law's harsh sanctions did not represent an acceptance of suicide."¹⁰⁵ But Justice Rehnquist's assertion *itself* shows the under-

101. *Glucksberg*, 521 U.S. at 713.

102. *Compassion in Dying v. Washington*, 79 F.3d 790, 809 (9th Cir. 1996), *rev'd sub nom.* *Washington v. Glucksberg*, 521 U.S. 702 (1997).

103. *Glucksberg*, 521 U.S. at 713.

104. *Id.* at 775 n.13 (Souter, J., concurring).

105. *Id.* at 713.

inclusive nature of a purely tradition-based rights analysis. No one has argued that suicide is generally proper or good, or that suicidal ideation should be fostered throughout society; as in the abortion context, no one has claimed that this conduct should be encouraged and accepted. The question for both suicide and abortion is more appropriately whether a majority should be able to criminalize it. For that inquiry, lack of majoritarian “acceptance” of suicide is not — and should not be — authoritative.

IV. A PRIVACY INTEREST IN SUICIDE UNDER A STATE CONSTITUTION’S EXPLICIT RIGHT OF PRIVACY

Regardless of one’s opinion of the Supreme Court’s tradition-based due process analysis of an individual’s right to suicide, much of the concern with tradition can be circumvented by evaluating the purported right to suicide as an aspect of the right of privacy. Under a state constitution, as contrasted to the federal constitution, a right of privacy analysis could remain substantially independent of tradition’s bridle.

The federal constitutional right of privacy relates to the Due Process Clause at least insofar as the Due Process Clause incorporates the federal right of privacy against the states. In light of the connection, Supreme Court privacy opinions typically attempt to somehow connect themselves to tradition and generally follow due process rhetoric.¹⁰⁶ Under a state constitution, an explicit right of privacy need not relate to due process, and thereby gains an additional degree of freedom from traditional and historical practice. An explicit state constitutional right to privacy would therefore make a proper source for at least a protected privacy interest, if not a protected right to suicide.¹⁰⁷

106. See *In re Soliman*, 134 F. Supp.2d 1238, 1254 (N.D. Ala. 2001) (“The Supreme Court has generally couched the right [of privacy] in terms of substantive due process, guaranteed by the Fourteenth Amendment.”).

107. In *Donaldson v. Lungren*, a California Court of Appeal found this argument persuasive. 2 Cal. App. 4th 1614 (Ct. App. 1992). In the context of a privacy challenge to a law forbidding assisted-suicide, the court noted,

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

A. STATE VERSUS FEDERAL RIGHT OF PRIVACY

United States Supreme Court doctrine suggests that the right of privacy relates predominantly to issues of sexuality.¹⁰⁸ For a state with an explicit privacy clause, however, reasons exist for departing from the typical pattern of interpreting state constitutional provisions in lockstep with their federal analogues.¹⁰⁹

To begin with, as Justice Brandeis explained, the drafters of the Constitution conferred to each other “the most comprehensive of rights[,] . . . the right most valued by civilized men.”¹¹⁰ This most-valued right was, “as against the government, the right to be let alone.”¹¹¹ If the “makers of our Constitution”¹¹² implicitly conferred this imperative right via the Constitution — a document lacking any clause explicitly referencing such right — then it seems logical that such a right be doubly respected when textually implanted in a state constitution.

But the reasons for more broadly interpreting a state constitutional privacy clause go beyond the fact that state constitutions explicitly mention the right to privacy.¹¹³ The purpose of such

Nevertheless, even if we were to characterize Donaldson’s taking his own life as the exercise of a fundamental right, it does not follow that he may implement the right in the manner he wishes here.

Id. at 1622. Justice Mallett of the Michigan Supreme Court believed that not only suicide, but physician-assisted suicide, should be characterized as a privacy right. See *People v. Kevorkian*, 527 N.W.2d 714, 752 n.2 (Mich. 1994) (Mallett, J., concurring in part and dissenting in part) (“The right that should be recognized here is a privacy right as well as a liberty right. . . . [T]he concept of privacy embodies the moral fact that a person belongs to himself and not others nor to society as a whole.”) (internal quotation marks omitted).

108. See Jed Rubenfeld, *The Right to Privacy*, 102 HARV. L. REV. 737, 738–39 (1989) (noting that the federal constitutional right to privacy as delineated by the Supreme Court is perfectly explained by reference to sexuality as “an area of life into which the state has no business intruding,” given that the groundbreaking cases involved abortion, marriage, and contraception).

109. See Robert A. Shapiro, *Identity and Interpretation in State Constitutional Law*, 84 VA. L. REV. 389, 420 n.123 (1998) (“In state constitutional law, however, the legitimacy issue is how to justify state judges’ divergence from the United States Supreme Court’s interpretation of analogous federal constitutional provisions.”) (quoting G. Alan Tour, *Understanding State Constitutions*, 65 TEMP. L. REV. 1169, 1170 n.3 (1992)).

110. *Olmstead v. United States*, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting).

111. *Id.*

112. *Id.*

113. As one commentator put it, “If one believes that independent interpretation needs legitimation, minor differences in language or history may be rather thin reeds. Evidence of original intent is often elusive and inconclusive, and small linguistic divergences [typically] provide little counterweight to the presumption in favor of federal doctrine.” Shapiro, *supra* note 109, at 426.

privacy provisions, when enacted, was certainly to espouse principles of individual autonomy and self-definition, freedom from government intervention in one's very personal affairs.¹¹⁴ The word "privacy" is defined as "the state of being in retirement from the company or observation of others; seclusion."¹¹⁵ In amending a constitution to include an explicit privacy clause, one would certainly expect that clause to leave certain personal areas of one's life "retired," placing those areas beyond the "observation" of the government.¹¹⁶

Institutional differences also suggest broader leeway for state constitutional interpretation. Federal judges appraising the constitutionality of state statutes under due process must be conservative. As Justice Harlan wrote, in the process of federal substantive due process review "[n]o formula could serve as a substitute . . . for judgment and restraint."¹¹⁷ Due to federalism concerns, the Supreme Court must "hesitate in announcing norms that will constrain governmental activity in all fifty states."¹¹⁸ Legitimacy concerns may also press against the issuance of such far-reaching norms, considering the shaky textual foundations¹¹⁹ and historical legitimacy¹²⁰ of federal judicial review. When analyzing the activity of the United States Supreme Court, one must recognize that "[t]he absence of any constitutional text explicitly supporting judicial review has presented a recurring concern in federal constitutional theory."¹²¹

114. Of course, "[e]vidence of original intent is often elusive and inconclusive," *id.*, but a commonsense understanding of the concept of privacy suggests that intimacy and things intrinsically personal would fall within most conceivable purposes for supporting such an enactment, along with the idea that the public should not be allowed to control certain individual decisions.

115. WEBSTER'S REVISED UNABRIDGED DICTIONARY (1998), available at <http://dictionary.reference.com/search?q=privacy> (last visited Oct. 31, 2004).

116. For example, the Alaska Supreme Court understood the Alaskan Constitutional Privacy Clause, added by voter initiative in 1972, to give greater freedom from government within the home, including the right to use marijuana. See *Ravin v. State*, 537 P.2d 494, 511 (Alaska 1975).

117. *Poe v. Ullman*, 367 U.S. 497, 542 (1961) (Harlan, J., dissenting).

118. See *Shapiro*, *supra* note 109, at 430; *Washington v. Glucksberg*, 521 U.S. 702, 723 (1997) ("To hold for respondents, we would have to . . . strike down the considered policy choice of almost every state.").

119. See U.S. CONST. Nowhere in the United States Constitution is the power to review state or federal legislation for constitutionality delegated to the Judiciary.

120. See *Marbury v. Madison*, 5 U.S. 137 (1803).

121. *Shapiro*, *supra* note 109, at 429.

State supreme courts, on the other hand, do not share such an overwhelming need for conservative constitutional interpretation. Most notably, “[j]udicial review under state constitutions generally rests on stronger textual or historical foundations than its federal analogue,”¹²² often with the state constitution “clearly contemplat[ing] judicial invalidation of statutes.”¹²³ Other states “have adopted new constitutions at a time when judicial review under the prior state constitution was a well-accepted practice,”¹²⁴ allotting an extra margin of legitimacy to the practice even absent a textual grant.

The community over which a state court presides is also substantially smaller, which is important for two reasons. First, unlike the national Congress, with its broad base of competing interest groups, smaller state legislatures are more prone to co-optation.¹²⁵ “[J]udicial deference to local control is repugnant . . . because the nature of local control itself implicates greater dangers of majoritarian oppression.”¹²⁶ Second, state constitutional decisions are more easily altered via state constitutional amendment. If the court gets it “wrong,” the voters in many states can simply “fix” it by ballot initiative.¹²⁷ State constitutional amendment procedures stand in stark contrast to their lumbering federal counterpart.

In considering a departure from federal doctrine, a state court’s deviation need not be based solely on the state’s intrinsic identity or on an understanding of the state’s distinctive “com-

122. *Id.*

123. *Id.* at 429 n.150. *See, e.g.*, GA. CONST. art. I, § 2, para. 5 (“Legislative acts in violation of this Constitution or the Constitution of the United States are void, and the judiciary shall so declare them.”); N.Y. CONST. art. VI, § 3(b)(2) (conferring jurisdiction to review judgments declaring that a state statute violates the state constitution); VA. CONST. art. VI, § 1 (same).

124. Shapiro, *supra* note 109, at 429.

125. *See* THE FEDERALIST No. 10, at 82 (James Madison) (Clinton Rossiter ed., 1961) (“The question resulting is, whether small or extensive republics are most favorable to the election of proper guardians of the public weal; and it is clearly decided in favor of the latter . . .”).

126. Blanchard, *supra* note 69, at 285–86; *see also* THE FEDERALIST No. 10, *supra* note 125.

127. “Eighteen states have constitutional initiative processes.” P. K. Jameson & Marsha Hosack, *Citizen Initiatives in Florida: An Analysis of Florida’s Constitutional Initiative Process, Issues, and Alternatives*, 23 FLA. ST. U. L. REV. 417, 433 (1995); *see, e.g.*, CAL. CONST. art. 2, § 8.

munity.”¹²⁸ The community to which the constitution corresponds “is not the actual group of people who happen to live in the state, but rather the aspirational community constituted by the principles set forth in the constitution.”¹²⁹ One valid approach, thus, is to view constitutional interpretation “not as a search for the values of the population, but as a search for the values generated by the ideals committed to the constitution.”¹³⁰

B. THE INDIVIDUAL INTEREST

One fact that informs the inquiry into the individual interest in suicide is that perspectives on suicide are often dependent on religion or even *determined* by religion.¹³² The basic problem with finding no individual interest in suicide is that legislative desire to criminalize suicide is “comprehensible only as an effort to define life’s meaning.”¹³³ This observation is important for two reasons. First, issues of deep religious conviction historically have been, and intrinsically are, kindling and fodder for majoritarian coercion and tyranny.¹³⁴ When a court, the “bulwark between majority will and the basic rights of individuals,”¹³⁵ approaches legislation restricting individual autonomy in such a religiously sensitive choice, and especially when the legislation accords with widely-held religious beliefs, the court should appreciate the likelihood that such legislation is a form of religious dogmatism turned political.

128. See Shapiro, *supra* note 109, at 391 (“For a constitution to merit independent interpretation, many scholars and judges assume, it must be grounded in an identifiable state community, an entity whose inhabitants share distinctive ideals, customs, and traditions.”).

129. *Id.* at 393.

130. *Id.*

132. See Richard C. Parks, Comment, *A Right To Die With Dignity: Using International Perspectives To Formulate A Workable U.S. Policy*, 8 TUL. J. INT’L & COMP. L. 447, 451–52 (2000) (noting the “tainting” effect Christianity has had on the dying with dignity debate in America).

133. *Cruzan v. Mo. Dep’t of Health*, 497 U.S. 261, 345 (1997) (Stevens, J., dissenting).

134. The Salem Witch Trials and the Spanish Inquisition, for example, may bring to mind the “vindictive dogmatism” of religious conviction that tyrannizes individuals. *Thomas v. Salatch*, 328 F. Supp. 18, 22 (E.D. La. 1971).

135. *Krischer v. McIver*, 697 So. 2d 97, 111 (Fla. 1997) (Kogan, C.J., dissenting).

Second, religion is simply an area where freedom is especially valuable. "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."¹³⁶ Defining our own relationship with God and the universe is a basic element of human life and fulfillment. As Justice Stevens points out, "Choices about death touch the core of liberty. . . . [N]ot much may be said with confidence about death unless it is said from faith, and that alone is reason enough to protect the freedom to conform choices about death to individual conscience."¹³⁷

The importance of autonomy and the person's feeling of self-determination likewise should not be undervalued in calculating the individual interest in suicide. "Like the decision of whether or not to have an abortion, the decision how and when to die is one of the most intimate personal choices a person may make in a lifetime, and a choice central to personal dignity and autonomy."¹³⁸ Moreover, "[i]ndividuals who believe they can influence the course of their lives . . . are likely to suffer less stress than individuals who believe their destiny is influenced largely by factors outside of themselves"¹³⁹ This is, of course, no secret; stress is largely determined by the perception of control or lack thereof. It is by no means uncommon for patients to experience great relief simply by knowing that, if things get bad enough, they retain *ultimate* control over their destiny. The comments of a physician who had treated more than four hundred AIDS patients illustrate this point. He "told each of them that whenever they thought treatment or pain had become too much, he would provide medicine for a painless suicide. Only four accepted his offer, but he reported that they all felt that they had regained some control over their lives."¹⁴⁰

As a final point on the individual interest in suicide, it might be argued that a person's privacy interests, and the derivative liberties therein, enlarge as a person approaches his or her last

136. *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833, 851 (1992) (citation omitted).

137. *Cruzan*, 497 U.S. at 343 (Stevens, J., dissenting).

138. *Compassion in Dying v. Washington*, 79 F.3d 790, 813-14 (9th Cir. 1996), *rev'd sub. nom.* *Washington v. Glucksberg*, 521 U.S. 702 (1997).

139. GORDON EDLIN ET AL., *HEALTH AND WELLNESS* 44 (6th ed. 1999).

140. Urofsky, *supra* note 65, at 335.

days. Consider the room in which a patient lies on his or her deathbed. People in the room surrounding the deathbed are quiet and subservient, almost as if to express the fact that anything they need or desire must be subordinated in favor of the interests of the dying patient. It might be said that the interests of the dying person are more important, possibly because they are among the dying person's last.¹⁴¹

As a general rule, however, it may be unwise to grant legal recognition to this relatively increased importance of dying patients' interest in suicide. Such legal recognition may depend upon a degree of infallibility in prediction of death that humans have not yet attained. Almost no medical situation guarantees that any particular patient will have a specifically delineated lifespan. Even if certain people's deaths can be predicted with certainty, we probably do not want to vest those people with a "right" to suicide by acknowledging their relatively greater individual interest in suicide. They presumably would be precisely those patients most prone to making judgments distorted by depression and most susceptible to being coerced into a suicide decision by others.

C. THE STATE VETO

Despite the strength of any individual interest in suicide based in a privacy clause, the state's interests would likely be strong enough to outweigh the individual interest under normal circumstances. Even if the individual privacy interest in suicide were determined to be "fundamental," the state could still advance various "compelling" interests to hinder the exercise of that fundamental right.

Among various other potential state interests, the state "has an interest in preserving and fostering the benefits that every human being may provide to the community — a community that thrives on the exchange of ideas, expressions of affection, shared memories, and humorous incidents, as well as on the material

141. *Cf. Krischer v. McIver*, 697 So. 2d 97, 111 (Fla. 1997) (Kogan, C.J., dissenting) ("To my mind, the right of privacy attaches with unusual force at the death bed. This conclusion arises in part from the privacy our society traditionally has afforded the death bed . . .").

contributions that its members create and support.”¹⁴² As Justice Stevens noted in *Glucksberg*, “The value to others of a person’s life is far too precious to allow the individual to claim a constitutional entitlement to complete autonomy in making a decision to end that life.”¹⁴³ The aggregate value that all other citizens place on a person’s life, even absent religious considerations, would generally constitute a sufficient counter-interest so as to offset any individual privacy interest claimed by one who would choose to commit suicide.¹⁴⁴ Considering just this aggregate interest of others, it becomes clear that finding a privacy interest in committing suicide need not imply any significant change from the status quo.

Even if the individual interest were found to be “fundamental,” and this characterization were understood to imply that the state can only attempt to ensure competency and appropriate consideration in decision-making, society’s current practices as a general matter need not change. The state could permissibly encroach on a citizen’s right to suicide in ubiquitous ways, to ensure that people who make such decisions are competent to do so, have fully considered all the alternatives, and are in no way coerced in their decision. It is an undisputed fact that “[t]he vast majority of suicides are ‘irrational’ efforts by the depressed or mentally disturbed.”¹⁴⁵ The presumption raised by this fact, even under a fundamental rights analysis, would permit the state wide latitude to interfere with the choice. Hospitals, for example, could continue to force treatment upon patients that attempt suicide, given the rational presumption that a person attempting suicide is acting in a myopic manner or is incompetent.¹⁴⁶

142. *Glucksberg*, 521 U.S. at 741 (Stevens, J., concurring).

143. *Id.*

144. When contemplating such an “aggregate” interest, it is probably best for the law to treat that value as fixed, irrespective of the individual in question. It is plausible to assert that the state has different interests in different individuals, according to each individual’s ability to contribute. Surely, though, it is better for the law to claim the same interest with regard to all citizens. To separately determine the state’s interest in specific individuals is problematic. Aside from being an administrative burden and an unsavory task with a heavy totalitarian gloss, it could lead to undesirable treatment or conceptualization of certain members of society. A popularity contest, or utility contest, would be an ugly, Orwellian procedure, as well as too difficult to measure consistently.

145. *People v. Kevorkian*, 527 N.W.2d 714, 750 (1994) (Levin, J., concurring in part and dissenting in part).

146. More than ninety-five percent of those who commit suicide have a major psychiatric illness at the time of death. See *Glucksberg*, 521 U.S. at 730. Given this mathematical

It does not follow, however, that establishment of a privacy interest in suicide would be a meaningless enterprise. The effect that recognition of the interest could have in the physician-assisted suicide context may be appreciated when one investigates the fluctuating significance that the words “suicide” and “physician-assisted suicide” have held over time.

V. WITHDRAWAL OF LIFE-SUSTAINING TREATMENT: TODAY’S “PHYSICIAN-ASSISTED SUICIDE”

Notwithstanding the current state of the law, physician-assisted suicide occurs regularly in our country. Clandestine agreements between doctors, patients, and patients’ families regularly encompass the provision of illegal assistance in suicide.¹⁴⁷ But even setting aside these arrangements that occur behind closed doors, “physician-assisted suicide” is already in a literal sense occurring openly in this country, in a legally-sanctioned way.

A. ALTERED MEANINGS

At common law, a patient’s refusal to accept life-sustaining treatment or hydration and nutrition constituted suicide.¹⁴⁸ As Justice Scalia pointed out in *Cruzan*, “American law has always accorded the State the power to prevent, by force if necessary, suicide — including suicide by refusing to take appropriate measures necessary to preserve one’s life.”¹⁴⁹ “Starving oneself to death is no different from putting a gun to one’s temple as far as

presumption about people who attempt suicide, the “[S]tate-run hospital” would still not be liable “for a violation of constitutional rights, nor . . . under general tort law, if . . . it pumps out the stomach of a person who has intentionally taken an overdose . . . despite that person’s wishes to the contrary.” *Cruzan v. Mo. Dep’t of Health*, 497 U.S. 261, 298–99 (1990) (Scalia, J., concurring).

147. See generally Julia Pugliese, Note, *Don’t Ask — Don’t Tell, The Secret Practice of Physician-Assisted Suicide*, 44 HASTINGS L.J. 1291, 1297–99 (1993); James M. Thunder, *Quiet Killings in Medical Facilities, Detention & Prevention*, 18 ISSUES L. & MED. 211 (2003); see also Urofsky, *supra* note 65, at 403 (noting a disturbing feature of the Court’s decision in *Washington v. Glucksberg*: that “the Justices seem aware of the fact that every day doctors help patients die, and . . . they are willing to allow this practice to continue in the form of a grey market.”).

148. See *Cruzan*, 497 U.S. at 293 (Scalia, J., concurring).

149. *Id.*

the common-law definition of suicide is concerned; the cause of death in both cases is the suicide's conscious decision to pu[t] an end to his own existence."¹⁵⁰ Accordingly, a physician's withdrawal of life-sustaining measures at the behest of the patient constituted physician-assisted suicide. "[A] physician . . . could be criminally liable for failure to provide care that could have extended the patient's life, even if death was immediately caused by the underlying disease that the physician failed to treat."¹⁵¹ Withdrawing life-sustaining treatment or food and water was a crime, as "assisted suicide" is today. That the "death was caused" by the "natural process of starvation" was "no defense."¹⁵²

Currently, the choice to forego life-sustaining treatment or nutrition and hydration is constitutionally protected,¹⁵³ even when the choice leads to death.¹⁵⁴ Whereas the Supreme Court has only recognized a protected liberty interest, most state legislatures and several state supreme courts have conclusively established some form of protected right to refuse life-sustaining treatment. As such, in hospitals around the nation, there is currently underway an epidemic of legalized "physician-assisted suicide."¹⁵⁵

150. *Id.* at 296–97 (internal citations omitted) (alterations in original).

151. *Id.* at 297.

152. *Id.* (internal quotation marks omitted).

153. For an analysis of the right to refuse treatment, see *supra* II.A.

154. *But see* *Von Holden v. Chapman*, 450 N.Y.S.2d 623 (App. Div. 1982) (holding that prison inmate has no constitutional right to commit suicide by refusing to eat, and that he may be force-fed). *Von Holden* is best understood in light of both pre-*Cruzan* uncertainty and the less restrictive test required of prison regulations that are claimed to burden prisoners' fundamental rights. On this second point, see *Washington v. Harper*, 494 U.S. 210, 223 (1990) ("[T]he proper standard for determining the validity of a prison regulation claimed to infringe on an inmate's constitutional rights is to ask whether the regulation is 'reasonably related to legitimate penological interests.' This is true even when the constitutional right claimed to have been infringed is fundamental, and the State under other circumstances would have been required to satisfy a more rigorous standard of review.") (internal citations omitted).

155. *But see* George J. Annas, *The Promised End — Physician Assisted Suicide and Abortion*, 35 DUQ. L. REV. 183, 195 (1996) (criticizing the suggestion that there is an epidemic of suicide and homicide in the nation's hospitals as "patently absurd"). As for legal conclusions, Annas may be correct. If the law makes an exception for withdrawal of life-sustaining treatment, for example, then ipso facto we cannot use the legal conclusion "homicide" to describe the conduct of a physician who withdraws life-sustaining treatment. But these words retain significance despite the law's pliable conceptualizations. For instance, to argue that one who refuses life-sustaining treatment or nutrition and hydration is *not* committing "suicide" in a very real sense — even if we agree with and accept his or her decision — may itself be considered "patently absurd."

This new state of the law is based on the tort principles of informed consent and battery. At common law a doctor could be held liable in tort for battery if he or she administered treatment to a patient without first obtaining the patient's informed consent. The patient autonomy protected by these tort principles is often illustrated by Justice Cardozo's statement that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body."¹⁵⁶

But as one commentator has pointed out, "Does anybody really believe . . . that when Justice Cardozo's statement was uttered in 1914 that he meant, or anybody interpreted him to mean, that every person of adult years and sound mind has the right to obtain another's help in committing suicide . . . ?"¹⁵⁷ Of course not, because this right to determine what one wants done "with his own body" had always been subordinate to a controlling prohibition of suicide. That the prohibition of suicide had traditionally predominated was undoubtedly the source of the Supreme Court's reluctance to announce a fundamental right to remove life-sustaining treatment in *Cruzan*. As stated by Justice Scalia in his *Cruzan* concurrence, "To raise up a constitutional right here we would have to create [a constitutional principle] out of nothing (for it exists neither in the text nor tradition)"¹⁵⁸

But the law *has* changed. Examining the specific conduct of physicians at issue (i.e., the withdrawal of life-sustaining treatment at the request of a patient), the way the change occurred was by altering which legal principle is allowed to control that conduct, given that both the prohibition of assisted suicide and the doctrine of informed consent arguably cover it. In other words, the scope of conduct covered by the historic prohibition of assisted suicide overlaps the scope of conduct required of a physician who conforms to the principle of informed consent in disconnecting a patient's life-sustaining treatment or food and hydration. At common law, the principle that assisted suicide is crimi-

156. *Schloendorff v. Society of New York Hospital*, 105 N.E. 92, 93 (N.Y. 1914).

157. Yale Kamisar, *The "Right to Die": On Drawing (and Erasing) Lines*, 35 DUQ. L. REV. 481, 507 (1996).

158. *Cruzan v. Mo. Dep't of Health*, 497 U.S. 261, 300 (1990) (Scalia, J., concurring).

nal trumped in this area of physicians' conduct.¹⁵⁹ Today, the principle that a patient has the right to refuse treatment, food, and water trumps, and requires immunity for doctors who act to effectuate this patient right.

The language used in this regard has also changed; a patient's refusal of life-sustaining treatment or food and hydration, for example, is no longer considered "suicide."¹⁶⁰ Although there are various trumpeted rationales for this,¹⁶¹ the real reason is simply that "assisted suicide" is illegal. In the past, if a patient's decision to have life-sustaining treatment withdrawn constituted "suicide," then doctors who accepted their patients' request and withdrew life-sustaining treatment would have been "assisting suicide." Moreover, the physician who, absent negligence, withdraws life-sustaining treatment, hydration, or nutrition, is no longer the "cause" of the patient's death.¹⁶² The trauma or illness, once caused, locks in the "cause." Subsequently, "[w]hen a life-sustaining treatment is withheld, the patient dies primarily because of [the] underlying disease."¹⁶³

Since "assisted suicide" is illegal, allowable conduct is reclassified as another, possibly new, concept. Physicians now "let die."¹⁶⁴ By unplugging the respirator or by surgically removing a feeding tube, the physician allows death and the patient the "meeting" that had been artificially postponed.¹⁶⁵ In an earlier era, allowing this postponed "meeting" of death and a human be-

159. *Id.* at 298 ("It has always been lawful not only for the State, but even for private citizens, to interfere with bodily integrity to prevent a felony. That general rule has of course been applied to suicide.") (internal citations omitted).

160. *See, e.g., In re Conroy*, 486 A.2d 1209, 1224 (N.J. 1985) ("[D]eclining life-sustaining medical treatment may not properly be viewed as an attempt to commit suicide.").

161. For one of the more extreme examples, see *id.* ("[P]eople who refuse life-sustaining medical treatment may not harbor a specific intent to die; rather, they may fervently wish to live, but to do so free of unwanted medical technology, surgery, or drugs, and without protracted suffering.") (internal citations omitted).

162. *See* Glasson, *supra*, note 8, at 93.

163. *Id.*

164. *See, e.g., In re Guardianship of Myers*, 62 Ohio Misc. 2d 763, 776 (1993) ("The benefits and arguments are overwhelmingly in favor of removal. It is time to remove the invasive and futile medical technology. It is time to *let Carla die.*") (emphasis added).

165. *See, e.g., Donaldson v. Lungren*, 2 Cal. App. 4th 1614, 1621-22 (Ct. App. 1992) (The patient "who is being kept alive by a life-support system has taken a detour that usually postpones an immediate encounter with death. In short, the medical treatment has prolonged life and prevented death from overtaking the patient. Stopping the treatment allows the delayed meeting with death to take place.").

ing would have been “aiding a suicide” or “murder” — criminal activity deserving moral condemnation and imprisonment.

B. LOOKING FORWARD

As Justice Stevens noted in *Glucksberg*,

[T]he source of Nancy Cruzan’s right to refuse treatment was not just a common-law rule. Rather, this right is an aspect of a far broader and more basic concept of freedom that is even older than the common law. This freedom embraces not merely a person’s right to refuse a particular kind of unwanted treatment, but also her interest in dignity, and in determining the character of the memories that will survive long after her death. . . . *Cruzan* rested not only on the common-law right to refuse medical treatment, but — at least implicitly — on the even more fundamental right to make this “deeply personal decision.”¹⁶⁶

The additional, implicit aspect of the right to refuse life-sustaining treatment that Justice Stevens speaks of is a component of the “right of privacy.” Indeed, many early cases on withdrawal of life-sustaining treatment were decided under the right of privacy, or under a combination of the common law rule and the right of privacy.¹⁶⁷ Under a right of privacy thus understood, the patient’s right of privacy immunizes the doctor from liability for assisting in the patient’s death by removing the treatment, food, or water sustaining the patient’s life.

The scope of such “deeply personal decisions” can very feasibly be said to cover the same activity as the current prohibition of “active” physician-assisted suicide, despite the doctrinal precedent to the contrary.¹⁶⁸ In a proper scenario, then, a court could change the law’s conceptualization of this area of physician conduct. Just as in the context of the withdrawal of life-sustaining treatment, the patient’s right of privacy could immunize a physi-

166. *Washington v. Glucksberg*, 521 U.S. 702, 743–44 (1997) (Stevens, J., concurring) (internal citations and footnotes omitted).

167. *See supra* note 11.

168. *See supra* note 70.

cian for activity that previously was — but no longer will be — termed “assistance in suicide.”

In much the same way as withdrawal of life-sustaining treatment, a physician who aids in the suicide of a patient need not be deemed to “cause” the patient’s death. The patient would not be under the care of the physician if the accident, trauma, or illness had never occurred. To minimize suffering, then, the law might allow the “cause” of the death to remain with the accident or illness, just as it does now with the withdrawal of life-sustaining treatment. Leaving the “cause” of death with the original accident or illness is especially appropriate in cases where “patients have no consciousness and no chance of recovery,” and where there is a “serious question as to whether the mere persistence of their bodies is *‘life’* as that word is commonly understood.”¹⁶⁹

VI. VOLUNTARY EUTHANASIA AFTER WITHDRAWAL OF LIFE-SUSTAINING HYDRATION AND NUTRITION FOR IMMOBILE, ONCE-COMPETENT PATIENTS

Neither state legislatures nor state supreme courts have made any liberty-enhancing alteration since the *Glucksberg* decision; Oregon remains the only “laboratory” from which empirical information can be gleaned with respect to the ongoing debate about physician-assisted suicide. Empirical data may be collected from the activity in Japan,¹⁷⁰ the Netherlands, or Colombia,¹⁷¹ but such information is inherently less beneficial, given the distinct legal, cultural, and medical settings generating the data. A possibility does exist, however, for the creation of another “laboratory,” one which does not require a state to go as far as a generalized legalization of physician-assisted suicide.

169. *Cruzan v. Mo. Dep’t of Health*, 497 U.S. 261, 345 (1990) (Stevens, J., dissenting).

170. Cases in 1962 and 1995 established a strictly-limited framework for when physician-assisted suicide is permissible in Japan. Alison C. Hall, Note, *To Die With Dignity: Comparing Physician Assisted Suicide in the United States, Japan and the Netherlands*, 74 WASH. U. L. Q. 803, 832–33 (1996).

171. On May 20, 1997, Colombia’s Constitutional Court legalized voluntary euthanasia for the terminally ill. *Washington v. Glucksberg*, 521 U.S. 702, 718 n.16 (1997).

A. THE LEGAL FRAMEWORK

In a state with an explicit constitutional right of privacy, one could argue that the right of privacy protects an individual interest in suicide, although that interest may be systematically overridden by countervailing state interests in the normal course of events.¹⁷² For a perpetually incompetent, immobile patient, however, upon termination of life-sustaining food and hydration, the individual privacy interest in suicide may override the state's countervailing interests. Whether it be because the patient's privacy interests can be seen as increasing due to the certain proximity of death, or because the state's interests lessen at such a time, the patient's right to privacy may have a more robust presence at the established end of life. At the point where the patient's immobility assures that only a slow, hopeless dehydration death awaits, the privacy interest in suicide might therefore become a "right" to suicide. Considering that such a right could only be effectuated through the assistance of another, the balance of arguments may suggest that the right should be construed broadly enough to immunize a physician who acts to vindicate the patient's previously made request for euthanasia.¹⁷³

Active voluntary euthanasia in these circumstances does not "look" like suicide. But as Justice Brennan asserted in *Cruzan*, "[t]o deny [a right's] exercise because the patient is unconscious or incompetent would be to deny the right."¹⁷⁴ As is the case with the right to refuse medical treatment, "[t]he right of an adult who . . . was once competent[] to determine the course of her medical treatment remains intact *even when she is no longer able to assert that right or to appreciate its effectuation*."¹⁷⁵ Allowing a

172. See *supra* Part III.

173. To establish beyond any possible doubt that the patient has no chance of recovery, the patient's indicated intent might be to receive the euthanasia two days after the termination of all life-sustaining treatment. The lag period would allow for any potentially beneficial shock to the patient's system that may be caused by the discontinuation of treatment to have its effect. Any and all possible concern about fallibility of the prognosis of death by dehydration would thereby be removed.

174. *Cruzan*, 497 U.S. at 309 (Brennan, J., dissenting) (quoting *Foody v. Manchester Memorial Hospital*, 482 A.2d 713, 718 (Conn. Super. Ct. 1984)).

175. *In re Conroy*, 486 A.2d 1209, 1229 (N.J. 1985) (emphasis added) ("After all, law respects testamentary dispositions even if the testator never views his gift being bestowed. Any other view would permit obliteration of an incompetent's panoply of rights

physician to act as an agent for the patient under these circumstances may be the “only practical way”¹⁷⁶ to prevent the loss of the patient’s newly acquired right to suicide.

Moreover, in certain situations one citizen’s rights may immunize the conduct of another. As mentioned in Part V, the right of patients to refuse life-sustaining treatment currently immunizes physicians who terminate life-sustaining procedures at those patients’ request. The Supreme Court, furthermore, has “recognized that the special relationship between patient and physician will often be encompassed within the domain of private life protected by the Due Process Clause[’s right to privacy].”¹⁷⁷ In order to truly protect a woman’s right to abortion, for example, the Supreme Court allowed women’s right to abortion to immunize physicians who perform those abortions.¹⁷⁸ A similar resolution is practical in this context.

B. THE INDIVIDUAL’S ARGUMENT

As Justice Levin explained in his opinion in *People v. Kevorkian*,¹⁷⁹

A rule allowing a person to have his respirator disconnected, but to take no other steps to end his life, condemns him to choke to death on his own sputum. Similarly, if the law bars a person who can only take nourishment through a feeding tube from taking steps in addition to ordering the

merely because the patient could no longer sense the violation of those rights.”) (internal citations omitted).

176. *In re Quinlan*, 355 A.2d. 647, 664 (N.J. 1976) (allowing Karen Quinlan’s right of privacy to be asserted on her behalf by her guardian, as this was the “only practical way to prevent destruction of the right”).

177. *Cruzan*, 497 U.S. at 340 n.12 (Stevens, J., dissenting) (citations omitted). *See also* *Paris Adult Theater I v. Slaton*, 413 U.S. 49, 66 n.13 (1973) (“[T]he constitutionally protected privacy of family, marriage, motherhood, procreation, and child rearing is not just concerned with a particular place, but with a protected intimate relationship. Such protected privacy extends to the doctor’s office, the hospital, the hotel room, or as otherwise required to safeguard the right to intimacy involved.”).

178. *See Roe v. Wade*, 410 U.S. 113, 126 (1973).

179. *People v. Kevorkian*, 527 N.W.2d 714 (Mich. 1994) (Levin, J., concurring in part and dissenting in part).

tube removed to end his life, he is required to suffer death by starvation and dehydration.¹⁸⁰

According to Justice Levin, the law should not limit a patient to a “half step when that would result in greater suffering.”¹⁸¹ The law, this Note proposes, should also not limit a patient to a half step when that *may* result in greater suffering.

It is unclear whether patients in permanent vegetative states¹⁸² like Terri Schiavo feel pain.¹⁸³ It is clear, however, that whether or not the mind of such a patient cognitively processes nerve stimulation, the nerves engage in a “pain” response upon interaction with ordinarily painful stimuli.¹⁸⁴ For Nancy Cruzan, for example, painful pinching elicited exaggerated grimaces that would endure for the duration of the pinch.¹⁸⁵ Although “suffering” and “mental preoccupation” may or may not accompany the painful response, it seems that patients in persistent vegetative states do at least experience “pain” in a basic form.

The argument that dehydration is not a “bad” way to die¹⁸⁶ weakens the argument for allowing voluntary euthanasia,¹⁸⁷ but

180. *Id.* at 750.

181. *Id.*

182. While patients in permanent vegetative states may not constitute the entire class of perpetually incompetent, immobile patients from whom life-sustaining hydration and nutrition is withdrawn, as a group they are particularly relevant to the option proposed in this Note.

183. In *In re Conroy*, the court stated,

The medical testimony was inconclusive as to whether, or to what extent, Ms. Conroy was capable of experiencing pain. Dr. Kazemi thought that Ms. Conroy might have experienced some degree of pain from her severely contracted limbs, or that the contractures were a reaction to pain, but that she did not necessarily suffer pain from the sores on her legs. According to Dr. Davidoff, it was unclear whether Ms. Conroy’s feeding tube caused her pain, and it was “an open question whether she [felt] pain” at all; however, it was possible that she was experiencing a great deal of pain.

486 A.2d 1209, 1217 (N.J. 1985). *But see* *Cruzan v. Mo. Dep’t of Health*, 497 U.S. 261, 301 n.2 (1990) (Brennan, J., dissenting) (“Vegetative state patients may *react reflexively* to sound, movements, and normally painful stimuli, but they do not *feel* any pain or *sense* anybody or anything.”) (emphasis in original) (citation omitted).

184. *See Cruzan*, 497 U.S. at 332 (Stevens, J., dissenting) (“[T]he highest cognitive brain function that can be hoped for is a grimace in recognition of ordinarily painful stimuli or an apparent response to sound.”) (internal quotation marks omitted).

185. *See The Death of Nancy Cruzan* (PBS Frontline, Mar. 24, 1992).

186. A “recent survey of nurses rated this a peaceful and good way to die.” Claudia Wallis, *The Twilight Zone of Consciousness*, *TIME*, Oct. 27, 2003, at 43–44.

seems to be an apology for the procedure rather than an accurate description.¹⁸⁸ The progressive effects of withholding food and water from a human being are as follows:

- (1) The mouth dries out and becomes caked or coated with thick material.
- (2) The lips become parched and cracked or fissured.
- (3) The tongue becomes swollen and might crack.
- (4) The eyes sink back into their orbits.
- (5) The cheeks become hollow.
- (6) The lining of the nose might crack and bleed.
- (7) The skin hangs loosely on the body and becomes scaly.
- (8) The urine becomes highly concentrated, burning the bladder.
- (9) The lining of the stomach dries out, causing dry heaves and vomiting.
- (10) Hyperthermia develops.
- (11) The brain cells begin drying out, causing convulsions.
- (12) The respiratory tract dries out, causing very thick secretions which can plug the lungs and cause death.
- (13) Eventually, the major organs fail, resulting in death.¹⁸⁹

Although one really cannot know what is occurring in the mind of any particular incompetent or vegetative patient, a person may rationally want to forego any risk of experiencing such a process.

Ameliorating these potential effects with narcotics may not be a completely satisfactory option. First, it may be difficult for physicians to know how much morphine to administer such a patient. In normal subjects, "an initial dose of 100 to 200 mg of morphine would be sufficient to cause profound sedation, respiratory depression, anoxia, and death; but tolerant subjects have been known to take as much as 4 g without adverse effect."¹⁹⁰ With such a wide variability amongst subjects, and variability with regard to the onset of drug tolerance, administration of

187. Cf. *In re Storar*, 420 N.E.2d 64 (N.Y. 1981) (placing importance on the fact that the blood transfusions did not cause substantial pain and thus ordering their continuation).

188. See *In re Estate of Longeway*, 549 N.E.2d. 292, 310 (Ill. 1989) ("A death by starvation and dehydration is extremely painful and not one which should be cavalierly imposed upon an incompetent individual.") (internal citations omitted); *Conroy*, 486 A.2d at 1217 ("Dr. Davidoff believed that the resulting thirst could be painful but that Ms. Conroy would become unconscious long before she died. Dr. Kazemi concurred that such a death would be painful.")

189. See Parks, *supra* note 132, at 476 n.196.

190. AVRAM GOLDSTEIN ET AL., PRINCIPLES OF DRUG ACTION: THE BASIS OF PHARMACOLOGY 593 (1968).

painkillers over an extended period of time in these circumstances entails significant uncertainty with regard to effectiveness.¹⁹¹

More fundamentally, patients cannot reliably expect to receive narcotics during this dehydration period. In this country, according to the New York State Task Force on Life and the Law,¹⁹² patients who are conscious and competent have significant trouble attaining sufficient pain relief.¹⁹³ “[T]he delivery of pain relief is grossly inadequate in clinical practice.”¹⁹⁴ If forty to eighty percent of patients with cancer, AIDS, and other diseases report inadequately treated pain,¹⁹⁵ and such patients are *capable of asking for help*, it is not unreasonable to expect a complete absence of pain care for patients who are silently dehydrating.

Pain, however, is not typically what drives the desire for assisted suicide,¹⁹⁶ and the other considerations are also relevant here. A patient may understandably be repulsed by the idea of his or her body lying in a bed for two weeks waiting to die. The thought of wasting away slowly, with one’s body helplessly progressing through the stages of dehydration, is frightening.¹⁹⁷ By contrast, allowing for the choice of euthanasia could “give[]

191. Drug “idiosyncrasy” could also theoretically reduce the predictability of painkiller effectiveness. *See id.* at 429 (“We may now define idiosyncrasy more precisely as a genetically determined abnormal reactivity to a drug.”) (emphasis omitted).

192. The reports from this Task Force were heavily relied upon by the Supreme Court in *Glucksberg*, and have been similarly relied upon by other courts. The Supreme Court describes the Task Force as:

[A]n ongoing, blue-ribbon commission composed of doctors, ethicists, lawyers, religious leaders, and interested laymen . . . was convened in 1984 and commissioned with “a broad mandate to recommend public policy on issues raised by medical advances.” Over the past decade, the Task Force has recommended laws relating to end-of-life decisions, surrogate pregnancy, and organ donation.

Washington v. Glucksberg, 521 U.S. 712, 719 (1997).

193. *See Parks*, *supra* note 132, at 456 n.57.

194. *Id.*

195. *Id.*

196. Although pain is typically one of the reasons cited by patients who desire assisted suicide, in a Washington study the “top reasons given for desiring assisted suicide” were “future loss of control (seventy-seven percent), being a burden (seventy-five percent), being dependent (seventy-four percent), and loss of dignity (seventy-two percent).” *See Parks*, *supra* note 132, at 468.

197. *Cf. Cruzan v. Mo. Dep’t of Health*, 497 U.S. 261, 310 (1990) (Brennan, J., dissenting) (noting the reasons why a patient may want to die as opposed to being maintained on a machine). The same reasons apply, to a somewhat lesser extent, for a person who would rather his or her body were spared the physical onslaught of dehydration.

proper recognition to the individual's interest in choosing a final chapter that accords with her life story."¹⁹⁸

Similarly, "[a] long, drawn-out death can have a debilitating effect on family members."¹⁹⁹ Each day of the dehydration period emotionally taxes family members, particularly those who brought the advance instructions of the patient to the doctor. A forward-looking individual may appropriately wish to spare his or her loved ones the tiresome, painfully extended "goodbye." Moreover, a "final chapter" like the one mentioned above may have vicariously positive effects on family members; on some level, knowing that the deceased brazenly faced whatever it is that comes when life ends may help grief-stricken family members face the rest of their own lives.

C. THE STATE'S COUNTERARGUMENTS

To evaluate arguments against allowing euthanasia for incompetent and immobile patients who have executed an advanced directive, a good place to start is with the state's arguments against physician-assisted suicide. In this factual context, however, most of the state's arguments for a general prohibition of physician-assisted suicide are simply inapplicable. For instance, concern that the patient has an undiagnosed or untreated mental illness that may be distorting his or her judgment is inapplicable.²⁰⁰ Likewise, concern that improperly managed physical symptoms may be distorting the patient's rationality is simply

198. *Washington v. Glucksberg*, 521 U.S. 702, 746–47 (1997) (Stevens, J., concurring).

199. *Cruzan*, 497 U.S. at 311 (Brennan, J., dissenting).

200. In *Krischer v. McIver*, 697 So. 2d 97 (Fla. 1997), for example, the court relied on evidence about the "widespread failure of American medicine to treat pain adequately or to diagnose and treat depression in many cases." *Id.* at 101. The court's concern was that "legal physician-assisted suicide could make it more difficult for the State to protect depressed or mentally ill persons, or those who are suffering from untreated pain, from suicidal impulses." *Id.* at 103; see also *Glucksberg*, 521 U.S. at 731 ("[B]ecause depression is difficult to diagnose, physicians and medical professionals often fail to respond adequately to seriously ill patients' needs. Thus, legal physician-assisted suicide could make it more difficult for the State to protect depressed or mentally ill persons . . . from suicidal impulses.") (internal citations omitted); Yale Kamisar, *Against Assisted Suicide — Even a Very Limited Form*, 72 U. DET. MERCY L. REV. 735, 752 n.17 (1995) ("Explained Dr. Cushing: 'It seems to me that a person with less options for medical care is more likely to fall into despair. And that is when these kinds of decisions are made — when the patient is depressed and believes there is no hope.'").

without basis.²⁰¹ It might even be argued that such a decision is not prone to irrationality at all: deciding to confront death by means of euthanasia as opposed to dehydration is at least a *prima facie* rational choice,²⁰² once we have assumed the withdrawal of life-sustaining hydration and nutrition from an incompetent and immobile (and thus dehydration-bound) patient.

1. *Institutional Effects on Marginalized Groups*

The state's argument regarding adverse effects on marginalized groups may preliminarily appear strong in these circumstances. In *Glucksberg*, the majority noted that “[i]f physician-assisted suicide were permitted, many might resort to it to spare their families the substantial financial burden of end-of-life health-care costs.”²⁰³ Such a fear is potentially relevant here, in that patients might choose active voluntary euthanasia in order to save their families the health-care costs associated with this period of dehydration. Additionally, given that there is typically a need for medical facilities, it could be argued that the availability of this option would eventually create a stigma upon those who refuse to make such a selection; people who draft living wills but choose not to incorporate this option might be seen as selfish for unnecessarily taking up the needed space. Moreover, once the availability of such an option is established, the possibility would exist for insurance companies to require beneficiaries to make this choice.²⁰⁴ Or they may just incorporate this option as the default in the fine print of their contracts, creating a situation where beneficiaries either must pay more to opt out, or are coerced into the decision based on their inability to articulate any strong reason for not desiring euthanasia in such a situation.

201. This argument was made in *Glucksberg*, for example, where “the State and *amici* express[ed] the concern that patients whose physical pain is inadequately treated will be more likely to request assisted suicide.” *Glucksberg*, 521 U.S. at 747 (Stevens, J., concurring).

202. Justice Stevens, for example, suggested in *Glucksberg* that since “pain and suffering become progressively more difficult to treat” as death nears, “[a]n individual adequately informed of the care alternatives . . . might make a rational choice for assisted suicide.” *Id.* at 748 (Stevens, J., concurring).

203. *Id.* at 732.

204. See, e.g., Urofsky, *supra* note 65, at 376 (noting United States Solicitor General Walter Dellinger's cautionary comment that “in a health care system attempting to treat pain and depression, lethal medication is the least costly treatment”).

The concerns about marginalized groups, however, are far less compelling under these circumstances than in the general physician-assisted suicide context. Here, the scenario generally assumes a hospitalized patient who has been incompetent and immobile long enough to satisfy physicians that there is no reasonable medical hope of recovery.²⁰⁵ In the case of a patient like Terri Schiavo, as with most patients for whom this procedure would be relevant, the added cost of an extra two-week hospital stay is relatively insignificant in comparison to the total medical costs incurred, and must be further offset by the cost of the drug used in the procedure. Any fear that insurance companies might attempt to pressure people to choose voluntary euthanasia, moreover, could be abated by a simple statute prohibiting such pressure, or by requiring hospitals to charge the same price for the procedure as they charge for two weeks of bed time.

To put these concerns in perspective, it is useful to compare any adverse effect on marginalized groups that this option may produce to the adverse effects on marginalized groups that could have been expected from allowing for the termination or withdrawal of life-sustaining treatment. Given that life-sustaining treatment can forestall death and commensurately raise medical costs, any theoretical link between medical cost and coercive effect upon patient choice is far clearer in the withdrawal context. In a society that allows individuals to forego extensive life-sustaining treatment of colossal financial magnitude, the argument that allowing people to forego the dehydration period will lead to wide-scale financial pressure to accept that option is dubious.

2. *Interest in Life*

The state's interest in preserving life is almost nonexistent under these facts. Generally, the state's interest in preserving life "may be seen as embracing two separate but related concerns:

205. A patient in a "permanent vegetative state," for example, has been in a vegetative state for at least three months. *See supra* note 2. Any concern that patients and doctors might misuse such a right by purposely provoking such incompetence, and then administering euthanasia, fails to comprehend the nature of the right. The touchstone question to ask when approaching the myriad of hypotheticals of attempts to abuse such a right, would be whether there was absolute assurance that in the absence of euthanasia the patient would have dehydrated to death.

an interest in preserving the life of the particular patient, and an interest in preserving the sanctity of all life.”²⁰⁶

The first interest, that of preserving the life of the particular patient, is greatly attenuated within this factual context. Under cases like *Quinlan*, which recognize that the state’s interest “weakens and the individual’s right to privacy grows as the . . . prognosis dims,”²⁰⁷ the state’s interest is at a consummate low-point, especially compared to the patient’s cresting privacy interest. Moreover, “the life that the state is seeking to protect in such a situation is the life of the same person”²⁰⁸ who has decided to seek death. “[I]t is not some other actual or potential life that cannot adequately protect itself.”²⁰⁹

That the Supreme Court does not require states to distinguish between the quality of individual lives²¹⁰ does not mean that the state’s interests in those lives are equivalent. Once it is established that a person has no chance of recovery, the people who know the patient must rationally be expected to begin preparing for the impending separation. At a certain point, it becomes safe to say that the rest of society should expect to depend on that person less, including emotionally, in preparation for that person’s departure from life. Thus, the aggregate interest of all other citizens in that specific life eventually lessens, irrespective of any valuation of the person’s life.

This “sliding” state interest resembles the approach used by the Supreme Court in *Planned Parenthood of Southeastern Pennsylvania v. Casey*.²¹¹ The difference between pre- and post-viability, and thus the line between permissible and impermissible prohibition on nontherapeutic abortion, is the interest the

206. *In re Conroy*, 486 A.2d 1209, 1223 (N.J. 1985).

207. *Brophy v. New England Sinai Hosp.*, 497 N.E.2d 626, 645 (Mass. 1986) (“[The state interest] wanes when the underlying affliction is incurable and would soon cause death regardless of any medical treatment.”) (internal quotation marks omitted); *In re Quinlan*, 355 A.2d 647, 664 (N.J. 1976); *accord* *People v. Kevorkian*, 527 N.W.2d 714, 759 (Mich. 1994) (Mallett, J., concurring in part and dissenting in part) (“[T]he state’s interests diminish as death nears for a terminally ill person.”).

208. *Conroy*, 486 A.2d at 1223.

209. *Id.*

210. *Cruzan v. Mo. Dep’t of Health*, 497 U.S. 261, 282 (1990) (“[W]e think a State may properly decline to make judgments about the ‘quality’ of life that a particular individual may enjoy.”). *See also* *Washington v. Glucksberg*, 521 U.S. 702, 729–30 (1997).

211. 505 U.S. 833 (1992).

state may claim on behalf of the unborn fetus.²¹² Although the woman's interest remains constant, viability marks the earliest point at which the state's interest in fetal life is constitutionally adequate to justify a legislative ban on nontherapeutic abortions. After viability, the communitarian interests and interests of other specific citizens outweigh the individual interest. Similarly, in the present case, the commencement of dehydration could feasibly mark the point when the state's interests must cede to the wishes of the patient. As noted by Justice Stevens in *Glucksberg*, "Although there is no absolute right to physician-assisted suicide . . . some individuals who no longer have the option of deciding whether to live or to die *because they are already on the threshold of death* have a constitutionally protected interest that may outweigh the State's interest in preserving life" ²¹³

To the extent these arguments do not sufficiently account for the second concern — the "interest in preserving the sanctity of all life" — one may properly question the validity of the state's actions in this area, given the potential for prolonged suffering. The communitarian approach would more properly be characterized as "[g]overnment tolerance of the choice," which would "reflect[] concern for individual self-determination, bodily integrity, and avoidance of suffering, rather than a deprecation of life's value."²¹⁴ As explained by the Massachusetts Supreme Court, "The constitutional right to privacy, as we conceive it, is an expression of the sanctity of individual free choice and self-determination as fundamental constituents of life. The value of life as so perceived is lessened . . . by the failure to allow a competent human being the right of choice."²¹⁵

212. *Casey*, 505 U.S. at 860 ("[V]iability marks the earliest point at which the State's interest in fetal life is constitutionally adequate to justify a legislative ban."). Previability, this state interest loses out to the woman's "urgent claims" for retaining "control over her destiny and her body, claims implicit in the meaning of liberty." *Id.* at 869. The woman's interest is constant, whereas the state's interest changes as the ability of society to expect the unborn fetus's participation in society becomes more certain.

213. *Glucksberg*, 521 U.S. at 745 (Stevens, J., concurring) (emphasis added).

214. *Conroy*, 486 A.2d at 1224 (quoting Norman L. Cantor, Quinlan, *Privacy, and the Handling of Incompetent Dying Patients*, 30 RUTGERS L. REV. 243, 250 (1977)).

215. *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 426 (Mass. 1977).

Although this attack rests merely on the belief that the state, by outlawing choice, is unsuccessfully pursuing its purported goal of preserving the “sanctity of life,” that lack of success may show that the state’s real interest is actually somewhat different from the interest proclaimed. The state’s “unflagging determination to perpetuate” such physical existence may be “comprehensible only as an effort to define life’s meaning, not as an attempt to preserve its sanctity.”²¹⁶ Defining life’s meaning, though, is an improper activity for the state. “It is not the province of secular government to circumscribe the liberties of the people by regulations designed wholly for the purpose of establishing a sectarian definition of life.”²¹⁷ As noted by Justice Stevens in his *Cruzan* dissent, “Although the State may properly perform a teaching function, and although that teaching may foster respect for the sanctity of life, the State may not pursue its project by infringing constitutionally protected interests for *symbolic* effect.”²¹⁸

As a final note on the state’s interest in preserving the “sanctity of life,” the enactment of an explicit privacy clause should at some point limit the communitarian motives of the legislature. Such is the function of constitutional rights. With regard to balancing the state’s need to legislate morality against the People’s right to be free of such control, constitutional rights establish a line beyond which communitarian motivations must yield. The well-delineated period of death by dehydration is an appropriately conservative place to draw that line.

3. *Interest in Deterring Suicide*

Any more specific interest in deterring suicide can be no more convincing than the state’s interest in preserving life. Ordinarily, a state may have an interest in establishing a norm of “not taking the easy route” and of working through one’s problems. It could be said that the state may properly pursue this goal by furthering

216. *Cruzan v. Mo. Dep’t of Health*, 497 U.S. 261, 345 (1990) (Stevens, J., dissenting).

217. *Id.* at 350.

218. *Id.* at 350–51 (quoting *Carey v. Population Services Int’l*, 431 U.S. 678, 715 (1977) (Stevens, J., concurring in part and concurring in judgment) (internal quotation marks omitted) (emphasis in original)).

a norm against suicide.²¹⁹ In our case, though, the patient has no option of working through his or her problems; he or she is in fact already committing “suicide,” as that term was understood at common law. Allowing euthanasia in this specific factual scenario could hardly have any effect on such norms.

Similarly, as opposed to a patient who retains the ability to change his or her decision, an incompetent and immobile patient’s decision under such circumstances to commit suicide — either by dehydration or by euthanasia — is unalterable. Such a patient, as distinguished from an incompetent but mobile patient, cannot acquire or consume food or water without assistance and cannot revoke his or her advance medical instructions.

Lastly, whereas requiring potential suicides to pursue their aims using violent or unsavory methods may generally be seen as a deterrent, no such deterrent is relevant here. This patient will commit “suicide,” regardless of whether the death occurs from dehydration or from a drug. For a patient already having begun the dehydration process, “suicide” will occur, in one form or another.

4. *Other State Concerns*

Another state concern articulated in the general physician-assisted suicide context is the fear of implicit coercion by doctors or misunderstandings between doctors and their patients.²²⁰ With decisions entered in advance directives, however, arguments about implicit coercion or even misunderstandings seem fallacious, as the physician will not be present at the time of the

219. See Sunstein, *supra* note 92, at 1145 (noting that a prohibition on suicide and assisted suicide “helps express and fortify norms in favor of dealing with difficult conditions in more constructive ways”).

220. *Id.* at 1123. As described by Sunstein, the dynamic of the patient-physician relationship in ordinary physician-assisted suicide cases could lead to unintended persuasion:

Suppose that a patient is confronted with a list of options from a doctor, one of which includes physician-assisted suicide. In some such cases the patient — confused or not — might feel actual or implicit pressure to accept the option of death. This is not because the option is, all things considered, the patient’s preferred one, but because the physician explicitly or implicitly favors it and because, under the circumstances, the physician has assumed the role of an authority figure. . . . Here, too, we have a case in which a ban on physician-assisted suicide supports rather than undermines autonomy.

Id. at 1143.

decision. A lawyer drafting an advance directive for his or her client, for example, would have no interest in persuading a client to opt for or against active voluntary euthanasia rather than dehydration, and a client would accordingly have little reason to perceive any such pressure.

Some might suggest that officially recognizing the right suggested by this Note would encourage physicians to notify patients of the option while they are hospitalized but still competent, potentially allowing for such misunderstandings or coercion to occur. This argument, however, ignores the current practice. Why, for example, has this not empirically been the case with patients regarding the withdrawal of life-sustaining treatment? Pressure to withdraw life-sustaining treatment would better serve a physician's conceivable interests than pressure to accept euthanasia afterward. A physician may have an interest in freeing up space in hospice centers or reducing ongoing medical expenses that may have to be absorbed by the health care facility. Coercing a patient to opt for euthanasia after withdrawal of life-sustaining treatment would only free up a bed for two weeks, whereas the preservation of medical supplies that would accompany the coercion of a patient into the decision to forego life-sustaining treatment could be incalculably greater.

The discussion of self-serving physicians segues to another state concern: the purported fear of disintegration of medical norms. Preliminarily, it should be noted that the assertion that allowing euthanasia in these circumstances will lead to a disintegration of medical norms is speculative. As a general rule, under fundamental rights analysis, to uphold a statute the connection between the enactment and the compelling state interest must not merely be speculative, but evidenced by tangible proof.²²¹

221. See, e.g., *Carey v. Population Services Int'l*, 431 U.S. 678, 696 (1977) (opinion of Brennan, J.) ("It is enough that we again confirm the principle that when a State, as here, burdens the exercise of a fundamental right, its attempt to justify that burden as a rational means for the accomplishment of some significant state policy requires more than a bare assertion, based on a conceded complete absence of supporting evidence, that the burden is connected to such a policy."); *American Academy of Pediatrics v. Lungren*, 66 Cal. Rptr. 2d 210, 256 (1997) ("[T]he assertion that physicians cannot be relied upon . . . is supported by no evidence in the present record. Mere supposition, even when plausible, is insufficient. When a state law burdens the exercise of a fundamental right, the government's attempt to justify that burden as a rational means for the accomplishment of some significant state policy requires more than a bare assertion, based on a conceded complete absence of supporting evidence, that the burden is connected to such a policy.").

Even under a balancing test, though, the need to maintain medical norms is a weak justification for denying an individual right. The same argument was made against allowing physicians to withdraw life-sustaining treatment from incompetent patients,²²² and was also made against allowing physicians to perform abortions — the Hippocratic oath previously even contained an anti-abortion element, which has since been conveniently removed.²²³ Yet the legalization of abortion or the legalization of the withdrawal of life-sustaining treatment has hardly ruined the integrity of the medical profession. To argue that allowing abortion or the removal of life-sustaining treatment *has* conclusively ruined the integrity of the medical profession is to suggest that this concern is ipso facto precluded, as the integrity of the country's medical profession has already been lost.

As Justice Blackmun stated in his dissenting opinion in *Bowers v. Hardwick*, “[W]e have ample evidence for believing that people will not abandon morality, will not think any better of murder, cruelty and dishonesty, merely because some private sexual practice which they abominate is not punished by the law.”²²⁴ Similarly, the permissibility of abortion and the withdrawal of life-sustaining treatment are “ample evidence” that the medical profession “will not abandon morality” if we allow physicians to do what they already believe is morally correct.

The physicians that perform the procedure *would* ipso facto believe the practice is morally correct. As in the abortion context, physicians who do not believe the procedure is morally acceptable could decline to perform it. It becomes clear that the argument about the integrity of the medical profession rests merely on the idea that once legal, increasing numbers of doctors will believe

222. See, e.g., *In re Conroy*, 486 A.2d 1209, 1224 (N.J. 1985).

223. As Judge Reinhardt noted, “Were we to adhere to the rigid language of the oath, not only would doctors be barred from performing abortions or helping terminally ill patients hasten their deaths, but according to a once-accepted interpretation, they would also be prohibited from performing any type of surgery at all, a position that would now be recognized as preposterous by even the most tradition-bound AMA members.” *Compassion in Dying v. State of Washington*, 79 F.3d 790, 829 (9th Cir. 1996) (footnotes omitted), *rev'd sub nom.* *Washington v. Glucksberg*, 521 U.S. 702 (1997); see also Hall, *supra* note 170, at 809 n.30 (“[T]he Oath formerly stated that a physician would not participate in abortion. This section was removed after abortion became more prevalent.”).

224. *Bowers v. Hardwick*, 478 U.S. 186, 212 (1986) (Blackmun, J., dissenting) (quoting H.L.A. Hart, *Immorality & Treason*, reprinted in *THE LAW AS LITERATURE* 220, 225 (L. Blom-Cooper ed. 1961)).

the practice is morally correct. As mentioned above, though, such communitarian arguments should yield at some point, given the individual constitutional right in question.

Another similar state concern is the fear of abuse, as emphasized in *Donaldson v. Lungren*.²²⁵ The argument, translated into our context, would be that allowing physicians to perform voluntary euthanasia will lead to non-voluntary euthanasia. Physicians will slide down the slippery slope, losing respect for society's valuation of life, and administer euthanasia to patients who have not expressed such an intent. Soon, euthanasia will pervade medicine, made available in "situations that would have been unthinkable at the beginning," with each successive attempt at limiting its provision effectively "crushed by the euthanasia juggernaut."²²⁶ As with so many of the state's potential arguments, though, it is unclear why euthanasia after life-sustaining hydration and nutrition have been withheld poses any greater risk of non-voluntary life termination than the risk, already present, that a physician might withdraw life-sustaining treatment from an incompetent and immobile patient that has not consented.²²⁷ Additionally, although the prediction is logically coherent, such predictive justifications should be evaluated in context.²²⁸ Even if physicians were tempted to perform non-

225. 2 Cal. App. 4th 1614 (Ct. App. 1992). In *Donaldson*, the court found this state interest dispositive. "[T]he state has a legitimate . . . interest in protecting society against abuses. This interest is more significant than merely the abstract interest in preserving life no matter what the quality of that life is. . . . This interest overrides any interest Donaldson possesses in ending his life through the assistance of a third person in violation of the state's penal laws." *Id.* at 1622.

226. James Bopp, Jr. & Richard E. Coleson, *Three Strikes: Is an Assisted Suicide Right Out?*, 15 ISSUES L. & MED. 3, 71, 75 (1999).

227. See *People v. Kevorkian*, 527 N.W.2d 714, 750 (Mich. 1994) (Levin, J., concurring in part and dissenting in part) ("The legitimate concerns about involuntary euthanasia apply with at least as much force to the withdrawal of life support where the person is incompetent . . .").

228. Opponents of assisted suicide quickly point to the Dutch experience as an illustration of how permitting physicians to administer euthanasia will lead to non-voluntary euthanasia. See Bopp & Coleson, *supra* note 226, at 71 (citing to the Rummelink Report and follow-up reports that disclose thousands of cases where patient consent was not obtained.). However, such statistical arguments are blind to another significant factor at play in the Dutch experience: The law *allows* in various circumstances for non-voluntary euthanasia. See *id.* (noting that "Dutch courts have approved the killing of infants with disabilities"); Parks, *supra* note 132, at 451-52 (explaining the Dutch "force majeure" exemption from criminal law that allows for legalized euthanasia, and noting that the exception may be utilized without patient consent "under extreme circumstances"). Although this other factor does not conclusively account for all of the nonvoluntary euthana-

voluntary euthanasia, the problem of preventing this practice is no different than that under current law.²²⁹

D. SUMMARY

The dehydration period is a peculiar factual context, due to the complete assurances that both the patient will dehydrate to death, and that such death will occur within a specifically delineated period of time. The singular nature of the situation projects a bright line, a line that helps to diffuse the fear that allowing such physician involvement in these cases might require allowing it for other incapacitated patients with less certain or less imminent deaths. Additionally, the bright line dispels otherwise serious concerns about unprincipled definitions of “terminal illness” and about the intrinsic unfairness that would accompany allowing assisted suicide exclusively for such an arbitrarily defined group.²³⁰ When coordinated with relevant conceptual extensions as discussed in Part V, this line may be an appropriate “next step” for the law relating to the end of life.

VII. CONCLUSION

As Justice Brennan wrote, “[T]here exists in modern America the necessity for protecting all of us from arbitrary action by governments more powerful and more pervasive than any in our an-

sia in the Netherlands, it may explain *why* and *how* the informed consent requirement has eroded.

229. See, e.g., Thunder, *supra* note 147. Thunder notes,

In 1998 The New England Journal of Medicine reported on a survey of physicians who regularly care for dying patients. . . . Of those who responded, 6%, all unnamed, hastened the death of at least one patient. Ezekiel Emanuel of the National Institutes of Health (NIH) has estimated that three to 13% of all physicians have hastened the death of a patient. Based on a survey of cancer specialists, he estimated that one percent of all patient deaths were hastened by physicians. “Hastening of death” refers to the primary motive of the physician — as opposed to having the primary but lawful motive of relieving pain.

Id. at 218–19.

230. See, e.g., *People v. Kevorkian*, 527 N.W.2d 714, 726 n.34 (Mich. 1994) (“No clear definition of ‘terminal illness’ is medically or legally possible, since only in hindsight is it known with certainty when someone is going to die.”); see also Kamisar, *supra* note 200, at 739–43 (arguing that any right or liberty to physician-assisted suicide should not and could not be limited to the “terminally ill”).

cestors' time."²³¹ Sadly, despite that necessity, the Supreme Court has "[a]dopt[ed] the premise that state courts can be trusted to safeguard individual rights," and has chosen "to limit the protective role of the Federal Judiciary."²³² For the most part, state courts have yet to answer the call.

A particularly sharp need exists for the protection of individual liberty in decisions surrounding the end of life. Law and opinion on the subject, however, trudge along with their characteristic anchoring to tradition and the status quo. This Note takes the optimistic approach that a controlled experiment, within the tightly delineated parameters of the dehydration period, would help to provide an empirical basis for understanding the issues surrounding physician-assisted suicide and euthanasia, and would put society in a more educated and objective position from which to contemplate these issues in the future.

More importantly, this Note argues that state courts might restore some degree of privacy to dying patients, as well as respect for their final wishes. Although Terri Schiavo never signed an advance directive or living will, for some of the thousands of Americans who do, the legal framework espoused by this Note could allow for inclusion of a standard secondary question in the paperwork: "Once hydration and nutrition are removed, would you rather have drug-induced death or let nature take its course?"

The truth remains that in hospitals around the country, patients linger in a "twilight zone of suspended animation where death commences while life, in some form, continues."²³³ In the comparatively impersonal and public setting in which death typically occurs nowadays,²³⁴ however, certain decisions of dying patients deserve protection, a place within that "realm of personal liberty which the government may not enter."²³⁵ The decision to

231. William J. Brennan, Jr., *State Constitutions and the Protection of Individual Rights*, 90 HARV. L. REV. 489, 495 (1977).

232. *Id.* at 502–03.

233. *Cruzan v. Mo. Dep't of Health*, 497 U.S. 261, 301 (1990) (Brennan, J., dissenting) (quoting *Rasmussen v. Fleming*, 154 Ariz. 207, 211 (1987)).

234. "Of the approximately 2 million people who die each year, eighty percent die in hospitals and long-term care institutions, and perhaps seventy percent of those after a decision to forgo life-sustaining treatment has been made." *Id.* at 302–03.

235. *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833, 847 (1992); see also *Jacobson v. Commonwealth of Massachusetts*, 197 U.S. 11, 29 (1905) ("There is, of

forego the dehydration period after the withdrawal of life-sustaining treatment should be one of those decisions.

course, a sphere within which the individual may assert the supremacy of his own will, and rightfully dispute the authority of any human government, — especially of any free government existing under a written constitution, to interfere with the exercise of that will.”).