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The Future of Physician-Assisted Suicide

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What will the result be the next time the U.S. Supreme Court faces physician-assisted suicide?

The future of physician-assisted suicide

Yale Kamisar

I believe that when the Supreme Court handed down its decisions in 1997 in *Washington v. Glucksberg*¹ and *Vacco v. Quill*,² proponents of physician-assisted suicide (PAS) suffered a much greater setback than many of them are able or willing to admit.

When, in 1996 within one month, the U.S. Courts of Appeals for the Ninth and Second Circuits became the first two U.S. appellate courts to hold that there was a right to assisted suicide under any circumstances,³ they generated a good deal of momentum in favor of PAS. The fact that there was no dissent in the Second Circuit case and the Ninth Circuit decision was supported by a large majority (8-3) contributed to this momentum. So did the directness and forcefulness of the majority

opinions—which contained strong language that could be used effectively to advance the PAS cause in op-ed pieces, talk shows, state legislatures, and state courts.

Then, the U.S. Supreme Court entered the fray. It disagreed with the lower federal courts virtually point by point and in effect eradicated all the lower courts' forceful and felicitous language.⁴

Nor is that all. The constitutional arguments that proponents of PAS made without success in the Supreme Court and the policy arguments they have been making, and will continue to make, in the state legislatures or state courts or on the op-ed pages greatly overlap. There are only so many arguments in favor of a "right" to PAS, and almost all were addressed by the Court in the *Glucksberg* and *Quill* cases. The Court, for example, considered the following arguments:

1. Withdrawal of life support is nothing more or less than assisted suicide; there is no significant moral or legal distinction between the two.

2. There is no meaningful difference between administering palliative drugs with the knowledge that they are likely to hasten

the patient's death and prescribing a lethal dose of drugs for the very purpose of killing a patient.⁵

3. The 1990 *Cruzan v. Director, Missouri Department of Health* case⁶ was not simply about the right to forgo unwanted medical treatment; it was really about personal autonomy and the right to control the time and manner of one's death.

4. Fourteenth Amendment Due Process protects one's right to make intimate and personal choices, such as those relating to marriage, procreation, child rearing—and the time and manner of one's death. As the Ninth Circuit observed, quoting from *Planned Parenthood v. Casey*: "Like the decision [whether] to have an abortion, the decision how and when to die is one of 'the most intimate and personal choices a person may make in a lifetime,' a choice 'central to personal dignity and autonomy.'"⁷

A majority of the Court, I think it's fair to say, did not find any of the arguments summarized above convincing.⁸ Thus, these arguments have lost a considerable amount of credibility and will be easier to rebuff when made again, albeit in a different setting.

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TONY STONE WORLDWIDE

I am well aware that in both *Glucksberg* and *Quill* Justice Sandra Day O'Connor provided the fifth vote to make Chief Justice William Rehnquist's opinions the opinions of the Court—by stating that she joined Rehnquist's opinion, yet writing separately. I am aware, too, that in large measure, Justices Ruth Bader Ginsburg and Stephen Breyer joined O'Connor's opinion.

However, there is no clear indication in O'Connor's brief concurring opinion that she found any of the principal arguments made by PAS proponents any more persuasive than Rehnquist did. There is no suggestion, for example, that she reads the *Cruzan* opinion any more broadly than Rehnquist does or that she interprets the stirring language in *Casey* any more expansively.

Nor is there any suggestion that she has any more difficulty accepting the distinction between forgoing life-sustaining medical treatment and actively intervening to bring about death. Nor is there any reason

to think that she has more trouble grasping the "double effect" principle (the principle that explains why a doctor forbidden to administer a lethal dose of drugs for the very purpose of killing a patient may increase the dosage of medication needed to relieve pain even though the increased dosage is likely to hasten death or increase its risk).

Indeed, in one respect at least, O'Connor may have gone a step further than Rehnquist. She may be saying—she is certainly implying—that the "double effect" principle is not only plausible but *necessary*.

Her position (and Breyer's) seems to be that if, for example, a state were to prohibit the pain relief that a patient desperately needs when the increased dosage of medication is so likely to hasten death or cause unconsciousness that, according to the state, the procedure smacks of assisted suicide or euthanasia, she (presumably along with Breyer and Ginsburg) would want to revisit the question.

I realize that the Supreme Court's fail-

The legal issues surrounding physician-assisted suicide are still very much alive.

ure to recognize a constitutional right to PAS, even under the most restricted conditions, does not prevent one from arguing that there is a common law right, a state constitutional right, or a "moral" or "political" right, to PAS. But it will be a good deal harder to engage in any kind of "rights talk" after the Supreme Court decisions than before.

I liked the result in the 1997 cases. Nevertheless, I have to agree with those commentators—many of whom were quite unhappy with the result—who believe that the Court will revisit the issue in the next 5 or 10 years. Unlike a goodly number of other Court watchers, however, I very much doubt that the next time the Court confronts the issue the result will be any different. There were a number of factors at work when the Court decided the 1997 PAS cases, and most of them will still be

The strong opposition of the American Medical Association is bound to influence some justices in future cases.

operating when the Court addresses the issue a second time.

For one thing, assisted suicide and other issues related to death and dying have been the subject of vigorous debate in recent years, and there is little reason to think this agitation will subside in the foreseeable future. For another thing, the rights of a politically vulnerable group are not at stake—as had been the situation when the Court intervened in prior instances.⁹

O'Connor put it well, I think, when, reiterating a point she had made during the oral arguments,¹⁰ she observed:

Every one of us at some point may be affected by our own or a family member's terminal illness. There is no reason to think the democratic process will not strike the proper balance between the interests of terminally ill, mentally competent individuals who would seek to end their suffering and the state's interests in protecting those who might seek to end life mistakenly or under pressure.¹¹

Another likely reason for the Court's reluctance to establish a constitutionally protected right to, or liberty interest in, assisted suicide, and one that will apply the next time around as well as it did the first time, is capsuled in the solicitor general's amicus brief: Once an exception to the general prohibition against PAS is mandated by the Court, however heavily circumscribed it might be at first, "there is no obvious stopping point."¹²

Thus, Rehnquist noted Washington state's insistence that the impact of the Ninth Circuit's decision—invalidating the state's assisted-suicide ban "only 'as applied to competent, terminally ill adults who wish to hasten their deaths by obtaining medication prescribed by their doctors'"—"will not and cannot be so limited."¹³ Then, he observed:

The [Ninth Circuit's] decision, and its expansive reasoning, provide ample support for the State's concerns. The court noted, for example, that the "decision of a duly appointed surrogate decision maker is for all legal purposes the decision of the patient himself"; that "in some instances, the patient may be unable to

self-administer the drugs and . . . administration by the physician . . . may be the only way the patient may be able to receive them"; and that not only physicians, but also family members and loved ones, will inevitably participate in assisting suicide. Thus, it turns out that what is couched as a limited right to "physician-assisted suicide" is likely, in effect, a much broader license, which could prove extremely difficult to police and contain.¹⁴

Although concurring, Justice Ginsburg neither joined Rehnquist's opinion nor wrote an opinion of her own;¹⁵ during the oral arguments she voiced skepticism that any right to PAS, no matter how narrowly limited initially, could or would be confined to the terminally ill or could or would stop short of active voluntary euthanasia.

When Kathryn Tucker, lead attorney for the plaintiffs in *Glucksberg*, urged the Court to recognize, or to establish, a constitutionally protected liberty interest "that involves bodily integrity, decisional autonomy, and the right to be free of unwanted pain and suffering,"¹⁶ Ginsburg retorted that "a lot of people would fit [this] category," not just the terminally ill.¹⁷ How, she wondered, do you "leave out the rest of the world who would fit the same standards?"¹⁸

At another point, Ginsburg suggested that the patient who is so helpless or in so much agony that she "is not able to assist in her own suicide," but must have a health professional administer a lethal injection, is "in a more sympathetic situation" than one who is able to commit suicide with the preliminary assistance of a physician.¹⁹

Position of medical groups

Still another factor must have had some impact on at least some members of the Court and is bound to influence at least some of the justices in future cases. That factor is the strong opposition of the American Medical Association (AMA) and other medical groups to the constitutionalization or legalization of PAS (regardless of how narrowly limited the constitutional right or the statutory authorization might be). As *New York Times* reporter Linda Green-

house has pointed out,²⁰ the amicus brief filed by the AMA in *Glucksberg* and *Quill* sharply contrasted with the one filed seven years earlier in *Cruzan*.

In *Cruzan*, the AMA told the Court that, under the circumstances, terminating life support was in keeping with respect for "the patient's autonomy and dignity."²¹ In *Glucksberg* and *Quill*, however, the AMA (and more than 40 other national and state health care organizations) told the Court

- "the ethical prohibition against physician-assisted suicide is a cornerstone of medical ethics";

- the AMA had repeatedly "reexamined and reaffirmed" that ethical prohibition and had done so as recently as summer 1996; and

- "physician-assisted suicide remains 'fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.'"²²

Recent and continuing trends in medical practice may only heighten the AMA's resistance to PAS. The next time the issue is presented, the AMA and other medical groups might well argue that new trends and developments make the need to maintain the absolute prohibition against PAS more important than ever. It would not be surprising if the next time around the AMA were to underscore the point recently made by two commentators:

Given the great pressures threatening medical ethics today—including, among other factors, a more impersonal practice of medicine, the absence of a lifelong relationship with a physician, the push toward managed care, and the financially based limitation of services—a bright line rule regarding medically-assisted death is a bulwark against disaster.²³

Legislative conundrum

Another factor at work in the assisted suicide cases, and one that will operate as well the next time the Court confronts the issue, is the justices' realization that if they were to establish a right to assisted suicide, however limited, the need to enact legisla-

tion implementing and regulating any such right would generate many problems. These inevitably would find their way back to the Court.

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

For example, three of the nation's most respected proponents of PAS, Franklin Miller, Howard Brody, and Timothy Quill, have questioned the desirability of the 15-day waiting period required by the Oregon Death with Dignity Act. This provision was designed to ensure that a patient's decision to elect assisted suicide is resolute.²⁴ According to Miller, Brody, and Quill, this "arbitrary time period . . . may be highly burdensome for patients who are suffering intolerably and may preclude access to assisted death for those who request it at the point when they are imminently dying."²⁵

The same three commentators have also criticized a provision of a Model State Act requiring that the discussion between physician and patient concerning a request for assisted suicide be witnessed by two adults.²⁶ They called it "unduly intrusive and unlikely to be effective."²⁷

On the other hand, they maintain that an Oregon provision requiring a second medical opinion on the decision is "not a reliable safeguard" because it "does not mandate that the consulting physician be genuinely independent."²⁸

Perhaps the most rigorous condition on PAS to be found is the requirement of Compassion in Dying that the approval of all the would-be-suicide's immediate family members be obtained.²⁹ (This organization provides professionals to help terminally ill people commit suicide. It was also one of the plaintiffs in *Glucksberg*.)

It is hard to believe that any group favoring PAS would retain this requirement if the Court were to establish a constitutional right to assisted suicide. But one can be fairly sure that if the Court were to es-

tablish this right, PAS opponents would fight hard to include a "family approval" provision in any legislation regulating assisted suicide.

They would also want mandatory waiting periods, specified information and procedures to ensure that the decision to choose PAS is "truly informed," and all sorts of notification requirements and bans on the use of public facilities, public em-

ployees, and public funds.³⁰

Although not insubstantial, the differences among proponents of PAS over the requisite conditions and procedures for carrying out the practice pale compared to the differences likely to exist between PAS proponents and those opposed to legalizing any PAS at all. In short, in many respects the legislative response to a Supreme Court decision establishing a

Few physicians assist patient suicides

A national survey found that although a substantial proportion of physicians have received requests from patients for lethal injections or prescriptions to hasten death, few have complied with their patients' wishes.

In 1996, researchers from Mount Sinai School of Medicine, New York; the University of Chicago; and the University of Rochester, New York, sent questionnaires to 3,102 physicians practicing in 10 specialties in which doctors are most likely to receive requests for assisted suicide. Sixty-one percent of those surveyed responded. The results were published in the April 23, 1998, issue of *The New England Journal of Medicine*.

Eleven percent of physicians said that under current legal constraints there were circumstances in which they would prescribe a fatal dose of medication to hasten a patient's death. Seven percent said they would provide a lethal injection.

Eighteen percent of the physicians said they have received requests from a patient to hasten death. Sixteen percent of the physicians receiving such requests, or 3 percent of the entire sample, have prescribed a fatal dose of medication. Five percent of the entire sample have given at least one lethal injection. All told, 6 percent have administered a lethal injection or written a lethal prescription at least once.

The study took place before Oregon voters approved the Death with Dignity Act in November 1997. Voters had

passed the act in 1994, but the state legislature asked for a repeal last year. Instead, 60 percent of voters reaffirmed the act.

Under the act, doctors may prescribe deadly doses of barbiturates and other drugs to adults of sound mind who have been given less than six months to live. The act applies only to Oregon residents. According to an article in *The Washington Post* on April 29, 1998, the act requires oral and written requests, consulting opinions by other physicians, a 15-day waiting period, and notification of pharmacists and state health authorities.

After the request is approved, the physician prescribes a fatal drug the patient may take at his or her discretion with or without a doctor present. Physicians may not give lethal injections.

Opponents fear the act will lead to a rash of suicides by patients with treatable diseases. However, in the six-month period since the act took effect, Compassion in Dying Federation, a national advocacy group headquartered in Oregon that counsels the terminally ill on assisted suicide, confirmed only 15 requests by patients seeking assisted suicide. Of those, seven patients' requests are being processed, four patients have died of natural causes, three patients were found ineligible for assistance, and one patient died after taking a lethal dose of barbiturates. Only one other case of physician-assisted suicide has been reported.

—Jennifer L. Reichert

right to assisted suicide is likely to be a replay of the response to *Roe v. Wade*,³¹ a specter that did not escape the attention of the justices last year.

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

You're not asking that [this Court engage in legislation] now. But surely that's what the next couple of generations are going to have to deal with, what regulations are admissible and what not if we uphold your position here. . . . [Y]ou're going to find the same thing . . . that perhaps has happened with the abortion cases, there are people who are just totally opposed and people who are totally in favor of them. So you're going to have those factions fighting it out in every session of the legislature—how far can we go in regulating this. And that will be a constitutional decision in every case.³²

Roe v. Wade ignited what has aptly been called a "domestic war,"³³ one that, after a quarter-century of tumult, seems finally to have come to an end in the courts. The

Court that decided the assisted suicide cases in 1997 was not eager to set off a new domestic war. I venture to say that the Court will not be eager to do so the next time around either. □

Notes

1. 117 S. Ct. 2258 (1997).
2. 117 S. Ct. 2293 (1997).
3. *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir. 1996) (en banc), *rev'd, remanded*, 117 S. Ct. 2258 (1997); *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996), *rev'd*, 117 S. Ct. 2293 (1997).
4. See generally Yale Kamisar, *On the Meaning and Impact of the Physician-Assisted Suicide Cases*, MINN. L. REV. (forthcoming 1998).
5. As the Ninth Circuit put it, there is no real distinction "between providing medication with a double effect and providing medication with a single effect, as long as one of the known effects in each case is to hasten the end of the patient's life." *Compassion in Dying*, 79 F.3d 790, 824.
6. 497 U.S. 261 (1990).
7. *Compassion in Dying*, 79 F.3d 790, 813, 814 (quoting *Planned Parenthood v. Casey*, 505 U.S. 833, 851 (1992)).
8. For a discussion of how the Court disposed of

these arguments, see Kamisar, *supra* note 4.

9. At one point in oral argument, Justice David Souter pointed out that in other cases in which the Court had intervened "there were certain groups who simply did not get a representative fair shake," but "that's not what we've got here. . . . [In this case], everybody is in the same boat." See Transcript of Oral Arguments at 41, *Washington v. Glucksberg*, 1997 WL 13671 (U.S. Jan. 8, 1997) (No. 96-110); see also Robert A. Burt, *Constitutionalizing Physician-Assisted Suicide: Will Lightning Strike Thrice?* 35 DUQ. L. REV. 159, 179 (1996); Cass R. Sunstein, *The Right to Die*, 106 YALE L.J. 1123, 1148 (1997).

10. See Oral Arguments, *Glucksberg*, *supra* note 9, at 39-40.

11. *Glucksberg*, 117 S. Ct. 2302, 2303 (O'Connor, J., concurring). Some might argue that in a system formally prohibiting PAS, the wealthy and the well connected will still obtain this help "underground." But the counterargument is that in a system formally authorizing PAS, the risks of abuse are likely to fall most heavily against members of disadvantaged groups. See generally Yale Kamisar, *Physician-Assisted Suicide: The Problems Presented by the Compelling, Heartrenching Case*, J. CRIM. L. & CRIMINOLOGY (forthcoming 1998).

12. Brief of the United States as Amicus Curiae at 26, *Glucksberg*, quoted by Rehnquist in *Glucksberg*, 117 S. Ct. 2258, 2274 n.23. There is considerable lit-

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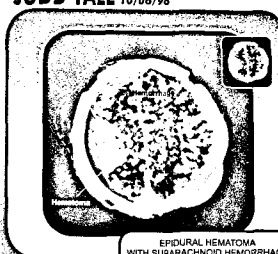
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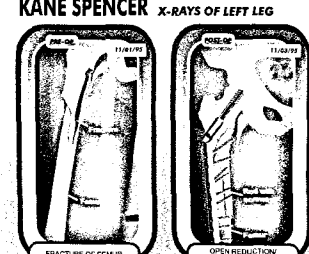
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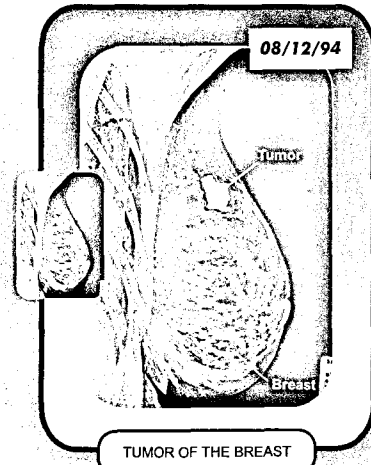
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erature on this point. See generally Yale Kamisar, *The "Right to Die": On Drawing (and Erasing) Lines*, 35 DUQ. L. REV. 481 (1996), and the articles and books quoted or cited therein.

13. *Glucksberg*, 117 S. Ct. 2258, 2274.

14. *Id.*

15. She said only that she "concur[red] in the Court's judgments in [*Glucksberg* and *Quill*] substantially for the reasons stated by Justice O'Connor in her concurring opinion." *Glucksberg*, 117 S. Ct. 2302, 2310 (Ginsburg, J., concurring).

16. Oral Arguments in *Glucksberg*, *supra* note 9, at 49-50.

17. *Id.* at 50.

18. *Id.*

19. *Id.* at 29 (emphasis added).

20. Linda Greenhouse, *An Issue for a Reluctant High Court*, N.Y. TIMES, Oct. 6, 1996, §4, at 3.

21. *Id.*

22. Brief of the American Medical Association, the American Nurses Association, and the American Psychiatric Association et al. as Amici Curiae at 5, *Glucksberg*, 1996 WL 656263 (U.S. Nov. 12, 1996) (No. 96-110) (quoting from §2.211 of the AMERICAN MEDICAL ASSOCIATION COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS CODE OF MEDICAL ETHICS).

23. Leon R. Kass & Nelson Lund, *Physician-Assisted Suicide, Medical Ethics and the Future of the Medical Profession*, 35 DUQ. L. REV. 395, 423 (1996).

24. Franklin G. Miller et al., *Can Physician-Assisted Suicide Be Regulated Effectively?* 24 J. L. MED. & ETHICS 225, 226 (1996).

25. *Id.*

26. See Charles H. Baron et al., *A Model State Act to Authorize and Regulate Physician-Assisted Suicide*, 33 HARV. J. ON LEGIS. 1, 28 (1996).

27. Miller et al., *supra* note 24, at 226.

28. *Id.* Thus, this procedural safeguard could be satisfied by "a friend or close colleague of the treating physician, or even by a subordinate physician under the treating physician's supervision." *Id.*

29. See Sylvia Law, *Physician-Assisted Death: An Essay on Constitutional Rights and Remedies*, 55 MD. L. REV. 292, 294 n.5 (1996).

30. As noted in *Glucksberg*, 117 S. Ct. 2258, 2266, two months before the Court decided the PAS cases, President Clinton signed the Federal Assisted Suicide Funding Restriction Act of 1997, prohibiting the use of federal funds in support of PAS. 42 U.S.C. §§14401-14408 (1997).

31. 10 U.S. 113 (1973).

32. Oral Arguments, *Glucksberg*, *supra* note 9, at 38-39. Added O'Connor, *id.* at 39: "I think that there is no doubt that [if those challenging the constitutionality of Washington's anti-assisted suicide law were to prevail] it would result . . . in a flow of cases through the court system for heaven knows how long."

33. See David J. Garrow, *All Over But the Legislating: There Was a Genuine War Over Abortion, These Writers Think, But the Armistice Appears to Be Durable*, N.Y. TIMES BOOK REV., Jan. 25, 1998, at 1.

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