

UNITED STATES LEGAL ASPECTS OF EUTHANASIA

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I. INTRODUCTION

Active euthanasia as practiced in the Netherlands is not legally permissible anywhere in the United States. A large majority of states make assisting in suicide a crime, whether the assistance is by a physician or anyone else. Although state courts and the U. S. Supreme Court have long held that a competent patient may refuse necessary lifesaving treatment, only one state has legalized physician-assisted suicide. And the Supreme Court has held that patients do not have a constitutional right to physician-assisted suicide. Courts are loath to use the word “euthanasia”

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in discussing right-to-die issues, referring instead to a right to hasten one's death or other phrases less pejorative than the term euthanasia.

II. AUTONOMY & PRIVACY

“Autonomy” can be understood by terms such as “self-rule”, “self-determination”, “self-government”, and “independence”.¹ For clarity, we should distinguish autonomy from privacy. As can be seen from the Supreme Court's use of “privacy” to mean “autonomy”, there is an overlap between the two concepts. Autonomy “has nothing to do with privacy in the ordinary sense (a liberty to enjoy one's solitude unwitnessed, unintruded upon, even unknown about in certain ways); but it is central to the constitutional doctrine of privacy-as-autonomy”.² It has been argued that the right to privacy is a plea for the right to misrepresent oneself to others.³ The distinction between autonomy and privacy is easier to express than that of their relationship. Perhaps the concept of privacy simply recognizes how we value autonomy, *i. e.*, our willingness to respect the privacy of an individual is a result of the value we place on autonomy. When a person says, “it's none of your business”, we recognize his right of autonomy by agreeing with him, *i. e.*, the grant of privacy. One aspect of autonomy that is especially relevant in the medical context is the autonomy of one's body. The law recognizes and protects such bodily autonomy in tort. Without consent, a simple unconsented to touching may constitute battery. In the early history of medical malpractice, lack of informed consent to surgery was often pleaded as battery.⁴ Bodily

1 Feinberg, Joel, “Autonomy, Sovereignty, and Privacy: Moral Ideals in the Constitution?”, 58 *Notre Dame L. Rev.*, 445 y 446, 1983.

2 *Ibidem*, at 485.

3 Epstein, Richard E., “The Legal Regulation of Genetic Discrimination: Old Responses to New Technology?”, 74 *Boston U. L. R.*, vol. 1, 12, 1994.

4 *Mohr v. Williams*, 104 N. W. 12 (Minn. 1905).

autonomy may also be violated by withholding requested treatment rather than by imposing treatment against one's will, but clearly the starting point is that a competent person has the decision making authority.⁵ Autonomy encompasses far more than mere bodily autonomy. The most basic autonomy-right is the right to choose how to live one's life, particularly in the area of critical life-decisions such as religion, marriage, procreation, career, personal values, etc.⁶ Autonomy has become institutionalized in American culture.⁷ Our liberal tradition exalts "separation, autonomy, individuation and natural rights" and equates "maturity... with personal autonomy".⁸

Consider also the comment from Justice Marshall in *Kelly v. Johnson*,⁹ "the values of privacy, self-identity, autonomy, and personal integrity [are those] I have always assumed the Constitution was designed to protect". Issues associated with privacy and autonomy originally focused on the individual's right to be left alone by the government, but have extended to our thinking about relationships with each other.¹⁰ One commentator said the phrase "it's none of your business" is as important to our vocabulary as "it's a free country".¹¹ Autonomy carries with it the idea that in making choices, one is aware of the foreseeable consequences and assumes responsibility for such consequences that flow to him from his voluntary choices.¹²

5 Feinberg, Joel, *op cit.*, nota 1, at 453.

6 *Ibidem*, at 454.

7 Kephart Cipriani, Jean, "The Limits of the Autonomy Principle: Refusal of Life-Sustaining Medical Treatment for Incompetent Persons", 22 *Hofstra L. Rev.*, 703, 1994.

8 *Ibidem*, at 704.

9 *Kelly v. Johnson*, 425 U. S. 238, 251 (1976) (Marshall, J., dissenting).

10 Kephart Cipriani, Jean, *op. cit.*, nota 7, at 704.

11 Kreimer, Seth F., "Sunlight, Secrets and the Scarlet Letters: The Tension Between Privacy and Disclosure in Constitutional Law", 140 *U. Pa. L. Rev.*, 1, 71, 1991.

12 Feinberg, Joel, *op. cit.*, nota 1, at 481.

III. PATIENT'S RIGHT TO REFUSE MEDICAL TREATMENT

1. *Wons v. Public Health Trust*

Moving forward one's death by refusing medical attention is sometimes referred to as "passive" euthanasia to be distinguished from "euthanasia", a term that describes the hastening of one's death done willingly and by the act of another.¹³ Several cases have involved a person's refusal to consent to lifesaving treatment, and the patient's right to refuse such treatment has been upheld by the courts.

In *Wons v. Public Health Trust*,¹⁴ the Florida Supreme Court considered whether a competent adult has a lawful right to refuse a life-saving blood transfusion. Plaintiff Norma Wons entered Jackson Memorial Hospital (operated by the Public Health Trust of Dade County) with dysfunctional uterine bleeding. Doctors informed her that she would require treatment in the form of a blood transfusion, or in all probability she would die. Mrs. Wons, a practicing Jehovah's Witness and mother of two minor children, declined the treatment on grounds that to receive blood from outside her own body would violate her religious principles. At the time, Mrs. Wons was conscious and able to make an informed decision about her treatment.

The Health Trust petitioned the circuit court to force Mrs. Wons to undergo a blood transfusion. At the hearing, Mrs. Wons's husband testified that he fully supported his wife's decision to refuse treatment and that, in the unfortunate event she were to die, their two children would be cared for by Mr. Wons and Mrs. Wons's mother and brothers. Nevertheless, the court granted the petition and ordered the hospital doctors to administer the blood transfusion. This was done while Mrs. Wons was unconscious. The trial judge reasoned that minor children have a right to be

13 "The Right to Die", 7 *Houston L. Rev.*, 654, 1970.

14 *Wons v. Public Health Trust*, 541 So. 2d 96 (Fla. 1989).

reared by two loving parents, a right that overrides a mother's rights of free religious exercise and privacy.

Upon regaining consciousness, Mrs. Wons appealed. The Florida Supreme Court analyzed an individual's right to refuse medical treatment in terms of their decision in *Satz v. Perlmutter*¹⁵ a case that established four criteria wherein the right to refuse medical treatment may be overridden by a compelling state interest. These factors are preservation of life, protection of innocent third parties, prevention of suicide, and maintenance of the ethical integrity of the medical profession.¹⁶ The court noted that these factors are by no means a "bright-line test" capable of resolving every dispute regarding the refusal of medical treatment. Rather, these factors are intended to be considered in making the difficult decision of when a compelling state interest overrides the basic constitutional rights of privacy and religious freedom. The court held that the state's interest in maintaining a two-parent home for the benefit of minor children does not override Mrs. Wons's constitutional rights of privacy and religion.¹⁷

The primary state interest advanced in this case, the protection of innocent third parties, has its basis in the doctrine of *parens patriae*, and seeks to prevent the abandonment of minor children.¹⁸ There would be no abandonment in this case. The testimony showed that in the event of Mrs. Wons's death, the father, with the aid of relatives, would care for her two minor children.¹⁹ Perhaps the most important state interest is the preservation of life. Should a favorable medical prognosis affect the state's interest? Is the state's interest in preservation of life less where chances of recovery are low? In principle, the court might recognize "quality of life" concerns, but the court here

15 *Satz v. Perlmutter*, 379 So. 2d 359 (Fla. 1978), aff'd 362 So. 2d 160 (Fla. 4th DCA 1980).

16 362 So. 2d, 160, 162.

17 *Wons v. Public Health Trust*, 541 So. 2d 96, 98.

18 *Satz v. Perlmutter*, 362 So. 2d, 160, 162.

19 *Wons v. Public Health Trust*, 541 So. 2d 96, 98.

said that a favorable prognosis does not mean that the state has an automatic right to intervene. Mrs. Wons could not return to a normal life, since receiving a blood transfusion is a serious sin for a Jehovah's Witness. The "cost" to the patient, whether economic, emotional, or spiritual must be viewed from the patient's perspective.²⁰ The remaining two *Perlmutter* state interests are the duty to prevent suicide and the maintenance of the ethical integrity of the medical profession. *Wons* is not a suicide case, since Mrs. Wons does not desire to die. Rather, she has chosen not to live, since living would require the violation of her religious beliefs. If the patient should die because no blood transfusion is administered, her death would be of natural causes, not suicide. Judge Ehrlich said that the ethical integrity of the medical profession is not seriously impaired under the facts of this case since existing medical mores recognize the right to refuse treatment in "appropriate cases", and that it is not necessary to deny the patient's right of self determination to recognize the interests of health care providers. Also, informed consent and the right of privacy have as foundations the right to bodily integrity and control of one's fate, and therefore, such rights are superior to concerns of maintaining the ethical integrity of the medical profession.²¹

2. *Cruzan v. Harmon*²²

Nancy Beth Cruzan was injured in an automobile accident on January 11, 1983. She was found in a ditch without detectable respiratory or cardiac function, but the paramedics were able to restore her breathing and heartbeat. She was transported to a hospital. Her neurosurgeon diagnosed a cerebral contusion complicated by the lack of oxygen (anoxia). Cruzan progressed to an

20 *Wons v. Public Health Trust*, 541 So 2d, 96, 100.

21 *Ibidem*, at 101.

22 *Cruzan v. Harmon*, 760 S.W. 2d 408, 411 (Mo. 1988) (en banc), aff'd sub nom. *Cruzan v. Director*, Mo. Dep't of Health, 110 S. Ct. 2841 (1990).

unconscious state and a gastrostomy feeding and hydration tube was implanted. For eight years, she remained in a persistent vegetative state. She retained motor reflexes but almost no cognitive function, although she could perhaps feel pain. Her medical condition was as follows: *a*) she did not require artificial life support to maintain respiration or circulation; *b*) her only responses to the environment were reflexive ones to sound and perhaps pain; *c*) she had suffered anoxia of the brain and cerebral cortical atrophy, a condition that was irreversible, permanent, progressive, and ongoing; *d*) her cognitive brain function was limited to her grimacing, perhaps in response to pain and sound; *e*) she was a spastic quadriplegic; *f*) all four of her extremities were contracted with irreversible damage, and *g*) she had neither cognitive nor reflexive ability to swallow food or water to maintain her daily needs.

However, Cruzan was not terminally ill. And according to experts she could have lived for another thirty years with the State of Missouri paying for her care.²³ Her parents sought and obtained a court order to have nutrition and hydration withdrawn. The Missouri Supreme Court later reversed the order. The court held there was no clear and convincing evidence that Cruzan would have wanted her life-sustaining treatment withdrawn. The court said her parents could not exercise “substituted judgment” since they could not comply with the formalities of Missouri’s living will statute.²⁴ The court held that the State of Missouri had a clear interest in preserving life, but that “the state’s interest is not in quality of life... [w]ere quality of life at issue, persons with all manner of handicaps might find the state seeking to terminate their lives. Instead, the state’s interest is in life; that interest is unqualified”.²⁵

23 S. E. Seicshnaydre, “Cruzan v. Director, Missouri Department Of Health: Discerning The Possibilities And The Limitations Of An Incompetent’s Exercise Of The Right To Refuse Treatment”, 65 *Tul. L. Rev.*, 1289, 1991.

24 Cruzan, 760 S.W.2d 408, 425.

25 *Ibidem*, at 420.

3. *Cruzan v. Director*²⁶

In *Cruzan v. Director*, the decision was affirmed by the U. S. Supreme Court which held that the U. S. Constitution does not forbid the “clear and convincing” evidence standard required under Missouri law. The Court also concluded that the Missouri Supreme Court’s finding that the evidence did not show clear and convincing proof of Cruzan’s desire to have hydration and nutrition removed was constitutional. Further, the due process clause does not require that a state accept the “substituted judgment” of family members without adequate proof that their views in fact reflect those of the patient.²⁷ The due process clause protects two separate interests, *i. e.*, *a*) an interest in life, and *b*) an interest in refusing medical treatment. Also, Missouri may seek to safeguard an individual’s personal choice between life and death by imposing a heightened evidentiary standard.²⁸

There were two dissents in the case. Justice Brennan argued that Cruzan possessed a fundamental right under the Constitution to be free of unwanted nutrition and hydration and that her right was not outweighed by any state interest. He felt that Missouri’s “procedural obstacles” impermissibly burdened the exercise of her right.²⁹ In his dissenting opinion, Justice Stevens found that Missouri only had an “abstract, undifferentiated interest in the preservation of life”. The Constitution therefore required the state to respect Cruzan’s “own best interests” which arguably would be satisfied by allowing her guardians to exercise her right to refuse medical treatment.³⁰

After the Supreme Court rendered its decision, the Cruzan family went back to the Probate court to present new evidence

26 *Cruzan v. Director*, Missouri Department of Health, 110 S. Ct. 2841, 1990.

27 *Idem*.

28 *Ibidem*, at 2852 y 2853.

29 *Ibidem*, at 2864 (Brennan, J., dissenting).

30 *Ibidem*, at 2879 (Stevens, J., dissenting).

from three of Cruzan's co-workers who all testified that Cruzan had previously said she would never want to live "like a vegetable". The state of Missouri withdrew from this action, and with a specific finding that the evidence was "clear and convincing" the Cruzan's were finally able to obtain an order to remove the nutrition and hydration tube. Cruzan's court-appointed guardian did not contest the matter. Nancy Cruzan died on December 26, 1990.³¹

IV. ADVANCE DIRECTIVES

As a result of the ruling in *Cruzan v. Director*, mechanisms for documenting a competent person's choice about terminating life-sustaining treatment became popular. Many states enacted statutes that provided for advanced medical directives including living wills and durable powers of attorney for health care.³² Congress responded by enacting The Patient Self-Determination Act of 1990³³ ("the Act"). The Act requires health care providers to furnish information to patients regarding advance medical directives, institutional protocols, and current state laws. The information describes the patient's right to refuse medical treatment in accordance with state law, whether statutory or case law. Further, the health care provider must outline its policies for respecting the patient's advance directives.³⁴ After providing the required advance directives information to the patient, the health care provider is required to document whether the patient has executed an advance directive. There have been a number of

31 Seicshnaydre, *65 Tul. L. Rev.*, 1289, 1301.

32 Salatka, Michael A., "The Patient Self-Determination Act of 1990: Issues Regarding the Facilitation of Advance Directives, Patient Autonomy, Assisted Suicide, and Euthanasia", *1 J. Pharmacy & Law*, 155, 1992.

33 Pub. L. No. 101-508, 4206, 104 Stat. 291 (1990). The Patient Self-Determination Act amends the Social Security Act's provisions on Medicare and Medicaid. Social Security Act 1927, 42 U. S.C. 1396, 1990.

34 Salatka, *op. cit.*, nota 32, at 157.

criticisms of the Act. The Act does not help clarify cases where a patient has not executed an advance directive, even in emergency situations where the victim cannot be admitted to a health care institution. Also, the Act does not alter state laws preventing a patient from refusing medical treatment, e. g., a patient who is not “terminally ill” under Illinois law cannot be certain his advance directive will be honored.³⁵ Even though her death (or life) was a strong factor in passing the legislation, the Act would not have helped Nancy Cruzan since she had not executed an advance directive.

Advance directives are usually living wills or durable powers of attorney. All fifty states have enacted a living will statute that allows competent individuals to exercise their right to refuse health care prior to their own incompetency. A large majority of states have also enacted durable powers of attorney statutes. As an alternative or addition to a living will, individuals may formulate advance directives by appointing an agent or proxy a durable power of attorney for health care under state law. The agent is authorized to perform certain acts or make authoritative decisions about medical treatment.³⁶

V. PHYSICIAN-ASSISTED SUICIDE

“Ending of the life of another in order to end that patient’s suffering is usually referred to as active euthanasia (or mercy killing) or, depending on the mechanism by which death occurs, assisted suicide”.³⁷ There are important differences between assisted suicide and active euthanasia. For example, active euthanasia could involve a physician injecting a patient with a lethal dose of barbiturates. Alternatively, the physician could merely prescribe a lethal dose of barbiturates, and allow the patient to

35 *Ibidem*, at 158.

36 *Ibidem*, at 159.

37 Meisel, Alan, *The Right to Die*, vol. 2, 1995, p. 482.

perform the injection. In the latter case, the physician would arguably be assisting the patient to commit suicide. The legal and moral distinction between assisted suicide and active euthanasia arises because the patient has the final control and “is the last human agent in bringing about death”.³⁸ Even with this distinction, assisting another in suicide is a crime in a large majority of states either by statute or common law (whether committed by a physician or anyone else).³⁹

The U. S. Supreme Court has recognized a basic constitutional “right to privacy”, but the name of the right is perhaps misleading. The right is more suggestive of a domain within which an individual’s choice must be respected, *i. e.*, a “sovereign personal right of self-determination”.⁴⁰ The Court has recognized the right of privacy in a number of cases involving rights of marital autonomy, abortion, heterosexual intimacies, contraceptives, and child-rearing.⁴¹ The right covers “only personal rights that can be deemed ‘fundamental’ or ‘implicit in the concept of ordered liberty.’ This privacy right encompasses and protects the personal intimacies of the home, the family, marriage, motherhood, procreation, and child-rearing...”⁴² Two cases have addressed the constitutionality of statutory prohibitions against assisted suicide. *Compassion in Dying* considered whether such statutes violate the due process clause of the Fourteenth Amendment which provides that a person may not be “deprived of life, liberty or property without due process of law”. The “due process of law” language may be confusing to those unfamiliar with constitutional law. As interpreted by the U. S. Supreme Court, certain rights (including some privacy rights) are encompassed within the term “liberty”, and a state may not infringe

38 *Ibidem*, at 486.

39 *Ibidem*, at 478.

40 *Ibidem*, at 483.

41 *Ibidem*, at 487.

42 *Paris Adult Theatre I v. Slaton*, 413 U. S. 49, 65 (1973) [quoting *Palko v. Connecticut*, 302 U. S. 319, 325 (1937)].

those rights “no matter what process it uses”.⁴³ The second case, *Vacco v. Quill*, considered whether prohibitions against assisted suicide violate the equal protection clause of the Fourteenth Amendment which provides that no state shall “deny to any person within its jurisdiction the equal protection of the laws”.

1. *Compassion in Dying v. State of Washington*

*Compassion in Dying*⁴⁴ was the first federal court of appeals case to address the constitutionality of statutes prohibiting assisted suicide. The question presented in the case is whether a person who is terminally ill has a constitutionally protected liberty interest in hastening what might otherwise be a protracted, undignified, and extremely painful death. Further, if such an interest exists, the court must consider whether or not the state of Washington may constitutionally restrict its exercise by banning a form of medical assistance that is frequently requested by terminally ill people who wish to die. The court held that there is a constitutionally protected liberty interest in determining the “time and manner” of one’s own death but that such interest must be weighed against the state’s legitimate and countervailing interests, especially those that relate to the preservation of human life. After balancing the competing interests, the court held that insofar as the Washington statute prohibits physicians from prescribing life-ending medication for use by terminally-ill, competent adults who wish to hasten their own deaths, the statute violates the due process clause of the Fourteenth Amendment.

The plaintiffs were four physicians who treat terminally ill patients, three terminally ill patients, and a Washington non-profit organization called Compassion In Dying.⁴⁵ The patients in-

43 Véase Burnham, William, *Introduction to the Law and Legal System of The United States*, 1999, p. 339.

44 *Compassion In Dying v. State Of Washington*, 79 F.3d 790 (9th Cir. 1996).

45 *Ibidem*, at 794.

cluded Jane Roe, a 69-year-old retired pediatrician who has suffered since 1988 from cancer that has now metastasized throughout her skeleton; John Doe, a 44-year-old artist dying of AIDS; and James Poe, a 69-year-old retired sales representative who suffers from emphysema that causes a constant sensation of suffocating.⁴⁶ All three were competent and died before the opinion had been rendered, but the case was allowed to continue on the basis that the issue would come up again and that terminally ill patients may die before the issue is decided by the court. In addition, the doctor's claims remained alive.

The court first asked whether there was a violation of the due process clause and said it must first determine whether there is a liberty interest in choosing the time and manner of one's death—in common parlance “Is there a right to Die?” The court held there is a liberty interest, and then analyzed whether prohibiting physicians from administering life-ending medication to terminally ill patients who wish to die violates such patient's due process rights.⁴⁷ The court notes that whether constitutional rights have been violated is determined by balancing the liberty interests of the plaintiffs against the relevant state interests. The court did not narrowly define the liberty interest as a constitutional right to aid in killing oneself. For an important reason, the court used broader and more accurate terms such as “the right to die”, “determining the time and manner of one's death”, and “hastening one's death”. The liberty interest encompasses a whole range of acts that are generally not considered to constitute “suicide”. An example is the act of refusing or terminating unwanted medical treatment. The court said a competent adult has a liberty interest in refusing to be connected to a respirator or in being disconnected from one, even if he is terminally ill and cannot live without mechanical assistance. Further, the court said the law does not classify as “suicide” the

46 *Ibidem*, at 795.

47 *Ibidem*, at 798.

death of a patient that results from the granting of his wish to decline or discontinue treatment nor does it label as assistance in suicide the acts of those who help the patient carry out that wish, whether by physically disconnecting the respirator or by removing an intravenous tube. The court said, “[a]ccordingly, we believe that the broader terms — ‘the right to die’, ‘controlling the time and manner of one’s death’, and ‘hastening one’s death’— more accurately describe the liberty interest at issue here”.⁴⁸

The court identified six relevant interests of the state: *a*) the general interest in preserving life; *b*) the specific interest in preventing suicide; *c*) the interest in avoiding the involvement of third parties and in precluding the use of arbitrary, unfair, or undue influence; *d*) the interest in protecting family members and loved ones; *e*) the interest in protecting the integrity of the medical profession, and *f*) the interest in avoiding adverse consequences that might ensue if the statutory provision at issue is declared unconstitutional.⁴⁹

The court pointed out that the state of Washington has already decided that its interest in preserving life should ordinarily give way to the wishes of the patients. At least in the case of competent, terminally ill adults who are dependent on medical treatment. In its Natural Death Act,⁵⁰ Washington permits adults to have “life-sustaining treatment withheld or withdrawn in instances of a terminal condition or permanent unconsciousness”.⁵¹ In adopting the statute, the Washington legislature necessarily determined that the state’s interest in preserving life is not so strong as to thwart the informed desire of a terminally ill, competent adult to refuse medical treatment.⁵²

48 *Ibidem*, at 802.

49 *Ibidem*, at 817.

50 *Ibidem*, citado en *Wash. Rev. Code* 70.122.020 *et seq.*

51 *Ibidem*, citado en *Wash. Rev. Code* 70.122.010.

52 *Ibidem*, at 817.

In this case, the concern regarding the third factor is that infirm, elderly persons will be subject to undue pressure to end their lives from callous, financially-burdened or self-interested relatives, or others who have influence over them. Persons with a stake in the outcome may exert pressure on the terminally ill to reject or decline life-saving treatment or may take other steps likely to hasten their demise. Surrogates under a mandate to exercise “substituted judgment” may make unfeeling life and death decisions for their incompetent relatives. The court concluded that involvement of physicians will help temper some of the problems of undue influence and also notes that the “terminally ill” patients would die anyway.

This case is a powerful statement of the constitutional rights of patients, whether or not patients are seeking assisted suicide, and shows the present outer boundaries of thinking in the areas of patients’ rights to autonomy, freedom of choice, and freedom from interference by a well-meaning state. It also shows how far as a society we have come in thinking about the nature of life, the quality thereof, and even the nature of death. Motivated in part by the activist patients in the AIDS arena, we have become active rather than passive patients, taking a serious role in treatment decisions that would in an earlier era have been unthinkable. In essence, physicians have begun to respect their patients’ rights of autonomy in both choosing and refusing treatment. *Compassion in Dying* perhaps shows the outer reaches of autonomy and the courts’ protection thereof. However, the U. S. Supreme Court reversed the case.

2. *Washington v. Glucksberg*

In *Washington v. Glucksberg*,⁵³ the U. S. Supreme Court reversed the circuit court’s decision in *Compassion in Dying*. *Glucksberg* held that the asserted right to assistance in commit-

53 *Washington v. Glucksberg*, 117 S.Ct. 2258 (1997).

ting suicide was not a fundamental liberty interest protected by the due process clause and that Washington's ban on assisted suicide was rationally related to a legitimate government interest. The Court said:

[a]n examination of our Nation's history, legal traditions, and practices demonstrates that Anglo-American common law has punished or otherwise disapproved of assisting suicide for over 700 years; that rendering such assistance is still a crime in almost every State; [and] that such prohibitions have never contained exceptions for those who were near death...⁵⁴

Considering that history, the Court concluded the asserted "right" to assistance in committing suicide is not a fundamental liberty interest protected by the due process clause.

The Court rejected the circuit court's descriptions of the interest at stake, *e. g.*, "determining the time and manner of ones death" and the "right to die". The Court said that "the question before the Court is more properly characterized as whether the 'liberty' specially protected by the [due process] Clause includes a right to commit suicide which itself includes a right to assistance in doing so".⁵⁵ The Court said that "this asserted right has no place in our Nation's traditions, given the country's consistent, almost universal, and continuing rejection of the right, even for terminally ill, mentally competent adults".⁵⁶ The Court said that to uphold the asserted right, it would have to "reverse centuries of legal doctrine and practice, and strike down the considered policy choice of almost every State".⁵⁷ The Court recognized the constitutionally protected right to refuse lifesaving hydration and nutrition that was at issue in *Cruzan*, but said its decision in *Cruzan* "was not simply deduced from abstract concepts of personal autonomy, but was instead grounded in the

54 *Ibidem*, at 2259.

55 *Ibidem*, at 2260.

56 *Idem*.

57 *Idem*.

Nation's history and traditions, given the common-law rule that forced medication was a battery, and the long legal tradition protecting the decision to refuse unwanted medical treatment".⁵⁸

The Court gave more credence to the issue of protecting the integrity of the medical profession than did the circuit court. The Court adopted the position of the American Medical Association that "physician-assisted suicide is fundamentally incompatible with the physician's role as healer".⁵⁹ The Court also expressed concern that physician-assisted suicide might be improperly used to reduce the "substantial financial burden of end-of-life health care costs".⁶⁰

The Court noted that terminal patients have options in addition to assisted suicide. Washington law permits physicians to minimize pain when withdrawing artificial life-support by administering medication that will hasten death even further. Also, Washington law permits physicians "to administer medication to patients in terminal conditions when the primary intent is to alleviate pain, even when the medication is so powerful as to hasten death and the patient chooses to receive it with that understanding".⁶¹ At the time of this decision, the state of Oregon had already passed a statute allowing physician-assisted suicide. Although the Court rejected a constitutional right to assisted suicide, it also believed that states are better able to deal with the issues through legislation. The Court said that "[t]he experimentation that should be out of the question in constitutional adjudication displacing legislative judgments is entirely proper, as well as highly desirable, when the legislative power addresses an emerging issue like assisted suicide".⁶² The Court "should accordingly stay its hand to allow reasonable legislative consi-

58 *Idem.*

59 *Ibidem*, at 2273.

60 *Idem.*

61 *Ibidem*, at 2289.

62 *Ibidem*, at 2293.

deration”. Further, the Court acknowledged “the legislative institutional competence”⁶³ as the better forum to address the issue.

3. *Quill v. Vacco*

In *Quill v. Vacco*,⁶⁴ plaintiff physicians argued that New York’s statute prohibiting assisted suicide violated the U. S. Constitution’s equal protection clause which provides that no state shall “deny to any person within its jurisdiction the equal protection of the laws”. Although the statute prohibited physicians from assisting their patients in suicide, New York law allowed patients on life support systems to hasten their deaths by requiring physicians to remove the life support systems. The court said there was nothing “natural” about causing death by withdrawing hydration, nutrition or ventilation. Further, the court felt that writing a prescription to hasten death “involves a far less active role for the physician than is required in bringing about death through asphyxiation, starvation and/or dehydration” and that “[t]he ending of life by these means is nothing more nor less than assisted suicide”.⁶⁵ Finding the distinction between removing live support and assisting in suicide irrational, the court held that “physicians who are willing to do so may prescribe drugs to be self-administered by mentally competent patients who seek to end their lives during the final stages of a terminal illness”.⁶⁶ However, the U. S. Supreme Court also reversed this case.

4. *Vacco v. Quill*

In *Vacco v. Quill*,⁶⁷ the U. S. Supreme Court reversed the Second Circuit’s holding that New York’s statute violated the

63 *Idem*.

64 *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996), rev’d 117 S. Ct. 2293 (1997).

65 *Ibidem*, at 729.

66 *Ibidem*, at 718.

67 *Vacco v. Quill*, 117 S.Ct. 2293.

equal protection clause. The Court held that New York had a number of valid reasons for distinguishing between refusing treatment and assisting a suicide. Such reasons include: *a)* prohibiting intentional killing and preserving life; *b)* preventing suicide; *c)* maintaining physicians' role as healers; *d)* protecting vulnerable patients from indifference, prejudice, and psychological and financial pressure to end their lives, and *e)* avoiding a possible slippery slope toward euthanasia.⁶⁸ The Court did not find the purported distinctions irrational and held that there "are valid and important public interests that easily satisfy the constitutional requirement that a legislative classification bear a rational relation to some legitimate end".⁶⁹

The Court said that "neither New York's ban on assisting suicide nor its statutes permitting patients to refuse medical treatment treat anyone differently from anyone else or draw any distinctions between persons. Everyone, regardless of physical condition, is entitled, if competent, to refuse unwanted lifesaving medical treatment; no one is permitted to assist a suicide".⁷⁰ Further, laws that apply evenhandedly to all comply with the equal protection clause.⁷¹ The Court distinguished refusal of life-sustaining treatment and assisted suicide on the legal principles of causation and intent. A patient refusing life-sustaining medical treatment dies from an underlying fatal condition while a patient ingesting lethal medication prescribed by a physician is killed by that medication.⁷² Further, a physician's intent in withdrawing perhaps futile treatment is merely to honor his patient's wishes, and a physician's aggressive prescribing is intended to ease pain, not cause death. Further, when a patient requests the removal of life support, he may not have the specific intent to die,

68 *Ibidem*, at 2295 y 2296.

69 *Ibidem*, at 2296.

70 *Ibidem*, at 2297 y 2298.

71 *Ibidem*, at 2298.

72 *Idem*.

but rather to be free of futile medical technology.⁷³ However, a patient injecting a lethal drug arguably has the specific intent to end his life.

5. *Oregon's Death with Dignity Act*

In 1997, Oregon became the first (and only) state where physician-assisted suicide is legal. The Death with Dignity Act⁷⁴ was a citizen's initiative passed by 51% of Oregon voters in 1994, and reaffirmed by 60% of voters in 1997 after surviving a number of legal challenges.

Under the statute, a competent adult (18 years of age or older) patient who is a resident of Oregon, and has been determined by an attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner in accordance with Oregon's Death With Dignity Act.⁷⁵

The patient must submit a written request substantially the form proscribed by statute, signed and dated by the patient and witnessed by at least two individuals who, in the presence of the patient, attest that to the best of their knowledge and belief the patient is capable, acting voluntarily, and is not being coerced to sign the request.⁷⁶ Witnesses must meet certain qualifications to reduce the possibility of fraud or coercion. For example, at least one of the witnesses must be a person who is not a relative of the patient by blood, marriage or adoption; a person who at the time the request is signed would be entitled to any portion of the estate of the qualified patient upon death under any will or by operation of law; or an owner, operator or em-

73 *Ibidem*, at 2298 y 2299.

74 Or. Stat. 127.800 *et. seq.*

75 *Ibidem*, 127.805.

76 *Ibidem*, at 127.810.

ployee of a health care facility where the qualified patient is receiving medical treatment or is a resident.⁷⁷ Further, the patient's attending physician may not be a witness.

Under the statute, the attending physician has a number of responsibilities.⁷⁸ The attending physician must make the initial determination of whether a patient has a terminal disease, is capable, and has made the request voluntarily.⁷⁹ He must confirm Oregon residency. He must ensure that the patient is making an informed decision by advising the patient of his or her medical diagnosis; prognosis, the risks associated with taking the medication to be prescribed; the probable result of taking the medication to be prescribed; and feasible alternatives, such as palliative care, hospice care and pain control. Further, the attending physician must refer the patient to a consulting physician for medical confirmation of the diagnosis, and for a determination that the patient is capable and acting voluntarily. If appropriate, he must refer the patient for counseling, and must recommend that the patient notify next of kin. Also, he should counsel the patient about the importance of having another person present when the patient takes the medication and of not taking the medication in a public place. The patient must be advised that he or she may rescind the request at any time and in any manner. There is a 15-day waiting period between the patient's initial oral request and the writing of a prescription, and a further 48-hour waiting period between the time of the patient's written request and the writing of a prescription.⁸⁰ The patient must again be offered the chance to rescind at the end of the 15-day waiting period.

A consulting physician must examine the patient and his or her relevant medical records and confirm, in writing, the attending physician's diagnosis that the patient is suffering from a

77 *Idem.*

78 *Ibidem*, at 127.815.

79 *Idem.*

80 *Ibidem*, at 127.850.

terminal disease, and verify that the patient is capable, is acting voluntarily and has made an informed decision.⁸¹

The entire process mandated by the statute must be documented in the patient's medical record, including all oral or written requests, the attending and consulting physicians' diagnosis, determination of capacity, and verification that the patient is acting voluntarily and made an informed decision.⁸² Further, the statute contains reporting requirements. It requires any health care provider dispensing medication pursuant to the statute to file a copy of the dispensing record with the Oregon Health Division (OHD).⁸³ The OHD prepares and makes publicly available an annual statistical report of the information collected. Both physicians and patients are protected from criminal prosecution if they comply with the statutory requirements.⁸⁴ Also, a patient's act of voluntarily ingesting medication pursuant to the statute cannot affect the patient's rights under a life, health, or accident insurance or annuity policy.⁸⁵

The statute specifically provides that it shall not be construed to authorize a physician or any other person to end a patient's life by lethal injection, mercy killing or active euthanasia.⁸⁶ However, actions taken in accordance with the statute shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law.⁸⁷

The Annual Report 2000 from OHD noted the following:

In 2000, a total of 39 prescriptions for lethal doses of medication were written, compared with 24 in 1998 and 33 in 1999. Twenty-six of the third-year prescription recipients died after ingesting the medication; eight died from their underlying disease; five

81 *Ibidem*, at 127.810.

82 *Ibidem*, at 127.855.

83 *Ibidem*, at 127.865.

84 *Ibidem*, at 127.885.

85 *Ibidem*, at 127.875.

86 *Ibidem*, at 127.880.

87 *Idem*.

were alive on December 31, 2000. In addition, one 1999 prescription recipient died in 2000 after ingesting the medication. In total, 27 patients ingested legally prescribed lethal medication in 2000 (26 patients who received prescriptions in 2000; 1 patient who received a prescription in 1999). During 1998 and 1999, 16 and 27 patients, respectively, died after ingesting the medications.⁸⁸

The report concluded that the number of terminally ill patients using lethal medication in 2000 remains small, with little change from 1999. Further, patients using physician-assisted suicide “are better educated, but otherwise demographically comparable to other Oregonians dying of similar diseases”.⁸⁹ Finally, physicians reported “patient concern about becoming a burden has increased during the last three years, though all patients expressed multiple concerns in the third year”.⁹⁰

VI. CONCLUSION

Laws prohibiting physician-assisted suicide have sometimes been blamed in part for physician’s unwillingness to adequately treat pain. But attitudes are changing. On September 1, 1999, the Oregon medical board disciplined a physician accused of undertreating the pain of six of his patients in a case of first impression. The action taken may reflect a policy shift in the way physicians and society view treatment for pain. In one instance, the physician prescribed Tylenol to treat pain suffered by a terminally ill elderly cancer patient. The physician was also cited for refusing morphine for an 82-year-old man with congestive heart failure, and for declining to resume pain medication for a woman on a mechanical ventilator. Although a few state medi-

88 Véase <http://www.ohd.hr.state.or.us/chs/pas/ar-smmry.htm> (visita 6 de abril de 2001).

89 *Idem.*

90 *Idem.*

cal boards have investigated complaints of physicians undertreating pain, a spokesperson for the Federation of State Medical Boards believes this is the first time a state board in the United States has taken action for giving too little pain medication. In years past, physicians have been disciplined for over-prescribing pain medication, particularly opioid analgesics, due to a largely groundless fear about patients becoming addicts. Newer studies find that most patients in severe pain do not become addicted to pain medication, and that many patients needlessly suffer pain. A study in 1998 that found one in four elderly cancer patients in nursing homes received nothing for their daily pain.⁹¹ A number of states have passed laws shielding physicians from disciplinary action if they prescribe drugs necessary to treat patients with intractable pain.

An ideal patient would be well informed and actively participate in all treatment decisions. Physicians do not have perfect patients. And doctors need to sensitively communicate with their patients about end-of-life issues. We routinely quote the Hippocratic Oath for principles of confidentiality and statements such as the physician shall do no harm, etc. The Oath also says "...I will follow that... regimen which... I consider for the benefit of my patients". The patient's judgment does not seem to deserve consideration.⁹² Physicians are admonished "to [conceal] most things from the patient while attending to him; [to] give necessary orders with cheerfulness and serenity... revealing nothing of the patient's future or present condition".⁹³ The AMA's first Code of Ethics was adopted twenty-five centuries later (1847) and also scolded patients that their "obedience... to the prescriptions of [their] physician should be prompt and implicit.

91 McCrary, S. Van, *New Research Indicates that Untreated Pain is a Major Problem Among Older Nursing Home Residents With Cancer*, 1 de julio de 1998 (<http://www.law.uh.edu/healthlawperspectives>).

92 Katz, Jay, "Informed Consent. Must it Remain a Fairy Tale?", *10 J. Con. H. L. & Pol'y* 69, sec. I (1994).

93 *Idem*.

[They] should never permit [their] own crude opinions... to influence [their] attention to [their physicians]”.⁹⁴ We must not allow our society’s new-found willingness to allow death to occur “naturally” to act as a license for not discussing the issue with each patient personally. Autonomy and respect for the patient demands such a discussion, even in the face of medical futility. As with many such issues, the answer probably lies in a better understanding of these complex issues by all medical professionals.