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Beyond Washington v. Glucksberg: Oregon's Death with Dignity Act Analyzed from Medical and Constitutional Perspectives

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BEYOND WASHINGTON v. GLUCKSBERG: OREGON’S DEATH WITH DIGNITY ACT ANALYZED FROM MEDICAL AND CONSTITUTIONAL PERSPECTIVES

STEVEN B. DATLOF¹

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INTRODUCTION

Physician-assisted suicide. An oxymoron. The concept goes against the grain. It runs counter to thousands of years of understanding of the physician’s role, embodied in the timeless credo: “Do no harm.”² It runs counter to themes that

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²Although not actually included in the Hippocratic Oath, “the promise to do no harm, *Primum Non Nocere*, is irrevocably bound to the Hippocratic principle of the sanctity of human life.” C. Everett Koop, *Introduction*, 35 DUQ. L. REV. 1, 2 (1996).

pervade western philosophy and literature. As Alexander Pope said in 1733: "Hope springs eternal in the human breast."³ Somewhat more recently, Yogi Berra expressed the same sentiment in equally timeless fashion with the remark: "It ain't over til it's over."⁴

Yet, as medicine and technology continue to advance, public debate increasingly focuses on whether in some hopeless situations, there comes a time to acknowledge that "it's over."⁵ Between eighteen to thirty percent of physicians report that they have received requests from patients for help in dying.⁶ Thirty-six percent of physicians indicate that they would assist terminally ill suffering patients in ending their lives were it legal to render such aid.⁷

Currently, Oregon stands alone in allowing patient and physician to openly carry out such end-of-life decisions. The Oregon Death with Dignity Act (DWDA),⁸ passed by voter referendum in 1994 and re-approved in 1997, is the only American law that authorizes a physician to aid a terminally ill, competent patient in committing suicide.⁹ A similar referendum was defeated by Michigan voters in November 1999.¹⁰ At the national level, Congress is considering legislation to bar physicians from prescribing medication for the purpose of hastening a patient's demise.¹¹

While physician-assisted suicide (PAS) is thus being debated in the legislature and in the polling booth, it is also being debated in the courtroom. Laws legalizing PAS and those prohibiting it have been the subject of disputes. Courts have therefore considered the rights at issue from opposite vantage points. For example, in *Lee v. Oregon*,¹² a challenge to the DWDA that ultimately failed because the plaintiffs lacked standing, the question was whether a law allowing PAS infringes the constitutional rights of vulnerable individuals who might need protection from having assisted suicide imposed on them.¹³ However, in *Washington v. Glucksberg* and *Vacco v. Quill*, the question was whether laws prohibiting assisted suicide

³ALEXANDER POPE, *An Essay on Man*, in THE COMPLETE POETICAL WORKS OF POPE 139 (Henry W. Boynton ed., 1903).

⁴YOGI BERRA, THE YOGI BOOK 121 (1998).

⁵*Id.*

⁶Diane E. Meier, M.D. et al., *A National Survey of Physician-Assisted Suicide and Euthanasia in the United States*, 338 NEW ENG. J. MED. 1193, 1195 (1998).

⁷*Id.*

⁸OR. REV. STAT. §§ 127.800-127.897 (1997).

⁹Patrick M. Dunn, *The Oregon Experience*, 6 ANNALS LONG-TERM CARE 333, 333 (1998).

¹⁰Charlie Cain & Tim Kiska, *Voters Overwhelmingly Reject Assisted Suicide*, DETROIT NEWS (Nov. 4, 1998) <<http://www.detnews.com/1998/election/9811/04/11040198.htm>>; Gary Henlein, *Assisted Suicide Finally Before Voters: It's Just 1 Proposal of a Trio the People Get to Decide Nov. 3*, DETROIT NEWS, Aug. 31, 1998, at D1.

¹¹Sarah Kellogg, *Congress Set to Tackle Assisted Suicide Bill*, GRAND RAPIDS PRESS, Sept. 16, 1998, at A1.

¹²*Lee v. Oregon*, 107 F.3d 1382, 1387-90 (9th Cir. 1997).

¹³*Id.* at 1386.

violate the constitutional rights of terminally ill individuals seeking assistance in ending their lives.¹⁴

This Article examines several aspects of the medical and legal debate on physician-assisted suicide. Part I describes the Oregon Death with Dignity Act, the only existing American law legalizing physician assisted suicide. Understanding the provisions of the DWDA provides a concrete, practical framework for discussing the medical and constitutional issues central to the PAS debate.

Part II considers the wisdom of the DWDA in light of current medical knowledge and practice. The law allows a patient, with only a few months to live, a humane end to intolerable suffering under controlled conditions. It is carefully crafted to ensure that patient and physician deliberate about the decision over at least a fifteen-day period, thereby discouraging impulsive behavior. It renders unnecessary the occasional practice of using high doses of sedating medications putatively for palliative purposes, but with the covert, inadequately discussed purpose of hastening the patient's death.¹⁵ However, the DWDA does not sufficiently account for the complex motivations of patients requesting suicide. In addition, the statute does not fully consider the subtleties involved in differentiating clinical depression from expected sadness in terminally ill patients. In order to address these problems, the Oregon legislature should amend the DWDA to mandate that a psychiatrist must evaluate every patient who requests assistance to end his life.

Part III of this Article examines whether the DWDA passes constitutional muster in light of the Supreme Court's recent landmark decisions in *Glucksberg* and *Vacco*. Consistent with its prevailing federalism jurisprudence,¹⁶ the Court refrained from finding new fundamental liberty interests¹⁷ in order to allow the state legislatures to determine policy on assisted suicide. The same approach in a due process or equal protection challenge to the DWDA logically would lead the Court to conclude that the law does not infringe upon fundamental liberty interests. The appropriate test of DWDA's constitutionality, therefore, would be the lenient "rational basis" test.¹⁸ DWDA is rationally related to legitimate state interests. Under this test, the Court likely would uphold the Oregon statute.

To complete the analysis, Part III also considers how the DWDA would fare in the less likely event that the Court finds that a challenge to the law implicates fundamental liberty interests. In this case, the statute would be scrutinized more searchingly, and its survival would be less certain.

¹⁴Washington v. Glucksberg, 521 U.S. 702, 708-09 (1997); Vacco v. Quill, 521 U.S. 793, 796-97 (1997).

¹⁵This doctrine, known as "double intent," is explained further in notes 92-97 and accompanying text.

¹⁶See *infra* note 142 for a discussion of "federalism jurisprudence."

¹⁷See *infra* note 106 for discussion of the distinction between "fundamental rights" and "fundamental liberty interests."

¹⁸See *infra* notes 136-47 and accompanying text for a discussion of how the Court's restrained approach to finding new fundamental liberty interests would lead it to apply the rational basis test to the DWDA.

II. THE OREGON DEATH WITH DIGNITY ACT

The DWDA consists of six sections: General Provisions; Written Request for Medication to End One's Life in a Humane and Dignified Manner; Safeguards; Immunities and Liabilities; Severability; and Form of the Request.¹⁹

The General Provisions section consists of key definitions of words and phrases used in the Act.²⁰ Most importantly, the definition of "terminal disease" limits the availability of assisted suicide to a narrow group of patients—those with medically confirmed incurable, irreversible disease and a prognosis of less than six months to live.²¹

The first section also defines an "incapable" patient as one who "lacks the ability to make and communicate health care decisions to health care providers."²² Only an adult, Oregon resident able to make and communicate these decisions, and therefore deemed "capable" may request medication according to Section 2.²³ The patient must have a terminal disease as defined by Section 1; and this condition must have been diagnosed by an attending physician and confirmed by another physician.²⁴ Both physicians must agree that the patient is capable and has made the request voluntarily.²⁵

Two witnesses must also attest to the capability of the patient and the voluntary nature of the request.²⁶ Recognizing the pressures that terminal patients face, the statute requires that at least one witness must not be a family member, a person with an interest in the patient's estate, or a person connected with the health care facility where the patient is receiving treatment.²⁷ Moreover, the patient's attending physician may not be a witness.²⁸

The "Safeguards" section outlines the responsibilities of the attending and consulting physicians.²⁹ Either physician must refer the patient for "counseling" if the doctor believes the patient is "suffering from a psychiatric or psychological disorder, or depression causing impaired judgment."³⁰ Thus, not every patient is referred for counseling. Upon referral, a state licensed psychiatrist or psychologist counsels the patient.³¹ This mental health professional must determine that the

¹⁹OR. REV. STAT. §§ 127.800-127.897 (1997).

²⁰*Id.* § 127.800.

²¹*Id.*

²²*Id.*

²³§ 127.805.

²⁴*Id.*

²⁵§§ 127.815, 127.820.

²⁶§ 127.810.

²⁷*Id.*

²⁸*Id.*

²⁹§§ 127.815, 127.820.

³⁰§ 127.825.

³¹§ 127.800.

patient is free from mental illness causing impaired judgment before the patient receives medication for the purpose of suicide.³²

In order to minimize impulsive behavior, the DWDA specifies that a patient must make three requests, two oral and one written.³³ There must be a waiting period of at least fifteen days between the two oral requests.³⁴ After the written request, there is a forty-eight hour waiting period before a prescription may be written.³⁵ Immediately before writing the prescription, the physician must verify that the patient is making an informed decision.³⁶ That is, the patient must appreciate the relevant facts and the doctor must inform the patient of his diagnosis, prognosis, and the risks and probable result of taking the medication.³⁷ The patient also must be informed that he may rescind his request at any time.³⁸

Section 4 immunizes health care providers from liability if they have complied with the DWDA in good faith.³⁹ However, coercing or exerting undue influence on a patient to request medication for the purpose of suicide is defined as a Class A felony.⁴⁰

The sample form of the request requires only that the patient write his name and diagnosis in the appropriate blanks, initial next to the decision made by the patient about whether to inform family, and sign at the bottom of the form.⁴¹ The form indicates that the patient understands his diagnosis, prognosis, and the nature of his request.⁴² It also indicates that he understands that the outcome of the request will be to end his life “in a humane and dignified manner.”⁴³ This is reiterated later with the words: “I expect to die when I take the medication to be prescribed.”⁴⁴

III. THE DEATH WITH DIGNITY ACT IN LIGHT OF MEDICAL KNOWLEDGE AND PRACTICE

Physicians are trained to view suicidal ideation as a symptom of depression.⁴⁵ Indeed, to many psychiatrists, their job in treating suicidal patients is to help patients

³²§ 127.825.

³³§ 127.840.

³⁴*Id.*

³⁵§ 127.850.

³⁶§ 127.830.

³⁷§§ 127.830(7), 127.830.

³⁸§ 127.845.

³⁹§ 127.885.

⁴⁰§ 127.890.

⁴¹§ 127.897.

⁴²*Id.*

⁴³*Id.*

⁴⁴*Id.*

⁴⁵In the authoritative manual of psychiatric diagnosis, suicidal ideation is a cardinal symptom of a “Major Depressive Episode.” DSM-IV DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 327 (4th ed.,1994) [hereinafter DSM-IV]. The other major symptoms

make adjustments so that suicide no longer seems necessary.⁴⁶ Yet the DWDA contradicts these notions by reflecting the belief that some terminally ill patients who are not mentally ill may nevertheless wish to die.⁴⁷

The Act excludes patients “suffering from a psychiatric or psychological disorder, or depression causing impaired judgment” from participating in PAS.⁴⁸ This construction is ambiguous. Did the authors of the DWDA intend to exclude all patients with any psychiatric or psychological disorders, or did they mean to prevent access to PAS by only the subset of patients with disorders causing impaired judgment?⁴⁹ Had the authors intended to exclude all mentally ill patients with or without impaired judgment, the additional clause excluding patients with “depression causing impaired judgment” would be redundant. Moreover, studies support allowing patients with psychiatric conditions that do not impact on their decision-making processes, such as mild to moderate depression, to participate in PAS.⁵⁰ Excluding only patients with conditions that impair judgment, therefore, is medically sound in light of this research.

By specifically prohibiting patients with “depression causing impaired judgment” from participating,⁵¹ the DWDA reflects the understanding that depression is by far the most common psychiatric disorder affecting patients with suicidal thoughts.⁵² This clause also implicitly accepts that while some depressed patients have impaired judgment, in other depressed patients judgment remains intact. Therefore, depressed

are: depressed mood most of the day, nearly every day; markedly diminished interest in usual activities; significant weight loss; sleep disturbance; agitation or lethargy that is observable by others; loss of energy; feelings of worthlessness or guilt; and diminished ability to concentrate. *Id.* A patient must have at least five of these symptoms during the same two-week period for a physician to diagnose a Major Depressive Episode. *Id.*

⁴⁶Yeates Conwell & Eric D. Caine, *Rational Suicide and the Right to Die*, 325 NEW ENG. J. MED. 1100, 1101 (1991).

⁴⁷§ 127.825.

⁴⁸*Id.*

⁴⁹“Judgment may be defined as the mental activity of comparing or evaluating alternatives within the framework of a given set of values for the purpose of deciding on a course of action.” Martin B. Keller & Theo C. Manschreck, *The Biologic Mental Status Examination II: Higher Intellectual Functioning*, in *OUTPATIENT PSYCHIATRY DIAGNOSIS AND TREATMENT* 203, 209 (Aaron Lazare ed., 1979). Evaluation of judgment is a standard part of the mental status evaluation, and judgment is often impaired by significant mental illness. *Id.*

⁵⁰See Mark D. Sullivan & Stuart J. Youngner, *Depression, Competence, and the Right to Refuse Lifesaving Medical Treatment*, 151 AM. J. PSYCHIATRY 971, 974-77 (1994) (citing studies showing that the impact of mild to moderate depression on preferences concerning life-sustaining treatment in the elderly is limited, and arguing that the presence of psychiatric illness does not necessarily render a patient incompetent to make a decision about dying). See also Linda Ganzini et al., *The Effect of Depression Treatment on Elderly Patients’ Preferences for Life-Sustaining Medical Therapy*, 151 AM. J. PSYCHIATRY 1631, 1634-35 (1994) (finding that remission of mild to moderate depression did not result in an increase in the desire for life-sustaining medical treatment in elderly patients).

⁵¹§ 127.825.

⁵²See *infra* notes 58-61 and accompanying text for a discussion of the prevalence of depression in suicidal patients.

patients with intact judgment could be candidates for PAS. An alternative, albeit less likely, interpretation of this clause is that the DWDA considers all individuals with depression to have impaired judgment. Under this interpretation, if an individual's judgment is not impaired he could not be diagnosed as depressed, but rather, merely as experiencing sadness as part of the adjustment process. Such an interpretation, however, would be inconsistent with current psychiatric diagnostic classifications, which do not specifically require impaired judgment to diagnose a depressive disorder.⁵³ Regardless of which interpretation is correct, the DWDA appears to acknowledge the difference between sadness that often accompanies terminal illness, and clinical depression with impaired judgment that requires treatment.⁵⁴

A. Distinguishing Depression from Sadness

Controversy exists, however, about whether physicians can distinguish sadness from clinical depression in terminally ill patients who are suicidal. In one study of 200 terminally ill patients, 17 (8.5%) acknowledged a pervasive desire to die.⁵⁵ Of these 17 potential candidates for PAS, researchers diagnosed 10 patients (58.8%) with depressive syndromes.⁵⁶ Thus, 7 patients (42.2%) who wished to end their lives were not suffering from "clinical" depression,⁵⁷ and might be appropriate for PAS.

Other studies, however, suggest that nearly all suicidal patients suffer from psychiatric disorders. In a study cohort of 44 terminally ill patients, 10 subjects expressed suicidal ideation.⁵⁸ Researchers diagnosed all 10 suicidal patients as severely depressed.⁵⁹ A British study retrospectively reviewed 100 suicides.⁶⁰ A panel of three psychiatrists reviewing information about these suicides diagnosed 93 of the 100 patients as mentally ill, and 70 patients as depressed.⁶¹ Some authors have extrapolated from the high percentage of mental illness in patients who commit suicide to suggest that the percentage of mental illness would be similar in patients requesting PAS.⁶² This reasoning overlooks the possibility that two populations of

⁵³See *supra* note 45 for the diagnostic criteria for a Major Depressive Episode.

⁵⁴DSM-IV differentiates periods of sadness that "are inherent aspects of the human experience" from a Major Depressive Episode. DSM-IV, *supra* note 45, at 326.

⁵⁵Harvey Max Chochinov et al., *Desire for Death in the Terminally Ill*, 152 AM. J. PSYCHIATRY 1185, 1187 (1995).

⁵⁶*Id.*

⁵⁷*Id.*

⁵⁸James Henderson Brown et al., *Is It Normal for Terminally Ill Patients to Desire Death?*, 143 AM. J. PSYCHIATRY 208, 210 (1986).

⁵⁹*Id.*

⁶⁰B. Barraclough et al., *A Hundred Cases of Suicide: Clinical Aspects*, 125 BR. J. PSYCHIATRY 355, 356 (1974).

⁶¹*Id.* at 356, 358.

⁶²See Herbert Hendin & Gerald Klerman, *Physician-Assisted Suicide: The Dangers of Legalization*, 150 AM. J. PSYCHIATRY 143, 143 (1992) (citing studies indicating that 95% of those who commit suicide have a diagnosable psychiatric illness as a reason to be wary of legalizing PAS). *But see* Linda Ganzini et al., *Attitudes of Patients with Amyotrophic Lateral Sclerosis and Their Care Givers Toward Assisted Suicide*, 339 NEW. ENG. J. MED. 967, 969-70

patients differ significantly. A patient who wishes to go through a carefully regulated process of consultations in order to legally end his life may be quite different from a patient who unilaterally decides to commit suicide despite legal and societal proscriptions. Moreover, in the British study the patients were a randomly selected sample of patients who committed suicide for any reason.⁶³ The authors did not mention if any of the study patients were terminally ill.⁶⁴

Current diagnostic criteria for depression further complicate difficulties in distinguishing depression from sadness in terminal suicidal patients. The fact that suicidal thinking is one of the cardinal criteria for depression confounds efforts to determine the relationship of suicidal thoughts to depression.⁶⁵ Other symptoms of depression such as weight loss, decreased appetite, fatigue, insomnia, and loss of energy are also common symptoms of terminal medical illness.⁶⁶ Despite these caveats, a 1997 study concluded that the distinction could be made very simply.⁶⁷ The authors found that by merely asking a patient: "Are you depressed?" they were able to identify every patient diagnosed with a depressive disorder using more complicated screening tools.⁶⁸ Other researchers suggest that the distinction between sadness and clinical depression may be more subtle,⁶⁹ primary care physicians may not be adequately skilled to recognize the difference,⁷⁰ and more research and standards are needed to guide physicians evaluating depression in the terminally ill.⁷¹

B. Assessing the Meaning of the Request for Suicide: The Need for Mandatory Psychiatric Evaluation

The question of whether a terminal patient may wish to commit suicide but not be clinically depressed is part of the larger debate about whether a patient's request for assistance in committing suicide can ever be rational. Physicians who work with

(1998). The authors found that while 56 of 100 patients with Amyotrophic Lateral Sclerosis said they would consider assisted suicide, only 11 of these 100 patients had a major depressive disorder. *Id.* Moreover, there was no difference in the prevalence of depression between those patients who would consider assisted suicide and those who would not. *Id.* at 969.

⁶³Barraclough, *supra* note 60, at 355.

⁶⁴*Id.* at 356, 358.

⁶⁵Brown, *supra* note 58, at 208.

⁶⁶*Id.* at 208-09.

⁶⁷Harvey Max Chochinov et al., "Are You Depressed?" *Screening for Depression in the Terminally Ill*, 154 AM. J. PSYCHIATRY 674, 675 (1997).

⁶⁸*Id.*

⁶⁹Conwell, *supra* note 46, at 1101; *see also* Ann Alpers & Bernard Lo, *Physician-Assisted Suicide in Oregon: A Bold Experiment*, 274 JAMA 483, 484 (1995) (discussing the difficulties in distinguishing sadness from clinical depression).

⁷⁰Conwell, *supra* note 46, at 1101; *see also* Susan D. Block & J. Andrew Billings, *Patient Requests for Euthanasia and Assisted Suicide in Terminal Illness: The Role of the Psychiatrist*, 36 PSYCHOSOMATICS 445, 448 (1995) (suggesting that primary care physicians are rarely adequately trained to differentiate sadness from depression).

⁷¹Timothy E. Quill et al., *The Debate Over Physician-Assisted Suicide: Empirical Data and Convergent Views*, 128 ANNALS INTERNAL MED. 552, 553 (1998).

terminal patients emphasize the importance of carefully exploring the possible meanings contained in a request to die.⁷² A patient may ask to die because of intractable pain for which better palliative care might be available if the patient made his needs known directly.⁷³ A request for suicide may be an expression of unconscious feelings of rage or guilt.⁷⁴ Or it may be a way of gaining control in a situation where the patient feels he has no control over his life.⁷⁵

Even a careful exploration of the meanings of a patient's request to die will not yield an easy answer about the appropriateness of the request. Physicians hold extremely strong convictions about PAS based on their fundamental values, religious, and philosophical beliefs.⁷⁶ This can lead the well-meaning physician to conclude that a request is rational if she believes that PAS is an acceptable option, or irrational if she is opposed to PAS.⁷⁷ Supporters of PAS emphasize that it is justified only in exceptional circumstances, for the small number of patients who will not respond to the best palliative care.⁷⁸ In such situations, the physician needs to decide whether the request for PAS is truly in keeping with the patient's values, and whether it is a truly informed, autonomous decision.⁷⁹

While the DWDA provides that the attending or consulting physician may refer a patient for counseling with a state licensed psychiatrist or psychologist,⁸⁰ the Oregon legislature should amend the statute to mandate that a psychiatrist must evaluate every patient who requests assistance to end his life.⁸¹ As explained above, this change is needed because of concern in the medical community about the difficulty in understanding the complex meanings of the patient's request for suicide, as well

⁷²Philip R. Muskin, *The Request to Die: Role for a Psychodynamic Perspective on Physician-Assisted Suicide*, 279 JAMA 323, 324-26 (1998).

⁷³Block & Billings, *supra* note 70, at 447; Muskin, *supra* note 72, at 325.

⁷⁴Muskin, *supra* note 72, at 324-26.

⁷⁵*Id.* at 324.

⁷⁶See Quill, *supra* note 71, at 556 (advising that physicians should not violate their fundamental values in the provision of care to the terminally ill).

⁷⁷See Sullivan, *supra* note 50, at 976-77 (opining that the wide variability in values with respect to life and death makes it difficult for a physician to objectively evaluate a patient's request to die).

⁷⁸Quill, *supra* note 71, at 556-57.

⁷⁹*Id.* at 74.

⁸⁰§ 127.825.

⁸¹Ezekiel J. Emanuel, *Oregon's Physician-Assisted Suicide Law. Provisions and Problems*, 156 ARCHIVES INTERNAL MED. 825, 827-28 (1996). Compare 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) (recommending psychiatric evaluation when uncertainty exists about the patient's judgment, but stopping short of suggesting such an evaluation should be mandatory for all patients considering PAS), with William Breitbart et al., *Interest in Physician-Assisted Suicide Among Ambulatory HIV-Infected Patients*, 153 AM. J. PSYCHIATRY 238, 242 (1996) (arguing that the "critical role" of psychiatric intervention in terminal illness is highlighted by findings that HIV-infected patients' interest in PAS is more a function of psychological distress than physical factors).

as because of the difficulty in distinguishing depression from appropriate sadness. Moreover, the psychiatrist should be someone with special expertise in helping terminally ill patients make end-of-life decisions.⁸²

C. Waiting Period

The DWDA is specific in addressing the issue of how long a patient must wait before a request for medication will be honored. The physician may not prescribe medication until at least fifteen days after the patient's initial request.⁸³

The purpose of this waiting period is two-fold: to allow the attending and consulting physicians adequate time to evaluate the patient, and to allow the patient time to reflect on his decision. One study raised concerns regarding the likelihood of the patient having a change of heart in this time period.⁸⁴ Six terminal patients who expressed persistent wishes to die were re-interviewed two weeks later.⁸⁵ In four of the six situations, the desire to die had significantly lessened.⁸⁶ While the study sample is obviously quite small, the results indicate that the question of the stability over time of suicidal ideation in terminal patients needs further investigation. In what percent of suicidal terminally ill patients will the ideation remain unchanged after one month? On the other hand, when a patient only has six months to live and is suffering throughout that time, how long is it fair to make the patient wait? The issue is complicated even further when the attending physician orders counseling before approving a patient's request for assisted suicide. The statute gives no guidelines about whether the mental health professional should treat the patient for a minimum time period before he may "clear" the patient for assisted suicide.

Ultimately, physicians must rely on their medical judgment to answer these questions. An attending physician who knows her patient well, having treated the patient through the course of the illness, will be able to make better decisions about the transience or impulsiveness of the request than a physician seeing the patient for the first time.⁸⁷ For this reason, critic Ezekiel Emanuel denigrates the Oregon law

⁸²The Dutch government has recently established, on a trial basis, a special team of doctors with special expertise in euthanasia to provide second opinions for primary care physicians in cases of possible euthanasia. *Minister Borst: Landelijk Network Euthanasie-artsen [Minister Borst: Nationwide Network of Euthanasia Doctors]*, NIEUWSSERVICE VAN RADIO NEDERLAND WERELDOMROEP [RADIO NETHERLANDS NEWS SERVICE] (Oct. 26, 1998) <<http://www.rnw.nl/>>. This pilot program has been enthusiastically received by doctors in Amsterdam, and the Minister of Health now supports establishing a nation-wide network of euthanasia consultants. *Id.* The need for such a program in a country with years of experience with PAS and euthanasia highlights the importance of having doctors expert in end-of-life decision-making involved in the process.

⁸³§ 127.850.

⁸⁴Chochinov, *supra* note 55, at 1189.

⁸⁵*Id.*

⁸⁶*Id.*

⁸⁷See James P. Farrell, Letter to the Editor, *Deciding Life and Death in the Courtroom: Debate and Clarification*, 279 JAMA 1259, 1259 (1998) (highlighting the importance of an ongoing relationship with a trusted family physician in reaching the best end-of-life decisions).

for not requiring that the patient make the request for PAS to her own personal physician.⁸⁸ Such a requirement, however, would broach complex questions about how to define an acceptable patient-physician relationship. For example, how many patient visits would be required before a doctor becomes the patient's "personal physician?" In addition, the DWDA would then also need to include special rules to handle the situation of a patient referred by a doctor who is morally opposed to PAS to one willing to participate in the process.

Emanuel raises the specter of doctors advertising their willingness to perform PAS, thus attracting patients whose requests were denied on careful consideration by their own physicians.⁸⁹ These fears exaggerate the danger of Oregon becoming an assisted suicide "mill." As of January, 1999, only fifteen to twenty terminally ill Oregonians have ended their lives under the provisions of the law.⁹⁰ Supporters of the DWDA argue that the small number of assisted suicides in the fourteen months since the law took effect proves that its safeguards are sufficient to prevent abuse.⁹¹

D. Clear Intent vs. "Double Intent"

According to Timothy Quill, M.D., physicians and patients sometimes engage in mutual deception and unclear decision making in end-of-life decisions because of the illegality of PAS.⁹² Dr. Quill points out that "double effect" laws are used as a substitute for PAS.⁹³ Under the doctrine of "double effect" or "double intent," a physician may give a terminally ill suffering patient high doses of sedating medication for the purpose of palliation – knowing that an "unintended" result may be to hasten the patient's death.⁹⁴ Quill argues, persuasively, that legalizing PAS allows patient and doctor to have open, in-depth discussions about what is happening to the patient, how the patient is experiencing the process of dying, and what options are open to him.⁹⁵ The informed decision that can result from this dialogue is far better than the superficial process of prescribing sedating medication ostensibly to

⁸⁸Ezekiel, *supra* note 81, at 827.

⁸⁹*Id.*

⁹⁰Michael Vitez, *Oregon Assisted-Suicide Law Little Used but Well Regarded*, PHILADELPHIA INQUIRER, Jan. 19, 1999, at A1.

⁹¹*Id.* at A1, A6. Some who opposed the DWDA when it became law now have either changed their minds or become more muted in their criticism. *Id.* at A6. For example, John F. Tuohy, a Catholic priest in charge of health care ethics for Oregon's Catholic hospital network, acknowledges that the DWDA is "being implemented thoughtfully and carefully." *Id.* The head of the Oregon Hospice Association now asserts that the law is "working well." *Id.*

⁹²Timothy E. Quill, Letter to the Editor, *The Oregon Death With Dignity Act*, 332 NEW ENG. J. MED. 1174, 1175 (1995).

⁹³*Id.*

⁹⁴Timothy E. Quill et al., *The Rule of Double Effect – A Critique of its Role in End-of-Life Decision Making*, 337 NEW ENG. J. MED. 1768, 1768 (1997); *see also*, Robert Schwartz & Katherine Watson, *Physician-Assisted Suicide*, 6 ANNALS LONG-TERM CARE 71, 72 (1998).

⁹⁵Quill, *supra* note 92, at 1175.

help the patient “live better,” even though death is the result.⁹⁶ Indeed, the openness fostered by PAS statutes such as Oregon’s DWDA should actually protect “vulnerable” patients from outcomes they truly may not desire. This contrasts sharply with the typical characterizations of the Oregon law as posing risks for vulnerable individuals.⁹⁷

IV. CONSTITUTIONAL ANALYSIS OF OREGON’S DEATH WITH DIGNITY ACT

The United States Supreme Court has not yet decided a case challenging a law legalizing physician assisted suicide, such as the DWDA. Proponents of PAS have argued that by recognizing that a patient has a right to refuse life-sustaining treatment in *Cruzan v. Director, Missouri Department of Health*,⁹⁸ the Court also essentially recognized the “right to die with dignity” that is the crux of the issue in PAS.⁹⁹ However, in *Washington v. Glucksberg*¹⁰⁰ and *Vacco v. Quill*,¹⁰¹ the Court recently upheld laws banning assisted suicide. In so doing, the Court distinguished the “constitutionally protected” right to refuse life-sustaining treatment recognized in *Cruzan*¹⁰² from a right to assisted suicide, which the Court declined to countenance.¹⁰³ This result does not necessarily mean that the Court would strike down the DWDA. The challenges in *Glucksberg* and *Vacco* to statutes criminalizing assisted suicide failed because the statutes did not violate constitutionally protected rights of the challengers.¹⁰⁴ The statutes were therefore evaluated according to the lenient rational basis level of review, and the Court found that they met this standard.¹⁰⁵ Similarly, the success of a challenge to the Oregon law would depend on whether the Court finds that the law violates fundamental rights or liberty interests of plaintiffs desiring protection from assisted suicide. How the Court frames the rights at issue will determine whether the DWDA is reviewed under the rational basis standard, under the more exacting “strict scrutiny” test, or under an intermediate

⁹⁶*Id.*

⁹⁷Ezekiel, *supra* note 81; *see also* Peter M. McGough, *Medical Concerns About Physician-Assisted Suicide*, 18 SEATTLE U. L. REV. 521, 527-28 (1995) (arguing based on data from the Netherlands that safeguards in the Oregon statute may prove ineffective to protect vulnerable individuals). *But see* Vitez, *supra* note 90, at A6 (arguing that greater openness in Oregon regarding end-of-life decisions has resulted in an improvement in palliative care for terminal patients).

⁹⁸497 U.S. 261 (1990).

⁹⁹William J. Tarnow, *Recognizing a Fundamental Liberty Interest Protecting the Right to Die: An Analysis of Statutes Which Criminalize or Legalize Physician-Assisted Suicide*, 4 ELDER L.J. 407, 409 (1996).

¹⁰⁰521 U.S. 702 (1997).

¹⁰¹521 U.S. 793 (1997).

¹⁰²*Glucksberg*, 521 U.S. at 722-23.

¹⁰³*Id.* at 728.

¹⁰⁴*Id.*; *Vacco*, 521 U.S. at 799.

¹⁰⁵*Glucksberg*, 521 U.S. at 728; *Vacco*, 521 U.S. at 799-800.

level of scrutiny.¹⁰⁶ Much can be divined about how the Court will frame the rights in question from the Court's decisions in *Glucksberg* and *Vacco*.

A. *Implications of Cruzan v. Director, Missouri Department of Health for the Death With Dignity Act*

A young, non-terminally ill patient was at the center of the controversy in the first "right to die" case considered by the Supreme Court.¹⁰⁷ At the age of 25, Nancy Beth Cruzan was severely injured in an automobile accident and left in a persistent vegetative state.¹⁰⁸ After several years in this condition, her parents sought discontinuation of the tube feedings that kept her alive.¹⁰⁹ The Missouri trial court acceded to the parents' wishes, but the Missouri Supreme Court reversed this decision.¹¹⁰ Missouri's highest court held that Nancy Cruzan's prior statements did not demonstrate by the required clear and convincing evidence that she preferred death to existence in a vegetative state.¹¹¹

While the Supreme Court affirmed the Missouri ruling regarding the necessary evidence of intent in the case of an incompetent patient,¹¹² the Court did establish a right to die for competent individuals under certain circumstances.¹¹³ This decision sparked a vociferous debate on the precise nature of the established right, a debate that continued in the years between *Cruzan* and *Glucksberg*.¹¹⁴

Contrary to what some scholars had predicted, the *Cruzan* Court did not extend the constitutional right of privacy developed in *Griswold v. Connecticut*¹¹⁵ and *Roe v. Wade*¹¹⁶ to right to die cases.¹¹⁷ In his majority opinion, Chief Justice Rehnquist

¹⁰⁶See Kathleen McGowan, *Physician Assisted Suicide A Constitutional Right?*, 37 CATH. LAW. 225, 232-33 (1997). The author points out that recent Supreme Court cases have discussed substantive due process rights in terms of a "liberty interest" in addition to using the traditional "fundamental right" analysis. *Id.* While a law that impinges on a liberty interest must survive heightened scrutiny, the level of scrutiny may be intermediate, rather than strict. *Id.*

¹⁰⁷Thomas Wm. Mayo, *Constitutionalizing the 'Right to Die,'* 49 MD. L. REV. 103, 104 (1990).

¹⁰⁸*Cruzan*, 497 U.S. at 266.

¹⁰⁹*Id.* at 267.

¹¹⁰*Id.* at 268.

¹¹¹*Id.* at 268-69.

¹¹²*Id.* at 283-84.

¹¹³*Id.* at 286 (finding that a state may "choose to defer" to the wishes of a competent patient to end her life if the state's evidentiary standard for intent is met).

¹¹⁴See Lawrence O. Gosdin, *Deciding Life and Death in the Courtroom From Quinlan to Cruzan, Glucksberg, and Vacco—A Brief History and Analysis of Constitutional Protection of the 'Right to Die,'* 278 JAMA 1523, 1523 (1997) (discussing the distinction between the right to die and the right to refuse medical treatment, and arguing that subsequent cases have shown that *Cruzan* stands for the latter principle).

¹¹⁵381 U.S. 479 (1965).

¹¹⁶410 U.S. 113 (1973).

formulated the issue not as the right to die, but as the “right to refuse unwanted medical treatment.”¹¹⁸ He then explicitly stated that this right does not come under the rubric of a “generalized constitutional right of privacy.”¹¹⁹ Rather, the majority viewed the right to refuse treatment as a Fourteenth Amendment liberty interest derived from the common law doctrine of informed consent.¹²⁰ This doctrine is rooted in the more specific right to protect one’s bodily integrity from unwanted intrusions.¹²¹

B. *The Glucksberg Court Clarifies Cruzan*

Because *Cruzan* was a 5-4 decision,¹²² and because of changes in Court membership,¹²³ uncertainty persisted regarding how the Court would apply the liberty interest recognized in *Cruzan* to assisted suicide. Three of the *Cruzan* dissenters (Justices Brennan, Marshall, and Blackmun) argued for a constitutionally protected right to die with dignity.¹²⁴ The fourth dissenter, Justice Stevens, more specifically linked the right to die with the right to privacy: “The failure of Missouri’s policy to heed the interests of a dying individual with respect to matters so private is ample evidence of the policy’s illegitimacy.”¹²⁵

By the time *Glucksberg* was decided, however, Justice Stevens was the lone *Cruzan* dissenter still on the Court.¹²⁶ All of the *Cruzan* majority, by contrast, remained, with the exception of Justice White.¹²⁷ Of the newcomers, only Justice Breyer explicitly formulated the right at issue in assisted suicide as the right to die with dignity.¹²⁸ Thus the tenuous *Cruzan* majority became a solid majority in *Glucksberg*.

The *Glucksberg* Court confidently reiterated that *Cruzan* did not recognize a right to die, but, merely a “constitutionally protected right” to refuse medical treatment.¹²⁹

¹¹⁷Mayo, *supra* note 107, at 109-10.

¹¹⁸*Cruzan*, 497 U.S. at 277-78.

¹¹⁹*Id.* at 279.

¹²⁰*Id.* at 278.

¹²¹Gosdin, *supra* note 114, at 1524.

¹²²*Cruzan*, 497 U.S. at 263-64.

¹²³See *infra* notes 126-28 and accompanying text for a discussion of changes in Court membership subsequent to *Cruzan*.

¹²⁴*Cruzan*, 497 U.S. at 302 (Brennan, J., dissenting).

¹²⁵*Id.* at 351 (Stevens, J., dissenting).

¹²⁶Justices Brennan, Marshall, and Blackmun retired in 1990, 1991, and 1994 respectively. GERALD GUNTHER & KATHLEEN M. SULLIVAN, CONSTITUTIONAL LAW app. at B-6 (13th ed. 1997).

¹²⁷*Id.* Justice White retired in 1993.

¹²⁸*Glucksberg*, 521 U.S. at 790 (Breyer, J., concurring).

¹²⁹*Id.* at 722-23. Chief Justice Rehnquist used the term “constitutionally protected right” to indicate that the right to refuse medical treatment did not rise to the level of a fundamental right. See Paul S. Kawai, *Should the Right to Die be Protected? Physician Assisted Suicide and Its Potential Effect on Hawaii*, 19 U. HAW. L. REV. 783, 788, 791-93 (1997). The author

This assumption allowed the Court to find that the right in *Cruzan* was a completely different right, analyzed in a different fashion, than the liberty interests at stake in PAS.

C. The Facts of Washington v. Glucksberg

The subject of the controversy in *Glucksberg* was a Washington statute that made assisting a suicide attempt a felony punishable by up to five years' imprisonment and up to a \$10,000 fine.¹³⁰ Three terminally ill patients, four physicians who treat terminally ill patients, and a Washington non-profit organization, Compassion in Dying, that counsels patients considering assisted suicide challenged the law.¹³¹ The plaintiffs asserted that the statute violated a fundamental liberty protected by the due process clause of the Fourteenth Amendment.¹³² They defined this fundamental liberty interest as the "right to choose a humane, dignified death."¹³³

D. Due Process Implications of Glucksberg for the Death With Dignity Act

While the Court upheld the Washington law prohibiting assisted suicide,¹³⁴ this does not mean that the Court would strike down a law permitting assisted suicide. Through both the overall tone of the majority and concurring opinions, and through explicit statements, the six justices who wrote opinions made it clear that the point of the *Glucksberg* decision was to promote debate on assisted suicide, not to end it.¹³⁵

For this reason, Chief Justice Rehnquist, in the majority opinion, emphasized the need to carefully formulate the liberty interest at issue.¹³⁶ He noted that the Court's traditional reluctance "to expand the concept of substantive due process" stems from a realization that finding a particular right or liberty interest deserves constitutional protection places "the matter outside the arena of public debate and legislative

reviews the Court's use of a balancing test in *Cruzan* to weigh the liberty interest of the patient against the state's interests. *Id.* Had the Court viewed the right at issue as a "fundamental" right, the Missouri regulation would have been measured according to the strict scrutiny standard. *Id.* at 791-92.

¹³⁰*Glucksberg*, 521 U.S. at 707.

¹³¹*Id.* at 707-08.

¹³²*Id.* at 708.

¹³³*Id.* at 722.

¹³⁴*Id.* at 705-06.

¹³⁵*Id.* The discussion that follows describes the pro-debate stances of Chief Justice Rehnquist and Justices O'Connor and Souter. Justice Ginsburg concurred "substantially for the reasons stated by Justice O'Connor." *Id.* at 789 (Ginsburg, J., concurring). Justice Stevens would not "foreclose the possibility that an individual plaintiff seeking to hasten her death . . . could prevail in a more particularized challenge." *Id.* at 750 (Stevens, J., concurring). Chief Justice Rehnquist indicated his agreement with Justice Stevens on this point by quoting him in his majority opinion. *Id.* at 735. Justice Breyer opined that the Court might have to revisit its conclusions in these cases "in a situation where there was no mechanism for the patient to receive appropriate palliative care." *Id.* at 792 (Breyer, J., concurring).

¹³⁶*Glucksberg*, 521 U.S. at 722-23.

action.”¹³⁷ Justice O’Connor agreed with this sentiment, opining that the legislature, through the “democratic process,” should define the rights of terminally ill patients to make end-of-life decisions.¹³⁸

Interestingly, Justice Scalia made the same point seven years earlier in his concurring opinion in *Cruzan*.¹³⁹ He argued that the States and the legislature, not the federal courts, should decide whether to honor patients’ end-of-life decisions.¹⁴⁰ Regarding PAS, he elaborated that the States are free to decide that “it is none of the State’s business if a person wants to commit suicide.”¹⁴¹ Thus Justice Scalia’s federalism jurisprudence approach in *Cruzan* has become the dominant approach in *Glucksberg*.¹⁴²

The Court refused to formulate broadly the right at issue in the challenge to the Washington law as the “right to die with dignity.”¹⁴³ Instead, Chief Justice Rehnquist delineated the right narrowly, as the “right to commit suicide which itself includes a right to assistance in doing so.”¹⁴⁴

Based on a historical analysis of law and tradition in America, the Court concluded that “the asserted ‘right’ to assistance in committing suicide is not a fundamental liberty interest protected by the Due Process Clause.”¹⁴⁵ Therefore, the Washington law only needed to withstand the rational basis test, rather than strict or intermediate level scrutiny, in order to be upheld.¹⁴⁶ The *Glucksberg* Court easily found that the law was rationally related to legitimate governmental interests.¹⁴⁷

¹³⁷*Id.* at 720.

¹³⁸*Id.* at 737 (O’Connor, J., concurring). See Katherine C. Glynn, *Turning to State Legislatures to Legalize Physician-Assisted Suicide for Seriously Ill, Non-Terminal Patients After Vacco v. Quill and Washington v. Glucksberg*, 6 J.L. & POL’Y 329, 348 (1997) (concluding that the *Glucksberg* Court decided that “if the right to physician-assisted suicide is to be established, it must be done by a state legislature and not the Court”).

¹³⁹*Cruzan*, 497 U.S. at 293 (Scalia, J., concurring).

¹⁴⁰*Id.* (Scalia, J., concurring).

¹⁴¹*Id.* at 299-300 (Scalia, J., concurring).

¹⁴²See Richard E. Coleson, *The Glucksberg and Quill Amicus Curiae Briefs: Verbatim Arguments Opposing Assisted Suicide*, 13 ISSUES L. & MED 3, 45-46. The author described the Court’s “federalism jurisprudence” as embodying respect for state sovereignty and the power of the people to govern their own affairs according to the Tenth Amendment. *Id.* at 45. Coleson argued that the Court should reverse the Ninth Circuit’s expansion of substantive due process in *Glucksberg* because this expansion “strikes at the very heart of this Court’s federalism jurisprudence.” *Id.* at 46-47.

¹⁴³*Glucksberg*, 521 U.S. at 722-23.

¹⁴⁴*Id.* at 723.

¹⁴⁵*Id.* at 728. The Court used the term “fundamental liberty interest” rather than “fundamental right.” *Id.* Had the Court found a fundamental liberty interest but not a fundamental right implicated, the Court might have used intermediate scrutiny to review the Washington law. See *supra* note 106. Since neither was implicated, rational basis review is all that was necessary. *Id.*

¹⁴⁶*Glucksberg*, 521 U.S. at 728.

¹⁴⁷*Id.* at 728-35.

The precise definition of the liberty interest at issue thus was a crucial aspect of the *Glucksberg* analysis. This question would similarly be a crucial part of the analysis of a challenge to Oregon's DWDA.¹⁴⁸ Defining the interest at stake in a restrained, narrow fashion would be consistent with the tone and specifics of *Glucksberg*. While the plaintiffs might frame their attack as a claim that the Act violates a constitutionally protected "right to live," the Court probably would reject this for the same reasons that it rejected the "right to die" as the liberty interest at stake in *Glucksberg*. Rather, a formulation more likely not to foreclose public and legislative debate would be whether a terminal patient has a fundamental right "to be protected from inadequately monitored assisted suicide."

Once the Court reached this narrow formulation of the right, it would then need to determine whether the right to be protected from inadequately monitored assisted suicide is a fundamental right or liberty interest. If the Court concluded that this liberty interest is not fundamental, the Oregon law, like the Washington statute in *Glucksberg*, would then be evaluated under the rational basis test.¹⁴⁹ Certainly the *Glucksberg* Court indicated that the DWDA could survive this level of scrutiny.¹⁵⁰ The government has a legitimate interest in protecting terminal patients from great pain and unnecessary suffering.¹⁵¹ The DWDA is rationally related to this interest.¹⁵²

The *Glucksberg* Court's reasons for concluding that the right to assisted suicide is not a fundamental liberty interest apply equally well to the analysis of rights asserted by those seeking protection from assisted suicide. As discussed above, the Court has indicated that it wants to promote, rather than stifle debate on end-of-life decision making. It has also stated that the legislature, not the courts, should be setting policy in this realm. The Court has acknowledged that refraining from expanding the concept of substantive due process by defining new fundamental rights serves these interests. Thus, the Court would not find a fundamental liberty interest in the right to be protected from assisted suicide.

¹⁴⁸See Jonathan R. Rosenn, *The Constitutionality of Statutes Prohibiting and Permitting Physician-Assisted Suicide*, 51 U. MIAMI L. REV. 875, 898 (1997) (pointing out, prior to the *Glucksberg* decision, that "even if no constitutionally protected right to assisted suicide exists, state legislatures may be free to pass laws creating such a right . . . provided the state created right does not impinge upon other constitutionally protected interests").

¹⁴⁹*Glucksberg*, 521 U.S. at 728 (reviewing the requirement that laws intersecting with non-fundamental liberty interests must pass the rational basis test).

¹⁵⁰*Id.* at 716 (recognizing that advances in medicine and technology are causing increased focus on the need to protect "dignity and independence at the end of life").

¹⁵¹Justice O'Connor sees "double intent" laws as legitimately protecting terminal patients from great suffering. *Id.* at 736-37 (O'Connor, J., concurring).

¹⁵²See Rosenn, *supra* note 148, at 882. Rosenn lists governmental policy considerations that provide a rational basis for PAS. *Id.* These are: "the interest in ending needless pain and suffering for those with diseases that offer no chance of recovery;" that government has an interest in assisting suicide to prevent patients from attempting to kill themselves on their own and potentially failing, causing serious injury that further worsens their quality of life; that society has an interest in distributing scarce and costly medical resources to those who want to live and to those who have a reasonable chance of recovery.

Justice Souter's concurring opinion highlighted the extent to which the Justices are willing to defer to state legislatures' decisions about PAS.¹⁵³ On the one hand, Justice Souter expressed concerns about protecting vulnerable individuals and about avoiding the "slippery slope" to euthanasia.¹⁵⁴ However, he asserted: "How, and how far, a State should act in that interest are judgments for the State."¹⁵⁵ Moreover, he predicted that, in light of the *Glucksberg* decision, state legislatures will continue to experiment with PAS laws; furthermore, he encouraged such experimentation.¹⁵⁶ Thus Justice Souter clearly subscribes to the federalist approach of supporting the prerogative of individual states to make their own laws permitting or prohibiting PAS; and, he is unlikely to limit this prerogative by finding a fundamental right or liberty interest on either side of the controversy.

The *Glucksberg* Court's treatment of "double intent" laws provides further evidence that the Court would uphold the DWDA.¹⁵⁷ Washington has a double intent law allowing a physician to treat a terminal patient in great pain with sedating medication with the understanding that such treatment may also hasten the patient's death.¹⁵⁸ Justices O'Connor and Breyer reasoned that the presence of such a law mitigated the need to find a fundamental right to assisted suicide.¹⁵⁹ Either Justice might have dissented if Washington had no double intent law. Given their approval of double intent and concern with the rights of suffering terminal patients, neither Justice would be likely to find that the DWDA violates a fundamental right or liberty interest.

Thus far the constitutional analysis of a due process challenge to the Oregon statute has assumed that the Court would define the right at issue narrowly and would conclude that it is not fundamental. To complete the due process analysis, we must also consider the less likely scenario that the Court might deem protection from PAS a fundamental right or liberty interest.

Chief Justice Rehnquist's historical analysis of assisted suicide in western democracies provides support for this conclusion.¹⁶⁰ The Chief Justice argued that western societies have disapproved of, and sometimes criminalized, assisted suicide for more than 700 years.¹⁶¹ In the United States, he noted that bans on assisted suicide express "the States' commitment to the protection and preservation of all human life."¹⁶²

¹⁵³*Glucksberg*, 521 U.S. at 787-88 (Souter, J., concurring).

¹⁵⁴*Id.* at 785-87 (Souter, J., concurring).

¹⁵⁵*Id.* at 787 (Souter, J., concurring).

¹⁵⁶*Id.* at 788-89 (Souter, J., concurring).

¹⁵⁷*Id.* at 736-37 (O'Connor, J., concurring), 791 (Breyer, J., concurring).

¹⁵⁸*Id.* at 791 (Breyer, J., concurring).

¹⁵⁹*Id.* at 736-37 (O'Connor, J., concurring), 791 (Breyer, J., concurring). See *supra* notes 91-96 and accompanying text for a discussion of why double intent is an inadequate substitute for PAS.

¹⁶⁰*Glucksberg*, 521 U.S. at 710-11.

¹⁶¹*Id.* at 711.

¹⁶²*Id.* at 710.

If the Court establishes a fundamental right to be protected from PAS, the DWDA would then have to survive strict scrutiny in order for it to withstand a constitutional challenge.¹⁶³ A State would need to show that the law is narrowly tailored to advance a compelling state interest.¹⁶⁴ Given the concerns raised in *Glucksberg* about depressed or incompetent individuals being considered for PAS,¹⁶⁵ the Court might conclude that the DWDA is not narrowly tailored enough to meet the strict scrutiny test. The *Glucksberg* Court, in references to the Oregon law, specifically acknowledged concerns about whether the safeguards in the law are sufficient to protect vulnerable individuals.¹⁶⁶ Under this analysis, the lack of mandatory psychiatric evaluation might prove fatal to the statute.

If the Court establishes a fundamental liberty interest to be protected from PAS, instead of a fundamental right, the Court might subject the DWDA to intermediate level scrutiny.¹⁶⁷ This test involves balancing the challenger's interests and the state's interests.¹⁶⁸ State interests in preventing suffering of the terminally ill, in preventing suffering of patients who fail in private attempts to commit suicide, and in allocating scarce medical resources¹⁶⁹ outweigh the hypothetical harm postulated by those attacking the Oregon statute.¹⁷⁰ Thus the DWDA would survive intermediate scrutiny.

E. *The Facts of Vacco v. Quill*

The *Glucksberg* Court reached its decision to uphold the Washington anti-PAS statute through a due process analysis.¹⁷¹ Because the Ninth Circuit did not reach the issue of equal protection, the Supreme Court also did not consider this issue.¹⁷² The Court did consider the equal protection analysis in *Vacco v. Quill*,¹⁷³ a case decided contemporaneously with *Glucksberg*. Moreover, in *Lee v. Oregon*, the challengers claimed that the DWDA violated their equal protection rights.¹⁷⁴ While the Ninth

¹⁶³Kawai, *supra* note 129 at 791; McGowan, *supra* note 105.

¹⁶⁴Kawai, *supra* note 129 at 791.

¹⁶⁵*Glucksberg*, 521 U.S. at 730-31.

¹⁶⁶*Id.* at 717 (citing *Lee v. Oregon*, 891 F. Supp. 1429 (D. Or. 1995), *vacated*, 107 F.3d 1382 (9th Cir. 1997), as raising the question of the sufficiency of the safeguards).

¹⁶⁷See McGowan, *supra* note 106 (discussing the uncertainty regarding whether the Court scrutinizes a law impinging on a fundamental "liberty interest" with intermediate level, or strict scrutiny).

¹⁶⁸See Kawai, *supra* note 129, at 791-93.

¹⁶⁹See *supra* note 152 for further discussion of governmental interests promoted by statutes permitting PAS.

¹⁷⁰See *Lee*, 107 F.3d at 1389 (rejecting the challenge to the Oregon statute because the plaintiffs' assertion of harm was too hypothetical to give them standing).

¹⁷¹*Glucksberg*, 521 U.S. at 710.

¹⁷²*Id.* at 709.

¹⁷³521 U.S. at 793.

¹⁷⁴891 F. Supp. at 1431.

Circuit rejected this challenge because of the plaintiffs' lack of standing,¹⁷⁵ such a challenge could eventually warrant consideration on a substantive basis.

In *Vacco*, the plaintiffs challenged a New York law prohibiting PAS as violative of equal protection.¹⁷⁶ The complaint asserted that the law unfairly distinguished between two similarly situated groups: terminally ill patients experiencing great suffering who wanted assistance in ending their lives but were denied this assistance, and those patients who differed from the first group only by virtue of requiring life-sustaining treatment to continue living.¹⁷⁷ Under New York law, members of the second group were allowed to end their lives by refusing or ending life-sustaining treatment, but the first group members were required to continue living.¹⁷⁸

F. Equal Protection Implications of Vacco v. Quill and Lee v. Oregon for the Death With Dignity Act

The *Vacco* Court first addressed the question of whether this classification infringed a fundamental right or involved a suspect classification.¹⁷⁹ Finding that the distinction did neither of these things, the Court only subjected the law proscribing PAS to rational basis level of scrutiny, rather than strict scrutiny.¹⁸⁰ The Court then asserted that "the distinction between assisting suicide and withdrawing life-sustaining treatment, a distinction widely recognized and endorsed in the medical profession and in our legal tradition, is both important and logical; it is certainly rational."¹⁸¹ New York's reasons for recognizing this distinction were easily viewed as serving legitimate ends.¹⁸² The Court therefore upheld the New York law.¹⁸³

A law legalizing PAS, however, would not distinguish between terminally ill patients and terminally ill patients on life-support, because both groups would have access to PAS. The challengers to the DWDA in *Lee v. Oregon* therefore simply raised the issue of whether the statute discriminates between terminally ill and non-terminally ill individuals.¹⁸⁴ The plaintiffs argued that this classification was not rationally related to a legitimate state interest.¹⁸⁵

The Oregon District Court agreed with the plaintiffs that the DWDA failed the rational basis test.¹⁸⁶ The court, therefore, was able to invalidate the law without considering whether a fundamental liberty interest was implicated in the equal

¹⁷⁵*Lee*, 107 F.3d at 1389-90.

¹⁷⁶*Vacco*, 521 U.S. at 797-98.

¹⁷⁷*Id.* at 798.

¹⁷⁸*Id.*

¹⁷⁹*Id.* at 799.

¹⁸⁰*Id.* at 799-800.

¹⁸¹*Id.* at 800-01.

¹⁸²*Vacco*, 521 U.S. at 808-09.

¹⁸³*Id.* at 809.

¹⁸⁴*Lee*, 891 F. Supp. at 1431.

¹⁸⁵*Id.*

¹⁸⁶*Id.* at 1438.

protection analysis. The analysis of the court, however, is based on a flawed application of the rational basis test that would not be followed by the Supreme Court.

The trial court first accurately enunciated the rational basis standard, noting that a statute is presumed valid if it “is rationally related to a legitimate State interest.”¹⁸⁷ Moreover, the court acknowledged that the rational basis standard defers to the judgment of the legislature by not requiring that the legislators articulate the rationale for a classification, nor must the state produce evidence to support the rational basis.¹⁸⁸ The court then listed the state interests promoted by the DWDA, and made no effort to dispute the legitimacy of these interests.¹⁸⁹ These interests included preventing unnecessary pain and suffering of terminally ill persons, preserving the right of competent adults to make critical health care decisions, avoiding “tragic cases” of “less humane,” possibly unsuccessful suicides, and protecting the terminally ill and their families from financial hardship.¹⁹⁰

Despite having made a case for the DWDA being rationally related to several legitimate state interests, the court held that the law failed the rational basis test.¹⁹¹ In reaching this conclusion, the court was actually balancing the interests of the terminally ill against those of the state.¹⁹² Such a standard is closer to intermediate level scrutiny than rational basis.¹⁹³ The *Lee* court reasoned that vulnerable terminally ill patients are entitled to the same protections from committing suicide that non-terminally ill patients receive.¹⁹⁴ Thus, these interests outweighed the state’s interests in allowing assisted suicide.

To apply heightened scrutiny to an equal protection claim a court must find that the classification drawn by the statute either “implicates a fundamental liberty interest”¹⁹⁵ or “targets a suspect class.”¹⁹⁶ The distinction between terminally ill and non-terminally ill patients is not one of the suspect classifications identified by the Supreme Court.¹⁹⁷ Moreover, the earlier discussion showed that the Court is unlikely to find that a due process challenge to a law permitting PAS implicates a fundamental right or liberty interest. The Court similarly is not likely to find a fundamental interest at issue in an equal protection challenge. The DWDA would

¹⁸⁷*Id.* at 1431.

¹⁸⁸*Id.*

¹⁸⁹*Id.* at 1434.

¹⁹⁰*Lee*, 891 F. Supp. at 1434.

¹⁹¹*Id.* at 1438.

¹⁹²*Id.* at 1433-34.

¹⁹³*See Kawai, supra* note 129, at 791-93 (discussing the balancing of interests in intermediate level scrutiny).

¹⁹⁴*Lee*, 891 F. Supp. at 1438.

¹⁹⁵*Id.* at 1432.

¹⁹⁶*Vacco*, 521 U.S. at 799.

¹⁹⁷*See Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 440 (1985) (listing race, alienage, and national origin as suspect classifications calling for a heightened standard of review).

therefore also be evaluated for equal protection purposes under a true rational basis test, and it would survive this level of review.

V. CONCLUSION

Oregon's DWDA provides a mechanism to bring the most serious end-of-life decisions out into the open. It should promote honest, in-depth discussion of these issues between patient and physician. In so doing, it should raise the level of end-of-life care received by patients. This process is far superior to the physician providing sedating medication with "double intent," without patient and physician overtly having arrived at a decision to hasten the patient's death.

The myriad meanings of a patient's request to end his life must be fully explored before medication is prescribed. Is better palliative care needed? Would the patient change his mind about suicide with counseling, an improved support system, or treatment for depression? Or is the patient's choice "rational," and not a by-product of a depressive disorder? While the patient should discuss these issues with her own physician, the issues are too complex to be decided without the help of a mental health specialist. A psychiatrist, preferably one expert in end-of-life care, should evaluate every patient requesting assisted suicide. The DWDA should be thus amended by the Oregon legislature.

This is not to say that the DWDA lacks provisions to safeguard the welfare of patients. The requirement of a second opinion consultation prevents an idiosyncratic physician from foisting his views on vulnerable patients, and enhances the likelihood that the decision will represent a mainstream medical opinion. The fifteen-day waiting period provides the patient with an opportunity to change his mind, and consequently deters impulsive behavior. Counseling by a psychiatrist or psychologist, though not required in every case, is mandatory when a question of depression is raised. While not perfect, many aspects of the DWDA are medically sound.

This Article has demonstrated that the DWDA is constitutionally sound as well. The Supreme Court probably would find that the law comports with constitutional requirements of due process and equal protection. In keeping with its decisions in *Glucksberg* and *Vacco*, the Court likely would define the rights asserted by challengers to the DWDA narrowly, as non-fundamental liberty interests. The statute would therefore be evaluated under the permissive rational basis constitutional standard. The Court has shown great willingness to allow the states to determine their own policies regarding end-of-life decision making through debate and legislation. Thus, the State of Oregon's determination that the DWDA rationally promotes the legitimate governmental interest of preventing unnecessary suffering of terminally ill individuals likely would be accepted by the Court.

Consistent with the philosophies of both Alexander Pope and Yogi Berra, upholding the DWDA would acknowledge that while "hope springs eternal,"¹⁹⁸ there still sometimes comes a time to acknowledge that "it's over."¹⁹⁹

¹⁹⁸POPE, *supra* note 3, at 139.

¹⁹⁹BERRA, *supra* note 4, at 121.