

# “Out, Out Brief Candle”: Constitutionally Prescribed Suicide for the Terminally III

By THOMAS J. MARZEN\*

## Introduction

Tomorrow, and tomorrow, and tomorrow,  
Creeps in this petty pace from day to day,  
To the last syllable of recorded time . . .  
Out, out, brief candle!<sup>1</sup>

The debate over when, if ever, assisted suicide or consensual homicide<sup>2</sup> should be permitted by law usually proceeds in a set pat-

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\* B.A., University of Illinois; J.D., Illinois Institute of Technology, Chicago-Kent College of Law; General Counsel, National Legal Center for the Medically Dependent and Disabled. The author thanks National Legal Center attorneys Daniel Avila, John Altomare, and Jane Brockmann for their research assistance.

1. WILLIAM SHAKESPEARE, *MACBETH* act 5, sc. 5, ll. 19-21, 23 (Kenneth Muir ed., Methuen & Co. Ltd 1984) (1951).

2. Here, “assisted suicide” means intentionally aiding or abetting another to commit suicide by an act, such as providing the other drugs or a weapon with knowledge that the other will use the means provided to commit self-killing, *see, e.g.*, MICH. COMP. LAWS § 752.1027(1) (1993). “Consensual homicide” or homicide-by-consent means intentionally causing the death of another with the other’s consent, such as shooting a gun at or injecting lethal drugs into the other at the other’s request. Direct homicide-by-consent or euthanasia is generally condemned on the principle that consent is not a defense to homicide. *See* WAYNE R. LAFAVE & AUSTIN W. SCOTT, JR., *CRIMINAL LAW* § 5.11, at 477 (2d ed. 1986). Although the two concepts are different, they are often confused in the present debate over assisted suicide, hastening death, and mercy killing. Thus, for example, the definitions of permissible conduct sanctioned by typical proposals for legislation allowing physician-assisted suicide conflate both concepts by defining “aid-in-dying” as “a medical procedure, or action, that will terminate the life of the qualified patient in a painless, humane and dignified manner whether administered by the physician at the patient’s choice or direction or whether the physician provides means to the patient for self-administration.” DEREK HUMPHRY, *LAWFUL EXIT* 136 (1993) (proposing a uniform model act).

The confusion in policy debate, however, underscores serious considerations in recognizing any form of assisted suicide as a right. First, the social, personal, and state interests and liberty interests at stake in assisted suicide and consensual homicide are identical unless there is a fundamental distinction to be drawn between self-killing with the aid of another and killing by another with consent. For example, if only assisted suicide is deemed a right, then a physician who intentionally provides a lethal dose to a patient is constitutionally immune, while a physician who administers the same dose is guilty of mur-

tern. Proponents seek to carve out by statute or constitutional rule a narrow exception to criminal prohibitions on homicide and assisted suicide—generally, to permit “aid-in-dying”<sup>3</sup> by a physician for a competent adult who has a “terminal condition” or “unbearable suffering.”<sup>4</sup> Opponents argue that there is no principled way to limit such an exception in logic or in law because there is no defensible foothold on this slippery slope<sup>5</sup> and hence, that it instead amounts to a precipice.<sup>6</sup>

The slippery-slope argument is that it is unclear how social policy or constitutional precedent would limit a recognized “liberty” to assisted suicide or consensual homicide to such a narrow category.<sup>7</sup> There is no discernable reason to limit sanctioned assisted suicide to those with terminal conditions—who, after all, are supposed to die in the near, foreseeable future—when those with non-terminal difficulties or disabilities might have to endure greater “unbearable suffering” for much longer periods of time. Thus, if a ban on assisted suicide imposes an “undue burden” on a supposed liberty interest in suicide, then those with long-term problems have a greater claim on the free exercise of this liberty than those with terminal conditions. Moreover, it makes no sense to carve out an exception for only competent adults since children and those with emotional, mental, or psychological disabilities might also have terminal conditions and suffer

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der, notwithstanding the consent of the patient in both cases. Second, even assuming that any such distinction can be drawn or makes constitutional sense, it generates the obvious prospect that, as a matter of constitutional doctrine, a defense of “assisted suicide” might be raised in any prosecution for homicide. Moreover, intentional homicides could be planned so as to provide for such a defense. This potential impediment to successful prosecution of intentional homicide alone forms a rational basis for a blanket ban on legal assisted suicide in service to a state’s interest in protection of human life. Indeed, this concern might well have formed the basis for earlier court decisions rejecting assisted suicide as a defense to prosecution for homicide. *See, e.g.,* *People v. Roberts*, 178 N.W. 690, 693 (Mich. 1920).

3. *See* discussion *supra* note 2.

4. *See, e.g.,* Robert A. Sedler, *The Constitution and Hastening Inevitable Death*, HASTINGS CTR. REP., Sept.-Oct. 1993, at 21, 25.

5. *See* Yale Kamisar, *When is There a Constitutional “Right to Die”? When is There No Constitutional “Right to Live”?*, 25 GA. L. REV. 1203 (1991); Yale Kamisar, *Some Non-Religious Views Against Proposed “Mercy-Killing” Legislation*, 42 MINN. L. REV. 969 (1958); James Bopp, Jr., *Is Assisted Suicide Constitutionally Protected?*, 3 ISSUES IN LAW & MED. 113, 139-40 (1987); *see also* Yale Kamisar, *Are Laws Against Assisted Suicide Unconstitutional?*, HASTINGS CTR. REP., May-June 1993, at 32, 34.

6. *See, e.g.,* Walter M. Weber, *A Cliff, Not a Slope: A Response to Margaret P. Battin*, 18 SUICIDE & LIFE-THREATENING BEHAV. 194 (1988).

7. Thomas J. Marzen et al., *Suicide: A Constitutional Right?*, 24 DUQ. L. REV. 1, 100-107 (1985).

unbearably, perhaps all the more because they cannot fully comprehend their fates or afflictions.

Proponents of a constitutional right to assisted suicide as well as at least three trial courts<sup>8</sup> have relied upon abortion and "right to die" cases as precedents that provide sufficient evidence of the inherently expansive nature of this liberty. Once recognized as a "right to privacy"<sup>9</sup> possessed by competent adults (and now treated as a "liberty interest"),<sup>10</sup> the abortion right was quickly extended to "mature" minors and granted to "immature" minors on "best interest" grounds.<sup>11</sup> Similarly, "right to die" caselaw initially concerned competent adults and their right to refuse medical care; now these cases often involve the issue of whether treatment or care might be withheld or withdrawn from incapacitated persons whose wishes are unknown or unknowable.<sup>12</sup> The right to refuse life-sustaining treatment is preserved by imputing to such persons a "best interest" decision or "substituted judgment" made by a third-party to reject treatment.<sup>13</sup>

Proponents of a narrow exception for assisted suicide thus bear the heavy burden of discounting the "slippery slope" argument. The logic and progression of the very precedents they rely upon in fact rather obviously predict the argument's shape. Moreover, the con-

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8. *Hobbins v. Attorney General*, No. 93-306-178-CZ (Mich. Cir. Ct. Wayne County May 20, 1993), *appeal docketed*, No. 164963 (Mich. App. Aug. 13, 1993); *People v. Kevorkian*, No. 93-11482 (Mich. Cir. Ct. Wayne County Dec. 13, 1993), *appeal docketed*, No. 171056 (Mich. App. Dec. 21, 1993); *People v. Kevorkian*, No. CR-92-115190-FC (Mich. Cir. Ct. Oakland County July 21, 1992), *appeal docketed*, No. 154740 (Mich. App. Nov. 6, 1992). Oral arguments were heard in all three cases on January 6, 1994.

9. *Roe v. Wade*, 410 U.S. 113, 153-54 (1973).

10. *Planned Parenthood v. Casey*, 112 S. Ct. 2791, 2807 (1992) (plurality opinion).

11. *Bellotti v. Baird*, 443 U.S. 622 (1979); *see also Hodgson v. Minnesota*, 110 S. Ct. 2926, 2972 (1990).

12. *See, e.g., United States v. University Hosp.*, 575 F. Supp. 607 (E.D. N.Y. 1983), *aff'd on other grounds*, 729 F.2d 144 (2d Cir. 1984); *In re Infant Doe*, No. GU 8204-004A (Monroe County Cir. Ct. Apr. 12, 1983), *petition for writ of mandamus and prohibition denied sub nom. State ex rel. Infant Doe v. Monroe Cir. Ct.*, No. 482 S 140 (Ind. Apr. 14, 1982), *appeal dismissed sub nom. In re Infant Doe*, No. 1-782A-157 (Ind. June 15, 1983), *cert. denied*, 104 S. Ct. 394 (1983) (the Monroe Circuit court opinion is printed as an appendix to HUMAN LIFE AND HEALTH CARE ETHICS 313-16 (James Bopp, Jr. ed. 1985)); *Brophy v. New Eng. Sinai Hosp., Inc.*, 497 N.E.2d 626 (Mass. 1986); *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417 (Mass. 1977); *Cruzan v. Harmon*, 760 S.W.2d 408 (Mo. 1988), *aff'd sub. nom. Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261 (1990). For an extensive survey of the relevant case law, see NATIONAL CENTER FOR STATE COURTS, GUIDELINES FOR STATE COURT DECISION MAKING IN LIFE-SUSTAINING MEDICAL TREATMENT CASES 155-79 (apps. A & B) (2d ed. 1992); *see also ALAN MEISEL, THE RIGHT TO DIE* Parts III & V (1989 & Supp. No. 2 1993).

13. *See supra* note 12.

temporary record of the Netherlands, the only nation legally entertaining euthanasia practices, testifies to its reality.<sup>14</sup>

Nevertheless, proponents of constitutionally legalized assisted suicide have asked the courts to confront the "hard case" (or the "camel's nose") posed by the desire of a competent adult with a terminal condition or "unbearable suffering" who wishes to commit suicide by ingesting a lethal dose of drugs prescribed by a physician with knowledge that this is what the patient will do.<sup>15</sup> Surely, they imply, in *this* case, the asserted liberty under the Fourteenth Amendment to the United States Constitution, or under similar provisions in state constitutions, outweighs any asserted countervailing state interest in preventing the person from committing suicide or the physician from supplying the means. They urge the courts to put aside the social and constitutional consequences of accepting any such "liberty": consider this case *sui generis*, then let the precedential chips fall where they may.<sup>16</sup>

It would, however, be a constitutional oddity were the courts to acknowledge a liberty interest deemed so compelling as to warrant striking down an interfering state statute, but so narrow in scope that

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14. Each year in the Netherlands, thousands of nonvoluntary cases of euthanasia take place despite explicit statutory prohibitions, see Richard Fenigsen, *The Netherlands: New Regulations Concerning Euthanasia*, 9 ISSUES IN LAW & MED. 167, 169-71 (1993); see *id.* at 170, and text accompanying notes 15-18, for declarations by government officials permitting de facto nonvoluntary euthanasia with impunity; see also Johannes J.M. van Delden et al., *The Rummelink Study: Two Years Later*, HASTINGS CTR. REP., Nov.-Dec. 1993, at 24-25; CARLOS F. GOMEZ, REGULATING DEATH: EUTHANASIA AND THE CASE OF THE NETHERLANDS 64, 85 ("Case 22"), 104-113, 120, 133-34 (1991); Leon R. Kass, *Is There A Right to Die?*, 23 HASTINGS CTR. REP., Jan.-Feb. 1993, at 34, 37 (note 2 and accompanying text).

In addition to incompetent and never-competent adolescents and adults, newborns and infants with disabilities are fast becoming the most vulnerable classes of persons subject to nonvoluntary euthanasia, see generally Cor Spreeuwenberg, *The Story of Laurens*, in 2 CAMBRIDGE Q. HEALTHCARE ETHICS 201, 261-63 (1993):

I concur that autonomy ought to be the point of departure in euthanasia decisions, but it should not be the only principle considered. Because newborns cannot exercise autonomy does not mean that they should be denied beneficence [medically caused death]. There are many less important decisions we make in their behalf, why should they be denied perhaps the most caring choice of all?

*Id.* at 262.

The Canadian Supreme Court commented on the Dutch experiment in its recent decision upholding Canada's ban on assisted suicide: "This worrisome trend supports the view that a relaxation of the absolute prohibition takes us down 'the slippery slope.'" *Rodriguez v. Attorney Gen. of Can. No. 23476*, slip op. at 29 (Can. Sept. 30, 1993) (Sopinka, J., writing for the majority).

15. See, e.g., Sedler, *supra* note 4, at 22-23.

16. *Id.*

it can only be freely exercised in such limited circumstances.<sup>17</sup> It would be rather like acknowledging that the Constitution protects freedom of speech, but only by certain qualified adults with a proven, urgent need to orate and only with the assistance of some guardian of speech licensed by the state.

Moreover, a judiciary that did not consider what sort of consequences might flow, legal and otherwise, from recognizing a right to assisted suicide would neither be responsible nor reflect a coherent vision of its obligations in the constitutional and social order. Law may proceed on a case-by-case basis in the courts, but common law trends and especially constitutional developments necessarily incorporate broad principles with potential applications in other contexts.

This Article argues that assisted suicide as a fundamental constitutional right lacks support in a number of areas. Initially, this Article shows the asserted liberty interest in assisted suicide has no historical basis and is not an implicit right under the Fourteenth Amendment's "liberty" guarantee. Second, this Article examines the fallacy of granting a constitutional liberty interest to assisted suicide solely to "rational" adults, and the consequences therefrom. Next, this Article argues the terms "terminal condition" and "unbearable suffering" are too nebulous to provide any critical distinctions between those activities which are protected by the Constitution and those which are not. Finally, awarding physicians the unique discretion to determine the appropriateness of physician-assisted suicide, this Article argues, will not further any legitimate state interests.

The "hard case" posed by proponents of assisted suicide should be considered on its own merits, as this Article intends to do. Nevertheless, to affirm the proponents' position, the courts must almost certainly first affirm a "liberty" that cannot be easily circumscribed by the narrow conditions that its proponents propose.

## I. The Nature of the Asserted "Liberty"

The "liberty" claimed is said to permit those with terminal conditions or unbearable suffering to receive physician assistance in directly ending their lives by a prescribed, lethal drug overdose.<sup>18</sup> Nowhere in the Constitution is such a right explicitly granted. Hence, proponents

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17. Such a limited right could no more remain within its initial boundaries than the right to vote could exist only as a right to be exercised by "literate" citizens. The shelf-life of "rationality," "terminal condition," and "physician-only assistance," as limits on the purported right to suicide, would be far shorter than that of voter literacy tests.

18. Sedler, *supra* note 4, at 23.

of such a liberty must argue that any such right or liberty is somehow implicitly guaranteed in the Constitution. This claim has several weaknesses.

### A. A Right to Assisted Suicide has No Historical Basis

An implicit right to assisted suicide has no historical basis because, although suicide is no longer treated as a crime as it was at common law,<sup>19</sup> attempted suicide continues to be regarded as an indici-um of psychological disability or emotional disturbance that fully justifies intervention by public authorities and private agents.<sup>20</sup> That suicide itself has been decriminalized by replacement of the common law of crimes with statutes that fail to penalize it hardly demonstrates that our society deems suicide to be an essential part of ordered liberty. It demonstrates only that pity has replaced retribution as a socially proper response to suicide and that a punitive model was replaced by a therapeutic one in the law. Suicide is still a harm to be avoided, not a right to be encouraged. Moreover, assisted suicide is separately punishable by statute in thirty states.<sup>21</sup> The purpose of these laws continues to be prevention and discouragement of suicide, though the method and rationale may vary from the earlier laws.

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19. *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 294-95 (1990) (Scalia, J., concurring).

20. All fifty states provide for the temporary involuntary commitment of individuals who are a danger to themselves, *see, e.g.*, CAL. WELF. & INST. CODE, §§ 5150, 5200, 5206, 5213, 5250(a), 5256.6, 5260 (West 1982); MICH. COMP. LAWS ANN. §§ 330.1401(a), 330.1468(2) (West 1992).

21. ALASKA STA. § 11.41.120(a)(2) (1989); ARIZ. REV. STAT. ANN. § 13-1103(A)(3) (1989); ARK. CODE ANN. § 5-10-104(a)(2) (Michie 1987); CAL. PENAL CODE § 401 (West 1988); COLO. REV. STAT. § 18-3-104(1)(b) (1990); CONN. GEN. STAT. ANN. § 53a-56(a)(2) (West Supp. 1993); DEL. CODE ANN. tit. 11, § 645 (1987); FLA. STAT. ANN. § 782.08 (West 1992); H.B. 819, 88th Ill. Gen. Assembly (signed by the Governor on Aug. 20, 1993); KAN. STAT. ANN. § 21-3406 (1988); ME. REV. STAT. ANN. tit. 17-A, § 204 (West 1983); MICH. COMP. LAWS ANN. § 752.1027 (West 1993); MINN. STAT. ANN. § 609.215 (West 1987); MISS. CODE ANN. § 97-3-49 (Supp. 1973); MONT. CODE ANN. § 45-5-105 (1991); NEB. REV. STAT. § 28-307 (1989); N.H. REV. STAT. ANN. § 630:4 (1986); N.J. STAT. ANN. § 2C:11-6 (West 1982); N.M. STAT. ANN. § 30-2-4 (1984); N.Y. PENAL LAW § 125.15(3) (McKinney 1987); N.D. CENT. CODE § 12.1-16-04 (1991); OKLA. STAT. ANN. tit. 21, §§ 813, 814, 815 (West 1983); OR. REV. STAT. § 163.125(1)(B) (1991); 18 PA. CONS. STAT. ANN. § 2505(b) (1983); S.D. CODIFIED LAWS ANN. § 22-16-37 (1988); 1993 Tenn. Pub. Acts 405; TEX. PENAL CODE ANN. § 22.08 (West 1988); WASH. REV. CODE ANN. § 9A.36.060 (West 1988); WIS. STAT. ANN. § 940.12 (West 1982).

## B. A Right to Assisted Suicide is Not Implicit in the Fourteenth Amendment's Due Process Clause

The claim that there nevertheless exists an "implicit" constitutional liberty or right to some form of assisted suicide therefore avoids the necessity of proving an historical or even contemporary concrete legal basis. Instead, this claim simply assumes that a right to suicide and its step-child, assisted suicide, is somehow contained within the concept of "liberty" envisioned by the framers of the Fourteenth Amendment or—if the framers had fully understood the true nature of liberty—is one that they would surely have embraced. A particular concept of personal autonomy that includes suicide and assisted suicide would thus be grafted to constitutional roots that recognized neither.

At least in cases of assisted suicide done by physician prescription for those with terminal conditions or unbearable suffering, proponents of this liberty hold that statutory prohibitions on assisted suicide strike an unfair balance between state and individual interests. The proponents' underlying theory here invokes the "balancing" approach developed in the abortion and "right to die" cases. It apparently presupposes that virtually anything one wants to do is protected as a "liberty" under the Fourteenth Amendment, from killing oneself to jaywalking—and that the sole rationale for restricting any conduct is the counterbalance of some compelling or otherwise valid state interest in limiting such conduct. At least in the cases of suicide and assisted suicide, the theory simply assumes that these are "liberties" against which state interests must be balanced, although the historical record demonstrates they are not explicitly protected liberties in the first place. Moreover, asserting a "liberty" under the Constitution to directly take one's own life based on precedents upholding abortion or the rejection of unwanted treatment fails to recognize that neither of these lines of cases concern the taking of a human life "born . . . in the United States."<sup>22</sup> A fetus is not yet born. And though surely death may be a known consequence of rejection of medical treatment, caselaw has been careful to characterize this outcome as the end result of a natural process of the affected person's illness or injury, rather than as the legally intended result of the rejection of treatment.<sup>23</sup> In-

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22. U.S. CONST. amend. XIV.

23. See, e.g., *In re Conroy*, 486 A.2d 1209, 1224 (N.J. 1985) ("Refusing medical intervention merely allows the disease to take its natural course; if death were eventually to occur, it would be the result, primarily, of the underlying disease, and not the result of a self-inflicted injury.").

deed, the courts have often rejected a right to suicide or euthanasia in the very process of affirming a right to refuse treatment,<sup>24</sup> and legislatures that have codified the right to refuse treatment in the same legislation reject any affirmative act to end life.<sup>25</sup>

Furthermore, the balancing theory conflates the firm distinction in the law between act (suicide, assisted suicide, and homicide-by-consent) and omission (withholding and withdrawing treatment or care). The cases sanctioning rejection of treatment are rooted in the rule that any "unconsented touching" without legal justification is a battery,<sup>26</sup> a rule from the same common law that regarded suicide as a felony.<sup>27</sup>

24. See, e.g., *DeGrella v. Elston*, 858 S.W.2d 698, 706-07 (Ky. 1993) (stressing that "mercy killing" and "euthanasia" or any other "affirmative or deliberate act to end life" are fundamental violations of the common law" as well as the state's living will law). The distinction between the withdrawal of treatment and the acts of homicide, euthanasia, and assisted suicide is also made in the seminal "right to die" case. See *In re Quinlan*, 355 A.2d 647, 670 (N.J. 1976). See also MEISEL, *supra* note 12, at 61-69, §§ 3.9 & 3.10.

25. Natural death/living will statutes: ALA. CODE § 22-8A-10 (1990); ALASKA STAT. § 18.12.080(f) (1992); ARIZ. REV. STAT. ANN. § 36-3210 (1992); ARK. CODE ANN. § 20-17-210(g) (Michie 1991); CAL. HEALTH & SAFETY CODE § 7191.5(g) (West 1993); COLO. REV. STAT. § 15-18-112(1) (1989); D.C. CODE ANN. § 6-2430 (1989); FLA. STAT. ANN. § 765.309(1) (West 1993); GA. CODE ANN. § 88-4111(b) (1986); HAW. REV. STAT. § 327D-13 (1992); ILL. ANN. STAT. ch. 755, ¶ 35/9(f) (Smith-Hurd 1992); IOWA CODE ANN. § 144A.11.6 (West 1989); KAN. STAT. ANN. §§ 65-28, 109 (1992); KY. REV. STAT. ANN. § 311.636 (Michie/Bobbs-Merill 1992); LA. REV. STAT. ANN. 1299.58.10(a) (West 1992); ME. REV. STAT. ANN. tit. 18A § 5-711(g) (West 1992); MD. CODE ANN., HEALTH-GEN § 5-610(3) (1990); MINN. STAT. ANN. § 145B.14 (West 1993); MISS. CODE ANN. § 41-41-117(2) (1992); MO. ANN. STAT. § 459.055(5) (Vernon 1992); MONT. CODE ANN. § 50-9-205(7) (1991); NEB. REV. STAT. § 20-412(7) (1992); NEV. REV. STAT. ANN. § 449.670(2) (Michie 1987); N.H. REV. STAT. ANN. § 137-H:10(II) (1992); N.C. GEN. STAT. § 90-320(b) (1990); N.D. CENT. CODE § 23-06.4-01 (1991); OHIO REV. CODE ANN. § 2133.12(d) (Anderson 1992); OKLA. STAT. ANN. tit. 63, § 3101.12(g) (West 1993); OR. REV. STAT. § 127.645(1) (1991); 20 PA. CONS. STAT. ANN. § 5402(b) (1992); R.I. GEN. LAWS § 23-4.11-10(f) (1992); S.C. CODE ANN. § 44-77-130 (Law. Co-op. 1992); S.D. CODIFIED LAWS ANN. § 34-12D-20 (1993); TEX. HEALTH & SAFETY CODE ANN. § 672.020 (West 1992); UTAH CODE ANN. § 75-2-1118 (1993); VA. CODE ANN. § 54.1-2990 (Michie 1993); WASH. REV. CODE ANN. § 70.122.100 (West 1993); W.VA. CODE § 16-30-10 (1991); WIS. STAT. ANN. § 154.11(6) (West 1989); WYO. STAT. § 35-22-109 (1988).

Durable power of attorney for health care statutes: 63 Del. Laws, ch. 386, § 3 ("Nothing in this act [authorizing durable powers of attorney for health care] shall be construed to condone, authorize or approve of mercy-killing [or] be construed to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying"); D.C. CODE ANN. § 21-2212 (1989); ILL. ANN. STAT. ch. 755, para. 40/50 (Smith-Hurd 1992); IND. CODE ANN. § 30-5-5-17(b) (Burns 1992); IOWA CODE ANN. § 144B.12.2 (West 1993); MASS. GEN. LAWS ANN., ch. 201D, § 12 (West Supp. 1993); MICH. COMP. LAWS ANN. § 700.496(20) (West Supp. 1993); N.Y. Pub. Health Law § 2989(3) (McKinney 1993); N.D. CENT. CODE § 23-06.5-01 (1991); R.I. GEN. LAWS § 23-4.10-9(f) (1992); WYO. STAT. § 3-5-211 (1992).

26. See W. PAGE KEETON ET AL., PROSSER & KEETON ON LAW OF TORTS § 9, at 39-42 (5th ed. 1984)

27. Marzen, *supra* note 7, at 56-63.



To invoke the right to reject treatment in support of a right to assisted suicide thus betrays the original firm distinction drawn between refusal of unwanted treatment and suicide.

### C. Other Constitutional Inconsistencies

Assertion of an "implicit" constitutional "liberty" to take one's own life and to receive assistance in doing so also fails to confront separate rational and constitutional problems. Put aside the absurdity of imputing to the Framers of the Fourteenth Amendment an intent to recognize a "liberty" for the newly freed slaves to kill themselves and to secure the assistance of others to do so. The Framers intended to protect the right to live, and the right to live is the "right to have rights."<sup>28</sup> But the claim that there is a right to suicide assumes that there is an unstated superior right, which is a right to have no rights at all. The concept of a "liberty" to kill oneself thus contains an inner contradiction. And the idea of a "liberty" to kill oneself with the assistance of another without state interference amplifies the contradiction by extending it to the social order.

The plain language of the Fourteenth Amendment itself recognizes in logical sequence that *first* "life" (not death) and *then* "liberty," should be provided substantive, procedural, and equal protection of the law.<sup>29</sup> The notion that there exists a "liberty" to seek and secure assistance to deprive oneself of the right to live that the state is forbidden to deny by way of anti-assisted suicide laws inverts the order—rendering this liberty the master of life when, in fact, life is the necessary prerequisite to any liberty.<sup>30</sup> The affirmative obligation of the state to recognize, in the first instance, the right of its citizens to live is thus transformed into an obligation to turn its back on conduct knowingly intended to deprive citizens of life, and thus all liberties—and this in the name of liberty. The "liberty" recognized by the Constitution does not include a right to sell oneself to another into slavery, thereby depriving oneself of liberty itself. Likewise, and for nearly identical reasons, the Constitution should not properly be construed in the name of liberty to recognize a right to seek and secure assistance of another to end one's life, thereby depriving one of all liberties.

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28. *Furman v. Georgia*, 408 U.S. 238, 290 (1972) (Brennan, J., concurring).

29. U.S. CONST. amend. XIV.

30. For an expanded exposition of this argument, see Joel Feinberg, *Voluntary Euthanasia and the Inalienable Right to Life*, 7 PHIL. & PUB. AFF. 93 (1978).

Some assert that the constitution that protects the person's right to assisted suicide "equally protects that person's right to choose *not* to hasten inevitable death."<sup>31</sup> One need not eschew a principle of inherent neutrality between choices for life and death, however, in order to prefer decisions for continued life. This is so because the Constitution itself is not neutral, affirming only an interest in "life," and placing interests in "liberty" then "property" in subsidiary order. If liberty were conceived to subsume life,<sup>32</sup> then an interest in "property" might likewise be conceived to subsume both liberty and life.

Any claim that the Constitution ought properly to recognize a right to assisted suicide necessarily assumes a recognized liberty to suicide itself. Yet paradoxically, suicide is now nowhere a crime and, in this sense, the state imposes no "burden" of any kind on completion of the act. The plea for recognition of a right to assisted suicide thus amounts to a plea for suicide of a *special sort*: suicide that is done with expert aid and instruction to assure its painless and certain completion.

The Constitution may protect a right to "define one's own concept of existence,"<sup>33</sup> but the right to do so rests upon the assumption that one exists in the first place. And even if in some sense this affirmative right includes its opposite—as though one might simply define one's self as a non-person who lacks existence—it is a step into another dimension, to claim one also has the right to enlist others in seeking a designer death.

"The choice between life and death" may be a "deeply personal decision of obvious and overwhelming finality,"<sup>34</sup> as the Supreme Court described it (while holding that the state may require clear and convincing evidence of patient intent to forego treatment in service to

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31. Sedler, *supra* note 4, at 25.

32. Proponents seem to argue in the context of suicide that any choice that contemplates multiple outcomes of philosophical, legal, moral, and personal significance is by virtue of the seriousness of these concerns a fundamental constitutional right. Thus, in *People v. Kevorkian*, No. 93-11482, slip op. at 26 (Mich. Cir. Ct. Wayne County Dec. 13, 1993), Judge Kaufman asserted that "the decision to commit suicide involves an intimate and personal choice, and given the nature of the decision certainly ranks among the most important that a person may make concerning one's own being." This argument includes, however, a non-sequitur. Similarly important would be personal decisions to cut off one's arm or leg or to mutilate one's face, but these decisions are not *protected liberty rights* under the Constitution. See *Bowers v. Hardwick*, 478 U.S. 186 (1986) (holding that sodomy is not a protected liberty interest). That a choice may be personally significant or of concern to philosophers, lawyers, and moralists tells us nothing about its constitutional weight.

33. *Planned Parenthood v. Casey*, 112 S. Ct. 2791, 2808 (1992) (plurality opinion).

34. *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 281 (1990).

an “unqualified interest” in the preservation of life).<sup>35</sup> Perhaps such a choice has a valid constitutional dimension in the context of a decision to reject the initiation or continuation of invasive life-sustaining care. But it is another thing altogether to claim that this choice includes a right to death-causing invasive means, and more: that this supposed right is broad enough to encompass a right to secure the services of others to effect such a purpose, as though either the Constitution or the state must sanction commerce in self-killing.

## II. The “Rational” Competent Adult

Assuming there exists some constitutionally cognizable liberty interest in suicide or assisted suicide, proponents assert that this right might only be exercised by competent adults. The apparent rationale for this is that only competent adults should be deemed capable of “rational suicide,” which is the conduct to be protected. Thus, for example, the trial court in *People v. Kevorkian*<sup>36</sup> found that there is a constitutional right to “rational” suicide, but held that the state has a compelling interest in preventing “irrational” suicide.<sup>37</sup> There are, as the court stated, “circumstances where a person’s decision to end their life, and the attempted execution of that decision, are not constitutionally protected, and could be proscribed by the state.”<sup>38</sup> According to the court,

the two easiest examples are attempted suicide by a child or incompetent person who suffers from no objective debilitating physical illness. These types of suicides would probably be placed at one end of the continuum labeled irrational suicide. At the other end of the continuum, labeled rational suicide, would be the suicide of a competent adult who has an objectively verifiable terminal illness and who, as a result of that terminal illness, suffers from significant, substantial, and continuous agony, and objective medical analysis confirms that any alleviation of this discomfort is extremely unlikely prior to death.<sup>39</sup>

The inquiry into whether or not suicide is “rational” is thus inextricably bound not only to competence, but also to certain verifiable conditions—conditions that the Constitution itself supposedly deems as justifiable or “rational” prerequisites to claiming an exception to an otherwise blanket prohibition on assisted suicide.

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35. *Id.*

36. No. 93-11482, slip op. at 34 (Mich. Cir. Ct. Wayne County Dec. 13, 1993).

37. *Id.* at 34.

38. *Id.* at 32.

39. *Id.* at 33.

The requirement that certain conditions be met before suicide/assisted suicide is deemed "rational" presumes to judge on constitutional grounds what are and what are not "good reasons" to kill oneself. The *Kevorkian* court, for example, assumes that at least its parade of horrors forms a "good reason," but it is utterly unclear why these or any other horrors should form a special basis upon which to assert an interest in "rational" suicide. Why not, for example—to paraphrase the *Kevorkian* court—also justify suicide as "rational" based on quality of *financial* life, when one has "an objectively verifiable . . . [dismal financial condition leading to bankruptcy] and who, as a result of that terminal [financial] condition, suffers from significant, substantial, and continuous agony, and objective . . . [financial] analysis confirms that any alleviation of this discomfort is unlikely prior to death?"<sup>40</sup>

Indeed, a better case could be made for one in a "terminal" financial condition than for one with a terminal medical condition since the perpetually impoverished who continue to survive would be a burden on the state, while those with terminal conditions must soon die in any case. The *Kevorkian* court implied as much by citing in support of its holding *Buck v. Bell*,<sup>41</sup> a case which upheld state eugenic sterilization laws precisely on the basis of the potential burden on the state imposed by future generations of supposed "imbeciles":

Although some cases have suggested that the state interest in preserving life should be blind to the quality of life, a number of cases suggest that the state's interest in preserving life does have a qualitative component. . . . More to the point is *Buck v. Bell*. In that case, the United States Supreme Court upheld a state statute that required the sterilization of certain women. The Court found that the state in that case had a sufficient interest to avoid the creation of certain life because the state concluded the quality of such life was too low and too much of a burden on society to permit. As a result of this decision of the United States Supreme Court, one could fairly ask, if the state is allowed to prevent the creation of life because it deems the resulting quality too low, how can it deprive a person of the right,

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40. *Id.* "Contemporary advocates [of rationale suicide] see a close analogy between a rational decision for suicide and the decision of the directors of a firm to declare bankruptcy and go out of business." Herbert Hendin, *Seduced by Death: Doctors, Patients and the Dutch Cure*, 10 ISSUES IN LAW & MED. (forthcoming in 1994) (citing Roger Brandt, *The Morality and Rationality of Suicide in A HANDBOOK FOR THE STUDY OF SUICIDE* 61 (Seymour Perlin ed. 1975).

41. 274 U.S. 200 (1927).

under certain circumstances, to come to that same conclusion with respect to their own life?<sup>42</sup>

The dark side of this supposed bright liberty in assisted suicide is thus exposed. The rationale for *Buck v. Bell* was bluntly stated by the U.S. Supreme Court: "It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind. . . . Three generations of imbeciles are enough."<sup>43</sup>

The purportedly objective "quality of life" judgments to be made in deciding who should live or die by way of assisted suicide are deemed by the *Kevorkian* court to have much in common with judgments made by the pre-World War II eugenics movement. Moreover, *Buck v. Bell* involved compulsory sterilization, not sterilization freely chosen. The specter is thus raised that if some "quality of life" criteria can be settled upon that warrant voluntary assisted suicide, then the same criteria could be used for other purposes. At the very least, those who are deemed sufficiently unfit for blanket protection under anti-assisted suicide statutes might also be consistently abandoned by the state's social welfare programs and exempted from civil laws that implicate any duty of care to sustain their lives or well-being.

In any case, linking a determination of what is "rational" to any pre-established set of criteria places the cart before the horse—or rather the horse within the cart. The Constitution does not place limits on liberties based on whether it deems the person's reasons for a personal choice to be valid or "rational," but permits limits to be placed on the exercise of choices in the name of legitimate state interests. From this perspective, it does not matter whether or not a decision is "rational" because otherwise, for example, an "irrational" homicide might be punished but a calculated "rational" murder could not.

Moreover, it is known that the vast majority of persons who choose to kill themselves—whether or not they have terminal conditions—have emotional or psychological illnesses.<sup>44</sup> The data fully sup-

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42. *Kevorkian*, slip op. at 27-28.

43. *Buck*, 274 U.S. at 207 (1927).

44. David C. Clark, "Rational" Suicide and People with Terminal Conditions or Disabilities, 8 ISSUES IN LAW & MED. 147, 153-55 (1992); Linda Ganzini et al., *Depression, Suicide, and the Right to Refuse Life-Sustaining Treatment*, 4 J. CLIN. ETHICS 337, 338 (1993); Herbert Hendin & Gerald Klerman, *Physician-Assisted Suicide: The Dangers of Legalization*, 150 AM. J. PSYCHIATRY 143, 143 (1993) ("[L]ike other suicidal individuals, patients who desire an early death during a terminal illness are usually suffering from a treatable mental illness, most commonly a depressive condition.").

port the presumption in the law that any decision to commit suicide renders competency suspect.<sup>45</sup> But the idea that this suicide liberty might be freely exercised by those with certain objective medical conditions, but not by those without them, assumes without warrant, competency in one case but not the other. This view thus implicitly discounts any serious consideration of competency, apparently on the invidious presumption that only people with such conditions are justified in wanting to kill themselves whether competent or not.

So unless the state is to abandon all suicidal persons, whether or not driven to suicide by emotional or psychological illness, it must at least sort out the competent from the incompetent in some fashion. This raises the question of whether the state ought to be required to engage in the investment necessary to harvest the few "true" exercises of this liberty from the forest of those rooted in emotional or psychological distress or duress. But for the state or one of its agents, judicial or otherwise, to act as a gatekeeper to select who should and who should not be deemed sufficiently competent (or rational or terminal) to die by way of assisted suicide raises obvious troubling questions involving the administration of any such process. As the *Kevorkian* court held, whatever the reasons offered by the person for assisted suicide, the judiciary (or the legislature subject to judicial oversight) would make the threshold decision based on its own "objective" criteria.<sup>46</sup> The prospect of dividing the sheep from the goats—those who may die and those who may not—might properly be a role declined based on a profoundly compelling state *disinterest* in such business.

If states may decline to create a process that might result in the execution of criminals—fraught as it is with potential for mistake, error, coercion, and inequity—then why may they not simply refuse on the same grounds to make any exception to a blanket prohibition on assisted suicide that would require them to engage in a similar process? The distinctions drawn by proponents of a *limited* right to assisted suicide assume that some boundaries based on at least volitional choice must be in place because, otherwise, many will die against their

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45. The idea of rational suicide itself finds no clinical support. See Steven A. King, *Letter to the Editor*, 271 JAMA 23 (1994). Dr. King criticizes an earlier article by Dr. Timothy E. Quill which states that "there is a growing clinical literature suggesting that some of these suicides may be rational[.]" *Id.* (quoting Timothy E. Quill, *Doctor, I Want to Die. Will You Help Me?*, 270 JAMA 870 (1993)). Dr. King notes that Dr. Quill cited only "editorials and commentaries, not clinical studies" to support his claim. *Id.* Dr. King remarks that "[s]ince the issue being discussed involves the termination of life, a more solid foundation supporting Quill's views would appear to be indicated." *Id.*

46. *Kevorkian*, slip op. at 32-35.

wills—thereby denying them both their right to “life” and their “liberty” interests in continued life. Based on the proponents’ own assumptions, therefore, opposing fundamental rights and interests are at stake in any selection process, weaving an intricately tangled web of substantive and due process issues of the highest order in which the state and judiciary would necessarily be enmeshed.

Surely the states may decline to become death’s arbitrators in favor of maintaining a blanket prohibition on assisted suicide. The Constitution by its plain language is ratcheted in favor of life, and it should not be construed to require that the states or the courts *must* select from among the population who is and who is not worthy of their protection or interest. As a California appellate court recently observed, while “it is conceivable to devise a judicial procedure to supervise . . . assisted death[,] . . . [w]e do not embark on such an enterprise because we hold that [individuals have] no constitutional right to a state-assisted death.”<sup>47</sup> The Canadian Supreme Court addressed this same issue in its recent decision *Rodriguez v. Attorney General of Canada*.<sup>48</sup> In *Rodriguez*, a woman petitioned the Canadian courts for authority to obtain suicide assistance. She challenged a Canadian federal law imposing a blanket ban on assisted suicide.<sup>49</sup> She based her petition on constitutional guarantees protecting “life, liberty and security of the person” found in the Canadian Charter of Rights and Freedoms.<sup>50</sup> In upholding the ban, the high court observed that the Canadian House of Lords had earlier rejected proposals to legalize assisted suicide for competent, terminally ill persons “because adequate guidelines to control abuse are difficult or impossible to develop.”<sup>51</sup> The Court concluded that

The foregoing is also the answer to the submission that the impugned legislation [banning assisted suicide] is overbroad. There is no halfway measure that could be relied upon with assurance to fully achieve the legislation’s purpose; first, because the purpose extends to the protection of the life of the terminally ill. Part of this purpose, as I have explained above, is to discourage the terminally ill from choosing death over life. Secondly, even if the latter consideration can be stripped from the legislative purpose, we have no assurance that the exception can

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47. *Donaldson v. Lungren*, 2 Cal. App. 4th 1614, 1623 (1992) (denying injunctive relief against prosecution to person with a brain tumor seeking cryogenic suspension).

48. No. 23476 (Can. Sept. 30, 1993).

49. See CRIMINAL CODE, R.S.C., ch. C-46, § 241 (1985) (Canada).

50. See CAN. CONST. pt. I, § 7.

51. *Rodriguez*, slip op. at 27 (Sopinka, J., writing for the majority).

be made to limit the taking of life to those who are terminally ill and genuinely desire death.<sup>52</sup>

The concern expressed here is not so much about a “slippery slope” as it is about a “slippery rink.” Its force lies not in contingent fears of “sliding down the slope” to killing other populations or groups beyond those with terminal conditions and unquestionable rationality. Rather, it arises from the difficulty of establishing within the given parameters of the class of terminal, competent persons that any one person seeking suicide is truly terminal and truly rational. It is not the slope of its surface, but its utter lack of sure footing that creates the danger.

Hence, Canada’s Supreme Court—the highest court in any nation to have considered the matter, a court in the common law tradition, and a court responsible for construing a constitution patterned after our own—upheld Canada’s complete statutory ban on assisted suicide. The same considerations apply to American jurisprudence: The Constitution ought not be construed to compel the state or the judiciary to engage in a selection process fraught with risk and based on arbitrary criteria for what is and is not a “rational” suicide.

### III. “Terminal Condition”

Recognizing some constitutional liberty interest in suicide, yet acknowledging that there exists some state authority to regulate the practice—that is, to place a “due” rather than “undue” burden on exercise of the liberty—presumes the existence of an identifiable class of persons who might properly assert this narrowly tailored right. Proponents of such a liberty argue that at least those who are “terminally ill” form a “distinct and identifiable” class of those who will die “within a relatively short period of time.”<sup>53</sup>

But there is, in fact, no consensus on what is a “terminal condition.” This is testified to by the variety of definitions found in state “living will” laws.<sup>54</sup> Moreover, it is doubtful that a unitary definition

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52. *Id.* at 44.

53. Sedler, *supra* note 4, at 22.

54. For a listing of state statutes defining “terminal condition,” see MEISEL, *supra* note 12, at 359. These definitions vary in two crucial respects. First, the time-based criteria they employ often differ, *see, e.g.*, CAL. HEALTH & SAFETY CODE § 7186(j) (West Supp. 1992) (death must occur in a “relatively short time”); COLO. REV. STAT. § 15-18-103(10) (1987 & Supp. 1992) (treatment only “postpone[s] the moment of death”); VA. CODE ANN. § 54.1-2982 (Michie Supp. 1992) (death must be “imminent”). Second, the treatment-based criteria they employ often differ as well, *see, e.g.*, GA. CODE ANN. § 31-32-2(13) (1991 & Supp. 1992) (one has a terminal condition only if one will die “regardless” of the use of life-



can be arrived at without arbitrary line-drawing that bears no relation to discernible constitutional principle.<sup>55</sup>

Life itself is, after all, a terminal condition in the broadest sense. In its narrowest sense, a terminal condition is only that which will result in the death of the person at a time unaffected by whether or not the full medical armory is employed—that is, a condition for which all treatment is useless to extend life even for a few moments, hours, or days. The gulf between these two extremes is fluid, defying any attempt to find firm ground between.

Is a condition “terminal” if one will die from it regardless of whether or not treatment or care is provided? If this is the case, then one is not terminal as long as any treatment is available that may provide continued survival—a respirator, resuscitation, chemotherapy, or tube feeding. But if this concept of a “terminal condition” is adopted, then it may be virtually impossible to ever honestly designate many persons as “terminal” as long as tubes, machines, and drugs exist that may sustain them. Yet it is the present specter of the use of such techniques to sustain life indefinitely that drives the legislative impulse to find the means, through “living wills” and otherwise, to sanction their rejection.<sup>56</sup>

On the other hand, developing criteria to define the terminal condition without reference to available, useful treatment is even more unsatisfactory. For example, a person with diabetes or a serious infection might continue to survive with the use of insulin or antibiotics, but will die without one or the other. A definition of “terminal condition” without reference to whether or not the lives of persons might be maintained with treatment would render “terminal” these and all others who rely on some form of treatment or care to survive—and, hence, render them eligible for assisted suicide.

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sustaining procedures); VA. CODE ANN. § 54.1-2982 (Michie Supp. 1992) (one has a terminal condition if one cannot recover from that condition).

The situation is further complicated because certain states include permanent or persistent vegetative state and/or irreversible coma within their statutory definition of “terminal condition.” See, e.g., FLA. STAT. ANN. § 765.101(17)(b) (West Supp. 1993); LA. REV. STAT. ANN. § 40:1299.58.2(10) (West 1992); NEB. REV. STAT. § 20-403(11) (Supp. 1992); R.I. GEN. LAWS § 23-4.11-2(h) (Supp. 1992); VA. CODE ANN. § 54.1-2982 (Michie Supp. 1992). But see *Cruzan v. Harmon*, 760 S.W.2d 408, 411 (Mo. 1988) (patient in a persistent vegetative state is not “terminally ill”).

55. Any constitutionally-based definition of “terminal illness” would necessarily preempt conflicting state definitions, overriding an arguable state prerogative to legislate in this area.

56. C. Everett Koop & Edward Grant, *The “Small Beginnings” of Euthanasia: Examining the Erosion in Legal Prohibitions Against Mercy-Killing*, 2 NOTRE DAME J. L. ETHICS & PUB. POL’Y 585, 605-06 (1986).

A time-based criterion may be introduced in some attempt to limit the duration of survival (*e.g.*, death will occur in a “relatively short time”) in an attempt to clarify the meaning of terminal condition. As it turns out, however, the addition of a time-based element only complicates the problem. If quick death will result from failure to employ medical treatment, then this simply means that those who need treatment most urgently would be deemed terminal even if the treatment would be entirely effective if it were provided. For example, one might have a deadly infection—but an infection that might be successfully treated with virtual certainty by use of available antibiotics. Nevertheless, one would be “terminal” under such a time-based definition.

On the other hand, a definition of terminal condition that includes both time-based *and* treatment-provided elements (*e.g.*, that death must occur even with treatment *and* within a relatively short time) raises obvious questions about the nature of “treatment” and the description of the time-based criterion.

It is assumed that the “treatment” involved is medical in nature, but it is difficult to see why, from a constitutional perspective, this should be so. The language of the Constitution itself provides no special privileges to medical professionals and, in any case, life may be as much threatened by lack of food, clothing, or shelter as by lack of some form of specifically “medical” attention. A person who is hypothermic or malnourished is “terminal” in a constitutionally indistinguishable sense from one who has a serious infection unless some form of intervention—“treatment”—is provided, whether or not by a physician. Certainly, the Framers of the Fourteenth Amendment would not have recognized such a distinction, when the only “treatment” then available for most illnesses involved, at most, home nursing care that lacked even those remedies now available without prescription.

A distinction between what is “medical treatment” and what is not has arisen in court controversies involving food and fluids delivered directly to the stomach or intestine by way of a tube. Once designated a form of non-medical “care,” as opposed to another form of medical “treatment,” intubation is now considered by the courts, at least impliedly, to be subject to a special set of rules permitting it to be withheld or withdrawn as any other form of medical treatment, rather

than subject to rules that would seem to apply in non-medical cases when use of tubes is not necessary to sustain life.<sup>57</sup>

It is true that the use of tubes usually involves a degree of bodily intrusion in the sense that tubes penetrate the skin or orifices of the body. It is not always the case, however, that this intervention involves "touching" any more intrusive or expensive than ordinary nursing care, or is any more technology-related than maintaining proper room temperature, both of which are also necessary for a patient's survival.

Similarly, persons with some disabilities cannot secure sustenance on their own or deliver it to themselves in the usual way. Is it "treatment" to provide them a prescribed nutritional regimen or to spoon feed them—and, if so, then what is the basis for denying suicide assistance in these circumstances? Are such persons "terminal"—and therefore eligible for assisted suicide—because they cannot themselves fulfill such major life functions? If not, then how is the inability to walk to a grocery store or lift a spoon to the mouth constitutionally distinguishable from the inability to swallow, to maintain heart functions without a pacemaker, or to survive without a respirator?

Apart from the essentially artificial distinction between medical attention and other forms of care necessary to sustain life, it is surely not the case that those who might advocate an exception to the ban on assisted suicide would find acceptable a rule that one must die within a "relatively short time" even with treatment to be eligible for prescribed suicide. This would mean, for example, that one who may be sustained indefinitely on a respirator or with tube feeding would not be "terminal"—and would probably not become so until they were so mentally and physically disabled that they were themselves not able to take the lethal drugs that a physician may prescribe. Thus, a person with Alzheimer's or Lou Gehrig's disease, who might be "terminal" in some sense—but not in a "short time"—would not be eligible for assisted suicide until such time as she was unable because of mental or physical disability to commit suicide by ingesting drugs or in any other way.

Moreover, introduction of a time-based element itself creates new problems. Consider a rule that a person must die within a "relatively short time" to be deemed terminal. Use of the term "relatively" begs the question: Relative to what? Immortality, indefinite life, years, months, days, or hours? And what is a "short" time?<sup>58</sup> On

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57. See MEISEL, *supra* note 12, at § 5.10, and the cases cited therein.

58. For fuller discussion, see Thomas J. Marzen, *The "Uniform Rights of the Terminally Ill Act": A Critical Analysis*, 1 ISSUES OF LAW & MED. 441, 465-68 (1986).

what basis can one claim the Constitution as authority to make any such distinction? Inherently vague and arbitrary criteria must necessarily be built into any definition of "terminal condition" that employs time-based elements, the fulfillment of which cannot in any case be predicted with any exactitude. Moreover, any such time-based criterion poses the prospect of permissive assisted suicide based solely on the age of the person, since by advancing age alone one approaches death. This entails by necessary implication the acceptance of an age-based discrimination that more readily sanctions assisted suicide for the old than the young.

In sum, the linchpin criterion of an existing "terminal condition" that, it is argued, should warrant constitutionally sanctioned assisted suicide turns out to contain its own "slippery slope," spanning from life itself to a life that no amount of treatment can prolong for even a moment. To select one place or the other as a bright line that renders assisted suicide a crime on one side and a constitutionally protected right on the other would simply be capricious.

If any line were drawn, human life by virtue of age and infirmity must be deemed less worthy of state protection as a matter of constitutional law. If this is so, then the state homicide codes logically must be revised to acknowledge that homicide of the aged and infirmed is a lesser crime—or no crime at all, if the person consents to the homicide—than that of the young and the healthy.

Moreover, it is impossible to see why or how the Constitution would concede a liberty interest in assisted suicide, yet grant no such interest in the case of homicide-by-consent for those with terminal conditions. That is, it makes no constitutional sense to distinguish between when a physician prescribes lethal drugs and when the physician administers them. The liberty interest in hastening inevitable death is identical in both cases; the "burden" the state places on the exercise of this supposed right by blanket prohibitions is the same. The two might be distinguished by virtue that the person administers the *coup de grace* to oneself in one case, while another person administers it in the other. Yet such a distinction concedes the weight of a social dimension that justifies the present state of the law, which leaves suicide itself unpunished while punishing assisted suicide. Furthermore, it deprives those unable because of disability to dispose of themselves of the opportunity to ever exercise a "right" to suicide.

In the end, the assertion that a "terminal condition" warrants a special exception for an asserted liberty interest in assisted suicide seeks to ratify a certain view of life faced with the prospect of death.

Death by one's own hand is perceived, perhaps perversely, as a kind of triumph over death itself, and aid is sought to assure this pyrrhic victory.

No doubt, some may seek to deny death by embracing it. But the Constitution does not protect the matchmaker.

#### IV. "Unbearable Suffering"

It is argued that when "unbearable suffering" occurs, special force is lent to the claim that a ban on assisted suicide should be deemed unconstitutional. No one doubts that human suffering exists or that some might deem some forms of suffering<sup>59</sup> as "unbearable."<sup>60</sup> But again, how can one carve out a constitutional niche that pretends to have any reasonable boundaries for such criteria?

If the concept is described only to include physical pain, then the reply is that almost all such pain can be abolished or alleviated through use of analgesics<sup>61</sup>—and can almost certainly be eliminated with the use of anesthetics that render one unconscious, or nearly so.<sup>62</sup> Proponents of a pain-based exception to a general ban on assisted suicide might object to the latter method, claiming that suicide, rather than anesthetics which compromise consciousness, is the preferred means of alleviating pain and vindicating liberty. Yet such a response would transform the claim for a pain-based exception into another more far-reaching claim: that *compromised consciousness* resulting from pain medication should also comprise an exception to an assisted suicide ban. In the alternative, proponents might claim that the effi-

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59. To "suffer" is defined as "1: to undergo or feel pain or distress . . . 4: to endure pain, disability, death, etc., patiently or willingly." RANDOM HOUSE DICTIONARY 1901 (2d ed. 1987).

60. "Unbearable" is defined as "1: . . . unendurable; intolerable." RANDOM HOUSE DICTIONARY 2503 (2d ed. 1987).

61. Martin L. Smith et al., *A Good Death: Is Euthanasia the Answer?*, 59 CLEVELAND CLIN. J. MED. 99, 107 (1992) (citations omitted) ("[N]inety to ninety-nine percent of terminal cancer pain can be controlled with the use of hospice and palliative care units."); Michael H. Levy, *Medical Management of Cancer Pain*, in PRINCIPLES AND PRACTICE OF PAIN MANAGEMENT 235 (Carol A. Warfield, ed. 1993) (same); see also MEISEL, *supra* note 12, at 291. Even the Hemlock Society's staunch right-to-die advocate, Derek Humphry, concedes that "[o]nly a small percentage of terminal physical pain cannot be controlled today." DEREK HUMPHRY, LET ME DIE BEFORE I WAKE: HEMLOCK'S BOOK OF SELF-DELIVERANCE FOR THE DYING 76 (1984).

62. John V. Hartline, *Compassionate Alternatives for the Terminally Ill*, MICH. MED., Apr. 1993, at 26, 27 ("Nevertheless, use of inadequate amounts of pain medication has been implicated as the most significant form of 'drug abuse' in the care of the terminally ill.") (reporting on a Michigan State Medical Society study of alternatives to assisted suicide).

cacy of methods available to alleviate or abolish pain should not be taken into account in assessing what sort of pain should be present to warrant an exception. The same sort of considerations apply to a broader exception based on the apparent emotional and psychological components involved in "suffering."<sup>63</sup> If physical and psychological suffering is truly what proponents of assisted suicide so compassionately wish to alleviate, why do they categorically reject less drastic methods that might prove effective?<sup>64</sup>

Claims of "pain" and "suffering" have been viewed skeptically enough in the tradition of civil law, and for the good reason that both have inherently subjective natures.<sup>65</sup> To qualify either or both by requiring that they also be "unbearable," ostensibly limiting the scope of an exception, in fact exponentially increases their subjectivity. Who is to judge whether or what kind of pain or suffering is "unbearable" to another person? Asking the judiciary to create such an exception to a criminal law would invite it to fashion a garment sewn from scraps of reason as clothing for a concept of liberty that will quickly burst its seams. The Constitution warrants no such obligation.

## V. Physician Assistance

However arbitrarily the class eligible to assist in suicide might be described, most proponents describe the class eligible to assist as consisting of only physicians.<sup>66</sup> Even though physicians acknowledge a duty to respect the wishes of competent patients, physicians as a class reject any duty to participate in euthanasia, assisted suicide, or capital punishment as utterly inconsistent with their mission to "do no

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63. Tia Powell & Donald B. Kornfeld, *On Promoting Rational Treatment, Not Rational Suicide*, 4 J. CLIN. ETHICS 334, 334 (1993) ("Many health professionals fail to distinguish between clinical depression and an appropriately sad reaction to a poor prognosis. Such practitioners give no thought to specific treatment for the patient's depression, thinking, 'I'd be depressed, too!' However, it has been well documented that depression is a common consequence of severe medical illness."). Another writer adds, "[t]he common tendency for clinicians and laypersons to overlook the diagnosis of clinical depression when 'reasons' for experiencing a depressed mood are present often leads to the omission of psychotherapeutic and psychopharmacological treatment measures that might alleviate the severity of a depressive illness, alleviate functional impairment, and reduce suicide risk," and concludes that, "[t]he key problem is that stressful life events . . . distract the evaluator from recognizing the authenticity of a depressive illness. . . ." Clark, *supra* note 44 at 158-59 (citations omitted).

64. See *supra* notes 61, 63.

65. See generally FOWLER V. HARPER ET AL., THE LAW OF TORTS § 25.10 (2d ed. 1986).

66. See, e.g., HUMPHREY, *supra* note 2, at 133; Sedler, *supra* note 4, at 21.

harm.”<sup>67</sup> It is nevertheless presumed that physicians are especially qualified to help end life in the name of mercy rather than retribution—indeed, that they are constitutionally empowered to do so. Presumably, this professional requirement as an element of the right to assist in suicide has several purposes. Physicians are well-educated, respected members of society and are licensed by the state to care for the lives and health of others. Their expert opinions should be and are generally respected, and they are given some deferential weight by the courts.<sup>68</sup> Hence, it is implied that if a physician prescribes drugs knowing that a patient with certain other qualifications will ingest them and die as a result, then this should be especially deemed a constitutionally protected form of assisted suicide. On the other hand, by implication, if a friend provides the same drugs under the same circumstances—or worse, provides a gun with careful instructions on how to assure a quick, painless death—then the Constitution might properly permit punishment of the friend.

Some might also claim that an intimate, long-term physician-patient relationship should be a prerequisite to assisted suicide<sup>69</sup> or that the aesthetics of a lethal overdose compared to a gunshot wound<sup>70</sup> should be considered. How the requisite degree of intimacy or a stan-

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67. Initially, the AMA House of Delegates adopted a moderate policy against physician-assisted suicide, concluding that “the societal risks . . . [were] too great . . . to condone . . . assisted suicide at this time.” See Franklin G. Miller & John C. Fletcher, *The Case for Legalized Euthanasia*, 36 PERSPS. IN BIOLOGY & MED. 159, 163-68 (1993) (discussing the AMA’s COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, DECISIONS NEAR THE END OF LIFE (Report B) (1991)) (AMA policy against euthanasia and assisted suicide).

At its recent annual conference, however, the AMA House of Delegates adopted a strengthened policy of “unqualified opposition” to physician assisted suicide because such practice is “fundamentally inconsistent with the physician’s professional role.” See Brian McCormick, *Continued Opposition: House Refuses to Open Door on Physician-Assisted Suicide*, AM. MED. NEWS, Dec. 20, 1993, at 7; *AMA Rejects Assisted Suicide*, LIFE AT RISK, Dec. 1993, at 2.

The AMA’s position on physician participation in capital punishment is comparable. See AMA’s CODE OF MEDICAL ETHICS, CURRENT OPINIONS, Op. 2.06 (1992) (policy against capital punishment); Council on Ethical & Judicial Affairs, American Medical Association, *Physician Participation in Capital Punishment*, 329 NEW ENG. J. MED. 1346-50 (1993); Brian McCormick, *Ethics Panel Spells Out Physician Role in Executions*, AM. MED. NEWS, Dec. 28, 1992, at 6.

68. NATIONAL CENTER FOR STATE COURTS, GUIDELINES FOR STATE COURT DECISION MAKING IN LIFE-SUSTAINING MEDICAL TREATMENT CASES 89-93 (2d ed. 1992).

69. Timothy E. Quill et al., *Care of the Hopelessly Ill—Proposed Clinical Criteria for Physician-Assisted Suicide*, 327 NEW ENG. J. MED. 1380, 1382 (1992); Howard Brody, *Assisted Death—A Compassionate Response to a Medical Failure*, 327 NEW ENG. J. MED. 1384 (1992).

70. See HUMPHRY, *supra* note 61, at 58-59.

dard for the aesthetics of suicide might be adduced from the Constitution is anyone's guess.

Reliance on a medical model to justify a newly created liberty for assisted suicide closely tracks the abortion paradigm,<sup>71</sup> where stated medical data initially formed the basis to distinguish between first and second trimester abortions based on relative risk of abortion and childbirth to maternal life. This method permitted the state to require abortion to be performed in a hospital in the latter, but not the former, period of pregnancy.<sup>72</sup> Likewise, the determination of fetal viability is left to the physician who might perform the abortion and whose decision triggers whether or not the state might forbid the abortion unless it was deemed necessary to preserve maternal life or health<sup>73</sup>—criteria broadly defined and also within the decisionmaking authority of an attending physician.<sup>74</sup> Indeed, the entire “zone of privacy” carved out to secure the abortion liberty exists only within the boundary of physician practice and decisionmaking discretion: a non-physician who performs an abortion may be punished as though the abortion liberty was never recognized.<sup>75</sup> By analogy, proponents of physician assisted suicide apparently suggest that medical licensure ought also to establish the outer boundaries of an asserted liberty interest in assisted suicide.

Thus, suggested critical criteria that warrants assisted suicide—existence of a “terminal condition” or “unbearable suffering”—would turn upon medical expertise and discretion just as, in the context of abortion, fetal viability and whether or not an abortion is “necessary” to preserve maternal “health” turns on medical discretion. Moreover, only physicians would be empowered to assist in suicide. All others who did so could be punished since they would fall outside the constitutionally protected “zone” this liberty provides.

The medical model was deemed crucial to the abortion right in order to assure protection of maternal life and health during the course of the abortion. Obviously, however, in the context of assisted suicide the proposed medical model has nothing whatever to do with preservation of patient life or health. To the contrary, physician in-

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71. It also attempts to parallel, to some degree, the withholding/withdrawing of treatment cases, where reliance on medical testimony standards is often evident. See MEISEL, *supra* note 12, at 156, § 6.10.

72. See *Roe v. Wade*, 410 U.S. 113, 163 (1973).

73. See *id.* at 163-64.

74. See *id.* at 165-66; *Doe v. Bolton*, 410 U.S. 179, 191 (1973).

75. *Connecticut v. Menillo*, 423 U.S. 9, 11 (1975).



volvement is intended to assure that both life and the prospect of health should end.

### A. Potential State Interests in Physicians Assisting Suicide

The claim that only physicians should be involved in assisted suicide thus assumes the existence of very different potential "state interests" to justify imposing burdens on the "liberty" to assisted suicide. What might these be? Since no court has stated them, they can only be inferred.

First, there is a potential state interest in assuring completed suicide. Here, the physician is understood to be in full control of a prescriptive armory of a kind and quantity that will assure avoidance of an "incomplete" suicide, a feared potential consequence of an "unprofessional" attempt. Perhaps the state has an interest in assuring the death of criminals to be executed or foreign enemies in war, the only other imaginable contexts in which such an interest is manifest. But unless some state asserts an interest of this sort, it is impossible to see how the courts can even consider its validity in the present context, much less bestow on physicians a unique constitutional privilege to pursue it.

Second, there is a potential state interest in assuring that death will come in a "humane" and "dignified" fashion. Here, the physician is understood to have the expertise to assure painless death and, presumably, that death will not result in a gruesome scene—a "back alley" suicide. A patina of social respectability is also apparently added by virtue of physician participation. Of course, physicians (unlike veterinarians) have no special training in euthanasia and, at present, are subject to professional sanctions if they practice it.<sup>76</sup> Even so, physicians undoubtedly know how to cause presumably painless death by virtue of knowledge mastered on how to preserve life and alleviate pain. The medical model presumes that at least some physicians will be found willing to use and develop their expertise in such a fashion, defying professional ethics in service to a blitzkrieg of advancing constitutional doctrine. But again, no state has asserted such an interest or empowered the medical profession to use its expertise in such a way; there is no constitutional basis to bestow such a role on the medical profession.

Third, there is a potential state interest in physician involvement as expert gatekeepers who would make the threshold determinations

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76. See *supra* note 67 and accompanying text.

that presumably justify assisted suicide: the presence of a competent adult who has a "terminal condition" or "unbearable suffering." First, competency is a legal, not medical determination;<sup>77</sup> additionally, assigning this role to physicians assumes that "terminal condition" and "unbearable suffering" have some constitutionally admissible meanings. If they do not, as has been argued here, then physicians may ascribe any meaning to them that they please—and thus become both architects and engineers, or judges and executioners, of the right to assisted suicide. But even assuming that constitutionally-based definitions of these terms can be stated, physicians would necessarily need to be provided great latitude in interpreting them. In the absence of such latitude, a "right to physician assisted suicide" would march on, forever shadowed by potential imprisonment of the physician at every step. Yet in the presence of such latitude, the compelling state interest in the protection of human life and the explicit right to life of the person under the Constitution both become playthings of physician discretion.

The role of gatekeeper thus firmly sets the medical profession painfully astride the very fence that it is supposed to guard. But while placing the medical profession in such an awkward policy position as a matter of constitutional law is one thing, placing patients in abject doubt as to just what purpose—life or death—these professionals in fact will serve is quite another. Any consolation that those few who seek suicide may find medical professionals willing and able to ratify and to assist in completion of such a purpose is easily outweighed by the distrust and acute ambivalence engendered in the majority by assigning such a disparate role to an unwilling profession as a matter of constitutional law.

### **B. The Contradictions in Physicians Being Constitutionally Sanctioned to Provide Death**

Consideration of never-asserted state interests in the face of a speculative right to assisted suicide may seem remote, perhaps even grotesque. But it is necessarily implicit in the claim that physicians have a unique constitutional warrant to assist in suicide by virtue of some special talent to assure certain, quick, and painless death. Acceptance of such a claim would be entailed were the courts seduced into accepting the argument that physician assisted suicide is somehow constitutionally different than hiring a contract killer or securing drugs from a street-corner dealer to help accomplish the same purpose.

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77. See *In re Hamlin*, 689 P.2d 1372, 1381 (Wash. 1984) (Rosellini, J., dissenting).

At present, at least, the medical profession declines to assume the mantle of either public or private executioner in service to "state interests" in efficient and "humane" death. But even if the profession, or some of its members, is or becomes inclined to do so, it would be simply incredible to so construe the Constitution as to *specifically* permit physicians to operate within a "zone of privacy" to cause death, when the only reason to defer to the profession in the first place is its mission to preserve life and health. It makes as much constitutional sense to bestow a special prerogative on the medical profession to assist in self-killing as it would to bestow the prerogative of the healer on the military or the state executioner. In service to the constitutional and state interests in life, the medical profession is, in fact, the last class that ought to be granted such a privilege.

Of course, the sophisticated case for physician assisted suicide is not now stated so forthrightly, but rather seeks to mask its premises and necessary consequences. In particular, proponents of assisted suicide seek to exploit the potential conflict between the physician's dual roles of preserving life and providing relief from pain. They then impute to the Constitution a value that favors relief of pain and suffering over preservation of life, such that the physician who provides the former cannot be accused of failing to serve the latter when the two physician roles are in balance. Why one value should be so firmly placed over the other is not explained. The presumption is apparently based on the belief that a person is better off dead than in pain or suffering, a notion the courts are expected to accept on judicial notice.

No concrete caselaw has been offered to support the hypothetical fear that such a conflict has been realized in litigation. Beyond this, however, the Constitution strikes no balance between interests in pain relief and life-prolongation that would determine under what conditions anti-assisted suicide statutes are legitimate exercises of state authority.

Like pain relief, other medical purposes may be either used or abused by the medical profession. For example, chemotherapy may be used in attempt to cure cancer even with some other unintended risks to life or health. But the same chemicals might be prescribed in such amounts that they are known and intended to cause death. Presumably, even proponents of physician assisted suicide would disapprove of such a use of chemotherapy, even while they approve of the use of analgesics to cause death. Yet, on what constitutionally discernable basis would this dichotomy rest? Moreover, there is no cognizable difference between physician prescribed suicide on the pretext

of pain relief and suicide by weapon provided by another on the pretext of self-defense. It is impossible to see why the Constitution grants more or less latitude in one case or the other, unless it is presumed that relief of pain somehow has greater constitutional value than protection of one's very life against an unjust aggressor.

Whatever constitutional warrant physicians may have by virtue of service to state and constitutional interests in the preservation of human life, the proposal to stretch this warrant to include its opposite, which is efficient death, not only undercuts its rationale, but transmutes the nature of the medical profession itself. By necessary implication, physicians would henceforth be deemed either killers or curers, as the case may be, rather than those licensed only as guardians of material life—potentially guilty not only of the wrongful deaths of those whose lives they negligently served, but also of the “wrongful living” of those whose deaths they did not assure<sup>78</sup> and the “wrongful dying” of those whom they failed to dispatch in accord with some death aesthetic. Such is the result that flows when the Constitution is construed to pour the practice of death into the practice of medicine.

### Conclusion

The claim that there ought to be a constitutionally recognized liberty for physicians to “hasten inevitable death” by knowingly prescribing lethal drug doses for suicidal patients places its weight on a house of cards. The categories relied upon to construct its case—“rational” suicide, “terminal condition,” “unbearable suffering,” and physician assistance—either have no constitutional foundation, cannot even be described with any certainty, or both. Though perhaps the courts have the power to impute to the Constitution such a rag-tag right, they should at least recognize that to do so would be to accept the invitation of its proponents to indulge in result-oriented jurisprudence of the most transparent sort.

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78. Cf. *Anderson v. St. Francis-St. George Hospital*, 614 N.E. 2d 841 (Ohio App. 1 Dist. 1992) (denying cause of action for “wrongful living” for person resuscitated contrary to person's wishes).