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Fatal Backlash: Advocating the Right to Die in America

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The emerging issue of an individual’s right to physician-assisted suicide presents a fascinating ethical, clinical and legal challenge. The normative distinction between physician-assisted suicide and other manifestations of the right to die is virtually negligible, since the traditional dichotomies relating to the ‘active’ and the ‘passive’, ‘acts’ and ‘omissions’, and ‘intention’ and ‘knowledge’, are unpersuasive in the context of prohibiting physician-assisted suicide alone. This paper critically analyzes American discourse on physician-assisted suicide both in the public policy and constitutional law spheres and concludes that the real opposition to the practice derives from the moral preferences of society. Given the actual motivations behind public opposition to physician-assisted suicide, the political dimensions of advocating legal reform require close scrutiny.

Recent constitutional developments appear to suggest that moral preferences cannot be accepted as a legitimate basis for curtailing any liberty interest. This has reignited the debate over the possibility of a constitutional recognition of the right to physician-assisted suicide. Commentators such as Yale Kamisar argue that the U.S. Supreme Court is still unlikely to recognize a right to physician-assisted suicide. His analysis is, however, somewhat unsatisfactory in view of: 1) an emerging awareness relating to the right to die, and 2) new state reforms legalizing physician-assisted suicide. Yet there are compelling reasons for avoiding the use of litigation at the federal level as a means of directly advocating the right to die. As seen in other instances, such as in the case of abortion rights, even if the Supreme Court were to recognize a constitutional right to physician-assisted suicide, such a decision may radicalize opponents and produce a counterproductive backlash that could cripple the movement. Hence it is crucial that this ‘emerging awareness’ is not disrupted by an imprudent intervention at the federal level. Efforts to introduce reform ought to be aimed at assisting the states. This approach, however, may still involve strategic interventions at the federal level, such as challenging the ‘coercive’ effects of particular federal legislation that discourage states from reforming their policies. Ultimately, advocates of the right to die must assess the overall risks involved in strategic litigation and weigh such risks against the potential benefit of ‘clearing the field’ for states to reform their policies unhindered.

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I. INTRODUCTION

Contemporary notions of dignity and autonomy often compel the belief that an individual ought to exercise agency over the intimate and personal choices she makes during her lifetime. This belief raises the question of whether decisionmaking autonomy enjoyed during life extends to decisions that pertain to death. Society’s response to this emerging issue presents a fascinating ethical, clinical and legal challenge.

The phrase ‘right to die’ encapsulates at least four different rights: (1) the right to refuse life-sustaining medical treatment; (2) the right to commit suicide; (3) the right to assistance in committing suicide; and (4) the right to active voluntary euthanasia. The general debate on this issue revolves around the rights of terminally ill patients, possibly because the right to die is mostly relevant in cases involving competent, terminally ill patients seeking a dignified death. This paper proceeds on the understanding that contemporary discourse on the right to die has moved beyond the recognition of the first two rights listed above and essentially revolves around issues pertaining to the third right. I will therefore critically examine American discourse on the

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right to die and inquire into both the normative desirability of physician-assisted suicide—and by extension, a broader conception of the right to die—and the feasibility of certain advocacy strategies aimed at legalizing physician-assisted suicide.

Existing literature on the right to die generally explores either its ethicality or constitutionality. A significant lacuna, however, exists in terms of analyzing the political implications of advocating the right to die. Achieving tangible change at the policy level requires that this gap be filled. In setting about this task, this paper is organized in three chapters. The first and second chapters survey the existing discourse within the public policy and constitutional law spheres. The final chapter contributes to this discourse by investigating the progress made at the state level and identifying certain key political dimensions that must be taken into account when developing an effective strategy for reform.

II. PUBLIC POLICY AND THE RIGHT TO DIE

Any advocacy movement seeking reform in respect of the right to die must possess a thorough understanding of the normative and public policy issues surrounding the subject. This chapter examines the numerous public policy arguments presented both in favor of and against the right to die. Many of these arguments are presented within specific contexts involving the refusal of life-sustaining treatment (“RLST”), physician-assisted suicide (“PAS”), and active voluntary euthanasia (“AVE”).

Bearing in mind the progression of the present debate on the right to die, we may, as a practical starting point, consider “the quintessential case of [PAS]: may a doctor permissibly supply the means of death to a competent, informed patient who is terminally ill, who has

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3 RLST involves the patient’s right to request her physician to withdraw treatment that is presently being administered, or to withhold treatment necessary for her survival. The former category may include the removal of ventilators or artificial means of nutrition and hydration, thereby allowing the “natural disease process to run its course.” The latter category involves the physician—upon the request of the patient—withholding necessary medication, or food and hydration. See Norman L. Cantor and George C. Thomas III, The Legal Bounds Of Physician Conduct Hastening Death, 48 BFLR 83, 88, 96-97 and 153 (2000); Alan Meisel, Barriers to Forgoing Nutrition and Hydration in Nursing Homes, 21 AM. J.L. & MED. 335, 352-55, 367 (1995). While the difference between the two categories and their respective subcategories hinges on subtle variations in the act undertaken by the physician and the degree of patient involvement, the acceptability and wide usage of these practices, collectively regarded as passive euthanasia, presently remains unchallenged. See R.G. Frey, Distinctions in Death, in EUTHanasia AND PHYSician-Assisted Suicide: FOR and AGAINST 17, 36 (R.G. Frey ed., 1998). The author comments: “it has been widely remarked that passive euthanasia is relatively common in our hospitals…and doctors do not all that reluctantly shy away from conceding that they take part in withdrawing treatment at the request of terminally ill patients.”

4 PAS “involves introduction into the body, at the patient’s initiative, of a lethal substance that the patient knows will cause death.” It usually contemplates the voluntary ingestion of barbiturates or opioid analgesics that prompts immediate death. See Cantor and Thomas, supra note 3, at 84 and 153.

5 In AVE, the physician performs the last causal act—usually administration of a fatal injection of sodium chloride or barbiturates—leading to the death of the patient. See Gerald Dworkin, Introduction, in EUTHanasia AND PHYSician-Assisted Suicide: FOR and AGAINST 3, 3 (R.G. Frey ed., 1998); Cantor and Thomas, supra note 3, at 84.
voluntarily requested the doctor’s assistance in dying, and whose request has survived treatment for depression.”

A. NORMATIVE ASYMMETRY

Prior to delving deeper into public policy debate concerning PAS, it may be appropriate to identify some of the normative and philosophical principles that underscore the distinction between PAS and other practices such as RLST and palliative care that hastens death (“PCHD”).

Since the law does not prohibit suicide, a patient is permitted to refuse life-sustaining treatment; an act that would ensure certain death. Deeming PAS unacceptable is therefore contingent on the view that requesting the withdrawal or withholding of treatment is distinguishable from requesting, say, a lethal dosage of barbiturates. This view rests on the belief that the “maintenance of bodily integrity against unwanted invasions” is fundamentally different from the “active introduction of substances into the body… knowingly caus[ing] death.” Yet this distinction need not necessarily be normatively decisive. R.G. Frey argues:

If suicide is permissible and if in order to commit suicide it must be possible for one to have access to the means of suicide; then we have no reason to believe that only withdrawing and withholding treatment are acceptable means of bringing about a patient’s death.

The principle distinction between RLST and PAS may still be put down to one of intentionality and causality i.e. the difference between letting the patient die and causing death. It suffices to say that the law recognizes the ‘act-omission’ dichotomy in a number of contexts and has fairly consistently assigned higher culpability in the former case.

Certain additional factors relating to the role of medical professionals seem to further justify the maintenance of the distinction between ‘acts’ and ‘omissions’. For example, Leon Kass argues that the ethical obligation of doctors not to kill is based on “specific duties and restraints long thought to be absolutely inviolate under…traditional medical ethics.” Simply put, the nature of the medical profession and the need to see physicians as ‘caregivers’ in the business of

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6 Frey, supra note 3, at 19. The author comments that depression is considered a factor here due to research that indicates that “palliative care for [patients suffering from depression] is not what it should be” and that ideal standards of palliative care in this department would reduce the number of terminally ill patients seeking PAS. Also see Robert I. Misbin, Physicians Aid in Dying, 325 NEW ENG. J. MED. 1304-1307 (1991); Russel Ogden, Palliative Care and Euthanasia: A Continuum of Care? 10 J. PALLIATIVE CARE 82-85 (1994); Kathleen Foley, The Relationship of Pain and Symptom Management to Patient Requests for Physician-Assisted Suicide, 6 JOURNAL OF PAIN AND SYMPTOM MANAGEMENT, 289-297 (1991).
7 Cantor and Thomas, supra note 3, at 89. For a more detailed discussion, see ROBERT N. WENNBERG, TERMINAL CHOICES: EUTHANASIA, SUICIDE, AND THE RIGHT TO DIE, 19-23 (1989).
8 Cantor and Thomas, supra note 3, at 153.
9 Id.
10 Frey, supra note 3, at 42.
11 For example, the American legal system has not recognized a duty to rescue. See Marin Roger Scordato, Understanding the Absence of a Duty to Reasonably Rescue in American Tort Law, 82 TUL. L. REV. 1447 (2008).
‘lifesaving’ rather than ‘life-taking’ suggests that a sharp distinction ought to be maintained between acts that cause death and omissions that lead to death.\textsuperscript{13}

There are, of course, obvious counterarguments that ought to be carefully examined. In the criminal law context, the offence of murder does not always maintain this normative asymmetry. For example, a parent who starves her child to death is no less guilty of murder than a parent who poisons her child. Justice Antonin Scalia postulates this exact view in his concurring opinion in \textit{Cruzan v. Director, Missouri Department of Health}.\textsuperscript{14} He opines that it is “no defense that the infant’s death was ‘caused’ by no action of the parent but by the natural process of starvation, or by the infant’s natural inability to provide for itself.”\textsuperscript{15} In such cases, the law draws no distinction between acts and omissions.

Thus it is at least logically questionable to assume such a distinction in the context of the right to die. It is not obvious that a physician who withholds life-sustaining treatment commits an omission rather than an act, particularly where the patient’s consent has not been obtained. A physician is equally culpable in both instances of withdrawing or withholding treatment and of administering a lethal dosage of barbiturates, should the patient’s wishes be otherwise. Yet the patient’s consent absolves the physician only where RLST is concerned, and not in the case of PAS.\textsuperscript{16}

Then the question remains: what governs this normative asymmetry? It is reiterated that the refusal to accede to a patient’s request for withdrawal of treatment amounts to an invasion of the patient’s bodily integrity.\textsuperscript{17} Thus it is the prohibition on battery that forms the exception to the general rule against aiding a patient’s death, thereby compelling physicians to accede to the patient’s request to die. Yet this exception relating to interference with bodily integrity presupposes a terminally ill patient’s right to commit suicide. As Justice Scalia rightly points out, “it has always been lawful not only for the state, but even for private citizens, to interfere with bodily integrity to prevent a \textit{felony}. That general rule has of course been applied to suicide. At common law, even a private person’s use of force to prevent suicide was privileged” (emphasis added).\textsuperscript{18} With the decriminalization of suicide, however, a competent, terminally ill patient’s right to commit suicide is ‘protected’ from the common law notion of interfering with bodily

\textsuperscript{13} Dworkin, \textit{supra} note 5, at 4-5. According to the American Medical Association, PAS is “fundamentally incompatible with the physician’s role as healer.” It is often contended that public trust and confidence in the medical profession would be adversely affected if “physicians [were] known to function as killers—providers or administrators of lethal poisons—rather than healers.” See Cantor and Thomas, \textit{supra} note 3, at 158; AMA Code of Medical Ethics § 2.21 (1992); Brief, Amici Curiae, Glucksberg (Nos. 1295-1858, 96-110).

\textsuperscript{14} 497 U.S. 261, 297 (1990) (Scalia, J., concurring).

\textsuperscript{15} \textit{Id.} Also see Lewis v. State, 72 Ga. 164 (1883); People v. McDonald, 49 Hun 67, 1 N.Y.S. 703 (5th Dept., App.Div.1888); Commonwealth v. Hall, 322 Mass. 523, 528, 78 N.E.2d 644, 647 (1948).

\textsuperscript{16} Justice Scalia points out that this distinction is likely to distort the causal nexus between the physician’s act of withholding or withdrawing treatment and the death of the patient who consented to such an act. He comments: “even as a legislative matter, in other words, the intelligent line does not fall between action and inaction but between those forms of inaction that consist of abstaining from “ordinary” care and those that consist of abstaining from “excessive” or “heroic” measures. Unlike action versus inaction, that is not a line to be discerned by logic or legal analysis, and we should not pretend that it is. See \textit{Cruzan}, 497 U.S. 261, at 296 (Scalia J., concurring).


\textsuperscript{18} \textit{Cruzan}, 497 U.S. 261, at 298 (Scalia J., concurring).
integrity to prevent a felony. This apparent change in the status of suicide now makes any interference with bodily integrity in the context of RLST unacceptable.

The above analysis, however, offers no explanation as to why assisting in the act of suicide is somehow unacceptable. Under the common law, the “ aider and abettor derives liability from the principal…” Since committing suicide is not a crime in the U.S., this traditional common law analysis alone cannot produce liability for assisting suicide. The only way assisting suicide, and more specifically PAS, might be deemed unlawful is if the legislature explicitly or implicitly declares it to be so, presumably on the basis of public policy.

Under current legal standards, a competent, terminally ill patient may be deeply sedated or provided with analgesics for the purpose of alleviating suffering. This process falls within the concept of ‘palliative care’ and is known to hasten death in some cases.

What purportedly sets PCHD apart from PAS is the physician’s intent to alleviate a patient’s pain and suffering, as opposed to supplying the means of death. Thus it is argued: “analgesics that risk accelerating death are lawful so long as the physician’s primary intent is to reduce suffering rather than to cause death.” Norman Cantor and George Thomas explain:

> The premise behind this assertion is that, for criminal law purposes, causing death as an unintended side effect (of providing pain relief) is different from intentionally causing death. This rationale attempts to transfer the double effect principle of moral philosophy to the criminal law context.

Hence, commentators such as Yale Kamisar argue that in the context of pain relief, “a physician may not administer a lethal dose of drugs for the very purpose of killing the patient, but…may administer increasing dosages of drugs to relieve the patient’s increasing pain—even though doing so will foreseeably hasten or increase the risk of death” (emphasis added).

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19 Cantor and Thomas supra note 3, at 105.
20 Id.
21 Id. 106. The authors note, however, that the Michigan Supreme Court ruled that assisting suicide could be prosecuted in Michigan as a common-law crime. See People v. Kevorkian, 527 N.W.2d 714, 716 (Mich. 1994).
22 Some commentators have described this practice as ‘terminal sedation’, defining it as the “administration of sedatives sufficient to render a dying patient somnolent during the remainder of the dying process.” See Cantor and Thomas supra note 3, at 138.
24 Id.
27 Id. at 113-114. Also see Stephen R. Latham, Acquinas and Morphine: Notes on Double Effect at the End of Life, 1 DEPAUL J. HEALTH CARE LAW 625 (1997); Patrick F. Norris, Palliative Care and Killing: Understanding Ethical Distinctions, 13 BIOETHICS FORUM 25 (1997).
This analysis is somewhat unconvincing given that specific ‘intent’ is largely indeterminable. A physician who “administers an only slightly risky analgesic dosage may harbor an intent to put the patient out of [her] misery by accelerating death.”\(^{29}\) In fact, physicians often provide large, dangerous dosages of analgesics intending not merely to alleviate pain and suffering but also to hasten death.\(^{30}\) Furthermore, there is compelling statistical data to suggest that in the case of PAS, “the doctor's intent might only be to provide the patient with the means to control her future, believing that such control will make it unnecessary for the patient to actually kill herself.”\(^{31}\) In such cases, the physician would lack an intention to ‘cause death’.

A more plausible distinction between PAS and PCHD seems to rest on the difference between ‘purpose’ and ‘knowledge’. Administering a dosage of morphine that could lead to death through respiratory depression is permissible, provided the physician’s purpose is to relieve pain and suffering. This is despite the fact that all medically competent people know, to a high degree of probability, that such a dosage will induce or hasten death.\(^{32}\) The legality of PCHD turns not so much on the physician’s specific intent, but on “standard criminal law principles of recklessness and justification.”\(^{33}\)

The ‘purpose-knowledge’ distinction is, however, problematic on two counts. First, the purpose of alleviating pain and suffering cannot justify any form of killing, including AVE.\(^{34}\) Second, a specific intention to kill is not necessary for homicide, since a reckless state of mind is often sufficient for culpability.\(^{35}\) Therefore, “if recklessness is otherwise established, proof that the actor’s primary object was to relieve pain would not justify the reckless conduct at issue.”\(^{36}\) In the case of PCHD, it is intuitively clear that a ‘reckless state of mind’ sufficient to establish criminal liability is present when a physician uses a large analgesic dosage knowing that it is likely to be fatal.\(^{37}\) Yet the overwhelming legal consensus in the U.S. suggests otherwise: plainly, that the criminal prohibition on assisted suicide does not apply to “a licensed health care

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\(^{29}\) Cantor and Thomas, supra note 3, at 114.

\(^{30}\) Id.; Also see Ronald E. Cranford, Going Out in Style, the American Way, 17 L. MED. & HEALTH CARE 208 (1989).

\(^{31}\) Gerald Dworkin, Sex, Suicide, and Doctors, 109 ETHICS 579-585, 584 (1999). The author comments that a survey of physicians in the U.S. revealed that of the patients provided with lethal prescriptions, only 59 percent used the prescriptions to end their lives. Also see Diane E. Meier, Carol-Ann Emmons, Sylvan Wallenstein, et al., A National Survey of Physician-Assisted Suicide and Euthanasia in the United States, 338 NEW ENG. J. MED., 1193-1201 (1998).

\(^{32}\) Frey, supra note 3, at 22.


\(^{35}\) Id.

\(^{36}\) Id. at 117; Cantor and Thomas, supra note 33, at 110-11. Also see Williams, supra note 34, at 322. Williams comments: “there is no legal difference between desiring or intending a consequence as following from your conduct, and persisting in your conduct with a knowledge that the consequence will inevitably follow from it, though not desiring that consequence. When a result is foreseen as certain, it is the same as if it were desired or intended.”

provider who administers, prescribes, or dispenses medication or procedures to relieve a person’s pain or discomfort, even if the medication or procedure may hasten or increase the risk of death, unless such medications or procedures are intended to cause death” (emphasis added).38 Peculiarly, the notion of recklessness seems to be absent in the context of PCHD.

Like the distinction between PAS and RLST, we are once again left with a policy-based explanation for the distinction between PAS and PCHD. Adopting a ‘risk-based’ approach to understanding this distinction,39 Cantor and Thomas argue that under the principle of recklessness, a physician who practices PCHD might still be made liable for knowingly causing the death of a patient.40 This position, though academically sound, only reveals the normative incongruity of present U.S. legal standards in permitting PCHD regardless of recklessness, while criminalizing PAS. These authors’ analysis, however, highlights the policy-based motivations for maintaining the distinction. They surmise:

A rational legislator could think that knowing or intentional killing, even for a worthy reason such as pain relief, is more heinous than behavior merely risking death. Phrased differently, a worthy object such as relief of suffering might warrant risk taking even though it would not warrant an intentional or knowing killing.41

In any event, this distinction reveals a further complication, since “the dividing line universally drawn in the literature between PAS and AVE...is a matter of who acts last, causally.”42 As in the case of AVE, it is the physician who carries out the final act in PCHD. Thus instances of PCHD would be more likely to be categorized as AVE if not for the presumed lack of intention. Intention, it seems, has an overly broad impact on a variety of distinctions that we choose to draw between what is deemed acceptable and unacceptable conduct, notwithstanding the causal nexus between the physician’s action and the ultimate death of the patient. Due to both the difficulty in ascertaining true intention and the perceivable disregard of the concept of recklessness in the case of PCHD, the distinction between PAS and PCHD is tough to maintain except for the policy preferences of a particular legislature.

B. ISOLATING THE TIPPING POINT


39 Cantor and Thomas, supra note 3, at 110-138. The authors surmise that the culpability of physicians using potentially lethal barbiturates ought to be contingent on the level of risk undertaken by its administration. The higher the risk of death, the more likely the physician had the requisite intent or knowledge to commit the offense of assisted-suicide.

40 Id.


42 Frey, supra note 3, at 27.
The spectrum of actions relating to the right to die juxtaposed against their respective acceptability further illustrates the logical difficulty of prohibiting PAS alone. If one is to accept the *status quo* as permitting RLST and PCHD, it seems inevitable that the prohibition of PAS would require justifications that go beyond the normative reasoning that supports this *status quo*. The following grid clarifies this position.

<table>
<thead>
<tr>
<th>Categorization</th>
<th>Description of Action</th>
<th>Final Act</th>
<th>Intention</th>
<th>Acceptability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Withdrawal of Care</td>
<td>Removal of artificial nutrition and hydration</td>
<td>Physician</td>
<td>Cause death</td>
<td>Acceptable</td>
</tr>
<tr>
<td></td>
<td>Unplugging ventilator</td>
<td>Physician</td>
<td>Cause death</td>
<td>Acceptable</td>
</tr>
<tr>
<td>Withholding of Care</td>
<td>Rejecting nutrition and hydration</td>
<td>Patient</td>
<td>Cause death</td>
<td>Acceptable</td>
</tr>
<tr>
<td></td>
<td>Acquiescing to the patient’s refusal of life-sustaining treatment</td>
<td>Patient and Physician</td>
<td>Cause death</td>
<td>Acceptable</td>
</tr>
<tr>
<td>PCHD</td>
<td>Administering potentially lethal analgesics</td>
<td>Physician</td>
<td>Reduce suffering</td>
<td>Acceptable</td>
</tr>
<tr>
<td>PAS</td>
<td>Supplying lethal barbiturates or opioid analgesics</td>
<td>Patient</td>
<td>Cause death</td>
<td>Unacceptable</td>
</tr>
<tr>
<td>AVE</td>
<td>Administering lethal barbiturates or opioid analgesics</td>
<td>Physician</td>
<td>Cause death</td>
<td>Unacceptable</td>
</tr>
</tbody>
</table>

The above grid appears to establish that the unacceptability of PAS is not solely contingent on the intention of the physician, as the act of withdrawing life support with the intention of causing death is deemed acceptable. Furthermore, the ‘act-omission’ distinction is unhelpful, since it remains unclear whether the act of withdrawal is an omission the same way the act of withholding is. Both these actions, regardless of whether they are interpreted as ‘acts’ or ‘omissions’, produce the result of the patient’s death, which is deemed acceptable. Frey comments:

So far as the active/passive distinction is concerned, what is the moral difference between the doctor supplying a pill that will produce death and his withdrawing feeding tubes that will produce death? Both happen as a result of a request by the patient for assistance in dying; both are effective in bringing about death and both feature the patient and doctor acting together to produce that death…It seems artificial to try and pry these cases apart by the active/passive distinction, when their essential similarity, morally is so close.\(^{43}\)

The distinction between ‘supplying the means of death’ and ‘withdrawing or withholding the means of life’ offers no determinative answer, since administering a potentially lethal dose of analgesics is deemed acceptable so long as the purported intention was to ‘reduce suffering’. This analysis reveals a labyrinth of complications, as the characterization of an act as PCHD as

\(^{43}\) *Id.* at 35.
opposed to PAS—or worse, AVE—boils down to the actual intention of the physician, regardless of knowledge. To complicate matters further, the distinction between providing a means of suicide and directly causing death is also tenuous, since under PCHD, it does not matter whether a physician administers the potentially lethal dose of morphine himself, so long as the intention was to reduce suffering and the outcome of death, though foreseeable, was not inevitable. Thus the disambiguation of the normative grounds for banning PAS reveals that deeming PAS unacceptable is based on a combination of factors almost arbitrary in its selection.

C. PAS AND PUBLIC POLICY

Some of the classic arguments against legalizing PAS include the likelihood of error and abuse; the potential harm to vulnerable groups through health care cutbacks and coercion; the damage caused to the medical profession; and the risk of involuntary euthanasia. None of these arguments suggests that making PAS available to competent, terminally ill patients is normatively undesirable in itself. Instead, these arguments rely on the potential for PAS to become unmanageable or to expand into areas that are perceived as being morally reprehensible. These arguments sacrifice the claim of eligible terminally ill patients in order to serve the greater social good of protecting ineligible patients from falling victim to involuntary active euthanasia or to some form of coerced PAS. It is the claim of the other that prevents the effectuation of any legitimate claim to PAS. Thus, when discussing the legalization of PAS, we are confronted with the question of slippery slopes. This is the essence of the opposition to PAS; an opposition that is rooted in the speculation that legalization of PAS will encourage the elimination of the ‘unwanted’.

Proponents of the slippery slope argument do not contend that the criteria for determining eligibility for PAS, such as terminal illness, competency and voluntariness are necessarily prone to definitional manipulation. Yet, they maintain that regardless of stable definitions for ‘terminal illness’, ‘competency’ and ‘voluntariness’, we would be led to terminating the incompetent or justifying involuntary active euthanasia. Some of the main public policy arguments for banning PAS are discussed below.

i. Social Risks

In its 1994 Report, the New York Task Force on Life and the Law concluded that the legalization of PAS would result in significant risks to minorities, the poor and the elderly. One of the key points made in the report is that the propensity towards conserving resources, together with the current haphazardness in the treatment of depression, would lead to the abuse of PAS. The report maintains that many patients who consider suicide during the course of terminal

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44 Dworkin, supra note 17, at 66-67.
45 For a discussion on slippery slope arguments, see DOUGLAS WALTON, SLIPPERY SLOPE ARGUMENTS (1992); Frederick Schauer, Slippery Slopes, 99 HARV. L. REV. 361-383 (1985).
47 Id. at 47.
illness often abandon the option in favor of a longer life if effective treatment is on offer. The authors of the report suggest that the under-treatment of both pain and depression may result in a higher—albeit artificial—demand for PAS, whereas proper diagnosis of depression and the effective treatment of both pain and depression would significantly reduce this demand. Legalizing PAS within such an environment is therefore dangerous, since it would encourage officials to cut corners where effective pain relief and proper diagnosis and treatment of depression are concerned. The result, as the New York Report suggests, is that vulnerable groups would be at risk.

The report also highlights the potential risk of people being coerced into terminating their lives in order to avoid becoming burdens on their families. This phenomenon would no doubt affect the choice set of others who could be perceived as ‘selfish’ for not making the same choices.  

John Arras suggests that the three main assumptions that underpin a justification of PAS—the voluntariness of the request; the exhaustion of alternatives; and monitoring to prevent abuse—are collectively unreliable. Thus, notwithstanding a normatively reasoned acceptance of the isolated deserving case, the primary objection to PAS lies in the incapacity of society to properly regulate it. The objection is essentially one of form rather than substance.

Frey offers an interesting rebuttal to Arras’s argument about social risk. He suggests that the lack of effective means of preventing abuse cannot amount to a normative prohibition of PAS, since “it is not beyond human ingenuity” to develop some mechanism for effectively monitoring the implementation of a PAS policy. Frey points out that other aspects of the law such as justified killings in criminal law clearly contemplate both slippery slope arguments involving social risks and effective guidelines to prevent abuse. Thus there is no reason to reckon that the proper regulation of PAS is beyond the scope of human competency. Furthermore—and closer to home—these same risks are equally applicable in the context of RLST. Yet the presence of such risks or the potential for some abuse has not warranted a ban on RLST.

ii. Damaging the Medical Profession

Commentators such as Leon Kass have argued strenuously against PAS on the basis that it is inconsistent with the goals of medicine—to sustain life and relieve suffering—and will therefore...

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50 See Herbert Hendin and Kathleen Foley, Physician-Assisted Suicide in Oregon: A Medical Perspective 106 MICH. L. REV. 1613, 1624-1625 (2008). The authors relate the story of Kate Cheney, an eighty-five-year-old Widow from Oregon diagnosed with terminal stomach cancer. After a psychiatrist’s assessment that she lacked the capacity to weigh options about assisted-suicide, Kate’s daughter sought a second opinion. The psychologist consulted concluded that though Kate’s “choices might have been influenced by her family's wishes and that her daughter, Erika, might have been somewhat coercive,” she in fact had the capacity to make her own choices. Kate therefore received the lethal drugs under the Oregon Law and later committed suicide. Also see Erin Hoover Barnett, A Family Struggle: Is Mom Capable of Choosing to Die? OREGONIAN, Oct. 17, 1999, at G01.
51 Frey, supra note 46, at 50. Also see Arras, supra note 49, at 82.
52 Frey, supra note 46, at 51-52.
53 Id. at 52.
severely damage public trust in the medical profession. He also argues that certain ethical principles under the Hippocratic oath, such as confidentiality, the prohibition of sexual relations with patients and the prohibition of dispensing deadly drugs, illustrate the need to place safeguards against acts which medical professionals are prone to commit. An unequivocal ban on PAS serves as a safeguard against the proclivity of physicians to ease their patients’ suffering in a manner that is inconsistent with the goals of medicine.

Responding to these arguments, Gerald Dworkin suggests that the presumption that medicine has a single goal—the preservation of the health of the patient—does not adequately explain medical practices relating to rhinoplasty or childbirth. Also, the presumption that physicians might be more inclined to dispense lethal drugs is counterintuitive, since a patient’s death often reflects poorly on a physician’s level of skill. Thus prohibiting PAS cannot be justified as part of the ethical regulation of the medical profession.

The negative impact of PAS on the public’s perception of the medical profession is, however, quite distinct from the ethical regulation of physicians. This may explain why RLST is regarded as acceptable, while PAS is not. For example, Paul Weithman draws a distinction between RLST and PAS by insisting that RLST “does not create the same public perception that physicians are sometimes willing to cause the deaths of their patients” as PAS does.

There are two possible responses to this argument. First, as Gerald Dworkin puts it, such a perception, if at all, “is based on mistake and confusion,” since a physician who withdraws or withholds artificial nutrition and hydration or who disconnects a ventilator is no doubt willing to cause the death of his patient. Second, when a physician prescribes a patient a lethal dose of barbiturates, he does not kill the patient, but only facilitates her decision to commit suicide. This act should not to be confused with an intention to cause the death of a patient per se, as a patient who has received lethal barbiturates may ultimately choose not to commit suicide. Thus the fact that PAS creates a particularly negative, yet misguided perception of the medical profession is not a valid justification for banning PAS. On the contrary, this predicament might be better addressed by raising awareness on the precise nature of PAS.

54 Kass, supra note 12, at 28. Also see David Orentlicher, Physician Participation in Assisted-Suicide, 262 J. AM. MED. ASSOC. 1844 (1989).
55 Kass, supra note 12, at 36-37.
57 Id.
59 See Gerald Dworkin, supra note 31, at 584.
60 Id.
61 Id.
iii. Unwarranted Expansion of the Right to Die

In *Compassion in Dying v. State of Washington*, the Ninth Circuit succinctly articulated the underlying normative basis for PAS:

A competent terminally ill adult, having lived nearly the full measure of his life, has a strong liberty interest in choosing a dignified and humane death rather than being reduced at the end of his existence to a childlike state of helplessness, diapered, sedated, incontinent.

Yet this analysis does not reveal the precise reason for drawing a ‘bright line’ between terminally ill patients and those others, including the elderly, who suffer from a “childlike state of helplessness, diapered, sedated, incontinent.” According to Arras, “the logic of the case of PAS, based as it is upon the twin pillars of patient autonomy and mercy, makes it highly unlikely that society could stop [with just these patients].” By logical extension, these twin pillars might also justify PAS for competent patients suffering from severe pain but who are not necessarily terminally ill. Likewise, Yale Kamisar points to the fact that patients suffering from Amyotrophic Lateral Sclerosis (“ALS”), Alzheimer’s disease or AIDS, or a “mangled survivor of a car accident” may all have equally compelling claims to PAS.

These claims seem to be normatively very similar to the claims made by the terminally ill. However, such moral questions cannot be answered easily, nor can they be disregarded altogether. Granting the terminally ill the right to choose PAS does not—and should not—suspend the debate on whether people suffering from other conditions ought to be eligible for PAS as well. Addressing this issue, Frey comments that the fear of a slippery slope of killing should not block any moral inquiry over cases, whether over PAS for the terminally ill or over other cases, wherein “the moral constraints on social policy are aired and decided upon.” Thus banning PAS for the terminally ill, purely upon a fear that it would lead to the legalization of PAS for those who are not terminally ill, predetermines the outcome of a subsequent moral debate.

Yale Kamisar argues against the legalization of PAS on the basis that its extension to AVE is both natural and unavoidable. Both he and Arras appear to conclude: “the distinctions that may have been used to separate PAS from AVE will be breached because the very considerations that drive PAS—autonomy and pain relief—also drive AVE.”

The moral distinction between PAS and AVE is somewhat tenuous, as the determination of who acts last in the chain of causation has little relevance to the question of whether the outcome

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64 Id. at 814.
65 Frey, *supra* note 46, at 52. Also see Arras, *supra* note 49, at 81.
66 Kamisar, *supra* note 2, at 1472.
69 Frey, *supra* note 46, at 53.
passes some moral standard. There may be little or no moral distinction between the actions of a doctor who assembles a machine through which a patient could breathe carbon monoxide and permits the patient to switch the machine on, and that of a doctor who switches the machine on himself. This being the case, the descent from PAS to AVE may not only be natural and unavoidable, but also desirable. There may be many terminally ill patients, who have passed the threshold requirements of competency, voluntariness and treatment for depression, whose conditions are so abysmal that they are incapable of ending their suffering themselves. Should such patients be any less deserving of the right to die than those terminally ill patients whose conditions are not so egregious as to deprive them of the capacity to perform the final act? Intuitively, it seems unfathomable that such a line be drawn, since in both PAS and AVE, “the choice rests fully with the patient…and the patient acts last in the sense of retaining the right to change his or her mind.” Thus AVE is not necessarily undesirable if the same safeguards of competency, monitoring for the lack of voluntariness, diagnosis and treatment of depression, and proper consideration of effective alternatives are ensured, as in the case of regulated PAS. Furthermore, the same guidelines and considerations that a physician would take into account when denying a request for PAS would be equally applicable in the case of AVE.

There is no denying that as far as the public’s perception of the medical profession is concerned, a physician playing an active role in the death of a patient might be less palatable than a physician prescribing a lethal drug and leaving it to the patient to determine the final outcome. While the line between PAS and AVE is demonstrably thin, the moral intuition that stimulates greater apprehension in terms of the latter case cannot be ignored. Evaluating the legitimacy of this moral intuition may require further deliberation by both policymakers and the medical profession. Yet, until such time, denying those few deserving patients the right to seek a dignified death through PAS, merely on the basis that PAS is normatively similar to AVE, seems manifestly overbroad.

**iv. Weakening the Prerequisite of Competency**

Some argue that PAS will not only expand beyond the terminally ill or lead to AVE, but that it will eventually lead to involuntary active euthanasia. In response, Frey poses the question: “if…we permit no other instances of PAS except under this condition [of competency], how do we get to killing off the incompetent or the senile, all or most of whom, we presume, want to live?”

If viewed through the slippery slope prism, the same arguments concerning the unavoidable descent to AVE and involuntary active euthanasia seem to be equally applicable in the case of

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70 Id., at 54.
71 Kamisar, supra note 2, at 1472. The author refers to Justice Ginsberg, who during the oral arguments in Washington v. Glucksberg suggested “that the person who is helpless or in so much agony that she “is not able to assist in her own suicide,” but must have a health professional administer a lethal injection, is “in a more sympathetic situation” than one who is able to end her life merely with the preliminary assistance of a physician.” See Transcript of Oral Argument, at 29, Washington v. Glucksberg 521 U.S. 702 (No. 96-110), 1997 WL 13671.
72 Dan W. Brock, Voluntary Active Euthanasia, HASTINGS CENTER REP., Mar.-Apr. 1992, at 10. Also see Kamisar, supra note 2, at 1474.
73 Frey, supra note 46, at 53.
74 Id. at 60.
RLST. In fact, where withdrawing artificial food and hydration or disconnecting a ventilator is concerned, the very circumstances in which a patient is dependant on some external apparatus for survival may place her in an even more vulnerable position than, say, a competent, terminal-ill patient who seeks PAS. However, it seems that in the case of RLST, the risk of abuse is outweighed by the certainty that the patient would be subjected to battery should her request be denied.

This line of reasoning is unsatisfactory on two counts. First, it suggests that the social risks—arguably much graver than those emanating from PAS—are somehow manageable in the case of RLST. To overlook these risks is not merely to say that they are relatively unimportant compared to the certainty of battery, but to also concede that whatever the risk, it is not significant enough to lead us down the path to executing the unwanted. Second, since we are now in the business of rating the wrongfulness of outcomes, i.e., that battery is worse than assisting death, then it is perfectly plausible to presume that supporters of RLST would find murder or manslaughter to be worse than battery. Thus, it is implicit that RLST will not result in a descent to involuntary active euthanasia, which for all intents and purposes, amounts to murder or manslaughter. Furthermore, in the case of RLST, we seem confident that concerns over the proper diagnosis and treatment of depression might be adequately addressed, and that abuse and coercion of vulnerable groups and social undesirables when it comes to, say, withholding expensive life-sustaining treatment, might be preventable, or at least, manageable. This confidence strongly suggests that with proper regulation, legalizing PAS would not lead to involuntary active euthanasia.

D. THE REGULATION OF PAS

PAS opponents such as Arras concede that patients who are “truly beyond the pale of good palliative and psychiatric care” might still seek the assistance of certain physicians who are willing to perform covert PAS. He argues that while such covert acts may not be subject to regulation, the continued criminalization of PAS is essential for the purpose of deterring widespread abuse.

Assuming that PAS does take place covertly, the maintenance of such an unregulated and covert setting exposes patients to endless possibilities of abuse. These patients are in fact more vulnerable to abuse in a system of covert PAS, where physicians and family members are not accountable to a regulatory system, than in a regulated system of legalized PAS, where

75 Arras, supra note 49, at 82.
76 Id.
77 Roger S. Magnusson, “Underground Euthanasia” and the Harm Minimization Debate, 32 J.L. MED. & ETHICS 486, 486 (2004). The author notes: “A national survey of 1,902 American physicians found that 3.3 percent had written at least one ‘lethal prescription’, while 4.7 percent had provided at least one lethal injection. A survey of American oncologists found that 3.7 percent had performed euthanasia, while 10.8 percent had assisted suicide.” Also see Diana Hassel, Sex and Death: Lawrence’s Liberty and Physician-Assisted Suicide, 9 U. PA. J. CONST. L. 1003, 1019 (2007); Kathryn L. Tucker, In the Laboratory of the States: The Progress of Glucksberg’s Invitation to States to Address End of Life Choice, 106 Mich. L. Rev. 1593, 1609 (2008). Tucker states that “a significant percentage of primary care physicians and an even larger percentage of oncologists in the United States report having been asked for their assistance in a patient’s hastened death; one quarter of them complied.”
78 Frey, supra note 46, at 57. Also see Martha Minow, Which Question, Which Lie?, 1997 Sup. Ct. Rev. 1, 27 (1997). Minow comments that if the covert practice of PAS were acknowledged, “questions such as inequality of access, abuse of the disabled, and appropriate regulation would have to be confronted.”
physicians are compelled to meet standards of transparency.\textsuperscript{79} Thus, as Kathryn Tucker points out, “the question is not whether aid in dying will occur, but whether it will occur in a regulated and controlled fashion with safeguards and scrutiny, or covertly, in a random, dangerous, and unregulated manner.

The example of Oregon serves to demonstrate that “a carefully drafted law does not place patients at risk.”\textsuperscript{81} In fact, a report assessing whether vulnerable groups have been put at risk in Oregon since the enactment of the Death with Dignity Act,\textsuperscript{82} concluded that there was no evidence supporting this concern.\textsuperscript{83} Research on this matter reveals that PAS in both Oregon and the Netherlands has not been forced upon “those who are poor, uneducated, uninsured, or otherwise disadvantaged.”\textsuperscript{84} In fact, the data suggests that a higher level of education is strongly associated with the use of PAS.

There is, however, a counternarrative in respect of the Oregon experience. Herbert Hendin and Kathleen Foley argue that “the advance in palliative care in the past ten years…has mostly diminished the need for assisted suicide and euthanasia…”\textsuperscript{86} They also suggest that “the more physicians know about palliative care, the less they favor [PAS]; the less they know, the more they favor it.”\textsuperscript{87} To this extent, Hendin and Foley are critical of the Oregon system, as it appears to afford physicians “great power” without ensuring that such power is exercised responsibly i.e. the responsibility to consider other options such as palliative care.

\textsuperscript{80} Tucker, supra note 77, at 1610.
\textsuperscript{81} Id. at 1603.
\textsuperscript{82} O.R.S. § 127.805.
\textsuperscript{83} Tucker, supra note 77, at 1603-1605. Also see Melinda A. Lee & Susan W. Tolle, Oregon's Assisted Suicide Vote: The Silver Lining, 124 ANNALS INTERNAL MED. 267 (1996). Furthermore, a report prepared for the Vermont legislature, which reviewed the Oregon model, concluded: “it is…apparent from credible sources in and out of Oregon that the Death with Dignity Act has not had an adverse impact on end-of-life care and in all probability has enhanced the other options.” See VT. LEGISLATIVE COUNCIL, OREGON'S DEATH WITH DIGNITY LAW AND EUTHANASIA IN THE NETHERLANDS: FACTUAL DISPUTES § 3E (2004), http://www.leg.state.vt.us/reports/05Death/DeathWithDignityReport.htm.
\textsuperscript{84} Tucker, supra note 77, at 1605.
\textsuperscript{85} Id. at 1604. The author concludes: “Those with a baccalaureate degree or higher were 7.9 times more likely than those without a high school diploma to choose physician-assisted dying.” Also see OFFICE OF DISEASE PREVENTION & EPIDEMIOLOGY, OR, DEPT OF HUMAN SERVS., EIGHTH ANNUAL REPORT ON OREGON'S DEATH WITH DIGNITY ACT 12 (2006), http://oregon.gov/dhs/ph/pas/docs/year8.pdf. According to this report, 100% of patients opting for PAS under the Dignity Act either had private health insurance, Medicare, or Medicaid, and 92% were enrolled in hospice care.
\textsuperscript{87} Id. at 1635. This seems to be true in the Dutch experience as well. See for example, Agnes van der Heide et al., End-of-Life Practices in the Netherlands under the Euthanasia Act, 356 NEW ENG. J. MED. 1957 (2007). The author notes: “In 2005, for the first time since the Netherlands legalized assisted suicide and euthanasia, a survey showed a slight drop in assisted suicide and a significant drop in euthanasia.” This was attributed to advances in palliative care.
\textsuperscript{88} Hendin and Foley, supra note 86, at 1639; Kathleen Foley & Herbert Hendin, The Oregon Experiment, in THE CASE AGAINST ASSISTED SUICIDE: FOR THE RIGHT TO END-OF-LIFE CARE 144, 144-45 (Kathleen Foley & Herbert Hendin eds., 2002). The authors list a number of purported defects in the Oregon system: “[physicians] are expected to inform patients that alternatives are possible without being required to be knowledgeable about such alternatives or to consult with someone who is. They are expected to evaluate patient decision-making capacity and judgment
Such criticism encourages constant review of the substantive and procedural safeguards put in place within a regulated system of PAS. Yet it does little to damage the case for legalizing PAS. This is partly because PCHD becomes an option only at the latter stages of terminal illness—when suffering is at its most acute. It cannot always accommodate the legitimate needs of competent, terminally ill patients who wish to avoid the indignity of suffering during the final stages of life. 89

The above analysis suggests that the public policy justifications for prohibiting PAS are mostly unconvincing. Yet opposition to PAS, at least in the U.S., remains relatively strong and continues to prevent widespread reform. An effective advocacy strategy to legalize PAS in the U.S. would therefore require a careful examination of the real motivations behind this opposition.

In the past, advocates of PAS have looked to the federal courts to bring about legal reform and effectuate social change. Yet, as witnessed in numerous advocacy campaigns, successful litigation at the federal level tends to spur a counterproductive backlash where a strong moral opposition is still prevalent. The following chapter critically examines the jurisprudential and political realities surrounding PAS as reflected in the U.S. constitutional debate on the right to die, and sets out compelling reasons for avoiding litigation at the federal level.

III. THE CONSTITUTIONAL RIGHTS OF THE TERMINALLY ILL

This chapter inquires into the question of whether a legitimate case for PAS can be resubmitted to the U.S. Supreme Court with the possibility of a more favorable outcome. I will thereafter examine whether advocating PAS at the federal level is prudent despite the likelihood of a favorable outcome, given the repercussions faced by similar social movements in the past.

A. CRUZAN AND THE CONSTITUTIONALITY OF RLST

The starting point of any constitutional discussion on the right to die is the case of Cruzan v. Director, Missouri Department of Health. 90 Nancy Cruzan was reduced to a persistent vegetative state following a near fatal road accident, and was dependent on a gastronomy feeding and hydration tube for survival. 91 The case dealt with the issue of withdrawing life-sustaining treatment, and more specifically, with the question of whether an incompetent person had a

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89 Examining this issue from a practical as well as constitutional perspective, Diana Hassel observes: “If faced with a case in which palliative care cannot relieve the suffering of a dying person or a situation where physicians feel constrained from giving effective levels of pain relief because of its possibly fatal effect…the issue of [PAS] should be reexamined. See Hassel, supra note 77, at 1029.


constitutionally protected right to refuse such treatment by virtue of the consent expressed by her surrogate. The State of Missouri required ‘clear and convincing’ evidence of the patient’s wishes to refuse treatment in order to grant a surrogate the authority to act on her behalf. The U.S. Supreme Court accordingly held that this requirement did not violate any constitutionally protected right of an incompetent patient.92 Since in Nancy Cruzan’s case, the evidence adduced in favor of such a wish did not seem to meet this evidentiary standard, the Court held that she was not entitled to have food and hydration withdrawn.93

Two important elements in this decision require consideration. First, the U.S. Supreme Court clearly defers to the state’s determination of the issue as far as the rights of incompetent, terminally ill patients are concerned.94 This element of the Court’s reasoning reveals a clear judicial preference towards permitting individual states to determine issues relating to the right to die. Second, this deferential approach seems to be restricted to cases involving incompetent patients. Though Cruzan by itself does not specify whether the liberty interest of a competent individual to refuse life-sustaining treatment is of a fundamental nature or not,95 the Court recognizes that there ought to be some constitutional protection provided to competent patients who seek RLST. Melvin Urofsky observes that the Court “for the first time acknowledged a constitutionally protected right to die and grounded it in the liberty interest of the Fourteenth Amendment’s Due Process Clause.”96

The above analysis suggests that the Court may not necessarily consider granting competent, terminally ill adults the right to PAS as unconstitutional, as long as the state, and not any federal institution, is tasked with the responsibility of assessing the policy implications of granting such a right. The analysis also informs future advocacy movements about where resources ought to be channeled in order to bring about sustainable reform. Cruzan thus provides the first real clue that advocacy at the state level would be more effective than litigation at the federal level—a realization that would come only after several more failures before the U.S. Supreme Court.

92 497 U.S., at 282.
93 Id. at 285.
94 In his concurring opinion, Justice Scalia contended that the entire issue ought to be left to the states to determine. There was some attempt on his part to revert to the traditional procedural due process doctrine of the Fourteenth Amendment by insisting that the Due Process Clause did not protect individuals from deprivations of liberty simpliciter. It was emphasized that in order for a claim to be made under the substantive due process doctrine, the claimant had to demonstrate that “the state [had] deprived him of a right historically and traditionally protected against state interference.” In Justice Scalia’s view, this requirement had not been met where a patient’s right to refuse food and hydration was concerned, thus leaving the matter to the regulation of the state. See 497 U.S., at 293-294. (Scalia, J., concurring).
96 Melvin Urofsky, Leaving the Door Ajar: The Supreme Court and Assisted Suicide, 32 U. Rich. L. Rev. 313, 325 (1999). Also see Erwin Chemerinsky, Washington v. Glucksberg was Tragically Wrong, 106 Mich. L. Rev. 1501, 1507-1508 (2008). The author notes that five members of the Cruzan Court—concurring Justice O’Connor and the four dissenters—seemed to go further than the Chief Justice and asserted that the right of competent persons to reject lifesaving medical treatment did exist.
B. GLUCKSBERG AND JUDICIAL CIRCUMSPECTION

In the 1997 case of Washington v. Glucksberg, the U.S Supreme Court declined to recognize a constitutionally protected right to PAS.\(^7\) The majority opinion, delivered by Chief Justice Rehnquist, first sought to establish a long and deeply rooted history of condemning the act of suicide as well as banning altogether the act of assisted suicide.\(^8\) The Court thereafter maintained that amidst rapid attitudinal changes in respect of the right to die, states have reaffirmed their commitment to the prohibition of assisted suicide.\(^9\)

The constitutional inquiry in Glucksberg begins with a reiteration of Justice Scalia’s contention in Cruzan that the Due Process Clause only protects fundamental rights and liberties that are deeply rooted in the nation’s history and tradition.\(^10\) Admittedly, the Court sought to establish this threshold requirement—that the challenged state action involved some fundamental right found to be deeply rooted in tradition—in order to avoid the need for a complicated “balancing of interests in each and every case.”\(^11\) Thus a particular action would require more than a reasonable relation to a legitimate state interest only where a fundamental right was involved.\(^12\) The Court considered its own opinion in Planned Parenthood of Southeastern Pennsylvania v. Casey\(^13\) where it interpreted the Due Process Clause to protect “certain fundamental rights and personal decisions relating to marriage, procreation, contraception, family relationships, child rearing, and education.”\(^14\) The Court also noted that many of those rights and liberties mentioned in Casey “involv[ed] the most intimate and personal choices a person may make in a lifetime.”\(^15\) Remarkably, the Court found that no such fundamental right or liberty interest existed in respect of terminally ill patients seeking PAS.\(^16\) Accordingly, it was held that banning assisted suicide was rationally related to the numerous legitimate state interests presented by the State of Washington, and was thus constitutionally permissible.\(^17\)

There were several political calculations that underscored the unanimous decision in Glucksberg. The Court opined that to hold for the respondents would be to “strike down the considered policy choice of almost every state.”\(^18\) This is a crucial revelation of the Court’s wariness towards decisions that are liable to be poorly received by the states. It was also possibly a reflection of certain lessons the Court had learned since its landmark judgment in Roe v.

\(^7\) 521 U.S. 702, 719–728 (1997)
\(^8\) Id. at 711-713.
\(^9\) Id. at 716-718.
\(^12\) Id.
\(^14\) Id. at 851.
\(^15\) Id.; 521 U.S., at 727.
\(^16\) Id. at 728.
\(^17\) Id. The Court relies on a number of public policy arguments against the legalization of PAS. The risk of abuse due to the failure to diagnose and treat depression; the undermining of the doctor-patient relationship; and slippery slope concerns over exposing vulnerable groups to coercion, were each identified and cited as legitimate state interests in upholding the ban on PAS.
\(^18\) Id. at 723.
Wade,\(^{109}\) which strengthened the anti-abortion movement and did little to improve access to abortion.\(^{110}\)

Importantly, only eighteen states had reformed their abortion laws even to some degree by the time the Court’s ruling in *Roe* was announced.\(^{111}\) These statistics largely explain the backlash that ensued.\(^{112}\) Thus the ‘post-*Roe*’ U.S. Supreme Court could be described as being more circumspect. Some commentators see this phenomenon as a manifestation of judges’ anxiety that their decisions potentially unleash “the kind of backlash that undermines both the Court and its holdings.”\(^{113}\) This is consistent with Michael Klarman’s observation that judges now prefer “to constitutionalize consensus and suppress outliers”\(^{114}\) rather than introduce expansive reforms through their decisions. To this extent, *Roe* stands in sharp contrast to later cases such as *Lawrence v. Texas*\(^{115}\) where the Court merely sought to suppress the policies of an outlier state.

The circumspect approach that characterized the post-*Roe* Supreme Court was no doubt influential in *Glucksberg*, since at the time, no state, except Oregon, had legalized PAS.\(^{116}\) A decision in favor of PAS in *Glucksberg*, at best, would have been perceived as an imposition of the liberal policies of one state on the rest of the union. It would have been a step too far removed from the legislative disposition of the majority of states, and contrary to contemporary public opinion.

An analysis of Justice Stevens’s concurring opinion may reveal the extent to which judges often go to maintain an uneasy compromise between the constitutional principles they are inclined to uphold and the political implications of upholding such principles.\(^{117}\) Justice Stevens was of the view that the slippery slope concerns of protecting the vulnerable from coercion and abuse and preventing a descent to euthanasia were *less significant* in the context of competent...

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\(^{109}\) 410 U.S. 113 (1973).

\(^{110}\) Gerald Rosenberg, *Courting Disaster: Looking for Changes in all the Wrong Places*, 54 DRAKE L. REV. 795, 811 2006. The author comments that the overwhelming majority of local institutions refused to implement the decision and provide access to abortion. This was mainly due to a strong anti-abortion movement that grew in response to the Court’s decision in *Roe*.

\(^{111}\) *Id.* at 810.

\(^{112}\) Widespread criticism of the Court’s ruling in *Roe* is often cited as the main reason for the Court’s decision to narrow the scope of *Roe* in the later case of Planned Parenthood of Southeastern Pennsylvania v. Casey 505 U.S. 833. Rejecting the trimester system introduced under *Roe*, the Court in *Casey* adopted an “undue burden standard” to determine the constitutionality of a state’s policy on abortion. It was held in promoting its interest in potential life throughout pregnancy, the state may take measures to ensure that the woman’s choice is informed. Any measures designed to advance this interest should not be invalidated if their purpose is to persuade the woman to choose childbirth over abortion and they do not cast an undue burden on the right to receive an abortion. For a more detailed discussion, see Neal Devins, *How Planned Parenthood v. Casey Pretty Much Settled the Abortion Wars*, 118 YALE L.J 1318 (2009).


\(^{115}\) 539 U.S. 558 (2003).

\(^{116}\) See O.R.S. § 127.805 (Death with Dignity Act).

\(^{117}\) See Kamisar, *supra* note 2, at 1465. The author observes that a compromized approach enabled Justice Stevens “to (a) “fully agree with the Court that the Due Process Clause does not include a categorical ‘right to commit suicide which itself includes a right to assistance in doing so’” yet (b) maintain that “there are times when [PAS] is entitled to constitutional protection.”” See 521 U.S., 742 (Stevens, J., concurring).
terminally ill patients seeking PAS. He concludes that though the state had a “compelling interest” in preventing PAS in the context of depression or coercion, such a legitimate interest did not apply to those competent and rational terminally ill patients who were not victimized by abuse or suffering from depression. The terminology, though scarcely conclusive, could be interpreted as an indication that interference with the liberty interest of terminally ill patients to seek PAS required justification on the basis of a compelling governmental interest. This requirement is usually reserved for ‘strict scrutiny’ inquiries involving suspect classifications under equal protection jurisprudence, or fundamental liberty interests under the substantive due process doctrine. Nevertheless, Justice Stevens refrains from clearly articulating this position. He instead withdraws to a suggestion that there is a need for continued debate in light of the fact that such a compelling interest is, so to speak, less compelling when applied to competent, terminally ill patients who are neither victimized by abuse nor suffering from untreated depression. The more obvious conclusion to be drawn from this analysis would be that the interests of such patients are of a ‘fundamental’ nature and that any interference with such liberty interests warranted a test more proximate to ‘strict scrutiny’ than to ‘minimum rationality’. The reason for Justice Stevens’s reluctance to properly articulate this conclusion could be attributed to his preference for avoiding perceivably unpopular judicial activism.

Justice Souter’s concurring opinion draws an interesting analogy between a terminally ill patient’s right to PAS and a woman’s right to abortion, focusing particularly on the necessary role played by physicians in both cases. Justice Souter notes:

Like the decision to commit suicide, the decision to abort potential life can be made irresponsibly and under the influence of others, and yet the Court has held in the abortion cases that physicians are fit assistants. Without physician assistance in abortion, the woman’s right would have too often amounted to nothing more than a right to self-mutilation, and without a physician to assist in the suicide of the dying, the patient’s right will often be confined to crude methods of causing death, most shocking and painful to the decedent’s survivors.

It is implicit that Justice Souter’s decision to uphold the ban on PAS rests solely on his acceptance of the slippery slope arguments against PAS. While on the one hand, Justice Souter highlighted how morally analogous PAS was to abortion, on the other, he drew a sharp

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118 521 U.S., 747 (Stevens, J., concurring).
119 Id. at 747.
120 See Poe v. Ullman 367 U.S. 497, 548 (1961) (Harlan, J., dissenting); Reno v. Flores, 507 U.S. 292, 301-302. Justice Souter, in his concurring opinion in Glucksberg, offers a caveat in this regard. In FN.8, he states, “[w]e have made it plain, of course, that not every law that incidentally makes it somewhat harder to exercise a fundamental liberty must be justified by a compelling counterinterest.” He cites Carey v. Population Services Int’l, 431 U.S. 678, 685-686, (1977) where it was held that “an individual’s [constitutionally protected] liberty to make choices regarding contraception does not ... automatically invalidate every state regulation in this area. The business of manufacturing and selling contraceptives may be regulated in ways that do not [even] infringe protected individual choices.” Justice Souter thus concludes that “a state law that creates a [substantial obstacle] for the exercise of a fundamental liberty interest requires a commensurably substantial justification in order to place the legislation within the realm of the reasonable.”
121 Id. at 752.
122 521 U.S., at 778 (Souter, J., concurring).
distinction between PAS and abortion in terms of their respective manageability. It was opined that a more cautious approach was warranted in respect of PAS, since physicians, as “gatekeepers,” were subject to constant temptation, thereby making PAS uncontainable. Moreover, owing to both the factual controversy regarding the success of Dutch regulation in preventing involuntary euthanasia and the incapacity of the judiciary to properly unravel this controversy, Justice Souter concluded that the matter was best determined by state legislatures, as they have superior opportunities to engage in experimentation and fact-finding inquiries.

These concurring opinions collectively suggest that some Justices in Glucksberg preferred to fallback on public policy constraints in order to avoid unpopular judicial activism. It seems at least five Justices were willing to recognize the right to die, to the extent that the liberty interest of terminally ill patients legitimized PCHD. Yet, these Justices sought to defer their support for PAS by drawing a thin distinction between those liberty interests that are purportedly easier to regulate, and the liberty interests in respect PAS. The factual controversy surrounding the effectiveness of regulating PAS ultimately established an easy escape route for most of these Justices, thereby enabling them to ‘pass the buck’ to state legislatures and avoid public backlash. Interestingly, however, later sociopolitical developments reveal that the lack of a radicalized movement against PAS provided the necessary space for some states including Washington to revisit the issue and effectuate reform.

C. LAWRENCE, PUBLIC MORALITY AND THE BACKLASH PHENOMENON

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123 Id. at 782-785.
124 Id. at 785.
125 See Termination of Life on Request and Assisted Suicide (Review Procedures) Act, Stb. 2001, nr. 137, ch. 2, art.2, § 1 (Neth.). This Act exempts a physician from criminal prosecution if she terminates a life at the person’s request and, if 1) the request is voluntary and well considered; 2) the patient’s suffering is lasting and unbearable; 3) the patient has been informed of her diagnosis and prognosis and the patient holds the conviction that there is no other reasonable solution; and 4) an independent physician has been consulted who has seen the patient and who gives a written opinion that the requirements of the Act have been followed. See Diana Hassel, supra note 77, at 1024. The author suggests that while PAS is widely accepted in the Netherlands, “some controversies have arisen concerning the assisted suicide and euthanasia regime” given the fact that “there is evidence that some physicians are administering euthanasia without an explicit request from the patient.” She also alludes to a new debate in the Netherlands about euthanasia performed on children, since the current law permits euthanasia for children aged twelve to sixteen with parental consent and new guidelines are set to permit euthanasia for terminally ill newborns as well. Also see Susan M. Wolf, Assessing Physician Compliance with the Rules for Euthanasia and Assisted Suicide, 165 ARCHIVES OF INTERNAL MED. 1677 (2005).
126 Id. at 787.
127 See Kamisar, supra note 2, at 1463. The author comments: “since Justices Stevens and Souter, who also wrote concurring opinions in Glucksberg, seemed to favor a right to PAS even more than Justices O’Connor, Ginsburg, and Breyer did, at least for compelling circumstances, there is reason to believe that five members of the Glucksberg Court were inclined to recognize a right to effective pain medication even if it might hasten death and to resist any legislative efforts to restrict the ability of terminally ill patients to obtain such pain relief.” Also see Robert A. Burt, The Supreme Court Speaks-Not Assisted Suicide but a Constitutional Right to Palliative Care, 337 NEW ENG. J. MED. 1234 (1997).
Both Glucksberg and its counterpart, Vacco v. Quill\textsuperscript{128} adopted the view that as far as PAS was concerned, there was nothing in the Constitution to suggest that a liberty interest in end-of-life decisions had reached the status of a fundamental right. Accordingly, a strict scrutiny test to evaluate state policy banning PAS would be unnecessary. This was largely a reflection of the U.S. Supreme Court’s understanding of the substantive due process doctrine at the time; particularly the manner in which the ‘rationality review’ test, as ordinarily applied, warranted a high level of deference to state legislatures. It was thus inconceivable that the Court would be willing to examine liberty interests not of a fundamental character in a closer light to determine whether the policy measure was indeed rationally related to a legitimate state interest.\textsuperscript{129} Barring a few exceptions in the equal protection context,\textsuperscript{130} the Court’s choice of test usually determined the outcome of its analyses and “[l]ed to the rejection of a constitutional challenge.”\textsuperscript{131} Thus, by implication, describing the liberty interest in seeking PAS as not ‘fundamental’ ensured that it was relegated to a rationality review inquiry. This characterization of the right ensured the

\textsuperscript{128} 521 U.S. 793 (1997). In this case, New York physicians asserted that, although it would be consistent with the standards of their medical practices to prescribe lethal medication for mentally competent, terminally ill patients who suffered great pain and desired a doctor’s assistance in taking their own lives, they were deterred from doing so by New York’s assisted suicide ban. The case featured prominent and well-respected physicians, including Timothy Quill, who had previously discussed publicly his role in assisting the suicide of a patient suffering from acute leukemia. Rather than base their claim on the Due Process Clause, the New York physicians relied on the Equal Protection Clause of the Fourteenth Amendment. They argued that RLST and PAS were identical and that New York treated terminally ill patients who sought PAS differently than similarly situated patients who sought RLST. The Second Circuit in Quill v. Vacco 80 F.3d 716, 731 (1996) found that though there was no fundamental right to PAS under the U.S. Constitution, the ban on assisted suicide was “not rationally related to any legitimate state interests.” On appeal, however, the U.S. Supreme Court quite clearly rejected the argument that terminally ill patients seeking PAS were in the same position as those seeking RSLT. It was held that, at least facially, neither the assisted suicide ban nor the law permitting RLST treated individuals differently, since “[e]veryone, if competent, [was] entitled to refuse unwanted lifesaving medical treatment, [while] no one [was] permitted to assist a suicide.” See 521 U.S., at 798-800. Also see Timothy E. Quill, Death and Dignity: A Case of Individualized Decision Making, 324 NEW ENG. J. MED. 691 (1991). Quill admitted to prescribing barbiturates notwithstanding the suspicion that his patient would take an overdose to commit suicide, and was prosecuted under assisted-suicide laws in New York. A grand jury in Rochester, however, refused to indict him. For a more detailed discussion, see Urofsky, supra note 96, at 337; Lawrence K. Altman, Jury Declines to Indict a Doctor Who Said he Aided in a Suicide, NY TIMES, July 27, 1991, at A1.

\textsuperscript{129} In City of Cleburne v. Cleburne Living Center 473 U.S. 432 (1985), purportedly using a rational basis review test in the equal protection context, the Court held that the policy measure at issue did not bare a rational relationship to any legitimate governmental interest. This was considered to be a significant departure from the usual deferential paradigm associated with the rationality review test under Williamson v. Lee Optical 348 U.S. 483 (1955). However, in the later decision of Bowers v. Hardwick 478 U.S. 186 (1986), the Court required that the right interfered with be of a fundamental nature in order to warrant strict scrutiny of the challenged statute. While this might have been consistent with the use of the strict scrutiny test in previous decisions, the Court seemed unwilling to engage in the type of “enhanced” rationality review test adopted in City of Cleburne. See Richard B. Saphire, Equal protection, Rational Basis Review, and the Impact of Cleburne Living Center, Inc. 88 KY. L.J. 591, 615 (2000). The author cites a number of commentators that suggest that the Court in City of Cleburne in fact applied “a very heightened standard of rationality review” or an “escalated version of nominal rationality review.” He also cites Michael Klarman’s argument that “the court mouthed rationality language while surreptitiously substituting a heightened review standard.” Also see Michael Klarman, An Interpretive History of Modern Equal Protection, 90 MICH. L. REV. 213, 234 (1991); Jay D. Wexler, Defending the Middle Way: Intermediate Scrutiny as Judicial Minimalism, 66 GEO. WASH. L. REV. 298, 317 n.123 (1998); Kathleen M. Sullivan, The Supreme Court, 1991 Term-Foreword: The Justices of Rules and Standards, 106 HARV. L. REV. 22, 61 n.248 (1992).


\textsuperscript{131} Saphire, supra note 129, at 593.
rejection of the constitutional challenge. However, much of this analysis needs to be revisited in the wake of the Court’s landmark decision in *Lawrence v. Texas.*

If judicial reluctance to recognize a fundamental liberty interest in PAS can be explained by contemporary public opinion on the subject, we must then ask the question: what drives public opinion? As in the case of abortion, PAS raises theological questions that profoundly affect many Americans. The capacity to establish and maintain certain exceptions to general moral prohibitions, such as for example, rape, incest or danger to the life of the mother in the case of abortion, is in many respects, fundamental to the intuitions that make RLST and PCHD somehow morally acceptable. These exceptions can only be explained as moral preferences dictated by religion, culture and social mores. Thus what lies at the heart of the opposition to PAS is a defense of moral preference.

It is critical to this discussion that a ‘moral preference’ be distinguished from a ‘normative rationale’. As discussed in the previous section on normative asymmetry, there is simply no compelling public policy basis for prohibiting PAS alone while permitting practices such as RLST and PCHD. However, opposition to PAS may still be guided by moral preferences or intuitions similar to those that usually drive objections to other contentious practices such as same-sex marriage and abortion.

Moral preferences within society often define the political dynamics of highly contentious cases. The Court in *Glucksberg* was certainly aware of and perhaps influenced by these moral preferences. The thinking of the Court at the time was that upholding the morals of society was a legitimate governmental interest that justified interfering with some liberty interest. This was certainly the thinking behind decisions such as *Bowers v. Hardwick,* where a state ban on sodomy was upheld. Yet the constitutional weight that may be afforded to moral preferences has evolved over the years since *Glucksberg.* The contemporary judicial view on this matter might be best understood by examining the U.S. Supreme Court’s decision in *Lawrence v. Texas.*

In *Lawrence,* the petitioner was observed engaging in a sexual act with another male in his own home and charged under the sodomy laws of the State of Texas. This raised the issue of whether homosexuals were free as adults to engage in such behavior in the exercise of their liberty under the Due Process Clause. Overruling *Bowers v. Hardwick,* the U.S. Supreme Court held that the Due Process Clause gave the petitioners the “full rights to engage in their conduct without intervention from the government.”

Justice Kennedy, delivering the plurality opinion, sought to apply the substantive due process doctrine to conclude that the criminalization of sodomy laws furthered “no legitimate state

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133 See Tucker, supra note 77, at 1604. Commenting particularly on the Oregon experience, the author suggests that even staunch opponents of PAS are forced to admit that “continued opposition to such a law can only be based on personal, moral, or religious grounds.” Also see Daniel E. Lee, *Physician-Assisted Suicide: A Conservative Critique of Intervention,* HASTINGS CENTER REP., Jan.-Feb. 2003, at 17.
137 478 U.S. 186 (1986).
138 539 U.S., at 578.
139 Id. at 572.
interest which can justify its intrusion into the personal and private life of the individual.”

However, he did not find it necessary to hold that the right to sexual autonomy was a fundamental right under the U.S. Constitution in order to reach this conclusion. Justice Kennedy justified his position by suggesting that the framers of the Constitution “knew that times can blind us to certain truths” and that “later generations can see that laws once thought necessary and proper in fact serve only to oppress.”

This type of interpretive originalism creates the space for some constitutional maneuvering as far as decriminalizing PAS is concerned. It establishes that historical grounds alone cannot justify a certain ban on conduct that many view as deeply personal and rooted in individual autonomy. It raises the question of whether a change in contemporary societal attitudes towards legalizing PAS might justify reconsideration of the constitutionality of its ban.

Justice O’Connor’s concurring opinion in Lawrence is also pertinent to this discussion. Instead of relying on the Due Process Clause of the U.S. Constitution, she contended that criminalizing only homosexual sodomy violated the Equal Protection Clause of the Fourteenth Amendment. Her opinion seeks to establish the principle that moral disapproval alone is not a legitimate governmental interest that can justify a particular classification. This may have interesting implications for the moral preferences pertaining to the ban on PAS. If for example, the distinction between PAS and RLST is entirely based on the moral palatability of the latter, such moral preferences may not amount to a legitimate governmental interest that can justify treating terminally ill patients who seek RLST differently than those who seek PAS. In essence, this conclusion may form a sufficient basis for overruling the decision in Vacco v. Quill. However, the words of Justice Scalia in his scathing dissent in Lawrence should not be ignored. He warns the Court that public morality remains the basis for a number of laws, including state laws against “bigamy, same-sex marriage, adult incest, prostitution, masturbation, adultery, fornication, bestiality, and obscenity.” He laments that these laws are “sustainable only in light of Bowers’ validation of laws based on moral choices,” and that they are each called into question under the Court’s ruling in Lawrence. The proliferation of same-sex marriage claims after Lawrence at least partially validates this hypothesis. Thus it seems unlikely that a future Court would be willing to disregard altogether public morality as a legitimate state interest.

140 Id. at 578.
141 Examining Justice Kennedy’s reasoning, Diana Hassel argues: “This more flexible approach to due process marked a departure from an earlier methodology that emphasized narrowly defining the scope of a fundamental right.” See Diana Hassel, supra note 77, 1007. Also see Nan D. Hunter, Living with Lawrence, 88 MINN. L. REV. 1103, 1112-13 (2004).
142 539 U.S., at 579.
143 Hassel, supra note 77, at 1030. Hassel argues: “just as the Lawrence decision was issued at a time when sodomy laws had begun to be repealed or found unconstitutional under state law, and when international norms rejected anti-sodomy laws, so does the current political and cultural background reveal a time of transition with respect to restrictions on physician-assisted suicide.” Also see Brian Hawkins, Note, The Glucksberg Renaissance: Substantive Due Process Since Lawrence v. Texas, 105 MICH. L. REV. 409, 410 (2006).
144 539 U.S., at 579. (O’Connor, J., concurring).
145 Id. at 582.
146 Id. at 590. (Scalia, J., dissenting).
147 Id.
Commentators such as Diana Hassel argue that *Glucksberg* is similar to *Bowers*, and like the latter case, is liable to be overruled by the post-*Lawrence* Supreme Court. She comments:

The Court could turn to the liberty interest articulated in Lawrence…and invalidate state laws criminalizing physician-assisted suicide. The groundwork for such an outcome has been laid: a doctrinal expansion of due process; increased state and foreign revision of assisted suicide laws; popular rejection of government interference with end of life decisions; and a growing willingness to face the reality of current end of life practices.\(^\text{148}\)

However, the analogy of *Lawrence* ought to be analyzed cautiously given the fact that the third party effects in respect of homosexual sodomy are not as acute or controversial as in the case of PAS. Much of the underlined policy arguments discussed above\(^\text{149}\) relate to the effects PAS might have on vulnerable groups and on the public’s perception of the medical profession. Thus these policy arguments must first be addressed and adequately debunked prior to placing any broad reliance on the moral preference analogy that *Lawrence* offers.

Another critical point of divergence between *Lawrence* and the issue of PAS relates to the socio-political backdrop that underscored the reasoning behind invalidating a ban on homosexual sodomy. This divergence suggests that *Lawrence* is not necessarily a good precedent to warrant Hassel’s optimism that the U.S. Supreme Court may be prepared to recognize PAS as a constitutional right.

*Lawrence* was an instance of relatively uncontroversial judicial activism that involved the suppression of an outlier state policy rather than a radical shift in constitutional law. It was, after all, merely judicial endorsement of the policies of forty six states that had no laws that specifically targeted homosexual sodomy. The decision thus affected only the four remaining outlier states. This situation may explain why the decision in *Lawrence* did not spur any real backlash from anti-gay-rights groups the way *Roe* radicalized the pro-life movement.\(^\text{150}\) The issue of same-sex marriage, by contrast, offers a very different outcome in terms of public backlash. In the case of *Goodridge v. Department of Public Health*,\(^\text{151}\) the Supreme Judicial Court of Massachusetts held that the state’s ban on same-sex marriage violated the state constitution. This was another instance of judicial activism that preceded any real legislative disposition towards reform. While the Court in *Goodridge* depended on *Lawrence* to some extent,\(^\text{152}\) the ruling was met with tremendous resistance from around the country, provoking the same type of backlash\(^\text{153}\) that had previously culminated in the enactment of the federal Defense

\(^{148}\) Hassel, *supra* note 77, at 1029.
\(^{149}\) See *supra*, at 16-25.
\(^{150}\) See Rosenberg, *supra* note 110, at 811.
\(^{151}\) 798 N.E.2d 941, 969 (Mass. 2003).
of Marriage Act. The crucial difference between Lawrence and Goodridge, once again, came down to the fact that Goodridge sought to do much more than merely suppress an outlier policy.

This distinction is precisely why Lawrence cannot be interpreted as an indication that the U.S. Supreme Court would be willing to reconsider Glucksberg and Vacco v. Quill. As long as a great majority of states continue to prohibit PAS, the Court is unlikely to be the vehicle of change.

In his seminal assessment of the implications of Lawrence for the future of PAS, Yale Kamisar presents several arguments as to why the Court will not overrule Glucksberg in the near future. First, the rights of a politically vulnerable group are not at stake in the case of PAS. Examining Justice Kennedy’s sentiments that “[Bowers’s] continuance as precedent demean[s] the lives of homosexual persons,” Kamisar endorses the view that “[d]ying people are clearly not a discrete and insular minority in the same, sure way as are black people subject to race discrimination laws [or] women subject to abortion restrictions.” Second, he asserts that there is no “emerging awareness” of a right or freedom to practice PAS. In contrast to the developments that preceded Lawrence, Kamisar notes “that no State Supreme Court has found a right to PAS in its own State Constitution. Nor, in the decade since Glucksberg, has any state legislature legalized PAS.” He also points out that prior to Lawrence—and even Bowers—the European Court of Human Rights (“ECtHR”) had ruled that prohibiting consensual homosexual conduct infringed the European Convention on Human Rights, while two decades later, the ECtHR held that a ban on assisted suicide did not violate any provision of the same European Convention.

Kamisar’s analysis, to a large extent, remains true today. However, since his Article appeared in June 2008, voters in Washington passed Initiative 1000 legalizing PAS for competent,

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154 1 U.S.C. § 7 (1997). The Defense of Marriage Act is considered to have been a response to developments with regard to same sex marriage in Hawaii at the time. See Baehr v. Miike, No. 91-1394, 1996 WL 694235, at *1. (Haw. Cir. Ct. Dec. 3, 1996). It is noted that the exact ramifications of Goodridge is yet to be fully understood. Iowa, Connecticut, Vermont and New Hampshire followed Massachusetts’ lead in legalizing same sex marriage. Yet, other states including California and recently, Maine have seen decisions of the state judiciary and legislature legalizing same sex marriage being overturned by the public via referenda. For an in depth discussion on recent developments pertaining to the same-sex marriage debate, see Margaret Talbot, A Risky Proposal, THE NEW YORKER, January 18, 2010.

155 Lawrence, 539 U.S., at 575.


157 Lawrence, 539 U.S., 567-570. See Kamisar, supra note 2, at 1469. The author refers to sections of the judgment where the Court cited evidence of this “emerging awareness.” For example, in 1955, when promulgating its Model Penal Code, the American Law Institute “made clear that it did not recommend or provide for ‘criminal penalties for consensual sexual relations conducted in private.’” Kamisar notes that six years later, “Illinois changed its laws to conform to the Model Penal Code” and “[o]ther states soon followed.”

158 Kamisar, supra note 2, 1467, 1471. The author notes that (at the time), “although bills to legalize PAS were introduced in more than twenty state legislatures…not a single one passed.” Also see Timothy Egan, Assisted Suicide Comes Full Circle, to Oregon, N.Y. TIMES, Oct. 26, 1997, at Al; Ezekiel J. Emanuel & Linda L. Emanuel, Assisted Suicide? Not in My State, N.Y. TIMES, July 24, 1997, at A21.


terminally ill residents,\textsuperscript{161} and the State Supreme Court of Montana found that there was no statutory impediment to PAS in Montana.\textsuperscript{162} These developments indicate that Kamisar’s analysis may soon become dated. Yet it is conceded that the current extent of these developments may do little to sway the Justices of the U.S. Supreme Court in favor of overruling \textit{Glucksberg}.

Judicial reluctance notwithstanding, a favorable decision in the U.S. Supreme Court today could, in any event, damage the movement seeking the legalization of PAS.\textsuperscript{163} A premature decision that precedes legislative disposition towards legalizing PAS runs the risk of radicalizing PAS opponents, as public backlash is more likely to arise in response to judicial activism as opposed to legislative initiatives. Klarman clarifies this phenomenon by explaining why the decisions of federal courts might provoke more backlash than other institutions. He argues: “Court rulings such as Brown and Goodridge produce political backlashes for three principal reasons: they raise the salience of an issue, they incite anger over “outside interference” or “judicial activism,” and they alter the order in which social change would otherwise have occurred.”\textsuperscript{164} Advocacy movements seeking reform in the area of PAS must consider this analysis carefully before attempting to have \textit{Glucksberg} overruled. Litigation at the federal level is ultimately undesirable, as it is likely to be counterproductive. The future strategy for reform must therefore be attuned to political realities at the federal level and avoid undermining progressive discourse at the state level.

\textbf{IV. STRATEGIZING REFORM}

Two principal conclusions may be drawn from the preceding discussion. First, the U.S. Supreme Court is unlikely to recognize a constitutional right to PAS, given the Court’s aversion to imposing the liberal policies of a few states on the rest of the union. Second, even if the Court finds it appropriate to overrule \textit{Glucksberg} and \textit{Vacco v. Quill}, such a drastic constitutional shift is likely to produce a counterproductive backlash. Thus the strategy for reform must essentially focus on the states and safeguard progressive discourse at the state level.

\textbf{A. A SURVEY OF THE STATES}

In 1994, the State of Oregon passed the Death with Dignity Act,\textsuperscript{165} which provides that “an adult who is capable, is a resident of Oregon, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner.”\textsuperscript{166} A number of safeguards including a

\textsuperscript{161} R.C.W. § 70.245 (The Washington Death with Dignity Act).
\textsuperscript{162} See Robert Baxter v. Montana 2009 MT 449.
\textsuperscript{163} Some commentators such as Diana Hassel suggest that the U.S. Supreme Court in \textit{Glucksberg} “encourage[d] democratic resolution of the proper limitations on assisted suicide, but perhaps anticipated the return of the issue to the Court.” See Hassel, supra note 77, at 1018. Also see Donald H.J. Hermann, \textit{The Question Remains: Are There Terminally Ill Patients Who Have a Constitutional Right to Physician Assistance in Hastening the Dying Process}, 1 DEPAUL. J. HEALTH CARE L. 445, 488-89 (1997).
\textsuperscript{164} Michael J. Klarman, \textit{Brown and Lawrence (and Goodridge)}, supra note 114, at 445.
\textsuperscript{165} O.R.S. § 127.800. In 1997, Measure 51 was introduced to repeal the Death with Dignity Act. However, the measure was rejected by 60% of voters. See http://bluebook.state.or.us/state/elections/elections22.htm.
\textsuperscript{166} O.R.S. §127.805.
provision that no person shall qualify to receive PAS solely on the grounds of age or disability were introduced to prevent relaxation on the prerequisite of terminal illness. In addition to this substantive threshold requirement, certain procedural safeguards were also introduced to prevent any relaxation on the prerequisites of competency and voluntariness.

Subsequent to Glucksberg, some remarkable developments have taken place in the State of Washington. Prior to the case, Initiative 119, introduced in order to legalize PAS by amending the state’s Natural Death Act of 1979, failed, receiving only 46 percent of the people’s vote. Notwithstanding defeat both in the legislative and judicial arenas, a second initiative, Initiative 1000, was introduced in 2008, which was approved by 57.82 percent of Washington State voters. Modeled on the Oregon statute, the Washington Death with Dignity Act permits an adult resident who is predicted to live no more than six months to self-administer lethal medication prescribed by a physician.

The examples of both Oregon and Washington demonstrate two important factors that support the legalization of PAS. In the case of Oregon, the ability to develop and enforce safeguards relating to the prerequisites of terminal illness, competency and voluntariness is fairly well demonstrated both by the structure of the Death with Dignity Act and its sustained enforcement for over a decade. Eleven years later, voters in the State of Washington, where such an initiative was previously defeated, found such a policy to be fit for replication. This is a crucial development in the debate on PAS, since it demonstrates the potential for long-term success through careful regulation, as well as the possibility for incremental attitudinal change amongst voters. In just seventeen years since the defeated Initiative of 1991, public support for PAS in Washington rose from 46 to 58 percent. Should such initiatives in other states, such as California or Maine, be reintroduced today, there is a reasonable likelihood that more than 50 percent of the voters would vote in favor of PAS.

This remarkable shift can only be explained by an ‘emerging awareness’ on the issue. There is some evidence to suggest that the level of education amongst voters in Washington might have influenced this emerging awareness. For example, of the thirty-nine counties in the State of Washington, San Juan, Jefferson and King registered voter percentages of 75, 72 and 64 percent.

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167 Id.
168 These include (1) the patient being of sound mind when she requests a prescription for a lethal dose of medication; (2) two witnesses, one non-doctor unrelated to the patient, confirming the patient’s request; and (3) the patient herself making a second request after 15 days. See O.R.S. § 127.810; § 127.820; § 127.825; and § 127.830 and O.R.S. § 127.850.
171 See R.C.W. § 70.245.
172 In California, Bill AB 374 of 1992 was defeated at the polls by a narrow margin of 4 percent (54-46 percent). Maine’s Death with Dignity Initiative was defeated by an even narrower margin (51-49 percent). However, Maine’s proposal was considered to be highly problematic considering the fact that mentally ill or depressed patients could obtain assistance in dying if a counselor determined that the patient’s judgment was not impaired. See International Task Force, Analysis of Maine Assisted Suicide Proposal, http://www.internationaltaskforce.org/mainean.htm.
respectively in favor of PAS—the highest in the state. By contrast, the counties with the lowest votes in favor of PAS—Yakima (42 percent) and Franklin (43 percent)—also happen to have the least educated workforces. This analysis reveals a direct correlation between emerging awareness and education. As in the case of many liberal social policies, it is safe to assume that support for PAS will grow simultaneously alongside other social indicators such as education and political awareness.

Commenting on the gay rights movement, Vincent J. Samar concludes:

> Since every society will promote a set of cultural values customarily, if not legally, it becomes very important to determine what the role of public education should be in adjudicating among different values. This is the case especially where people’s self-esteem may be at stake and the dominant culture is less than neutral in its devaluation of the self-esteem of certain groups.

The most recent debate over PAS at the state level came in Montana in the case of Baxter v. Montana. This case involved a terminally ill patient’s request that the right to PAS be recognized under the Montana Constitution. The petitioner, Robert Baxter suffered from lymphocytic leukemia and died prior to the court’s decision to uphold his right to PAS. On appeal, the Montana Supreme Court affirmed the judgment of the lower court and held that public policy did not prevent a physician from assisting in the death of a competent, terminally ill patient. However, the Court was unwilling to make a pronouncement on whether the state constitution protected the right to PAS. This reservation might be explained once again by the reluctance of the judiciary to produce expansive constitutional interpretations on subjects where more politically responsive institutions have remained undecided. In his concurring opinion, Justice John Warner noted:

> This Court correctly avoided the constitutional issue Baxter desires to present. No question brought before this Court is of greater delicacy than one that involves the power of the legislature to act. If it becomes indispensably necessary to the case to answer such a question, this Court must meet and decide it; but it is not the habit of the courts to decide questions of a constitutional nature unless absolutely necessary to a decision of the case.

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173 See Website of the Washington Secretary of State, supra note 170.
174 See Website of the Washington State Department of Commerce, County Profiles, http://www.choosewashington.com/locate/counties/Pages/default.aspx. Statistics on the percentage of the population with bachelor’s degrees or higher: San Juan (40%), Jefferson (28%) and King (40%).
175 Id. Only 15 percent of the population in Yakima has bachelor’s degrees or higher; the percentage in Franklin stands at 13.6.
177 Id. at 192.
179 Id. at 25.
180 Id. at 26.
Having examined the states that have legalized PAS, I now turn to the laws of other states. A recent study by Katherine Wingfield and Carl Hacker reveals that there is hardly any real consensus or uniform approach amongst the states.\textsuperscript{181} While certain states do not specifically prohibit PAS, other states do so and even impose additional penalties for physicians who assist in a suicide.\textsuperscript{182} For example, Vermont does not directly mention or prohibit PAS anywhere in its statutes, while Massachusetts “only implicitly prohibits mercy killing.”\textsuperscript{183} By contrast, Arkansas and Rhode Island, criminalize PAs,\textsuperscript{184} and states such as Minnesota and Oklahoma impose an “additional penalty of licensure revocation for health care professionals” found guilty of the general offense of assisting suicide.\textsuperscript{185} Curiously, thirty-nine states prohibit the act of assisted suicide generally rather than specifically targeting physicians.\textsuperscript{186} As noted above, of these thirty-nine states, Oregon, Washington and possibly, Montana offer exceptions to the general rule by exempting physicians under certain conditions.\textsuperscript{187}

Some states implicitly prohibit PAS by declaring: “various acts, such as prescribing or dispensing medication, are not assisted suicide unless they are performed for the purpose of bringing about the death of the patient.”\textsuperscript{188} This restriction seems to amount to a virtual—if not direct—legalization of PCHD. A good example is Indiana’s law, which provides that “[a] licensed health care provider who administers, prescribes, or dispenses medications or procedures to relieve a person’s pain or discomfort [does not commit the crime of assisting suicide], even if the medication or procedure may hasten or increase the risk of death, unless such medications or procedures are intended to cause death.”\textsuperscript{189}

\textsuperscript{182} Id.
\textsuperscript{183} Id. See MASS. GEN. LAWS. ANN. ch. 201D, § 12 (West 2004).
\textsuperscript{184} Id. See ARK. CODE ANN. § 5-10-106 (Supp. 2007); ARK. CODE ANN. § 17-95-704 (Supp. 2005); R.I. GEN. LAWS § 11-60-1 (2002).
\textsuperscript{185} Id. See MINN. STAT. ANN. § 147.091 Subd. 1(w) (West 2005); OKLA. STAT. ANN. tit. 63, § 3141.8 (West 2004). Nine States in total impose the additional penalty of licensure revocation or suspension for physicians who assist in such action. These states include: Kansas, Kentucky, Minnesota, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, and Virginia. See Wingfield & Hacker, supra note 181, at 53.
\textsuperscript{186} Wingfield & Hacker, supra note 181, at 49-50. The authors list Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Virginia, Washington, and Wisconsin as states that prohibit only assisting suicide generally.
\textsuperscript{187} Examining the statutory framework in Montana, Wingfield and Hacker conclude that it is “the only state whose explicit prohibition only applies to a suicide attempt while “[no] other explicit prohibition within the statutory compilations address[es] assistance in a suicide which is completed.” See Wingfield & Hacker, supra note 181, at 52. Also see MONT. CODE ANN. § 45-5-105(1) (2005 & Supp. 2006). The statute declares that “[a] person who purposely aids or solicits another to commit suicide, but such suicide does not occur, commits the offense of aiding or soliciting suicide.” However, as the authors point out, “[t]he annotator’s notes following this provision try to provide some guidance by mentioning that if the suicide is successful, the person who offered assistance may be prosecuted for either deliberate or mitigated deliberate homicide.”
\textsuperscript{188} Wingfield & Hacker, supra note 181, at 54. These include Alabama, Colorado, Hawaii, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Minnesota, North Dakota, Ohio, Oklahoma, Rhode Island, South Carolina, South Dakota, Tennessee and Virginia.
\textsuperscript{189} IND. CODE. ANN. § 35-42-1-2.5 (a) (1) (LexisNexis 2004). Similarly, Colorado provides that a medical caregiver “who prescribes or administers medication for palliative care to a terminally ill patient” will not be guilty of
In stark contrast to other states, Massachusetts, North Carolina, and Vermont have no statutory prohibitions on PAS or assisted suicide generally. For example, Vermont's chapter on “Advance Directives,” states that “[n]othing in this chapter shall be interpreted to affect the statutory or common law in existence at the time of enactment applicable to death intentionally hastened through the use of prescription medication.” Wingfield and Hacker speculate that “[t]his might easily be a reference to…even [PAS] because [it] might involve the use of prescription medication.” These commentators seem to suggest that there is nothing in the Vermont statutes or common law that “makes it illegal to use such medication to intentionally hasten death.”

Georgia’s laws on assisted suicide makes for another interesting case study. The state’s statutory chapter on “Crimes against the Person” includes the crime of “Assisting Suicide.” The provision reads: “Any person who publicly advertises, offers, or holds himself or herself out as offering that he or she will intentionally and actively assist another person in the commission of suicide and commits any overt act to further that purpose is guilty of a felony.” According to Wingfield and Hacker, Georgia’s law does not impose penalties on any one “who privately agrees to assist in a suicide without using coercion.” They suggest that physicians who assist competent, terminally ill patients in dying without publicizing such services—the opposite of, say, Dr. Kevorkian—may escape punishment under this statute.

This review appears to demonstrate that the statutory approaches to PAS across the U.S. are as diverse as they are nuanced. Thus the strategy for reforming state policy must be tailored towards both the sociopolitical context of the state concerned and the sophistication of its statutory framework. Indeed, there could be nothing more inappropriate than a blanket federal solution to this issue, particularly one emanating from the judiciary.

B. Federal Attempts to Thwart the States

manslaughter, but offers the caveat that the statute “shall not be interpreted to permit a medical caregiver to assist in the suicide of the patient.” See COLO. REV. STAT. ANN. § 18-3-104(4) (a) and § 18-3-104(4)(c) (2006).

Wingfield & Hacker, supra note 181, at 56.

VT. STAT. ANN. tit. 18 § 971.5(c) (Supp. 2005).

Wingfield & Hacker, supra note 181, at 57.

Id. at 57-58. The authors note that similar to Vermont, Massachusetts’s chapter on ‘Health Care Proxies’, states that nothing in the relevant statutory sections “shall be construed to constitute, condone, authorize, or approve suicide or mercy killing, or to permit any affirmative or deliberate act to end one’s own life other than to permit the natural process of dying.” The authors further observe: “no punishment for violations is given. Although mercy killing may be broadly interpreted to include other acts such as assisted suicide or euthanasia, one might argue that Massachusetts actually has no statutory basis for finding such acts to be illegal.” See MASS. GEN. LAWS ANN. ch. 201D, § 12 (West 2004).

See Wingfield & Hacker, supra note 181, at 59-60.


Id. § 16-5-5(b). The statute also imposes a punishment on anyone “[w]ho knowingly and willfully commits any act which destroys the volition of another, such as fraudulent practices upon such person’s fears, affections, or sympathies; duress; or any undue influence…and thereby intentionally causes or induces such other person to commit or attempt to commit suicide…” See Id. §16-5-5(c).

Wingfield & Hacker, supra note 181, at 60.

Id.
A more generalized intervention strategy may still be appropriate when dealing with federal attempts to coerce states into adopting policies against PAS. Interestingly, the attitude of the judiciary towards such efforts to undermine PAS reform in the states was evident in the case of *Gonzales v. Oregon*.\(^{199}\) *Gonzales* involved an Interpretive Rule issued in 2001 by Attorney General John Ashcroft that addressed the implementation and enforcement of the Controlled Substances Act (“CSA”)\(^{200}\) with respect to Oregon’s Death with Dignity Act.\(^{201}\) The Rule determined that “using controlled substances to assist suicide was not a legitimate medical practice and that dispensing or prescribing them for this purpose was therefore unlawful under the CSA.”\(^{202}\) Justice Kennedy, delivering the majority opinion of the Court, observed that the CSA explicitly contemplated a role for the states in regulating controlled substances.\(^{203}\) The Court thus declared that the Attorney General had exceeded his delegated authority by determining that PAS was not a legitimate medical practice, since “the structure of the CSA…conveys unwillingness to cede medical judgments to an executive official that lacks medical expertise.”\(^{204}\) The Court also indicated its suspicion that this was a federal attempt to undermine PAS in the State of Oregon, commenting: “The importance of the issue of [PAS], which has been the subject of an earnest and profound debate across the country, makes the oblique form of the claimed delegation all the more suspect.”\(^{205}\) The Court concluded that the CSA was meant by Congress to combat drug abuse and did not authorize the Attorney General to “effect a radical shift of authority from the states to the federal government to define general standards for medical practice in every locality.”\(^{206}\)

Though *Gonzales* comes nowhere near a recognition of a constitutional right to PAS, the decision is essentially premised on the idea that the regulation of PAS should be left to the states. This type of deference is also based on the theory that the development of sound national policies on contentious issues first requires states to act as laboratories in which crucial policy experimentation could take place.\(^{207}\) If the courts are generally inclined to adopt such a

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\(^{201}\) Incidentally, John Ashcroft was also the Governor of Missouri during the time of Nancy Cruzan’s case. His ‘pro-life’ position was hence well known. See Colby, *From Quinlan to Cruzan to Schiavo: What have we Learned?* *supra* note 91, at 286.

\(^{202}\) 546 U. S., at 249. The Attorney General relied on his power under the Act to deny registration to a physician seeking to dispense controlled substances, where the issuance of such registration would be inconsistent with the public interest. See 21 U. S. C. §823(f).

\(^{203}\) 546 U. S., at 251. The preemption clause of the Act provided that “no provision of this subchapter shall be construed as indicating an intent on the part of the Congress to occupy the field in which that provision operates…to the exclusion of any state law on the same subject matter which would otherwise be within the authority of the state, unless there is a positive conflict between that provision…and that state law so that the two cannot consistently stand together.”

\(^{204}\) *Id.* at 266.

\(^{205}\) *Id.* at 268.

\(^{206}\) *Id.* at 275. Citing Hillsborough County v. Automated Medical Laboratories, Inc., 471 U.S. 707, 719 (1985), the Court opined that even though the federal government can set uniform national standards in terms of regulation of health and safety, it has always been “primarily, and historically, a matter of local concern.” See *id.* at 271.

\(^{207}\) In his famous dissenting opinion in *New State Ice v. Liebmann*, Justice Brandeis commented: “It is one of the happy incidents of the federal system that a single courageous state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country. This Court has the power to prevent an experiment. But in the exercise of this high power, we must ever be on our guard, lest we erect our
sympathetic attitude towards the states, it may be worthwhile considering whether a more robust strategy of challenging federal interference is desirable.

C. CLEARING THE PATH FOR REFORM

The Federal Assisted Suicide Funding Restriction Act of 1997\(^{208}\) ("FASFRA") remains a clear example of federal attempts to influence state policies on PAS. Under the Act, "no funds appropriated by Congress for the purpose of paying (directly or indirectly) for the provision of health care services may be used...to provide any health care item or service furnished for the purpose of causing, or for the purpose of assisting in causing, the death of any individual, such as by assisted suicide."\(^{209}\) Some of the federal health care funding programs to which restrictions apply include Medicare, Medicaid, the long-term care ombudsman program, block grants to states for social services, the Indian health care program, the military health care system, the Federal Employees Health Benefits plans, health care for Peace Corps volunteers and medical services for federal prisoners.\(^{210}\)

One of the sponsors of this Act was none other than Senator (as he was then) John Ashcroft. Hence, there is little doubt that the statute was a direct response to the Oregon Death with Dignity Act.\(^{211}\) In this context, we are confronted with the question of whether the FASFRA is a legitimate exercise of Congress’s spending power under the Constitution.\(^{212}\) While the FASFRA directly places funding restrictions on states such as Oregon and Washington, it may additionally affect those other states ‘on the fence’ as far as PAS is concerned. This begs the question: does the FASFRA coerce these states to refrain from legalizing PAS? The ramifications of such federal intrusion—particularly in light of recent health care reform—is certainly worth consideration.

States that have sought to legalize PAS during the past two decades have, on most occasions, adopted a *modus operandi* that involved legislative initiatives or ballot measures directly voted on by the public. Both in Oregon and in Washington, public support for PAS, i.e., the actual percentage of the voting population in support of PAS, was critical to its legalization. By contrast, efforts to legalize PAS in California and Maine failed due to the lack of public support at the referenda held in those states. This chosen method of legalization compels the view that any undue interference with voter choice, particularly when it emanates from outside the state, becomes detrimental to reform. The FASFRA, however, places broad restrictions on the funding of health care programs. Thus it entrenches the view that the federal government deems PAS unlawful.\(^{213}\) This sends a strong and possibly coercive message to the voting public that PAS ought not to be legalized.

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\(^{208}\) 42 U.S.C.A. Chapter 138.
\(^{209}\) Id. at § 14402 (a)(1).
\(^{210}\) Id. at § 14402 (d).
\(^{211}\) See id. § 14401 (3), which lists one of Congress’s findings: "[b]ecause of recent legal developments, it may become lawful in areas of the United States to furnish services in support of [PAS]."
\(^{213}\) 42 U.S.C.A. § 14401 (a)(2).
The federal government often adopts moral positions on contentious issues. This is clearly evident in the case of abortion. However, unlike abortion funding, where it has been held that states are not compelled to use Medicaid funds to channel resources towards abortion, the FASFRA specifically prevents states from utilizing certain funds for any activity related to PAS. Notwithstanding this basic distinction, the FASFRA is still quite similar to the Hyde Amendment, which sought to deny public funding for “certain medically necessary abortions.” In *Harris v. McRae*, the U.S. Supreme Court, in a 5-4 split decision, ruled that states participating in the Medicaid program were not obligated to fund medically necessary abortions, for which federal reimbursement was unavailable under the Hyde Amendment. One of the questions considered by the Court was the constitutionality of the Hyde Amendment itself. The Court held that the amendment “places no governmental obstacle in the path of a woman who chooses to terminate her pregnancy, but rather, by means of unequal subsidization of abortion and other medical services, encourages alternative activity deemed in the public interest.”

*Roe v. Wade* had already established a constitutionally protected right to abortion. Thus the Court in *Harris* inquired into the question of whether the Hyde Amendment impinged upon any substantive constitutional right recognized by *Roe*. The FASFRA, however, restricts funding for an activity that is not constitutionally protected to begin with. Instead, it involves a type of federal coercion that prejudices the policymaking freedom of the states. Thus, as unhelpful as the precedent set by *Harris* might be, it is somewhat encouraging that the Court’s ruling in that case does not necessarily govern a constitutional inquiry in respect of the FASFRA.

In contrast to the Hyde Amendment, the FASFRA exerts pressure on the voters of states—particularly those who are dependent on federal funding for health care benefits—to vote against the legalization of PAS on the assumption that it will affect in some way the health benefits they currently receive. Realistically speaking, restrictions on funding for “items” or “services” specifically related to PAS may not affect other benefits under these programs at all. However, in a climate where public campaigns against PAS at the state level have been grossly misleading, any false impressions the FASRA creates in respect of its effects on health care benefits may hinder reform at the state level.

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214 In *Beal v. Doe* 432 U. S. 438 (1977), U.S. Supreme Court held that that it was not inconsistent with the goals of Title XIX of the Social Security Act (Medicaid) for states to refuse to fund unnecessary medical services. Thus the Court indicated that states were free to include coverage for nontherapeutic abortions only if they choose to do so. Similarly, in *Maher v. Roe*, 432 U. S. 464 (1977), the Court held that the Equal Protection Clause of the Fourteenth Amendment did not require a state participating in the Medicaid program to pay expenses incident to nontherapeutic abortions if the state had a specific policy in favor of paying expenses incident to childbirth. In *Poelker v. Doe*, 432 U. S. 519 (1977) (per curiam), the Court upheld a municipal regulation that denied indigent pregnant women nontherapeutic abortions at public hospitals. For a further discussion on abortion funding, see Eileen L. McDonagh, *My body, My Consent: Securing the Constitutional Right to Abortion Funding*, 62 ALB. L. REV. 1057 (1999).


216 See *Harris v. McRae* 448 U.S. 297, 301 (1980).

217 448 U.S. 297.

218 Id. at 306-311.

219 Id. at 315.

220 Id. at 312.

221 In the lead up to the 2008 vote in Washington, groups such as Coalition Against Assisted Suicide ran public media campaigns stating, amongst other things, that “Initiative 1000 tells doctors it’s OK to give a lethal drug overdose to a seriously ill person even if they are suffering from depression.” See http://www.noassistedsuicide.com/ads.html. This was inaccurate since section 6 of the proposal clearly provided that where the patient suffered
A constitutional challenge on the FASFRA would involve an analysis of congressional spending power. Chief Justice Rehnquist in *South Dakota v. Dole* laid down a four-prong test in this regard: (1) the exercise of the spending power must be in pursuit of the general welfare; 2) if congress desires to condition the states’ receipt of federal funds, it must be unambiguous; 3) the conditions might be illegitimate if they are unrelated to the federal interest concerned; and 4) constitutional provisions may provide an independent bar to the conditional grant of federal funds. \(^{223}\)

It is unclear as to whether the present U.S. Supreme Court would be willing to limit Congress’s spending power where the conditions imposed on the states are not at the threshold stage (i.e. where the granting of funds is contingent on the fulfillment of some condition), but at the stage of actual expenditure (i.e. where conditions are placed on how federal funds may be spent). Unlike making the availability of funds contingent on the state’s fulfillment of some condition—such as adopting a minimum legal age of twenty-one for the purchase and possession of alcohol, in order to receive federal aid for highways—the FASFRA places restrictions on how federal funds are to be utilized. It would therefore be difficult to predict the Court’s approach to congressional spending power in the context of the FASFRA. Interestingly, Stone *et al.*, comment:

> Over time, the Court’s interpretation of the spending power has seemed to dovetail with its treatment of the commerce power: In eras where the commerce power was relatively circumscribed, the Court seemed more willing to impose limits on the spending power as well, while in eras where the commerce power was treated as close to plenary, the Court also deferred to congressional use of the spending power.\(^{224}\)

The U.S. Supreme Court's recent treatment of Congress’s commerce power may indicate how it would approach a contemporary question relating to the spending power. Prior to 1995, “[u]nder each of the three prongs—substantial effects, channels, and instrumentalities of commerce—Congress’s power to regulate expanded throughout the twentieth century.”\(^{225}\) This broad interpretation of the commerce power was overhauled in *United States v. Lopez*, \(^{226}\) where the Court struck down the Gun-Free School Zones Act on the basis that it exceeded the scope of Congress’s commerce power.\(^{227}\) Justice Kennedy, in his concurring opinion, contended:

> Were the Federal Government to take over the regulation of entire areas of traditional state concern, areas having nothing to do with the regulation of commercial activities, the

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from psychiatric or psychological disorder or depression causing impaired judgment, counseling was mandatory and PAS would be unavailable so long as the patient suffers from such conditions. See R.C.W. § 70.245.060.


\(^{223}\) *Id.* at 213.

\(^{224}\) STONE *ET AL.*, *supra* note 95, at 294.


\(^{227}\) *Id.*; McGimsey, *supra* note 225, at 1702.
boundaries between the spheres of federal and state authority would blur and political responsibility would become illusory.\textsuperscript{228}

The Court’s enthusiasm for defending federalism as seen in \textit{Lopez} and later in \textit{Morrison}\textsuperscript{229} may have suffered a slight setback in the case of \textit{Gonzales v. Raich}.\textsuperscript{230} In \textit{Gonzales}, the Court upheld the constitutionality of a federal ban on cannabis based on the theory that the ban was a constitutional exercise of Congress’s powers under the Commerce Clause.\textsuperscript{231} This decision, however, does not imply that the U.S. Supreme Court has abandoned its support for federalism. Justice Scalia, in his concurring opinion, clarifies:

Unlike the power to regulate activities that have a substantial effect on interstate commerce, the power to enact laws enabling effective regulation of interstate commerce can only be exercised in conjunction with congressional regulation of an interstate market, and it extends only to those measures necessary to make the interstate regulation effective...This is not a power that threatens to obliterate the line between what is truly national and what is truly local.\textsuperscript{232}

A carefully constructed challenge on the constitutionality of the FASFRA is certainly plausible given the contemporary judicial emphasis placed on federalism under the U.S. Constitution. There is some persuasive force in such an approach; and the Court may well reiterate the view that the regulation of PAS ought to be left to the states without any federal interference whatsoever.

The case of \textit{Gill v. Office of Personnel Management}\textsuperscript{233} provides an interesting example of a strategic challenge on federal intrusion. The plaintiffs in this case successfully challenged section 3 of the Defense of Marriage Act (“DOMA”)\textsuperscript{234} on the grounds that it \textit{inter alia} overrides a state’s determination on marriage and declares same sex couples ‘not married’ for the purposes of all federal laws and programs, even though “at least until 1996, the United States has consistently deferred to the sovereignty of the states when the marital status of an individual has been used as a marker of eligibility or access to some benefit, right, or responsibility identified by the federal government.”\textsuperscript{235} Margaret Talbot notes: “[\textit{Gill}] insists not on the constitutionality

\textsuperscript{228} \textit{Lopez}, 514 U.S., at 577 (Kennedy, J., concurring). Also see McGimsey, \textit{supra} note 225, at n.176. The author observes: “Justice Kennedy also pointed out that over forty states had already enacted laws criminalizing the possession of firearms on or near school grounds, demonstrating that if a state desired to address this problem, it clearly would have the ability to do so.”

\textsuperscript{229} \textit{U.S. v. Morrison} 529 U.S. 598 (2000). In this case, following the precedent of \textit{Lopez}, the U.S. Supreme Court, in a 5-4 split decision, concluded that acts of violence such as those that the Violence Against Women Act of 1994 was meant to remedy had only an “attenuated” effect, not a substantial one, on interstate commerce. Thus it was held that Congress lacked authority, both under the Commerce Clause and the Fourteenth Amendment, to enact the law.

\textsuperscript{230} 545 U.S. 1 (2005).

\textsuperscript{231} \textit{Id.} at 19. Applying the standard established under \textit{Wickard v. Filburn} 317 U.S. 111 (1942), it was held that “the regulation is squarely within Congress’ commerce power because production of the commodity meant for home consumption, be it wheat or marijuana, has a substantial effect on supply and demand in the national market for that commodity.”

\textsuperscript{232} \textit{Id.} at 38 (Scalia, J., concurring).

\textsuperscript{233} United States District Court for the District of Massachusetts, Civil Action No. 1:09-Cv-10309.

\textsuperscript{234} 1 U.S.C. § 7.

of same-sex marriage but on the unconstitutionality of denying federal benefits to a class of citizens whose marriages are recognized by the state.”

It is dangerous to draw broad comparisons between PAS and same-sex marriage, since in the latter case, the federal benefits denied to same-sex couples are arguably more fundamental to the recognition of their status and the protection of their liberty interests. By contrast, the federal benefits denied to competent, terminally ill patients from Oregon or Washington may not be as critical to the recognition of their status or the enjoyment of their rights under state law. Since “poverty, standing alone is not a suspect classification” it may be difficult to challenge the FASFRA on equal protections grounds the same way Gill challenged the DOMA. However, the case serves to illustrate the type of approach necessary to combat federal intrusion into a sphere that is judicially recognized as falling within the exclusive competency of the states.

There is still some risk involved in challenging the FASFRA. Since only two states officially permit PAS, drawing attention to the issue at the federal level could be premature. Thus advocates ought to be cautious when considering this strategy. Existing jurisprudence appears to demonstrate the Court’s willingness to recognize state sovereignty in regulating PAS. If this decision-making process at the state level can somehow be safeguarded despite the FASFRA, it may be prudent to hold off any constitutional challenge to the federal statute until more states begin to consider PAS in a positive light.

V. CONCLUSION

The normative distinction between PAS and other manifestations of the right to die such as RLST or PCHD is virtually negligible since the traditional dichotomies relating to the ‘active’ and the ‘passive’, ‘acts’ and ‘omissions’, or ‘intention’ and ‘knowledge’, have little value in the context of prohibiting PAS alone. This brings us to the tentative conclusion that PAS is opposed on public policy grounds pertaining to its manageability. Yet the experience in Oregon seems to weaken public policy presumptions as well, leading us to conclude that the real opposition to PAS derives from public morality and from the moral preferences of a particular society.

This conclusion has twin consequences for seeking the recognition of a constitutional right to PAS in the U.S. Supreme Court. First, an analysis of Glucksberg and Vacco v. Quill demonstrates that the Court is unwilling to recognize a fundamental liberty interest in PAS, as it wishes to avoid criticism for recognizing a right that the states have thus far rejected. Even if one constitutes a legitimate government interest, this court must hold that Section 3 of DOMA as applied to Plaintiffs violates the equal protection principles embodied in the Fifth Amendment to the United States Constitution.” See Judgment dated July 8, 2010, at 38. The decision was later stayed pending appeal and the Department of Justice entered an appeal on October 12, 2010. See Denise Lavoie, Feds Appeal Mass. Rulings Against US Marriage Law, THE BOSTON GLOBE, October 12, 2010.

236 Talbot, supra note 154, at A50.
237 Harris, 448 U.S., at 323.
238 For example, both the current statutory framework and the recent legislative findings in Vermont suggest that there is a fair chance that this state will soon consider the legalization of PAS. See VT. LEGISLATIVE COUNCIL, OREGON’S DEATH WITH DIGNITY LAW AND EUTHANASIA IN THE NETHERLANDS: FACTUAL DISPUTES; Wingfield & Hacker, supra note 181, at 45.
considers the implications of *Lawrence*—that moral preferences cannot be a legitimate basis for curtailing any liberty interest, fundamental or not—the fact that *Lawrence* merely suppressed an outlier state policy, and recognizing PAS would amount to doing the exact opposite, might ultimately be decisive. Although the Court is unlikely to enforce the public policy choices of two or three states on the rest of the union, a favorable response from the Court would not, in any event, be of much benefit. Even if the Court were to recognize a constitutional right to PAS, such a decision would probably radicalize opponents of PAS and produce a counterproductive backlash that could set the movement back.

The truth remains that change—albeit incremental—is taking place amongst the states. It is crucial that this ‘emerging awareness’ not be disrupted by an imprudent intervention at the federal level. In fact, the case of *Gonzales v. Oregon* demonstrates the U.S. Supreme Court’s willingness to protect—at least implicitly—this emerging awareness, as long as it takes place at the state level. Thus efforts to propel this reform ought to be aimed at assisting the states. One possible intervention at the federal level that requires careful consideration is a challenge on the constitutionality of the FASFRA. The recent jurisprudential shift towards restricting congressional power, as well as the Court’s implicit commitment to permitting the states to decide the issue of PAS unhindered by federal intrusion, signify the plausibility of this strategy. Ultimately, advocates of PAS have to weigh the risks involved in such a strategy against the potential benefit of ‘clearing the field’ for states to reform their policies on PAS.

In the end, any academic discussion on a topic of such personal, even cosmic, importance as the right to die must take into account the realities that govern the predicament of a terminally ill patient. It is difficult to examine this issue without acknowledging those countless individuals who spend their last remaining moments on Earth robbed of their autonomy, stripped of their dignity. Whatever the public policy or constitutional outcomes a particular advocacy strategy may produce, the motivations for reforming the law on PAS is no doubt driven by the undying belief that “avoiding intolerable pain and the indignity of living one’s final days incapacitated and in agony is…'[a]t the heart of [the] liberty…to define one’s own concept of existence, of meaning, of the universe, and of the mystery of human life.'”

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