MEDICALLY ASSISTED DYING

I. INTRODUCTION

There has been a significant debate in the United States and elsewhere over the past two decades over the propriety of medically assisted death; that is, medical care designed to help a patient die how and when the patient wants to die. Every state allows a physician to aid a patient who wishes to discontinue life-sustaining medical care, at least under most circumstances. May a health care provider also provide affirmative intervention that will hasten the patient's death? Under what circumstances?

The language we use to discuss these questions has become especially divisive over the past few years, and we must be careful how we use words that have become laden with political and philosophical meaning. "Euthanasia," for example, generally refers to an affirmative act that directly and immediately causes the death of a patient for the benefit of that patient. "Involuntary euthanasia" is sometimes used to describe euthanasia against the will of the patient, although sometimes it means euthanasia without the formal and expressed consent of the patient. "Voluntary euthanasia" is sometimes used to refer to euthanasia upon request of the patient, although most careful thinkers avoid using that term altogether. "Active euthanasia" sometimes refers to some affirmative act of euthanasia, while "passive euthanasia" generally refers, technically incorrectly, to withholding or withdrawing life-sustaining treatment.

"Suicide" can refer to any act taken by a person to intentionally end his life (including the act of a patient taking a prescribed lethal dose of medication), but sometimes it refers only to an act taken by someone acting irrationally, or under the influence of extraordinary emotional distress or mental disease (and not, for example, to the act of a terminally ill, competent patient who knowingly takes a prescribed lethal dose to end his suffering). Both "euthanasia" and "suicide" have highly negative connotations, and the people who use those terms generally oppose the propriety of the act. The words "death" and "killing" in this context also have strong negative connotations, and those terms are used to describe medically assisted dying primarily by those who oppose its legality.

On the other hand, "Death with Dignity," which often refers to these same acts, has a positive connotation. Is anyone opposed to death with dignity? That is why advocates of the practice now made legal in Oregon and Washington placed that title on the laws that were ultimately approved by the voters in each of those state. Those opposed to such laws view the use of the word "dignity" in this context to imply negatively that dying without affirmative intervention is somehow undignified. Similarly, "Right to Die" is generally a popular concept, and that term is used almost exclusively by those who approve of the use of this practice. For years, however, the phrase was used to describe the withdrawal of life-sustaining treatment. Using the same phrase in this context implicitly argues that there is no difference between the two. Although earlier editions of this casebook used the term, "physician assisted suicide" or "physician assisted death," both are abandoned in this issue because they are now used almost exclusively by those who oppose this role for physicians. The authors were tempted by the term,

“Aid in Dying,” which has been adopted by many medical organizations to describe the practice, but that term is used primarily by those who support this role for physicians.

As you read the materials that follow, make sure that you identify with specificity exactly what practice is being considered. While there are a few countries that permit euthanasia under certain limited circumstances, that has never really been an option available in the United States and it is rarely part of the legal debate. In this country, the debate has centered on the propriety (and legality) of a medically prescribed lethal dose designed to be ingested by a competent, fully informed patient who originally requested a prescription for it from a physician.

II. THE CONSTITUTIONAL FRAMEWORK

Washington v. Glucksberg

Supreme Court of the United States, 1997.

521 U.S. 702, 117 S.Ct. 2258, 138 L.Ed.2d 772.

REHNQUIST, C. J., delivered the opinion of the Court, in which O'CONNOR, SCALIA, KENNEDY, and THOMAS, JJ., joined. O'CONNOR, J., filed a concurring opinion, in which GINSBURG and BREYER, JJ., joined in part. STEVENS, J., SOUTER, J., GINSBURG, J., and BREYER, J., filed opinions concurring in the judgment.

CHIEF JUSTICE REHNQUIST delivered the opinion of the Court.

The question presented in this case is whether Washington's prohibition against "causing" or "aiding" a suicide offends the Fourteenth Amendment to the United States Constitution. We hold that it does not.

* * *

The plaintiffs assert [ ] "the existence of a liberty interest protected by the Fourteenth Amendment which extends to a personal choice by a mentally competent, terminally ill adult to commit physician-assisted suicide." [ ] Relying primarily on Planned Parenthood v. Casey, [ ] and Cruzan v. Director, Missouri Dept. of Health, [ ] the District Court agreed, [ ] and concluded that Washington's assisted-suicide ban is unconstitutional because it "places an undue burden on the exercise of [that] constitutionally protected liberty interest." [ ] The District Court also decided that the Washington statute violated the Equal Protection Clause's requirement that " 'all persons similarly situated ... be treated alike.' "[ ]

A panel of the Court of Appeals for the Ninth Circuit reversed, emphasizing that "in the two hundred and five years of our existence no constitutional right to aid in killing oneself has ever been asserted and upheld by a court of final jurisdiction." [ ] The Ninth Circuit reheard the case en banc, reversed the panel's decision, and affirmed the District Court. [ ] Like the District Court, the en banc Court of Appeals emphasized our Casey and Cruzan decisions. [ ] The court

also discussed what it described as "historical" and "current societal attitudes" toward suicide and assisted suicide, [ ] and concluded that "the Constitution encompasses a due process liberty interest in controlling the time and manner of one's death—that there is, in short, a constitutionally-recognized 'right to die.' "[ ] After "weighing and then balancing" this interest against Washington's various interests, the court held that the State's assisted-suicide ban was unconstitutional "as applied to terminally ill competent [ ] adults who wish to hasten their deaths with medication prescribed by their physicians." [ ] We granted certiorari [ ] and now reverse.

I

We begin, as we do in all due-process cases, by examining our Nation's history, legal traditions, and practices. [ ] In almost every State—indeed, in almost every western democracy—it is a crime to assist a suicide. The States' assisted-suicide bans are not innovations. Rather, they are longstanding expressions of the States' commitment to the protection and preservation of all human life. [ ] Indeed, opposition to and condemnation of suicide—and, therefore, of assisting suicide—are consistent and enduring themes of our philosophical, legal, and cultural heritages. [ ]

More specifically, for over 700 years, the Anglo—American common-law tradition has punished or otherwise disapproved of both suicide and assisting suicide. * * * [The Chief Justice then reviews the common law of England and the American colonies and states with regards to suicide, from the 13th century to the present.]

* * *

Attitudes toward suicide itself have changed since [the 13th Century prohibitions on suicide] * * * but our laws have consistently condemned, and continue to prohibit, assisting suicide. Despite changes in medical technology and notwithstanding an increased emphasis on the importance of end-of-life decisionmaking, we have not retreated from this prohibition. Against this backdrop of history, tradition, and practice, we now turn to respondents' constitutional claim.

II

The Due Process Clause guarantees more than fair process, and the "liberty" it protects includes more than the absence of physical restraint. [ ] The Clause also provides heightened protection against government interference with certain fundamental rights and liberty interests. [ ] In a long line of cases, we have held that, in addition to the specific freedoms protected by the Bill of Rights, the "liberty" specially protected by the Due Process Clause includes the rights to marry, [ ]; to have children, [ ]; to direct the education and upbringing of one's children, [ ]; to marital privacy, [ ]; to use contraception, [ ]; to bodily integrity, [ ] and to abortion, [ ]. We have also assumed, and strongly suggested, that the Due Process Clause protects the traditional right to refuse unwanted lifesaving medical treatment. [ ]

But we "have always been reluctant to expand the concept of substantive due process because guideposts for responsible decisionmaking in this unchartered area are scarce and open-

ended." [ ] By extending constitutional protection to an asserted right or liberty interest, we, to a great extent, place the matter outside the arena of public debate and legislative action. We must therefore "exercise the utmost care whenever we are asked to break new ground in this field" [ ] lest the liberty protected by the Due Process Clause be subtly transformed into the policy preferences of the members of this Court [ ].

Our established method of substantive-due-process analysis has two primary features: First, we have regularly observed that the Due Process Clause specially protects those fundamental rights and liberties which are, objectively, "deeply rooted in this Nation's history and tradition" [ ] and "implicit in the concept of ordered liberty," such that "neither liberty nor justice would exist if they were sacrificed" [ ]. Second, we have required in substantive-due-process cases a "careful description" of the asserted fundamental liberty interest. [ ] Cruzan, *supra*, at 277–278. Our Nation's history, legal traditions, and practices thus provide the crucial "guideposts for responsible decisionmaking" [ ] that direct and restrain our exposition of the Due Process Clause. As we stated recently in Flores, the Fourteenth Amendment "forbids the government to infringe ... 'fundamental' liberty interests at all, no matter what process is provided, unless the infringement is narrowly tailored to serve a compelling state interest." [ ]

* * *

Turning to the claim at issue here, the Court of Appeals stated that "properly analyzed, the first issue to be resolved is whether there is a liberty interest in determining the time and manner of one's death" [ ] or, in other words, "is there a right to die?" [ ]. Similarly, respondents assert a "liberty to choose how to die" and a right to "control of one's final days," [ ] and describe the asserted liberty as "the right to choose a humane, dignified death" [ ] and "the liberty to shape death" [ ]. As noted above, we have a tradition of carefully formulating the interest at stake in substantive-due-process cases. For example, although Cruzan is often described as a "right to die" case [ ] we were, in fact, more precise: we assumed that the Constitution granted competent persons a "constitutionally protected right to refuse lifesaving hydration and nutrition." [ ] The Washington statute at issue in this case prohibits "aiding another person to attempt suicide," [ ] and, thus, the question before us is whether the "liberty" specially protected by the Due Process Clause includes a right to commit suicide which itself includes a right to assistance in doing so.

* * * With this "careful description" of respondents' claim in mind, we turn to Casey and Cruzan.

[The Chief Justice next discusses the Cruzan case, where, he says,] "we assumed that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition."

* * *

The right assumed in Cruzan, however, was not simply deduced from abstract concepts of personal autonomy. Given the common-law rule that forced medication was a battery, and the long legal tradition protecting the decision to refuse unwanted medical treatment, our assumption

was entirely consistent with this Nation's history and constitutional traditions. The decision to commit suicide with the assistance of another may be just as personal and profound as the decision to refuse unwanted medical treatment, but it has never enjoyed similar legal protection. Indeed, the two acts are widely and reasonably regarded as quite distinct. [ ] In Cruzan itself, we recognized that most States outlawed assisted suicide?and even more do today—and we certainly gave no intimation that the right to refuse unwanted medical treatment could be somehow transmuted into a right to assistance in committing suicide. [ ]

Respondents also rely on Casey. There, the Court's opinion concluded that "the essential holding of Roe v. Wade should be retained and once again reaffirmed." [ ] We held, first, that a woman has a right, before her fetus is viable, to an abortion "without undue interference from the State"; second, that States may restrict post-viability abortions, so long as exceptions are made to protect a woman's life and health; and third, that the State has legitimate interests throughout a pregnancy in protecting the health of the woman and the life of the unborn child. [ ] In reaching this conclusion, the opinion discussed in some detail this Court's substantive-due-process tradition of interpreting the Due Process Clause to protect certain fundamental rights and "personal decisions relating to marriage, procreation, contraception, family relationships, child rearing, and education," and noted that many of those rights and liberties "involve the most intimate and personal choices a person may make in a lifetime." [ ]

* * *

That many of the rights and liberties protected by the Due Process Clause sound in personal autonomy does not warrant the sweeping conclusion that any and all important, intimate, and personal decisions are so protected, [ ] and Casey did not suggest otherwise.

The history of the law's treatment of assisted suicide in this country has been and continues to be one of the rejection of nearly all efforts to permit it. That being the case, our decisions lead us to conclude that the asserted "right" to assistance in committing suicide is not a fundamental liberty interest protected by the Due Process Clause. The Constitution also requires, however, that Washington's assisted-suicide ban be rationally related to legitimate government interests. [ ] This requirement is unquestionably met here. As the court below recognized, [ ] Washington's assisted-suicide ban implicates a number of state interests. [ ]

First, Washington has an "unqualified interest in the preservation of human life."

* * *

Relatedly, all admit that suicide is a serious public-health problem, especially among persons in otherwise vulnerable groups. [ ] The State has an interest in preventing suicide, and in studying, identifying, and treating its causes. [ ]

* * *

The State also has an interest in protecting the integrity and ethics of the medical profession. * * * [T]he American Medical Association, like many other medical and physicians'

groups, has concluded that "physician-assisted suicide is fundamentally incompatible with the physician's role as healer." [ ] And physician-assisted suicide could, it is argued, undermine the trust that is essential to the doctor-patient relationship by blurring the time-honored line between healing and harming. [ ]

Next, the State has an interest in protecting vulnerable groups—including the poor, the elderly, and disabled persons—from abuse, neglect, and mistakes. * * * [One respected state task force] warned that "legalizing physician-assisted suicide would pose profound risks to many individuals who are ill and vulnerable.... The risk of harm is greatest for the many individuals in our society whose autonomy and well-being are already compromised by poverty, lack of access to good medical care, advanced age, or membership in a stigmatized social group." [ ] If physician-assisted suicide were permitted, many might resort to it to spare their families the substantial financial burden of end-of-life health-care costs.

* * * The State's assisted-suicide ban reflects and reinforces its policy that the lives of terminally ill, disabled, and elderly people must be no less valued than the lives of the young and healthy, and that a seriously disabled person's suicidal impulses should be interpreted and treated the same way as anyone else's. [ ]

Finally, the State may fear that permitting assisted suicide will start it down the path to voluntary and perhaps even involuntary euthanasia. * * * [Justice Rehnquist then discussed how this fear could arise out of the practice in the Nertherlands.]

We need not weigh exactingly the relative strengths of these various interests. They are unquestionably important and legitimate, and Washington's ban on assisted suicide is at least reasonably related to their promotion and protection. We therefore hold that [ ] [the Washington ban on assisting suicide] does not violate the Fourteenth Amendment, either on its face or "as applied to competent, terminally ill adults who wish to hasten their deaths by obtaining medication prescribed by their doctors."[*] [ ]

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[*]Justice Stevens states that "the Court does conceive of respondents' claim as a facial challenge—addressing not the application of the statute to a particular set of plaintiffs before it, but the constitutionality of the statute's categorical prohibition.... " [ ] We emphasize that we today reject the Court of Appeals' specific holding that the statute is unconstitutional "as applied" to a particular class. [ ] Justice Stevens agrees with this holding, [ ] but would not "foreclose the possibility that an individual plaintiff seeking to hasten her death, or a doctor whose assistance was sought, could prevail in a more particularized challenge," ibid. Our opinion does not absolutely foreclose such a claim. However, given our holding that the Due Process Clause of the Fourteenth Amendment does not provide heightened protection to the asserted liberty interest in ending one's life with a physician's assistance, such a claim would have to be quite different from the ones advanced by respondents here.

Throughout the Nation, Americans are engaged in an earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a democratic society. The decision of the en banc Court of Appeals is reversed, and the case is remanded for further proceedings consistent with this opinion.

It is so ordered.

JUSTICE O'CONNOR, concurring [in both Glucksberg and Vacco].*

Death will be different for each of us. For many, the last days will be spent in physical pain and perhaps the despair that accompanies physical deterioration and a loss of control of basic bodily and mental functions. Some will seek medication to alleviate that pain and other symptoms.

The Court frames the issue in this case as whether the Due Process Clause of the Constitution protects a "right to commit suicide which itself includes a right to assistance in doing so," [ ] and concludes that our Nation's history, legal traditions, and practices do not support the existence of such a right. I join the Court's opinions because I agree that there is no generalized right to "commit suicide." But respondents urge us to address the narrower question whether a mentally competent person who is experiencing great suffering has a constitutionally cognizable interest in controlling the circumstances of his or her imminent death. I see no need to reach that question in the context of the facial challenges to the New York and Washington laws at issue here. [ ] The parties and amici agree that in these States a patient who is suffering from a terminal illness and who is experiencing great pain has no legal barriers to obtaining medication, from qualified physicians, to alleviate that suffering, even to the point of causing unconsciousness and hastening death. [ ] In this light, even assuming that we would recognize such an interest, I agree that the State's interests in protecting those who are not truly competent or facing imminent death, or those whose decisions to hasten death would not truly be voluntary, are sufficiently weighty to justify a prohibition against physician-assisted suicide. [ ]

Every one of us at some point may be affected by our own or a family member's terminal illness. There is no reason to think the democratic process will not strike the proper balance between the interests of terminally ill, mentally competent individuals who would seek to end their suffering and the State's interests in protecting those who might seek to end life mistakenly or under pressure. As the Court recognizes, States are presently undertaking extensive and serious evaluation of physician-assisted suicide and other related issues. [ ] In such circumstances, "the ... challenging task of crafting appropriate procedures for safeguarding ... liberty interests is entrusted to the 'laboratory' of the States ... in the first instance." [ ]

In sum, there is no need to address the question whether suffering patients have a constitutionally cognizable interest in obtaining relief from the suffering that they may

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*Justice Ginsburg concurs in the Court's judgments substantially for the reasons stated in this opinion. Justice Breyer joins this opinion except insofar as it joins the opinions of the Court.

experience in the last days of their lives. There is no dispute that dying patients in Washington and New York can obtain palliative care, even when doing so would hasten their deaths. The difficulty in defining terminal illness and the risk that a dying patient's request for assistance in ending his or her life might not be truly voluntary justifies the prohibitions on assisted suicide we uphold here.

JUSTICE STEVENS, concurring in the judgments [in both Glucksberg and Vacco].

The Court ends its opinion with the important observation that our holding today is fully consistent with a continuation of the vigorous debate about the "morality, legality, and practicality of physician-assisted suicide" in a democratic society. [ ] I write separately to make it clear that there is also room for further debate about the limits that the Constitution places on the power of the States to punish the practice.

I

The morality, legality, and practicality of capital punishment have been the subject of debate for many years. In 1976, this Court upheld the constitutionality of the practice in cases coming to us from Georgia, Florida, and Texas. In those cases we concluded that a State does have the power to place a lesser value on some lives than on others; there is no absolute requirement that a State treat all human life as having an equal right to preservation. Because the state legislatures had sufficiently narrowed the category of lives that the State could terminate, and had enacted special procedures to ensure that the defendant belonged in that limited category, we concluded that the statutes were not unconstitutional on their face. In later cases coming to us from each of those States, however, we found that some applications of the statutes were unconstitutional.

Today, the Court decides that Washington's statute prohibiting assisted suicide is not invalid "on its face," that is to say, in all or most cases in which it might be applied. That holding, however, does not foreclose the possibility that some applications of the statute might well be invalid.

* * *

History and tradition provide ample support for refusing to recognize an open-ended constitutional right to commit suicide. Much more than the State's paternalistic interest in protecting the individual from the irrevocable consequences of an ill-advised decision motivated by temporary concerns is at stake. There is truth in John Donne's observation that "No man is an island." The State has an interest in preserving and fostering the benefits that every human being may provide to the community—a community that thrives on the exchange of ideas, expressions of affection, shared memories and humorous incidents as well as on the material contributions that its members create and support. The value to others of a person's life is far too precious to allow the individual to claim a constitutional entitlement to complete autonomy in making a decision to end that life. Thus, I fully agree with the Court that the "liberty" protected by the Due Process Clause does not include a categorical "right to commit suicide which itself includes a

right to assistance in doing so." [ ]

But just as our conclusion that capital punishment is not always unconstitutional did not preclude later decisions holding that it is sometimes impermissibly cruel, so is it equally clear that a decision upholding a general statutory prohibition of assisted suicide does not mean that every possible application of the statute would be valid. A State, like Washington, that has authorized the death penalty and thereby has concluded that the sanctity of human life does not require that it always be preserved, must acknowledge that there are situations in which an interest in hastening death is legitimate. Indeed, not only is that interest sometimes legitimate, I am also convinced that there are times when it is entitled to constitutional protection.

II

In Cruzan [ ] the Court assumed that the interest in liberty protected by the Fourteenth Amendment encompassed the right of a terminally ill patient to direct the withdrawal of life-sustaining treatment. As the Court correctly observes today, that assumption "was not simply deduced from abstract concepts of personal autonomy." [ ] Instead, it was supported by the common-law tradition protecting the individual's general right to refuse unwanted medical treatment. [ ] We have recognized, however, that this common-law right to refuse treatment is neither absolute nor always sufficiently weighty to overcome valid countervailing state interests. * * *

Cruzan, however, was not the normal case. Given the irreversible nature of her illness and the progressive character of her suffering, Nancy Cruzan's interest in refusing medical care was incidental to her more basic interest in controlling the manner and timing of her death. In finding that her best interests would be served by cutting off the nourishment that kept her alive, the trial court did more than simply vindicate Cruzan's interest in refusing medical treatment; the court, in essence, authorized affirmative conduct that would hasten her death. When this Court reviewed the case and upheld Missouri's requirement that there be clear and convincing evidence establishing Nancy Cruzan's intent to have life-sustaining nourishment withdrawn, it made two important assumptions: (1) that there was a "liberty interest" in refusing unwanted treatment protected by the Due Process Clause; and (2) that this liberty interest did not "end the inquiry" because it might be outweighed by relevant state interests. [ ] I agree with both of those assumptions, but I insist that the source of Nancy Cruzan's right to refuse treatment was not just a common-law rule. Rather, this right is an aspect of a far broader and more basic concept of freedom that is even older than the common law. This freedom embraces, not merely a person's right to refuse a particular kind of unwanted treatment, but also her interest in dignity, and in determining the character of the memories that will survive long after her death. In recognizing that the State's interests did not outweigh Nancy Cruzan's liberty interest in refusing medical treatment, Cruzan rested not simply on the common-law right to refuse medical treatment, but—at least implicitly—on the even more fundamental right to make this "deeply personal decision," [ ].

* * *

While I agree with the Court that Cruzan does not decide the issue presented by these cases, Cruzan did give recognition, not just to vague, unbridled notions of autonomy, but to the more specific interest in making decisions about how to confront an imminent death. Although there is no absolute right to physician-assisted suicide, Cruzan makes it clear that some individuals who no longer have the option of deciding whether to live or to die because they are already on the threshold of death have a constitutionally protected interest that may outweigh the State's interest in preserving life at all costs. The liberty interest at stake in a case like this differs from, and is stronger than, both the common-law right to refuse medical treatment and the unbridled interest in deciding whether to live or die. It is an interest in deciding how, rather than whether, a critical threshold shall be crossed.

III

The state interests supporting a general rule banning the practice of physician-assisted suicide do not have the same force in all cases. First and foremost of these interests is the " 'unqualified interest in the preservation of human life' "[ ].

* * *. Although as a general matter the State's interest in the contributions each person may make to society outweighs the person's interest in ending her life, this interest does not have the same force for a terminally ill patient faced not with the choice of whether to live, only of how to die. * * *

Similarly, the State's legitimate interests in preventing suicide, protecting the vulnerable from coercion and abuse, and preventing euthanasia are less significant in this context. I agree that the State has a compelling interest in preventing persons from committing suicide because of depression, or coercion by third parties. But the State's legitimate interest in preventing abuse does not apply to an individual who is not victimized by abuse, who is not suffering from depression, and who makes a rational and voluntary decision to seek assistance in dying.

* * *

The final major interest asserted by the State is its interest in preserving the traditional integrity of the medical profession. The fear is that a rule permitting physicians to assist in suicide is inconsistent with the perception that they serve their patients solely as healers. But for some patients, it would be a physician's refusal to dispense medication to ease their suffering and make their death tolerable and dignified that would be inconsistent with the healing role * * * .

* * * I do not * * * foreclose the possibility that an individual plaintiff seeking to hasten her death, or a doctor whose assistance was sought, could prevail in a more particularized challenge. Future cases will determine whether such a challenge may succeed.

IV

* * *

There may be little distinction between the intent of a terminally-ill patient who decides to remove her life-support and one who seeks the assistance of a doctor in ending her life; in both situations, the patient is seeking to hasten a certain, impending death. The doctor's intent might also be the same in prescribing lethal medication as it is in terminating life support. * * *

Thus, although the differences the majority notes in causation and intent between terminating life-support and assisting in suicide support the Court's rejection of the respondents' facial challenge, these distinctions may be inapplicable to particular terminally ill patients and their doctors. Our holding today in Vacco v. Quill that the Equal Protection Clause is not violated by New York's classification, just like our holding in Washington v. Glucksberg that the Washington statute is not invalid on its face, does not foreclose the possibility that some applications of the New York statute may impose an intolerable intrusion on the patient's freedom.

There remains room for vigorous debate about the outcome of particular cases that are not necessarily resolved by the opinions announced today. How such cases may be decided will depend on their specific facts. In my judgment, however, it is clear that the so-called "unqualified interest in the preservation of human life," [ ] is not itself sufficient to outweigh the interest in liberty that may justify the only possible means of preserving a dying patient's dignity and alleviating her intolerable suffering.

JUSTICE SOUTER, concurring in the judgment.

* * *

When the physicians claim that the Washington law deprives them of a right falling within the scope of liberty that the Fourteenth Amendment guarantees against denial without due process of law, they are not claiming some sort of procedural defect in the process through which the statute has been enacted or is administered. Their claim, rather, is that the State has no substantively adequate justification for barring the assistance sought by the patient and sought to be offered by the physician. Thus, we are dealing with a claim to one of those rights sometimes described as rights of substantive due process and sometimes as unenumerated rights, in view of the breadth and indeterminacy of the "due process" serving as the claim's textual basis. The doctors accordingly arouse the skepticism of those who find the Due Process Clause an unduly vague or oxymoronic warrant for judicial review of substantive state law, just as they also invoke two centuries of American constitutional practice in recognizing unenumerated, substantive limits on governmental action. * * *

* * *

[Justice Souter explained that he was adopting Justice Harlan's approach to the Constitutional evaluation and protection of unenumerated rights under the Due Process Clause, as articulated in his dissent in Poe v. Ullman.] My understanding of unenumerated rights in the wake of the Poe dissent and subsequent cases avoids the absolutist failing of many older cases without embracing the opposite pole of equating reasonableness with past practice described at a

very specific level. [ ] That understanding begins with a concept of "ordered liberty," [ ] comprising a continuum of rights to be free from "arbitrary impositions and purposeless restraints" [ ].

* * *

This approach calls for a court to assess the relative "weights" or dignities of the contending interests, and to this extent the judicial method is familiar to the common law. Common law method is subject, however, to two important constraints in the hands of a court engaged in substantive due process review. First, such a court is bound to confine the values that it recognizes to those truly deserving constitutional stature, either to those expressed in constitutional text, or those exemplified by "the traditions from which [the Nation] developed," or revealed by contrast with "the traditions from which it broke." [ ]

The second constraint, again, simply reflects the fact that constitutional review, not judicial lawmaking, is a court's business here. The weighing or valuing of contending interests in this sphere is only the first step, forming the basis for determining whether the statute in question falls inside or outside the zone of what is reasonable in the way it resolves the conflict between the interests of state and individual.

* * *

The State has put forward several interests to justify the Washington law as applied to physicians treating terminally ill patients, even those competent to make responsible choices: protecting life generally [ ] discouraging suicide even if knowing and voluntary [ ] and protecting terminally ill patients from involuntary suicide and euthanasia, both voluntary and nonvoluntary [ ].

It is not necessary to discuss the exact strengths of the first two claims of justification in the present circumstances, for the third is dispositive for me. * * * [Justice Souter then explained why the Washington state legislature, on the basis of information now available, could have reasonably decided that a statute forbidding assisting suicide might protect terminally ill patients.]

* * *

The Court should accordingly stay its hand to allow reasonable legislative consideration. While I do not decide for all time that respondents' claim should not be recognized, I acknowledge the legislative institutional competence as the better one to deal with that claim at this time.

JUSTICE BREYER, concurring in the judgments [in both Glucksberg and Vacco].

I believe that Justice O'Connor's views, which I share, have greater legal significance than the Court's opinion suggests. I join her separate opinion, except insofar as it joins the

majority. * * *

I agree with the Court in Vacco v. Quill [ ] that the articulated state interests justify the distinction drawn between physician assisted suicide and withdrawal of life-support. I also agree with the Court that the critical question in both of the cases before us is whether "the 'liberty' specially protected by the Due Process Clause includes a right" of the sort that the respondents assert. [ ] I do not agree, however, with the Court's formulation of that claimed "liberty" interest. The Court describes it as a "right to commit suicide with another's assistance." [ ] But I would not reject the respondents' claim without considering a different formulation, for which our legal tradition may provide greater support. That formulation would use words roughly like a "right to die with dignity." But irrespective of the exact words used, at its core would lie personal control over the manner of death, professional medical assistance, and the avoidance of unnecessary and severe physical suffering—combined.

* * *

I do not believe, however, that this Court need or now should decide whether or a not * * * [a right to die with dignity] is "fundamental." That is because, in my view, the avoidance of severe physical pain (connected with death) would have to comprise an essential part of any successful claim and because * * * the laws before us do not force a dying person to undergo that kind of pain. [ ] Rather, the laws of New York and of Washington do not prohibit doctors from providing patients with drugs sufficient to control pain despite the risk that those drugs themselves will kill. [ ] And under these circumstances the laws of New York and Washington would overcome any remaining significant interests and would be justified, regardless.

* * *

Were the legal circumstances different—for example, were state law to prevent the provision of palliative care, including the administration of drugs as needed to avoid pain at the end of life—then the law's impact upon serious and otherwise unavoidable physical pain (and accompanying death) would be more directly at issue. And as JUSTICE O'CONNOR suggests, the Court might have to revisit its conclusions in these cases.

* * *

VACCO V. QUILL

Supreme Court of the United States, 1997.

521 U.S. 793, 117 S.Ct. 2293, 138 L.Ed.2d 834.

CHIEF JUSTICE REHNQUIST delivered the opinion of the Court.

In New York, as in most States, it is a crime to aid another to commit or attempt suicide, but patients may refuse even lifesaving medical treatment. The question presented by this case is

whether New York's prohibition on assisting suicide therefore violates the Equal Protection Clause of the Fourteenth Amendment. We hold that it does not.

* * * Respondents, and three gravely ill patients who have since died, sued the State's Attorney General in the United States District Court. They urged that because New York permits a competent person to refuse life-sustaining medical treatment, and because the refusal of such treatment is "essentially the same thing" as physician-assisted suicide, New York's assisted-suicide ban violates the Equal Protection Clause. [ ]

The District Court disagreed * * *.

The Court of Appeals for the Second Circuit reversed. [ ] The court determined that, despite the assisted-suicide ban's apparent general applicability, "New York law does not treat equally all competent persons who are in the final stages of fatal illness and wish to hasten their deaths," because "those in the final stages of terminal illness who are on life-support systems are allowed to hasten their deaths by directing the removal of such systems; but those who are similarly situated, except for the previous attachment of life-sustaining equipment, are not allowed to hasten death by self-administering prescribed drugs." [ ] The Court of Appeals then examined whether this supposed unequal treatment was rationally related to any legitimate state interests, and concluded that "to the extent that [New York's statutes] prohibit a physician from prescribing medications to be self-administered by a mentally competent, terminally-ill person in the final stages of his terminal illness, they are not rationally related to any legitimate state interest." [ ] We granted certiorari [ ] and now reverse.

The Equal Protection Clause commands that no State shall "deny to any person within its jurisdiction the equal protection of the laws." This provision creates no substantive rights. [ ] Instead, it embodies a general rule that States must treat like cases alike but may treat unlike cases accordingly. [ ] If a legislative classification or distinction "neither burdens a fundamental right nor targets a suspect class, we will uphold [it] so long as it bears a rational relation to some legitimate end." [ ]

New York's statutes outlawing assisting suicide affect and address matters of profound significance to all New Yorkers alike. They neither infringe fundamental rights nor involve suspect classifications. [ ] These laws are therefore entitled to a "strong presumption of validity." [ ]

On their faces, neither New York's ban on assisting suicide nor its statutes permitting patients to refuse medical treatment treat anyone differently than anyone else or draw any distinctions between persons. Everyone, regardless of physical condition, is entitled, if competent, to refuse unwanted lifesaving medical treatment; no one is permitted to assist a suicide. Generally speaking, laws that apply evenhandedly to all "unquestionably comply" with the Equal Protection Clause. [ ]

The Court of Appeals, however, concluded that some terminally ill people—those who are on life-support systems—are treated differently than those who are not, in that the former

may "hasten death" by ending treatment, but the latter may not "hasten death" through physician-assisted suicide. [ ] This conclusion depends on the submission that ending or refusing lifesaving medical treatment "is nothing more nor less than assisted suicide." [ ] Unlike the Court of Appeals, we think the distinction between assisting suicide and withdrawing life-sustaining treatment, a distinction widely recognized and endorsed in the medical profession and in our legal traditions, is both important and logical; it is certainly rational. [ ]

The distinction comports with fundamental legal principles of causation and intent. First, when a patient refuses life-sustaining medical treatment, he dies from an underlying fatal disease or pathology; but if a patient ingests lethal medication prescribed by a physician, he is killed by that medication. [ ]

Furthermore, a physician who withdraws, or honors a patient's refusal to begin, life-sustaining medical treatment purposefully intends, or may so intend, only to respect his patient's wishes and "to cease doing useless and futile or degrading things to the patient when [the patient] no longer stands to benefit from them." [ ] The same is true when a doctor provides aggressive palliative care; in some cases, painkilling drugs may hasten a patient's death, but the physician's purpose and intent is, or may be, only to ease his patient's pain. A doctor who assists a suicide, however, "must, necessarily and indubitably, intend primarily that the patient be made dead." [ ] Similarly, a patient who commits suicide with a doctor's aid necessarily has the specific intent to end his or her own life, while a patient who refuses or discontinues treatment might not. [ ]

The law has long used actors' intent or purpose to distinguish between two acts that may have the same result. [ ] Put differently, the law distinguishes actions taken "because of" a given end from actions taken "in spite of" their unintended but foreseen consequences. [ ]

Given these general principles, it is not surprising that many courts, including New York courts, have carefully distinguished refusing life-sustaining treatment from suicide. * * *

Similarly, the overwhelming majority of state legislatures have drawn a clear line between assisting suicide and withdrawing or permitting the refusal of unwanted lifesaving medical treatment by prohibiting the former and permitting the latter. [ ] And "nearly all states expressly disapprove of suicide and assisted suicide either in statutes dealing with durable powers of attorney in health-care situations, or in 'living will' statutes." [ ] Thus, even as the States move to protect and promote patients' dignity at the end of life, they remain opposed to physician-assisted suicide.

* * *

This Court has also recognized, at least implicitly, the distinction between letting a patient die and making that patient die. In Cruzan [ ] we concluded that "the principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions," and we assumed the existence of such a right for purposes of that case [ ]. But our assumption of a right to refuse treatment was grounded not, as the Court of Appeals supposed, on the proposition that patients have a general and abstract "right to hasten death," [ ] but on well established, traditional rights to bodily integrity

and freedom from unwanted touching [ ]. In fact, we observed that "the majority of States in this country have laws imposing criminal penalties on one who assists another to commit suicide." [ ] Cruzan therefore provides no support for the notion that refusing life-sustaining medical treatment is "nothing more nor less than suicide."

For all these reasons, we disagree with respondents' claim that the distinction between refusing lifesaving medical treatment and assisted suicide is "arbitrary" and "irrational."[11] Granted, in some cases, the line between the two may not be clear, but certainty is not required, even were it possible. Logic and contemporary practice support New York's judgment that the two acts are different, and New York may therefore, consistent with the Constitution, treat them differently. By permitting everyone to refuse unwanted medical treatment while prohibiting anyone from assisting a suicide, New York law follows a longstanding and rational distinction.

New York's reasons for recognizing and acting on this distinction—including prohibiting intentional killing and preserving life; preventing suicide; maintaining physicians' role as their patients' healers; protecting vulnerable people from indifference, prejudice, and psychological and financial pressure to end their lives; and avoiding a possible slide towards euthanasia—are discussed in greater detail in our opinion in Glucksberg, ante. These valid and important public interests easily satisfy the constitutional requirement that a legislative classification bear a rational relation to some legitimate end.

The judgment of the Court of Appeals is reversed.

* * *

JUSTICE SOUTER, concurring in the judgment.

Even though I do not conclude that assisted suicide is a fundamental right entitled to recognition at this time, I accord the claims raised by the patients and physicians in this case and Washington v. Glucksberg a high degree of importance, requiring a commensurate justification. [ ] The reasons that lead me to conclude in Glucksberg that the prohibition on assisted suicide is not arbitrary under the due process standard also support the distinction between assistance to suicide, which is banned, and practices such as termination of artificial life support and death-hastening pain medication, which are permitted. I accordingly concur in the judgment of the

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[11]Respondents also argue that the State irrationally distinguishes between physician-assisted suicide and "terminal sedation," a process respondents characterize as "inducing barbiturate coma and then starving the person to death." [ ] Petitioners insist, however, that " 'although proponents of physician-assisted suicide and euthanasia contend that terminal sedation is covert physician-assisted suicide or euthanasia, the concept of sedating pharmacotherapy is based on informed consent and the principle of double effect.' "[ ] Just as a State may prohibit assisting suicide while permitting patients to refuse unwanted lifesaving treatment, it may permit palliative care related to that refusal, which may have the foreseen but unintended "double effect" of hastening the patient's death. [ ]

Court.

* * *

Notes and Questions

1. The Ninth Circuit's *en banc* decision and an extraordinarily diverse and thoughtful set of opinions in *Glucksberg* can be found at Compassion in Dying v. Washington, 79 F.3d 790 (9th Cir.1996). The *en banc* court reversed a 2–1 decision of the original panel, which also included an impassioned opinion on each side of the issue. See 49 F.3d 586 (9th Cir.1995). The meticulously organized district court opinion in *Compassion in Dying* case is reported at 850 F.Supp. 1454 (W.D.Wash.1994). The Second Circuit's opinion in *Quill v. Vacco* can be found at 80 F.3d 716 (2d Cir.1996).

2. These cases generated many highly emotional responses. Although the Supreme Court's unanimous decision brought a semblance of propriety back to the discussion of these issues, supporters and opponents of medically assisted dying continue to attack the arguments of their opponents—and, as in the case of the abortion debate—they continue to attack their opponents, too. Some of the commentary on the Ninth Circuit opinions was especially personal. Judge Reinhardt (who wrote the primary decision finding the Washington law to be unconstitutional) was roundly criticized for his ACLU connections, which, some said, made it impossible for him to fairly decide the case. On the other hand, Judge Noonan (who would have upheld the statute for the first panel) had been criticized for his right-to-life connections and his Catholic faith which, others argued, made it impossible for *him* to be impartial. Should judges recuse themselves from cases involving these difficult and controversial bioethics issues if they have deeply held personal beliefs about the underlying practice—here medically assisted dying? Does it make a difference if they were members (or officers, or high ranking employees) of organizations which have taken explicit positions on the underlying issues? On the particular case in litigation? Should they recuse themselves if the issue is one on which the religion to which they subscribe has taken a formal position? Should Catholic judges recuse themselves from abortion and medically assisted dying cases? Should judges who belong to the United Church of Christ (which has been strongly pro-choice for decades) recuse themselves from abortion cases? Should the member of a congregation whose rabbi helped organize a voting rights march recuse himself from all voting rights cases? Is their obligation any different from the obligation of a judge who is a dedicated ACLU (or American Family Association or Republican Party) member and who confronts a case upon which the ACLU (or the American Family Association, or the Republican Party) has taken a firm position?

3. Judge Calabresi concurred in the Second Circuit decision in the *Quill* case, but on entirely different grounds. Depending on the theory of statutory construction that he had explained fifteen years earlier in his text, A Common Law for the Age of Statutes (1982), he concluded that the history of the New York manslaughter statute suggested that there was no reason to believe that its framers ever intended it to apply to cases of competent terminally ill patients seeking aid in dying from physicians. Still, as he pointed out, "neither *Cruzan*, nor *Casey*, nor the language of our Constitution, nor our constitutional tradition clearly makes these

laws invalid."

So, what should the court do with a "highly suspect" but "not clearly invalid" statute that may no longer serves the purposes for which it was originally promulgated? The answer, according to Judge Calabresi, is the "constitutional remand."

> I contend that when a law is neither plainly unconstitutional * * * nor plainly constitutional, the courts ought not to decide the ultimate validity of that law without current and clearly expressed statements by the people or their elected officials of the state involved. It is my further contention, that, absent such statements, the courts have frequently struck down such laws, while leaving open the possibility of reconsideration if appropriate statements were subsequently made.

Thus, Judge Calabresi finds the New York statute unconstitutional, but he "takes no position" on whether verbatim identical statutes would be constitutional "were New York to reenact them while articulating the reasons for the distinctions it makes. . . ." Is this a reasonable way to deal with ancient statutes effectively criminalizing medically assisted dying? Is this argument still available to those challenging state statutes that forbid assisting suicide?

4. Why has medically assisted dying engendered such passion over the last several decades? Daniel Callahan has a suggestion:

> The power of medicine to extend life under poor circumstances is now widely and increasingly feared. The combined powers of a quasi-religious tradition of respect for individual life and a secular tradition of relentless medical progress creates a bias toward aggressive, often unremitting treatment that appears unstoppable.
>
> How is control to be gained? For many the answer seems obvious and unavoidable: active euthanasia and assisted suicide.

19 Hastings Ctr. Rep., Special Supplement, 4 (1989). Dr. Callahan goes on to suggest that those who strongly oppose euthanasia, as he does, ought to focus on "dampening . . . the push for medical progress, a return to older traditions of caring as an alternative to curing, and a willingness to accept decline and death as part of the human conditions (not a notable feature of American medicine)." Is he right? It used to be that people were afraid that if they went to the hospital they would die there. Now people are afraid that if they go to the hospital they will be kept alive there. Is it this fear that gives rise to our current interest in euthanasia?

5. Medically assisted dying may constitute murder, manslaughter, some other form of homicide, or no crime at all, depending on the language of the state statute and the nature of the physician's act. While most states criminalize assisting suicide, it is not always easy to determine what conduct is prohibited by those statutes. Consider one representative statute:

> Every person who deliberately aids, or advises, or encourages another to commit suicide, is guilty of a felony. Cal. Pen. Code § 401.

Would this statute apply to a physician who clamps a feeding tube? To a physician who withholds antibiotics? To a physician who prescribes morphine to a patient in persistent pain, and provides enough tablets to take a lethal dose? To a physician who prescribes that same morphine and tells the patient what would constitute a lethal dose? To those who publish instructions on how to commit suicide for the use of those who are terminally ill or in excruciating pain? To those who make generally available information about how to commit suicide at home? See McCollum v. CBS, Inc., 202 Cal.App.3d 989, 249 Cal.Rptr. 187 (1988), rejecting application of the statute to those who play rock music with lyrics that suggest that suicide is acceptable.

6. Might women, specifically, be put at risk in a society that permits medically assisted dying? That argument is made by Susan Wolf, who regularly has argued that women's requests should be better respected by the health care system and that requests to remove life sustaining treatment should be heeded.

> As I have argued, there is a strong right to be free of unwanted bodily invasion. Indeed, for women, a long history of being harmed specifically through unwanted bodily invasion such as rape presents particularly compelling reasons for honoring a woman's refusal of invasion and effort to maintain bodily intactness. When it comes to the question of whether women's suicides should be aided, however, or whether women should be actively killed, there is no right to command physician assistance, the dangers of permitting assistance are immense, and the history of women's subordination cuts the other way. Women have historically been seen as fit objects for bodily invasion, self-sacrifice, and death at the hands of others. The task before us is to challenge all three.
>
> Certainly some women, including some feminists, will see this problem differently. That may be especially true of women who feel in control of their lives, are less subject to subordination by age or race or wealth, and seek yet another option to add to their many. I am not arguing that women should lose control of their lives and selves. Instead, I am arguing that when women request to be put to death or ask help in taking their own lives, they become part of a broader social dynamic of which we have properly learned to be extremely wary. These are fatal practices. We can no longer ignore questions of gender or insights of feminist argument.

Susan Wolf, Gender, Feminism and Death: Physician Assisted Suicide and Euthanasia, in S. Wolf, Feminism and Bioethics: Beyond Reproduction 308 (1996). For an account of Professor Wolf's thoughtful approach to death and dying, see Daniel Bergner, Death in the Family, New York Times Magazine (December 2, 2007), reporting that 72% of the 75 individuals assisted by Kervorkian were women. But see data on Oregon's experience, below.

Susan Wolf also wrote a moving account of her own father’s death, including her own response when he inquired whether it could be “accelerated” beyond withdrawing treatment. Her answer to her father was no, and she explains why in her essay; but she doesn’t romanticize his dying and the great difficulties he and his family faced in getting the end-of-life care he

needed. Confronting Physician-Assisted Suicide and Euthanasia: My Father's Death, 38 Hastings Ctr. Rept. 23 (2008).

8. Organized medical groups generally oppose any medical participation in euthanasia or assisted death. As to euthanasia, the AMA Council on Ethical and Judicial Affairs provides:

Opinion 2.21, Euthanasia

> Euthanasia is the administration of a lethal agent by another person to a patient for the purpose of relieving the patient's intolerable and incurable suffering.
>
> It is understandable, though tragic, that some patients in extreme duress--such as those suffering from a terminal, painful, debilitating illness--may come to decide that death is preferable to life. However, permitting physicians to engage in euthanasia would ultimately cause more harm than good. Euthanasia is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.
>
> The involvement of physicians in euthanasia heightens the significance of its ethical prohibition. The physician who performs euthanasia assumes unique responsibility for the act of ending the patient's life. Euthanasia could also readily be extended to incompetent patients and other vulnerable populations.
>
> Instead of engaging in euthanasia, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication. (issued 1994)

As to Physician Assisted Suicide, the Council has adopted this position:

Opinion 2.211 - Physician-Assisted Suicide

> Physician-assisted suicide occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act (eg, the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide).
>
> It is understandable, though tragic, that some patients in extreme duress--such as those suffering from a terminal, painful, debilitating illness--may come to decide that death is preferable to life. However, allowing physicians to participate in assisted suicide would cause more harm than good. Physician-assisted suicide is fundamentally incompatible

> with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.
>
> Instead of participating in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible. Multidisciplinary interventions should be sought including specialty consultation, hospice care, pastoral support, family counseling, and other modalities. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication. (issued 1994)

Does the AMA oppose both of these kinds of medically assisted dying because it is morally reprehensible, or because it is too morally complicated?

> A strict proscription against aiding in death may betray a limited conceptual framework that seeks the safety of ironclad rules and principles to protect the physician from the true complexity of individual cases. Patients seeking comfort in their dying should not be held hostage to our inability or unwillingness to be responsible for knowing right from wrong in each specific situation. Christine Cassel & Diane Meier, Morals and Moralism in the Debate Over Euthanasia and Assisted Suicide, 323 NEJM 750, 751 (1990).

9. In a footnote in *Vacco*, Justice Rehnquist raises the issue of the legal status of "terminal sedation," which is sometimes described as "palliative sedation" because it is employed to provide palliation both in patients who are quickly approaching death and in those who are suffering but not yet otherwise terminal. Patients whose suffering cannot be ameliorated in any other way can be sedated with enough medication so that they are put into a medication-induced coma. This sedation may be accompanied by the withdrawal of other forms of treatment, including artificial nutrition and hydration. This withdrawal may (and, with the withdrawal of nutrition and hydration, will) lead to the patient's death. Justice Rehnquist suggests that terminal sedation, which has not given rise to the ethical objections that have come with medically assisted dying, is distinguishable from an affirmative act intended to bring about death, applying the principle of "double effect." Do you agree? Under *Vacco*, whether terminal sedation is treated like the withdrawal of life sustaining treatment or like an affirmative act causing death makes all the legal difference. As an ethical and legal matter, should terminal sedation be treated like the withdrawal of treatment or like medically assisted dying? See J.A. Rietjens et al., Terminal Sedation and Euthanasia: A Comparison of Clinical Practices, 166 Archives Internal Med. 749 (2006). T. Morita et al., Terminal Sedation for Existential Distress, 17 Am. J. Hospital Palliation 189 (2000).

In 2008, over a decade after Glucksberg was decided, the AMA adopted a policy providing that it was the ethical obligation of physicians to offer palliative sedation, at least to some terminally ill patients:

> **Opinion 2.201 - Sedation to Unconsciousness in End-of-Life Care**

The duty to relieve pain and suffering is central to the physician's role as healer and is an obligation physicians have to their patients. Palliative sedation to unconsciousness is the administration of sedative medication to the point of unconsciousness in a terminally ill patient. It is an intervention of last resort to reduce severe, refractory pain or other distressing clinical symptoms that do not respond to aggressive symptom-specific palliation. It is an accepted and appropriate component of end-of-life care under specific, relatively rare circumstances. When symptoms cannot be diminished through all other means of palliation, including symptom-specific treatments, it is the ethical obligation of a physician to offer palliative sedation to unconsciousness as an option for the relief of intractable symptoms. When considering the use of palliative sedation, the following ethical guidelines are recommended:

(1) Patients may be offered palliative sedation to unconsciousness when they are in the final stages of terminal illness. The rationale for all palliative care measures should be documented in the medical record.

(2) Palliative sedation to unconsciousness may be considered for those terminally ill patients whose clinical symptoms have been unresponsive to aggressive, symptom-specific treatments.

(3) Physicians should ensure that the patient and/or the patient's surrogate have given informed consent for palliative sedation to unconsciousness.

(4) Physicians should consult with a multidisciplinary team, if available, including an expert in the field of palliative care, to ensure that symptom-specific treatments have been sufficiently employed and that palliative sedation to unconsciousness is now the most appropriate course of treatment.

(5) Physicians should discuss with their patients considering palliative sedation the care plan relative to degree and length (intermittent or constant) of sedation, and the specific expectations for continuing, withdrawing, or withholding future life-sustaining treatments.

(6) Once palliative sedation is begun, a process must be implemented to monitor for appropriate care.

(7) Palliative sedation is not an appropriate response to suffering that is primarily existential, defined as the experience of agony and distress that may arise from such issues as death anxiety, isolation and loss of control. Existential suffering is better addressed by other interventions. For example, palliative sedation is not the way to address suffering created by social isolation and loneliness; such suffering should be addressed by providing the patient with needed social support.

(8) Palliative sedation must never be used to intentionally cause a patient's death.

Council on Ethical and Judicial Affairs (2008)

Why did the AMA conclude that palliative sedation was inappropriate for "existential" suffering, i.e., agony and loss of control? What if no other treatments are available to deal with the existential suffering? Can all suffering (except physical pain) be treated through the provision of social support? Should palliative sedation be reserved for those with physical, not psychic, pain? See A. de GraeffA, M. Dean,. Palliative Sedation Therapy in the Last Weeks of Life: a Literature Review and Recommendations for Standards, 10 J Palliat Med. 67 (2007). At least one study suggests that palliative sedation does not actually shorten the lives of cancer patients. M. Maltoni et al., Palliative Sedation in End-of-Life Care and Survival: a Systematic Review, 30 J. Clin.Oncology 1378 (2012).

II. LEGISLATION TO SUPPORT MEDICALLY ASSISTED DYING—"DEATH WITH DIGNITY" INITIATIVES

The debate over the proper role of physicians in assisting their patients in death has been carried on through the legislative and citizen initiative processes as well as through litigation. "Death with Dignity" initiatives were narrowly defeated in California in 1991 and in Washington in 1992. However, Oregon's "Death with Dignity" initiative was approved by voters in the November 1994 election, and it thus became part of the statute law of Oregon.

The Oregon Death With Dignity Act

Or.Rev.Stat. §§ 127.800–.897.

127.800. Definitions.

The following words and phrases, whenever used in ORS 127.800 to 127.897, have the following meanings:

(1) "Adult" means an individual who is 18 years of age or older.

(2) "Attending physician" means the physician who has primary responsibility for the care of the patient and treatment of the patient's terminal disease.

(3) "Capable" means that in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, psychiatrist or psychologist, a patient has the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available.

(4) "Consulting physician" means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's disease.

(5) "Counseling" means one or more consultations as necessary between a state licensed psychiatrist or psychologist and a patient for the purpose of determining that the patient is

capable and not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.

(6) "Health care provider" means a person licensed, certified or otherwise authorized or permitted by the law of this state to administer health care or dispense medication in the ordinary course of business or practice of a profession, and includes a health care facility.

(7) "Informed decision" means a decision by a qualified patient, to request and obtain a prescription to end his or her life in a humane and dignified manner, that is based on an appreciation of the relevant facts and after being fully informed by the attending physician of:

(a) His or her medical diagnosis;

(b) His or her prognosis;

(c) The potential risks associated with taking the medication to be prescribed;

(d) The probable result of taking the medication to be prescribed; and

(e) The feasible alternatives, including, but not limited to, comfort care, hospice care and pain control.

(8) "Medically confirmed" means the medical opinion of the attending physician has been confirmed by a consulting physician who has examined the patient and the patient's relevant medical records.

(9) "Patient" means a person who is under the care of a physician.

(10) "Physician" means a doctor of medicine or osteopathy licensed to practice medicine by the Board of Medical Examiners for the State of Oregon.

(11) "Qualified patient" means a capable adult who is a resident of Oregon and has satisfied the requirements of ORS 127.800 to 127.897 in order to obtain a prescription for medication to end his or her life in a humane and dignified manner.

(12) "Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.

127.805. Who may initiate a written request for medication.

(1) An adult who is capable, is a resident of Oregon, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner in accordance with ORS

127.800 to 127.897.

(2) No person shall qualify under the provisions of ORS 127.800 to 127.897 solely because of age or disability.

127.810. Form of the written request.

(1) A valid request for medication under ORS 127.800 to 127.897 shall be in substantially the form described in ORS 127.897, signed and dated by the patient and witnessed by at least two individuals who, in the presence of the patient, attest that to the best of their knowledge and belief the patient is capable, acting voluntarily, and is not being coerced to sign the request.

(2) One of the witnesses shall be a person who is not:

(a) A relative of the patient by blood, marriage or adoption;

(b) A person who at the time the request is signed would be entitled to any portion of the estate of the qualified patient upon death under any will or by operation of law; or

(c) An owner, operator or employee of a health care facility where the qualified patient is receiving medical treatment or is a resident.

(3) The patient's attending physician at the time the request is signed shall not be a witness.

(4) If the patient is a patient in a long term care facility at the time the written request is made, one of the witnesses shall be an individual designated by the facility and having the qualifications specified by the Department of Human Services by rule.

127.815. Attending physician responsibilities.

(1) The attending physician shall:

(a) Make the initial determination of whether a patient has a terminal disease, is capable, and has made the request voluntarily;

(b) Request that the patient demonstrate Oregon residency pursuant to ORS 127.860;

(c) To ensure that the patient is making an informed decision, inform the patient of:

(A) His or her medical diagnosis;

(B) His or her prognosis;

(C) The potential risks associated with taking the medication to be prescribed;

(D) The probable result of taking the medication to be prescribed; and

(E) The feasible alternatives, including, but not limited to, comfort care, hospice care and pain control;

(d) Refer the patient to a consulting physician for medical confirmation of the diagnosis, and for a determination that the patient is capable and acting voluntarily;

(e) Refer the patient for counseling if appropriate pursuant to ORS 127.825;

(f) Recommend that the patient notify next of kin;

(g) Counsel the patient about the importance of having another person present when the patient takes the medication prescribed pursuant to ORS 127.800 to 127.897 and of not taking the medication in a public place;

(h) Inform the patient that he or she has an opportunity to rescind the request at any time and in any manner, and offer the patient an opportunity to rescind at the end of the 15 day waiting period pursuant to ORS 127.840;

(i) Verify, immediately prior to writing the prescription for medication under ORS 127.800 to 127.897, that the patient is making an informed decision;

(j) Fulfill the medical record documentation requirements of ORS 127.855;

(k) Ensure that all appropriate steps are carried out in accordance with ORS 127.800 to 127.897 prior to writing a prescription for medication to enable a qualified patient to end his or her life in a humane and dignified manner; and

(A) Dispense medications directly* * *or [(B) through a pharmacist].

(2) Notwithstanding any other provision of law, the attending physician may sign the patient's death certificate.

127.820. Consulting physician confirmation.

Before a patient is qualified under ORS 127.800 to 127.897, a consulting physician shall examine the patient and his or her relevant medical records and confirm, in writing, the attending physician's diagnosis that the patient is suffering from a terminal disease, and verify that the patient is capable, is acting voluntarily and has made an informed decision.

127.825. Counseling referral.

If in the opinion of the attending physician or the consulting physician a patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment, either physician shall refer the patient for counseling. No medication to end a patient's life in a humane and dignified manner shall be prescribed until the person performing the counseling determines that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.

127.830. Informed decision.

No person shall receive a prescription for medication to end his or her life in a humane and dignified manner unless he or she has made an informed decision as defined in ORS 127.800 (7). Immediately prior to writing a prescription for medication under ORS 127.800 to 127.897, the attending physician shall verify that the patient is making an informed decision.

127.835. Family notification.

The attending physician shall recommend that the patient notify the next of kin of his or her request for medication pursuant to ORS 127.800 to 127.897. A patient who declines or is unable to notify next of kin shall not have his or her request denied for that reason.

127.840. Written and oral requests.

In order to receive a prescription for medication to end his or her life in a humane and dignified manner, a qualified patient shall have made an oral request and a written request, and reiterate the oral request to his or her attending physician no less than fifteen (15) days after making the initial oral request. At the time the qualified patient makes his or her second oral request, the attending physician shall offer the patient an opportunity to rescind the request.

127.845. Right to rescind request.

A patient may rescind his or her request at any time and in any manner without regard to his or her mental state. No prescription for medication under ORS 127.800 to 127.897 may be written without the attending physician offering the qualified patient an opportunity to rescind the request.

127.850. Waiting periods.

No less than fifteen (15) days shall elapse between the patient's initial oral request and the writing of a prescription under ORS 127.800 to 127.897. No less than 48 hours shall elapse between the patient's written request and the writing of a prescription under ORS 127.800 to 127.897.

* * *

127.860. Residency requirement.

Only requests made by Oregon residents under ORS 127.800 to 127.897 shall be granted. Factors demonstrating Oregon residency include but are not limited to [being licensed to drive, registering to vote, owning property, and paying taxes in Oregon.]

* * *

127.880. Construction of Act.

Nothing in ORS 127.800 to 127.897 shall be construed to authorize a physician or any other person to end a patient's life by lethal injection, mercy killing or active euthanasia. Actions taken in accordance with ORS 127.800 to 127.897 shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law.

* * *

127.897. Form of the request.

A request for a medication as authorized by ORS 127.800 to 127.897 shall be in substantially the following form:

REQUEST FOR MEDICATION TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER

I, _______, am an adult of sound mind.

I am suffering from _______, which my attending physician has determined is a terminal disease and which has been medically confirmed by a consulting physician.

I have been fully informed of my diagnosis, prognosis, the nature of medication to be prescribed and potential associated risks, the expected result, and the feasible alternatives, including comfort care, hospice care and pain control.

I request that my attending physician prescribe medication that will end my life in a humane and dignified manner.

INITIAL ONE:

_______ I have informed my family of my decision and taken their opinions into consideration.

_______ I have decided not to inform my family of my decision.

_______ I have no family to inform of my decision.

I understand that I have the right to rescind this request at any time.

I understand the full import of this request and I expect to die when I take the medication to be prescribed. I further understand that although most deaths occur within three hours, my death may take longer and my physician has counseled me about this possibility.

I make this request voluntarily and without reservation, and I accept full moral responsibility for my actions.

[Signature line; witness lines]

* * *

Early in 1999 the Oregon Department of Health issued its first annual report, which collected data on those who received lethal prescriptions under the Act during its first year of operation. Each year for eight years the Oregon Department of Health issued a comprehensive annual report describing activity under the Death with Dignity Act. Starting with the report for the ninth year of the operation of the statute, reflecting activity in 2006 and released in 2007, the Department of Health made available a brief summary of activity under the statute and other charts and tables. All of the annual reports, and the summaries (starting in 2007), are available at http://public.health.oregon.gov/providerpartnerresources/evaluationresearch/deathwithdignityact/pages/ar-index.aspx. The Summary released in 2013 provides detailed information on the first fifteen years of operation under the statute, with a focus on activity over the most recent year.

Oregon Department of Human Services, Oregon's Death With Dignity Act—2012
(released January, 2013).

Under Oregon's Death with Dignity Act (DWDA), terminally-ill adult Oregonians are allowed to obtain and use prescriptions from their physicians for self-administered, lethal medications. The Oregon Public Health Division is required by the Act to collect information on compliance and to issue an annual report. The key findings from 2012 are listed below. * * *

- Since the law was passed in 1997, a total of 1,050 people have had DWDA prescriptions written and 673 patients have died from ingesting medications prescribed under the DWDA.

- Of the 115 patients for whom DWDA prescriptions were written during 2012, 67 (58.3%) ingested the medication; 66 died from ingesting the medication, and one patient ingested the medication but regained consciousness before dying of underlying illness and is therefore not counted as a DWDA death. The patient regained consciousness two days following ingestion, but remained minimally responsive and died six days following ingestion.

- Eleven (11) patients with prescriptions written during the previous year (2011) died after ingesting the medication during 2012.

- Twenty-three (23) of the 115 patients who received DWDA prescriptions during 2012 did not take the medications and subsequently died of other causes.
- Ingestion status is unknown for 25 patients who were prescribed DWDA medications in 2012. Fourteen (14) of these patients died, but follow-up questionnaires indicating ingestion status have not yet been received. For the remaining 11 patients, both death and ingestion status are pending (Figure 2).

- Of the 77 DWDA deaths during 2012, most (67.5%) were aged 65 years or older; the median age was 69 years. As in previous years, most were white (97.4%), well-educated (42.9% had a least a baccalaureate degree), and had cancer (75.3%).
- Most (97.4%) patients died at home; and most (97.0%) were enrolled in hospice care either at the time the DWDA prescription was written or at the time of death. Excluding unknown cases, all (100.0%) had some form of health care insurance, although the number of patients who had private insurance (51.4%) was lower in 2012 than in previous years (66.2%), and the number of patients who had only Medicare or Medicaid insurance was higher than in previous years (48.6% compared to 32.1%).
- As in previous years, the three most frequently mentioned end-of-life concerns were: loss of autonomy (93.5%), decreasing ability to participate in activities that made life enjoyable (92.2%), and loss of dignity (77.9%).
- Two of the 77 DWDA patients who died during 2012 were referred for formal psychiatric or psychological evaluation. Prescribing physicians were present at the time of death for seven patients (9.1%) during 2012 compared to 17.3% in previous years.
- A procedure revision was made mid-year in 2010 to standardize reporting on the follow-up questionnaire. The new procedure accepts information about the time of death and circumstances surrounding death only when the physician or another health care provider was present at the time of death. Due to this change, data on time from ingestion to death is available for 11 of the 77 DWDA deaths during 2012. Among those 11 patients, time from ingestion until death ranged from 10 minutes to 3.5 hours.

• Sixty-one (61) physicians wrote the 115 prescriptions provided during 2012 (range 1-10 prescriptions per physician).

• During 2012, no referrals were made to the Oregon Medical Board for failure to comply with DWDA requirements.

Notes and Questions

1. The Oregon Death with Dignity Act provides that no contract or statute can affect a person's request for physician assisted suicide, and that no insurance policy can be conditioned upon, or affected by, a patient's decision to choose (or reject) physician assisted suicide. The measure includes a section providing immunity for those who follow the requirements of the statute, and imposing liability on those who violate it.

2. Does the report address whether the requirements of Section 127.815 were followed? How would the Department determine the answer to that question? Those who are skeptical about whether the annual report accurately presents the impact of the Act point out that the report can describe only those cases that are reported to the state. They argue that cases that do not comply with the specific requirements of the statute will not be reported. It is in this potential body of unreported cases that evidence for concerns over the effectiveness of the statute's boundaries would be found.

3. As the Summary published in 2013 indicates, most Oregonians who have sought medically assisted dying have done so because of their fear of losing control of their lives (and the concomitant suffering that would follow), not because of physical pain. In 2013, more than three times as many patients listed loss of autonomy as a reason for seeking medically assisted dying as listed inadequate pain control. An excerpt from Oregon's Second Annual Report, published in 2000, explains this:

> Responses from both physician and family interviews indicate that patient's decisions to request PAS were motivated by multiple interrelated concerns. Physical suffering was discussed by several families as a cause of loss of autonomy, inability to participate in activities that made life enjoyable, or a "non-existent" quality of life. For example, "She would have stuck it out through the pain if she thought she'd get better ... [but she believed that] when quality of life has no meaning, it's no use hanging around." For another participant, a feeling of being trapped because of ALS contributed to concern about loss of autonomy. Family members frequently commented on loss of control of bodily functions when discussing loss of autonomy. Those reporting patient concern about being a burden on friends and family also reported concern about loss of autonomy and control of bodily functions. Reasons for requesting a prescription were sometimes so interrelated they were difficult to categorize. According to one family member being asked to distinguish reasons for the patient's decision, "It was everything; it was nothing; [he was suffering terribly]."

> Difficulty categorizing and differences in interpreting the nature of the concerns made physician and family member responses hard to compare quantitatively. Nonetheless, family interviews corroborate physician reports from both years that patients are greatly concerned about issues of autonomy and control. In addition, responses of both physicians and family consistently pointed to patient concerns about quality of life and the wish to have a means of controlling the end of life should it become unbearable. As one family member said, "She always thought that if something was terminal, she would [want to] control the end ... It was not the dying that she dreaded, it was getting to that death."
>
> * * *
>
> Oregonians choosing physician-assisted suicide appeared to want control over how they died. One woman had purchased poison over a decade before her participation, when her cancer was first diagnosed, so that she would never be without the means of controlling the end of her life should it become unbearable. Like many others who participated, she was described as "determined" to have this control. Another woman was described as a "gutsy woman" who was "... determined in her lifetime, and determined about [physician-assisted suicide]." Family members expressed profound grief at losing a loved one. However, mixed with this grief was great respect for the patient's determination and choice to use physician-assisted suicide. As one husband said about his wife of almost 50 years, "She was my only girl; I didn't want to lose her ... but she wanted to do this."

Could the expressed concerns have been relieved by better medical and nursing care? Should these individuals have toughed it out, or did they choose the better course for themselves? For their families? Are those who do take advantage of the statute brave? Cowardly?

4. The Oregon initiative was immediately challenged for a wide range of reasons. Some argued that it discriminated against the disabled, for example, by coercing them into choosing medically assisted dying, and others argued it discriminated against the disabled because those with physical disabilities that made it impossible to take oral medications would not be able to use the statute. The United States District Court in Oregon issued a preliminary injunction against enforcing the initiative shortly after its passage and issued a permanent injunction several months later. Ultimately, the Ninth Circuit reversed the District Court, finding that those challenging the Oregon initiative had no standing to raise the issue in federal court. Lee v. Oregon, 107 F.3d 1382 (9th Cir.1997).

5. The federal government has not ignored medically assisted dying, either. Even before the Oregon statute became effective, Congress passed the Assisted Suicide Prevention Restriction Act of 1997, which outlawed the use of federal money to aid medically assisted dying, directly or indirectly.

Shortly after the Oregon Death with Dignity Act became effective, some suggested that any physician who prescribed a lethal drug under that statute would be prescribing that drug without a "legitimate medical purpose," and thus would be acting inconsistently with the federal

Controlled Substances Act (CSA). A physician's violation of the Act could lead to both the loss of prescribing authority and criminal indictment. In 1998, after the matter had been pending for some time, the United States Department of Justice published a report concluding that use of controlled substances under the Oregon statute would satisfy the "legitimate medical purpose" requirement of the federal Act.

Members of the House and Senate then introduced the Lethal Drug Abuse Prevention Act of 1998, which would have expanded the authority of the Drug Enforcement Agency to investigate lethal use of controlled substances, which could not be used with the *intent* of causing death. Supporters of medically assisted dying joined many of their staunchest opponents and mainstream medical organizations (including the AMA) to oppose the bill because, they said, it would be likely to chill physicians from providing adequate pain relief at the end of life. Although the bill failed, it was resurrected in slightly milder form in 2000 as the Pain Relief Promotion Act ("PRPA"), which included a well publicized section announcing that the provision of medication with the intent to manage pain (and not the intent to cause death) was protected. The 2000 version of the bill also provided for the education of health care professionals on issues related to pain management, and it was supported by the AMA (but opposed by the ABA, the American Cancer Society and most groups advocating for improved pain management). Although the stated purpose of PRPA was to promote adequate pain relief practices, its effect would be (and, some say, its real purpose was) to render it impossible for physicians in Oregon to carry out the provisions of the Death With Dignity Act. PRPA died when Congress adjourned in late 2000, and there have not been serious attempts to undermine the Oregon statute through federal legislation since that time.

In 2001, however, the Attorney General, John Ashcroft, issued an interpretive rule that reversed the 1998 Department of Justice position on the issue of the application of the CSA and implemented an enforcement action. Within a day of the announcement of this change in the federal position, Oregon sought relief from the Attorney General's decision in the federal court. A private action seeking an injunction against the Ashcroft position was filed shortly thereafter on behalf of an Oregon oncologist. The District Court immediately restrained the United States from enforcing the new interpretation of the CSA, and in 2006 the Supreme Court determined that the Attorney General's interpretive rule was beyond the scope of his authority and was improperly promulgated. Gonzales v. Oregon, 546 U.S. 243, 126 S.Ct. 904, 163 L.Ed.2d 748 (2006). The Court left open the possibility that the Attorney General could properly promulgate a substantive rule that would bar the operation of the Oregon Death with Dignity Act, and that Congress could amend the Controlled Substances Act to achieve this end.

6. The Oregon statute has been amended, but the changes are not substantial. The legislature added the definition of "capable," added some new language designed to encourage patients to discuss the matter with their families, and provided some factors to be considered in determining residency. The amendments also made clear the broad extent of the institutional conscience exception to the statute, which permits health care institutions to limit physicians from engaging in assisted death on their premises or in their organizations, and it changed the written consent form to assure that patients recognize that death will probably, but not always, take place about three hours after taking the medication.

7. Emboldened by the success in Oregon, many groups have sought state statutes that would accomplish what Oregon's Measure 16 did. A measure similar to the Oregon statute was very narrowly defeated at the polls in Maine in 2000. In part as a result of the narrow defeat of the Maine measure, during the next legislative session both supporters and opponents of medically assisted dying joined to support a number of bills improving the quality of end-of-life care in that state. In 2002 the Hawai'i House of Representatives passed an Oregon-like bill that came within a couple of votes of passing the Senate. More recently, the California legislature has given serious consideration to (but has not passed) a bill that would have provided for medically assisted dying, and advocates in that state expect the issue to arise again over the next few years, probably through the initiative process. It would not be surprising to see $100 million spent by both sides in such an initiative battle if it develops in the next few years.

8. Advocates for medically assisted dying in Washington made that state the second to use the initiative process to provide for medically assisted dying. Former Washington Governor Booth Gardner, who had Parkinson's disease, became the leading advocate for an Oregon-like statute. For the story of Governor Gardner's "last campaign" from the perspective of someone who opposes medically assisted dying, see Daniel Bergner, Death in the Family, New York Times Magazine (December 2, 2007). The Washington Death with Dignity statute, R.C.W. section 70.245, became effective in 2009. Like Oregon, Washington has published annual reports with substantial detail about the use of the statute within the state. Overall, the Washington data looks very much like that from Oregon. In 2011, 103 Washington patients received prescriptions under the statute, and 90 dies from ingesting the medication. Almost all were from west of the Cascades, 94% were White Non-Hispanics, about half were married, and three fourths had at least some college education. Washington State Department of Health, 2011 Death with Dignity Report. After a very hard-fought and expensive initiative battle over an almost identical statute in 2012, the voters of Massachusetts soundly rejected any change in the law. For an account of the meaning of euthanasia and suicide in our society and others, and a description of how these arguments are likely to be discussed in the future, see Margaret Battin, Ending Life: Ethics and the Way We Die (2005).

9. In 2013 the Vermont Legislature passed the Patient Choice at End of Life Act, which adopted essentially the Oregon process until 2016, when that portion of the Act would sunset and be replaced with a section that would permit aid in dying to become a part of the normal medical process in Vermont, not subject to any special legally imposed administrative requirements. One libertarian senator – a vote needed to pass the legislation – held out against a pure Oregon model because of the burdens it placed on those who decided, in consultation with their physicians, to participate in aid in dying. Some believe that in 2016 this Vermont statute will usher in a new era of legal regulation (or, rather, non-regulation) of aid in dying – an era that recognizes that a decision to seek aid in dying is not legally different from any other health care decision. Here is the language of the Vermont statute that becomes effective in 2016:

Vermont Patient Choice at End of Life Act, Sections 5289 and 5290

§ 5289. PROTECTION OF PATIENT CHOICE AT END OF LIFE

A physician with a bona fide physician–patient relationship with a patient
with a terminal condition shall not be considered to have engaged in
unprofessional conduct under 26 V.S.A. § 1354 if:
(1) the physician determines that the patient is capable and does not
have impaired judgment;
(2) the physician informs the patient of all feasible end-of-life services,
including palliative care, comfort care, hospice care, and pain control;
(3) the physician prescribes a dose of medication that may be lethal to
the patient;
(4) the physician advises the patient of all foreseeable risks related to the
prescription; and
(5) the patient makes an independent decision to self-administer a lethal
dose of the medication.

§ 5290. IMMUNITY FOR PHYSICIANS
A physician shall be immune from any civil or criminal liability or
professional disciplinary action for actions performed in good faith compliance with the
provisions of this chapter.

10. Is there some common ground available to those, on the one hand, who believe that permitting medically assisted dying is necessary for patients to be properly treated at the end of life, and those, on the other hand, who believe that medically assisted dying must be outlawed for patients to be properly treated? Both groups agree that pain is often inadequately treated at the end of life, in part because physicians fear legal action for homicide (if pain relief results in the death of the patient) or distribution of drugs (if the condition of a patient requires a larger dose of narcotic medication than is standard).

In some states advocates on both sides of the medically assisted dying issue have joined together to support intractable pain relief statutes, which are designed to protect health care providers who deliver adequate pain relief from adverse licensing and criminal actions. These statutes generally provide that a health care provider will not be liable in a state disciplinary proceeding or a criminal action for the aggressive prescription of pain medication as long as the use of that medication is in accord with accepted guidelines for pain management. Several states have promulgated intractable pain relief acts, and several more are considering them. For a model "Pain Relief Act," see 24 J.L., Med. & Ethics 317 (1996). See also, Ann Alpers, Criminal Act or Palliative Care? Prosecutions Involving the Care of the Dying, 26 J. L. Med. & Ethics 308 (1998), identifying factors that create a risk of prosecution. For a series of articles on the relationship between pain relief and medically assisted dying, with the conclusion that we ought to create a system that provides excellent palliative care in every case and allows for medically assisted dying in the rare cases in which it is necessary, see Timothy Quill & Margaret Battin, eds., Physician–Assisted Dying: the Right to Excellent End-of-Life Care and Patient Choice (2004). See also, Kathleen Foley, The Case Against Assisted Suicide: For the Right to End of Life Care (2002), written by a leading palliative care physician.

11. Federal and state policy may conflict on one kind of palliative care—the use of marijuana. Some cancer patients, patients with glaucoma, AIDS patients, patients with multiple

sclerosis, those with migraine headaches and others find that they can obtain relief from some of the symptoms of the disease–or from some of the side effects of the treatments for the disease–through the use of marijuana. In particular, some cancer patients find that marijuana helps them overcome the nausea that follows the use of many chemotherapeutic agents. While several states have now legalized the use of marijuana under such circumstances, the manufacture and distribution of marijuana is still a felony under the Federal Controlled Substances Act (CSA). In 2001, the Supreme Court determined that there was no medical necessity defense available to those who manufactured or distributed marijuana to patients in violation of the Federal law. U.S. v. Oakland Cannabis Buyers' Cooperative, 532 U.S. 483, 121 S.Ct. 1711, 149 L.Ed.2d 722 (2001). Four years later the Supreme Court confirmed that the CSA marijuana prohibition fell within Congress's commerce power. Gonzales v. Raich, 545 U.S. 1, 125 S.Ct. 2195, 162 L.Ed.2d 1 (2005). Several states now have institutionalized formal programs for distributing marijuana to those who are found to be in medical need (under highly varying state standards). In 2012 the federal government indicated that it would not seek legal redress against those who acted strictly within their state legal limitations in providing patients with medical marijuana through non-commercial enterprises. Despite this, though, the United States has sought to close down several large and otherwise legal medical dispensaries in California and elsewhere. In 2012 the voters in Colorado and Washington approved new regulatory schemes that would allow (and tax) the use of marijuana, even for non-medical purposes, and that has added a measure of additional confusion to the resolution of problems caused by the apparent conflict between federal and state laws. On the same day, voters in California, where medical marijuana is easily available, rejected the same approach. In Colorado, which has allowed and regulated medical marijuana for over a decade, the provisions with regard to recreational use go into effect in 2014.

12. The public interest in this issue is not limited to the United States. Medically assisted dying has been tolerated in the Netherlands, as a legal matter, since 1969, and it was formally legalized by the parliament in 2001 in cases of intractable suffering (not just pain), where the patient has been informed of all of the alternative treatments available, has consulted two physicians, and has followed other requirements established by the national medical association. Belgium recently joined the Netherlands in legalizing medically assisted dying through the legislative process, and the practice is now officially tolerated under some circumstances in Switzerland. The Constitutional Court of Colombia has approved legislation that provides for medically assisted dying, and there has been an active debate over the propriety of permitting medically assisted dying in France, Venezuela and Australia. Australia's Northern Territory's parliament passed The Rights of the Terminally Ill Act (1995), which permitted what some have called "voluntary euthanasia" under some circumstances; however, the national parliament effectively overturned that territorial statute. For a brief description of the current state of the law in other countries, see Alan Meisel & Kathy Cerminara, The Right to Die (3d ed. 2005).

The European Court of Human Rights considered a challenge to the laws of the United Kingdom that outlawed medically assisted dying in Pretty v. United Kingdom, 35 Eur. H. R. Rep 1 (2002). Applying analysis similar, in many respects, to that in *Glucksberg* and *Vacco*, the Court found that the United Kingdom had the authority to enforce its law. An English court again confirmed the legal prohibition against medically assisted dying in 2012.

During that same year a trial court in British Columbia reached a different conclusion, announcing that a terminally ill, competent patient had a right to medically assisted dying under conditions more or less equivalent to those in the laws of neighboring Washington and Oregon, where there was unbearable physical or psychic suffering. Finally, in 2012 the Dying with Dignity Committee, made up of Quebec National Assembly members, recommended that medically assisted dying be permitted in the Province despite the fact that Canada criminalizes assisting suicide. A legal commission report in 2013 backed up the original Commission report, and the Quebec parliament is expected to undertake the issue in mid-2013. Representative of the Parti Quebecois, which included the legislation as a part of their election platform, explained that medically assisted dying was not any kind of "suicide," and that, in any case, it was an issue of health, which is within the jurisdiction of the provinces, not the national government. The Canadian Medical Association has encouraged a national debate on the issue and expressed the view that changes to the law of "therapeutic homicide" should come through the legislative process, not the judicial process. Several years before the *Glucksberg* case was decided on this side of the border, the Canadian Supreme Court reached essentially the same conclusion in the *Rodriguez v. British Columbia (Attorney General)* case, which remains good law, although it has been the subject of both judicial and legislative challenge in 2014.

Problem: Drafting Legislation

You are the nonpolitical legislative counsel to a state legislature. Currently that state has a statute prohibiting assisting suicide. You have been asked by several members of the legislature to draft bills relating to medically assisted dying. One member has asked you to draft a bill that would outlaw all medically assisted dying, under all circumstances. A second member wants you to draft a bill that would put as few limitations on medically assisted dying as is possible; this libertarian member believes that the decision should be left to individual doctors and patients. Another member has asked you to draft a statute that would protect health care providers from potential liability for participating in medically assisted dying, and would give providers an option to avoid participating in medically assisted dying if they chose not to do so. Yet another member has asked you to draft a statute that would prohibit managed care organizations from directly or indirectly giving any incentives to their members to choose medically assisted dying. Finally, one long time incumbent has asked you to draft a consensus statute—one with enough political support across the spectrum that it has a reasonable chance of passing.

How would you go about drafting these statutes? How would they be different? What facts (about the legal landscape in this state, about the politics of the current officeholders, about the religious backgrounds of those within the state, about other issues) would you want to have before you started drafting these statutes?

III. LITIGATION UNDER STATE LAW IN SUPPORT OF MEDICALLY ASSISTED DYING

BAXTER V. MONTANA
Supreme Court of Montana.

2009 MT 449, 354 Mont. 234, 224 P.3d 1211 (2009).

JUSTICE LEAPHART delivered the Opinion of the Court.

* * *

We rephrase the following issue[ ] on appeal:

I. Whether the District Court erred in its decision that competent, terminally ill patients have a constitutional right to die with dignity, which protects physicians who provide aid in dying from prosecution under the homicide statutes.

* * *

BACKGROUND

This appeal originated with Robert Baxter, a retired truck driver from Billings who was terminally ill with lymphocytic leukemia with diffuse lymphadenopathy. * * *. Mr. Baxter wanted the option of ingesting a lethal dose of medication prescribed by his physician and self-administered at the time of Mr. Baxter's own choosing.

* * *

DISCUSSION

The parties in this appeal focus their arguments on the question of whether a right to die with dignity—including physician aid in dying—exists under the privacy and dignity provisions of the Montana Constitution. The District Court held that a competent, terminally ill patient has a right to die with dignity under Article II, Sections 4 and 10 of the Montana Constitution. Sections 4 and 10 address individual dignity and the right to privacy, respectively. The District Court further held that the right to die with dignity includes protecting the patient's physician from prosecution under Montana homicide statutes. The District Court concluded that Montana homicide laws are unconstitutional as applied to a physician who aids a competent, terminally ill patient in dying.

[T]his Court is guided by the judicial principle that we should decline to rule on the constitutionality of a legislative act if we are able to decide the case without reaching constitutional questions. [ ] Since both parties have recognized the possibility of a consent defense to a homicide charge [ ] we focus our analysis on whether the issues presented can be resolved at the statutory, rather than the constitutional, level.

We start with the proposition that suicide is not a crime under Montana law. In the aid in dying situation, the only person who might conceivably be prosecuted for criminal behavior is the physician who prescribes a lethal dose of medication. In that the claims of the plaintiff physicians are premised in significant part upon concerns that they could be prosecuted for extending aid in dying, we deem it appropriate to analyze their possible culpability for homicide by examining whether the consent of the patient to his physician's aid in dying could constitute a statutory defense to a homicide charge against the physician.

The consent statute would shield physicians from homicide liability if, with the patients' consent, the physicians provide aid in dying to terminally ill, mentally competent adult patients. We first determine whether a statutory consent defense applies to physicians who provide aid in dying and, second, whether patient consent is rendered ineffective [ ] because permitting the conduct or resulting harm "is against public policy."

Section 45-5-102(1), MCA, states that a person commits the offense of deliberate homicide if "the person purposely or knowingly causes the death of another human being . . . ." Section 45-2-211(1), MCA, establishes consent as a defense, stating that the "consent of the victim to conduct charged to constitute an offense or to the result thereof is a defense." Thus, if the State prosecutes a physician for providing aid in dying to a mentally competent, terminally ill adult patient who consented to such aid, the physician may be shielded from liability pursuant to the consent statute. This consent defense, however, is only effective if none of the statutory exceptions to consent applies. Section 45-2-211(2), MCA, codifies the four exceptions:

Consent is ineffective if: * * *(d) it is against public policy to permit the conduct or the resulting harm, even though consented to.

* * * [W]e find no indication in Montana law that physician aid in dying provided to terminally ill, mentally competent adult patients is against public policy.

Section 45-2-211(2)(d), MCA, renders consent ineffective if "it is against public policy to permit the conduct or the resulting harm, even though consented to." [The Court discussed Montana precedent, which had considered the application of the "public policy" exception to the consent provision in the case of mutual violence of combatants.] This "against public policy" exception to consent applies to conduct that disrupts public peace and physically endangers others. Clearly [ ] unruly, physical and public aggression between individuals falls within the parameters of the "against public policy" exception. * * *

A survey of courts that have considered this issue yields unanimous understanding that consent is rendered ineffective as "against public policy" in assault cases characterized by aggressive and combative acts that breach public peace and physically endanger others.

* * *

[S]heer physical aggression that breaches public peace and endangers others is against public policy. In contrast, the act of a physician handing medicine to a terminally ill patient, and the patient's subsequent peaceful and private act of taking the medicine, are not comparable to the violent, peace-breaching conduct that this Court and others have found to violate public policy.

* * *

[A] physician who aids a terminally ill patient in dying is not directly involved in the final decision or the final act. He or she only provides a means by which a terminally ill patient himself can give effect to his life-ending decision, or not, as the case may be. Each stage of the physician-patient interaction is private, civil, and compassionate. The physician and terminally ill patient work together to create a means by which the patient can be in control of his own mortality. The patient's subsequent private decision whether to take the medicine does not breach public peace or endanger others.

* * *

Under § 45-5-102, MCA, a "person commits the offense of deliberate homicide if: (a) the person purposely or knowingly causes the death of another human being . . . ." In physician aid in dying, the physician makes medication available for a terminally ill patient who requests it, and the patient would then choose whether to cause his own death by self-administering the medicine. The terminally ill patient's act of ingesting the medicine is not criminal. There is no language in the homicide statute indicating that killing "oneself," as opposed to "another," is a punishable offense, and there is no separate statute in Montana criminalizing suicide. There is thus no indication in the homicide statutes that physician aid in dying—in which a terminally ill patient elects and consents to taking possession of a quantity of medicine from a physician that, if he chooses to take it, will cause his own death—is against public policy.

There is similarly no indication in the Terminally Ill Act that physician aid in dying is against public policy.

* * *

The Rights of the Terminally Ill Act very clearly provides that terminally ill patients are entitled to autonomous, end-of-life decisions, even if enforcement of those decisions involves direct acts by a physician.

* * *

The Terminally Ill Act, in short, confers on terminally ill patients a right to have their end-of-life wishes followed, even if it requires direct participation by a physician through withdrawing or withholding treatment. [ ] Nothing in the statute indicates it is against public policy to honor those same wishes when the patient is conscious and able to vocalize and carry out the decision himself with self-administered medicine and no immediate or direct physician assistance.

* * *

The Dissent * * * cites § 45-5-105, MCA, stating that a person may be prosecuted for aiding or soliciting suicide only if the individual *does not die*. [ ] The statute's plain meaning is clear. It is also inapplicable. The narrow scenario we have been asked to consider on appeal involves the situation in which a terminally ill patient affirmatively seeks a lethal dose of medicine and subsequently self-administers it, causing his own death. Section 45-5-105, MCA, unambiguously applies *only* when the suicide *does* not occur.

* * * Here, the legislature could not have provided clearer, more unambiguous language. If the person does not die, the statute is triggered. If they do die, the statute is not triggered. * * *.

* * *

Even if this Court were to extend consideration to § 45-5-105, MCA, as a generalized reflection of the legislature's views on third party involvement in suicides, there remains no indication that the statute was ever intended to apply to the very narrow set of circumstances in which a terminally ill patient *himself* seeks out a physician and asks the physician to provide him the means to end his own life. As the Dissent states, the original enactment addressed situations

of a third party "encouraging" a suicide. [ ] The present version reflects the same focus in the "soliciting" language. The statute's plain language addresses the situation in which a third party unilaterally solicits or aids another person. In physician aid in dying, the solicitation comes from the patient himself, *not* a third party physician.

There is no indication that the 1973 Montana legislators contemplated the statute would apply to this specific situation in which a terminally ill patient seeks a means by which he can end his own incurable suffering.

* * *

In conclusion, we find nothing in Montana Supreme Court precedent or Montana statutes indicating that physician aid in dying is against public policy. The "against public policy" exception to consent has been interpreted by this Court as applicable to violent breaches of the public peace. Physician aid in dying does not satisfy that definition. We also find nothing in the plain language of Montana statutes indicating that physician aid in dying is against public policy. In physician aid in dying, the patient— not the physician—commits the final death-causing act by self-administering a lethal dose of medicine.

Furthermore, the Montana Rights of the Terminally Ill Act indicates legislative respect for a patient's autonomous right to decide if and how he will receive medical treatment at the end of his life.

* * *

[The concurring opinion of **Justice Warner**, who agreed that there was no need to address the Constitutional issue, is omitted.]

Justice Nelson, specially concurring.

* * *

* * * For the reasons which follow, I agree with the Court's analysis under the consent statute (§ 45-2-211, MCA), and I further conclude that physician aid in dying is protected by the Montana Constitution as a matter of privacy [ ] and as a matter of individual dignity [ ].

* * *

CONSTITUTIONAL ANALYSIS

* * * [P]hysician aid in dying is also firmly protected by Montana's Constitution. [B]ecause I so passionately believe that individual dignity is, in all likelihood, the most important—and yet, in our times, the most fragile— of all human rights protected by Montana's Constitution, I proceed to explain what I believe the right of dignity means within the context of this case—one of the most important cases the courts of this state have ever considered.

* * *

A. Terminology and Language

First, let me be clear about one thing: This case is not about the "right to die." Indeed, the notion that there is such a "right" is patently absurd, if not downright silly. No constitution, no statute, no legislature, and no court can grant an individual the "right to die." Nor can they take such a right away. "Death is the destiny of everything that lives. Nothing ever escapes it." [ ] Within the context of this case, the only control that a person has over death is that if he expects its coming within a relatively short period of time due to an incurable disease, he can simply accept his fate and seek drug-induced comfort; or he can seek further treatment and fight to prolong death's advance; or, at some point in his illness, and with his physician's assistance, he can embrace his destiny at a time and place of his choosing. The only "right" guaranteed to him in any of these decisions is the right to preserve his personal autonomy and his individual dignity, as he sees fit, in the face of an ultimate destiny that no power on earth can prevent.

Thus noted, the Patients and the class of individuals they represent are persons who suffer from an illness or disease, who cannot be cured of their illness or disease by any reasonably available medical treatment, who therefore expect death within a relatively short period of time, and who demand the right to preserve their personal autonomy and their individual dignity in facing this destiny.

In choosing this language, I purposely eschew bright-line tests or rigid timeframes. What is "relatively short" varies from person to person. I take this approach [ ] for the following nonexclusive reasons. **First,** the amount of physical, emotional, spiritual, and mental suffering that one is willing or able to endure is uniquely and solely a matter of individual constitution, conscience, and personal autonomy. **Second**, "suffering" in this more expansive sense may implicate a person's uniquely personal perception of his "quality of life." This perception may be informed by, among other things, one's level of suffering, one's loss of personal autonomy, one's ability to make choices about his situation, one's ability to communicate, one's perceived loss of value to self or to others, one's ability to care for his personal needs and hygiene, one's loss of dignity, one's financial situation and concern over the economic burdens of prolonged illness, and one's level of tolerance for the invasion of personal privacy and individual dignity that palliative treatment necessarily involves. Suffering may diminish the quality of life; on the other hand, the lack of suffering does not guarantee a life of quality. There is a difference between living and suffering; and the sufferer is uniquely positioned and, therefore, uniquely entitled to define the tipping point that makes suffering unbearable. **Third**, while most incurable illnesses and diseases follow a fairly predictable symptomatology and course, every illness and disease is a unique and very personal experience for the afflicted person. Thus, the afflicted individual's illness or disease informs his end-of-life choices and decisions in ways unique and personal to that individual's life, values, and circumstances. **Fourth**, advancements in medical treatment may become available during the period between the time when he is diagnosed as being incurably ill and the predicted (estimated) time of death. With those advancements, a person initially given three months to live may well expect to live two more months or two more years with a new medicine or treatment. **Fifth**, individual access to medical care may vary. A person living in proximity to a medical research facility may have access to medicines and treatments as part of a clinical trial, while another person living in a sparsely populated rural area may not have that opportunity. One individual may have access to hospice care; another may not. Sadly, an insured individual may have access to medicine and treatment that an uninsured individual does not. **Sixth**, each individual's family situation is different. One individual may not have close family relationships; another may have a strongly involved and supportive family. One person's family may live within a short distance, while another person's family may be spread across the country or around the globe. The ability to say final goodbyes and the ability to die, at a predetermined time and place, perhaps in the company of one's partner or friends and loved ones, is important to

many individuals and to their families. **Seventh**, and lastly, to many who are incurably ill and dying, the prospect of putting their partner or family through their prolonged and agonizing death is a source of deep emotional and spiritual distress.

Additionally, in my choice of language, I have intentionally chosen not to use emotionally charged and value-laden terms such as "terminal" and "suicide." "Terminal" conjures up the notion that the individual is on some sort of inevitable slide or countdown to death. This term trivializes the fact that many individuals, with what appear to be medically incurable diseases, nevertheless retain steadfast hope and faith that their condition will be reversed, along with a personal resolve to fight for life until the very end. Labeling an individual as "terminal" may not only discourage the individual from seeking treatment but may also discourage further treatment efforts by healthcare providers. A "terminal" diagnosis fails to acknowledge that medicine usually cannot predict the time of death with the sort of exactitude that the use of the term connotes.

Similarly, the term "suicide" suggests an act of self-destruction that historically has been condemned as sinful, immoral, or damning by many religions. Moreover, in modern parlance, "suicide" may be linked with terrorist conduct. Importantly, and as reflected in the briefing in this case, society judges and typically, but selectively, deprecates individuals who commit "suicide." On one hand, the individual who throws his body over a hand grenade to save his fellow soldiers is judged a hero, not a person who committed "suicide." Yet, on the other hand, the individual who shoots herself because she faces a protracted illness and agonizing death commits "suicide" and, as such, is judged a coward in the face of her illness and selfish in her lack of consideration for the pain and loss her act causes to loved ones and friends. Assisting this person to end her life is likewise denounced as typifying " 'a very low regard for human life.' [ ] To the contrary, however, the Patients and their amici argue that a physician who provides aid in dying demonstrates compassionate regard for the patient's suffering, recognition of the patient's autonomy and dignity, and acknowledgement of death's inevitability.

"Suicide" is a pejorative term in our society. Unfortunately, it is also a term used liberally by the State and its amici (as well as the Dissent) in this case. The term denigrates the complex individual circumstances that drive persons generally—and, in particular, those who are incurably ill and face prolonged illness and agonizing death—to take their own lives. The term is used to generate antipathy, and it does. * * * The Patients and the class of people they represent do not seek to commit "suicide." Rather, they acknowledge that death within a relatively short time is inescapable because of their illness or disease. And with that fact in mind, they seek the ability to self-administer, at a time and place of their choosing, a physician-prescribed medication that will assist them in preserving their own human dignity during the inevitable process of dying. Having come to grips with the inexorability of their death, they simply ask the government not to force them to suffer and die in an agonizing, degrading, humiliating, and undignified manner. * * *

Finally, I neither use the terms nor address "euthanasia" or "mercy killing." Aside from the negative implications of these terms and the criminality of such conduct, the Patients clearly do not argue that incompetent, nonconsenting individuals or "vulnerable" people may be, under any circumstances, "euthanized" or "murdered." * * * The only reason that "homicide" is implicated at all in this case is because (a) the State contends that a licensed physician who provides a mentally competent, incurably ill patient with the prescription for a life-ending substance, to be self-administered by the patient if she so chooses, is guilty of deliberate homicide and (b) our

decision holds that it is not against public policy under the consent statute to permit the physician to do so.

With that prefatory explanation, I now turn to Article II, Section 4 and the right of individual dignity.

Construction of Article II, Section 4

Article II, Section 4 of Montana's 1972 Constitution provides:

Individual dignity. The dignity of the human being is inviolable. No person shall be denied the equal protection of the laws. Neither the state nor any person, firm, corporation, or institution shall discriminate against any person in the exercise of his civil or political rights on account of race, color, sex, culture, social origin or condition, or political or religious ideas.

[I]t is my view that the first clause of Article II, Section 4 (the Dignity Clause) is a stand-alone, fundamental constitutional right. [ ]

* * *

The Right of Human Dignity

Human dignity is, perhaps, the most fundamental right in the Declaration of Rights. This right is "inviolable," * * *. Significantly, the right of human dignity is the only right in Montana's Constitution that is "inviolable." [ ] No individual may be stripped of her human dignity under the plain language of the Dignity Clause. No private or governmental entity has the right or the power to do so. Human dignity simply cannot be violated—no exceptions. * * *

But what exactly is "dignity"? It would be impractical here to attempt to provide an exhaustive definition. Rather, the meaning of this term must be fleshed out on a case-by-case basis (in the same way that the parameters of substantive due process have been determined on a case-by-case basis). * * * [I]n our Western ethical tradition, especially after the Religious Reformation of the 16th and 17th centuries, dignity has typically been associated with the normative ideal of individual persons as intrinsically valuable, as having inherent worth as individuals, at least in part because of their capacity for independent, autonomous, rational, and responsible action.

* * *

Given its intrinsic nature, it is entirely proper, in my view, that the right of dignity under Article II, Section 4 is absolute. Indeed, human dignity transcends the Constitution and the law. Dignity is a fundamental component of humanness. It is inherent in human self-consciousness. * * * While the government may impinge on privacy rights, liberty interests, and other Article II rights in proper circumstances (e.g., when one becomes a prisoner), the individual always retains his right of human dignity. So too with persons suffering from mental illness or disability and involuntary commitment: Each retains the right to demand of the State that his dignity as a human being be respected despite the government's sometimes necessary interference in his life.

I am convinced that each of us recognizes this intrinsic, elemental nature of human dignity. Indeed, that recognition explains why we collectively recoil from the pyramid of naked enemy soldiers prodded by troops with guns and dogs at Abu Ghraib; why disgust fills most of us at the descriptions and depictions of water boarding and torture; and why we revolt from ethnic

cleansing and genocide. It is why we should collectively rebel, as well, when we see our fellow human beings in need from lack of food, clothing, shelter, medical care, and education.

* * *

I believe this is why we also collectively recoil from accounts of our fellow human beings forced to endure the humiliation and degradation of an agonizing death from an incurable illness. Pain may, in theory, be alleviated to the point of rendering the person unconscious. But in those circumstances, we still cannot deny that the individual's human dignity has been dealt a grievous blow long before death claims her body.

* * *

The State asserts that it has compelling interests in preserving life and protecting vulnerable groups from potential abuses. This broad assertion, however, is entirely inadequate to sustain the State's position in opposition to physician aid in dying. We are dealing here with persons who are mentally competent, who are incurably ill, and who expect death within a relatively short period of time. The State has failed to explain what interest the government has in forcing a competent, incurably ill person who is going through prolonged suffering and slow, excruciating physical deterioration to hang on to the last possible moment. Moreover, the State has not come close to showing that it has any interest, much less a "compelling" one, in usurping a competent, incurably ill individual's autonomous decision to obtain a licensed physician's assistance in dying so that she might die with the same human dignity with which she was born. * * *

* * *

III. CONCLUSION

* * *

This right to physician aid in dying quintessentially involves the inviolable right to human dignity—our most fragile fundamental right. Montana's Dignity Clause does not permit a person or entity to force an agonizing, dehumanizing, demeaning, and often protracted death upon a mentally competent, incurably ill individual for the sake of political ideology, religious belief, or a paternalistic sense of ethics. * * *

JUSTICE RICE, dissenting.

The prohibition against homicide—intentionally causing the death of another— protects and preserves human life, is the ultimate recognition of human dignity, and is a foundation for modern society, as it has been for millennia past. Based upon this foundation, Anglo-American law, encompassing the law of Montana, has prohibited the enabling of suicide for over 700 years. [ ]. However, in contradiction to these fundamental principles, the Court concludes that physician-assisted suicide does not violate Montana's public policy. In doing so, the Court has badly misinterpreted our public policy: assisting suicide has been explicitly and expressly prohibited by Montana law for the past 114 years. More than merely setting aside the District Court's order herein, I would reverse the judgment entirely.

A flaw that underlies the Court's analysis is its failure to distinguish between the physician's basic intention in the assisted-suicide case from the physician's intention while rendering treatment in other cases. As developed further herein, the intentions in these two cases are diametrically opposed, and create the very difference between a criminal and noncriminal act.

Physician-assisted suicide occurs when a physician provides a lethal drug with the intent to cause, when the drug is taken by the patient, the patient's death. With palliative care, the physician does not intend his or her actions to cause the patient's death, but rather intends to relieve the patient's pain and suffering. For this reason a physician providing palliative care, even in cases where the treatment arguably contributes to the patient's death, lacks the requisite mental state to be charged under homicide statutes. [ ] A similar distinction arises in the withholding or withdrawal of medical treatment that merely prolongs the dying process, pursuant to the Montana Rights of the Terminally Ill Act. Under the Act, a patient may refuse treatment and allow death to occur naturally, and physicians incur no liability, having not administered any death-causing treatment. [ ]

* * *

The Statutory Prohibition on the Aiding or Soliciting of Suicide

* * *

In 1973, the Legislature revised the [aiding or soliciting suicide] statute to read:

(1) A person who purposely aids or solicits another to commit suicide, but such suicide does not occur commits the offense of aiding or soliciting suicide.

(2) A person convicted of the offense of aiding or soliciting a suicide shall be imprisoned in the state prison for any term not to exceed ten (10) years.

Section 94-5-106, RCM (1973). The Legislature codified this provision within the homicide statutes. The current version of the statute is the same as the 1973 version, except that the Legislature has increased the potential punishment for the crime by authorizing a $ 50,000 penalty. [ ]

Under the wording of the current version of the statute, a person may be prosecuted for aiding or soliciting another to commit suicide only if the victim survives. The purpose of this change of the statutory language from the pre-1973 version was explained by the Criminal Code Commission that proposed it. When the victim dies, the act is to be prosecuted as a homicide. * * *

Thus, under Montana law, physicians who assist in a suicide are subject to criminal prosecution irrespective of whether the patient survives or dies. If the patient survives, the physician may be prosecuted under aiding or soliciting suicide. [ ]. If the patient dies, the physician may be prosecuted under the homicide statutes. [ ]

Importantly, it is also very clear that a patient's consent to the physician's efforts is of no consequence whatsoever under these statutes. The Commission Comments explain that a physician acting as the agency of death may not raise "consent or even the solicitations of the victim" as a defense to criminal culpability.

* * *

The Montana Rights of the Terminally Ill Act

* * *

The operative words in the Montana Act are those permitting a patient to "withhold" and "withdraw" life-sustaining treatment. [ ] Largely self-evident, to "withhold" means "to desist or refrain from granting, giving, or allowing." [ ] Similarly, "withdraw" is defined as "to take back or away (something bestowed or possessed)." [ ] Neither word incorporates the concept of affirmatively issuing a life-ending drug to a patient. Rather, the plain language permits only the taking away of, or refraining from giving, certain medical treatment—that which merely prolongs the dying process. [ ]

[I]t is incongruous to conclude there is no legal distinction between the withdrawal of life-prolonging medical treatment and the provision of life-ending treatment. This distinction is clearly recognized by the wording of our statutes, discussed above, and by the courts. * * *

* * *

The 1972 Montana Constitution

* * *

The Constitutional Convention adopted the Individual Dignity Section for the express purpose of providing equal protection and prohibiting discrimination. * * * Nothing within [the Montana Constitutional Convention's] discussions or explanations suggests even a thought that the dignity clause contained vague, lurking rights that might someday manifest themselves beyond what the delegates or the citizens of Montana who approved the Constitution believed, and overturn long-established law, here, the policy against assisted suicide. The reference to dignity therefore provides an aspirational introduction to the already well-established substantive legal principles providing the operative vehicles to achieve dignity: equal protection and the prohibition upon discrimination. [ ] Likewise, the right to privacy did not alter the State's policy against assisted suicide. There is nothing within either the language of the provision or the convention proceedings which would reflect any such intention. [ ] For such reasons, not one court of last resort has interpreted a constitutional right of privacy to include physician-assisted suicide. [ ] * * *

Because we live in a democracy, this policy may someday change. Controlling their own destiny, Montanans may decide to change the State's public policy after what would be, no doubt, a spirited public debate. In fact, efforts in that regard have already started. [ ] This Court should allow the public debate to continue, and allow the citizens of this State to control their own destiny on the issue.

Until the public policy is changed by the democratic process, it should be recognized and enforced by the courts. It is a public policy which regards the aiding of suicide as typifying "a very low regard for human life," [ ], and which expressly prohibits it. Instead, the Court rejects the State's longstanding policy. It ignores expressed intent, parses statutes, and churns reasons to avoid the clear policy of the State and reach an untenable conclusion: that it is against public policy for a physician to assist in a suicide if the patient happens to live after taking the medication; but that the very same act, with the very same intent, is not against public policy if the patient dies. In my view, the Court's conclusion is without support, without clear reason, and without moral force.

I would reverse.

Notes and Questions

1. What difference does it make that the opinion of the court rests upon statutory and common law analysis, and not on state constitutional law? In what ways is the opinion of Justice Leaphart stronger than the opinion of Justice Nelson, and in what ways would Justice Nelson's approach provide a stronger basis for the right to medically assisted dying? Note that Justice Leaphart's opinion sets the statutory and common law default position—the state of law without any specific state legislation—as one that permits medically assisted dying. As a legal matter, which approach is stronger? As a political matter, which approach is stronger?

2. What kind of statutory changes in Montana would lead to a change in the law of medically assisted dying in that state? At the next plenary legislative session following *Baxter*, in 2011, the legislature was squarely confronted with bills that would outlaw physician aid-in-dying, and with a bill that would formally legalize it and impose the same kinds of restrictions that are imposed in Washington and Oregon. The bills were carefully followed by the press, and there was a good deal of advocacy activity by partisans on both sides of the issue. Ultimately, the legislature rejected all of the bills on both sides of the issue, and left the law as it stood the day after *Baxter* was decided. Under these circumstances, what, exactly, is the law of physician aid-in-dying in Montana?

3. Those opposed to aid in dying also sought to use the administrative process to reinstate the ban. An attempt to have the Montana Board of Medical Examiners declare that they would impose professional sanctions against any Montana physician who provided medically assisted dying in accord with the *Baxter* opinion was met with this response in 2012:

Physician Aid in Dying

> As a result of *[Baxter],* the Montana Board of Medical Examiners has been asked if it will discipline physicians for participating in such aid-in-dying. This statement reflects the Board's position on this controversial question.
>
> The Board recognizes that its mission is to protect the citizens of Montana against the unprofessional, improper, unauthorized and unqualified practice of medicine by ensuring that its licensees are competent professionals. [ ] In all matters of medical practice, including end-of-life matters, physicians are held to professional standards. If the Board receives a complaint related to physician aid-in-dying, it will evaluate the complaint on its individual merits and will consider, as it would any other medical procedure or intervention, whether the physician engaged in unprofessional conduct as defined by the laws and rules pertinent to the Board.

Mont. Bd. Of Med. Examiners, Position Statement No. 20 (2012). This statement was applauded by those who support aid-in-dying and who believe that it should be treated like any other medical procedure. Montanans Against Assisted Suicide and for Living with Dignity, an advocacy group opposed to aid in dying, asked the Board to withdraw the statement, which, those advocates said, was issued without proper notice, without statutory authority, and in violation of the principle of separation of powers. They argued that the Position Statement put doctors and the public at risk.

4. Are you convinced by Justice Leaphart's analysis of the consent defense in a homicide case? His argument has two steps. First, consent is a defense to homicide unless that would be contrary to public policy (for example, where it would lead to a breach of the peace). Second, the Montana statute criminalizing aiding suicide does not apply to this case because it only applies when the victim does not die. Does it make sense to read the Montana law on aiding

suicide as criminalizing such conduct only if the subject of the suicide actually dies? Suppose that, in an effort to cause a lovelorn teenager to kill himself, a person purchases a handgun and gives it to that person while taunting him. If the suicide victim shoots himself and dies, the person providing the handgun appears to have committed the crime of aiding suicide. But what if the victim has bad aim and only maims himself? Has anyone committed a crime? What is the logical justification for this?

5. Although litigation to establish the kind of right recognized in *Baxter* has been rejected by appellate courts as a matter of state law in Florida, California, Alaska, and, on procedural grounds, in Connecticut, several years have passed since the substantive cases were litigated. Would you expect to see more litigation modeled on the Montana approach? Litigation seeking a right to medically assisted dying under state constitutional law has failed in the few states where it has been tried. In Krischer v. McIver, 697 So.2d 97 (Fla.1997), a terminally ill AIDS patient and his physician sought an injunction against the prosecution of the physician for assisting in his patient's suicide. The Florida Supreme Court rejected a claim that the privacy provision of the Florida Constitution included the right to have a physician assist in one's suicide. The Court announced that a properly drawn statute authorizing physician-assisted suicide would be constitutionally permissible, but that principles of separation of powers left the decision about whether it should be made legal to the legislature. The Chief Justice filed a vigorous dissent, arguing that, " * * *the right of privacy attaches with unusual force at the death bed. * * * What possible interest does society have in saving life when there is nothing of life to save but a final convulsion of agony? The state has no business in this arena." 697 So.2d at 111. See also Sampson v. State, 31 P.3d 88 (Alaska 2001).

6. Oregon and Washington have changed their statutes by initiative to allow for some form of medically assisted dying, and Montana has done so through litigation that has also enjoyed substantial public support in the state. Is there some reason that this phenomenon is centered in the Northwest? Demographically and politically, how is that part of the country different from the rest of the country? Might matters of race and ethnicity, religion, cultural values, and a deep libertarian streak distinguish this part of the country?

7. Montana is the only state with a "human dignity" provision in its constitution (although Puerto Rico also has such a provision, also taken from the German constitution). Why do you think no other state has adopted such a provision? Could other state constitutional guarantees ("privacy" or "right to pursue happiness" provisions, for example) serve the same purpose and lead to the same result?

8. *Baxter* allows for physicians to participate in medically assisted dying, at least to the extent of providing a prescription for a lethal dose of medication under limited circumstances. How far does this right go? Does the logic of the opinion also support extending the right to more affirmative acts of a physician—administering the lethal dose, for example? Also, is the protection that extends to those who engage in aid in dying limited to physicians? Could nurses and other health care workers engage in this same conduct, at least if they are otherwise authorized to do so under Montana scope of practice limitations? Does this opinion also permit family members and friends to participate and assist a patient? By being present when the patient takes a lethal dose that has been prescribed by a physician? By providing a patient a glass of water? By encouraging the patient to take the dose? In other ways?

9. The Affordable Care Act forbids the federal and state governments, and all health care providers and health plans that receive funding through the ACA (i.e., virtually all providers and

health plans) from discriminating against institutional or individual providers who do not provide goods or services for purposes of "assisted suicide, euthanasia or mercy killing." Under this section, a religious hospital that refuses to permit "assisted suicide, euthanasia or mercy killing" at its facilities, for example, even when such conduct is legal under state law, must be treated just like a hospital that will permit those procedures. Does "assisted suicide, euthanasia or mercy killing," for purpose of ACA, include the kind of medically assisted dying permitted in Montana under *Baxter*? In any case, the ACA explicitly provides that this assisted suicide non-discrimination provision does not affect the physician's legal obligations with regard to withholding or withdrawing medical treatment, including nutrition and hydration, and that it does not affect treatment provided with the purpose of alleviating pain or discomfort, even if that palliative care increases the risk of death, as long as the treatment is not furnished with the purpose of causing the death of the patient.

Problem: Medically Assisted Dying: A Legal Issue or a Medical Issue?

Our conflict over medically assisted dying has been fought in the arena of law. Is there a right to engage in medically assisted dying? Do homicide and suicide statutes prohibit the practice of medically assisted dying? Those with more libertarian views tend to support finding such a right; those with strongly developed religious views or a more expansive view of criminal law are less likely to find such a right. The battles over legislation and most of the reported litigation reflect this rights-oriented legal battle over this issue.

Instead, should we be asking whether medically assisted dying is within the medical standard of care? If we were to take this approach, we would treat medically assisted dying as one of many end-of-life care possibilities, and we would let providers determine if it is appropriate on a case by case basis. Instead of arguing about the issue to courts, we would leave it to health care professionals, who could offer to their patients whatever came within the standard of care.

Do you think the issue is best analyzed as one of legal rights and obligations, ultimately to be decided by courts, or is it best analyzed as one of good medicine, ultimately to be determined by the physician and her patient in each case?