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PRESCRIPTION FOR DEATH: A SECOND OPINION

Edward J. Larson*

INTRODUCTION

The growing debate over legalizing physician-assisted suicide typically leads to disagreement over the type of patients who would be eligible for it. Proponents often seek to justify legalization by pointing to compelling cases of mentally competent but terminally ill individuals crying out for release from pain through death with dignity.\(^1\) Opponents of legalization counter by questioning how many such cases actually exist, and by raising concerns about its impact on elderly, infirm, and other vulnerable people.\(^2\) The proponents’ perspective clearly controlled the recent ruling in Compassion in Dying v. Washington,\(^3\) in which Federal District Judge Barbara Rothstein held that certain persons have a constitutional right to receive a physician’s assistance in committing suicide.\(^4\) That unprecedented holding, which has excited widespread comment,\(^5\) relied heavily on the compelling circumstances of three individuals\(^6\) to

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* Associate Professor of Law and History, University of Georgia, and Fellow, Discovery Institute; B.A. 1974, Williams College; M.A. 1976, University of Wisconsin-Madison; J.D. 1979, Harvard University; Ph.D. 1984, University of Wisconsin-Madison. The author wishes to thank Yale Kamisar, Bruce Chapman, and John West for their generous advice and encouragement in the preparation of this article.


2. Id.


4. The court concluded that “competent, terminally ill adult[s] ha[ve] a constitutionally guaranteed right under the Fourteenth Amendment to commit physician-assisted suicide.” Id. at 1462. The court went on to find that the statutory ban placed “an undue burden on the exercise of a protected Fourteenth Amendment liberty interest by terminally ill, mentally competent adults acting knowingly and voluntarily, without undue influence from third parties, who wish to commit physician-assisted suicide.” Id. at 1467.


6. The plaintiffs, Jane Roe, John Doe and James Poe were suffering from cancer, AIDS, and
overturn a state law against assisted suicide.7

I. HISTORICAL VALIDITY OF THE LAW

_Compassion in Dying_ involved a Washington State statute that is similar to laws in most American jurisdictions — like most states, Washington does not outlaw suicide or attempted suicide.8 Rather, the law at issue proscribes aiding or causing the suicide of another.9 It provides: "[a] person is guilty of promoting a suicide attempt when he knowingly causes or aids another person to attempt suicide."10

emphysema respectively. Each was competent and had been diagnosed to be in the terminal phase of his disease. Each wished to hasten his death by taking drugs prescribed by his doctor. _Compassion in Dying_, 850 F. Supp. at 1456-57.

7. Id. at 1467.
8. Id. at 1458.
9. WASH. REV. CODE § 9A.36.060(1) (1988). Promoting suicide is a felony punishable by imprisonment for up to five years and a fine of up to $10,000. _Id._ § 20.020 (1)(c). Over thirty states currently outlaw assisted suicide. ALAN MIESEL, THE RIGHT TO DIE, § 3.10, at 60 (Supp. II 1994); see ALASKA STAT. § 11.41.120 (Michie 1993); ARIZ. REV. STAT. ANN. § 13-1103(A)(3) (Supp. 1994); ARK. CODE ANN. § 5-10-104(a)(2) (Michie 1993); CAL. PENAL CODE § 401 (West 1988); COLO. REV. STAT. § 18-3-104 (1)(b) (Supp. 1994); CONN. GEN. STAT. §§ 53a-56 (West 1985); DEL. CODE ANN. tit. 11, § 645 (Michie Supp. 1994); FLA. STAT. ANN. § 782.08 (West 1992); GA. CODE ANN. § 16-5-5 (1994); HAW. REV. STAT. § 707-702 (1987); IND. CODE ANN. § 35-42-1-2.5 (Burns 1994); KAN. STAT. ANN. § 21-3406 (1993); ME. REV. STAT. ANN. tit. 17-A, § 204 (West 1983); MICH. COMP. LAWS § 752.1027 (West Supp. 1994) (stating that the criminal offense of assistance to suicide does not apply to prescribing or administering medications or procedures if the intent is to relieve pain and not to cause death even if the medication or procedure may hasten or increase the risk of death); MINN. STAT. ANN. § 609.215 (West Supp. 1995) (providing that health care workers who administer, prescribe, or dispense "medications or procedures to relieve another person's pain or discomfort," even if it hastens the risk of death, is not considered aiding suicide or aiding attempted suicide as contemplated by the statute unless knowingly administered to cause death); MICH. CODE ANN. § 97-3-49 (1994); MO. ANN. STAT. § 565.023(2) (Vernon Supp. 1994); MONT. CODE ANN. § 45-5-105 (1993); NEB. REV. STAT. § 28-307 (1989); N.H. REV. STAT. ANN. § 630:4 (1986); N.J. STAT. ANN. § 2C:11-6 (West 1982); N.M. STAT. ANN. § 30-2-4 (Michie 1994); N.Y. PENAL LAW § 120.30 (McKinney 1987); N.D. CENT. CODE § 12.1-16-04 (Michie Supp. 1993); OKLA. STAT. tit. 21, §§ 813-18 (West 1983); OR. REV. STAT. § 163.125(1)(b) (1993); PA. STAT. ANN. tit. 18, §§ 2505-06 (1983 & Supp. 1994); TENN. CODE ANN. § 39-13-216 (Michie Supp. 1994); TEX. PENAL CODE ANN. § 22.08 (West 1989); WASH. REV. CODE § 9A.36.060 (1988); WIS. STAT. ANN. § 940.12 (West 1982).

Some states qualify the prohibitions to permit the administration of pain relief, even if such therapy increases the risk or occurrence of death. See, e.g., MICH. COMP. LAWS § 752.1027 (West Supp. 1994) (stating that the criminal offense of assistance to suicide does not apply to prescribing or administering medications or procedures if the intent is to relieve pain and not to cause death even if the medication or procedure may hasten or increase the risk of death); MINN. STAT. ANN. § 609.215 (West Supp. 1995) (providing that health care workers who administer, prescribe, or dispense "medications or procedures to relieve another person's pain or discomfort," even if it hastens the risk of death, is not considered aiding suicide or aiding attempted suicide as contemplated by the statute unless knowingly administered to cause death).

Obviously, this is a broad prohibition. Nothing in the statute focuses on physicians as actors or on the elderly, terminally ill, or those in pain as recipients. It protects all life and discourages suicide without regard to the victim's condition, covering confused teenagers and depressed 40-year-olds, as well as the infirm. Indeed, the statute was enacted long before modern medical technology highlighted the issues of a patient's right to die and physician-assisted suicide. As a practical matter, rather than a philosophical musing, these issues simply did not arise before the current generation because there was so little that a physician could do to forestall death.

Restrictions against assisted suicide were in place in Washington even before the region became a state. The second bill passed by the first territorial legislature for Washington, in 1854, provided, "[e]very person deliberately assisting another in the commission of self-murder, shall be deemed guilty of manslaughter." Throughout the years, Washington has retained similar prohibitions against assisted suicide, and an effort to amend it to allow physician-assisted suicide was defeated by state voters in 1991. The laws restricting assisted suicide manifest a broad public concern for preserving life. More critically, it suggests that the law does not so intrude on "personal rights that can be deemed 'fundamental' or 'implicit in the concept of ordered liberty'" as to violate our constitutionally protected right to privacy, at least as that right is defined in the key

11. The language of the Washington statute provides simply that a person is guilty if he "knowingly causes or aids another person . . . ." Id.
12. Id. In fact, the state claimed that the statute as enacted was designed to promote two primary interests — the prevention of suicide and the protection of those at risk of undue influence of others who would aid them in committing suicide. Compassion in Dying, 850 F. Supp. at 1464. For a discussion of these interests, see infra notes 57-105 and accompanying text.
14. See John E. Ruark et al., Initiating and Withdrawing Life Support, 318 NEW ENG. J. MED. 25 (1988) (stating that one hundred years ago only rudimentary supportive care was available for critically ill patients).
15. 1854 Wash. Laws p. 78, § 17.
17. See Jane Gross, Voters Turn Down Mercy Killing Idea, N.Y. TIMES, Nov. 7, 1991, at B16 (explaining the initiative, voted down by Washington state voters, which would have allowed physicians to assist in the deaths of terminally ill patients who asked to die).
line of decisions running from *Griswold v. Connecticut*¹⁹ to *Roe v. Wade.*²⁰

Simply because the Washington State bar historically has been against physician-assisted suicide does not, in and of itself, make it a good rule. As Oliver Wendell Holmes keenly observed, “[i]t is revolting to have no better reason for a rule of law than that so it was laid down in the time of Henry IV. It is still more revolting if the grounds upon which it was laid down have vanished long since, and the rule simply persists from blind imitation of the past.”²¹ Yet Washington State’s age-old stance against assisted suicide does not run afoul of this dictum. Preserving life and preventing death remain a socially protected, common goal in this country. In its present form, the Washington law reflects the influence of the Model Penal Code,²² which one court recently described as “widely regarded as the greatest criminal law reform project of this century

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¹⁹. 381 U.S. 479 (1965). In *Griswold,* the Supreme Court considered the constitutionality of a Connecticut statute which made it illegal for any person to use contraception or to assist another in the use of contraception. *Id.* at 480. Justice Douglas, writing for a plurality stated that the marital relationship lies “within the zone of privacy created by several fundamental constitutional guarantees,” and that a law banning the use of contraceptives “cannot stand in light of the familiar principle . . . 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.’” *Id.* at 485 (quoting *N.A.A.C.P. v. Alabama*, 377 U.S. 288, 307 (1964)).

In his concurring opinion, Justice Goldberg quoted from an earlier Supreme Court decision to conclude that judges “must look to the ‘traditions and [collective] conscience of our people’ to determine whether a principle is ‘so rooted [there] . . . as to be ranked as fundamental.’” *Id.* at 493 (Goldberg, J., concurring) (quoting *Snyder v. Massachusetts,* 291 U.S. 97, 105 (1937)). Applying a similar test to review the constitutionality of a new state law against assisted suicide, a Michigan appellate court recently concluded that “the right to commit suicide” is neither “implicit in the concept of ordered liberty” nor “deeply rooted in this Nation’s history and tradition.” *Hobbins v. Attorney General,* 518 N.W.2d 487, 492 (Mich. Ct. App. 1994) (citations omitted).

²⁰. 410 U.S. 113 (1973). In *Roe,* the Court considered whether the right of privacy encompassed a woman’s decision whether or not to terminate her pregnancy. *Id.* at 153. The Court held that, because a woman’s right to decide whether or not to terminate a pregnancy is fundamental, the state must have a compelling interest in impinging upon that right. *Id.* at 155-56. The Court found that before the viability of a fetus, the state does not have a compelling interest to overcome the woman’s right of privacy. *Id.* at 156. For a thorough discussion of the *Roe* and *Griswold* line of cases and their constitutional significance, see *Lawrence H. Tribe, American Constitutional Law* § 15-10, at 1337-1362 (2d ed. 1988).


The drafters of the Model Penal Code considered the arguments in favor of de-criminalizing assisted suicide, but ultimately decided to retain the traditional feature of Anglo-American criminal law of preserving life. In the commentary to the Code, the drafters noted that "the interests in the sanctity of life that are represented by the criminal homicide laws are threatened by one who expresses a willingness to participate in taking the life of another, even though the act may be accomplished with the consent, or at the request, of the suicide victim." Indeed, it is difficult to think of a more effective way of discouraging suicide than to stop others from helping the victim. In the past thirty years, following the publication of the Model Penal Code, eight states have passed new statutes specifically outlawing assisted suicide and eleven other states, including Washington, revised their existing statutes. In short, the history of the Washington State law against assisted suicide suggests an original intent and current purpose of discouraging suicide generally. In this respect, it is similar to such statutes in most states, none of which has ever been declared unconstitutional, and differs from Michigan's controversial law against assisted suicide, which recently was enacted to stop one physician from helping terminally-ill patients kill themselves.

Before Judge Rothstein's recent decision in Compassion in Dying, there was no hint in any published judicial opinion that Washington's law against assisted suicide, or others like it elsewhere in America, were unconstitutional. Indeed, contrary to the implications of her decision, the United States Supreme Court in its 1990 deci-

24. See Model Penal Code § 210.5 cmt. 5 (1962) (discussing how the interest in the sanctity of life would be undermined by allowing assisted suicide).
25. Id.
sion involving the right to die, *Cruzan v. Director, Missouri Dept. of Health,*[^28] suggested that laws against assisted suicide were constitutional.[^28] In her decision, Judge Rothstein wrote:

In *Cruzan,* the Supreme Court considered whether a competent person has a constitutionally protected liberty interest in refusing unwanted, life-sustaining medical treatment including artificially delivered food and water essential to life. In his majority opinion, Justice Rehnquist acknowledged that this principle “may be inferred from our prior decisions,” . . . and that “the logic of the cases . . . would embrace such a liberty interest.” . . . He then assumed for the purposes of the case before the Court “that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition.”[^30]

Judge Rothstein went on to inquire “whether a constitutional distinction can be drawn” between the situation in *Cruzan* involving the withdrawal of life-sustaining medical treatment and the case of competent, terminally ill patients who wish to hasten death with a physician’s aid.[^31] “In other words,” she asked, “is there a difference for purposes of finding a Fourteenth Amendment liberty interest between refusal of unwanted treatment which will result in death and committing physician-assisted suicide in the final stage of life?”[^32]

Judge Rothstein failed to note that the *Cruzan* Court all but answered this very question in the negative. Almost immediately following the quoted passage suggesting that patients can refuse treatment, Chief Justice Rehnquist added, “[m]oreover, the majority of States in this country have laws imposing criminal penalties on one who assists another to commit suicide. We do not think a State is required to remain neutral in the face of an informed and voluntary decision by a physically able adult to starve to death.”[^33] This observation suggests that the Supreme Court would uphold a clean bar against assisted suicide, such as Washington’s historic statute. Additionally, the court would likely find a constitutionally meaningful line between a patient’s right to refuse medical treatment and her demand for assistance in committing suicide.

[^29]: See id. at 284 (upholding state law requiring clear and convincing evidence to refuse life-sustaining treatment).
[^31]: Id.
[^32]: Id.
II. EVALUATING THE LIBERTY INTEREST

Beyond the law's untainted legislative history and the total absence of constitutional precedent for Judge Rothstein's holding, current public-policy arguments strongly support the law. Judge Rothstein struck down the Washington statute on the grounds that mentally competent, terminally ill adults wishing to commit physician-assisted suicide have a protected liberty interest under the Fourteenth Amendment of the U.S. Constitution. In *Cruzan*, the Supreme Court noted that individual liberty interests are something less than constitutional rights and must be balanced against competing societal interests to determine whether they prevail. The State of Washington, in its defense of the statute prohibiting assisted suicide, raised two of these societal interests, both of which were twisted by the court.

A. Discouraging Suicide

The first state interest identified in *Compassion in Dying* involved protecting life by preventing suicide. With respect to this interest, the court wrote:

In support of the first interest, prevention of suicide, defendants point to statistics concerning the rate of suicide in Washington among various age groups, particularly the young. Obviously, the State has a strong, legitimate interest in deterring suicide by young people and others with a significant natural life span ahead of them. But this case is not about people for whom suicide would abruptly cut life short. Plaintiffs in this case are people suffering through the final stage of life with no hope of recovery.

It must be stressed, however, that the court struck down the law for everyone, not just the three terminally ill plaintiffs involved in the case. The case failed to indicate the force of the state's suicide

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34. See supra notes 11-20 and accompanying text (detailing the arguments which support the law).
35. *Compassion in Dying*, 850 F. Supp. at 1467.
36. 497 U.S. at 279.
37. The states contended that they have an interest both in preventing suicide and in protecting those at risk of suicide from undue influence from others who would aid them in completing the act. *Compassion in Dying*, 850 F. Supp. at 1464.
38. See infra notes 57-105 and accompanying text (discussing the court's analysis of the societal interests).
40. Id.
41. Judge Rothstein noted that the state's legitimate interest in suicide prevention would not be "abrogated by allowing mentally competent, terminally ill patients to freely and voluntarily com-
statistics. Suicide is a major social concern in both the state of Washington and the country as a whole. Ranking among the top ten causes of death in the United States, with more than 25,000 cases reported annually. In Washington State, suicide takes twice as many lives annually as all infectious diseases and over two-thirds as many deaths as automobile accidents. The state vigorously seeks to combat both of these other causes of death, and logically attempts to discourage suicide as well.

In America, suicide by young people has increased dramatically in recent years, with persons aged 15-to-24 years now committing about 20 percent of all suicides. Indeed, the number of suicides by persons in that age group is nearly as high as all Americans over 50 years of age, who are the presumed target population for physician-assisted suicide. Further, there are twice as many suicides by persons aged 25-to-44 as by senior citizens. These figures are even more dramatic among some ethnic groups, such as Native American, where the suicide rate is over twice as high for youths as for adults and four times higher for youths than for senior citizens. In Washington State, the relative youth of suicide victims is suggested by the state statistic that the average number of years lost by each suicide is over twice that lost by each cancer death.

Advocates of physician-assisted suicide tend to focus on cases involving the elderly, particularly those who are terminally ill. However, the issue is far from simple even in those most compelling cases. According to suicide researcher David Clark, "[t]he major studies all agree in showing that the fraction of suicide victims struggling with a terminal illness at the time of their death is in the
range of 2% to 4%.”50 Even among senior citizens, Clark added, most “were in relatively good physical health when they died by suicide.”51 Further, University of Rochester geriatric psychiatrists Yeates Conwell and Eric Caine recently noted that “90 to 100 percent of the [suicide] victims die while they have a diagnosable psychiatric illness, an observation that is equally true in suicides among the elderly.”52 Such illness typically involves treatable depression.53 Conwell and Caine warned that many physicians are ill-equipped to assess the presence of depressive illness in the elderly population.54 Without this ability, physicians, although well-intentioned, might be influenced by their personal biases about aging, the psychological effects of chronic disease, and dependency, when considering a patient’s wish for assistance in suicide.55 This observation clearly implicates the ruling in Compassion in Dying, which extended the authority to prescribe lethal drugs to all physicians, and not just to those trained in geriatric psychiatry.56

In addressing the state’s concern for protecting life, Judge Rothstein added, “[t]he State’s interest in preventing suicide by prohibiting any manner of assisted suicide in actuality arises out of its apprehension of the ‘slippery slope’ problem. The State is concerned that allowing any exception to a total ban will encourage the gradual development of a more permissive attitude toward suicide.”57 After conceding “the general validity” of this concern, the court dismissed it by stating: “[t]he court has no doubt that the legislature can devise regulations which will define the appropriate boundaries of physician-assisted suicide for terminally ill individuals, and at the same time give due recognition to the important public policy con-

51. Id. at 152-53.
53. Id.
54. Id. at 1102.
55. Id.
57. Id. at 1464. Judge Rothstein continued: “That attitude, the State fears, will erode the societal constraints now hindering people from committing suicide themselves or countenancing the thought as an appropriate course of action for others, and will result in more suicides by those temporarily depressed, distraught, or mentally disturbed.” Id.
cerns regarding the prevention of suicide." This bald affirmation, which presumes Solomonic wisdom for the part-time state legislators of Washington, provides a peculiar basis for voiding an earlier enactment by those same solons.

More critically, Judge Rothstein incorrectly characterized the slippery slope involved in the case. The issue is not that a limited exception to the law against assisted suicide will encourage greater acceptance of suicide, but rather that it involves maintaining those limits, which is not as easy as the court suggests. Admittedly, the line between assisted suicide and terminating treatment, the one Judge Rothstein found unconstitutional, is not neat and logical. No line is — hence creating the slippery slope.

The line that Judge Rothstein drew between the "terminally ill" and other seriously ill persons is a particularly difficult one to maintain. University of Michigan constitutional scholar Yale Kamisar noted:

> Why should the non-terminal nature of a person's suffering disqualify her as a candidate for assisted suicide? If personal autonomy and the termination of suffering are the key factors fueling the right to assisted suicide, how can we exclude those with non-terminal illnesses or disabilities who might have to endure greater suffering over a much longer period of time? Why should a quadriplegic or a person afflicted with severe arthritis have to continue to live what she considers an intolerable existence for a number of years. Why doesn't such a person have an equal claim — or even a greater one — to assisted suicide?

Kamisar's questions expose a fatal flaw in Judge Rothstein's reasoning here — one that was reflected in the right-to-die litigation involving Elizabeth Bouvia. Bouvia was a mentally competent, 28-year-old quadriplegic who suffered from a Jobian litany of afflictions and was physically dependent on a feeding tube but not terminally

58. Id. at 1465.
59. See supra note 57 and accompanying text (discussing Judge Rothstein's response to the concern that allowing physician-assisted suicide will result in a greater acceptance of suicide).
60. Compassion in Dying, 850 F. Supp. at 1467. Judge Rothstein also struck down the statute as violating equal protection. The Judge stated:

> The distinction between the terminally ill patient who requests that her physician remove the life support systems necessary to maintain her life, and the terminally ill patient whose condition does not require life support systems but who seeks physician-administered aid to end her life, is not a narrowly drawn classification tailored to serve a compelling state interest.

ill. She sought to end her life by requesting the discontinuation of tube feeding. In reviewing her case, the trial court concluded that the right to have life-support equipment disconnected was limited to comatose and terminally ill patients and, thus, rejected her request. A California appellate court properly disagreed, stating that “there is no practical or logical reason to limit the exercise of this right to ‘terminal’ patients.”

Elizabeth Bouvia’s condition was physically obvious. However, it is also difficult to see why the line should be drawn at the point of objectively documented suffering. Shouldn’t a person’s subjective apprehension of suffering control if, as Judge Rothstein asserted, “personal autonomy” is the controlling factor? That inevitable result was reached recently in the Netherlands, which is the only nation that currently condones physician-assisted suicide. In the past, that policy was limited to the terminally ill who suffer severe physical pain. In 1994, however, the Dutch Supreme Court held that it also protected a physician who had assisted in the suicide of a seri-

63. Id. at 300.
64. Id. at 298.
65. Id. at 302.
66. Id.
67. The court noted that the plaintiff was completely bedridden. “Except for a few fingers of one hand and some slight head and facial movements, she is immobile.” Id. at 300. The court further noted that she was totally dependent on others for “feeding, washing, cleaning, toileting, turning, and helping her with elimination and other bodily functions.” Id.
69. See Maurice A. deWachter, Euthanasia in the Netherlands, HASTINGS CTR. REP., Mar.-Apr. 1992, at 23, 23 (stating that although euthanasia is still technically illegal, physicians who adhere to three conditions recognized by the Dutch courts and endorsed by the State Commission on Euthanasia are not subject to criminal sanctions). The three conditions noted by deWachter not subject to criminal sanctions are: 1) voluntariness; 2) unbearable suffering; and 3) consultation. Id.; see also G. ST even Neely, The Constitutional Right to Suicide 158-64 (1994) (discussing the development of Euthanasia law in the Netherlands). The definition of euthanasia widely accepted in the Netherlands is “the active termination of a patient’s life at his or her request, by a physician.” deWachter, supra at 23.
70. Neely, supra note 69, at 159. A 1971 Dutch decision afforded a terminally ill patient with unbearable suffering the right to request and receive assistance in dying from his attending physician. Id. In the case, a Dutch physician injected her terminally ill mother with a lethal dose of morphine. Id. When the physician was brought to trial, the court acknowledged that it was not unusual for a physician in the Netherlands to prescribe pain medication that would shorten a patient’s life. Id. A 1981 ruling expanded the right to cover non-terminal patients afflicted with continuous, unbearable physical and spiritual suffering. Id. In 1983, the standard was further relaxed to require only continuous suffering without any mention of unbearable suffering as a condition. Id. See generally Carlos F. Gomez, Regulating Death: Euthanasia and the Case of the Netherlands (1991) (discussing the practice of euthanasia in the Netherlands and the controls set up to limit its practice).
ously and irreversibly depressed but otherwise healthy patient.71 As the Dutch physician stated, "[i]ntolerable psychological suffering is no different from intolerable physical suffering."72

Judge Rothstein's decision dealt only with assisted suicide, where the victim performs the final act.73 The logic of the ruling, however, equally applies to euthanasia, where the physician performs the final act.74 Washington and every other state condemn active euthanasia as murder.75 Yet some otherwise competent, terminally ill persons physically are unable to perform a final, death-causing act. If physician-assisted suicide is a constitutional right for such people, then why should they be denied a right to die when and how they choose simply because they cannot perform the final act by themselves?76 Indeed, the Netherlands has one of the most liberal policies on physician-assisted suicide,77 but cases of physician-performed euthanasia are over five times more common in that country than cases of physician-assisted suicide.78 Similarly, even though Judge Rothstein

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71. See Anastasia Toufexis, Killing the Psychic Pain, TIME, July 4, 1994 at 61 (discussing the recent ruling by the Dutch Supreme Court that physician assisted suicide is lawful).
72. Id.
73. The American Medical Association (AMA) defines "assisted suicide" to be when a "physician provides a patient with the medical means and/or the medical knowledge to commit suicide." COUNCIL ON ETHICAL & JUDICIAL AFFAIRS, AMERICAN MEDICAL ASSOCIATION, 5 CODE OF MEDICAL ETHICS REPORTS 269 (1994) (Rept. # 59, Physician-Assisted Suicide). In a nationwide study of physicians regarding euthanasia and other medical decisions concerning the end of life, "assisted suicide" was defined as the "intentional assistance given to a person to terminate his or her own life upon that person's request." AMERICAN MEDICAL ASSOCIATION, EUTHANASIA — PHYSICIAN ASSISTED SUICIDE: LESSONS IN THE DUTCH EXPERIENCE, BOARD OF TRUSTEES REPORT 1-93-51 at 3 (1993).
74. The AMA defines "euthanasia" as "the administration of a lethal agent by another person to a patient for the purpose of relieving the patient's intolerable and incurable suffering." COUNCIL ON ETHICAL & JUDICIAL AFFAIRS, AMERICAN MEDICAL ASSOCIATION, AMA ETHICAL OPINION 2.21. EUTHANASIA, CURRENT OPINIONS ANN. (1994). "Euthanasia" was defined in a nationwide study as "an intentional act to terminate life by a person other than the person involved upon request of the latter." AMERICAN MEDICAL ASSOCIATION, EUTHANASIA — PHYSICIAN ASSISTED SUICIDE: LESSONS IN THE DUTCH EXPERIENCE, BOARD OF TRUSTEES REPORT 1-93-51, at 3 (1993).
75. Kamisar, supra note 42, at 35-36 (stating that there is a uniform ban among the states against active euthanasia and discussing generally the distinction between active euthanasia and assisted suicide).
76. See id. at 35 (stating that the distinction between assisted suicide and euthanasia is mechanical and without a real difference).
77. See supra notes 69-71 (discussing the Netherlands' policy and law on euthanasia).
78. Toufexis, supra note 71, at 61; see also DAVID CUNDIFF, EUTHANASIA IS NOT THE ANSWER 102 (1992) (stating that in one study on euthanasia in the Netherlands the physician performed euthanasia at the request of the patient in 1.8% of all deaths in the study whereas the physician provided medication for the patient to commit suicide in 0.3% of the cases); D. Alan Shewman, Active Voluntary Euthanasia: A Needless Pandora's Box, 3 ISSUES L. & MED. 219, 229-30 (1987) (discussing the expansion of euthanasia in the Netherlands).
limited her holding to adults, why should minors be excluded? A Florida court recently ruled that a mentally competent minor had the same right to refuse life-sustaining medical treatment as an adult. Inevitably, a similar extension will follow for a liberty interest in physician-assisted suicide.

There is no certain end to this slippery slope. Granting constitutional protection to a terminally ill patient's desire for a physician-assisted suicide will initiate an avalanche of predictable equal protection challenges destined to broaden the impact of the initial ruling. This process is illustrated by the landmark pair of United States Supreme Court decisions protecting an individual's constitutional right to obtain contraceptives. The first decision found that married persons have, as a part of "the notions of privacy surrounding the marriage relationship," a constitutionally protected privacy right to obtain contraceptives despite a state law outlawing such devices for everyone. When another state sought to save its law against contraceptives by adding an exemption for married persons, the Supreme Court properly ruled that it "violates the rights of single persons under the Equal Protection Clause of the Fourteenth Amendment." Should Judge Rothstein's holding stand with respect to physician-assisted suicide for the terminally ill, equal protection analysis will surely extend it on to others.

B. Preventing Undue Influence

The other major concern raised by the state in defense of the stat-

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79. The liberty interest protected by the Fourteenth Amendment in physician-assisted suicide was ascribed to those "competent, terminally ill adults." Compassion in Dying v. Washington, 850 F. Supp. 1454, 1462 (W.D. Wash. 1994).
80. Benito "Benny" Agrelo, a fifteen year old liver transplant recipient, decided to stop taking his medicine which was designed to help his body accept the transplanted organ. Behind a Boy's Decision to Forgo Treatment, N.Y. TIMES, June 13, 1994, at A12. Benny complained that the drug caused back and leg pain and severe headaches. Id. He stated that he'd "rather stay home and live as close [as he] can to a natural life and die without having side effects." Id. A Broward County Circuit Court judge upheld Benny's decision to forego the drug therapy. Id.
81. Judge Rothstein found not only that mentally competent, terminally ill adult patients had a constitutional right to physician-assisted suicide, but that the Washington statutory ban imposed an undue burden upon the exercise of that right. Compassion in Dying, 850 F. Supp. at 1465. Further, Judge Rothstein noted that the law, "by creating an exception for those patients on life support, yet not permitting competent, terminally ill adult patients . . . the equivalent option . . . of exercising their rights to hasten their deaths with medical assistance" violates the Equal Protection Clause. Id. at 1467.
83. Griswold, 381 U.S. at 486.
84. Eisenstadt, 405 U.S. at 443.
ute involved preventing undue influence, duress, abuse, and mistake in the commission of physician-assisted suicide. Dismissing this defense, Judge Rothstein wrote:

[...]he State's second state interest, protecting people from committing suicide due to undue influence or duress, is also unquestionably a legitimate consideration. But it is undisputed that plaintiffs in this case are mentally competent individuals who have reached a decision to commit physician-assisted suicide free from any undue influence.

After noting that Washington State law allows individuals to refuse life-sustaining medical treatment and permits such decisions to be made by proxy decision-makers, the judge added, "[t]he potential risk of abuse and undue influence is often just as great and may be greater in certain cases for a patient who requests to be disconnected from a life support system. The risk of abuse is especially present if the patient is incompetent and a surrogate is making the decision." But Judge Rothstein provided no evidence to support her opinions on this point.

There is good reason for concern about the risk of unintended undue influence here, especially when dealing with the elderly. According to Yale Kamisar, "‘Ageism’ . . . may manifest itself in a failure to recognize treatable depression, . . . the view that an elderly person's desire to commit suicide is more 'rational' than a younger patient's would be." That could lead to the easy acceptance of physician-assisted suicide by physically ill senior citizens without sufficient investigation of their motives. In a recent book on suicide, George Colt observed, "[a]lthough we shrink from the idea of elderly suicide and euthanasia, we encourage it by our neglect and indifference." Similarly, sociologist Menno Boldt stated,

85. Compassion in Dying, 850 F.Supp. at 1465.
86. Id.
87. Judge Rothstein noted that the Washington code allows an individual to refuse life sustaining treatment, a right which was affirmed by the Washington Supreme Court. Id. (citations omitted). Further, Judge Rothstein noted that the Washington code allows for such decisions regarding such treatments to be exercised by "an authorized representative holding a durable power of attorney." Id. (citation omitted).
88. Id.
89. See Cundiff, supra note 78, at 62-63 (discussing how elderly people may feel pressured to ask for euthanasia).
90. Kamisar, supra note 42, at 39 (discussing the dangers of establishing a right to suicide, particularly for the elderly).
91. Id. at 38-39. For an analysis of this issue as it applies to the practice of euthanasia in the Netherlands, see Gomez, supra note 70, at 104-13.
“[s]uicidal persons are succumbing to what they experience as an overpowering and unrelenting coercion in their environment to cease living.” That sense of coercion could be increased by condoning physician-assisted suicide. In her analysis of the subject, ethicist Sissela Bok concluded that “the possibility of abuses and errors” in the practice of euthanasia, especially in cases involving the “senile” and the “powerless,” outweigh the potential benefit of the practice for some compelling cases.

Based on the testimony of such experts, state legislators reasonably could find that this coercion might intensify in a state that sanctions physician-assisted suicide. Indeed, they could conclude that, if physician-assisted suicide is legal, freely discussed, and openly practiced, then more people, especially the infirm and the elderly, will see it as a socially acceptable way to save society, their family, and themselves from the burdens of old age and serious illness. Even if legislators could not prove that legalizing physician-assisted suicide for the terminally ill would unduly encourage these and other people to take their own lives, and increase the likelihood of duress and mistake in this context, they surely have a reasonable basis for responding to these concerns by outlawing the procedure. Indeed, given the magnitude of this societal interest, it should be enough to sustain the statute unless there is some alternative, less burdensome, means to redress it. Judge Rothstein’s decision failed to address this point other than by simply professing that, despite her ruling, the legislature could still “devise regulations” designed to prevent “abuse, coercion or undue influence from third parties” in the practice of assisted suicide. Yet her decision struck down just such a regulation, without suggesting any workable alternative.

Further, even where abuse, coercion, and undue influence from third parties is not present, a person diagnosed with a terminal illness might choose physician-assisted suicide not because she wants to die, but because she fears the pain that may come at a later stage of her illness or losing control over life-sustaining treatment decisions in the event that she becomes incompetent. Should physician-

93. See Kamisar, supra note 42, at 39 (quoting Menno Boldt).
94. Sissela Bok, Euthanasia and the Care of the Dying, in The Dilemma of Euthanasia 1, 8-9 (John A. Behnke & Sissela Bok eds., 1975).
95. For an analysis of this issue, see Gomez, supra note 70, at 104-13; see also Cundiff, supra note 78, at 62-63 (discussing how frail and elderly people may feel pressured to ask for euthanasia in order to save their families financial and emotional burdens).
assisted suicide be condoned, then a patient might accept that route without fully exploring the very real alternatives of pain management, which can be effective in nearly every case,97 and advance treatment directives,98 which can protect a person's control over lifesustaining treatment after she becomes incompetent.99 In this respect, a report from America's leading bio-ethics study center, The Hastings Center, dismissed the argument for assisted suicide as a means to avoid a painful death by observing, "[i]f medicine's capacity for relieving pain and suffering were fully tapped, there would probably be no significant foundation for this argument."100 It and other commentaries on the subject have endorsed advance treatment directives as preferable means to preserve self-determination over terminal health-care decisions.101 By adopting the name "Compas-sion in Dying," the entity instigating this litigation professed concern for the rights and interests of the infirm.102 But legislators reasonably could believe that, on balance, a law against assisted suicide helps the terminally ill much more than it hurts them. It protects them from the duress and mistakes that could lead vulnerable human beings to premature death.103 At the very least, this is a determination — a balancing of societal benefits and burdens — best

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The call for euthanasia is often based upon the notion that the terminally ill are bound to suffer horribly, and that this suffering can only be relieved by death itself. Like all lies and half truths, this is in danger of being believed, if for no other reason than because it is so often and so loudly trumpeted by misinformed persons in the pro-euthanasia lobby. It cannot be stated firmly enough that this is a false premise.

It is false in the sense that it does not have to be so, for there is already much that can be done which will effectively alleviate suffering.

*Id.*


100. *Id.* at 129.

101. *Id.* at 78-84; see also Bok, supra note 94, at 9 (favoring endorsed advanced treatment directives).

102. Compassion in Dying is a Washington non-profit organization which provides free information, counseling and assistance both to mentally competent, terminally ill adults who are considering suicide and to their families. Compassion in Dying v. Washington, 850 F. Supp. 1454, 1458 (W.D. Wash. 1994).

103. For a discussion of duress and undue influence, see *supra* notes 85-105 and accompanying text.
left to the democratic process rather than to judicial fiat. In 1991, Washington State voters rejected a ballot initiative to legalize physician-assisted suicide. The court should not overrule the judgment of the people.

III. EXAMINING EQUAL PROTECTION

In *Compassion in Dying*, the plaintiffs raised a second objection to the Washington State law against assisted suicide. As the court explained:

> [p]laintiffs in this case contend that Washington State law unconstitutionally distinguishes between two similarly situated groups of mentally competent, terminally ill adults. Under current state law, those terminally ill persons whose condition involves the use of life-sustaining equipment may lawfully obtain medical assistance in terminating such treatment, including food and water, and thereby hasten death, while those who also suffer from terminal illnesses, but whose treatment does not involve the use of life support systems, are denied the option of hastening death with medical assistance.

In short, plaintiffs equated a patient whose death is being postponed *solely* due to the intervention of medical treatment with a person who is diagnosed as being terminally ill *but* remains able to survive without treatment. Without providing a scintilla of authority for her decision on this point, Judge Rothstein concluded, "[t]he court finds the two groups of mentally competent, terminally ill adults at issue here to be similarly situated."

The absence of authority on this point is striking because it deals with a central issue in medical ethics. Although some modern medical ethicists and physicians agree with Judge Rothstein's position, the great weight of authority maintains that there is a fundamental difference between allowing patients to die by withdrawing medical intervention and hastening death through a medical intervention.

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106. *Id.* at 1466.
107. *Id.*
108. *Id.*
109. *Id.* at 1467.
111. See *infra* notes 108-32 and accompanying text (discussing the authorities that maintain a distinction between allowing patients to die by withdrawing medical intervention and hastening death with affirmative medical action).
This distinction dates at least as far back in Western medical tradition as the ancient Hippocratic Oath, which has been described as “the earliest and most impressive document in medical ethics.” Referring to this oath, the Supreme Court in Roe v. Wade observed, “it represents the apex of the development of strict ethical concepts in medicine, and its influence endures to this day.” Under the Hippocratic Oath, which is attributed to the 4th century B.C. Greek physician Hippocrates, a physician may refrain from treating patients but may never prescribe any “deadly medicine,” even if asked.

The major Anglo-American professional associations of physicians vigorously maintain this distinction today. For example, the American Medical Association condemns physician-assisted suicide as “contrary to that for which the medical profession stands” while it condones the withdrawal of life-sustaining treatment if it is in accordance with “the decision of the patient and/or his immediate family.” The British Medical Association took a similar position stating, “[t]here is a distinction between an active intervention by a

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114. Id. at 131.
115. The text of the Hippocratic Oath is reprinted in Millikin, supra note 113, at 101; see also Willard Gaylin et al., Doctors Must Not Kill, 259 JAMA 2139, 2139 (1988) (commenting on the Oath of Hippocrates and the distinction between failing to treat patients and prescribing deadly medicine).
116. See infra notes 117-18 and accompanying text (discussing the American Medical Association and British Medical Association’s position on affirmative medical action to terminate life).

Assisted suicide occurs when a physician provides a patient with the medical means and/or the medical knowledge to commit suicide. . . . In physician-assisted suicide, the patient performs the life-ending act, whereas in euthanasia, the physician administers the death-causing drug or other agent.

Assisted suicide and euthanasia should not be confused with the provision of a palliative treatment that may hasten the patient’s death . . . .

Assisted suicide also must be distinguished from withholding or withdrawing life-sustaining treatment, in which the patient’s death occurs because the patient or the patient’s proxy, in consultation with the treating physician, decides that the disadvantages of treatment outweigh its advantages and therefore that treatment is refused.

COUNCIL ON ETHICAL & JUDICIAL AFFAIRS, AMERICAN MEDICAL ASSOCIATION, 5 CODE OF MEDICAL ETHICS REPORTS 269-70 (1994) (footnotes omitted) (Rept. # 59, Physician-Assisted Suicide). The American Medical Association continues to condemn physician assisted suicide as “fundamentally inconsistent with the physician’s professional role.” Id. at 274.
doctor to terminate life and a decision not to prolong life (a non-treatment decision)."118

Leading medical ethicists also accept this distinction. For example, in an influential 1987 report asserting the right of patients to refuse life-sustaining treatment, the Hastings Center observed:

[s]ome persons who accept this right of patients to decide to forgo treatment are concerned nevertheless that the values supporting it, and in particular self-determination, necessarily imply that voluntary euthanasia and assisted suicide are also justified. We disagree. Medical tradition and customary practice distinguish in a broadly acceptable fashion between the refusal of medical interventions and intentionally causing death or assisting suicide.119

Elaborating on this distinction, the report explained:

Our society forbids assisting suicide or active euthanasia, even if the motive is compassionate. This prohibition serves to sustain the societal value of respect for life and to provide some safeguards against abuse of the authority to take actions that shorten life. It also encourages us to provide decent and humane care to those who suffer, and to those who are dependent, ill, or impaired. Since these people are already vulnerable to being mistreated, undertreated, or avoided, eroding the legal prohibition of active euthanasia might well further endanger them. Respecting the individual's liberty to direct his or her own life requires, however, that patients generally be allowed to refuse medical interventions, even if others feel that this is contrary to the patient's best interests.120

Four of America's premier physician-ethicists, Willard Gaylin, Leon R. Kass, Edmund D. Pellegrino, and Mark Siegler, jointly declared, "[g]enerations of physicians and commentators on medical ethics have underscored and held fast to the distinction between ceasing useless treatments (or allowing to die) and active, willful, taking of life . . . ."121 In a statement that utterly denounces Judge Rothstein's position, these four distinguished scholars added, "[n]either legal tolerance nor the best bedside manner can ever make medical killing medically ethical."122 An exhaustive study by the official New York State Task Force on Life and the Law reached a similar conclusion in 1994.123

119. HASTINGS CENTER, supra note 99, at 128.
120. Id.
121. Gaylin, supra note 115, at 2139.
122. Id.
123. NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT (1994). Also in 1994, in the litigation spawned by Dr. Jack Kevorkian's practice of physician-assisted suicide, a Michigan appellate
Given the overwhelming weight of medical and ethical authority against her position, it is not surprising that Judge Rothstein did not cite any basis (other than her own opinion) for equating physician-assisted suicide with terminating life-sustaining medical treatment.\(^1\) Physicians and medical ethicists typically view the two situations as fundamentally different, despite any amount of subtle judicial draftsmanship to make it appear otherwise. The only evidence that Judge Rothstein offered in support of her equal-protection claim is the irrelevant observation that Washington State law permits patients to refuse life-sustaining treatment.\(^2\) "Thus," she reasoned, "the State has already recognized that its interest in preventing suicide does not require an absolute ban."\(^3\) Of course, Washington State does not outlaw suicide — it simply tries to discourage it through a law against assisting suicide.\(^4\) Further, the state law she cited, the Washington Natural Death Act, expressly provides that the termination of life-sustaining treatment pursuant to the Act "shall not, for any purpose, constitute a suicide."\(^5\) Moreover, that Act incorporates an absolute ban against "mercy killing."\(^6\) Finally, as noted above, mainstream medical and ethical opinion does not equate terminating life-sustaining treatment with assisted suicide.\(^7\) As the 1987 Hastings Center report concluded, "a reasonable, if not unambiguous, line [can] be drawn between foregoing life-sustaining treatment on the one hand, and active euthanasia or assisted suicide of the other."\(^8\) Judge Rothstein simply ignored this line and wrongly ordered the state to do likewise.

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\(^1\) Hobbins v. Attorney General, 518 N.W.2d 487, 493 (Mich. Ct. App. 1994). According to one legal analysis of that decision, "[i]t distinguished the right to refuse treatment recognized in \textit{Cruzan} . . . as only 'to passively die a natural death,' not to actively intervene to hasten one's death." Goldberg, \textit{supra} note 27, at 73.


\(^3\) Id.

\(^4\) See \textit{supra} notes 125-32 and accompanying text (discussing the distinction drawn by Judge Rothstein).


\(^6\) Id.

\(^7\) See \textit{supra} notes 9-17 and accompanying text (discussing Washington's laws against assisting suicide).

\(^8\) WASH. REV. CODE § 70.122.070(1) (1993).

\(^9\) Id. § 70.112.100.

\(^10\) See \textit{supra} notes 120-24 and accompanying text (discussing how the majority of ethicists and medical professionals maintain a distinction between terminating life-sustaining treatment and assisted suicide).

IV. CONCLUSION

Even Judge Rothstein conceded that legitimate, constitutionally valid interests support a law against assisted suicide in the vast majority of cases. Yet she struck down the entire statute on the basis of three compelling cases, where the terminally ill patients were allegedly suffering uncontrollable pain, rather than simply enjoin the application of the law in those instances. Indeed, there is no indication that the state would have prosecuted physicians for assisting these dying patients to commit suicide. By the court's own terms, it should not have allowed judicial review of the statute in such a situation. "Regarding the applicable standard of review," Judge Rothstein wrote, "the Supreme Court held in Casey that, in order to demonstrate the unconstitutionality of a state statute, plaintiffs had to show that it would 'operate as a substantial obstacle' to the exercise of a constitutional right and would, therefore, constitute an 'undue burden.'" Otherwise, the statute should not be overturned in a facial challenge to its constitutionality. Elaborating on this standard, she quoted from an appellate court ruling that Casey, which invalidated a Pennsylvania anti-abortion statute, "requires only that a plaintiff show an abortion regulation would be an undue burden 'in a large fraction of the cases.'" Certainly a law restricting abortion only applies to women seeking abortions, and Casey correctly reviewed it prior to its application. But a law broadly restricting people from aiding a suicide attempt does not primarily involve persons of the type at issue in this case. Indeed, the court defined the plaintiff class as terminally ill, mentally-competent, adults acting knowingly and voluntarily without undue influence, who seek physician aid, without indicating how many people

133. Id. at 1456-57.
134. A committee of leading physicians in this field suggested that although no medical decision can be immune from prosecution, courts in the United States generally have not attached consequences in such cases. Sidney H. Wanzer et al., The Physician's Responsibility Toward Hopelessly Ill Patients, 320 NEW ENG. J. MED. 844, 847 (1989). The official comment to the Model Penal Code section dealing with this issue makes a similar suggestion. MODEL PENAL CODE § 210.5 cmt. 5 (1962). For the text of this comment, see supra note 24 and accompanying text.
136. Id. at 1463 (quoting Casey v. Planned Parenthood, 14 F.3d 848, 863 n.21 (3d Cir. 1994)).
this includes.\textsuperscript{138} Surely it constitutes only a small fraction of the number of persons protected by a law against assisted suicide. Therefore, this case did not offer a proper vehicle for reviewing the overall statute.

In the course of her decision, Judge Rothstein acknowledged, "[o]bviously the state has a strong, legitimate interest in deterring suicide by young people."\textsuperscript{139} She also admitted, "[i]t is well within the legislative prerogative to enact regulations and restrictions which will ensure that undue influence from third parties plays no part in the choice of physician-assisted suicide."\textsuperscript{140} This is precisely what Washington's statute against assisted suicide does, and Judge Rothstein has not shown that there is any better way to accomplish it.

\textsuperscript{138} Compassion in Dying, 850 F. Supp. at 1467.
\textsuperscript{139} Id. at 1464.
\textsuperscript{140} Id. at 1466.