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Bioethics and Law in the United States: A Legal Process Perspective

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Abstract: An analytical exposition of the law regarding a patient's "right to die" as it has developed in the United States over the last 30 years provides an exemplar overview of the variety of legal mechanisms that American legal institutions can and do bring to bear to deal with the challenges posed by new developments in medicine and the biosciences. Opposing "pro-life" and "pro-choice" ideological and political forces have been channeled through the federal and state legislative, judicial, and executive branches, where the various legal actors have developed legal principles that so far provide patients with a right to refuse any form of life-prolonging treatment while denying them (in all but one state) the right to physician-assisted suicide. The tension between these forces continues to exist, and the law is in a constant process of change.

1. Introduction

Over the last few decades, America has served in the avant-garde of the effort to develop new law to respond to the challenges presented by rapid advances in medicine and the life sciences. A meaningful substantive overview of all these developments cannot be provided in a short essay. First, the areas of challenge are numerous, cover a broad range, and are ever-growing. They include, but are not limited to, such issues as patients' rights, abortion, organ transplantation, fetal and embryonic research, stem cell research, genetic research and therapy, etc. Second, the legal system of the United States is multi-layered and complicated. Legal regulation may take the form of laws made by state and local governments as well as the federal government, and they may be issued not only by legislatures, but also by administrative agencies within the executive branch, and they may be developed by the state and federal judiciary who interpret state and federal constitutional provisions and apply principles of judge-made common law. Thus, I will provide here an overview of only one (and one of the earliest) of the areas of development of "Law and Bioethics" in the United States, in the hope that it will be valuable not only for its coverage of the substantive law in that area, but also for the aid it may offer as a key to understanding the way that the American legal process is able to respond to the challenges raised in all such areas.¹

In the last thirty years, a body of law has developed in the United States that establishes for American medical patients what has come to be called "the right to die." The high water mark of that development thus far was reached in the last decade of the Twentieth Century. In 1990, the United States Supreme Court rendered its opinion in *Cruzan v. Director, Missouri Department of Public Health*, in which it recognized a federal constitutionally based right of patients to refuse unwanted life-saving medical treatment - including artificial nutrition and

¹ For a broader and more detailed, although somewhat outdated, treatment of this same subject, see Charles H. Baron, *DROIT CONSTITUTIONNEL ET BIOÉTHIQUE: L'EXPÉRIENCE AMÉRICAINNE* (Economica 1997).

hydration.² In 1994 the voters of the state of Oregon passed by initiative process America's first (and still only) state law legalizing and regulating physician-assisted suicide.³ But today, the process of further development of the right to die seems to be stalled, and the law protecting this right is left at an awkward, unstable, and even dangerous stage. Beyond that, there are indications that some of the progress made in protecting patient autonomy in this area is in peril of being undone. "Pro-life" political forces are currently engaged, over a wide-range of issues of modern bioethics and medical ethics, in a reactionary effort to undo many of the legal trends of the last three decades and retard future development. In the larger context of current political tensions in the United States between protection of individual liberties and efforts to promote religious and moral conformity, it is unclear how the law will develop in the near future.

2. Judicial Development of "The Right to Die."

Tension between pro-life and pro-choice political forces in the United States has shaped development of "the right to die" from its beginning. The movement to improve the plight of terminally ill patients -- to prevent them from being forced by outdated laws to endure long periods of suffering and indignity as part of the dying process -- arose against the background of the effort to legalize abortion and of the U.S. Supreme Court's 1973 landmark decision in *Roe v. Wade*.⁴ When the Supreme Court of New Jersey decided the first of the right-to-die cases, *In re Quinlan*,⁵ in 1976, it was no surprise that recognition of such a right would come first from the courts of the state rather than from its legislature or its executive branch. The decision in *Roe* had heightened the level of political activism of right-to-life groups across the country. Elected officials were predictably wary of the price they might pay at the polls for appearing weak on issues of respect for human life in all its forms. Thus, it was natural that Karen Quinlan's father should turn to the courts of his state to seek relief when his daughter's physicians -- fearing prosecution for homicide or assisting suicide -- refused to remove life-support from his 22 year old daughter, Karen, who had been determined to be in a permanent vegetative state. Judges in New Jersey, like federal judges and judges in many other American states, are appointed to the bench and do not stand for popular election. As a result, they are not as vulnerable as legislators to the threat of political retribution. Moreover, the courts offered other advantages over the legislature as institutions for modifying the law to accommodate the pressures on society created by progress in medicine and biotechnology. Although, common law judges clearly "make law," the tradition is for them to do so by incorporating values from, and building incrementally upon, judicial precedents established in earlier cases. And, in deciding the cases before them, they are expected to write opinions that explain their decisions in a fashion that limits, as much as possible, the rule justifying the result to only what is necessary to reach the decision on the facts of the particular case. Unlike legislators, they need not draft laws in broad, sweeping form and in a fashion which anticipates and accommodates all possible exceptions. They can make law tentatively. They can establish a rule in one case; broaden the rule in a later case if it is determined to have been fashioned too narrowly, limit it if it was stated too broadly, or overrule it altogether if the court concludes it to have been a mistake. In all of this, they are able to draw

² 497 U.S. 261 (1990).

³ Oregon Death with Dignity Act.

⁴ 410 U.S. 113 (1973).

⁵ 355 A.2d 647 (N.J. 1976).

on the work of sister courts, state and federal, employing decisions of other jurisdictions as “persuasive authority,” building upon them by accepting what seems reasonable and modifying or rejecting what does not. As I have pointed out in an earlier article on this subject, it was in just this fashion that American courts dealt with the challenges of new technology in the Nineteenth Century:

During the Nineteenth Century, when American society was challenged by the development of new technologies such as the railroad and the telegraph, it was the common law courts of the various states that crafted legal responses attempting to balance the various interests involved. The justices of the state supreme courts worked together in developing a new body of common law to govern these new technologies. They wrote opinions in which they claimed to be drawing their norms from basic values already recognized in past common law decisions in both America and England and to be applying those norms to the facts of the cases before them. The Supreme Judicial Court of Massachusetts was one of the leading courts in this effort. The Court’s Chief Justice, Lemuel Shaw, came to be called “America’s Greatest Magistrate” in recognition of his contribution to the framing of law in this area. But justices from many courts, building on each other’s decisions, contributed to the establishment of these legal norms on a case-by-case basis.⁶

Beginning with the decision of the New Jersey court in *Quinlan*, American courts, in the last third of the Twentieth Century, engaged themselves in a cooperative effort to develop principles for providing patients with the power to control the timing and circumstances of their deaths. In *Quinlan*, the New Jersey court granted Karen’s father the authority as her guardian to exercise what they found to be her constitutionally based right to refuse treatment under her medical circumstances. But, it is important to note that the decision did not rest upon recognition of an absolute right to refuse treatment. Indeed, as the New Jersey court notes in its opinion, recognition of such a right would have been inconsistent with decisions it had rendered only a decade before in which it had authorized physicians to force blood transfusions upon Jehovah’s Witness patients who objected to such treatment on religious grounds.⁷ The court’s holding in *Quinlan* was restricted to cases like Karen’s where medical treatment offered no hope of being restored to a meaningful “quality of life.” Her case was different from that of the Jehovah’s Witnesses, said the court, in that the latter were “most importantly [patients] apparently salvable to long life and vibrant health; - a situation not at all like the present case.”⁸ The driving factor in *Quinlan* appeared to be the fact that allowing a patient in a permanent vegetative state to die was the reasonable and humane thing to do. In the end, the court did not even require that Karen Quinlan’s wishes be taken into consideration in deciding whether or not she should be removed from life support. Testimony that had been offered at trial of what she had told friends she would want if she were ever

⁶ Charles H. Baron, Normativité et Biomédecine aux Etats-Unis, in Brigitte Feuillet-Le Mintier (ed.), NORMATIVITÉ ET BIOMÉDECINE at 13, (2003).

⁷ *Quinlan*, 355 A.2d at 661-62.

⁸ *Id.* at 663.

permanently on life support was rejected by the court as being “without sufficient probative weight.”⁹ Instead of attempting to establish Karen’s wishes, the court gave discretion to her physicians to decide whether or not life support should be withdrawn - so long as that decision was agreed to by her guardian, her family, and a hospital ethics committee.

Quinlan, in many ways, represented an effort on the part of the medical profession to take back a freedom from regulation it had enjoyed prior to the advent of modern high-technology medicine. When patients died at home, under the care of family physicians, and in a context that did not afford seemingly unlimited options for prolonging life, attending physicians regularly made decisions for patients and families that “enough was enough.” But by the 1960’s and 1970’s, hospital staff was being confronted with the need to make increasingly stark life and death decisions in a frighteningly public environment. The very recent history of legal treatment of abortion decision-making was not such as to inspire confidence that doctors could consider themselves immune from legal prosecution. In the wake of the Thalidomide abortion controversy in the United States, professional practices regarding abortion had come under public scrutiny and legal control had been tightened in many jurisdictions. The solution to this problem had come with the decision in *Roe* in 1973. On the basis of a “right to privacy” it had previously found in the Due Process Clause of the Fourteenth Amendment to the United States Constitution,¹⁰ the *Roe* Court had delegated to the pregnant woman’s attending physician almost all aspects of the determination of whether or not an abortion could be performed.

In *Quinlan*, the New Jersey Supreme Court essentially followed the lead of *Roe*. Where *Roe* had used the federal constitutional right to privacy to protect professional autonomy at the beginning of life, *Quinlan* used that right (and a right to privacy that the court found in the New Jersey Constitution as well) to protect professional autonomy at the end of life. Because the patient was in a permanent vegetative state, and there was no reasonable chance that medical treatment could restore her to a higher “quality of life,” the patient’s right to life was outweighed by her right to privacy. Thus, her physician could lawfully hasten her death by removing her from her ventilator so long as this was agreed to by her guardian, her family, and an appropriate hospital ethics committee.

In 1977, the year following *Quinlan*, the Supreme Judicial Court of Massachusetts rendered a decision in a case that was very like *Quinlan* in many ways but unlike it in significant respects as well, and the Massachusetts court extended the principles of *Quinlan* in some ways and restricted them in others. The case was *Saikewicz v. Superintendent of Belchertown State Hospital*.¹¹ It was brought by physicians at a state hospital for the mentally retarded who were seeking permission to withhold chemotherapy treatment from a 67 year old, profoundly mentally retarded inmate who was terminally ill with cancer. Without chemotherapy, the patient would die of his cancer within weeks or months. With the treatment, the patient might live for as much as a year, but at the cost of the serious side effects of chemotherapy. A decision to treat him was complicated by the fact that his profound state of mental retardation would prevent him from

⁹ Id. at 664.

¹⁰ See *Griswold v. Connecticut*, 381 U.S. 479 (1965).

¹¹ 370 N.E.2d 417 (Mass. 1977).

understanding why he was being subjected to the discomforts of chemotherapy. It would also prevent him from enjoying the sense of hope that a competent patient might obtain from the sense that every effort was being made to defeat the disease.

The Massachusetts court, like the New Jersey court in *Quinlan*, provided the physicians with legal permission to withhold treatment. Like the *Quinlan* court, the *Saikewicz* court based its decision on the right to privacy (which it, like the New Jersey court, found in its state constitution as well as in the federal constitution), and it held that this right outweighed interests in preserving life in circumstances, like those in the case before it, where treatment could not significantly improve the patient's "quality of life." Thus, *Saikewicz* followed *Quinlan* and even extended its holding to apply to patients who were being treated for a terminal illness -- not just to patients in a permanent vegetative state. However, in other important respects, *Saikewicz* represented a significant break from *Quinlan*. Rather than empowering physicians to make decisions for incompetent patients (so long as the patient's guardian, family members, and a hospital ethics committee agreed), the court held that physicians were bound to follow the wishes of the patient. The "informed consent" or "informed refusal" of the patient, and not professional discretion, were to govern. And where the power to consent or refuse could not be exercised by a patient because of mental incompetency, physicians looking for legal protection would be required to ask a court to decide what the patient would want for himself. "We do not view the judicial resolution of [the question] whether potentially life-prolonging treatment should be withheld from a person incapable of making his own decision [as] a 'gratuitous encroachment' on the domain of medical expertise," said the court. "Rather, such questions of life and death seem to us to require the process of detached but passionate investigation and decision that forms the ideal on which the judicial branch of government was created. Achieving this ideal is our responsibility and that of the lower court, and is not to be entrusted to any other group purporting to represent the 'morality and conscience of our society' no matter how highly motivated or impressively constituted."¹²

Over the next decade, the courts of Massachusetts made good use of this mandate to further refine the "informed refusal" principles of *Saikewicz*. By the end of this process, patient autonomy would become the bedrock norm of "the right to die." But *Saikewicz*, like *Quinlan*, had not itself recognized an absolute right of patients to refuse life-saving treatment. In *Saikewicz*, the court limited its holding to cases where treatment could be characterized as merely "life-prolonging," rather than "life-saving." The Massachusetts court claimed it was relying upon "a substantial distinction in the State's insistence that human life be saved where the affliction is curable, as opposed to the State interest where, as here, the issue is not whether but when, for how long, and at what cost to the individual that life may be briefly extended."¹³ In a series of cases decided from 1978 to 1980, the Massachusetts courts supplanted such "quality of life" factors with criteria based on the objective "intrusiveness" of the proposed treatment. Thus, in *Lane v. Candura*,¹⁴ a 77 year old woman was permitted to refuse a lifesaving amputation of her leg because "[t]he magnitude of the invasion proposed in this case is decisive in applying the balancing test."¹⁵ And in the cases of *Commissioner of Correction v. Myers*¹⁶

¹² Id. at 435.

¹³ *Saikewicz*, 370 N.E.2d at 425-26.

¹⁴ 376 N.E.2d 1232 (Mass. App. Ct. 1978).

¹⁵ Id. at 1233 n.2.

and *In re Spring*,¹⁷ the Massachusetts Supreme Judicial Court decided that a patient could refuse life-saving kidney dialysis because such therapy was “intrusive.” Although dialysis did not “require the sacrifice of a limb or entail substantial pain,” said the Court, it was, nonetheless, “a relatively complex procedure, which requires considerable commitment and endurance from the patient who must undergo the treatment three times a week.”¹⁸ Finally, in 1986, in *Brophy v. New England Sinai Hospital*,¹⁹ the court reached the conclusion that even proof of objective “intrusiveness” should no longer be required as a condition for the exercise of the right of “informed refusal.” Mr. Brophy, a patient in a permanent vegetative state, had made very clear while mentally competent that, if he were ever forced to live on life support in an unconscious state, he would want someone to “just shoot me, pull the plug.” To comply with his wishes, his family asked to have him removed from all life support - including artificial nutrition and hydration. The court granted the family’s request despite the fact that Mr. Brophy was neither “terminally ill nor in danger of imminent death from any underlying illness” and despite the fact that nutrition and hydration might not be considered intrusive in any objective sense. It was enough, the court held, that Mr. Brophy would consider the treatment intrusive because it stood in the way of his dying with dignity.

These developments in Massachusetts were being closely observed by courts in other states including those of New Jersey. When, in 1985, the New Jersey Supreme Court was faced with *In re Conroy*²⁰, its first “right to die” case since *Quinlan*, the court adopted most of the principal points of doctrine that had been developed in the courts of Massachusetts. The patient in that case, Claire Conroy, was a mentally-incompetent eighty four year old nursing home patient who was being kept alive by, among other things, artificial nutrition and hydration. “She suffered from arteriosclerotic heart disease, hypertension, and diabetes mellitus; her left leg was gangrenous ... ; she had [bed sores] on her left foot, leg, and hip; an eye problem required irrigation; she ... could not control her bowels; she could not speak; and her ability to swallow was very limited.”²¹ Believing that Ms. Conroy should be allowed to die, her guardian (who was also her nearest relative) applied to the courts for permission to have her removed from life support. Despite the fact that Ms. Conroy was not in a permanent vegetative state nor terminally ill, the court decided that she could be removed from life support if it could be proved that this is what she would have wanted if competent. The court admitted it had erred in *Quinlan* when it disregarded “evidence of statements Ms. Quinlan made to friends concerning artificial prolongation of the lives of others who were terminally ill.”²² And it made clear that it was placing no objective limits on Ms. Conroy’s right to refuse continued life support. “Ms. Conroy’s right to self-determination,” said the court, “would not be affected by her medical condition or prognosis.”²³ Indeed, said the court, “a young, generally healthy person, if competent, has the same right to decline life-saving medical treatment as a competent elderly person who is terminally ill.”²⁴

¹⁶ 399 N.E.2d 452 (Mass. 1979).

¹⁷ 405 N.E.2d 115 (Mass. 1980).

¹⁸ Myers, 399 N.E.2d at 457.

¹⁹ 497 N.E.2d 626 (Mass. 1986).

²⁰ 486 A.2d 1209 (N.J. 1985).

²¹ Id. at 1217.

²² Id. at 1230.

²³ Id. at 1226.

²⁴ Id.

By 1990, when the U.S. Supreme Court decided the narrow constitutional question presented to it in *Cruzan*,²⁵ the Court could note that state supreme courts across the United States had made it the general law of the country that patients had a right to refuse any sort of medical treatment. By slow steps, on the facts of one case at a time, and by means of a cooperative dialogue, the courts had first recognized such a right only where the courts and the medical profession agreed that the decision seemed a reasonable one, but ended in protecting the autonomy of patients to make even choices that seemed “irrational.” As a capstone to this development, in 1992, in the case of *In Re Hughes*,²⁶ the New Jersey Supreme Court took the long-overdue step of making its earlier case law regarding Jehovah’s Witnesses consistent with developments since Quinlan. In a decision that essentially overruled those earlier cases, the court stated: “[A] competent Jehovah’s Witness or person holding like views has every right to refuse some or all medical treatment, even to the point of sacrificing life. .. Should a patient decide, with full knowledge of the potential situation, to refuse life-sustaining medical treatment and the patient communicates this decision via clear and convincing oral directives, actions or writings, the patient’s desires should be carried out.”²⁷

3. Legislative Procedures for Proxy Decision Making

While these legal developments were taking place in the courts of New Jersey and Massachusetts, there was, for many years, no action taken by the legislatures of those states. This was unfortunate. Although there are advantages to law-making by gradual judicial development of a body of precedent, there are, of course, advantages to law-making by legislatures. Such advantages are typically the correlatives of the advantages of law-making by courts. There are, for example, the obvious advantages of law-making by an elected body that can give the people what they want rather than what a court thinks they should want. There are the advantages of having general rules laid out in advance of the occurrence of problems so that the problems may be avoided. There are the advantages that stem from not having to justify law-making on the basis of principles of “reason” When law-making calls for the establishment of essentially arbitrary rules, e.g., rules of the road regarding right of way, speed limits, minimum requirements of age and competence for a driver’s license, etc., the job cannot easily be performed by a court. And there are many other advantages as well. In *Conroy*, the New Jersey Supreme Court explicitly noted some of these advantages. “Perhaps it would be best,” said the court, “if the Legislature formulated clear standards for resolving requests to terminate life-sustaining treatment for incompetent patients. As an elected body, the Legislature is better able than any other single institution to reflect the social values at stake. In addition, it has the

²⁵ *Cruzan v. Director Missouri Dep’t of Public Health*, 497 U.S. 261 (1990). The court’s narrow holding in the case was that Missouri had not violated the U.S. Constitution by requiring proof of the wishes of a PVS patient at a level of “clear and convincing evidence” before artificial nutrition and hydration could be removed.

²⁶ 529 A.2d 404 (N.J. 1987).

²⁷ *Id.* at 1153. For a detailed discussion of the legal developments in the United States regarding Jehovah’s Witnesses and blood transfusions, see Charles H. Baron, Blood Transfusions, Jehovah’s Witnesses and the American Patients’ Rights Movement, 3 JOURNAL OF CHINESE AND COMPARATIVE LAW 19 (2000)

resources and ability to synthesize vast quantities of data and opinions from a variety of fields and to formulate general guidelines that may be applicable to a broad range of situations.²⁸

By 1987, in the face of a continuing absence of “right to die” legislation in New Jersey, the state court felt obliged to take steps that might have been better left to the legislature. In the case of *In re Peter*²⁹ the court noted with regret the absence of legislation providing for the execution of a “living will” - “a written statement that specifically explains the patient’s preferences about life-sustaining treatment.”³⁰ Many other states, the court observed, had passed statutes recognizing the validity of “living wills” and prescribing procedures for their execution. “Unfortunately,” said the court, “the New Jersey Legislature has not enacted such a law.”³¹ New Jersey also had not enacted a health care proxy law - a type of statute, passed in many other states, that enabled patients to appoint health care agents empowered to make life-sustaining treatment decisions if the patients became mentally-incompetent. Despite the lack of such statutory authority, Hilda Peter, the patient in the case before the court, had executed a document purporting to appoint a friend as her agent to make health care decisions for her. The court decided to grant legal validity to the document. It did so by providing a strained construction to New Jersey’s general statute providing for the appointment of agents. “Although the statute does not specifically authorize conveyance of durable authority to make medical decisions,” said the court, “it should be interpreted that way.”³²

But, the court continued to make clear that it would prefer that the legislature play its proper role in law-making. In an effort to encourage action from the state legislature, the New Jersey court gave evidence of backing away from its reliance upon the right to privacy as its principal basis for the “right to die.” In 1985, in *Conroy*, the court held that the right to refuse artificial nutrition and hydration could be justified entirely upon common law principles of informed consent and refusal. There was no need, the court thought, to consider whether Ms. Conroy’s rights were protected as well by the federal and state constitutions. In 1987, in *In re Farrell*,³³ the court held that a patient’s right to refuse treatment rested “primarily” on the common law. As a later court pointed out, these were decisions to “smooth the path for legislative action.”³⁴ American legislatures have the power to overrule common law, but they do not have the power to override constitutional rights. Massachusetts and some other states that had earlier relied upon the right to privacy followed the New Jersey lead.³⁵ In 1991, the New Jersey legislature finally enacted legislation providing for “advance directives for health care.”³⁶ Earlier, the Massachusetts legislature had passed legislation providing for the appointment of “health care proxies.”³⁷ In doing so, the two state legislatures brought their jurisdictions in step with the vast majority of American states. By 1994, 47 states had enacted some form of living

²⁸ *Conroy*, 486 A.2d at 1220-21 (footnote omitted).

²⁹ 529 A.2d 419 (N.J. 1987).

³⁰ *Id.* at 426.

³¹ *Id.*

³² *Id.*

³³ 529 A.2d 404 (N.J. 1987).

³⁴ *Hennessey v. Coastal Eagle Point Oil Co.*, 609 A.2d 11, 27 (NJ. 1992) (Pollock, J. concurring).

³⁵ See, for example, *Norwood Hospital v. Munoz*, 564 N.E.2d 1017 (Mass. 1991).

³⁶ *Advance Directives for Health Care*, NJ. STAT. ANN. §§ 26:2H-53 to -78 (West 1996).

³⁷ *HEALTH CARE PROXIES*, MASS. GEN. LAWS ch. 201 D (1996).

will legislation,³⁸ and all but two states had passed some form of health care agency act.³⁹ These statutes achieved progress of a sort that is difficult to work out on a case-by-case, common law basis. They laid out clear and precise general procedures for establishing the validity of living wills and for appointing health care proxy decision-makers. And, to deal with situations where patients failed to take advantage of living will or health care proxy laws before becoming incompetent, a growing number of jurisdictions also began to warn patients that, failing a choice on their part, health care proxies would be selected for them on the basis of criteria chosen by the legislature.⁴⁰

Some of the state statutes went beyond merely prescribing procedures for formalizing expressions of patient will. In such instances, tension could be generated between the courts and legislatures of the states. For example, in *McConnell v. Beverly Enterprises*,⁴¹ the Supreme Court of Connecticut found itself confronted with a statute in which the legislature seemed clearly to have eliminated a patient's right to refuse artificial nutrition and hydration.⁴² Mrs. McConnell, the patient in the case before the court, was a fifty-seven year old woman who had worked as a nurse in emergency medicine up until the time of an accident that had rendered her comatose. On the basis of her professional experience, she had communicated to her friends and family her firm wish never to be kept on any sort of life support in the event of permanent incapacity. Despite the clear language of statute, all of the judges of the Connecticut court held that Mrs. McConnell had a right to have artificial nutrition and hydration stopped. At least one of the justices would have decided the case on the basis of either the right to privacy (which would have overridden the statute) or the common law (which he argued had not been explicitly supplanted by the statute). A majority of the justices felt obliged to decide the case under the statute, but they did so only after giving the statute a strained interpretation that would avoid questions regarding the statute's constitutionality. The court first noted how often it, like the Supreme Court of New Jersey, had called upon its state legislature to take action in this area of the law. "When the legislature has attempted to respond to this urgent request for statutory assistance, we have an obligation to pursue the applicability of statutory criteria before resorting to an exploration of residual common law rights, if any such rights indeed remain." The court then interpreted the statute to prohibit only cessation of spoon feeding and water provided by mouth. This interpretation, said the court, permitted a decision employing the statute and, at the same time, avoided the possibility that the statute might be found unconstitutional. Subsequently, the Connecticut legislature amended the language of the statute, not to overrule the McConnell decision, but rather to bring it into explicit conformity with the interpretation that the court had given it in that case.

4. Physician-Assisted Suicide and Active Euthanasia

³⁸ Alan Meisel, *THE RIGHT TO DIE* § 11.12 (1989 & 1994 supp. No. 2).

³⁹ Choice in Dying, 1991 REFUSAL OF TREATMENT LEGISLATION, Intro - 2 (1994 update).

⁴⁰ *Id.*

⁴¹ 553 A.2d 596 (Conn. 1989).

⁴² CONN. GEN. STAT. ANN. §§ 19a-570 to -580d (West. Supp. 1977).

Until 1986, all “right to die” decisions of the Massachusetts Supreme Judicial Court were unanimous. In that year, in *Brophy*, three of seven justices wrote dissenting opinions. One of the dissenting justices wrote:

[The trial judge in this case] found that “Brophy’s decision, if he were competent to make it, would be primarily based upon the present quality of life possible for him, and would not be based upon the burdens imposed upon him by receiving food and water through a G tube, which burdens are relatively minimal.” . . . Suicide is primarily a crime of commission, but can, and indeed must, also be conceived of as an act of omission at times. See *In re Caulk*, 125 N.H. 226, 228, 231-232, 480 A.2d 93 (1984) (suicide can be committed by starvation [or dehydration]). If nutrition and hydration are terminated, it is not the illness which causes the death but the decision (and act in accordance therewith) that the illness makes life not worth living. There is no rational distinction between suicide by deprivation of hydration or nutrition in or out of a medical setting - both are suicide.⁴³

Unlike Jehovah’s Witnesses refusing blood transfusions, Mr. Brophy had no objections to the form of treatment - there was nothing to indicate that he found artificial nutrition or hydration particularly horrific or that he would have refused them if there was hope of being restored to a normal, sapient existence. Unlike Mr. Saikewicz, Mr. Brophy had no objections to treatment because it was better to die sooner from a terminal disease by refusing burdensome treatment than to live a slightly longer life while suffering painful and disorienting side effects. Mr. Brophy’s objections were based on the fact that he would rather be dead than continue subsisting in a meaningless and undignified state that imposed pointless costs on his family and society in general. As the Brophy dissenters pointed out (in terms that anticipated those Justice Scalia would use in his concurring opinion in *Cruzan*⁴⁴), it is impossible to differentiate this sort of “refusal of treatment” from physician-assisted suicide without a display of legal legerdemain and the use of legal fictions. Nonetheless, American courts have thus far resisted all efforts to have them take the next logical step and judicially extend the ‘right to die’ to include requests by terminally ill patients for physician assistance in hastening death by prescribing lethal medication that patients can use to end their lives at a time and in circumstances of their own choosing.

Three state appellate courts have so far ruled on this question under their state constitutions and the 14th amendment to the U.S. Constitution. In 1997, in *Krischer v McIver*,⁴⁵ the Florida Supreme Court overturned a lower court ruling that had held that a Florida statutory prohibition on assisting suicide violated the state’s constitutional provision protecting a right to privacy to the extent that the statutory ban prevented a competent, suffering, terminally-ill patient from obtaining assistance in hastening death from a willing physician. In reversing the lower court, the Supreme Court based its decision on acceptance of a conventional distinction between “active” and “passive” means of hastening death – finding the latter, but not the former,

⁴³ Id. at 642-643.

⁴⁴ 497 U.S. 261, 292 (1990) (Scalia, J., concurring).

⁴⁵ 697 So.2d 97 (Fla. 1997).

to be constitutionally protected. The court expressed belief that clinging to the distinction was necessary to prevent a slide down a “slippery slope” to approving involuntary euthanasia and cited, as support for this, the conclusion of a 1994 New York Task Force on Life and the Law that proposed “a clear line for public policies and medical practice between forgoing medical interventions and assistance to commit suicide or euthanasia.”⁴⁶ In 2001, in *Sampson v. State*,⁴⁷ the Supreme Court of Alaska also held statutory prohibitions on assisted suicide to be constitutional - even as applied to terminally ill patients seeking assistance from willing physicians. In that case, the court found that privacy rights explicitly guaranteed under the state constitution had been compromised, stating that “[t]o the extent that the . . . statute’s general prohibition of suicide prevents terminally ill patients from seeking a physician’s help in ending their lives, the provision substantially interferes with [patients’] general privacy and liberty interests, as guaranteed by the Alaska Constitution”⁴⁸ However, the court concluded that the burden on such rights was justified by state interests in preventing abuses that might follow on approval of such “active” means of hastening death and, again, relied upon and reaffirmed the distinction between acts and omissions to act in causing death. In *People v. Kevorkian*,⁴⁹ decided in 2001, the Michigan Court of Appeals rejected a physician’s claim that state and federal constitutional provisions required reversal of his second degree murder conviction arising from his use of active measures to hasten the death of a consenting, terminally ill patient. Again, the court justified denying constitutional protection based on a concern that “expanding the right to privacy would begin, as the steps in the progression of defendant’s argument supporting voluntary euthanasia clearly indicate, the slide down the slippery slope toward [involuntary] euthanasia.”⁵⁰

The U.S. Supreme Court weighed in on this matter in two companion cases in 1997. *Washington v. Glucksberg*⁵¹ was an appeal from a decision in which the U.S. Court of Appeals for the Ninth Circuit had declared Washington’s statutory prohibition of assisted suicide (to the extent that it prohibited competent, terminally ill, suffering patients from obtaining medication that could be used to voluntarily hasten their deaths) to be unconstitutional under the Due Process clause of the Fourteenth Amendment. *Vacco v. Quill*⁵² was an appeal of a similar decision by the U.S. Court of Appeals for the Second Circuit invalidating a similar New York law, but under the Equal Protection clause of the Fourteenth Amendment. Both decisions were overturned in the Supreme Court by a 9 to 0 vote. The result was complicated by the fact that, in addition to Chief Justice Rehnquist’s opinion for the court in the two cases, five justices, Stevens, O’Connor, Souter, Ginsburg, and Breyer wrote their own opinions. A majority of the justices seemed agreed that the court’s decision in *Cruzan* was to be explained as not recognizing a fundamental right to die “deduced from abstract concepts of personal autonomy”⁵³ but rather resting merely upon long-standing principles of bodily integrity protecting individuals from unconsented-to touching. Because statutes prohibiting physician-assisted suicide do not

⁴⁶ New York State Task Force on Life & the Law, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context* (1994).

⁴⁷ 31 P.3d 88 (Alaska 2001).

⁴⁸ *Id.* at 95.

⁴⁹ 639 N.W.2d 291 (Mich. App. 2001).

⁵⁰ *Id.* at 306.

⁵¹ 521 U.S. 702 (1997).

⁵² 521 U.S. 793 (1997).

⁵³ *Id.* at 719.

impinge upon the right to be free from such touching, the court held that such statutes are to be subjected to less strict constitutional scrutiny than laws that force treatment on patients, and it found that those statutes could be justified by a number of rational state interests, including concern that suicidal patients might be clinically depressed, that vulnerable populations of patients might suffer pressure or discrimination from family members and medical personnel, and that allowing physician-assisted suicide might lead to the practice of involuntary euthanasia. In part, the court seemed to rest its decision on the belief that legalization of physician-assisted suicide was made unnecessary by the fact that adequate palliation of suffering was available to terminally ill patients, and the court seemed to give legal sanction to practices such as “terminal sedation” (medicating suffering patients into unconsciousness, after which artificial nutrition hydration might be terminated) and use of Catholic doctrine regarding the principle of “double effect” to justify injecting painkillers in amounts high enough to hasten the death of suffering patients so long as the intent of the doctor is merely to suppress pain.

5. Tensions and Dangers in the Current Doctrine

The reasoning of the decisions dealing with physician-assisted suicide do not bear close scrutiny. Under current law, positive acts, like switching off a ventilator, are treated as mere “omissions to act.” Physicians’ acts in hastening death with pain medication are considered not to be acts of homicide so long as the physician who prescribes the medication is thinking (while prescribing) that he or she is primarily trying to suppress pain and only incidentally shortening life. These conceptual oddities are defended as providing “bright line” distinctions between what is forbidden and what is permitted in ending the lives of terminally ill patients. But, there is little evidence that they work in practice. Even opponents of physician-assisted suicide admit the difficulty physicians presently have in understanding and applying current criteria for deciding what is lawful and what is not in hastening the death of patients.⁵⁴ Moreover, experience over the years since *Quinlan* shows that grabbing at bright-line distinctions doesn’t keep us from sliding down slippery slopes. *Quinlan*’s recognition of the right of a patient in a permanent vegetative state to refuse (by proxy) an indefinite existence on a ventilator, for example, seems to be on the verge of becoming today’s right of any competent patient to hasten death by refusing to eat or to drink.⁵⁵ Advocates of a bright-line distinction are continually forced to look for new stopping points. Yale Kamisar, who used to argue that respect for human life would be unalterably undermined if laws regarding homicide and assisted suicide were interpreted to allow patients to refuse life-prolonging treatment, now argues only against allowing exceptions for physician-assisted suicide and active euthanasia.⁵⁶

⁵⁴ See, for example, Katherine Foley, “Compassionate Care, Not Assisted Suicide,” in *The Case against Assisted Suicide: For the Right to End-of-Life Care*, edited by Katherine Foley and Herbert Hendin (Baltimore: Johns Hopkins University Press 2002), 293-309, 304.

⁵⁵ See Rob McStay, “Terminal Sedation, Palliative Care for Intractable Pain, Post Glucksberg and Quill,” 29 *American Journal of Law & Medicine* 45 (2003).

⁵⁶ Compare Yale Kamisar, “Some Non-Religious Views against Proposed ‘Mercy-Killing’ Legislation,” 42 *Minnesota Law Review* 969, 977 (1958) with Yale Kamisar, “Rise and Fall of the ‘Right’ to Assisted Suicide,” in *The Case against Assisted Suicide: For the Right to End-of-Life Care*, edited by Katherine Foley and Herbert Hendin (Baltimore: Johns Hopkins University Press 2002), 72-74.

Attempting to cling to bright-line distinctions does not seem to offer us much protection, and it comes at significant cost. Denying physician-assisted suicide as an option to terminally ill patients means enforced suffering for many patients. If hastening of death is available only to those who can obtain it through refusal of life-prolonging treatment, such as cardiopulmonary resuscitation or artificial ventilation, then patients who do not need such treatment are required to soldier on. Opponents of physician-assisted suicide warn that the price of too much compassion for a particular suffering, terminally ill patient may be abuse of other patients and a general undermining of respect for human life. These seem to be empirical claims—appeals to laws of cause and effect. However, it is sometimes hard to know exactly what is being predicted. That doctors or relatives will not fully understand how to use the criteria for determining when it is all right, and when not, to assist a suffering patient to end his life? That they will make mistakes in determining the relevant facts? That they will cheat (out of self-interest, on the basis of prejudice, and the like)? Or is it a more global claim that the bonds of civilization will be generally cast aside once our society no longer enshrines as an absolute principle the sanctity of human life? Whatever the precise import of the claims, they are serious and deserve to be taken seriously. They were, of course, taken seriously by the U.S. courts that gradually fashioned what has become the right to refuse life-prolonging treatment. At each stage, the courts recognized that respect for the rights of individual suffering patients required more than merely giving in to fear of the unknown. Taking tentative steps, the courts promulgated substantive standards and procedural protections that were designed to mitigate the risk of slippery slope problems while freeing palliative care practitioners to act with greater respect for patient autonomy and increased compassion for the plight of the terminally ill.

Would legalizing physician-assisted suicide make the risks any greater or more intractable? The patient who is considering a hastened death by refusal of life support is no less vulnerable to depression, coercion, prejudice, financial pressure, ineffective communication, mental incompetence, failure of adequate palliative care, impatience of medical personnel, or mistaken prognosis or diagnosis than the patient who is considering a hastened death by physician-assisted suicide. Indeed, as to some of these risks, legalization of refusal of treatment would seem more dangerous than legalization of physician-assisted suicide. Is a vulnerable patient more likely to succumb to a request that she commit suicide or to the statement, “You know, Mrs. Jones, maybe we’ve put you through enough. Maybe it’s time to think of giving up?” Are impatient or prejudiced medical personnel more likely to be tempted to cut financial and emotional costs by means of physician-assisted suicide or by terminating life-prolonging treatment that they can claim has become “medically inappropriate?” Ironically, there may be less slippery-slope basis for denying patients the option of physician-assisted suicide than for denying them the right to refuse treatment. At the very least, there is no more.

Despite the illegality of physician-assisted suicide and euthanasia, many American health care professionals admit to engaging in one or the other practice when they feel circumstances require it. Although the American Medical Association takes a public stand against physician-assisted suicide,⁵⁷ it seems opposed only to its legalization, not to its practice. Despite a number of articles reporting fairly widespread practice of physician-assisted suicide—some of them

⁵⁷ P.R. Muskin, “The Request to Die: Role for a Psychodynamic Perspective on Physician-Assisted Suicide, 279 *Journal of the American Medical Association* 2099 (1997).

published in the pages of its own journal⁵⁸ -- the association has not taken steps to find out who these physicians are in order to have them disciplined. Indeed, it has not even expressed shock to find that the practice is going on. Rather than being concerned with protecting society and patients from the evils of assisted suicide, the American Medical Association appears concerned to protect its members from the evils of legalization—the bad public relations or increased legal oversight that might result from an admission that doctors sometimes take positive steps to terminate the lives of suffering patients. Moreover, mercy killings by family members are regularly reported in the American press; many more most likely go unreported and undetected. Prosecutions are often dropped, grand juries do not indict, and trial juries acquit. When there are convictions, they are usually followed by light sentences. Overall, mercy killings receive increasingly lenient treatment. Judges and prosecutors express decreased willingness to pursue such cases because they view them more compassionately than they previously did and because of “lack of evidence, uncooperative family members, and juries’ reluctance to convict defendants.”⁵⁹

Maintaining the present legal regime unduly heightens the risk of deadly mistakes and abuse in the treatment of terminally ill patients. In the face of increasing sympathy for the plight of suffering patients, the legal system largely looks the other way when physicians—and even family members—assist in suicide. Of course, persons providing assistance have to keep in mind that there is always the chance that they could be caught and punished, and some argue that the threat of punishment provides a check against abuse sufficient to ensure that assistance in suicide and euthanasia will be employed in only the most compelling and meritorious cases. In the 1970s some commentators similarly argued that the threat of criminal punishment was enough to regulate decisions to withdraw life-prolonging treatment from terminally ill patients.⁶⁰ However, American medicine has wisely abandoned the “slow codes” and secret do not resuscitate orders of days gone by in favor of open procedures for permitting patients to die without undergoing last-ditch efforts at resuscitation. Post hoc criminal review is a very rough tool for regulating such sensitive decisions—especially when both the life of the patient and the freedom and reputation of the actor are at stake. Criminal review comes too late to rectify errors and at a time when patients can no longer be interviewed as to whether steps were taken on the basis of their competent, informed, and voluntary consent. Leaving regulation to the possibility of post hoc criminal review also discourages honest communication among health care professionals and between professionals and their patients.⁶¹ It inhibits helpful professional consultations and the development of medical protocols. Fear of open discussion creates the possibility that physician’s orders or patient’s wishes will be misread.⁶² Making matters worse, the chilling effect of post hoc criminal review extends beyond the realm of technically illegal practices such as physician-assisted suicide. Among other things, physicians’ fear of appearing after the fact to

⁵⁸ A.L. Back, J.I. Wallace, H.E. Starks, and R.A. Pearlman, “Physician-Assisted Suicide and Euthanasia in Washington State: Patient Requests and Physician Responses,” 275 *Journal of the American Medical Association* 919 (1996); S.H. Miles, “Physicians and Their Patients’ Suicides,” 271 *Journal of the American Medical Association* 1786 (1994).

⁵⁹ S.P. Freedberg, “Murder or Mercy?” *St. Petersburg (Fla.) Times*, January 31, 1999, A1.

⁶⁰ See, for example, R.A. Burt, “Conversations with Silent Patients,” in *Genetics and The Law II* edited by A. Milunsky and G.J. Annas (New York: Plenum, 1980) at 159.

⁶¹ See, Back, et al., footnote 59, above.

⁶² D.A. Asch, “The Role of Critical Care Nurses in Euthanasia and Assisted Suicide,” 334 *New England Journal of Medicine* 1374, 1376 (1996).

have intentionally hastened a patient's death with morphine is a leading cause of undertreatment of pain in terminally ill patients.⁶³

The risk of deadly mistakes and abuse in the treatment of terminally ill patients is exacerbated in yet another way by the current regime. In attempting to maintain a bright-line distinction between physician-assisted suicide and refusal of life-prolonging treatment, the regime does not treat decisions opting for the latter as seriously as it should. Decisions like that in the *Brophy* case - to refuse treatment because life is no longer worth living - raise the same issues of patient autonomy and compassion toward suffering patients that are raised by physician-assisted suicide, and they face all the same risks of abuse and mistake. Yet the present regime categorizes them as mere determinations to "let nature take its course."

6. Statutory Responses to the Situation

The five justices who wrote individual opinions in *Glucksberg* all made clear that they were leaving the door open for a future case that might convince them that physician-assisted suicide should be constitutionally protected. Justices O'Connor, Ginsburg, and Breyer suggested that such a case might be one that established the unavailability of adequate treatment for palliation of the pain and suffering of the terminally ill. Justices Stevens and Souter argued more generally that new facts of other sorts relevant to the balancing of individual rights and state interests might lead them to reach a different result. Although Chief Justice Rehnquist responded to these opinions in a footnote⁶⁴ that suggested it was possible that future facts could lead to a different result in specific cases, he concluded his opinion for the Court by saying: "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.'"⁶⁵

The democratic process in the United States has, in fact, shown some slow progress in protecting the rights of terminally ill, mentally competent patients. But it has been more obviously the arena for a hard-fought ideological battle in which there have been steps backward as well as forward. Public opinion in the United States is increasingly favorable to allowing terminally ill patients the right to a physician-hastened death. In 1947, 54 percent of respondents to a Gallup poll answered "no" when asked, "When a person has a disease that cannot be cured, do you think doctors should be allowed by law to end a patient's life by some painless means if the patient and his family request it?" Another 9 percent said "don't know" and only 37 percent said "yes."⁶⁶ However, by 1973, these percentages were nearly reversed. When asked the same question by Gallup in that year, 53 percent of respondents said "yes," 7 percent were undecided,

⁶³ Katherine Foley, "Compassionate Care, Not Assisted Suicide", footnote 55, above.

⁶⁴ 521 U.S. 702, 734 n.24.

⁶⁵ Id. 735-36.

⁶⁶ Gallup Poll, June 6-11, 1947, Gallup Organization.

and only 34 percent were opposed.⁶⁷ Surveys conducted between 1988 and 1993 showed a 15 percent gain in support for death with dignity laws. In 1988, 58 percent of respondents answered “yes” to a Roper poll that asked, “When a person has a painful and distressing terminal disease, do you think doctors should . . . be allowed by law to end the patient’s life if there is no hope of recovery and the patient requests it?” Only 27 percent of those polled said “no” and 14 percent were undecided.⁶⁸ By 1990, a Gallup poll produced a 65 percent favorable response.⁶⁹ In 1993, a Harris poll recorded 73 percent of respondents answering “yes.”⁷⁰ And in 1996, a Gallup poll reported 75 percent.⁷¹ Nonetheless, because of strong and well-financed campaigns fought largely by religious groups opposed to legalization, the legislative process has shown itself slow to respond to public opinion.

In 1991, proponents of physician-hastened dying in the State of Washington bypassed their state legislature and went directly to the voters with an initiative proposition that would have legalized euthanasia by lethal injection. The proposed law lost by a vote of 46 to 54 percent. In the next year, a similar initiative proposal was put to the voters in California. In a battle which was hard fought and heavily financed, the proposal lost by the same margin. However, in 1994, voters in Oregon were offered an initiative proposition which proposed legalizing only physician-assisted suicide and expressly prohibiting “lethal injection, mercy killing [and] active euthanasia.”⁷² Known as the “Oregon Death with Dignity Act,” the law was passed by a margin of 51 to 49 percent. Opponents of the law continued their battle against it, first by obtaining an injunction in federal court⁷³ and, then, while the injunction held up the operation of the law, by arranging to put a repeal question before the voters in the 1997 election. In February of 1997, the injunction was lifted by the Court of Appeals for the Ninth Circuit,⁷⁴ and, at the November election, the repealer was defeated by a vote of 60 to 40 percent. Since 1997, the Oregon Death with Dignity Act has operated without any of the dire consequences or abuses that had been predicted by its opponents. By the end of the first year, even the strongest opponents of the act admitted that it was working in exemplary fashion. The head of the Oregon Hospice Association, which had opposed the law, acknowledged that the act was “giving Oregonians one more option at the end of life. It’s just one of many choices.”⁷⁵ A Catholic priest in charge of health care ethics for Oregon’s Catholic hospital network said: “It’s not the harbinger of destruction that people thought it was going to be. . . . We’d rather people didn’t choose it, but it challenges us to provide better care so they won’t choose it.”⁷⁶

The act permits terminally ill, adult Oregon patients to obtain a lethal prescription from a participating physician only so long as 1) the physician and a consulting physician confirm the patient’s diagnosis and the fact that he is terminally ill, 2) the physician and a consulting

⁶⁷ Gallup Poll, July 6, 1973, Gallup Organization.

⁶⁸ Roper Organization Poll, February 1988, Roper Center for Public Opinion Research.

⁶⁹ Gallup Poll, November, 1990, Gallup Organization.

⁷⁰ Harris Poll, November, 1993, Harris Interactive.

⁷¹ Gallup Poll, April, 1996, Gallup Organization.

⁷² Oregon Death with Dignity Act, sec. 127.805.

⁷³ *Lee v. Oregon*, 891 F.Supp. 1429 (D. Or. 1995).

⁷⁴ *Lee v. Oregon*, 107 F.3d 1382 (9th Cir., Feb 27, 1997).

⁷⁵ Michael Vitez, In Oregon, Some Find Comfort in Assisted-Suicide Option, *Philadelphia Inquirer*, Jan. 19, 1999, at A1.

⁷⁶ *Id.*

physician determine that the patient is capable of competently making the request and that the patient's judgment is not impaired by depression or some other psychiatric or psychological disorder (if there is doubt, the patient must be referred to psychiatrist or psychologist for counseling), and 3) the physician informs the patient of all feasible alternatives to assistance in dying, such as pain control and hospice care. The patient must make a request in writing and make two oral requests at least 15 days apart. All prescriptions written under the act must be reported to the Oregon Health Division. Each year, the Health Division must report statistics in order to monitor the act's operation. In February 1999, the Oregon Health Division reported that, in the first year under the act, 23 terminally ill patients had been prescribed lethal medication, 15 had died after taking the medication, 6 had died from underlying illnesses, and two were still alive. Comparison of the 15 cases with a selected group of control patients strongly suggested that "sex, race, urban or rural residence, level of education, health insurance coverage, and hospice enrollment" were not factors in whether patients received physician assistance in dying. Ten of the 15 were under hospice care at the time of death, and three of the others refused it. Only one patient gave "inadequate" pain control as a reason for requesting aid in dying. The predominant reasons given were "loss of autonomy due to illness" and "loss of control of bodily functions."⁷⁷ The Oregon Health Division has continued to publish annual reports.⁷⁸ Over the first six years of the act's operation, there was a significant increase in prescriptions issued (67 in 2003) and patients using physician-assisted suicide (42 in 2003). But in the last three years, the numbers have held steady or decreased⁷⁹ and the Health Division characterizes the numbers as still very small compared to the average 31,000 Oregon deaths every year. Most important, there is still no suggestion that opponents' fears of abuse have been realized in any way.

At present, Oregon remains the only American state where physician-assisted suicide is legal. A Michigan attempt at passing an initiative, very quickly cobbled together after the success in Oregon, was soundly defeated at the polls in 1998. A better organized initiative effort in Maine in 2000 was also defeated, but by a margin of only 49 to 51 percent. In 2002, Hawaii came close to being the first state to have physician-assisted suicide legalized by a state legislature rather than by popular initiative process. As this is written, legalization efforts, through legislation or the initiative process are being mounted and planned in several states.

⁷⁷ Chin A. E., Hedberg K., Higginson G. K., Fleming D. W., *Legalized Physician-Assisted Suicide in Oregon – The First Year's Experience*, 340 *New England Journal of Medicine* 577 (1999).

⁷⁸ See Sullivan A. D., Hedberg K., Fleming D. W., *Legalized Physician-Assisted Suicide in Oregon — The Second Year*, *N Engl J Med* 2000; 342:598-604, Feb 24, 2000. Special Reports; Sullivan A. D., Hedberg K., Hopkins D., *Legalized Physician-Assisted Suicide in Oregon, 1998–2000*, *N Engl J Med* 2001; 344:605-607, Feb 22, 2001. Correspondence; Hedberg K., Hopkins D., Southwick K., *Legalized Physician-Assisted Suicide in Oregon, 2001*, *N Engl J Med* 2002; 346:450-452, Feb 7, 2002. Correspondence; Hedberg K., Hopkins D., Kohn M., *Five Years of Legal Physician-Assisted Suicide in Oregon*, *N Engl J Med* 2003; 348:961-4, Mar 6, 2003. Correspondence; and Richard Leman, MD & David Hopkins, MS, "Sixth Annual Report on Oregon's Death with Dignity Act", Oregon Department of Human Services, Office of Disease Prevention and Epidemiology, March 10, 2004. Available at: <http://www.dhs.state.or.us/publichealth/chs/pas/ar-index.cfm>.

⁷⁹ In 2006, 65 prescriptions were filled, 35 patients took the medications, 19 died of their underlying disease, and 11 were alive at the end of the year. Since the law was passed in 1997, 292 patients have died under the terms of the law. Summary of Oregon's Death with Dignity Act – 2006, Death With Dignity National Center, <http://egov.oregon.gov/DHS/ph/pas/docs/year9.pdf>.

7. Current Political Efforts to Undo Protection of the “Right to Die.”

Frustrated in their efforts to undo the Oregon experiment in that state’s legislature and the federal courts, opponents of legalization of physician-assisted suicide were forced to resort to the national legislature and executive branch. In 1998, U.S. Congressman Henry Hyde proposed legislation (“The Lethal Drug Abuse Prevention Act”⁸⁰) that would have amended the federal Controlled Substances Act to remove Drug Enforcement Agency (DEA) prescription authority from any physician who “has intentionally dispensed or distributed a controlled substance with a purpose of causing, or assisting in causing, the suicide or euthanasia of any individual.” This would have denied any Oregon physician who prescribed a controlled substance under the Death with Dignity Act the right to prescribe controlled substances for any purpose. The bill was never passed into law, in great part because of opposition from the American medical community which feared putting the federal government in charge of deciding whether physicians who prescribed pain medication for dying patients were doing it merely to control pain or also to shorten life. For similar reasons, a modified version of the bill, called the “Pain Relief Promotion Act”⁸¹ and proposed in the Congress in 1999, was never enacted into law. In the face of those legislative defeats, newly-elected President Bush’s Attorney General, John Ashcroft, issued a directive that made it unnecessary to amend the Controlled Substances Act. On November 6, 2001, he advised the American medical community that the Department of Justice would interpret the act as already prohibiting use of controlled substances for physician-assisted suicide on the ground that assisting suicide was not a “legitimate medical purpose” within the meaning of the statute and related regulations.⁸² However, the Attorney General’s directive never achieved its intended effect. Immediately challenged in federal court in Oregon on constitutional and statutory grounds, the directive’s operation was suspended by the issuance of an injunction⁸³ which was affirmed in May of 2004 by the U. S. Court of Appeals for the Ninth Circuit.⁸⁴ On January 17, 2006, the United States Supreme Court put a final end to Ashcroft’s end run around the legislature, holding (by a 6 to 3 vote), that the Attorney General’s directive went beyond the authority granted him by Congress under the Controlled Substances Act.⁸⁵

In the national effort to undo the progress made in the “right to die” movement over the last thirty years, reactionary forces have appealed to the legislative and executive branches in the states as well. Ironically, one of the most prominent recent instances of such an effort is reminiscent of *Quinlan* – the case where the movement all began. Like Karen Quinlan, Terri Schiavo was a woman whose continuance on life support had become the subject of highly-publicized litigation. In 1990, when she was 26 years old and residing in Florida with her husband, Mrs. Schiavo suffered a cardiac arrest from what doctors believe was a potassium imbalance, and she was ultimately diagnosed as being in a permanent vegetative state. She had never executed a living will or health care proxy, but Florida law provided that her husband should serve as her proxy decision-maker, and he reported that conversations with her made clear to him that she would prefer to have artificial nutrition and hydration removed and be

⁸⁰ HR 4006, 105th Cong., 2d Sess. (1998).

⁸¹ HR 2260, 106th Cong., 1st Sess. (1999).

⁸² Fed. Reg. 56,607 (Nov. 9, 2001).

⁸³ *Oregon v. Ashcroft*, 192 F.Supp.2d 1077 (D. Or. 2002).

⁸⁴ 368 F.3d 1118 (9th Cir.(Or.) May 26, 2004).

⁸⁵ *Gonzales v. Oregon*, 546 U.S. 243 (2006).

permitted to die a natural death. Mrs. Schiavo's parents, Robert and Mary Schindler, publicly disputed both the diagnosis of permanent vegetative state and the conclusion that their daughter would prefer to be dead. The matter was then taken to court for resolution of the factual disputes. On four separate occasions, the courts of Florida had ruled against the parents.⁸⁶ As the Schindlers lost in the courts, however, they gained national publicity for their cause and drew the support of various right to life groups who, among other things, promoted a massive campaign of protest letter writing to the Florida state legislature and Florida Governor Jeb Bush. In response to the letters, the Florida legislature, on October 21, 2003, took the unprecedented step of passing a law that authorized Governor Bush to issue a stay of the court orders, and Governor Bush immediately granted the stay. Mr. Schiavo then filed suit in the courts of Florida to have the statute and Governor Bush's action declared a violation of both the Florida and U.S. constitutions. On May 5, 2004, the Florida circuit court held the stay to be unconstitutional.⁸⁷ On September 23, that decision was unanimously affirmed by the Supreme Court of Florida in an opinion that reproved Governor Bush and the Florida legislature for violating principles of separation of powers by claiming the ability to stay a judicial proceeding.⁸⁸

The Schindlers and their right to life allies then trained their efforts on the federal government. First, they attempted an appeal to the United States Supreme Court from the decision of the Florida court. However, on January 24, 2005, the high. Court refused review. The Florida decisions had been based upon state law and the state constitution, and they presented no proper federal question to be reviewed by the Court. Thereafter, the Schindlers brought political power to bear on the U.S. Congress and the President of the United States. On March 8, 2005, a Republican representative from Florida, David Weldon, introduced legislation aimed at continuing the artificial feeding of Mrs. Schiavo. After two weeks of highly publicized debate in both houses of the Congress, including an extraordinary and pointed Senate session on Palm Sunday, the Congress passed and the President signed, on March 21,⁸⁹ a "private bill" that purported to authorize the Federal District Court for the Middle District of Florida to hear the Schindler claims that had already been rejected by the U.S. Supreme Court and to require the court to issue an order that the artificial feeding be continued. When suit was filed in the designated court the next day, the judge refused to issue the requested order to continue Mrs. Schiavo's feeding, finding there was no valid federal legal basis for doing so. Over the following weeks, the Schindlers brought repeated suits and appeals to the state courts and federal courts in Florida, to the United States Court of Appeals for the 11th Circuit (which includes Florida) and the to the Supreme Court of the United States. All of these efforts were held to be without merit. On March 31, 2005, Mrs. Schiavo finally died. An autopsy was ordered, and, on May 17, the Medical Examiner issued a report concluding that Mrs. Schiavo's condition was consistent the diagnosis that she was in a permanent vegetative state and that, in any event, the

⁸⁶ See *Schindler v. Schiavo*, 780 So.2d 176 (Fla. 2d DCA 2001); *Schindler v. Schiavo*, 792 So.2d 551 (Fla. 2d DCA 2001); *Schindler v. Schiavo*, 800 So.2d 640 (Fla. 2d DCA 2001); and *Schindler v. Schiavo*, 851 So.2d 182 (Fla. 2d DCA 2003).

⁸⁷ *Schiavo v. Bush*, 2004 WL 980028 (Fla.Cir.Ct., May 5, 2004).

⁸⁸ *Bush v. Schiavo*, 885 So.2d 321 (2004).

⁸⁹ S.686, An act for the relief of the parents of Theresa Marie Schiavo.

damage to her brain was irreversible: “No amount of therapy or treatment would have regenerated the massive loss of neurons.”⁹⁰

In the end, the only winners coming out of the Schiavo affair appear to have been the courts. As a result of performing in a fashion that suggested they remained steadfastly true to the law while being placed under enormous political pressure, the judges involved seem to have bolstered the reputation of the judiciary. The U.S. Congress and President did not fare so well. A Harris Poll released on April 15, 2005 reported that 58% of the people polled disapproved of how the Congress handled the case and 51% disapproved of how President Bush handled it.⁹¹ The Congress’ involvement of the Schiavo affair was made an issue in the November 2006 midterm elections, and it may well have played a role in the Democrats winning majorities in both the House and the Senate. However, national right to life organizations have exploited the publicity surrounding the case as a basis for having the legislatures of Florida, Alabama, and Georgia consider legislation that would restrict the right to refuse life-prolonging treatment within the narrowest constitutional bounds consistent with the U.S. Supreme Court’s decisions in *Cruzan*, *Glucksberg*, and *Quill*.⁹²

8. Conclusion

As with most areas of American law, that dealing with the “right to die” is in a state of flux. There are a number of lines of tension at work in this development. The most obvious are ideological ones that currently permeate American politics in which traditional constitutional and common law principles of individual liberty are regularly placed in conflict with pressures toward religious and moral conformity. For a variety of reasons, the more political branches of government in the United States seem at present to be particularly vulnerable to the pressures of religious and moral conformism. However, American courts have, for the most part, continued to play their traditional role of moderating extreme influences of the moment and protecting traditions of individual liberty in many areas of the law, including that regarding “the right to die.” There are no signs that this tension will be significantly reduced in the near future.

⁹⁰ Medical Examiner, District Six, Pasco & Pinellas Counties, Florida, Report of Autopsy, Theresa Schiavo, Case No. 5050439 (May 17, 2005).

⁹¹ Harris Poll, April, 2005, Harris Interactive..

⁹² See, for example, Alabama House Bill 104 (2004).