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Toward A More Perfect Union: A Federal Cause of Action for Physician Aid-in-Dying

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INTRODUCTION

“Liberty finds no refuge in a jurisprudence of doubt.”¹ With these words, the Supreme Court introduced Planned Parenthood v. Casey,² its most significant opinion on abortion since Roe v. Wade.³ In addition to affirming a woman’s freedom from unduly burdensome government intrusion in pre-viability abortions, Casey exposes a potential crisis in the states caused by the failure to protect Supreme Court tested and approved rights.⁴ Absent federal involvement, constitutional rights often remain in doubt. Abortion is one of these rights. As this Note contends, so too is the right to die. It is perhaps not surprising that the discussion of abortion lends itself to euthanasia as well. Both issues demand the consideration of life and, concomitantly, death.⁵

². Id. at 2791.
³. 410 U.S. 113 (1973).
⁴. Casey, 112 S. Ct. at 2803 (citations omitted) (noting that “[nineteen] years after our holding that the Constitution protects a woman’s right to terminate her pregnancy in its early stages, that definition of liberty is still questioned”).
⁵. There are those who believe that the abortion precedent is not an appropriate analogy for euthanasia, since abortive procedures do not effect a living being. See, e.g., Joseph P. Shapiro & David Bowermaster, Death on Trial, U.S. News & World Rep., Apr. 25, 1994, at 31, 39. This is debatable. In Casey, the Court characterized the state’s authority to regulate the practice of abortion as an interest in the potentiality of human life. Casey, 112 S. Ct. at 2819–20. Those who argue that abortion is not a proper analogy for euthanasia also ignore the fact that under certain circumstances a woman may elect to abort after the point of fetal viability. Finally,
The controversy surrounding Dr. Jack Kevorkian's role in the deaths of twenty individuals⁶ is reflective of the right-to-die debate itself. Armed with his lethal "Mercitron," Kevorkian has vowed to continue to help suffering patients⁷ despite the State of Michigan's criminal ban on assisted suicide.⁸ Unlike his clinician colleagues, Kevorkian, a non-clinician, does not have access to the resources of a fully equipped medical facility to "treat" his patients. Some of those who wish to enlist the services of Kevorkian consequently have been forced to forsake the refuge of a hospital in favor of a cot in the back of a rusting Volkswagen van.⁹

In many ways, the parallels between Kevorkian's van and the pre-Roe abortion mills are striking. Both were illegal. The services each provides were, and are, frequently performed, despite their illegality. And like its back-alley counterpart, Kevorkian's van is unsanitary, and ostensibly beyond the sweep of State regulatory bodies. John O'Hair, the Michigan prosecutor who pursued the criminal conviction of Kevorkian, suggested that Kevorkian's patients are subjected to inhumane conditions.¹⁰ In response to his prosecution, Kevorkian

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10. Rogers Worthington, Suicide Doctor Finally to Have Day in Court, CHI. TRIB., Aug. 18, 1993, at A2. At a press conference after the decision to bring the first set of
remarked, "[physician aid-in-dying] is not a matter of law, legislators, ethicists, theologians, or philosophers. It’s a medical matter." 11

To suffering persons, Kevorkian’s statement is persuasive. Physician aid-in-dying is unquestionably a medical concern. 12

The fact that individuals consult their physicians and ask for assistance in ending an intolerable existence is strong evidence that patients view assisted death as an appropriate medical matter. A 1991 study conducted by the Harvard University School of Public Health in conjunction with the Boston Globe shows that a large percentage of the population perceive an appreciable difference between doctors who assist patients in life and death decisions and those individuals who render assistance without the requisite medical training and background. 13 Sixty-four percent of those polled favored the legalization of physician aid-in-dying. 14 However, only thirty-seven percent of those polled thought assistance by a relative or close friend should be permitted. 15

The medical profession does, and should, enjoy a presumption that its efforts are in the best interests of a patient. This presumption logically extends to the legal status of physician aid-in-dying as well. But Kevorkian is mistaken when he argues that medical matters are not the affairs of government. Courts have long recognized that individual liberties must be

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11. Id.
14. Id.
15. Id. Professor Dan Brock of Brown University believes that the study demonstrates the public’s confidence in the medical profession to act responsibly. Brock argues that it is preferable for society to restrict the authority to a group that has the professional training and norms which tend to minimize abuse. Id.
balanced against countervailing state interests. It is precisely because physician assistance-in-dying has such irrevocable consequences that governmental protection is needed. Medicine should not be exempt from social or penal codes.

The problem created by doctors like Kevorkian is more pervasive than it might initially appear. He is not alone. Many physicians are confronted with requests for death. Some, including Dr. Timothy Quill of Rochester, New York, are publicly open to the idea of assisting their patients to cope with dying and, potentially, to die. A recent study surveying Rhode Island physicians’ attitudes toward assisted suicide reveals that twelve percent have been asked by patients to administer a lethal injection, and twenty-eight percent would comply with such requests if the practice were legalized. Yet, evidence of physician willingness to administer a lethal injection is not dispositive. More important is the notion that physician aid-in-dying as a medical decision is deserving of judicial and legislative latitude. Despite Justice Scalia’s fear that imposing a “background of federal constitutional imperatives” will confuse the issue and embroil physician aid-in-dying in a controversy similar to abortion, the prospect of subjecting ailing individuals to Kevorkian’s death machine or other means of surreptitious, illegal physician-assisted suicide should motivate a federal alternative. A more perfect union demands no less.

It is in this spirit of reform that this Note argues for the constitutional protection of physician assistance-in-dying under the Due Process Clause. This Note maintains that

18. Id. at 873.
Physician Aid-in-Dying

Physician aid-in-dying for terminally ill or suffering patients should be allowed to challenge state statutes prohibiting physician aid-in-dying as a violation of their rights under the Constitution and the laws of the United States by filing a federal claim pursuant to 42 U.S.C. § 1983. The reasons for undertaking a section 1983 suit are twofold. First, given the Supreme Court's failure to define precisely the parameters of competent decisions to die, a federal cause of action would force further consideration of the issue by the Court. Second, a section 1983 suit seeking injunctive relief against a state prosecutor would insulate physicians from criminal liability and would in all likelihood lead to greater medical compliance with patient requests for death.

Part I of this Note investigates the possible foundations of a constitutional right to physician aid-in-dying triggering section 1983 protection and the opposing state interests in preventing suicide. Part II examines the nature and scope of, and obstacles to a request for section 1983 relief. Finally, Part III focuses on the public policy implications associated with recognizing a federal cause of action.

Before proceeding to more substantive areas, it is important to detail the theoretical posture of this Note. The purpose of this preface is to avoid any misconceptions or ambiguities that might otherwise result. The primary concern of this Note is not whether physician aid-in-dying is normatively desirable, but rather to determine what the logical extensions to Cruzan v. Director, Missouri Dep't of Health might be for the more humane administration of suffering individuals who would like to choose the time and place of their deaths. As the literature in the field on the ethics of euthanasia is already exhaustive, this commentary presupposes, as did Cruzan, that a competent individual has a constitutionally safeguarded right to refuse life-saving medical treatment. Fully cognizant of the profusion of conflicting precedent on the issue, the Note limits its discussion to instances where the patient is competent.

23. Id. at 278.
24. These requirements ensure that an individual patient is minimally capable of autonomous decision making. Unfortunately, such a standard precludes participation by those who may be suffering the most: Alzheimer's patients, the mentally impaired, newborns, and those surviving in a persistent vegetative state. Proxy decision making or substituted judgment by a court, guardian ad litem, friend, or
where evidence of the patient's desires is unequivocal, 25 where the patient is free of duress, coercion or undue influence, 26 and where there is a legitimate medical basis for the participation of a physician. 27 Furthermore, this Note takes the position that the differences between active and passive conduct, 28 and ordinary and extraordinary treatments 29 are merely a matter of semantics. Justice Scalia best summarized this position when he wrote in Cruzan that "Starving oneself to death is no different from putting a gun to one's temple as far as the common-law definition of suicide is concerned; the cause of death in both cases is the suicide's conscious decision to "pu[t]
an end to his own existence." Finally, the Note is predicated on the opinion that physicians are the principal actors in patient assisted deaths. Little attention is given to other medical personnel who also attend to patients. This omission, however, does not reflect a desire to preclude more ancillary health care staff from participation if they so choose. Many, if not all, of the arguments presented are equally applicable to medical persons other than doctors. Mindful of the burden this responsibility places upon physicians, this Note nevertheless contends that doctors who take part in physician aid-in-dying should remain involved from beginning to end.

I. BASES FOR CONSTITUTIONAL PROTECTION OF PHYSICIAN AID-IN-DYING

Patient challenges to state prohibitions against physician aid-in-dying are properly predicated upon the Fourteenth Amendment's guarantee of due process. Conduct explicitly is violative of due process if a person, patient or otherwise, suffers a deprivation of a protected liberty interest. In the alternative, a patient might contend that federal relief is necessary to preserve the privacy of the physician-patient relationship from unwarranted and burdensome state interference.

The language of the Fourteenth Amendment is purposefully broad. Declining to enumerate specific rights within the purview of due process reserves to contemporary society the power to tailor the Constitution to newly recognized liberties. In order to pass constitutional muster under the Due Process Clause, a law must be both reasonably related to the regulated activity and in the interest of the community.

30. *Cruzan*, 497 U.S. at 296–97 (Scalia, J., concurring) (quoting 4 William Blackstone, Commentaries 189 (1854)).
32. The Fourteenth Amendment reads in pertinent part: "No State shall . . . deprive any person of life, liberty, or property, without due process of law . . . ." *Id.*
A. The Liberty Interest Implicated in Physician Aid-in-Dying

Before an individual is deprived of a constitutionally protected liberty, the Fourteenth Amendment provides the right to a hearing. Since the early 1900s, the Supreme Court has been reluctant to extend the substantive reach of the Due Process Clause. Thus, when a due process claim arises in an untested context, the Supreme Court engages in a two-pronged analysis. First, the Court determines the private interest threatened; then it balances that interest against the state interest in regulating the behavior. Traditionally, the Court has extended due process protection only to those rights found to be "implicit in the concept of ordered liberty" or "deeply rooted in this Nation's history and tradition."

The most recent framework for determining the status of a particular liberty is found in Planned Parenthood v. Casey. The Court wrote:

[Matters which] involv[e] the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State.

35. See Ferguson v. Skrupa, 372 U.S. 726, 729-30 (1963) (noting that a law does not violate due process by being unwise or burdensome); Lincoln Federal Labor Union v. Northwestern Iron & Metal Co., 335 U.S. 525, 533-34 (1949) (finding that state laws guaranteeing the right to unionize do not violate due process); United States v. Carolene Prods. Co., 304 U.S. 144, 148 (1938) (upholding a Congressional prohibition on the sale of imitation milk products); West Coast Hotel Co., 300 U.S. at 391-92 (upholding a minimum wage for women); see also Moore v. City of East Cleveland, 431 U.S. 494, 544 (1977) (White, J., dissenting) (cautioning against extending substantive rights under the due process clause).
37. Id.
41. Id. at 2807.
The Court's language easily embraces the right of a competent person to decide to die with medical assistance. If, as *Casey* indicates, marriage, procreation, contraception, child rearing, and other matters indirectly affecting our lives are impliedly part of ordered liberty, then certainly decisions which directly affect our lives, such as the choice between life and death, should be similarly protected. The Court conceded this in *Cruzan*. In writing for the Court, Chief Justice Rehnquist commented that "[t]he choice between life and death is a deeply personal decision of obvious and overwhelming finality. To now hold that a suffering individual may not avail herself of physician assistance to effectuate a deeply personal decision to die would be incongruous.

The controversy does not end here. Even if one concludes that assisted deaths are not central to personal dignity and autonomy, the question remains whether such an inquiry is appropriate in the first place. Some courts have found the first prong of the Court's test to be wanting. Continued reference by the courts to practices customary at the time of the ratification of the Fourteenth Amendment needlessly confines the amendment to antiquity. One of the most persuasive as well as most recent commentaries on this retrospective methodology is found in *Michigan v. Kevorkian*. In evaluating the constitutionality of Michigan's statute criminalizing assisted suicide, Judge Richard Kaufman concludes that:

[An exclusively historical analysis] would place a straightjacket upon the Constitution, and not permit it to

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42. *Id.*
44. It is argued by some critics that it is a philosophical contradiction for a person to end his life in the course of exercising autonomy because in addition to destroying his body, he destroys the autonomy he held out to be so paramount. Without launching into an involved philosophical discourse, this contention can be easily refuted. First, this argument persists in the continued distinction between passive and active assistance, rejected earlier. *See supra* notes 28–30 and accompanying text. Second, persons who refuse life-saving treatment and elect to "passively" end their lives exercise the same autonomy-destroying autonomy as those persons who engage in more active conduct. The double standard logically and legally cannot stand.
46. *See, e.g., Cruzan*, 497 U.S. at 294 (Scalia, J., concurring).
be the living, dynamic document that has endured for more than 200 years . . . a document that permits protection of fundamental liberty and personal privacy, even when history and tradition would severely intrude in these areas.\(^{48}\)

Judge Kaufman notes that even the Supreme Court has, on occasion, rejected this approach.\(^{49}\) Evidence of the Court’s inconsistent stance on due process can be found in *Loving v. Virginia*,\(^{50}\) where Virginia’s laws banning interracial marriage were struck down as unconstitutional.\(^{51}\) *Loving* recognizes that the specific practices of the states at the time of the Fourteenth Amendment’s ratification are not the exclusive demarcation of safeguarded liberties.\(^{52}\)

Other decisions by the Court dismissing a strict historical examination to determine the reach of constitutional rights include matters as pivotal as the right to trial by jury,\(^{53}\) desegregation,\(^{54}\) and birth control.\(^{55}\) Thus, a conclusion that assisted suicide was illegal in 1868 should not be a per se bar to further consideration of the issue.

\(^{48}\) Id. at *7.\(^{49}\) Id.; see also Planned Parenthood v. Casey, 112 S. Ct. 2791, 2805 (1991) (“It is also tempting . . . to suppose that the Due Process Clause protects only those practices, defined at the most specific level, that were protected against government interference by other rules of law when the Fourteenth Amendment was ratified. But such a view would be inconsistent with our law.”) (citations omitted).\(^{50}\) 388 U.S. 1 (1967).\(^{51}\) Id. at 12. With respect to the protected Fourteenth Amendment interest implicated by interracial marriages, the Court in *Casey* wrote:

> Marriage is mentioned nowhere in the Bill of Rights and interracial marriage was illegal in most States in the 19th century, but the Court was no doubt correct in finding it to be an aspect of liberty protected against state interference by the substantive component of the Due Process Clause in *Loving v. Virginia*.\(^{52}\)

The right to privacy as developed by *Griswold v. Connecticut* and its progeny provides formidable constitutional motivation for legitimizing the role of physicians in patient euthanasia. At their core, *In re Quinlan*, the first case involving a request to remove a patient from life support equipment, and its counterparts reflect this. Indeed, one court was persuaded that:

The constitutional right to privacy, as we conceive it, is an expression of the sanctity of individual free choice and self-determination as fundamental constituents of life. The value of life as so perceived is lessened... by the failure to allow a competent human being the right of a choice.

Even though explicit mention of privacy is lacking in the Constitution, the Supreme Court has repeatedly held that "a right of personal privacy, or a guarantee of certain areas or zones of privacy, does exist under the Constitution." This privacy interest is implicitly grounded in the substantive protections of the Fourteenth Amendment.
Seven areas have been expressly identified as fundamental liberties protected by the Fourteenth Amendment or by the Constitution generally: the rights to procreation,\textsuperscript{62} contraception,\textsuperscript{63} abortion,\textsuperscript{64} marriage,\textsuperscript{65} the formation of a family,\textsuperscript{66} child rearing,\textsuperscript{67} and education. The doctor-patient relationship is conspicuously absent. Nonetheless, strong precedent exists to suggest that medical decision making by a patient in consultation with a physician ought to be a privacy-protected activity.

In \textit{Whalen v. Roe},\textsuperscript{68} the Court considered a New York State statute requiring that all prescriptions written for "schedule II" drugs, the most dangerous of the legal drugs which the State found had a potential for abuse, be filed with the State.\textsuperscript{69} While the Court concluded that the statute was a permissible exercise of the state's police power\textsuperscript{70} and did not violate a constitutional privacy interest,\textsuperscript{71} two lines of thought emerged which may facilitate the recognition of a privacy interest in physician aid-in-dying. First, the Court failed to disturb the lower courts' conclusion that "the doctor-patient relationship is one of the zones of privacy accorded constitutional protection."\textsuperscript{72} The Supreme Court's omission could be construed to include doctor-patient consultation, decision making and treatment in the currently narrow scope of constitutionally protected personal privacy. Supporting this interpretation is \textit{Paris Adult Theater I v. Slaton},\textsuperscript{73} where the Court wrote:

\begin{quote}
[T]he constitutionally protected privacy of family, marriage, motherhood, procreation, and child rearing is not
\end{quote}

\begin{footnotes}
\item[64.] Roe, 410 U.S. at 153. \textit{But see} Webster v. Reproductive Health Serv., 492 U.S. 490, 520–21 (1989) (plurality opinion) (narrowing the privacy right established by \textit{Roe}).
\item[68.] 429 U.S. 589 (1977).
\item[69.] \textit{Id.} at 592–93.
\item[70.] \textit{Id.} at 598.
\item[71.] \textit{Id.} at 603–04.
\item[73.] 413 U.S. 49, \textit{reh'g denied}, 414 U.S. 881 (1973).
\end{footnotes}
just concerned with a particular place, but with a protected intimate relationship. Such protected privacy extends to the doctor's office, the hospital . . . or as otherwise required to safeguard the right to intimacy involved.74

Whalen also offers a more direct argument endorsing a privacy interest in physician aid-in-dying. Joining the patients, the attending physicians, relying on Doe v. Bolton,75 asked the Court to resolve whether the statute unduly burdened their right "to practice medicine free of unwarranted state interference."76 Noting that the doctors' claim was derivative of, not independent from, their patients', the Court rejected this contention.77 The Court had little difficulty distinguishing the situation of these physicians from that of the physicians in Bolton.78 The Court found that if impediments were not burdensome to a patient's decision, but "merely made the physician's work more laborious or less independent . . . [the statutes] would not have violated the Constitution."79 The locus of the Court's constitutional appraisal was the impact on a patient's privacy.

Statutes proscribing physician aid-in-dying satisfy Whalen's requirements for an undue burden. Laws categorically preventing patients from realizing their decision to end a painful existence through the assistance of a personal physician are overbroad. Since the impact is borne entirely by the patient, such prohibitions are precisely the obstacles rejected by the Whalen and Bolton course.

To speak about privacy, however, requires at least a rudimentary understanding of the concept.80 In his now famous dissent in Olmstead, Justice Brandeis referred to privacy as "the right to be let alone . . . ."81 More recently, the Court noted the existence of a "right to privacy, no less important than any other

74. Id. at 66 n.13.
75. 410 U.S. 179 (1973); see id. at 197-98, 199.
77. Id.
78. The Court maintained that the "statutory restrictions on the abortion procedures were invalid because they encumbered the woman's exercise of that constitutionally protected right by placing obstacles in the path of the doctor upon whom she was entitled to rely for advice in connection with her decision." Id. at 605 n.33.
79. Id.
right carefully and particularly reserved to the people . . . .”82
This sentiment is also the animating force behind “the familiar
principle, so often applied by [the] Court that a ‘governmental
purpose to control or prevent activities constitutionally subject
to state regulation may not be achieved by means which sweep
unnecessarily broadly and thereby invade the area of protected
freedoms.’”83 Despite the considerable attraction of a constitu-
tional right to privacy, an adequate definition of this right is
not readily apparent.

One of the most succinct and insightful commentaries is by
Professor Philip Kurland of the University of Chicago, who
writes:

The concept of a constitutional right of privacy still
remains largely undefined. There are at least three facets
that have been partially revealed, but their form and shape
remain to be fully ascertained. The first is the right of the
individual to be free in his private affairs from governmental
surveillance and intrusion. The second is the right of an
individual not to have his private affairs made public by the
government. The third is the right of an individual to be free
in action, thought, experience, and belief from governmental
compulsion.84

It is the freedom from state compulsion which most directly
concerns physician aid-in-dying.

The ideal of privacy includes both the positive, “the freedom
to,” and the negative, “the freedom from,” aspects of liberty. The
second component is overlooked frequently in the right-to-die
cases. It is nonetheless seriously implicated. A meaningful
analysis of the right to die should not preclude an examination
of the law’s liberty-limiting or enhancing aspect. The law must
consider its compulsive effect on the lives of the citizenry.85
Lawmakers should proceed with caution when legislating
normative matters.86 Such caution is necessary to avoid a way

377 U.S. 288, 307 (1965)).
84. Philip B. Kurland, The Private I: Some Reflections on Privacy and the Consti-
tution, U. CHI. MAG., Autumn 1976, at 7, 8 (quoted in Whalen v. Roe, 429 U.S. 589,
599 n.24 (1977)).
85. Rubenfeld, supra note 80, at 739–40.
86. The Court admonished those who would devise or interpret laws according
to their own particular moral intuition, stating that: “Some of us as individuals find
of life imposed by a "progressively more normalizing state."

Laws which impose burdens that reshape a person's life violate the right to privacy under author Jed Rubenfeld's theory. The failure to recognize a constitutional right to die with physician assistance imposes such an overwhelming burden on the life of the person forced to obey. The fundamental question to be addressed under this definition, therefore, is the extent to which criminal prohibitions on physician aid-in-dying influence or dominate the lives of individuals.

The life of a person suffering from a painful affliction is a classic example of a "life almost totally occupied" by the consequences of laws against assisted deaths. If privacy is to truly protect against intrusive state actions, then it must protect the patient's decision to reject a life pervaded by pain.

Despite these thoughts, the right to privacy must be considered against a post-Griswold backdrop of resistance to attempts to construe privacy liberally. Without elaboration, the Court noted that any federal constitutional right to refuse life-saving medical treatment "is more properly analyzed in terms of a Fourteenth Amendment liberty interest" than as being "encompassed by a generalized constitutional right of privacy . . . ." The Court's preference aside, ignoring the considerable state precedent to the contrary would be unwise, particularly when the Court itself counseled that the matter should be developed in the laboratory of the states.

abortion offensive to our most basic principles of morality, but that cannot control our decision. Our obligation is to define the liberty of all, not to mandate our own moral code." Planned Parenthood v. Casey, 112 S. Ct. 2791, 2806 (1991).

87. Rubenfeld, supra note 80, at 784.
88. Id.
89. Id. at 785–87.
90. Id. at 795. For an explanation of the doctrinal differences between physician-assisted suicide and "ordinary" suicide, see id. at 794–96.
91. See, e.g., Bowers v. Hardwick, 478 U.S. 186, 189 (1986) (finding that state laws prohibiting sodomy are constitutional). Yet Bowers' narrow interpretation of privacy principles does not reject or abolish the already considerable case law. The court merely declined to extend constitutional protection to the specific conduct of homosexual sodomy. Id. at 190–92. As one commentator argues, "a decision to draw the line here is nothing more than a judgment that this particular activity is either less fundamental or more unsavory than the activities protected in prior cases." Rubenfeld, supra note 80, at 747 (emphasis in original).
93. See supra note 58 and accompanying text.
C. State Interest in Prohibiting Physician-Aid-in-Dying

Once a right is recognized as constitutional, a court must then proceed to balance personal liberty interests against countervailing state interests. This is the second step in reconciling an alleged Due Process violation. Four state interests have been identified in right to die cases: (1) the preservation of life, (2) the protection of innocent third parties, (3) the maintenance of the ethical integrity of the medical profession, and (4) the prevention of suicide.

1. The State Interest in the Preservation of Life—The seminal case of Karen Ann Quinlan recognized that the interest in preserving the life of a patient weakens as the degree of bodily intrusion increases and the possibility of recovery decreases. Balancing the interests at stake requires a court to weigh the value of life in and of itself against the quality of the individual’s life, where continued treatment will prolong a painful existence brought on by disease. Although this appraisal might be more sympathetic to a patient suffering from a terminal illness, the rationale for overcoming the state interest is equally appropriate for non-terminal cases.

Proponents of the absolute sanctity of life frequently maintain that patients who request judicial endorsement of their right to die demand quality of life determinations, and that such determinations are contrary to autonomous decision making by the patient. In Cruzan, Chief Justice Rehnquist stated that "a State may properly decline to make judgments about the 'quality' of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of life."
human life to be weighed against the constitutionally protected interests of the individual."\textsuperscript{101} The Chief Justice failed, however, to appreciate the difference between a state's estimation of an individual's life and its simple respect for a patient's quality of life decision. The former threatens liberty interests. The latter, by contrast, shows the utmost deference to the belief that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body . . . ."\textsuperscript{102} It is for the patient as rights-bearer to judge whether continued existence will "demean or degrade" her humanity.\textsuperscript{103}

2. \textit{The State Interest in the Protection of Innocent Third Parties}—When an individual's conduct poses a harm to innocent third parties, the state's interest in intervening to protect these innocent lives is manifest.\textsuperscript{104} At one time, this state interest operated as an absolute restraint on the liberty of an adult who was the parent of a minor child. A decision by a parent or guardian which might orphan a child was impermissible.\textsuperscript{105} The New York Court of Appeals concluded, however, that although there is "no question that the State has an interest in protecting the welfare of children . . . the patient's right to decide the course of his or her own medical treatment [is] not conditioned on the patient being without minor children . . . ."\textsuperscript{106} The court went on to say that a state cannot prohibit parents from "engaging in dangerous activities because there is a risk that their children will be left orphans."\textsuperscript{107} Thus, even this once insurmountable state interest has proven susceptible to mitigation.

3. \textit{The State Interest in Maintaining the Ethical Integrity of the Medical Profession}—Critics argue that physician aid-in-dying violatives the fundamental tenet of medicine: above all else do no harm.\textsuperscript{108} The Hippocratic Oath, it is argued, stands as a testament to this commitment to beneficence and

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\item \textsuperscript{101} Cruzan v. Director, Missouri Dep't of Health, 497 U.S. 261, 282 (1990).
\item \textsuperscript{102} Schloendorff v. Society of New York Hosp., 105 N.E. 92, 93 (N.Y. 1914) (discussing the proposition that medical treatment without consent constitutes assault).
\item \textsuperscript{103} Brophy, 497 N.E.2d at 635.
\item \textsuperscript{104} Fosmire v. Nicoleau, 551 N.E.2d 77, 81 (N.Y. 1990) (stating that the state can be expected to intervene to protect third parties from an individual's actions, but rarely protects individuals from themselves).
\item \textsuperscript{105} See, e.g., In re President of Georgetown College, 331 F.2d 1000, 1008 (D.C. Cir. 1964); In re Dubreuil, 603 So. 2d 538, 540–41 (Fla. Dist. Ct. App. 1992).
\item \textsuperscript{106} Fosmire, 551 N.E.2d at 83.
\item \textsuperscript{107} Id. at 84.
\item \textsuperscript{108} See Willard Gaylin et al., Doctors Must Not Kill, 259 JAMA 2139 (1988).
\end{itemize}
\end{footnotesize}
non-maleficence. Medical students rarely study the Oath, however, even in the context of ethics courses, and only forty-eight percent of all medical schools include any version of the Oath in graduation exercises. Moreover, the Oath holds little practical guidance for modern medicine. In addition to forbidding physicians from administering lethal medication, the Oath precludes physician participation in abortions or charging every student a fee for medical training. These latter provisions are widely disregarded.

Standing in contrast to the more stringent canons of Hippocrates are the Principles of Medical Ethics adopted by the American Medical Association (AMA). The Principles require a doctor not only to render medical services "with compassion and respect for human dignity," but also to "seek changes" in the law when the law is "contrary to the best-interests of the patient." The AMA guidelines strongly encourage, if not demand, a physician to assist a patient to die if such action medically is indicated and in the patient's best interests.

Perhaps the most compelling evidence comes from medical practitioners themselves. In 1991, attorneys for the Hennepin County Medical Center asked a court to appoint an independent conservator to make medical decisions for eighty-seven patients.

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110. Lawrence K. Altman, Despite Many Shifts, Oath as Old as Apollo Endures in Medicine, N.Y. TIMES, May 15, 1990, at C1.

111. In pertinent part, the Hippocratic Oath reads:

I swear... to teach [the children of my own teacher] this art [of medicine]—if they so desire to learn it—without fee and covenant. . . . I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect. Similarly, I will not give to a woman an abortive remedy.


113. Id.
year-old Helga Wanglie. Mrs. Wanglie was dependent on a ventilator. The hospital sought to remove Mrs. Wanglie from the respirator over the objections of her family. Even in the absence of clear and convincing evidence that Mrs. Wanglie wished to discontinue ventilation, doctors nevertheless sought judicial intervention. In rejecting the hospital's claim, the court held that the testimony from physicians and staff was "unconvincing." This professional inconsistency suggests that federal or state reliance on medical standards in limiting patient autonomy is misplaced.

4. The State Interest in Preventing Suicide—In Cruzan, Chief Justice Rehnquist remarked that "a State is [not] required to remain neutral in the face of an informed and voluntary decision by a physically able adult to starve to death." While the Chief Justice's statement may be interpreted as allowing a bright-line rule against assisted suicide, this Note contends that physician aid-in-dying can be distinguished from Cruzan on two grounds. First, Cruzan is limited to the death requests of a "physically able adult." Even though Nancy Beth Cruzan survived in a persistent vegetative state, at no point did the plurality speak about state prohibitions of assisted deaths in the context of a terminal or severely debilitating disease. A federal cause of action for physician assistance in the death of patients acknowledges the distinction between healthy, physically capable individuals referred to in Cruzan and those who are not. Second, Justice Rehnquist

115. Id. at 3.
116. The court found that "[a]t no time when Helga Wanglie was conscious and able to express her own wishes did any physician or staff member at the Hennepin County Medical Center discuss her treatment preferences with her." Id.
117. Id. at 4. For additional discussions regarding the propriety of futile treatment, see generally Allen J. Bennett, When is Medical Treatment 'Futile'?; 9 ISSUES L. & MED. 35 (1993) (discussing examples of futile cases and the New York State "do not resuscitate" law); Daniel Callahan, Medical Futility, Medical Necessity: The Problem-Without-A-Name, HASTINGS CENTER REP., July--Aug. 1991, at 30 (discussing the bioethical issues involved in futile medical treatment); Lawrence J. Schneiderman et al., Medical Futility: Its Meaning and Ethical Implications, 112 ANNALS INTERNAL MED. 949 (1990) (defining when medical treatment should be considered futile); Sidney H. Wanzer et al., The Physician's Responsibility Toward Hopelessly Ill Patients, 310 New Eng. J. Med. 955 (1984) (discussing recent efforts to define policies on the use of life-sustaining procedures on hopelessly ill patients).
118. Wanglie, No. PX-91-283.
120. Id.
addressed only the issue of self-imposed starvation. Entirely absent from his discussion is the role of physician participation in patient deaths. Any attempt to read *Cruzan*’s specific holding as instructive on every instance of a patient decision to die is far too extreme. The opinion must be read narrowly.

This Note also posits that a federal cause of action for physician aid-in-dying can accommodate *Cruzan*’s unwillingness to approve the practice of suicide. In general, suicides ought to be proscribed; however, when the situation involves a seriously ill or terminal patient, compassion militates against rigid adherence to tradition. The states have already acknowledged this by consistently distinguishing physician-assisted deaths from “ordinary” suicides. Again, the single most important theme emerging from the opinions is the disparity between a healthy, productive life and a life racked with pain and suffering.

II. THE NATURE AND SCOPE OF SECTION 1983

Title 42, section 1983 of the United States Code is the principal vehicle for private citizens to secure constitutionally ensured rights against infringement by states. In fiscal year 1960, only 287 section 1983 suits were filed in or removed to federal district court. By 1985, however, that number had risen to 36,500. It is estimated that section 1983 litigation

121. *Id.*
122. *See infra* Part III.C.
123. *See, e.g.*, Bouvia v. Superior Court, 225 Cal. Rptr. 297, 306 (Cal. Ct. App. 1986) (stating that the patient’s “decision to allow nature to take its course is not equivalent to an election to commit suicide”); Lane v. Candura, 376 N.E.2d 1232, 1233, 1236 (Mass. App. Ct. 1978) (holding that a patient has a legal right to refuse treatment); McKay v. Bergstedt, 801 P.2d 617, 625–27 (Nev. 1990); *In re* Conroy, 486 A.2d 1209, 1224 (N.J. 1985) (stating that “declining life-sustaining medical treatment may not properly be viewed as an attempt to commit suicide”). It is unclear, however, how these courts would address more active intervention, on a level analogous to Kevorkian’s, if a distinction between passive and active conduct by physicians is legislated.
125. *Id.* This figure includes 19,000 cases filed by prisoners.
constitutes over ten percent of the federal court docket.\textsuperscript{126} Congress created section 1983 as a remedy for deprivations of federally protected rights caused by conduct of state officers.\textsuperscript{127} A section 1983 cause of action arises when a person, acting under color of any state statute, ordinance, regulation, custom or usage abridges the rights of any citizen guaranteed by the federal Constitution and laws of the United States.\textsuperscript{128} The statute provides federal relief in three circumstances: (1) where state laws are on their face constitutionally repugnant; (2) where state remedies are inadequate as written to provide full relief; and (3) where state law, as implemented, fails to provide relief.\textsuperscript{129}

A. The History of Section 1983

Section 1983 is a product of the Civil Rights Act of 1871.\textsuperscript{130} Like the Civil War Amendments to the Federal Constitution, section 1983 was enacted to counter the widespread discrimination against blacks in the American South. Originally entitled "An Act to enforce the Provisions of the Fourteenth Amendment to the Constitution of the United States, and for other Purposes,"\textsuperscript{131} the statute was Congress' method of controlling the "campaign of violence and deception . . . fomented by the Ku Klux Klan . . . ."\textsuperscript{132} Given this backdrop, the courts have consistently advanced the broad remedial power of section 1983.\textsuperscript{133} While the Civil Rights Acts of 1871 and 1964 primarily addressed concerns of racial discrimination, neither act has ever been construed so narrowly. To the contrary, any

\textsuperscript{130} Ch. 22, 17 Stat. 13 (1873).
\textsuperscript{131} Id.
violation of constitutional or statutory rights, including but not limited to discrimination because of race, color, religion, or national origin is a satisfactory basis for a section 1983 claim.\textsuperscript{134} As stated in \textit{Mitchum v. Foster}: “The very purpose of § 1983 [is] to interpose the federal courts between the States and the people, as guardians of the people’s federal rights—to protect the people from unconstitutional action under color of state law, ‘whether that action be executive, legislative, or judicial.’”\textsuperscript{135}

\section*{B. The Elements of a Section 1983 Cause of Action}

A section 1983 claim can only be pursued when the deprivation of constitutional rights is attributable to a person acting under color of state law.\textsuperscript{136} The Supreme Court has interpreted “under color of state law” to mean any abuse of authority vested in an individual by virtue of state law and exercised in his capacity as a state official.\textsuperscript{137} Section 1983 relief is unavailable when the alleged discrimination or deprivation is the result of purely private conduct.\textsuperscript{138} A private, non-state officer or employee who acts in concert with a state agent to bring about the alleged unlawful activity may nevertheless be implicated in illicit section 1983 conduct.\textsuperscript{139} Since the Eleventh Amendment generally bars suits against state governments in federal courts,\textsuperscript{140} federal intervention is

\textsuperscript{134} See Scher v. Board of Educ., 424 F.2d 741, 743 (3d Cir. 1970); Bonanno v. Thomas, 309 F.2d 320, 321 (9th Cir. 1962); Nanez v. Ritger, 304 F. Supp. 354, 356 (E.D. Wis. 1969).

\textsuperscript{135} 407 U.S. 225, 242 (1972) (quoting \textit{Ex parte Virginia}, 100 U.S. 339, 346 (1879)).


\textsuperscript{138} Duzynski v. Nosal, 324 F.2d 924, 930 (7th Cir. 1963); Spampinato v. M. Breger & Co., 270 F.2d 46, 49 (2d Cir. 1959), cert. denied, 361 U.S. 944 (1960); see also District of Columbia v. Carter, 409 U.S. 418, 424–25 (1973) (noting that section 1983 does not provide relief against private or federal actions).


\textsuperscript{140} U.S. CONST. amend. XI. The Amendment reads: “The Judicial power of the United States shall not be construed to extend to any suit in law or equity, commenced or prosecuted against one of the United States by Citizens of another State,
only permitted when a claim is against culpable state officers.\textsuperscript{141} State prosecutors who are charged with enforcing state laws are appropriate section 1983 defendants.\textsuperscript{142}

The Supreme Court has recognized that state officials need some level of immunity from section 1983 lawsuits.\textsuperscript{143} Immunity reflects the notion that absent bad faith it would be unjust to subject an individual officer to liability merely because of his position.\textsuperscript{144} Two species of immunity are identified by the courts: absolute and qualified. Absolute immunity against damages actions predicated on official actions is extended to those who perform presidential,\textsuperscript{145} legislative,\textsuperscript{146} judicial,\textsuperscript{147} and prosecutorial\textsuperscript{148} functions. Those officers not qualifying for the above immunity have been provided a qualified "good faith" immunity defense. The controlling test for granting this defense focuses on whether the official's discretionary conduct violated "clearly established statutory or constitutional rights of which a reasonable person would have known."\textsuperscript{149}
Where a section 1983 suit seeks relief in the form of monetary damages, state prosecutors performing quasi-judicial functions are afforded absolute immunity. This immunity, however, does not extend to suits seeking injunctive relief.

C. The Potential Obstacles Confronting a Section 1983 Suit for Physician Aid-in-Dying

In recent years, the Supreme Court has imposed additional burdens for remedying constitutional violations under section 1983. First, in an effort to distinguish due process from traditional tort principles, a section 1983 victim must demonstrate that the rights violation was not the result of mere negligence. A valid section 1983 cause of action arises only when it is alleged that a state government or its agents acted intentionally. In the context of physician aid to an ailing patient, this requirement is easily satisfied. The very act of criminalizing suicide-assistance conduct is the result of a conscious decision by both legislators in codifying and prosecutors in enforcing the law. The goal of state laws against physician aid-in-dying is to directly interfere with, if not suspend outright, the liberty of a patient. The intentionality requirement is therefore manifest in the state prohibitions.

A second limitation on section 1983 claims is the condition that a plaintiff exhaust state post-deprivation remedies when the allegedly unconstitutional conduct is random, that is, not caused by established procedures. If a state otherwise provides adequate post-deprivation compensation, a plaintiff may be denied federal relief. This standard was first articulated in Parratt v. Taylor. In Parratt, a Nebraska inmate filed a section 1983 claim alleging that the negligent denial of a $23.50 hobby kit by prison officials constituted a deprivation of property, and thus

151. Supreme Court of Virginia v. Consumers Union, 446 U.S. 719, 736–37 (1980); see infra notes 175–84 and accompanying text.
a violation of due process. The Supreme Court held that the prisoner failed to establish a colorable section 1983 claim. The Court decided that a meaningful pre-deprivation hearing by a state is impracticable when the property deprivation is the result of a “random and unauthorized” act by a state agent. The existence of post-deprivation procedures for the reimbursement of the lost property was all the process due Parratt.

In the years since, there has been much debate both in the high court and the lower courts over the parameters of Parratt. A brief survey of subsequent, related cases helps to clarify the implications for section 1983 suits in physician aid-in-dying. In Logan v. Zimmerman Brush Co., the Court found that Parratt’s endorsement of post-deprivation remedies did not apply to situations where the property deprivation is the result of an established state procedure. The Court’s distinction parallels the requirement in section 1983 suits that the injurious conduct be in an official, rather than personal, capacity.

After Logan, the issue became whether Parratt’s analysis was equally germane to intentional, rather than negligent, property deprivations. The Court in Hudson v. Palmer found that such a distinction was unfounded. Reiterating its position in Logan, the Court emphasized that the controlling issue in Parratt was the State’s ability to provide a pre-deprivation hearing, not the negligence or intent accompanying the deprivation conduct.

The most recent controversy, one more on point for physician

155. Id. at 529-31.
156. Id. at 539-41.
157. Id. at 543-44.
158. 455 U.S. 422 (1982).
159. Id. at 435-36. In distinguishing Parratt from the case at bar, the Court noted “Parratt . . . was dealing with a ‘. . . random and unauthorized act by a State employee. . . . [and was] not a result of some established State procedure.’” Continuing, the Court concluded that Parratt “was not designed to reach . . . a situation” where the deprived right is the product of state policy. Id. (quoting Parratt, 451 U.S. at 436).
160. See supra Part II.B.
162. Id. at 533. The Court stated: “We can discern no logical distinction between negligent and intentional deprivations of property insofar as the ‘practicability’ of affording pre-deprivation process is concerned. The state can no more anticipate and control in advance the random and unauthorized intentional conduct of its employees than it can anticipate similar negligent conduct.” Id.
163. Id. at 534.
aid-in-dying, is whether *Parratt* encompasses liberty, as well as property, deprivations.

The Supreme Court attempted to answer this question in *Zinermon v. Burch*. There, a medicated and allegedly disoriented hospital patient authorized his own commitment to a Florida State mental institution. The patient subsequently brought a section 1983 suit against the physicians, administrators, and staff members at the hospital contending that, because at the time of his "voluntary" admission he was incompetent to give the required informed consent, his admission violated his constitutional liberty. Relying on *Parratt* and *Hudson*, the hospital argued that the patient's complaint was facially deficient because it alleged only a "random, unauthorized violation" of state regulations by the hospital staff.

The Court rejected the hospital's defense, concluding that since the state specifically delegated liberal authority to the hospital to admit patients to mental institutions and thereby deprive those patients of substantial liberty, the hospital's use of that authority was neither random nor unauthorized. Ironically, the Court also rejected the patient's argument that a deprivation of liberty is qualitatively different from a deprivation of property.

Despite these efforts to clarify *Parratt*, *Parratt*'s applicability to a federal cause of action for physician aid-in-dying remains questionable. As *Zinermon* confirmed, *Parratt*'s due process treatment does not extend to established state practices. Numerous lower courts have interpreted *Zinermon* as compelling the meticulous scrutiny of a state's "random and unauthorized" defense. It thus appears that state post-deprivation

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165. *Id.* at 114–15.
166. *Id.* at 115.
167. *Id.* at 138.
168. *Id.* at 132. The Court stated that "[w]e . . . do not find support in precedent for a categorical distinction between a deprivation of liberty and one of property." *Id.* (citations omitted). The Court maintained that "where the State is truly unable to anticipate and prevent a random deprivation of a liberty interest" the application of the *Parratt* rule is not automatically precluded by the nature of the interest. *Id.* at 132. However, the Court conveniently overlooked Justice Blackmun's concurring opinion in *Parratt*, which specifically noted that the principles motivating a post-deprivation remedy for an inexpensive hobby kit do not lend themselves to the more substantive considerations of life or liberty. *Parratt*, 451 U.S. at 541 (Blackmun, J., concurring).
remedies will only satisfy due process concerns when the conduct questioned under section 1983 is truly unforeseeable.\textsuperscript{170}

Laws against physician aid-in-dying are certainly exempt from the \textit{Parratt} standards, since codified criminal proscriptions are part of a state's policy, and neither random nor unauthorized.\textsuperscript{171} Under section 1983, actions of state employees are attributable to a state if those actions conform to a state's expressed policy.\textsuperscript{172} Finally, if \textit{Parratt} is read as protecting due process through post-deprivation remedies for constitutionally illicit state policies, then \textit{Parratt} is fundamentally at odds with \textit{Monroe v. Pape}.\textsuperscript{173} Such an interpretation would strain \textit{Parratt} and its subsequent treatment beyond reason. \textit{Monroe}'s meaning is plain: deprivation of a constitutional right without prior procedures for comment or protest violates due process.\textsuperscript{174} Unless and until \textit{Monroe} is overturned, the Court should not disturb the substantive guarantees that have been in place for more than three decades.

\textbf{D. Section 1983 Implications for Physician Aid-in-Dying}

This portion of the Note explores two potential classes of defendants in section 1983 suits initiated by patients in redressing physician aid-in-dying: state prosecutors and hospitals.

\textit{1. State Prosecuting Attorneys—}A patient's section 1983 suit against a prosecuting attorney would seek to estop the criminal prosecution of a physician who facilitates the death of a patient. The strength of this preemptive strategy is derived from the landmark decision of \textit{Ex parte Young}.\textsuperscript{175}

\begin{enumerate}
\item \textsuperscript{170} Easter House v. Felder, 910 F.2d 1387, 1402 (7th Cir. 1990) (en banc), cert. denied, 498 U.S. 1067 (1991).
\item \textsuperscript{171} See supra notes 153–69 and accompanying text.
\item \textsuperscript{172} Pembaur v. City of Cincinnati, 475 U.S. 469, 477–79 (1986); Monell v. New York City Dep't of Social Servs., 436 U.S. 658, 694 (1978).
\item \textsuperscript{173} 365 U.S. 167 (1961); see Vail v. Board of Educ., 706 F.2d 1435, 1454–55 (7th Cir. 1983) (Esbach, J., concurring) (discussing the conflict between \textit{Parratt} and \textit{Monroe}).
\item \textsuperscript{174} Monroe v. Pape, 365 U.S. 167, 169–72 (1961) (finding that petitioners present a solid claim under section 1983 where their home is searched and one is arrested without warrants regardless of post-deprivation remedies available through state law).
\item \textsuperscript{175} 209 U.S. 123 (1908).
\end{enumerate}
issue in Young was whether then Attorney General for the State of Minnesota, Edward T. Young, could be enjoined from enforcing a Minnesota law regulating railroad transit rates held to be unconstitutional.\footnote{Id. at 148–49.} Young's defense rested with the Eleventh Amendment's prohibition of lawsuits against a state by a private citizen.\footnote{Id. at 149.} Young maintained that any action against his person as Attorney General was, in effect, an action against the State of Minnesota, and thus violative of the Eleventh Amendment.\footnote{Id. at 159.}

The Supreme Court resoundingly rejected Young's argument. The Court attributed its decision to a line of cases dating back to 1824.\footnote{Id. at 149.} Justice Peckham best summarized the essence of the precedent by declaring:

> [I]ndividuals who, as officers of the State, are clothed with some duty in regard to the enforcement of the laws of the State, and who threaten and are about to commence proceedings, either of a civil or criminal nature, to enforce against parties affected an unconstitutional act, violating the Federal Constitution, may be enjoined by a Federal Court of equity from such action.\footnote{Id. at 150–55.}

Such lawsuits filed against state officers are not precluded by the Eleventh Amendment.

The Court specifically considered the appropriateness of injunctive relief against a state official.\footnote{Id. at 155–56.} Young claimed that because the Minnesota Attorney General had no statutory duty to enforce the law in every instance, the Court was not permitted to "control him as Attorney General in the exercise of his discretion."\footnote{Id. at 152–60.} Again the Court was unpersuaded. Although agreeing with the general proposition that courts are not to interfere with legitimate prosecutorial discretion, the Court held that there is no impermissible interference when an officer is merely enjoined from enforcing an unconstitutional
Where there is a conflict between state and federal laws, a state cannot claim immunity to protect its officers from suit. The ramifications for physician aid-in-dying are clear. *Young* and its progeny stand for the proposition that Eleventh Amendment concerns are not implicated in suits against state officers, including state prosecutors. Like Edward T. Young, Michigan prosecutor John O'Hair and his counterparts across the country are responsible in their official capacity for prosecuting those who violate laws outlawing assisted suicide. In this context, injunctive relief is appropriate as it would both prevent the enforcement of unconstitutional state laws and preserve patients' federal rights.

A more difficult question is whether state prosecutors, even in the absence of absolute immunity, are qualifiedly immune from section 1983 litigation. The case law is unclear. In *Mitchell v. Forsyth*, the Supreme Court reconsidered the standard for qualified immunity originally articulated in *Harlow v. Fitzgerald*, namely that government officials are not liable for civil damages "insofar as their conduct does not violate clearly established statutory or constitutional rights of which a reasonable person would have known." The Court emphasized that *Harlow* does not, and should not, immunize state officers when "an official could be expected to know that his [sic] conduct would violate statutory or constitutional rights..." The *Harlow* rule both liberalizes and restricts relief under section 1983. While qualified immunity allows courts to define narrowly the class of persons entitled to absolute immunity and thereby increase the number of possible defendants against whom a plaintiff could file a section 1983 suit, plaintiffs are not at liberty to subject officials to litigation for every perceived encroachment. As *Harlow* noted, the failure to recognize immunity for good-faith performance of duty where appropriate is costly.

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183. *Id.* at 159. (noting that "[a]n injunction, to prevent [an officer] from doing that which he has no legal right to do is not an interference with the discretion of an officer").
184. *Id.* at 159–60.
187. *Id.* at 818.
distract officials from their governmental duties, inhibit prosecutorial discretion, and deter citizens from entering public service.\(^\text{190}\)

A common misconception limits Harlow's efficacy. In some courts, qualified immunity has presented an insurmountable obstacle to plaintiffs seeking section 1983 relief. In Benson v. Allphin,\(^\text{191}\) for example, the United States Court of Appeals for the Seventh Circuit upheld the qualified immunity of the Director and Assistant Director of the Illinois Department of Revenue against an allegation of wrongful termination stemming from comments made by an employee. Although purporting to view the evidence in a light most favorable to the plaintiff, the court decided it was not clearly established that the actions of the defendants violated plaintiff's First Amendment rights.\(^\text{192}\) The court attempted to apply the Harlow analysis, but discovered that it did not adequately define "clearly established statutory or constitutional rights," the pivotal phrase affording qualified immunity.\(^\text{193}\) More specifically, the Benson court found significant ambiguity regarding the courts whose decisions may establish "clearly established" constitutional rights.\(^\text{194}\) The majority expressed reservations about an exclusive focus on Supreme Court jurisprudence, given the infrequency with which that Court hears cases on the issue.\(^\text{195}\) Moreover, the court went on to question the belief that any issue of law dependent on a balancing test can ever be "clearly established."\(^\text{196}\) Ultimately, the Court resolved the immunity issue through a balancing of the countervailing interests.\(^\text{197}\)

Benson illustrates the improper application of Harlow. First, Harlow is a rights-based approach. It explicitly requires a court to focus on the allegedly deprived right. Benson, however, subordinates the plaintiff's claimed liberty to an investigation of the defendants' conduct.\(^\text{198}\) The court noted that at oral argument the defendants conceded that evidence amply demonstrated that their actions were motivated by

\begin{enumerate}
\item Id. at 814, 816.
\item 786 F.2d 268 (7th Cir. 1986), cert. denied, 479 U.S. 848 (1986).
\item Id. at 277–78.
\item Id. at 275.
\item Id.
\item Id.
\item Id. at 276.
\item Id.
\item Id.
\end{enumerate}
plaintiff's exercise of his First Amendment rights.\textsuperscript{199} The court paid little attention to this admission. Second, since qualified immunity is an affirmative defense, it is the defendant who must bear the evidentiary burden. This burden of proof requires that the defendant, not the plaintiff, demonstrate by a preponderance of the evidence that the constitutional right alleged to have been deprived is not "clearly established." A plaintiff, therefore, should enjoy a presumption that the rights violated are explicitly constitutional. Benson, however, denied relief because the plaintiff had not clearly demonstrated a denial of a constitutional right. Accordingly, Benson's approach is inconsistent with Mitchell v. Forsyth.\textsuperscript{200}

In Mitchell, the United States Supreme Court declared that Harlow's authority is predicated on a recognition that the public interest is best served when an official's duties are exercised in instances where clearly established rights are not implicated.\textsuperscript{201} The public interest is not served when officials act upon rights whose constitutionality is in question. As Harlow suggests, when a prosecutor has doubts about the constitutionality of the rights to be infringed, she should be made to hesitate.\textsuperscript{202} Thus, in a jurisprudence inclined, if not devoted, to the protection of federal rights, state officials accused of unlawful deprivation of constitutional rights must bear the burden of justifying their actions. To require plaintiffs to prove that a right is "clearly established" when they may be in the process of asking a court to answer that very question undermines the function of section 1983.

2. Hospitals—Hospitals, public and private, may be vulnerable to section 1983 suits. Medical facilities owned and managed by a state have long been recognized as proper defendants in claims of federal rights deprivations.\textsuperscript{203} The potential liability of private hospitals is more questionable.\textsuperscript{204}

\textsuperscript{199} Id. at 276–77.
\textsuperscript{200} 472 U.S. 511 (1985).
\textsuperscript{201} Id. at 525.
\textsuperscript{202} Harlow v. Fitzgerald, 457 U.S. 800, 819 (1982).
\textsuperscript{203} See, e.g., Wofford v. Glynn Brunswick Memorial Hosp., 864 F.2d 117, 118 (11th Cir. 1988); Tarabishi v. McAlester Regional Hosp., 827 F.2d 648, 651–52 (10th Cir. 1987); Downs v. Sawtelle, 574 F.2d 1, 6–9 (1st Cir.), cert. denied, 439 U.S. 910 (1978); Spence v. Staras, 507 F.2d 554, 557 (7th Cir. 1974); Meredith v. Allen County War Memorial Hosp. Comm'n, 397 F.2d 33, 35 (6th Cir. 1968).
\textsuperscript{204} Compare Ruffler v. Phelps Memorial Hosp., 453 F. Supp. 1062 (S.D.N.Y. 1978) (finding that a private hospital was a state actor because it performed public function) \textit{with} Harvey v. Harvey, 949 F.2d 1127 (11th Cir. 1992) (finding that a private hospital was not a state actor because its conduct failed to satisfy public
Since section 1983 relief is generally not available against individuals who act in a personal rather than official capacity, a similar limitation is imposed on entities. Yet, there is ample evidence to the contrary.205

Courts hearing the issue of hospital liability usually concentrate on the receipt of public financial support. The most common source of federal funding to private hospitals is in the form of Hill-Burton programs.206 The Hill-Burton finances provide public and not-for-profit private medical centers with funds for construction or renovation of facilities. Some federal circuit courts have held that receipt of Hill-Burton funds by a private hospital may establish a sufficient state connection to be considered action under "color of state law" for section 1983.207 This stems from the fact that to qualify for the federal program, the state within which the hospital is located must submit a comprehensive plan justifying the expansion and detailing state mechanisms for enforcing minimum standards of care and operation.

A more tenable justification for holding private hospitals liable "under color of law" is the influence of state regulatory and statutory measures. At least one federal court has had the opportunity to consider the issue. In Doe v. Charleston Area function, state compulsion, or nexus/joint action tests). The "public function" theory of imputing state action to private hospitals is consistent with the Supreme Court's treatment of other private actors. See, e.g., Flagg Bros., Inc. v. Brooks, 436 U.S. 149, 157–66 (1978) (holding that the actions of a private actor are attributable to the state only if those actions are traditionally held exclusively by the state or the state compels the action); Jackson v. Metropolitan Edison Co., 419 U.S. 345, 350–51 (1974) (asserting that a private actor may be treated as a state actor where nexus between state and private actions is sufficiently close).

205. See, e.g., Chiaffitelli v. Dettmer Hosp., Inc., 437 F.2d 429 (6th Cir. 1971) (finding that where members of a hospital's board of directors, under the hospital's charter, were responsible to the public, the hospital's conduct constituted state action); Eaton v. Grubbs, 329 F.2d 710 (4th Cir. 1964) (finding that where a purely private hospital's deed contained a reverter clause permitting the city or county to convert building for other purposes, the hospital's conduct is controlled sufficiently by the state to be considered state action); Sokol v. University Hosp., Inc., 402 F. Supp. 1029 (D. Mass. 1975) (finding state action where hospital accreditation process integrated state and federal licensing).


Physician Aid-in-Dying  

Medical Center, Inc. (CAMC), 208 a twenty-one year-old unmarried student brought a section 1983 class action suit alleging that the hospital’s prohibition of all but emergency abortions amounted to State actions for the assessment of the rights deprivation. Although the plaintiff succeeded in finding a physician with staff privileges at the hospital willing to perform the previability abortion, the Charleston Area Medical Center refused. The District Court denied the plaintiff’s complaint on the grounds that she had failed to establish irreparable harm. The Fourth Circuit reversed. Finding that the hospital’s policy on abortion “faithfully followed” the West Virginia criminal abortion statute, the court concluded that such compliance established a sufficiently close nexus between the state and the hospital to be treated as state action. 209

The court relied on Adickes v. S.H. Kress & Co. 210 for the review of the hospital’s policy. The Adickes standard for determining if an act is done “under color of law” requires a showing of two facts: (1) the existence of a state-enforced custom; and (2) that the private actor was motivated by that state-enforced custom. 211 This standard is relevant to physician aid-in-dying. At its most rudimentary level, state action may be imputed to private conduct when such conduct is compelled by state law. 212 The court went on to say that state regulation need not reach the level of compulsion “to clothe what is otherwise private conduct with ‘state action.’” 213

In resolving the further issue of irreparable injury, the Court held in accordance with Roe v. Wade 214 and Doe v. Bolton 215 that denial of a first-term abortion violated the right to be let alone and could cause psychological trauma. 216

The Fourth Circuit’s interpretation of the West Virginia abortion statute and its effect on private hospitals provides

208. 529 F.2d 638 (4th Cir. 1975). But see Greco v. Orange Memorial Hosp. Corp., 513 F.2d 873 (5th Cir. 1975) (concluding that where private hospital’s board of directors had exclusive control over medical policy, state action could not be implicated in the performance or nonperformance of elective abortions, even though hospital leased premises from county).
209. CAMC, 529 F.2d at 645.
211. Id. at 173–74.
212. CAMC, 529 F.2d at 643–44.
213. Id. (quoting Simkins v. Moses H. Cone Memorial Hosp., 323 F.2d 959 (4th Cir. 1963), cert. denied, 376 U.S. 938 (1964)).
216. CAMC, 529 F.2d at 644.
some insight on the issue of physician aid-in-dying. In many ways, the problems are indistinguishable. Like the young woman in CAMC, Thomas Hyde and Dr. Ali Khalili were able to enlist Jack Kevorkian, but were prevented from carrying out their plans in a hospital setting because of state laws. The coercive effect of the West Virginia abortion statute on private hospitals is directly analogous to hospital policies prohibiting the active assistance of patient suicides by doctors. The Fourteenth Amendment ramifications cannot be easily dismissed.

III. PUBLIC POLICY IMPLICATIONS OF PHYSICIAN AID-IN-DYING

A comprehensive evaluation of a section 1983 cause of action for physician assistance in patient deaths necessarily entails an examination of the likely effects on public policy.

A. Federal Involvement Eliminates Disparity Among the States

In *Cruzan*, Justice O'Connor argued that the authority to protect individual liberty interests in the context of life-saving or life-ending medicine should be delegated to the laboratory of the states. In the time since *Cruzan*, opponents of physician aid-in-dying have argued that Justice O'Connor's advice manifests a desire by the Court not to encourage federal initiatives. This assumption, however, is incorrect. Justice O'Connor's admonition is viewed more accurately as an indication of the Court's continued concern for principles of federalism and an appreciation of a lack of state consensus on the issue of physician aid-in-dying. It does not, as some

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contend, stand for a blanket prohibition of federal involvement. Indeed, Justice O'Connor's opinion emphasizes that *Cruzan* is only applicable to the practices of one state, and specifically to the procedures for safeguarding the rights of incompetent patients. Justice O'Connor does not speak to decisions by rational and fully competent individuals to end a painful existence.

In this light, this Note maintains that *Cruzan* does not govern the discussion of a federal claim for physician assistance in patient deaths. The Court's history is replete with rulings which establish the federal parameters for novel rights. Physician aid-in-dying deserves similar consideration.

Judicial uncertainty over the constitutionality of physician action to hasten patient deaths has resulted in a series of conflicting state decisions. In practice, the strength of a patient's interest is largely dependent upon the jurisdiction hearing the case. The right-to-die cases are illustrative of the schizophrenic nature of state holdings. Some parties will be successful, while others similarly situated will not, leading to the conclusion that the disparate impact in the laboratory of the states is unfair. It is also antithetical to federal rights jurisprudence. A federal alternative is entirely consistent with Congress' prerogative to protect against deprivations of constitutional rights.


221. *Id.*

222. See supra notes 49–55 and accompanying text.


226. The incidence of travel by women from states prohibiting abortions to states permitting abortions in the years preceding *Roe* is enlightening. In 1972, approximately 44% of all legal abortions performed in the United States involved women who were not residents of the state where the abortion was performed. NANETTE J. DAVIS, FROM CRIME TO CHOICE—THE TRANSFORMATION OF ABORTION IN AMERICA 228 (1985). By contrast, two years after *Roe*, that number had decreased to 13.4%. *Id.* Although similar statistics do not exist for people who travel to states which do not criminalize the practice of physician aid-in-dying, at least one of Kevorkian's "patients," Dr. Ali Khalili, traveled from Illinois to Michigan to retain Kevorkian's services. Robert Ourlian, *Tape: Kevorkian's Last Patient Wanted Quick End to His Pain*, DETROIT NEWS, Jan. 23, 1994, at 1C.

227. See supra notes 124–35 and accompanying text.
The patchwork of state laws on physician aid-in-dying should also inspire federal involvement because of the consequences for interstate commerce. The discussion of this issue deserves more analysis than this Note is able to allocate. In the context of abortion, one commentator observed that state methods which bar women from seeking the refuge of a state which offers easier access to abortion are "repugnant" to the commerce clause.\(^{228}\) State laws that interfere with the movement of citizens of the United States from one state to another because their activities are morally contested are impermissible.\(^{229}\) The right to unimpeded interstate travel is fundamental.\(^{230}\) This Note borrows much of its opinion on the interplay between physician aid-in-dying and the interstate commerce clause from that commentator's comparable thoughts on abortion. Laws obstructing the travel of patients from states criminalizing physician aid-in-dying to states which do not conflict with the precepts of the commerce clause, and thus warrant federal protection.

### B. A Federal Cause of Action for Physician Aid-in-Dying Comports with Standing Requirements

Generally, for a plaintiff to establish a cognizable claim for federal court review, three requirements must be satisfied. First, a plaintiff must allege that he suffered or will suffer an injury. Second, a plaintiff must prove that the injury inflicted is fairly traceable to defendant's conduct. Third, a plaintiff must allege that a favorable court verdict will redress the injury sustained.\(^{231}\) In addition to these three basic elements, the Supreme Court has identified a series of supplemental


\(^{229}\) \textit{Id.} (citing Jones v. Helms, 452 U.S. 412 (1981)).


principles limiting standing. Most relevant in this instance is the requirement that a party assert only his rights and not those of a third party.

Patients who wish to avail themselves of physician assistance in their deaths have sufficient personal concern in the controversy to justify litigation. Implicit in Cruzan's distrust of surrogate decision making in the withdrawal of lifesaving treatment is the notion that a surrogate is inherently unable to exercise the patient's "personal" choice. Absent evidence of the patient's desires, the Court was reluctant to immunize substituted judgment from the reach of state police power. The recognition by the Court that the resolution to die is deeply personal illustrates the continued relevance and influence of standing.

The standing criteria creates other interesting implications for active assistance by doctors in patient deaths. Of the individual elements, proof of injury may be the most onerous burden imposed on a patient seeking injunctive relief. Few courts have held that a law which results in the continued existence of a person is a harm justiciable by the federal judiciary.

The imminence of the injury may also bar standing. Because state prosecutors may decide in their discretion not to prosecute a physician who assists in a patient's death, the state may argue that there was no injury in fact. In City of Los Angeles v. Lyons, the Supreme Court determined the appropriateness of injunctive and declaratory relief against the Los Angeles Police Department (LAPD) for the use of "chokeholds" in arrests where the victim does not threaten

233. Id. at 499.
234. Cf. Baker v. Carr, 369 U.S. 186, 204 (1962) (holding that a plaintiff must show "such a personal stake in the outcome of the controversy as to assure that concrete adverseness which sharpens the presentation of issues upon which the court so largely depends for illumination of difficult constitutional questions").
236. Id. at 284.
237. Compare Commissioner of Correction v. Myers, 399 N.E.2d 452, 453 (Mass. 1979) (ordering prison inmate to undergo lifesaving hemodialysis treatments to uphold orderly prison administration) with In re Garrett, 547 A.2d 609, 614 (Del. Ch. 1988) (granting a petition seeking guardianship of mentally impaired inmate who refused nourishment, even though the court felt denying the right to starvation to a competent inmate would result in "chilling cruelty").
deadly force.\textsuperscript{239} The Court held that federal courts could not hear Lyons's petition for injunctive relief.\textsuperscript{240} Central to the Court's ruling was its determination that the threat of future injury to Lyons was merely conjectural.\textsuperscript{241} To establish a controversy meriting federal review, the Court said that Lyons would have to prove one of two "incredible assertions," either: (1) that all police officers in the LAPD always employed the chokehold when confronting a citizen or (2) that the city ordered or authorized police officers to use the chokehold in this manner.\textsuperscript{242} Since the LAPD manual did not suggest using chokeholds to combat unresisting arrestees, the Court ruled that the future threat to Lyons's person was not genuine.\textsuperscript{243}

The Lyons rule strikingly is inapplicable to section 1983 suits challenging state interference in physician aid-in-dying. An interpretation of Lyons as precluding constitutional challenges to state laws where a victim can only demonstrate potential future enforcement is fundamentally at odds with Ex Parte Young.\textsuperscript{244} In Young, one of the defenses raised by the State of Minnesota was that prosecutorial discretion safeguarded malicious or unconstitutional enforcement of the laws.\textsuperscript{245} The Court rejected this argument.\textsuperscript{246} Young's reasoning should be dispositive of Lyons's standing requirement as well.

Prosecutorial discretion is immaterial when the law which may be enforced conflicts with the guarantees of the federal constitution.\textsuperscript{247} The Court declared that by virtue of statutory authority, a state attorney general has a duty to enforce the laws of the state.\textsuperscript{248} The Court concluded that the power, duties and function of the attorney general meant that these state officers were properly included as parties to litigation.

\textsuperscript{239} Id. at 97–98. The complaint alleged that Lyons was stopped by members of the LAPD for a traffic or vehicle code violation. At some point during the encounter, the officers seized Lyons and without provocation applied a "chokehold." Lyons lost consciousness as a result of the maneuver and suffered damage to his larynx. Id.

\textsuperscript{240} Id. at 101.

\textsuperscript{241} Id. at 102–03 (finding that past exposure to illegal conduct was evidence of a threat of repeated injury but that the probability of future harm in this case rested on the likelihood of plaintiff's rearrest).

\textsuperscript{242} Id. at 105–06.

\textsuperscript{243} Id. at 110. In fact, the Court went so far as to say "[a]bsent a sufficient likelihood that [Lyons] will again be wronged in a similar way, Lyons is no more entitled to an injunction than any other citizen of Los Angeles . . . ." Id. at 111.

\textsuperscript{244} 209 U.S. 123 (1908).

\textsuperscript{245} Id. at 158; see supra notes 175–79 and accompanying text.

\textsuperscript{246} Young, 209 U.S. at 158–59.

\textsuperscript{247} Id. at 159–60.

\textsuperscript{248} Id. at 161.
Physician Aid-in-Dying under the Fourteenth Amendment.\textsuperscript{249} In light of Young, neither a person nor a physician considering to assist another in dying may be prosecuted. This fact should not deny a plaintiff standing in federal court.

Standing can be easily satisfied within the parameters established by Lyons. The court, in that case, found that a plaintiff could present a justiciable controversy by showing that the city ordered or authorized police officers to act in a manner consistent with the complained of conduct.\textsuperscript{250} By analogy, for a patient to access the federal judiciary, she simply would have to prove that the state gave prosecuting attorneys the authority to prosecute those who violate criminal prohibitions of assisted suicide.

\textit{C. Physician Aid-in-Dying Does Not Constitute State Endorsed Suicide}

At common law, suicide and assisted suicide were crimes.\textsuperscript{251} The justification for including these activities in the penal code stemmed from three sources. First, suicide was thought to be offensive to God\textsuperscript{252} and Biblical teachings.\textsuperscript{253} One result of this belief was the ignominious burial of the victim’s body. Instead of a churchyard, the more frequent practice was to drive a stake through the body and bury the person at the crossroads of a highway.\textsuperscript{254} Second, by depriving the monarchy of a subject, suicide was considered a crime against the Crown.\textsuperscript{255} Third, there was the concern for protecting defenseless persons, including the suicide victim himself.\textsuperscript{256} Those who assisted in the criminal act of suicide were likewise guilty of

\begin{itemize}
  \item \textsuperscript{249} \textit{Id.}
  \item \textsuperscript{250} City of Los Angeles v. Lyons, 461 U.S. 95, 105–06 (1983).
  \item \textsuperscript{251} 4 WILLIAM BLACKSTONE, COMMENTARIES 188–89 (1854).
  \item \textsuperscript{252} \textit{Id.} at 189.
  \item \textsuperscript{253} Hales v. Petit, 75 Eng. Rep. 387, 400 (1565). One of the most comprehensive treatments of suicide as a religious crime can be found in GLANVILLE WILLIAMS, THE SANCTITY OF LIFE AND THE CRIMINAL LAW (1957).
  \item \textsuperscript{254} 4 BLACKSTONE, supra note 251, at 190.
  \item \textsuperscript{255} \textit{Id.} at 189.
  \item \textsuperscript{256} This thought reflects the contemporary notion that those who contemplate suicide are physically or mentally ill and in need of medical assistance, not discipline. Maria T. Celocruz, \textit{Aid-in-Dying: Should We Decriminalize Physician-Assisted Suicide and Physician-Committed Euthanasia?}, 18 AM. J. L. & MED. 369, 375 (1992).
\end{itemize}
a crime. With the independence of America, the appeasement of the monarchy and God as official state policy became impermissible. Thus, the only viable reason for the proscription of suicide today remains the protection of vulnerable persons.

This reasoning is still compelling, as *Cruzan* attests. Nonetheless, the prudence of this policy is questionable when the individual whose life is at issue is competent. Along these lines, one commentator has remarked:

> [T]he state's paternalistic concern evaporates if the suicidal individual is demonstrably rational. Thus, if states can legislate adequate safeguards to ensure the rationality of those who wish to commit suicide, a limited right to suicide and suicide assistance can be granted consistent with the state's historical interest in suicide prevention.

Echoing this argument, one judge has posited that the implementation of regulatory procedures which facilitate rational decisions to die actually might dissuade people from resorting to Kevorkian-type practitioners, and encourage them to receive professional counseling. It would seem, therefore, that the conditions in which a state may exercise legitimately its police power to criminalize assisted suicide depends on the rationality of the decision.

This Note contends that the most salient distinction between rational and irrational decisions to die is the presence of an objectively verifiable terminal or unbearably painful medical condition. Involving a physician, perhaps subject to review by a hospital ethics committee, in the evaluative process should quiet many of the concerns about potential abuse. Many states already acknowledge this distinction.

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258. *CeroCru*, *supra* note 256, at 375-76.
262. The Missouri Supreme Court accurately depicted the landscape within the states in *Cruzan v. Harmon*, 760 S.W.2d 408 (Mo. 1988) (en banc). The court then went on to identify 54 cases in 16 states supporting their conclusion. *Id.* at 412-13 n.4. The court noted that "[n]early unanimously, those courts [of our sister states] have found a way to allow persons wishing to die . . . to meet the end sought." *Id.* at 413. Justice Blackmar's dissent is particularly persuasive. In reference to the cases cited by the majority, he counseled: "Many other judges have struggled with problems
In McKay v. Bergstedt,\textsuperscript{263} for example, the Nevada Supreme Court held that a curable affliction is patently distinguishable from illnesses where the primary issues are "when, for how long and at what cost to the individual [his] life may be briefly extended."\textsuperscript{264} The Bergstedt decision is even more impressive when it is revealed that the Court also believed that the State of Nevada's interest in Bergstedt's life was "compelling and fundamental."\textsuperscript{265} The factual background of the case centered on Kenneth A. Bergstedt, a thirty-one year-old mentally competent quadriplegic. Bergstedt's quadriplegia resulted from a swimming accident at the age of ten. He had lived with his disability for twenty-one years prior to his petition. Bergstedt was also ventilator dependent, his existence indefinitely sustainable. The Court and all parties involved considered him a non-terminal patient.\textsuperscript{266}

Bergstedt had been raised and cared for all his life by his father. Unfortunately, in the years immediately preceding the petition, his father's own health was rapidly declining. Despite his quadriplegia, Bergstedt could read, watch television, and orally operate a computer. However, a life without his father was an unbearable prospect. Bergstedt thus petitioned the Nevada courts asking that they remove his ventilator and to declare his ensuing death not a suicide.\textsuperscript{267} The Nevada Supreme Court granted both of his requests. The court noted that Nevada policy does not require that "every life must be preserved against the will of the sufferer."\textsuperscript{268}

In distinguishing Bergstedt's death from "ordinary suicide," the court considered three factors: the patient's attitude, physical condition, and prognosis.\textsuperscript{269} The court declared that the preservation of life by the state only relates to meaningful life\textsuperscript{270} and that "only the sufferer can determine the value of continuing mortality."\textsuperscript{271}

\begin{thebibliography}{9}
\bibitem{263} 801 P.2d 617 (Nev. 1990).
\bibitem{264} Id. at 623 (alteration in original) (quotations omitted).
\bibitem{265} Id.
\bibitem{266} Id. at 620.
\bibitem{267} Id.
\bibitem{268} Id. at 624 (citation omitted).
\bibitem{269} Id. at 625.
\bibitem{270} Id. at 626.
\bibitem{271} Id. at 624.
\end{thebibliography}
Bergstedt is instructive on the constitutionality of physician aid-in-dying since the plaintiff was both competent and non-terminal. Although it is true that the opinion might be distinguished on the grounds that the hospital’s involvement in his death was merely passive, the logic can be extended easily to more active forms of medical assistance. As the court made clear:

Society had no right to force upon [an individual] the obligation to remain alive under conditions that he considered to be anathema. To rule otherwise would place an unwarranted premium on survival at the expense of human dignity, quality of life, and the value that comes from a natural and timely entrance [of death].272

Yet, Bergstedt is not an isolated example. Of the more than thirty states codifying laws against the assistance, incitement, or solicitation of suicide,273 only three individuals have been convicted between 1920 and 1983.274 In criminal prosecutions
of physicians for assisted suicide, not one doctor has ever been imprisoned. The most recent manifestation of public uncertainty over the criminality of physician aid-in-dying is the May 1994 acquittal of Dr. Jack Kevorkian for facilitating the death of Thomas W. Hyde, Jr., a terminally ill man. Comments made by jurors after the verdict reveal that there is support for the proposition that restrictive state legislation in this area is an impermissible intrusion into patient privacy. The jury also apparently found credible Kevorkian's defense that, at least with respect to legal liability, there is a difference between conduct intended to assist in a suicide and conduct intended to relieve pain but accompanied by death.

CONCLUSION

A federal cause of action for physician aid-in-dying is not the remedy for eliminating patient suffering. It is, however, an instrument through which individuals may, with the assistance of personal clinicians, be offered a comprehensive array of options. This Note maintains that diversity of choice is preferable to one imposed by a state. A federal alternative is therefore well supported by precedent, compassion, and common sense. Motivating this argument is the belief that the deeply personal nature of the implicated liberty and privacy interests accompanying decisions about assisted death should preclude a system predicated exclusively upon plenary state authority. State interests in the welfare of its citizens, though legitimate, are vulnerable to mitigation. As numerous state courts have already observed, when faced with an increasingly grim prognosis, the state's interest becomes secondary to the comfort of the afflicted.

In this light, while states may be permitted, perhaps even encouraged, to regulate physician assistance in patient deaths,

277. Id. at A20. One juror who had cared for her terminally sister and father for 14 years remarked, "I don't feel it's our obligation to choose for someone else how much pain and suffering they can go through." Id.
absolute prohibitions of the practice through criminal sanctions encroach upon the domain reserved to the Federal Constitution. As the primary means of realizing constitutionally-endorsed rights, section 1983 offers patients a unique opportunity to challenge unduly restrictive state laws in federal courts. Until and unless state legislatures take the initiative to devise laws respecting the Fourteenth Amendment's protection of intimately autonomous decision making, federal intervention is necessary to stave off the inevitable crisis of rights in the states. The citizenry of a more perfect union deserve no less.