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## **The Right to Die: Constitutional and Statutory Analysis**

**Updated December 21, 2003**

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# The Right to Die: Constitutional and Statutory Analysis

## Summary

Recently, there have been a series of court and legislative actions regarding the proposed withdrawal of nutrition and hydration from a Florida patient, Theresa Schiavo, a patient who has suffered severe brain damage. This case has brought new attention to the issue of "right to die." Although the popular term "right to die" has been used as a label to describe the current political debate over end-of-life decisions, the underlying issues include a variety of legal concepts, some distinct and some overlapping. For instance, "right to die" could include, at a minimum, suicide, passive euthanasia (allowing a person to die by refusal or withdrawal of medical intervention), assisted suicide (providing a person the means of committing suicide), active euthanasia (killing another), and palliative care (providing comfort care which accelerates the death process). Recently, a new category has been suggested -- physician-assisted suicide -- which appears to be an uncertain blend of assisted suicide or active euthanasia undertaken by a licensed physician.

Yet, exercising one or another of these "rights to die" may have drastically different legal consequences: some currently have no legal consequence, some are a violation of common-law, some are a violation of statute, some may have contractual consequences, some may result in civil action such as confinement, some are currently protected by legislation, and some may be protected by the United States Constitution. This report examines the legal status of the five distinct issues: 1) suicide, 2) passive euthanasia, 3) assisted suicide, 4) active euthanasia, and 5) palliative care. The report examines the history of how each of these issues has been treated, reviews current and pending legislation, and evaluates the constitutional right of a person to pursue these courses of action. It also addresses whether these types of decisions can be made on behalf of legally incompetent patients, and what standards apply.

The report notes that current state regulations prohibiting assisted suicide have been upheld by the Supreme Court, and that similar prohibitions against active euthanasia are likely to be upheld against constitutional challenge. The Due Process Clause of the Fourteenth Amendment, however, appears to limit a state's ability to regulate passive euthanasia (termination of medical treatment). Finally, palliative care may ultimately be found to be protected by the Fourteenth Amendment, but the possible abuse of such care may raise policy concerns.

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# The Right to Die: Constitutional and Statutory Analysis

## I. Introduction

### A. Background

Recently, there have been a series of court and legislative actions regarding the proposed withdrawal of nutrition and hydration from a Florida patient, Theresa Schiavo, who has suffered severe brain damage. The treatment of this patient has brought new attention to the issue of “right to die.” Although the issue of “right to die” has many common themes, the individual aspects of each case may have a significant affect on the outcome of any proceeding. While a detailed examination of the Schiavo case is beyond the scope of this report, the case is briefly addressed under the topic of “passive euthanasia.”

One of the greatest scientific achievements of this century has been the development of medical technology to cure disease and to prolong lives. Before 1900, most deaths in this country were the result of communicable diseases, such as influenza or pneumonia, which could kill people of all ages.<sup>1</sup> Today, in contrast, deaths due to these illnesses have decreased dramatically, and most people succumb to chronic degenerative diseases related to age such as heart disease, cancer and cerebrovascular disease.<sup>2</sup>

These advances, however, do not come without burdens. Chronic degenerative diseases tend to be manifested years before death occurs, and because some medical intervention often exists, persons with these conditions tend to die more slowly and often painfully.<sup>3</sup> The advent of AIDS has also resulted in an increase in the number of deaths which occur after extended periods of pain and physical disability. Consequently, patients are increasingly being confronted with decisions regarding whether to pursue or decline aggressive medical treatment. Further, there are indications that some patients are making decisions which affirmatively hasten their

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<sup>1</sup> G. Steven Needley, *Chaos in the "Laboratory of the States": The Mounting Urgency in the Call for Judicial Recognition of a Constitutional Right to a Self-Directed Death*, 26 U. TOL. L. REV. 81, 85 (1994).

<sup>2</sup> *Id.*

<sup>3</sup> One in every two Americans dies of a disease diagnosed at least 29 months in advance; chronic conditions were the cause of more than 87% of deaths in 1978. *Id.* at 86.

deaths, whether through increasing levels of pain control medications or by other means.<sup>4</sup>

The increase in the number of end-of-life decisions has coincided with the expansion of patients' rights and involvement in medical decision-making. Yet the legal community has not yet come to terms with the implications resulting from this increased patient autonomy. State legislatures have made only piece-meal attempts to confront end-of-life decisions, federal involvement has been minimal, and the courts which have attempted to resolve some of these legal issues are faced with little precedent, inapplicable legislation, murky constitutional theory, and clashing legal doctrines. Prompt resolution of these issues is frustrated by a lack of political consensus among major societal institutions.<sup>5</sup> For those reasons, the law in this area may be less a reflection of a coherent legal structure than a reaction to the immediate concerns and societal pressures surrounding specific cases.

For example, a majority of patients with terminal illnesses or their guardians will face decisions as to whether life-sustaining medical treatment should be refused or withdrawn, allowing the individual to die.<sup>6</sup> By design or necessity, most such decisions are made by agreement among interested parties, such as the patient, his or her family, attending doctors and hospital administrators.<sup>7</sup> On occasion, however, because of fear of legal liability, disagreement among the institutions and individuals involved, or because of moral objections, these decisions are made only after litigation in state, or occasionally federal, courts.

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<sup>4</sup> It is estimated that 6,000 terminal patients a day die as a foreseeable result of pain control medication. *Compassion in Dying v. Washington*, 79 F.3d 790, 811 (9th Cir. 1994)(en banc). A survey by the American Society of Internal Medicine indicated that one in five doctors have participated in assisting a patient's suicide. *Id.*

<sup>5</sup> While our society has a long-standing moral aversion to suicide of physically healthy persons, attitudes toward hastening death in the cases of seriously ill patients are more complex. Despite existing laws on the books against assisted suicide or intentional killing, there have been few prosecutions under these statutes and many doctors privately admit helping people to die. Richard A. Know, *One in Five Doctors Say They Assisted a Patient's Death, Survey Finds*, BOSTON GLOBE, Feb. 28, 1992, at 5. For instance, in the case of Dr. Jack Kevorkian, who admitted responsibility in assisting over forty ill persons commit suicide (and was eventually convicted of second-degree murder), there were no successful prosecutions for assisted suicide. Jack Lessenberry, *Kevorkian is Arrested and Charged with Suicide*, NEW YORK TIMES, Nov. 8, 1996, at A19. While some argue against societal approvals of such activities, others argue that it is better to regulate this behavior rather than allowing it to flourish underground. Esther B. Fein, *The Right to Suicide, Some Worry, Could Evolve Into a Duty to Die*, NEW YORK TIMES, April 7, 1996, at A24.

<sup>6</sup> Of the approximately two million people who die in the United States every year, 80% die in hospitals, and perhaps 70% of those die after a decision to forgo life-saving measures is made. *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 302 (1990)(J. Brennan, dissenting).

<sup>7</sup> Decisions regarding the withdrawal of medical support are generally made, not by courts, but by the individuals or institutions directly involved. Gasner, *Right to Die Lives Locally*, Nat'l L.J., July 23, 1990, at 13, col. 1. Thousands of patients die every day upon withdrawal of medical support; yet since 1976, the number of right to die cases number in the low hundreds. *Id.* at 14.

Further, one of the most influential legal doctrines in the area of "right to die" is the constitutional right of privacy and of bodily integrity, the limits of which are anything but clear. Under the so-called privacy cases, the Supreme Court has established certain individual rights regarding the issues of marriage,<sup>8</sup> contraception<sup>9</sup> and abortion.<sup>10</sup> The Court has also entered the right to die area, provisionally approving of the termination of medical treatment, but setting limits at which the state's interest in viable life cannot be overridden.<sup>11</sup> This decision, however, may be seen as an outgrowth of a line of cases protecting bodily integrity. Other decisions by the court regarding the breadth of the right to privacy, which are now generally called "liberty interests" under the Fourteenth Amendment,<sup>12</sup> bring the establishment of a broader privacy based "right to die" into doubt.

For example, the Supreme Court rejected an argument that statutes prohibiting assisted suicide violate either the Equal Protection Clause or a protected "liberty interest" under the Due Process Clause of the Fourteenth Amendment. Two United States Courts of Appeals had determined that severely ill patients have a right under the Fourteenth Amendment to seek medical assistance to cause their own deaths. Both of these cases, *Quill v. Vacco*<sup>13</sup> and *Compassion in Dying v. Washington*,<sup>14</sup> were reversed by the Supreme Court. By resolving the issues in *Quill* and *Compassion in Dying*, the Supreme Court effectively ended the likelihood that a significant expansion of the "right to die" will arise through the courts. It did not, however, preclude such expansion by legislatures.

## B. How Broad Is the Right to Die?

Although the popular term "right to die" has been used as a label to describe the current political debate over end-of-life decisions, the underlying issues include a variety of legal concepts, some distinct and some overlapping. For instance, "right to die" could include, at a minimum, suicide, passive euthanasia (allowing a person to die by refusal or withdrawal of medical intervention), assisted suicide (providing a person the means of committing suicide), active euthanasia (killing another), and palliative care (providing comfort care which accelerates the death process). Recently, a new category has been suggested -- physician-assisted suicide -- which appears to

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<sup>8</sup> *Loving v. Virginia*, 388 U.S. 1 (1967).

<sup>9</sup> *Griswold v. Connecticut*, 381 U.S. 479 (1965).

<sup>10</sup> *Roe v. Wade*, 410 U.S. 113 (1973).

<sup>11</sup> *Cruzan v. Missouri Dept. of Health*, 497 U.S. 261 (1990).

<sup>12</sup> *See, e.g., Paris Adult Theatre v. Slaton*, 413 U.S. 49 (1973)(obscenity cannot be displayed even to consenting adults).

<sup>13</sup> *Quill v. Vacco*, 80 F.3d 716 (2nd Cir. 1996), *reversed*, 521 U.S. 793 (1997).

<sup>14</sup> *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir. 1996)(en banc), *reversed*, 521 U.S. 702 (1997).

be an uncertain blend of assisted suicide or active euthanasia undertaken by a licensed physician.<sup>15</sup>

Yet, exercising one or another of these "rights to die" may have drastically different legal consequences: some currently have no legal consequence, some are a violation of common-law, some are a violation of statute, some may have contractual consequences, some may result in civil action such as confinement, some are currently protected by legislation, and some may be protected by the United States Constitution. It should also be noted that the legal and moral status of these rights may vary dramatically depending on the medical status of the individual patient. While early legal discussions of the right to die were primarily associated with terminal illness, more recent discussions have focused on medical situations involving high levels of pain, futile prognosis, diminished quality of life, or even on mental suffering.<sup>16</sup>

While some advocates would find little distinction between these various methods of terminating a person's life,<sup>17</sup> and would give the patient the discretion to decide what is a sufficient basis for exercising that option, other commentators find that maintaining distinctions between different situations is important to prevent abuses, or to conform to professional, societal or moral concerns.<sup>18</sup> One of the major policy arguments made regarding the right to die is the concern that recognizing a right to die in one circumstance will be generalized to include other circumstances where different considerations may be relevant; in other words, there is a concern that granting a right to die is the first step down a slippery slope.<sup>19</sup>

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<sup>15</sup> *Compassion in Dying v. Washington*, 79 F.3d at 844, 852 (J. Beezer, dissenting).

<sup>16</sup> STAFF OF THE SUBCOMMITTEE ON THE CONSTITUTION, COMMITTEE ON THE JUDICIARY, *Physician-Assisted Suicide and Euthanasia in the Netherlands*, 104th Cong., 2d Sess. at 2 (Comm. Print 1996)(discussing the development of assisted suicide in Holland).

<sup>17</sup> Note, *Physician-Assisted Suicide and the Right to Die with Assistance*, 105 Harv. L. Rev. 2021 (1992)(noting similarities between withdrawal of medical treatment and assisted suicide).

<sup>18</sup> As Professor Yale Kamisar has said, "how you phrase the question will determine your answer." Yale Kamisar, *Against Assisted Suicide -- Even a Very Limited Form*, 72 U. Det. Mercy L. Rev. 735 (1995). For instance, the United States Court for the Ninth Circuit, in reviewing an assisted suicide statute, characterized the constitutional right at stake as the "liberty interest in determining the time and manner of death." *Compassion in Dying v. Washington*, 79 F.3d at 801. As stated by the court, however, this broader "right" would seem to encompass any of the several ways of choosing death, from termination of medical treatment to euthanasia.

<sup>19</sup> For instance, while some persons would restrict the assisted suicide debate to the terminally ill, the distinction between the terminally ill and persons with incurable conditions was one of the first distinctions to fall when courts considered the issue of termination of medical treatment. See *Cruzan v. Missouri*, 497 U.S. 261 (1990)(constitutional rights to termination of medical treatment apply to persistently vegetative patient); Note, *supra* note 17, at 2026. Thus, one commentator has suggested that if a right to assisted suicide is established for the terminally ill, that no principled distinction could be made to prevent similar acts by persons who are handicapped, in physical pain, or even clinically depressed. Yale Kamisar, *supra* note 18, at 748 (1995).

(continued...)

## C. The Constitutional Genesis: the Right to Privacy

In *Glucksberg v. Washington*, the Supreme Court evaluated the holding of the United States Court of Appeals for the Ninth Circuit in *Compassion in Dying v. Washington* that the Fourteenth Amendment to the Constitution protects the right of an individual to seek and obtain physician-assisted suicide.<sup>20</sup> In doing so, the Court revisited a controversial area of constitutional law, the so-called right to privacy. This relatively amorphous right was first substantively addressed in the contraceptive area, but has subsequently been expanded to include other decisions of a personal nature.

The right of privacy sought a permanent home in the Constitution for a number of years. First proposed in an 1890 article in the *Harvard Law Review* by Samuel Warren and Louis Brandeis,<sup>21</sup> it reappeared years later in a Supreme Court dissenting opinion regarding the Fourth Amendment.<sup>22</sup> However, in 1965, in the landmark case of *Griswold v. Connecticut*,<sup>23</sup> the Court established the concept of a constitutional guarantee of privacy which "emanated" from the Bill of Rights, even if it was not specifically identified in it. In *Griswold*, the Court struck down a law which prevented the use of contraceptives. The Supreme Court ruled that the right of married couples to make decisions regarding procreation was guaranteed by the Constitution.<sup>24</sup> This

<sup>19</sup> (...continued)

Concerns have also been raised that once a "right to die" has been legally established, society may begin to expect those who are old, poor or sick to take advantage of this right as a matter of duty. In this context, it is noted that many disabled people withdraw suicide requests when given adequate care. *Id.* at 744. For example, in *McKay v. Bergstedt*, 801 P.2d 617 (Nev. 1990), a thirty-one year old competent, non-terminal quadriplegic obtained a court order permitting the removal of his respirator, despite clear indications that his desire to die was based on the impending death of his primary care-taker, his father, and the presumed attendant lowering in quality of his care.

<sup>20</sup> 518 U.S. 1057 (1996)(*cert. granted sub nom.* *Glucksberg v. Washington*).

<sup>21</sup> Warren and Brandeis, *The Right of Privacy*, 4 Harv. L. Rev. 193 (1890).

<sup>22</sup> *See Olmstead v. United States*, 277 U.S. 438 (1928)(J. Brandeis, dissenting)(arguing against the admissibility in criminal trials of secretly taped telephone conversations). In *Olmstead*, Justice Brandeis noted:

The makers of our Constitution undertook to secure conditions favorable to the pursuit of happiness . . . They sought to protect Americans in their beliefs, their emotions and their sensations. They conferred, as against the Government, the right to be let alone - the most comprehensive of rights and the right most valued by civilized men. To protect that right, every unjustifiable intrusion by the Government upon the privacy of the individual, whatever the means employed, must be deemed a violation of the Fourth Amendment.

277 U.S. at 473.

<sup>23</sup> 381 U.S. 479 (1965).

<sup>24</sup> The facts of *Griswold*, are relatively straightforward. *Griswold*, the Executive Director of Connecticut Planned Parenthood, was arrested, along with the Medical Director of the organization, and charged as accessory to a crime. The defendants in question were accused  
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holding was supported, however, by a variety of competing theories set forth by different justices, which left the scope of the right to privacy in an unsettled state.<sup>25</sup>

In the case of *Roe v. Wade*,<sup>26</sup> the Court expanded the theory of the *Griswold* case to the issue of abortion. The opinion of the court in that case focused on the medical and legal history of abortion, and appears to have relied to a large degree on the medical consequence of decisions concerning pregnancy.<sup>27</sup> The Court ultimately concluded that the Constitution provided protection for autonomy in reproductive decisions, and set forth a substantive structure to evaluate laws restricting abortion.<sup>28</sup> The Court has subsequently established the Due Process Clause of the Fourteenth Amendment as the basis for the protection of these and other "liberty interests," preferring to avoid the parlance of a generalized constitutional right of privacy. The holding of *Roe v. Wade* was modified in recent years by the case of *Casey v. Planned Parenthood of Southeastern Pennsylvania*,<sup>29</sup> but the central holding regarding the

<sup>24</sup> (...continued)

of having aided and abetted the violation of a Connecticut law which prohibited the use of any drug, medicinal article or instrument for the purpose of preventing conception. The defendants challenged whether such a law could be constitutionally enforced by a state, and the Supreme Court ruled that it could not, as the right of married couples to use contraception was guaranteed by the Constitution.

<sup>25</sup> Justice Douglas, in the plurality opinion, noted that the Supreme Court had previously found that fundamental rights could be extended to establish "penumbral" rights, or rights whose enforcement would protect the underlying right. Finding that privacy rights are contained in the First Amendment, the Third Amendment, the Fourth Amendment, the Fifth Amendment, and the Ninth Amendment, Justice Douglas held that the institution of marriage was protected by these "penumbral" rights, and was thus exempt from such regulation. 381 U.S. at 484-485. In concurrence, Justice Goldberg found the right to privacy to be contained in the Ninth Amendment, which states that "the enumeration of rights in the Constitution shall not be construed to deny or disparage those rights retained by the people," and to be applied to the states through the Fourteenth Amendment. 381 U.S. at 499. Justice Harlan, also in concurrence, found that the contraception statute violated the Fourteenth Amendment as it violated basic values "implicit in the concept of ordered liberty," 381 U.S. at 500, while Justice White also found the right in the Fourteenth Amendment. It is these last two opinions that would eventually come to be the basis for the modern right to privacy.

<sup>26</sup> 410 U.S. 113 (1973).

<sup>27</sup> See 410 U.S. at 152.

<sup>28</sup> The Court found that in the first trimester, the risks of abortion were less than the risk of childbirth, and thus the mother was to be unrestricted in her ability to choose the less medically risky route of abortion. During the second trimester, the risks to the mother increase, thus allowing the state to intervene for purposes of regulating those aspects of an abortion which may affect a mother's health and safety. 410 U.S. at 163. Such factors would include the particular qualifications of the physician performing the procedure, the facility where the procedure should take place, and licensing requirements. *Id.* Finally, in the third trimester, when the fetus may be capable of life outside of the mother's womb, and thus be "viable," the state may ban abortion completely. *Id.*

<sup>29</sup> On June 29, 1992, the Supreme Court issued its opinion in the case of *Casey v. Planned Parenthood of Southeastern Pennsylvania*, 505 U.S. 833 (1992), which reviewed the ruling  
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existence of a liberty interest in choosing whether or not to terminate a pregnancy is unchanged.<sup>30</sup>

It is not always clear when the right to privacy is likely to be extended to activities not previously addressed by Supreme Court decisions. If a general test can be discerned as to when a "right of privacy" or "liberty interest" can act as a shield against governmental action, it would appear to require that two basic questions be considered. First, is the activity to be regulated one which is deeply rooted in the history of the nation,<sup>31</sup> or second, is it so central to personal autonomy that neither liberty nor justice would exist without constitutional protection.<sup>32</sup> In the abortion context, however, this protection appears to be subject to an exception if there is a "viable" life being threatened by the activity.<sup>33</sup> When life is at risk because of a protected activity, such as when an abortion is sought in the third trimester, concerns about a "right of privacy" may be outweighed by the need to protect that viable life.

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<sup>29</sup> (...continued)

of the United States Court of Appeals for the Third Circuit concerning Pennsylvania's abortion laws. The Pennsylvania Abortion Control Act of 1982 generally allows abortions, but imposes regulations that delay a woman's access to the procedure.

<sup>30</sup> The Court in *Casey* upheld the provision of information to women seeking abortions, the twenty-four hour waiting period, and the requirement that a minor obtain the consent of a parent or judge. The Court, however, struck down the section of the law which dictates that a woman must notify her husband of her intent to have an abortion. The Court also upheld the medical reporting requirements on clinics and doctors performing abortions, although a requirement that a women report why she did not notify her husband of the abortion was struck down. The core of the plurality opinion is section IV, which upheld the right of a woman to have an abortion, but rejected the trimester structure established by *Roe v. Wade*. Under *Roe*, states were prevented from imposing any restrictions designed to protect "potential life" on abortions performed in the first and second trimesters of pregnancy; only in the third trimester could the state impose restrictions to protect "potential life." Under *Casey*, however, the Court held that laws restricting abortions to protect "potential life" could be imposed at anytime prior to viability, if such laws did not pose an "undue burden" on the women's ability to have an abortion. Consequently, the Court found that certain of the above-noted restrictions, which applied during the first and second trimesters of pregnancy and would have been unconstitutional under *Roe v. Wade* and subsequent Supreme Court cases, *see City of Akron v. Akron Center for Reproductive Health*, 462 U.S. 416 (1983); *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747 (1986), were now constitutional on their face.

<sup>31</sup> *Bowers v. Hardwick*, 478 U.S. 186, 192 (1986) *overturned by* *Lawrence v. Texas*, 123 S.Ct. 2472 (2003)(finding that homosexual activity, historically forbidden by legislation, is not a fundamental liberty implicit in the concept of ordered liberty, and is therefore not protected by the 14th Amendment). In the case of abortion, for example, the interest of individuals in making their own medical decisions and in making their own decisions regarding their family are cited as strong historical reasons for leaving to the individual the decision whether to have an early abortion. Thus, an affirmative answer to this first question will generally serve to inhibit governmental intervention.

<sup>32</sup> *Id.*

<sup>33</sup> *See supra* note 28.

## II. Five Types of Right to Die

This section will examine the legal status of five distinct issues concerning the "right to die:" 1) suicide, 2) passive euthanasia, 3) assisted suicide, 4) active euthanasia, and 5) palliative care. The historical tradition surrounding these will be examined with an eye to the Supreme Court's preference that constitutionally protected liberty interests be "rooted in the nation's history and tradition." This section will also examine present statutory and constitutional implications of each of these areas. It should be noted that some legal doctrines in this area are unsettled, while others are still evolving.

### A. Suicide

#### 1. Historical Precedent.

From the sparse record of ancient times, we can discern that the attitudes of the Greeks and Romans toward suicide were ambiguous.<sup>34</sup> By the Middle Ages, however, the influence of the Catholic Church was dominant, and the practice was condemned as a violation of religious and civil law.<sup>35</sup> English common law inherited this aversion to suicide and would sometimes impose posthumous deprivation of religious ceremony, and significant penalties were generally directed against the estate of the person committing suicide.<sup>36</sup> There are indications, however, that suicide in the face of suffering was treated less harshly.<sup>37</sup> The founding fathers of this country, on the other hand, were uninterested in imposing punishment upon the innocent heirs to the estates of persons committing suicide,<sup>38</sup> and the legal tradition of punishing suicide was generally abandoned soon after the adoption of the Constitution.<sup>39</sup> Consequently, in the American legal tradition, there has been little or no punishment imposed for suicide or attempted suicide.<sup>40</sup>

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<sup>34</sup> In ancient times, as today, suicide was generally disfavored. Roman law generally forbade suicide and imposed a penalty of forfeiture of property upon the estate of the decedent. Thomas J. Marzan, Mary K. O'Dowd, Daniel Crone & Thomas Balch, *Suicide: A Constitutional Right?*, 24 *Duquesne Law Review* 26 (1985). However, it appears that suicide in particular circumstance was seen as either acceptable or even commendable. *Compassion in Dying v. Washington*, 79 F.3d at 806-08. In particular, it appears that suicide that was prompted by pain or sickness was generally not punishable under Roman law. Marzan, *supra*, at 22-23.

<sup>35</sup> *Compassion in Dying v. Washington*, 79 F.3d at 808.

<sup>36</sup> 79 F.3d at 846 (J. Beezer, dissenting).

<sup>37</sup> Catherine D. Shaffer, *Criminal Liability for Assisting Suicide*, 86 *Colum. L. Rev.* 348, 349 (1986); *Compassion in Dying v. Washington*, 79 F.3d at 808-809.

<sup>38</sup> *Compassion in Dying v. Washington*, 79 F.3d at 844 (J. Beezer, dissenting).

<sup>39</sup> Thomas J. Marzan, *supra* note 34, at 64-69.

<sup>40</sup> Catherine D. Shaffer, *supra* note 37, at 349 (1986); *Compassion in Dying v. Washington*, 79 F.3d at 809.

## 2. State Legislation.

Although there are currently no criminal punishments associated with suicide or attempted suicide, this does not mean that these acts are without legal consequence. The trend of modern American law has generally been that a person who is suicidal should not be treated as a criminal, but as mentally ill.<sup>41</sup> Further, a person who assists such a suicide may be prosecuted under the laws of many states.<sup>42</sup> Thus, while suicide is not punished *per se*, it is not free of significant legal consequence.<sup>43</sup>

In practice, however, the way in which a person engaged in a suicidal attempt is treated may vary based on context. Where a suicidal attempt appears to be the result of depression or mental problems, the state will generally intervene, and the person will be confined until such time as their suicidal urges have subsided. On the other hand, certain public, political acts, such as fasting, have sometimes been engaged in without government intervention. Nor is it clear that a court is likely to intervene in the cases of terminally ill patients who take their own lives.<sup>44</sup>

## 3. Constitutional Status.

Although there are no criminal penalties associated with suicide, the threat of confinement might be seen as an infringement on one's personal autonomy as a consequence of making an important and fundamental life decision. Thus, it could be argued that the right to commit suicide should be found to be a liberty interest protected under the Fourteen Amendment. There has been little litigation of this issue in the courts, however, and Supreme Court *dicta* seems to favor the notion that the state has a constitutionally defensible interest in preserving the lives of healthy citizens.<sup>45</sup> However, the issue of the constitutional status of suicide of the seriously ill has not been squarely faced.

One of the strongest conceptual problems with a constitutional right to suicide for the seriously ill is how such a right would be limited. Suicide is often associated with depression, and certain life events, such as a terminal illness, may trigger depression in some individuals and not in others.<sup>46</sup> On its face, it is not clear how a constitutional right to act on suicidal impulses related to depression would vary among the terminally ill, the chronically-ill, the disabled, the temporarily-impaired, or the

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<sup>41</sup> *Compassion in Dying v. Washington*, 79 F.3d at 847 (J. Beezer, dissenting).

<sup>42</sup> *See infra* notes 83-86 and accompanying text.

<sup>43</sup> For instance, many life insurance contracts include exclusions for suicide. *Compassion in Dying v. Washington*, 79 F.3d at 852 (J. Beezer, dissenting).

<sup>44</sup> *See Campbell v. Supreme Conclave Improved Order Heptasophs*, 49 A. 550 (1901) ("sometimes self-destruction, humanly speaking, is excusable, as where a man curtails by weeks or months the agony of an incurable disease.").

<sup>45</sup> *Cruzan v. Missouri Dept. of Health*, 497 U.S. 261, 280 (1990) ("We do not think that 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").

<sup>46</sup> Catherine D. Shaffer, *supra* note 37, at 356-357. For instance, whether or not a person attempts suicide is often affected by the quality of relationships with others. *Id.* at 357.

physically robust. Further, if the right were only extended to those individuals who were not depressed but who were making a "rational decision" regarding an untenable circumstance, a court would be required to engage in an evaluation of social and psychological factors that are generally alien to the establishment of constitutional rights.<sup>47</sup>

## **B. Passive Euthanasia: Refusal or Termination of Medical Treatment**

### **1. Historical Precedent: Common Law Battery.**

Passive euthanasia, or the refusal or termination of medical treatment by a patient, has historical roots in criminal law. Under common law doctrine, an unauthorized touching was the basis for a charge of battery. In the medical field, this has been applied to prevent and punish the application of medical treatment without the full and informed consent of the individual involved or a suitable representative.<sup>48</sup> Even when the government seeks to impose unauthorized medical treatment, the courts have generally required that the government show compelling needs to impose such treatment.<sup>49</sup>

### **2. State Legislation Regarding Passive Euthanasia: Treatment Directives.**

As the right to refuse medical treatment existed at common law and has, with a few notable exceptions,<sup>50</sup> generally been honored by the courts, decisions by competent patients to terminate treatment do not appear to have attracted the attention of state legislatures. However, the situation often arises that a patient with a serious medical condition will become so ill that he cannot communicate or he is not competent to make a medical care decision. This situation is prevalent enough that a Model Code entitled Uniform Rights of the Terminally Ill Act was developed, and most states have adopted some procedure by which medical treatment decisions can be made by individuals in advance.

#### ***a. The Living Will Option***

Most states have statutes based on the Uniform Rights of the Terminally Ill<sup>51</sup> which authorize an individual to execute a Treatment Directive directing the

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<sup>47</sup> Thomas J. Marzan, *supra* note 34, at 107.

<sup>48</sup> Note, *supra* note 17, at 2026. *See, e.g.*, *Hershley v. Brown*, 655 S.W.2d 671, 676 (Mo. App. 1983).

<sup>49</sup> *See* *Washington v. Harper*, 494 U.S. 210 (1990)(state interest in maintaining order overrides a prisoner's liberty interest in avoiding the forced application of anti-psychotic drugs)

<sup>50</sup> *See infra* note 71.

<sup>51</sup> *Unif. Rights of the Terminally Ill*, 9B U.L.A. 609 (1989).

withholding or withdrawal of life-sustaining procedures.<sup>52</sup> These Treatment Directives, referred to as "Living Wills", are generally only applicable when the individual, sometimes referred to as the "declarant" or "principal," is terminally ill and death is imminent. The required form of a "Living Will" may vary from state to state, but a properly executed "Living Will" should be easily enforceable in the state in which it was drafted. These "Living Will" statutes also offer significant legal protections. For instance, those involved in termination of medical treatment are generally immunized by statute from liability for allowing a patient to die. Further, life insurance benefits which might be jeopardized by termination of medical treatment are generally protected. Finally, the application of penal laws which might prohibit suicide are generally voided by the operation of these statutes.

***b. Appointment Directives: Durable Power of Attorney for Health Care.***

All states provide that an individual can delegate legally binding authority to another individual. This delegation of authority is sometimes referred to as the delegation of the "power of attorney." A "durable" power of attorney, which is also provided by state statute, is drafted so as to be effective when a person is incompetent to make decisions for himself. Some states have specifically provided that these durable powers of attorney may be used to delegate the authority to make medical decisions, even where such decisions may lead to the death of the individual. Thus, using a durable power of attorney, a person can appoint another individual to make medical decisions for him if he becomes incapacitated.<sup>53</sup>

A durable power of attorney, often set forth in an "Appointment Directive," offers a number of advantages over a Living Will. A person who delegates health-making decisions using this procedure does not have to anticipate every possible medical situation which may arise. By utilizing a power of attorney, the medical treatment decision can be deferred until such time as the medical situation has occurred; in this way, the appointed decision-maker can evaluate the specific details of the medical situation before making a decision. An Appointment Directive can also contain directions to the appointed decision-maker describing what medical treatment should or should not be used, as with a Living Will. The appointed decision-maker need not be a professional attorney; rather, the appointment can be given to any competent adult, with some exceptions, whether they be family, friend or other.

A health proxy is similar to a durable power of attorney, but is generally contained within a Treatment Directive. As with the durable power of attorney, the health proxy may be given specific instructions by the declarant regarding what medical treatment should be provided, or the proxy may be given the discretion to

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<sup>52</sup> See Marguerite A. Chapman, *The Uniform Right of the Terminally Ill Act: Too Little, Too Late?*, 42 *Arkansas Law Review* 319 (1989). Although many states have authorized "Living Wills" and "durable powers of attorney," these documents are apparently still relatively uncommon, and the problematic court cases appear to arise most often because patients have not prepared such wills. *Id.*

<sup>53</sup> Gregory Gelfand, *Living Will Statutes: The First Decade*, 1987 *Wis. L. Rev.* 737, 794 (1987).

make these decisions. Generally, the only significant difference between a health proxy and a durable power of attorney is that a health proxy, like most Treatment Directives, can only be exercised when a patient is terminally ill; a durable power of attorney is usually not so limited.

### 3. Constitutional Status.

As noted above, the right to refuse medical treatment has been addressed by legislation at the state level. However, even in those cases where no medical directive has been completed, or where the state law does not cover a particular medical circumstance, individuals or their guardians have still sought to make a medical decision which will ultimately cause the death of the patient. In this type of situation, implementation of a patient's wishes might be sought under the Fourteenth Amendment of the Constitution. This was the litigation posture which led to the case of *Cruzan v. Missouri Department of Health*.<sup>54</sup>

At the time of the litigation in *Cruzan*, Nancy Cruzan lay in a hospital bed<sup>55</sup> in what is called a persistent vegetative state.<sup>56</sup> In Nancy's case, there was sufficient brain-stem activity to control unconscious activities, such as breathing and heart functioning, and sometimes she would respond to pain or noise. Nancy apparently went through sleep and wake cycles, but when her eyes were open they moved randomly, and she did not seem aware of her environment. Her body was stiff, she lay in a fetal position, and her arms and legs were permanently contracted. Medical opinion was that she would never interact significantly with the world around her again.<sup>57</sup>

Although Nancy was able to take nutrition through spoon-feeding following the accident, it was determined that artificial nutrition and hydration were medically indicated. Thus, approximately three weeks after the accident, with the permission of both her parents and her husband, a feeding tube was surgically implanted in her stomach. It is this medical decision which Nancy's parents sought to reverse. With this feeding tube in place, Nancy Cruzan could have lived up to another thirty years. Without it, she would die, most likely through dehydration. At the time of the litigation, Nancy Cruzan had been in a persistent vegetative state for over six years.

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<sup>54</sup> 497 U.S. 261 (1990).

<sup>55</sup> In 1983, Nancy Cruzan, 25 years old, was involved in a car accident on a deserted country road. 497 U.S. at 266. She was found face down on a frozen ground with no signs of life. Although an emergency team was able to restore breathing and heartbeat, Nancy Cruzan's brain had been oxygen-starved for too long, and she suffered severe brain damage. *Id.*

<sup>56</sup> According to the Academy of Neurology, persistent vegetative state patients are permanently unconscious and devoid of thought, emotion and sensation. The state is described as a form of eyes-open permanent unconsciousness in which the patient has periods of wakefulness and physiological sleep/wake cycles. Amicus Brief for Academy of Neurology at 3, *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1989)(No. 88-1503). It was estimated that 10,000 patients were being maintained in a persistent vegetative state in the United States. *Id.*

<sup>57</sup> 497 U.S. at 267.

Although the State of Missouri has a "Living Will" statute,<sup>58</sup> it was not in effect at the time of Nancy's accident, nor did Nancy write out such a will. The statute was relevant, however, because it specifically excluded the possibility that a patient's Living Will could provide for the withdrawal of nutrition or hydration tubes. Thus, the Missouri legislature appeared to have made a decision that the withdrawal of nutrition and hydration was not within the realm of acceptable conduct even with the written consent of the patient.<sup>59</sup> Based on this finding, the Missouri Supreme Court held that the state's interest in protecting life would require a clear and convincing showing of Nancy's wishes prior to withdrawal of medical treatment.<sup>60</sup>

The *Cruzan* case, because of its facts, presented two legal issues to the Supreme Court: first, whether Nancy Cruzan had the constitutional right, even absent legislative approval, to consent to the withdrawal of nutrition and hydration; second, whether this right could be exercised by a guardian, and what standard of proof would be required to show that such a course of action was the intent of the patient. The Supreme Court ultimately decided that the state may require clear and convincing evidence of her wishes, and as her guardians did not have sufficient proof, the nutrition and hydration could not be withdrawn.<sup>61</sup> The Supreme Court did not technically decide the issue whether the Missouri court could have acted contrary to a clear and convincing expression of Nancy Cruzan to withdraw medical procedures, although, as discussed later, the implication of the case is that it could not.

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<sup>58</sup> Mo. Rev. Stat. §459.010 *et seq.* (1986).

<sup>59</sup> The Supreme Court of Missouri graphically pointed out in its opinion how this case differed from many previous medical decision cases. Nancy was not dead, nor was she terminally ill, and she could have lived up to thirty years in her condition. Essentially, the decision, as stated by the court, was whether the hospital should be allowed to cause Nancy Cruzan to die by starvation or dehydration. The Supreme Court of Missouri considered the case as one of first impression for Missouri, and declined to allow the hospital to withdraw nutrition and hydration. *Cruzan v. Harmon*, 760 S.W.2d 408, 427 (Mo. 1989)(en banc).

<sup>60</sup> *Cruzan v. Harmon*, 760 S.W.2d 408, 426 (1988)(en banc).

<sup>61</sup> The Court found that it was not constitutionally required that guardians or family be allowed to effectuate such a decision. *Cruzan*, 497 U.S. at 284. Rather, the Court determined that not only could a state require that a patient's own personal wishes be examined, but that absent clear and convincing evidence of such wishes, a state could decline to allow withdrawal of treatment. To bolster this argument, the Court cited other instances in which a state may require certain formalities prior to implementing the wishes of an individual, such as the requirement that a will be in writing. *Id.* However, it does not appear that the Missouri Supreme Court requirement of "clear and convincing" evidence was based on the assumption that most individuals would prefer life to death; rather, the requirement would appear to have been based on a non-individualized state interest in "life" irrelevant of the wishes of the individual. *Id.* at 280-281. As the Court concurred that there was no "clear and convincing" evidence of Nancy Cruzan's wishes, the Supreme Court held that Missouri's generalized interest in the preservation of life allowed the State to refuse the guardian's wishes to terminate treatment. *Id.* at 286-87.



The Court, in deciding the *Cruzan* case, first examined the case of *In re Quinlan*,<sup>62</sup> one of the first state court cases to examine these issues. Karen Quinlan, similarly to Nancy Cruzan, had suffered severe brain damage as a result of oxygen starvation, and medical opinion agreed that she would not regain cognitive function. Karen Quinlan, unlike Nancy Cruzan, was both attached to a respirator and provided nourishment by a feeding tube, and her guardians sought only removal of the respirator. In *Quinlan*, the New Jersey Supreme Court found that Karen Quinlan had a right of privacy to terminate her life in its vegetative state. This right, however, was not found to be absolute, but was to be balanced against the rights of the state. The *Quinlan* court found that the state's interest in preserving life diminishes as the degree of bodily invasion increases, and as the prognosis dims. Ultimately, there comes a point at which the individual's rights overcome the state's interest. The court further found that the only practical way to give effect to this right would be to let the guardian and the family use their best judgment in making a decision.<sup>63</sup>

The majority opinion of the *Cruzan* Court, authored by Chief Justice Rehnquist and joined by Justices White, O'Connor, Scalia and Kennedy, appears to have implicitly accepted the primary holding of the *Quinlan* and related state cases, which was that a patient has a constitutional right to refuse medical treatment that sustains life.<sup>64</sup> However, the language of the opinion did leave some ambiguity as to the general application of this right.<sup>65</sup> Justice O'Connor, in her concurring opinion, leaves

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<sup>62</sup> 355 A.2d 647 (N.J. 1976), *cert denied*, 429 U.S. 922 (1976).

<sup>63</sup> The *Cruzan* Court noted that since the case of *Quinlan*, many other courts have found legal grounds to allow termination of medical treatment. It would appear, however, that these cases have been based on two distinct lines of legal reasoning. The first, consistent with *In Re Quinlan*, is the finding that there is a constitutional right of privacy which protects decisions made concerning life-sustaining treatment. The second line of reasoning is based on the common law right to refuse medical treatment, expressed as the requirement of informed consent. Under common-law, a physician who performs a medical procedure without valid consent is performing a battery, and the law will act to prevent and punish such treatment. *Hershley v. Brown*, 655 S.W.2d 671, 676 (Mo. App. 1983). Thus, the argument is made, individuals who wish to decline medical treatment, even if such will result in their death, have the right to do so.

<sup>64</sup> 497 U.S. at 280.

<sup>65</sup> The majority opinion states the following:

Petitioners insist that under the general holdings of our cases, the forced administration of life-sustaining medical treatment, and even of artificially-delivered food and water essential to life, would implicate a competent person's liberty interest. Although we think the logic of the cases discussed would embrace such a liberty interest, the dramatic consequences involved in refusal of such treatment would inform the inquiry as to whether the deprivation of that interest is constitutionally permissible. But for purposes of this case, we assume that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition.

no such ambiguity, and sets forth an extensive opinion of the basis and scope of this right. Further, Justices Brennan, Marshall, Blackmun and Stevens, in dissent, also recognize the existence of this right. Only Justice Scalia, in a concurrence, signals that he would have resisted the Court's acceptance of this constitutional doctrine. Thus, despite the ambiguous language contained in the majority opinion, five justices -- O'Connor, Brennan, Marshall, Blackmun and Stevens -- appear to support the establishment of a right to termination of medical treatment.

#### 4. Implications of *Cruzan*.

The statutes of the various states do not generally provide for the implementation of any form of Directive other than Living Wills and durable powers of attorney. Yet, there may be other instructions which a person desires to leave regarding his medical treatment,<sup>66</sup> and *Cruzan* appears to have upheld a person's constitutional right to refuse any medical treatment even if the result will be death. Thus, under *Cruzan*, an individual's right to refuse medical treatment may be broader than the rights which are granted by most state statutes.

For instance, as noted earlier, many states' "Living Will" laws deal only with terminal illness, and thus do not apply where the patient is in a persistent vegetative state, but in no immediate danger of death.<sup>67</sup> Theoretically, an advance medical directive could be drafted which set forth the procedure to be followed if a patient became persistently vegetative, but it might not qualify under a state's Living Will statute. The holding in *Cruzan*, however, implies that a state may not prohibit a clear advance medical directive, at least regarding life-sustaining technology.<sup>68</sup> Thus, to be

<sup>65</sup> (...continued)

The second sentence of this quote appears to hedge the question as to whether refusal of medical treatment by a patient should always be respected, at least when the consequences may be "dramatic". Arguably, this may be because another case could occur where a state interest would outweigh the patient's liberty interest. In fact, in the Supreme Court cases cited in *Cruzan*, medical treatment was imposed over objection of a competent patient based on an overriding state interest. *See* *Washington v. Harper*, 494 U.S. 210 (1990)(state interest in maintaining order overrides a prisoner's liberty interest in avoiding the forced application of anti-psychotic drugs); *Parham v. J.R.*, 442 U.S. 584, 604-08 (1979)(a state's interest in certain administrative procedures used in confining a child to mental institution overrides the child's liberty interest).

<sup>66</sup> An advance medical directive is a statement by a competent person indicating his wishes regarding medical treatment in the event of future incompetence. LAZAROFF & ORR, *LIVING WILLS AND OTHER ADVANCE DIRECTIVES, ETHICAL ISSUES IN THE CARE OF THE ELDERLY* 523 (1986). Generic advance directives have firmly established legal precedents, but their use in medical contexts has generally not been addressed by statute. Unlike most "Living Will" statutes, advance directives may be used to address medical questions during any period of incompetence, not just those periods association with terminal illness.

<sup>67</sup> *See* Unif. Rights of the Terminally Ill Act §3, 9B U.L.A. 615 (1980).

<sup>68</sup> Generally, states may not act so as to unreasonably burden the exercise of constitutional rights. Thus, a state may not erect procedural barriers for a patient to express his intent to exercise his constitutional right to refuse medical treatment. *Cruzan*, 497 U.S. at 305 (J. Brennan, dissenting). While the Supreme Court was willing to accept a requirement of clear  
(continued...)

consistent with *Cruzan*, a state may be required to fully implement an advance medical directive despite its own statute.<sup>69</sup>

A question left unresolved by *Cruzan*, however, is what type of medical treatment may be refused under the Fourteenth Amendment.<sup>70</sup> While refusing to be attached to a respirator or a heart-lung machine is clearly within a patient's right to refuse treatment, it is not clear that the same can be said for a diabetic who refuses to take insulin, an individual who declines the provision of antibiotics, or an accident victim who refuses attempts to stem arterial bleeding. Of even greater concern is the possibility that an individual can attempt a suicide and leave a suicide note invoking a constitutional right to resist medical treatment.

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<sup>68</sup> (...continued)

and convincing evidence, it did so only after significant analysis. Consequently, the implication of the *Cruzan* case would appear to be that a state may only act to facilitate a patient's desires, and not to restrict or arbitrarily nullify them. For this reason, any state statutes or court opinions which restrict the use of advanced medical directives and durable powers of attorney might be held to overly burden a patient's intent and desire to refuse medical treatment.

<sup>69</sup> An issue not explicitly addressed by the Court was the type of limitations that may be placed upon an individual appointed by the patient to make medical decisions. Such an appointment, called a durable power of attorney because the appointment remains applicable even after an individual has become incompetent, generally leaves considerable discretion to the appointed individual to make a decision for the principal. Such an appointment may be preferable to a living will, as the appointed surrogate can make a detailed evaluation of the medical situation, and make a determination as to the patient's treatment. What is unclear is whether such a surrogate could be held to a "best interest" of the patient standard, or whether the fact of the appointment of the individual by the patient to exercise his or her constitutional rights would preclude any challenge to the decision made by that individual. The *Cruzan* court stated that "[w]e are not faced with the question of whether a State might be required to defer to the decision of a surrogate if competent and probative evidence established that the patient herself had expressed a desire that the decision to terminate life-sustaining treatment be made for her by that individual". *Cruzan*, 497 U.S. at 287, n.12.

Concerns were raised, prior to *Cruzan*, that a living will or other advance directive executed in one state might not be honored in another state. The *Cruzan* case would appear to dispel most of these concerns. Assuming that an individual had clearly set out his wishes with sufficient detail to cover a particular medical situation, it would appear that any state court would be required to acknowledge the document, and give effect to it. Absent some indication of fraud or changed circumstance, the imposition of specific technical requirements such as to the form or number of witnesses would appear to be inconsistent with an individual's constitutional right to refuse medical treatment as established under *Cruzan*.

It is not yet clear what type of evidence a state can require before it will implement a Directive which is not authorized by its statute. It would appear, however, that a written directive which complied with the procedural requirements of a state's living will or durable power of attorney statutes would be strong evidence of a patient's medical intent, and would ultimately be enforced by a court.

<sup>70</sup> The Supreme Court opinion in *Cruzan* contained almost no discussion concerning why this particular type of medical technology, provision of nutrition and hydration, could be withdrawn, even though the distinction between nutrition/hydration support and other forms of medical support engendered considerable discussion in the court below. *Cruzan v. Harmon*, 706 S.W.2d at 423-24.

This question may be especially crucial to the lower courts in disposing of cases, such as have arisen in the past, where otherwise healthy individuals have rejected medical treatment for religious or other reasons.<sup>71</sup> There is little indication that the Court considered whether these distinctions would still be valid after *Cruzan*. However, a close scrutiny of the language of the opinion reveals a notion that there is a difference between providing "life-sustaining treatment" to a dying patient, and "life-saving treatment" to a healthy patient.

Life-sustaining treatment does not appear to be a term of art, but is used differently in different contexts.<sup>72</sup> For purposes of this discussion, however, we will define life-sustaining technologies as those drugs, medical devices, or procedures that by continuous application can keep an individual alive who would otherwise die within the near future.<sup>73</sup> Life-saving technology, on the other hand, could be defined to include those treatments which will keep an individual alive, but need not be maintained on a continuous basis because the underlying condition is arrested, reversed or cured. These definitions represent points on a continuum, and some treatments may appear to fall in between depending on the context in which they are provided.<sup>74</sup>

Under common law, the right to refuse medication represents one of the longest standing individual "rights," bolstering the argument for a constitutional right to refuse life-sustaining intervention. Where a technology is life-saving, however, courts have been less reluctant to override a patient's wishes, especially when the underlying

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<sup>71</sup> Much of the case law in the area of refusal or termination of medical treatment to competent patients involves the refusal of patients to accept medical treatment because of religious beliefs. These often involve Jehovah's Witnesses who are prohibited by their religion from accepting blood transfusions. Although a court will often weigh religious belief in making its decisions, many of these cases resulted in an order being issued requiring medical treatment. *See* *United State v. George*, 239 F. Supp. 752 (D. Conn. 1965)(39-year-old father of four children); *Powel v. Columbia Presbyterian Medical Center*, 49 Misc. 2d 215, 267 N.Y.S.2d 450 (1965)(blood required for post-operative caesarian care); *John F. Kennedy Memorial Hospital v. Heston*, 58 N.J. 576, 279 A.2d 670 (1971)(transfusions ordered for 22-year-old woman based on state interest in conservation of life, and need to permit hospital to function according to professional standards).

<sup>72</sup> *See, e.g.*, Uniform Rights of the Terminally Ill Act §1, 9B U.L.A. 161 (1989)(1996 Supp.) (defining "life-sustaining treatment" as a medical procedure which serves only to prolong the process of dying).

<sup>73</sup> *See* Office of Technology Assessment (OTA), *Life-Sustaining Technologies and the Elderly* 4 (1987).

<sup>74</sup> For example, the application of antibiotics in an otherwise healthy individual which cures a dangerous infection, and returns that individual to sustained health, would appear to be a life-saving technology. On the other hand, continual doses of antibiotics to fight off recurring infection in an elderly nursing home patient may be seen an life-sustaining technology. *Id.*

condition is medically treatable.<sup>75</sup> Thus the question arises, what did the Court approve of, and what lines implicitly were drawn.

Let us speculate for the moment that the Court assumed that the administration of artificial nutrition and hydration was found to be a form of life-sustaining technology. As the withdrawal of all nutrition would ultimately kill any patient, and there was no indication that the nutrition and hydration could be successfully withdrawn without threatening the life of Nancy Cruzan, the Court, by inference, appears to be sanctioning refusal of a life-sustaining technology. However, during a general discussion of a state's interest in preserving life and preventing suicide, the Court makes the following statement: "[w]e 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" (emphasis added). This *dicta* appears to represent some concern that in a different fact situation, such as where a healthy individual attempted suicide by fasting, states may intervene. Such intervention, which might include the use of medical technology, thus appears to be distinguishable from the *Cruzan* case. Thus, the court does appear to recognize that some life-saving, as opposed to life-sustaining, medical technology might be imposed on an individual despite his or her constitutional rights under the Fourteenth Amendment.

## 5. The *Schiavo* case.

According to the Florida Court of Appeals Theresa Schiavo, at the age of 27, suffered a cardiac arrest as a result of a potassium imbalance, and never regained consciousness.<sup>76</sup> Since 1990, she has lived in nursing homes and a hospice with constant care, where she is fed and hydrated by tubes. Although she has had numerous health problems, none have been life threatening. According to the appellate court, the evidence is overwhelming that Theresa is in a permanent or persistent vegetative state.<sup>77</sup> Further, Theresa's brain damage is incurable, as much of the cerebral cortex had been replaced by cerebral spinal fluid.

In 2001, the court of appeals considered whether to allow the termination of life-prolonging procedures under chapter 765 of the Florida Statutes<sup>78</sup> and under the constitutional guidelines enunciated by the Supreme Court in the case of *In re*

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<sup>75</sup> See *supra* note 71. It should also be noted that there appears to be no common law precedent for "suicide" in our legal system. See Thomas P. Marzan, *supra* note 34 at 1 (1985). Arguably, the refusal of life-saving medical technology may in some cases represent a form of suicide, for instance where a protest fast becomes life-threatening. Thus, arguably, the constitutional right that can be inferred from *Cruzan* would not extend as far as refusal of all life-saving medical technology.

<sup>76</sup> *In Re* Guardianship of Theresa Marie Schiavo, 780 So. 2d 176 (Fla. App. Ct. 2001).

<sup>77</sup> Unlike a coma, a person in a persistent vegetative state is not unconscious, but is characterized by cycles of wakefulness and sleep without cognition or awareness. See *supra* note 56 and accompanying text.

<sup>78</sup> Chapter 765 deals with Health Care Advance Directives.

*Guardianship of Browning*.<sup>79</sup> In the case of *Browning*, the Florida Supreme Court held that, under the Florida Constitution, the guardian of a patient who is incompetent but not in a permanent vegetative state and who suffers from an incurable, but not terminal condition, may exercise the patient's right of self-determination to forego sustenance provided artificially by a nasogastric tube. The case, however, did require that the guardian have clear and convincing proof that the patient would not have wanted food and water provided to them in their present medical circumstance.

In the *Schiavo* case, the trial court had found that, despite conflicting testimony, there was sufficient evidence to support such a finding. Although the testimony only involved a few oral statements to her friends and family about the dying process, the appeals court found that there was a sufficient basis for the trial court's conclusion. The appeals court finding was clearly influenced by the nature of Theresa Schiavo's medical condition, and whether she would have wanted continued medical care after being in a persistent vegetative state for over ten years.

This court decision, however, was followed by a series of legal proceedings initiated by the parents of Theresa Schiavo<sup>80</sup> and others,<sup>81</sup> intended to overturn or delay implementation of the appeals court decision. Then, in October of 2003, the Florida Legislature passed a bill granting the Governor the authority to "stay" the withholding of nutrition and hydration in a situation such as existed in the *Schiavo* case,<sup>82</sup> a power which the Governor promptly exercised.<sup>83</sup> This legislative "stay," however, has been challenged as a violation of the doctrine of separation of powers, and a decision in the case is currently pending.

### C. Assisted Suicide

Although suicide is not a crime in this country, assisting another person to commit suicide may, in many states, result in criminal penalties being imposed.<sup>84</sup> Legal scholars have argued that it is logically inconsistent to punish a person who is "aiding and abetting" the principal actor, here the person committing suicide, when

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<sup>79</sup> 568 So. 2d 4 (Fla. 1990).

<sup>80</sup> See e.g., *In Re Guardianship of Theresa Marie Schiavo*, 792 So. 2d 551 (Fla. Ct. App. 2001); *In Re Guardianship of Theresa Marie Schiavo*, 800 So. 2d 640 (Fla. Ct. App. 2001); *In Re Guardianship of Theresa Marie Schiavo*, 851 So. 2d 182 (Fla. Ct. App. 2003).

<sup>81</sup> See, e.g., *Advocacy Center for Persons with Disabilities v. Schiavo*, 2003 U.S. Dist. LEXIS 19949 (M.D. Fla. October 21, 2003).

<sup>82</sup> See Fla. Stat. § 765.404 note.

<sup>83</sup> See Laurie Cunningham, *Legal Experts Say New Law Allowing Governor to Overrule Court Violates Separation of Powers*, Miami Daily Business Review 1 (October 23, 2003).

<sup>84</sup> It is important to distinguish assisting suicide from euthanasia. While assisting a person to commit suicide by providing them the means to commit suicide is a specific crime with mild to moderate criminal penalties, affirmatively killing a person, even with that person's consent, is murder, and can expose a person to significant jail sentences. Catherine D. Shaffer, *supra* note 37, at 348.

the latter is not punished.<sup>85</sup> Such laws, however, roughly parallel laws which protect minors and incompetent persons from exploitation, such as laws against statutory rape.<sup>86</sup> Thus, while a state may decide that treatment would be more effective than punishment for a suicidal person, the state might also reason that punishment would be a more effective deterrent to prevent persons from assisting a suicide. Further, such law can serve as a protection against a person attempting to encourage or coerce a vulnerable person to commit suicide.<sup>87</sup>

## 1. Historical Precedent.

Assisted suicide, as with suicide generally, has a long history of disfavor.<sup>88</sup> Unlike legal prohibitions regarding suicide, however, which were not adopted by the American legal system, laws against assisted suicide have been on the books for many years.<sup>89</sup> Thirty-five states currently have statutes with penalties for assisted suicide<sup>90</sup> and nine more have penalties based on case law.<sup>91</sup> It is not clear, however, whether these statutes have ever been vigorously enforced, and for many years the prosecution of such cases appears to have been almost nonexistent.<sup>92</sup> There are a few examples, however, of convictions for assisted suicide where long sentences have been imposed.<sup>93</sup>

One of the reasons that few cases have been brought in this area is that where a person is suicidal because of pain or disability, juries appear reluctant to convict persons who assist them in committing suicide. For example, starting in 1990, Jack Kevorkian, a retired pathologist, assisted scores of patients to commit suicide. Various attempts to convict him of assisted suicide, however, were stymied by juries refusing to convict. There are indications that the juries that acquitted Dr. Kevorkian engaged in jury nullification, *i.e.* the jury found that all the elements of the crime had been established, but failed to convict anyway.<sup>94</sup> Because jury nullification establishes

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<sup>85</sup> *Id.*

<sup>86</sup> An adult who engages in sexual conduct with a minor may be charged with statutory rape, although the minor engaged in the sexual act willingly.

<sup>87</sup> Catherine Shaffer, *supra* note 37, at 364-65.

<sup>88</sup> Thomas J. Marzan, *supra* note 34, at 15, 20, 24.

<sup>89</sup> For instance, the two statutes at issue in the cases of *Vacco* and *Glucksberg* before the Supreme Court date from the 19th century. *Id.* at 73.

<sup>90</sup> Michael Peltier, *U.S. Man Wants Doctors to Help Him Kill Himself*, Reuters World Service (May 8, 1997).

<sup>91</sup> *Id.*

<sup>92</sup> From 1930 through 1985, not one state court decision on assisting suicide appears. Catherine D. Shaffer, *supra* note 37, at 358.

<sup>93</sup> Thomas J. Marzan, *supra* note 34, at 77.

<sup>94</sup> Jack Lessenberry, *supra* note 5 at A14.

no precedent and provides no guidelines, however, Dr. Kevorkian's actions remain of dubious legality.<sup>95</sup>

## 2. State Legislation.

Although there is currently a movement to legalize assisted suicide and active euthanasia legislatively, this movement has little or no precedent in this country<sup>96</sup> or in others.<sup>97</sup> The only example of domestic legislation approving of physician-assisted suicide is an initiative passed by Oregon. This initiative allows persons who are terminally ill to seek assistance in committing suicide if they meet certain criteria.<sup>98</sup> A federal district court held that because the referendum failed to distinguish between competent and mentally incompetent persons, depriving the mentally incompetent of the protections of law afforded to the non-terminally ill, the law was a violation of the Fourteenth Amendment.<sup>99</sup> This decision, however, was vacated on other grounds.<sup>100</sup> Of more significance, Attorney General Ashcroft has threatened the withdrawal of the controlled substances licenses of doctors who use such substances for the purpose of assisting suicide.<sup>101</sup>

## 3. Constitutional Status.

In *Glucksberg v. Washington*, the Supreme Court held that the right to assisted suicide is not a fundamental liberty interest protected under the Due Process Clause of the Fourteenth Amendment.<sup>102</sup> In *Quill v. Vacco*, decided the same day, the Court held that enforcement of assisted suicide laws does not unreasonably discriminate, in violation of the Equal Protection component of the Fourteenth Amendment, against

<sup>95</sup> Dr. Kevorkian was ultimately convicted of second degree murder for directly administering lethal drugs to a terminally ill patient, and was sentenced to 10 to 25 years in prison.

<sup>96</sup> The cases of *Quill* and *Compassion in Dying* concerned laws which forbid assisted suicide; the case holdings, which approved of assisted suicide, were based on constitutional grounds.

<sup>97</sup> Holland, the only country which has ventured into this area, has not passed legislation authorizing assisted suicide, but has authorized suicide through a series of court cases. STAFF OF THE SUBCOMMITTEE ON THE CONSTITUTION OF THE COMMITTEE ON THE JUDICIARY, *supra* note 16, at 5. In 1995, the Northern Territory of Australia passed a law authorizing physician-assisted suicide, which has been implemented and utilized. Associated Press, *Suicide Law Divisive in Australia*, Fresno Bee, January 7, 1997, at A9.

<sup>98</sup> See *Lee v. Oregon*, 891 F. Supp. 1429, 1431 (D. Or. 1995), *vacated on other grounds*, 107 F.3d 1382 (9th Cir. 1997).

<sup>99</sup> 891 F.Supp. at 1437.

<sup>100</sup> 107 F.3d. 1382 (9th Cir. 1997).

<sup>101</sup> See *Oregon v. Ashcroft*, 192 F. Supp. 2d 1077 (2002). This directive, however, was challenged as being outside of the scope of the Attorney General's statutory authority, and has been enjoined. *Id.* An appeal of this order is pending before the United States Court of Appeals for the Ninth Circuit.

<sup>102</sup> 521 U.S. 702 (1997).



persons who are suffering or terminally ill.<sup>103</sup> The ultimate impact of this decision is that the "right to die" is unlikely to be expanded significantly by the courts.

**a. Substantive Due Process.**

Under the Fourteenth Amendment a "liberty interest" may only be infringed if there is a sufficient state interest to justify such. If a "liberty interest" is deemed to be fundamental, then it may not be infringed except by a narrowly tailored regulation which furthers a compelling state interest.<sup>104</sup> Where a liberty interest is not fundamental, a court will subject an infringement to a much less restrictive analysis.

In *Glucksberg*, the United States Court of Appeals for the Ninth Circuit, struck down an assisted suicide statute, drawing heavily from Supreme Court cases concerning abortion. In particular, the court noted the emphasis on protecting personal autonomy in *Casey v. Planned Parenthood of Pennsylvania*,<sup>105</sup> which reaffirmed that the Fourteenth Amendment protected a woman's decision to have an abortion. Characterizing laws against assisted suicide as essentially forcing suffering patients to endure torture at the end of life,<sup>106</sup> the court found a generalized right in hastening one's own death, and consequently struck down the assisted suicide statute as a restriction on a fundamental liberty interest.<sup>107</sup>

The Supreme Court rejected this interpretation of the Fourteenth Amendment, noting that the Court moves with "utmost care" before breaking new ground in this area of liberty interests.<sup>108</sup> Generally, the Court, which distinguishes between heavily protected "fundamental rights" and less protected "substantive rights," has indicated an unwillingness to expand the number of "fundamental rights" protected under the Fourteenth Amendment. The Court requires either that such rights must be deeply rooted in history<sup>109</sup> or so central to personal autonomy that neither liberty nor justice would exist without them.<sup>110</sup> An analysis of these two criteria led the Court to reject the broad interpretation of fundamental rights suggested by the circuit court in *Glucksberg*.

*i. Whether Assisted Suicide Is a Fundamental Right.*

First, the Supreme Court rejected the argument that suicide or assisted suicide is rooted in the nation's history and tradition. As noted above, suicide and assisted

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<sup>103</sup> 521 U.S. 793 (1997).

<sup>104</sup> *Collins v. City of Harker Heights*, 503 U.S. 115, 123 (1992).

<sup>105</sup> 505 U.S. 833 (1992).

<sup>106</sup> 79 F.3d at 814.

<sup>107</sup> *Id.* at 839.

<sup>108</sup> *Glucksberg*, 521 U.S. at 720.

<sup>109</sup> *See Bowers v. Hardwick*, 478 U.S. 186, 192, *reversed by Lawrence v. Texas*, 123 S.Ct. 2472 (2003).

<sup>110</sup> *Id.*

suicide have long been disfavored by our judicial system, and even the absence of criminal sanction for suicide has not prevented the legal system from using the civil commitment system as a route to prevent suicide. Further, there is a deep societal resistance to suicide that includes many major religions and many groups associated with health care.<sup>111</sup>

The Court easily dismissed the historical approach, noting an almost universal rejection of the practice in the Nation's history.<sup>112</sup> As to the second element - whether the right at issue is "so central to personal autonomy that neither liberty nor justice would exist without them" - the Court rejected the application of this broad language, and distinguished cases regarding personal autonomy such as *Casey v. Planned Parenthood of Pennsylvania* and *Cruzan v. Missouri Department of Health*.

The District Court in *Glucksberg*, which struck down the assisted suicide statute, had felt that the right to die was similar to the right to abortion. That court found many similarities between the two situations, including the intimacy of the decision, and the susceptibility to untoward influence by other persons.<sup>113</sup> But, unlike abortion, which involves the competing interests of the mother and the fetus, the court emphasized that assisted suicide involves only the individual and his or her own interests.<sup>114</sup> The *en banc* Court of Appeals, which upheld the district court, also relied heavily on language in *Casey* which affirmed the right to abortion as one of the "most intimate and personal choices a person may make in their life-time, choices central to personal dignity and autonomy."<sup>115</sup>

The Supreme Court rejected this use of *Casey*, noting that while many of the interests protected by the Due Process Clause involved personal autonomy, this did not mean that all important, intimate, and personal decisions are so protected.<sup>116</sup> The Court, again noting the Nation's historical rejection of assisted suicide, declined to extend the reasoning of *Casey* to cover this practice. This was consistent with the Court's previously expressed reluctance to extend the reasoning of *Roe v. Wade* into other areas of "personal autonomy."<sup>117</sup>

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<sup>111</sup> See *Amicus Curiae* Brief for the American Medical Association, *Vacco v. Quill*, No. 95-1858, at 2 (U.S. 1996)(the American Medical Association, the American Nurses Association, the American Psychiatry Association, and 43 other medical societies oppose a constitutional right to assisted suicide).

<sup>112</sup> *Glucksberg*, 521 U.S. at 728.

<sup>113</sup> *Compassion in Dying v. Washington*, 850 F. Supp. at 1460-1461.

<sup>114</sup> *Id.* at 1460.

<sup>115</sup> 79 F.3d at 801, *quoting* *Casey v. Planned Parenthood*, 505 U.S. at 851 (1992).

<sup>116</sup> 521 U.S. at 724.

<sup>117</sup> For instance, the line of cases leading up to *Roe* concerned primarily the areas of marriage, procreation and family relationships. Despite this focus on sexual activity, the Court, in a case called *Bowers v. Hardwick*, rejected an argument that there is a fundamental liberty interest in engaging in homosexual conduct. 478 U.S. at 186. *Bowers*, with its focus on the autonomy to engage in consensual sexual activity, would appear to be a close analogy

(continued...)

The Court had even less trouble distinguishing the instant case from *Cruzan v. Missouri Department of Health*,<sup>118</sup> which addresses the right to terminate medical treatment.<sup>119</sup> In *Cruzan*, the Supreme Court was developing that line of cases which derived from the right to bodily integrity. The *Cruzan* case was important because it dealt with the small but significant subcategory of informed consent cases that involve the refusal of medical treatment when it is apparent that withdrawal of the treatment would result in death. That is a separate issue from whether a person can affirmatively request that another person cause his death. All cases which have dealt with the right to die have recognized and maintained the distinction between "active" and "passive" medical intervention,<sup>120</sup> and the Supreme Court declined to eliminate this distinction.

*ii. State Interests in Preventing Assisted Suicide.*

If the Court had determined that a fundamental liberty interest exists in assisted suicide, then it would have examined whether there was a compelling governmental interest which was narrowly tailored to justify an infringement on this right. However, as the Court found that there was no fundamental right to assisted suicide, the state needed only to show that its interests were rationally related to any infringement. The Court found numerous state interests, including: 1) a general interest in the preservation of life, and a specific interest in maintaining barriers against suicide; 2) an interest in avoiding situations where it would be to the advantage of a third party to influence a person to commit suicide; 3) an interest in maintaining the integrity of the medical profession; and 4) an interest in preventing acts such as voluntary or involuntary euthanasia.

Historically, the state has been found to have a legitimate interest in discouraging physically healthy individuals from committing suicide.<sup>121</sup> The district court in *Glucksberg* argued that interest was insufficient when applied to terminally ill persons, and suggested that a legislature could define the appropriate circumstance

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<sup>117</sup> (...continued)

to the line of case leading up to *Roe*, and would certainly be more analogous to that line of cases than would a right to assisted suicide.

<sup>118</sup> 497 U.S. 261 (1990).

<sup>119</sup> 521 U.S. at 725-26.

<sup>120</sup> Traditionally, the law distinguishes between acts of "omission" and acts of "commission." Thomas J. Marzan, *supra* note 34, at 10. For instance, while the law traditionally prevents people from touching you without your permission, the law does not generally allow others to harm you intentionally, even if you give your consent. *Compassion in Dying v. Washington*, 49 F.3d 586, 592 (9th Cir. 1994), *reversed*, 79 F.3d 790 (9th Cir. 1995)(en banc). This distinction is clearly seen in the area of medical treatment. The risks and benefits of medical treatment are almost always tentative and questionable, and it is a basic tenet of law that an individual, as an exercise of personal autonomy, makes his or her own decision as to whether to accept or refuse a particular medical treatment.

<sup>121</sup> *Compassion in Dying v. Washington*, 850 F. Supp. at 1461.

where assisted suicide could be banned.<sup>122</sup> The Supreme Court held, however, that a state is not compelled to make such distinctions regarding quality of life.<sup>123</sup>

Unlike termination of medical treatment, which by its nature involves terminal or incurable persons, assisted suicide can be extended to a larger population.<sup>124</sup> Thus, the argument has been made that societal pressure against devoting resources to the poor, elderly, infirm or disabled would result in subtle or unsubtle pressure for those persons to seek assisted suicide rather than face an uncertain medical or economic future.<sup>125</sup> Here, the Court held that a state could rationally consider as too high the risk that an assisted suicide statute would be manipulated to encourage a person to commit suicide.<sup>126</sup>

The Court also held that a state may assert an interest in allowing its medical profession to set standards to protect both its integrity and the trust of the populace.<sup>127</sup> Many medical organizations consider doctor-assisted suicide to be incompatible with a doctor's Hippocratic oath, and would be concerned that such a role for doctors would lead to a conflict with their roles as healers.<sup>128</sup> There is also a concern that if assisted suicide were considered a treatment option, the progress in the ability of physicians to combat serious disease would be undermined.<sup>129</sup>

Finally, the Court held that permitting assisted suicide could start society down the path to active euthanasia, both voluntary and involuntary.<sup>130</sup> As noted earlier, advocates for physician-assisted suicide often do not distinguish between assisted suicide and euthanasia, despite the potential for abuse where the patient does not control the final administration of the lethal treatment. The Court noted that allowing assisted suicide would create the potential for this line to be crossed without detection, and that it would be extremely difficult to police or contain this distinction.<sup>131</sup>

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<sup>122</sup> *Id.* at 1455.

<sup>123</sup> 521 U.S. at 729.

<sup>124</sup> Yale Kamisar, *supra* note 18, at 755.

<sup>125</sup> *Compassion in Dying v. Washington*, 49 F.3d at 592. It has also been noted that it may be in the financial interest of a person related to or caring for an ill patient for that patient to die. *Id.* at 592-93.

<sup>126</sup> 521 U.S. at 732. It should be noted, however, that others have argued that such dire predictions, made with regard to the assertion of other rights, have failed to come true. *Compassion in Dying v. Washington*, 79 F.3d at 825-26 (noting arguments that women would be pressured into abortions if the procedure were legalized).

<sup>127</sup> 521 U.S. at 731.

<sup>128</sup> *Compassion in Dying v. Washington*, 49 F.3d at 592.

<sup>129</sup> *Id.* It has been argued, however, that since doctors are already engaged in the unregulated practice of assisted suicide, that the integrity of the profession would be better served by regulation of the practice. *Compassion in Dying v. Washington*, 79 F.3d at 828.

<sup>130</sup> 521 U.S. at 732.

<sup>131</sup> *Id.*

### ***b. Equal Protection.***

In *Quill v. Vacco*, a separate argument was made that enforcing a statute banning assisted suicide would discriminate against individuals who are terminally-ill but are not on life support. This argument relies on the fact that individuals with terminal diseases have a constitutional right, and often a statutory right, to request termination of medical treatment, which will ultimately cause their deaths. If terminally-ill patients not on life support are found to be similarly situated, then the denial of the right to assisted suicide is arguably a violation of equal protection.

As with due process fundamental rights analysis, equal protection analysis uses different standards by which to evaluate a law, depending on the class of people being discriminated against. While a high level of scrutiny is reserved for certain "suspect classifications" such as race or religion,<sup>132</sup> and an intermediate level of scrutiny is applied to certain others such as "gender classifications,"<sup>133</sup> distinctions based on other characteristics, such as medical condition, would generally be evaluated under a rational basis test. Thus, if a court can ascertain any rational governmental interest in making such a distinction, the law will be upheld.<sup>134</sup>

The Court in *Vacco* noted that the class of individuals being discriminated against here, terminally ill patients not on life support, would not constitute a traditional "suspect classification."<sup>135</sup> Consequently, a court would need to look only at whether there was a rational basis to distinguish between the treatment of persons who are on life support and those who are not. The Court noted that the distinction between assisting suicide and withdrawing life-sustaining treatment was widely recognized both legally and medically, and comported with fundamental legal principles of causation and intent.<sup>136</sup> Thus, the Court held that maintaining a distinction between letting a person die by natural means and causing their death was certainly a sufficient rational basis to preclude a successful equal protection challenge.

## **D. Active Euthanasia**

Active euthanasia, or administering a lethal treatment to a person, could arguably be treated in the same way as assisted suicide. Certainly the line between assisted suicide and active euthanasia has been blurred by commentators and the media in their discussions of the right to die.<sup>137</sup> For instance, the phrase "physician assisted" suicide has often been used without distinguishing whether a doctor was prescribing a lethal treatment or administering it.<sup>138</sup> Further, the argument can be made that if a person has

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<sup>132</sup> *Quill v. Vacco*, 80 F.3d at 726.

<sup>133</sup> *Id.*

<sup>134</sup> *Id.* at 725.

<sup>135</sup> *Vacco*, 521 U.S. at 799.

<sup>136</sup> *Id.* at 801.

<sup>137</sup> 80 F.3d at 747.

<sup>138</sup> *Id.*

the right to self-administer a lethal treatment, then he should have the right to seek such treatment from others.<sup>139</sup>

The distinction between assisted suicide and active euthanasia is, however, both legally and practically significant, and is maintained in almost all legal jurisdictions. In the case of assisted suicide, the actual fatal procedure is completed by the patient, thus shielding the person assisting from direct legal responsibility for the death. Although, many states have specific statutes that ban assisting in a suicide, the act is not treated as homicide, is rarely prosecuted and has relatively low criminal penalties.<sup>140</sup> The situation is different if another person actually implements the fatal procedure. Since a person cannot generally consent to a crime, killing a patient, even if he asks to be killed, is considered murder, a serious crime in all fifty states.<sup>141</sup> Even prominent proponents of the right to assisted suicide have been uncomfortable with advocating active euthanasia,<sup>142</sup> although others argue that maintaining a distinction between the two would be difficult.<sup>143</sup>

Ultimately, the most significant distinction between assisted suicide and active euthanasia may be the susceptibility of active euthanasia to abuse. While a person who provides a patient the means of committing suicide may be in a position to bring pressure on that person to do so, the decision would ultimately lie with the patient, and thus there is no issue of consent. Where another party commits the act, however, the issue of consent must be addressed, and it may be difficult to establish such consent when the patient is dead. Because active euthanasia appears to be more susceptible to abuse than does assisted suicide, a state could reasonably distinguish between these two "rights" as a matter of public policy. Enforcement prohibitions on active euthanasia may be difficult, however, as the practice appears to most often occur under the guise of palliative care.<sup>144</sup>

## E. Palliative Care

Another form of medical treatment which can result in a hastened death is palliative care. Palliative care is medical treatment to relieve pain, but in terminal cases, the escalating levels of pain medication can ultimately reach toxic levels, killing the patient.<sup>145</sup> This type of treatment is less controversial than the other categories, and

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<sup>139</sup> *Id.*

<sup>140</sup> Catherine D. Shaffer, *supra* note 37 at 352.

<sup>141</sup> *Id.* at 351.

<sup>142</sup> Yale Kamisar, *supra* note 18, at 747 (noting that Dr. Quill, the named plaintiff in the *Quill v. Vacco* case, initially resisted arguing for euthanasia because of the risk involved).

<sup>143</sup> *Id.* at 749-750.

<sup>144</sup> Susan Okie, *AIDS Doctors Report Prescribing Lethal Drugs*, WASHINGTON POST, February 11, 1997, Health Section at 5.

<sup>145</sup> *Compassion in Dying v. Washington*, 79 F.3d at 839 (J. Beezer, dissenting).

generally has few legal repercussions.<sup>146</sup> In fact, Justice O'Connor, in a concurring opinion in *Glucksberg*, has indicated that a patient may have a constitutional right to palliative care.<sup>147</sup>

Because palliative care can ultimately result in a shortened life-span, however, it would appear to raise policy concerns similar to the other "right to die" issues.<sup>148</sup> Further, the line between palliative care and active euthanasia is extremely difficult to monitor, and it appears that to the extent that unsanctioned euthanasia is being practiced by doctors, much of it may occur under the guise of palliative care. While palliative care by itself may raise few policy issues, its susceptibility to abuse may make it the most likely area where evasion of the law occurs.

#### **IV. Who Decides: Individuals, Guardians, and the Court**

Medical decision-making regarding terminally or chronically ill persons has the additional complication that many such patients are comatose or so disabled that they are not legally competent to make health care decisions. Consequently, the issue arises as to whether the various "rights to die" can be exercised by others on behalf of the legally incompetent individual, and what standards should apply. While virtually all the law in this area relates to the termination of medical treatment, such situations could also arise if active euthanasia became a legal option.<sup>149</sup>

Differing standards have been adopted by various courts to address the problem of discerning an unresponsive patient's desires for medical treatment. Some courts attempt to discern the "subjective intent" of the patient, either through (1) written documents such as a Living Will, advance medical directives, or a durable power of attorney; (2) specific oral statements; (3) generalized inquiries regarding a patient's prior attitudes and past statements; or (4) attempts to discern what a patient would decide, if cognizant and given the relevant facts regarding her prognosis.<sup>150</sup> There is also another line of cases which focuses less on the subjective intent of the patient, and more on the objective condition of the patient. Under this "objective test," the issue becomes whether the burdens of a patient's condition are such as to justify a

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<sup>146</sup> At least one judge has distinguished palliative care as without legal consequence, because the intent of the act is pain relief, and not to kill. 79 F.2d at 857 (J. Kleinfield, dissenting).

<sup>147</sup> *Glucksberg*, 521 U.S. at 797-98 (O'Connor, J., concurring).

<sup>148</sup> STAFF OF THE SUBCOMMITTEE ON THE CONSTITUTION, COMMITTEE ON THE JUDICIARY, 104TH CONG., *supra* note 15, at 5.

<sup>149</sup> As legally incompetent patients would most likely be incapable of committing suicide, surrogate decision-making would appear to either involve termination of medical treatment or active euthanasia.

<sup>150</sup> See *Developments in the Law of Medical Technology and the Law*, 103 Harv. L. Rev. 1519, 1647-49 (1990); Kaenezis, *Patient's Right to Refuse Treatment Allegedly Necessary to Sustain Life*, 93 A.L.R.3d 67 (1979).

withdrawal; the opportunity for oppression and abuse, however, generally leads a court to take a hard look at the facts of such a case.

Using the above standards, many courts have found ways to approve the withdrawal of medical treatment from terminally ill or persistently vegetative patients. Some courts, however, have resisted these efforts, especially in the more difficult cases where there is no clear indication of the intent of the individual. This, for example, was the case when the Missouri Supreme Court refused to allow the parents of Nancy Cruzan to authorize the withdrawal of nutrition and hydration. In *Cruzan*, however, the United States Supreme Court did little more than decide that requiring proof of Nancy's intent by clear and convincing evidence was acceptable. What is unclear is whether there are any alternative tests which may be overly burdensome to this newly identified constitutional right.

### A. The Subjective Intent Test

Prior to the Supreme Court's decision in *Cruzan*, many courts had determined that an incompetent patient who did not wish to have life-sustaining medical technology used indefinitely, as evidenced by previous statements made by that patient when competent, should have those wishes given effect.<sup>151</sup> For instance, in the *Cruzan* case, in order to fulfill this "subjective intent test," the trial court had attempted to discern what Nancy Cruzan's attitude was toward sustained medical intervention. The court found that Nancy Cruzan was a vivacious, active, outgoing and independent person who preferred to do everything for herself. About a year prior to her accident, Nancy apparently had discussions in which she expressed the feeling that she would not wish to continue to live if she couldn't be at least half-way normal. Based on these two factors, the trial court found that Nancy Cruzan would have rejected her existing medical treatment.<sup>152</sup>

As has been discussed previously,<sup>153</sup> the Missouri Supreme Court reversed this decision, holding that Nancy's intent had not been shown by clear and convincing evidence. This standard, which had been utilized previously in other jurisdictions, was ultimately upheld by the Supreme Court, but in doing so, the Court did not indicate whether a more burdensome requirement than clear and convincing evidence could

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<sup>151</sup> See, e.g., *In Re Storar*, 52 N.Y. 2d 363, 420 N.E. 2d 64, *cert denied*, 454 U.S. 858 (1981).

<sup>152</sup> Relying solely on these two factors, the trial court appeared to expand what would normally be considered proof of "consent" under a common-law right to refuse treatment. Generally, for there to be true informed consent to refuse medication, a patient would need to be specifically aware of the possible circumstance of his or her physical condition, and would need to indicate specifically what could or could not be done. Apparently, the trial court, faced with conflicting social mores, was attempting to balance the benefits of continued treatment against the burdens of continued treatment. This attempt at balancing sometimes becomes even more overt under the objective test.

<sup>153</sup> See *supra* notes 58-61 and accompanying text.



be required, and thus did not explicitly address the degree to which a state could hinder this newly recognized right.<sup>154</sup>

## B. The Objective Test

A more difficult question arises if a patient has left no prior written or oral indications as to his or her medical wishes in the case of a serious illness. A number of lower courts, when confronted with a patient who has left little or no indication as to his intent, have developed rationales to objectively establish what the patient would want, if he were aware of his circumstance. These "objective tests," or the related "best interest standards," attempt to move beyond the subjective intent of the patient, and focus instead on the details of the present situation. In the *In the Matter of Conroy* case,<sup>155</sup> the New Jersey Supreme Court, refusing to terminate life-support for an incompetent but conscious patient,<sup>156</sup> established two alternative standards to the subjective test to be used when the patient in question had not made his wishes clear concerning the withdrawal of medical treatment - the limited objective and the purely

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<sup>154</sup> In contrast to Missouri's "clear and convincing" standard, a majority of the states that have considered the issue allowed a form of "substituted judgment," so that a family member or guardian can make a decision for an incompetent patient. Gasner, *supra* note 7 at 14.

<sup>155</sup> 86 A.2d 1209 (N.J. 1985).

<sup>156</sup> In *In the Matter of Conroy*, 486 A.2d 1209 (N.J. 1985), Claire Conroy was an eighty-two year old resident of a nursing home, and her only surviving relative, a nephew, was appointed as her guardian. Ms. Conroy, because of an organic brain syndrome, had become increasingly confused, disoriented, and physically dependant. As with Nancy Cruzan, a feeding tube had been implanted to provide nutrition and hydration. When her nephew brought suit seeking termination of medical treatment, Ms. Conroy was confined to bed in a semi-fetal position. She suffered from heart disease, hypertension, diabetes, gangrene, and a variety of other infections. On the other hand, she could move her head, neck and arms, could scratch herself, and would attempt to pull at her bandages. Medical doctors testified that Ms. Conroy was not comatose or in a chronic vegetative state, although her mental condition was severely deteriorated. 486 A.2d at 1221.

To resolve the case, the New Jersey Supreme Court tried to balance the interests of the State against the burdens of treatment. The court identified four state interests in such circumstances - preserving life, preventing suicide, safeguarding the integrity of the medical profession, and protecting innocent third parties. *See Satz v. Perlmutter*, 362 So.2d 359, 360 (Fla. 1980). The court indicated that the burden of being maintained on a life-support system could, in some instances, outweigh the interests of the State.

In refusing to allow the withdrawal of Ms. Conroy's feeding and nutrition, the Supreme Court of New Jersey noted the vulnerability of nursing home populations, and the sometimes grossly inadequate care and concern that they receive. The court further noted that Ms. Conroy, although resistant to medical intervention throughout her life, had not specifically addressed or provided for the contingency of being incapacitated and in need of medical intervention. Ultimately, the court found that there was insufficient evidence to support a finding either that Ms. Conroy's wishes would be to terminate treatment, or that the burdens imposed by continued treatment outweighed the state interest in life. Consequently, the court declined to condone the removal of the feeding tube, even while contemplating the possibility that absent an expression by the patient as to the withholding of health care, a court might allow the withdrawal of medical care by a guardian.

objective tests.<sup>157</sup> Under the limited objective test, life-sustaining treatment may be withheld when there is trustworthy evidence that the patient would have refused treatment, and where the decision-maker is satisfied that the burdens of continued life outweigh the benefits for the patient.<sup>158</sup> Under a purely objective test, where there is no evidence of subjective intent, not only must the burdens of treatment outweigh the benefits, but the medical treatment must cause such recurring, severe and unavoidable pain that administering the life-sustaining treatment would be inhumane.<sup>159</sup> Under these tests, the *Conroy* court found that there was insufficient evidence to allow the withdrawal of Ms. Conroy's feeding tube.<sup>160</sup>

The fate of the "objective intent" tests after *Cruzan* is uncertain. The tests are clearly not overly burdensome to the right of the patient to refuse treatment, as they are only invoked when there is little or no indication of subjective intent. Whether the test is sufficiently attentive to the actual wishes of the patient, or whether the "objective test" instead bypasses the need for an expressed desire by a patient, and merely applies the desires of the guardian, the care-provider, or the court, however, remain valid questions. As the Court pointed out in *Cruzan*, there is as much a Due Process right to "life" as there is to death,<sup>161</sup> and there may be situations where guardians are not acting to protect the patient. Thus, although unstated, the Court's *Cruzan* decision, by relying almost entirely on individual autonomy, may signal that "objective" decisions, which rely on third party choices, do not have the same constitutional protections. Based on *Cruzan*, therefore, a state might ban its courts from considering any factors except the expressed desires of the individual.<sup>162</sup>

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<sup>157</sup> 486 A.2d at 1233.

<sup>158</sup> *Id.*

<sup>159</sup> Under the limited or purely "objective test", courts appear to be introducing the concept of balancing the benefits of life against the "benefits" of death, albeit still within the context of individual rights. For instance, the *Conroy* court restricted its balancing to the physical pain being felt by the patient because of continuing treatment. Arguably, this would limit the application of the test to the conscious patient, as the value of life in a vegetative state or in a coma is outside of our daily evaluation of "benefits and burdens." Privacy, bodily integrity, pain and suffering would not appear to be of particular relevance to a determination of what was in the best interests of a vegetative or comatose patient.

<sup>160</sup> 486 A.2d at 1243.

<sup>161</sup> *Cruzan*, 497 U.S. at 281.

<sup>162</sup> Because the Missouri Supreme Court focused on the subjective intent of Nancy Cruzan, the *Cruzan* Court did not have the opportunity to evaluate any "objective" consideration which a court might ultimately weigh in this area. Because these fundamental life decisions regarding dying have been debated primarily in the courts, and not legislatures, the focus has been on individual rights versus the state's interest. The ultimate balancing decisions which society as a whole might make on these issues have been avoided by many states. Ultimately, society may need to reconcile individual wishes, the interests of the immediate family, and the interests of society at large on the use of medical resources, and this would appear to be a role for the legislatures.

## C. The Never-Competent Patient

An unaddressed implication of the *Cruzan* opinion is that a state may provide that only "competent" expressions of the desire to resist medical treatment need be honored.<sup>163</sup> Thus, arguably, a minor child or an individual permanently incompetent because of disease or mental disability could be effectively prohibited from exercising his right to have medical treatment withdrawn. Some state courts have allowed such individuals to have medical treatment withheld based on variations of the objective tests.<sup>164</sup> If, however, an incompetent patient were sufficiently lucid to make his or her wishes known, an argument could be made that to deny the right to have treatment withheld would be an Equal Protection violation.<sup>165</sup>

## V. The Federal Role

### A. Federal Versus State Jurisdiction

Traditionally, state legislatures have jurisdiction over the health and safety of their populations, and consequently, most legislation regarding the right to die has been enacted at the state level. As noted, many states have passed laws regarding advance medical directives and durable powers of attorney, and some states have begun to revisit the issues of assisted suicide. While there are various constitutional issues which may place limits on the ability of states to legislate in these areas, there is no question that the states have the authority generally to address these issues.

The United States Constitution, on the other hand, does not grant the federal government a general jurisdiction to regulate health issues or to enforce criminal laws.<sup>166</sup> Although over the last fifty years, the Congress has exercised increasing

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<sup>163</sup> The *Cruzan* opinion upheld the Missouri Supreme Court, stating that "Missouri . . . has established a procedural safeguard to assure that the action of a surrogate conforms as best it may to the wishes expressed by the patient while competent." *Cruzan*, 497 U.S. at 280.

<sup>164</sup> See, e.g., *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E. 2d 417 (1977). The reasoning of this court was that the patient, a 67 year old profoundly retarded man, would have refused treatment if he had been competent and aware of his circumstance. This holding has, however, been criticized as circular.

<sup>165</sup> The *Cruzan* court summarily dismissed an equal protection argument that its holding would unjustly discriminate between the rights of competent patients and the rights of incompetent patients. *Cruzan*, 497 U.S. at 261. The Court held this argument inapplicable because the issue being discussed was the choices made *by* a competent person versus the choice made *for* an incompetent person. If a lucid, but incompetent person could make his wishes known, however, the reasoning of the Court in *Cruzan* might be distinguished.

<sup>166</sup> Early federal criminal law was generally based on the Property Clause of the Constitution, U.S. Const., Art. IV, §3 (granting jurisdiction over federal property and territories). Many of the laws found in the federal criminal code relate to offenses occurring on federal property or which otherwise affect federal interests. For instance, most federal "street crimes" such as assault, arson, sexual abuse and robbery are restricted in application to the "Special Maritime and Territorial Jurisdiction of the United States," which includes

(continued...)

authority over health and criminal law issues based on the Commerce Clause,<sup>167</sup> or has indirectly regulated such areas by conditioning grants of money to states, a recent Supreme Court decision would appear to limit the scope of legislation which could be passed directly under the Commerce Clause.

### 1. *United States v. Lopez.*

In *United States v. Lopez*,<sup>168</sup> the Supreme Court brought into question the extent to which the Congress can rely on the Commerce Clause as a basis for federal jurisdiction. The *Lopez* case is significant in that it is the first time since 1937 that the Supreme Court has struck down a federal statute based on a finding that the Congress had exceeded its powers under the Commerce Clause.<sup>169</sup> In doing so, the Court revisited its prior cases, sorted the Commerce Power into three categories, and asserted that the Congress could not go beyond three categories of commerce regulation: 1) regulation of channels of commerce; 2) regulation of instrumentalities of commerce; and 3) regulation of economic activities which "affect" commerce.<sup>170</sup>

The *Lopez* Court found that because a federal law prohibiting the possession of guns near a school<sup>171</sup> fell into none of the three categories set out above, the Congress did not have the authority to pass the Gun-Free School Zones Act. It held that it is not a regulation of channels of commerce, nor does it protect an instrumentality of commerce. Finally, its effect on interstate commerce was found to be too removed to be "substantial." The Court noted that the activity regulated, the possession of guns in school, neither by itself nor in the aggregate affected commercial transactions.<sup>172</sup>

The Court went on to note that the statute contained no requirement that interstate commerce be affected or that the gun had been previously transported in interstate

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<sup>166</sup> (...continued)

certain federal lands and places of federal interest, such as the United States territories, the high seas, and aircraft. 18 U.S.C. §7 (1988).

<sup>167</sup> The United States Constitution provides that the Congress shall have the power to regulate commerce with foreign nations and among the various states. U.S. Const. Art. I, §8, cl. 3. This power has been cited as the constitutional basis for a significant portion of the laws passed by the Congress over the last fifty years, and it currently represents one of the broadest bases for the exercise of Congressional powers.

<sup>168</sup> 514 U.S. 549 (1995).

<sup>169</sup> Herman Schwartz, *Court Tries to Patrol a Political Line*, Legal Times 25 (May 8, 1995).

<sup>170</sup> Within the third category of activities which "affect commerce," the Court determined that the power to regulate commerce applied to intrastate activities only when they "substantially" affect commerce. 514 U.S. at 559.

<sup>171</sup> The Gun-Free School Zones Act of 1990 made it a federal offense for "any individual knowingly to possess a firearm at a place that the individual knows, or has reasonable cause to believe, is a school zone." 18 U.S.C. §922(q)(1)(A)(1988 ed., Supp. V).

<sup>172</sup> 514 U.S. at 567-68. The Court rejected arguments that possession of guns in school affected the national economy by its negative impact on education. *Id.*

commerce.<sup>173</sup> Nor was the criminalization of possession of a gun near a school part of larger regulatory scheme which did regulate commerce.<sup>174</sup> Finally, the Court indicated that criminal law enforcement is an area of law traditionally reserved to the states.<sup>175</sup>

## **2. Commerce Clause Jurisdiction over the Right to Die.**

Under the *Lopez* case, it would appear that direct federal legislation regarding the health care area would be limited unless such activity was shown to fall under the Commerce Clause.<sup>176</sup> An argument can be made that to the extent a medical professional was involved with a terminally or chronically ill patient when an end-of-life decision was made, the federal government would have jurisdiction to regulate, based on the commercial nature of the doctor-patient relationship.<sup>177</sup> However, even if the federal government might prohibit medical professionals from engaging in these activities, in situations where the aid provided to a patient was neither commercial in nature, nor was supplied by a medical professional, the federal government may be powerless to prevent individuals from engaging in such acts.

## **B. Relevant Federal Legislation**

### **1. The Patient Self-Determination Act.**

In 1990, Congress passed the Patient Self-Determination Act,<sup>178</sup> which requires that providers of health care service<sup>179</sup> under Medicare and Medicaid maintain written policies and procedures related to Living Wills and other advance directives. The providers are required to provide written information to all adult patients of their rights under State law to make decisions about their medical care, including the right to refuse care and to formulate an advance medical directive. The providers must also inquire whether a person has executed an advance directive, and ensure compliance with State law regarding such directives.

### **2. Assisted Suicide Funding Restriction Act.**

In the 105th Congress, the Congress passed the "Assisted Suicide Funding

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<sup>173</sup> 514 U.S. at 561-62.

<sup>174</sup> *Id.*

<sup>175</sup> 514 U.S. at 580-81 (Kennedy, J., concurring).

<sup>176</sup> Health care appears to be an example of a substantive area traditionally reserved to the states. See *id.* Historically, the health and safety of the populace is regulated at the state, and not the federal level.

<sup>177</sup> Even if a particular act were rendered without payment, it might be characterized as affecting "commerce" if it were part of a larger regulatory scheme regarding commercial transactions between doctors and patients.

<sup>178</sup> 42 U.S.C. §1395cc(f) (1994).

<sup>179</sup> This includes hospitals, nursing homes, home health agencies, hospices, HMOs and other prepaid organizations.

Restriction Act of 1997,"<sup>180</sup> which prohibits the use of federal funds to pay for assisted suicide. Reminiscent of the Hyde Amendments, which prohibit the use of federal funds to pay for abortions, this legislation prevents federal monies from being paid for any goods or services related to assisted suicide, euthanasia or mercy killing. The law also prevents use of federal funding to support legal advocacy. Although there is no indication that any federal monies were being used for such purposes, the legislation appears to be a constitutional exercise of Congress' spending power to regulate in the area of the "right to die."

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<sup>180</sup> Pub. L. 105-12 (1997).