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I. INTRODUCTION

As you approach your twilight years, it may be difficult to come to terms with your mortality. However, if you were diagnosed with a fatal disease and faced the possibility of spending your last minutes on this earth suffering in excruciating pain, the idea of death may well be very comforting. The Supreme Court recently decided two cases dealing with a terminally ill patient’s right to die.1 The Supreme Court essentially side stepped the issue and left it to the individual states to pass legislation regarding whether a patient with a fatal disease has the right to physician-assisted suicide.2

This Note will examine the Court’s decisions in Vacco and Glucksberg and discuss their implications on a terminally ill patient’s right to die. Part II traces the history of the Court’s expansion of constitutional rights and its interpretation of the right to die.3 Part III presents the facts and procedural history of Vacco and Glucksberg,4 followed by an analysis of the majority and the concurring opinions in Part IV.5 Part V then considers Vacco’s and Glucksberg’s judicial, legislative, and social impact.6 Part VI concludes with a look at the future of physician-assisted suicide in light of the Court’s decisions in Vacco and Glucksberg.7

2. See Vacco, 117 S. Ct. at 2302; Glucksberg, 117 S. Ct. at 2275.
3. See infra notes 8-148 and accompanying text.
4. See infra notes 149-72 and accompanying text.
5. See infra notes 173-216 and accompanying text.
6. See infra notes 217-68 and accompanying text.
7. See infra notes 269-73 and accompanying text.
II. HISTORICAL BACKGROUND

A. Equal Protection and Substantive Due Process

1. Equal Protection

The Equal Protection Clause of the Fourteenth Amendment of the United States Constitution provides that similarly situated people must receive similar treatment. However, this constitutional guarantee does not forbid states from drafting legislation which imposes classifications on differently situated people. Depending on the class of persons subject to discrimination, the courts use three different levels of review in determining whether the governmental classification has violated the Equal Protection Clause: strict scrutiny, middle-level review, and rational basis.

Strict scrutiny is the standard of review reserved for situations where the law involves a suspect classification or impairs a constitutional fundamental right. Suspect classifications are defined as those classifications based on race, national origin, or alienage. In order to survive strict scrutiny review, the suspect classification must be deemed necessary to promote a compelling state interest. Courts use a middle-level or level of intermediate review to evaluate semisuspect classifications, such as gender and illegitimacy. Under this standard of review, classifications must "serve important governmental objectives and must be

10. See, e.g., Plyler, 457 U.S. at 216 ("'[T]he Constitution does not require things which are different in fact or opinion to be treated in law as though they were the same.'" (quoting Tigner v. Texas, 310 U.S. 141, 147 (1940))); Reed v. Reed, 404 U.S. 71, 75 (1971).
substantially related to achievement of those objectives." A rational basis standard of review applies to all other classifications which neither burden a fundamental right nor involve a suspect classification. When employing the rational basis standard, the courts are highly deferential to legislatures and the legislation is entitled to a presumption of validity as long as the classification is "rationally related to a legitimate state interest." Rationally related has been defined by the Court as a justification which is "reasonable, not arbitrary, and must rest upon some ground of difference having a fair and substantial relation to the object of the legislation." 

2. Substantive Due Process

The Due Process Clause of the Fourteenth Amendment of the United States Constitution also provides that it is improper to place undue burdens on the exercise of a protected liberty interest. The Due Process Clause limits the substantive power of the states to regulate certain areas of human life. In analyzing whether a state has run afoul of the Due Process Clause, it is necessary to determine whether the state law has infringed upon a fundamental right. The Due Process Clause protects fundamental rights which are "deeply rooted in this Nation's history and traditions" and "implicit in the concept of ordered liberty." Typical fundamental rights include the right to associate, the right to travel, and

20. The Fourteenth Amendment provides, in pertinent part, that "[n]o State shall make or enforce any law which shall... deprive any person of life, liberty, or property without due process of law." U.S. Const. amend. XIV, § 1.
27. See Dunn v. Blumstein, 405 U.S. 330, 338 (1972); Shapiro, 394 U.S. at 630.
the right to privacy.\textsuperscript{28} If a law infringes upon a fundamental right, then it is necessary to apply a strict scrutiny standard of review.\textsuperscript{29} Strict scrutiny requires that the law must be deemed necessary to further a compelling state interest.\textsuperscript{30} If no fundamental right exists, then courts utilize a rational basis standard of review.\textsuperscript{31} A rational basis level of review requires that the law be rationally related to a legitimate governmental interest.\textsuperscript{32} The standard of review a court applies is a crucial factor in determining whether a law is invalidated or upheld.\textsuperscript{33} The rational basis standard of review is not very rigorous, and laws subjected to this standard of review are almost always upheld.\textsuperscript{34} However, laws subjected to a strict scrutiny level of review are almost always invalidated because the burden of the state to offer a compelling state interest to justify an infringement on a fundamental right is difficult to meet.\textsuperscript{35}

B. Right to Privacy

The fundamental right to privacy has often been called the right to personal autonomy.\textsuperscript{36} Even though the Constitution makes no explicit reference to a right of privacy,\textsuperscript{37} several of the amendments in the Bill of Rights implicitly protect the individual privacy interests by creating a "penumbra" or "zone" of privacy.\textsuperscript{38}

The first case to recognize an individual's right to privacy was \textit{Griswold v. Connecticut}.\textsuperscript{39} In \textit{Griswold}, the Court declared a fundamental right for married individuals to use birth control and determine child bearing decisions.\textsuperscript{40} The Court extended the right to use contraceptives to all individuals in \textit{Eisenstadt v. Baird}.\textsuperscript{41} In \textit{Eisenstadt}, the Court held that "[i]f the right [to] privacy means anything, it is
the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child.\textsuperscript{42} Roe v. Wade\textsuperscript{43} and Planned Parenthood v. Casey\textsuperscript{44} extended the right to privacy concerning child bearing decisions, which was established in Griswold and Eisenstadt, to include a prohibition on state laws that completely ban abortions.\textsuperscript{45} The Court stated that it is impermissible to unduly burden a woman's right to have an abortion.\textsuperscript{46} Moreover, numerous cases also recognized a fundamental right to privacy in controlling family life and relations.\textsuperscript{47} However, in recent years, the Court has been reluctant to expand the protected right to privacy to other activities; thus, the Court has not found new fundamental rights.\textsuperscript{48} In Bowers v. Hardwick,\textsuperscript{49} the Court made a broad statement about the proper role for the judiciary in recognizing new fundamental rights.\textsuperscript{50} The Court stated that it is "most vulnerable and comes nearest to illegitimacy when it deals with judge-made constitutional law having little or no cognizable roots in the language or design of the Constitution."\textsuperscript{51} Furthermore, the Court reasoned that "[t]here should be, therefore, great resistance to expand the substantive reach of those clauses [the Due Process Clauses of the Fifth and Fourteenth Amendments], particularly if it requires redefining the category of rights deemed to be fundamental."\textsuperscript{52} As a result, the Court is now reluctant to expand the concept of substantive due process and declare new fundamental rights, such as a general right to die.\textsuperscript{53}

\textsuperscript{42} Id. at 453-54 (citing Stanley v. Georgia, 394 U.S. 557 (1969); Skinner v. Oklahoma, 316 U.S. 535 (1942); Jacobsen v. Massachusetts, 197 U.S. 11 (1905)).
\textsuperscript{43} 410 U.S. 113 (1973).
\textsuperscript{44} 505 U.S. 833 (1992).
\textsuperscript{45} See id. at 846.
\textsuperscript{46} See id.
\textsuperscript{47} See generally Moore v. City of E. Cleveland, Ohio, 431 U.S. 494 (1977) (holding that there is a fundamental right for relatives to live together); Loving v. Virginia, 388 U.S. 1 (1967) (holding that there is a fundamental right to marry); Skinner v. Oklahoma, 316 U.S. 535 (1942) (holding that there is a fundamental right to control procreation); Pierce v. Society of Sisters, 268 U.S. 510 (1925) (holding that there is a fundamental right to control and direct child rearing and education).
\textsuperscript{49} 478 U.S. 186 (1986).
\textsuperscript{50} See generally id. (rejecting the notion that there is a fundamental right to engage in homosexual activity).
\textsuperscript{51} Id. at 194.
\textsuperscript{52} Id. at 195.
\textsuperscript{53} See Thomas, supra note 48, at 36.
C. Right to Die

In discussing the general right to die, there are five different categories involved, each addressing different legal issues: suicide, passive euthanasia, physician-assisted suicide, active euthanasia, and palliative care.54

1. Suicide

Under English common law, committing suicide was a criminal act.55 In the early years of our country, many states adopted the policy of English common law and regarded suicide as a criminal act.56 Modernly, however, committing suicide imposes no criminal punishment or civil liability.57

2. Passive Euthanasia

Passive euthanasia involves allowing a person to die because the patient refuses or withdraws from medical treatment.58 Some courts have held that a patient’s right to refuse or discontinue unwanted medical treatment derives from the Fourteenth Amendment’s right to privacy,59 while other courts maintain that the right is rooted in the common law doctrine of informed consent.60 Still, other courts have held that the right to refuse or withdraw medical treatment is rooted in both the constitutionally protected right to privacy and the common law doctrine of informed consent.61 Today, the well-recognized right to passive euthanasia is familiar; however, this right was the subject of much debate not very long ago.62

In the seminal case of *In re Quinlan*,63 the New Jersey Supreme Court held that a patient had a right to terminate medical treatment in order to end the patient’s life
under certain conditions. The court derived the right to discontinue medical treatment from the implicit right to privacy found in the Fourteenth Amendment. 

The court stated that the implicit right was "[p]resumably . . . broad enough to encompass a patient's decision to decline medical treatment under certain circumstances, in much the same way as it is broad enough to encompass a woman's decision to terminate pregnancy under certain conditions." However, the court reasoned that this right was limited due to the important state interest of preserving life. The court did indicate, however, that the state's important interest diminished as the "degree of bodily invasion [for medical treatment] increases and the [patient's] prognosis dims." Furthermore, the court determined that a competent patient or the guardian of an incompetent patient under the circumstances of this case could make the decision to terminate medical treatment. The court also stated that a physician would not be held criminally liable for withdrawing life sustaining medical treatment in circumstances similar to this case. Additionally, the court extended protection from prosecution to third parties who helped the patient terminate medical treatment pursuant to the patient's right to privacy.

While many state courts found a valid right to refuse unwanted medical treatment, it was not until Cruzan v. Director, Missouri Department of Health that the Supreme Court addressed the issue. In Cruzan, the Court held that a "competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment." The Court further held that a patient's right to refuse medical treatment may outweigh the important state interest of preserving life in some situations. However, the Court felt that a competent patient's right

64. See Quinlan, 355 A.2d at 663. In this case, the patient was in a "chronic persistent vegetative state" with no hope of recovery. See id. at 654.
65. See id. at 663.
66. See id. (citing Roe v. Wade, 410 U.S. 113, 153 (1973)).
67. See id.
68. See id. at 664.
69. See id.
70. See id. at 669. The court came to their conclusion partly because when the life support equipment was withdrawn, the patient died from the natural causes of the underlying disease. See id. at 670.
72. See Jeremy A. Sitcoff, Note, Death with Dignity: AIDS and a Call for Legislation Securing the Right to Assisted Suicide, 29 J. MARSHALL L. REV. 677, 690 (1996) (citing ALAN MEISEL, I THE RIGHT TO DIE 4, 45 n.6 (2d ed. 1995)).
74. Id. at 278.
75. See id. at 279-80.
to decline artificial life sustaining measures, such as hydration and nutrition, would outweigh any of the state's countervailing interests, such as preserving life. Moreover, the Court reasoned that the "choice between life and death is a deeply personal decision" in which the "Due Process Clause protects an interest in life as well as an interest in refusing life-sustaining medical treatment." In deciding the outcome of *Cruzan*, the Court placed great significance on common law, which considered forced medication a battery, and the long legal tradition protecting a patient's decision to refuse unwanted medical treatment. If the patient was incompetent, as in *Cruzan*, the Court stated that a surrogate decision maker could exercise the right to withdraw medical treatment. The *Cruzan* decision initiated a debate over the scope of a person's right to die, including whether or not *Cruzan* opened the door to physician-assisted suicide.

3. Physician-Assisted Suicide

Physician-assisted suicide involves the situation where a physician gives a person wishing to commit suicide the means to carry out the suicide. While the line between physician-assisted suicide and euthanasia blurs, there is an important distinction. Physician-assisted suicide refers to the situation where a physician provides a patient with the means to end her life, such as a lethal dosage of drugs, but the patient actually performs the death-causing act herself, such as injecting herself with the drug. On the other hand, active euthanasia refers to the situation where a physician participates in performing the action that ends a patient's life, such as by actually administering the lethal dosage of drugs to a patient.

In the case of physician-assisted suicide, the person assisting the suicide receives immunity from a homicide charge because the patient completes the fatal procedure. However, the person assisting the suicide is not totally immune from

76. See id. at 279.
77. See id. at 281.
78. See id. at 269-77.
79. See id. at 280. Because of the state's interest in preserving life, the Court held that the state could implement a clear and convincing evidence standard in order for the surrogate to make the decision for the incompetent patient. See id. at 280-85 (citations omitted).
80. See Daniels, supra note 56, at 769.
81. See Thomas, supra note 48, at 31.
82. See England, supra note 8, at 360 (citing John Glasson, M.D., Report of the Council on Ethical and Judicial Affairs of the American Medical Association; Physician-Assisted Suicide, 10 ISSUES L. & MED. 91, 92 (1994)); see also Thomas, supra note 48, at 36 (noting important and practical differences between physician-assisted suicide and active euthanasia that justify separate legal treatment).
83. See England, supra note 8, at 360 (citing Glasson, supra note 82, at 92 (reporting on the ethical considerations associated with physician-assisted suicide)).
84. See id. (citing Glasson, supra note 82, at 92); infra notes 138-39 and accompanying text (defining active euthanasia and discussing its treatment as a homicide).
85. See Thomas, supra note 48, at 36.
criminal charges because most states have separate criminal statutes dealing with physician-assisted suicide, which is currently against the law in a majority of states. In thirty-five states there are statutes imposing penalties for physician-assisted suicide, while nine other states impose penalties through case law. However, several states have tried to enact legislation which would legalize physician-assisted suicide for the terminally ill. California was the first state to attempt to legalize physician-assisted suicide with the 1988 California Humane and Dignified Death Initiative. However, the initiative was never put to a vote because it failed to attain the number of signatures required to get the initiative on the ballot. In 1991, Washington became the first state to have a physician-assisted suicide initiative reach the voters. However, the voters rejected the ground-breaking initiative by a vote of fifty-four percent to forty-six percent. In 1992, four other states introduced bills into their legislatures, none of which passed into law. In the same year, California voters again rejected a physician-assisted suicide proposal, one with considerably stricter guidelines than the 1991 Washington initiative, by a vote of fifty-two percent to forty-eight percent. Presently, Oregon is the only state where legislation legalizing physician-assisted suicide has passed, although by the narrowest of margins, fifty-one percent.

86. See id.; Gostin, supra note 22, at 1524-25.
87. See Gostin, supra note 22, at 1525.
89. See id. The initiative required the patient to be terminally ill and competent. See id.
90. See id. at 1318.
91. See id. at 1320. The Aid in Dying Act was the initiative’s popular name. See id. at 1319 (noting that the initiative was to amend sections 70.122.010-.905 of the Revised Code of Washington, WASH. REV. CODE §§ 70.122.010-.905 (1990)). The initiative required that the patient be terminally ill with two doctors estimating death within the following six months, that the patient be mentally competent, and that the patient make a written request for assistance. See id.
94. See id. at 1320; Sandi Dolbee, Right-to-Die Measure Rejected by State Voters: Lack of Safeguards a Major Factor, Opponents Believed, SAN DIEGO UNION TRIB., Nov. 4, 1992, at A3. The proposition required that the patient have a terminal illness which would result in death within six months in the opinion of two physicians. See Pugliese, supra note 88, at 1320 (indicating that sections 2525-2525.24 of the California Civil Code, CAL. CIV. CODE §§ 2525-2525.24 (West 1992), would codify the proposition).
to forty-nine percent. Voters passed the Death with Dignity Act in 1994, but due to appeals, it did not go into effect until 1997. Under the Oregon Act, a competent, adult resident who is terminally ill may make a written request for medication for the "purpose of ending his life in a humane and dignified manner." The physician involved must determine whether the patient has a terminal illness and is making a voluntary request. Additionally, the physician must inform the patient of his medical diagnosis, prognosis, the risks of taking the requested medication, the probable outcome if the patient decides to go through with the plan, and feasible alternatives available. It is then necessary to refer the patient to a consulting physician, who must confirm the diagnosis of the patient and the patient's ability to act voluntarily. If a doctor determines the patient is suffering from depression, then either physician must deny the request and refer the patient for psychiatric counseling. Additionally, the qualified patient must make an oral request, a written request, and another oral request reiterating his desire within fifteen days of his initial request. The Oregon Act further mandates a fifteen day waiting period between the initial request made by the patient and the writing of the prescription by the physician, as well as a minimum forty-eight hour cooling-off period between the written request and the writing of the prescription.

Since the Oregon vote, many state legislatures have introduced proposals to legalize physician-assisted suicide, but none of the proposals have been enacted. Many proposals closely parallel the Oregon Act, such as the ones in California and Massachusetts; thus, they are referred to as Copycat Acts. These Copycat Acts contain identical safeguards and employ the same definitions as the Oregon Act. Other proposals use broader language and appear more flexible, such as the one in Michigan. As to date, no legislature has enacted any of these proposed acts. Conversely, Iowa and Rhode Island recently passed legislation which prohibits

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95. See Daniels, supra note 56, at 786; Thomas, supra note 48, at 34.
98. See OR. REV. STAT. § 127.815; Sitcoff, supra note 72, at 702.
99. See OR. REV. STAT. § 127.815; Sitcoff, supra note 72, at 702.
100. See OR. REV. STAT. § 127.825; Sitcoff, supra note 72, at 702.
101. See OR. REV. STAT. § 127.840; Sitcoff, supra note 72, at 702.
102. See OR. REV. STAT. § 127.850; Sitcoff, supra note 72, at 702.
104. See id. at 705.
105. See id. The Michigan Act allows a patient to specify under which situations they will allow physician-assisted suicide, thus not limiting the act to terminally ill patients. See id. at 706.
physician-assisted suicide. Furthermore, in April, President Clinton signed the Federal Assisted Suicide Funding Restoration Act of 1997, which prohibits federal funding of physician-assisted suicide.

Despite the prohibition of physician-assisted suicide, there appears to be a lack of enforcement of the law because no American doctor has ever been convicted for assisting a patient suicide. Dr. Timothy Quill published an article in 1991 describing his experience with prescribing a lethal dose of painkillers to one of his terminally ill patients. However, a grand jury refused to indict the physician, which is an "important indicator of the general direction of the debate over euthanasia" and physician-assisted suicide in this country. Additionally, Dr. Jack Kevorkian has been acquitted in all of his trials involving physician-assisted suicide. Moreover, public opinion polls consistently demonstrate growing public support for physician-assisted suicide for the terminally ill. In 1950, only thirty-four percent of the American population believed in the concept of physician-assisted suicide. This figure has steadily increased over the years, reaching its highest approval percentage of eighty-one percent in 1991. The legalization of physician-assisted suicide is also gaining support from the medical community. Despite the American Medical Association's firm stance against physician-assisted suicide, surveys reveal that individual doctors are in favor of physician-assisted suicide.

111. See Sitcoff, supra note 72, at 693 (citations omitted).
112. See Timothy E. Quill, Death and Dignity: A Case of Individualized Decision Making, 324 NEW ENG. J. MED. 691, 691 (1991); Sitcoff, supra note 72, at 693 & n.118.
116. See Blendon et al., supra note 113, at 2659 (indicating survey results from a Gallup Poll Organization).
117. See id. at 2658-59 (indicating survey results from a Harvard School of Public Health and Boston Globe Poll).
118. See England, supra note 8, at 365-66 (citations omitted).
120. See England, supra note 8, at 365-66; Pugliese, supra note 88, at 1315 (indicating a 1988 survey by the San Francisco Medical Society revealing that a majority of physicians favored physician-assisted suicide, with seventy percent replying that a terminally ill patient should have the option of
In addition, other countries are taking part in similar physician-assisted suicide debate. For example, the Netherlands was the first country to openly allow physicians to assist terminally ill patients with suicide. While euthanasia and physician-assisted suicide are still considered illegal in the Netherlands, "physicians can avoid prosecution by adhering to strict [legal] guidelines." Prosecution will not result for a physician's role in assisting with a patient's suicide if "the patient requested the procedure consciously and voluntarily, the patient was experiencing suffering that could not be relieved by any other means, and the physician had consulted with another physician who agreed that euthanasia was acceptable under the circumstances." While the Dutch have spent incredible efforts in establishing sufficient guidelines for physicians, the data obtained in surveys indicates that the guidelines have become "dispensable... rather than essential requirements." The Dutch Government's Commission on Euthanasia commissioned a 1990 survey which found that there were over 1000 cases where the patient did not explicitly request euthanasia and almost 5000 of 8750 cases where the patient did not consent. However, due to inaccurate reporting by physicians, the true number of suicides in the Netherlands is not known, which has given rise to much speculation on the actual results of the Dutch euthanasia experiment. Yet, the Dutch authorities have expressed their continued satisfaction with their system, saying that "the medical actions and decision process concerning the end of life are of high quality." The Swiss also allow "doctor-assisted suicide in carefully controlled situations." Conversely, Canadian courts recently rejected a claim to establish physician-assisted suicide as a fundamental right. A committee in Great Britain also 'refused to recommend any change[s}
in ... [their physician-assisted suicide prohibition]." Moreover, New Zealand's Parliament rejected a proposal that would have legalized physician-assisted suicide.\textsuperscript{131} In Australia, the Northern Territory legalized physician-assisted suicide and voluntary euthanasia in 1995,\textsuperscript{133} but the Australian Senate voted to overturn the law in 1997.\textsuperscript{134} The law, which went into effect in 1996, was the first of its kind which explicitly allowed physicians the right to help their patients commit suicide.\textsuperscript{135} During the year it was in effect, the law required that the patient be mentally and physically competent, that the request be supported by three doctors, including a specialist and a psychiatrist, and a nine day cooling-off period before the death could proceed.\textsuperscript{136} Even though Australia recently reversed its position on physician-assisted suicide, Columbia's Constitutional Court recently legalized voluntary euthanasia for terminally ill patients.\textsuperscript{137}

4. Active Euthanasia

Active euthanasia involves the killing of another person and occurs when a physician actually administers a lethal treatment to a patient rather than just merely prescribing the lethal treatment.\textsuperscript{138} Currently, all fifty states consider euthanasia a homicide because "a person cannot generally consent to a crime," such as the killing of another person.\textsuperscript{139}

5. Palliative Care

Palliative care refers to medical treatment which relieves pain, such as a high dosage of drugs prescribed by a physician, even if the dosage might hasten death.\textsuperscript{140} In an attempt to lessen a terminally ill patient's suffering and pain, dosages of pain

131. See id. (citations omitted).
132. See id. (citing Graeme, MPs Throw Out Euthanasia Bill, DOMINION (WELLINGTON), Aug. 17, 1995, at 1).
136. See id.
138. See Thomas, supra note 48, at 36.
139. See id.
140. See id.
medication can reach toxic levels, thereby killing the patient. Generally, a physician who causes a patient’s death due to palliative care is not punished because the physician’s intent is to relieve pain rather than to kill.

Regardless of whether the right to die is “exercised by refusal of treatment, by assisted suicide, or by seeking euthanasia,” the right derives from the fact that the death is freely chosen. Thus, when the issue of physician-assisted suicide came before the Supreme Court in Vacco and Glucksberg, it came within the context of cases and legislative proposals, as well as other countries’ experiences with the same issue, all of which carefully debated the rights of patients to make decisions at the end of life. Even though the Court recognized a generalized right for competent patients to refuse unwanted medical treatment in Cruzan, there was no recognition of a general right to commit suicide, either alone or with the aid of a physician. "The courts . . . [have] persistently affirmed one categorical distinction: that between withdrawing life-sustaining treatment on the one hand, and active euthanasia or physician-assisted dying on the other." Unlike the situation in Cruzan, there has never been a long standing acceptance of suicide nor has it received a protected status in our Nation’s history. Thus, the Court did not recognize a fundamental right to die.

III. FACTS OF THE CASE

A. Vacco v. Quill

In Vacco, the plaintiffs were three terminally ill patients dying from cancer and AIDS. All three were mentally competent adults in the final stages of fatal diseases and wanted their respective physicians to prescribe medications which

142. See Thomas, supra note 48, at 36.
144. See Gostin, supra note 22, at 1526.
146. Gostin, supra note 22, at 1523.
147. See Glucksberg, 117 S. Ct. at 2263. The liberty interest recognized in Cruzan “was not simply deduced from abstract concepts of personal autonomy,” but was rather based on common law notions of forced battery. See id. at 2270. Decisions to commit suicide “may be just as personal and profound as the decision to refuse unwanted medical treatment, but it has never enjoyed similar legal protection.” See id.
148. See Vacco, 117 S. Ct. at 2296; Glucksberg, 117 S. Ct. at 2275.
would quickly bring about their deaths. Three physician plaintiffs joined in the case stating that "in the regular course of their medical practice, they treated terminally ill patients who requested assistance in the voluntary self-termination of life." Furthermore, the physicians believed that it was consistent with modern medical standards to prescribe drugs which would hasten their patients' deaths in a "certain and humane manner." Because of New York statutes that made it a felony to intentionally help another person commit suicide, the physicians believed that they could not assist their terminally ill patients by prescribing the requested drugs without facing criminal prosecution. The plaintiffs challenged the constitutionality of the New York statutes claiming that the patients had a fundamental right to physician-assisted suicide under the Due Process and Equal Protection Clauses of the Constitution. The United States District Court in the Southern District of New York held that the patients had no fundamental right to physician-assisted suicide protected by the Due Process Clause nor did the statutes violate the Equal Protection Clause. The district court rejected the plaintiffs' claims, stating that fundamental rights are "deeply rooted in the nation's history and traditions" and because helping someone commit suicide has traditionally been a crime in the majority of American states, physician-assisted suicide is not deeply rooted in our history or traditions. The district court also held that New York had a rational basis for the legal distinction of allowing patients to refuse medical treatment and not allowing physician-assisted suicide because the distinction rested on the difference between natural and artificial death, as well as New York's legitimate interest in preserving life. The Second Circuit of the United States Court of Appeals upheld the district court's ruling that no fundamental right to physician-assisted suicide existed, but reversed the court's

151. See id. at 80.
152. See id.
153. See N.Y. PENAL LAW §§ 120.30, 125.15(3) (McKinney 1998).
154. See Quill, 870 F. Supp. at 80.
155. See id.
156. See U.S. CONST. amend. XIV; supra notes 8-35 and accompanying text (giving the historical context for the Supreme Court's standard of review and application of such review to due process questions).
158. See id. at 83 (citing Bowers v. Hardwick, 478 U.S. 186, 191-92 (1986); Moore v. City of E. Cleveland, Ohio, 431 U.S. 494, 503 (1977)).
159. See id. at 84 (citing Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261, 280 (1990)); see also MODEL PENAL CODE § 210.5(2) (stating that it is a crime to cause, aid, or solicit a suicide).
160. See Quill, 870 F. Supp. at 84.
holding that the statutes did not violate the Equal Protection Clause of the Constitution. The Second Circuit reasoned that the state's interest in preserving life "lessens as the potential for life diminishes," and thus, the statutes which prohibit physician-assisted suicide for terminally ill patients are not rationally related to a legitimate state interest.

B. Washington v. Glucksberg

Like the plaintiffs in Vacco, the three terminally ill patients in Glucksberg were mentally competent adults in the terminal phases of their illnesses and desired to end their excruciating pain by taking prescribed drugs which would hasten their deaths. Five physicians, who regularly treated terminally ill patients, joined as plaintiffs in the case, as did Compassion in Dying, which provides services for terminally ill patients. The plaintiffs challenged the constitutionality of the Washington statutes that prohibited assisting a suicide attempt. The United States District Court in the Western District of Washington held that competent, terminally ill adults had a fundamental right to die protected by the Due Process Clause because individuals have the right to make their own choices about "matters which are essential to personal autonomy and basic human dignity." Furthermore, the district court held that there was a violation of the plaintiffs' equal protection rights because the Washington law unconstitutionally distinguished between two groups of similarly situated individuals; the law permitted mentally competent, terminally ill patients to refuse life-sustaining equipment, but it prohibited the same group of individuals to hasten death by taking prescribed drugs. A three judge panel of the Ninth Circuit of the United States Court of Appeals overturned both of the district court's holdings. However, upon rehearing en banc, the Ninth Circuit reversed the panel's findings and affirmed the district court's holding that the plaintiffs had a fundamental right to die protected by the Due Process Clause.

162. See id. at 729 (citing In re Quinlan, 355 A.2d 647 (1976)).
163. See id. at 731.
165. See id. at 1457-58.
166. See WASH. REV. CODE ANN. §§ 9A.20.020(1) (c), .36.060(2) (West 1998).
167. See Compassion in Dying, 850 F. Supp. at 1459.
168. See id. at 1461-62.
169. See id. at 1466-67.
IV. ANALYSIS OF THE COURT'S OPINIONS

A. The Majority Ruling

1. Vacco v. Quill

In Vacco, Chief Justice Rehnquist discussed the equal protection claim and held that New York's statutes prohibiting physician-assisted suicide did not violate the Constitution. Chief Justice Rehnquist began the opinion by stating that the Equal Protection Clause requires that states treat similarly situated people the same. Chief Justice Rehnquist wrote that the New York statutes deserved a "'strong presumption of validity" because they do not infringe upon a fundamental right nor involve suspect classifications, and therefore, the correct level of scrutiny is the rational basis test. Chief Justice Rehnquist rejected the claim that the statutes treated medically competent, terminally ill patients differently; he reasoned that every competent person can refuse life sustaining equipment, but no one may assist in a suicide. Chief Justice Rehnquist stated that the important and rational distinction between physician-assisted suicide and refusal of life sustaining equipment had been "widely recognized and endorsed in the medical profession and in our legal traditions." Chief Justice Rehnquist also pointed out that if a patient refuses medical treatment, the patient dies from the underlying terminal disease; however, when the patient takes deadly drugs prescribed by a physician, death results from the lethal

174. See id.
175. See id. at 2297 (citing Plyler v. Doe, 457 U.S. 202, 216 (1982)).
176. See id. (quoting Heller v. Doe, 509 U.S. 312, 319 (1993)).
177. See id. (citing Glucksberg, 117 S. Ct. at 2267-71). The proper standard of review is the rational basis test because the statutes neither infringe upon a fundamental right nor involve a suspect classification. See Romer v. Evans, 517 U.S. 620, 631 (1996) (citing Heller, 509 U.S. at 319).
178. See Vacco, 117 S. Ct. at 2297-98.
179. See id. at 2298 (citing Personnel Adm'r v. Feeney, 442 U.S. 256, 272 (1979)).
dosage of drugs, not the disease.\textsuperscript{180} In further support, Chief Justice Rehnquist noted that the majority of states prohibit physician-assisted suicide while permitting the right to refuse life-sustaining treatment.\textsuperscript{181} States, New York included, have consistently held that public policy requires drawing the line between ""killing"" and ""letting die."\textsuperscript{182} Moreover, Chief Justice Rehnquist pointed out that the Supreme Court itself recognized the distinction between making and letting a patient die in 

\textit{Cruzan}.\textsuperscript{183} For all of these reasons, Chief Justice Rehnquist rejected the respondents’ claim and declared that the statutes’ classifications withstood the rational basis test.\textsuperscript{184} Chief Justice Rehnquist concluded by stating that New York’s justifications for the statutes, which are discussed more fully in \textit{Glucksberg},\textsuperscript{185} were important state interests which "easily satisfy the constitutional requirement that a legislative classification bear a rational relation to some legitimate end."\textsuperscript{186}

\section*{2. Washington v. Glucksberg}

In \textit{Glucksberg},\textsuperscript{187} Chief Justice Rehnquist began the opinion by closely examining the United States legal history and traditions regarding suicide and physician-assisted suicide.\textsuperscript{188} Chief Justice Rehnquist also noted that state legislatures are "currently engaged in serious, thoughtful examinations of physician-assisted suicide."\textsuperscript{189} Chief Justice Rehnquist then considered the respondents’ constitutional claim that the Washington statutes violated the Due Process Clause because they were in violation of a patient’s fundamental right to die.\textsuperscript{190} Chief Justice Rehnquist stated that historically the right to physician-assisted suicide has received consistent and almost universal rejection.\textsuperscript{191} Chief

\begin{enumerate}
\item \textit{See id.} (citing People v. Kevorkian, 527 N.W.2d 714, 718 (1994); Matter of Conroy, 486 A.2d 1209, 1226 (1985); \textit{In re Colyer}, 660 P.2d 738, 743 (1983); Glasson, \textit{supra} note 82, at 92). There is a difference between causation and intent. \textit{See id.}
\item \textit{See id.} at 2300 (citing \textit{Glucksberg}, 117 S. Ct. at 2265-67).
\item \textit{See id.} at 2301 (citations omitted).
\item \textit{See id.} (citing \textit{Cruzan} v. Director, Mo. Dep’t of Health, 497 U.S. 261, 278 (1990)).
\item \textit{See id.}
\item \textit{See infra} notes 195-97 and accompanying text.
\item \textit{See Vacco}, 117 S. Ct. at 2302.
\item \textit{See id.} at 2262-67. "[F]or over 700 years, the Anglo-American common law tradition has punished or otherwise disapproved of both suicide and assisting suicide." \textit{Id.} at 2263 (citing \textit{Cruzan}, 497 U.S. at 294-95 (Scalia, J., concurring)).
\item \textit{See id.} at 2267.
\item \textit{See id.}
\item \textit{See id.} at 2269. The right to commit suicide with a physician’s assistance has never received protection in our nation’s history. \textit{See id.} Many states have begun to re-examine the prohibition because of changes in medical technology; however, they have not retreated from the prohibition because the laws have “consistently condemned, and continue to prohibit, assisting suicide.” \textit{See id.}
\item 138
Justice Rehnquist next distinguished the *Cruzan* holding by asserting that *Cruzan* involved forced medication, which was considered a battery at common law, and therefore, a refusal of unwanted medication has enjoyed a long standing tradition of judicial and legislative protection.\(^{192}\) Moreover, Chief Justice Rehnquist stated that the Constitution does not "warrant the sweeping conclusion that any and all important, intimate, and personal decisions" should receive constitutional protection.\(^{193}\) Thus, based on this country's long standing refusal to recognize physician-assisted suicide, Chief Justice Rehnquist concluded that no fundamental right was at issue before the Court.\(^ {194}\)

Although there was an absence of a fundamental right, the majority did note that it is possible for the Washington statutes to have a rational relationship to a legitimate state interest and therefore pass the requisite rational basis standard of review.\(^{195}\) Chief Justice Rehnquist listed the following state interests that warrant a ban on physician-assisted suicide: (1) preserving life; (2) preventing suicide; (3) protecting a doctor's integrity and ethics; (4) protecting vulnerable people from undue influence; and (5) preventing euthanasia from growing more popular, the so-called slippery slope justification.\(^{196}\) Because these were the justifications asserted in support of prohibiting physician-assisted suicide, the Washington statutes were found to be rationally and reasonably related to a legitimate state interest.\(^{197}\) Chief Justice Rehnquist concluded by pointing out that the majority holding permits the states to engage in continued "debate about the morality, legality, and practicality of physician-assisted suicide."\(^{198}\) However, in a footnote, Chief Justice Rehnquist emphasized that although the Court's decision rejected the circuit court's "specific holding that the statute is unconstitutional 'as applied' to a particular class,"\(^{199}\) the Court's "opinion does not absolutely foreclose" the possibility that a plaintiff could prevail under circumstances different from the circumstances of this case.\(^{200}\)

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192. See id. at 2270.
193. See id. at 2271 (citing San Antonio Indep. Sch. Dist. v. Rodriguez, 411 U.S. 1, 33-35 (1973)).
194. See id.
195. See id.
196. See id. at 2272-75.
197. See id. at 2275.
198. See id.
199. See id. at 2275 n.24.
200. See id.
B. Concurring Opinions

1. Justice Souter

Justice Souter wrote separate concurring opinions for each case.\(^{201}\) He wrote separately to address whether the statute imposes "'arbitrary impositions'" or "'purposeful restraints'" inconsistent with the Due Process Clause.\(^{202}\) Justice Souter believed that the state interest of "protecting patients from mistakenly and involuntarily deciding to end their lives" was sufficient to justify the statutes.\(^{203}\) He further stated that the Court preferred using the legislative process of each individual state in order to decide whether to allow physician-assisted suicide.\(^{204}\)

2. Justice O'Connor

Concurring with the majority opinion, Justice O'Connor\(^{205}\) wrote separately to point out that there is no reason to decide whether terminally ill patients have a constitutional right to obtain relief from their suffering because the patients could obtain palliative care in both Washington and New York.\(^{206}\) She agreed with the majority opinion that there is no generalized right to die, but left unresolved the possibility that a limited right to have a physician prescribe drugs to alleviate suffering might exist, even if these drugs would hasten death.\(^{207}\)

3. Justice Stevens

Justice Stevens used his concurring opinion to assert that there is room for further debate on the constitutional limits placed on states when punishing physician-assisted suicide.\(^{208}\) Justice Stevens disagreed with the majority's reasoning because he believed that there are situations where statutes, such as those in New York and Washington, may be unconstitutional due to unique circumstances, resulting in a legitimate interest in hastening death which would be
entitled to constitutional protection.\textsuperscript{209} Moreover, he stated that the distinctions between \textit{Cruzan} and \textit{Vacco} and \textit{Glucksberg} is more blurred than the majority opined.\textsuperscript{210} Furthermore, while the facial challenge of the statutes failed in these cases, Justice Souter believed that there might be an individual plaintiff who could prevail in a more particularized challenge.\textsuperscript{211}

4. Justice Ginsburg

Justice Ginsburg's concurring opinion merely reiterated her support for Justice O'Connor's reasoning.\textsuperscript{212}

5. Justice Breyer

Justice Breyer also wrote separately to support Justice O'Connor's stance, but differed from the Court's reasoning that the right to physician-assisted suicide is essentially the "right to commit suicide with another's assistance";\textsuperscript{213} rather, Justice Breyer asserted that it was the "right to die with dignity."\textsuperscript{214} He believed that the right to die with dignity involves "personal control over the manner of death, professional medical assistance, and the avoidance of unnecessary and severe physical suffering."\textsuperscript{215} Justice Breyer could foresee a case where a state's ban on physician-assisted suicide infringes upon a constitutional right.\textsuperscript{216}

\textsuperscript{209} See id. at 2305 (Stevens, J., concurring).
\textsuperscript{210} See id. at 2305-07 (Stevens, J., concurring). Justice Stevens believed that the freedom to refuse unwanted medical treatment espoused in \textit{Cruzan} also recognized the patient's interest in dignity and determining the manner of death. See id. at 2306 (Stevens, J., concurring). Moreover, Justice Stevens thought that \textit{Cruzan} implicitly recognized an "even more fundamental right to make this 'deeply personal decision.'" See id. at 2307 (Stevens, J., concurring) (quoting \textit{Cruzan} v. Director, Mo. Dep't of Health, 497 U.S. 261, 289 (1990) (O'Connor, J., concurring)).
\textsuperscript{211} See id. at 2309 (Stevens, J., concurring). Justice Stevens believed that these challenges merited individual scrutiny depending on the specific facts of each case. See id. at 2310 (Stevens, J., concurring). Justice Stevens rejected the notion that the state's interest in preserving life would always be "sufficient to outweigh the interest in liberty that may justify the only possible means of preserving a dying patient's dignity and alleviating her intolerable suffering." See id. (Stevens, J., concurring).
\textsuperscript{212} See id. at 2310 (Ginsburg, J., concurring).
\textsuperscript{213} See id. at 2311 (Breyer, J., concurring).
\textsuperscript{214} See id. (Breyer, J., concurring).
\textsuperscript{215} See id. (Breyer, J., concurring).
\textsuperscript{216} See id. (Breyer, J., concurring). The New York and Washington statutes did not prohibit doctors from providing drugs to terminally ill patients in order to alleviate their pain, even if those drugs carried a risk of killing the patient. See id. (Breyer, J., concurring). Justice Breyer believed that a different outcome would occur if no palliative care was available to the patients. See id. at 2312 (Breyer, J., concurring).
V. IMPACT OF THE COURT’S DECISIONS

A. Judicial Impact

The immediate judicial impact of Vacco and Glucksberg is precedent that there is no fundamental right to die or right to physician-assisted suicide.\textsuperscript{217} However, statutes such as those in New York and Washington, while not invalid on their face, might be deemed unconstitutional when subjected to a particularized challenge in the future.\textsuperscript{218} Despite the Court’s unanimity in the Vacco and Glucksberg decisions, the Court left open the possibility of a more particularized challenge.\textsuperscript{219} In fact, five justices chose to write concurring opinions discussing the statutes as applied to other circumstances,\textsuperscript{220} and Chief Justice Rehnquist did not disagree with the possibility of a more particularized challenge.\textsuperscript{221} Justice Breyer stated that it was possible to infringe upon a patient’s liberty interest if the statute prohibited "personal control over the . . . avoidance of unnecessary and severe physical suffering."\textsuperscript{222} A situation such as this may arise where there is no palliative care available in the state.\textsuperscript{223} For example, a competent, terminally ill patient, whose pain is not reducible by any life sustaining method, might be able to succeed with a constitutional claim for physician-assisted suicide if the state prevented him from receiving relief from his pain.\textsuperscript{224} Another situation where a more particularized challenge might succeed is where a state subjects a physician to severe criminal penalties for complying with a competent, terminally ill patient’s request for physician-assisted suicide because he is suffering in extraordinary pain.\textsuperscript{225} Kathryn Tucker, the Seattle litigator who unsuccessfully brought the Glucksberg Supreme Court challenge, plans to bring another claim to mandate federal recognition of the right to have adequate access to pain medicine at the end

\begin{footnotesize}
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\item[218.] See Glucksberg, 117 S. Ct. at 2309 (Stevens, J., concurring).
\item[219.] See Gostin, supra note 22, at 1523; Cass R. Sunstein, Supreme Caution: Once Again, the High Court Takes Only Small Steps, WASH. POST, July 6, 1997, at C1.
\item[220.] Justices Souter, O’Connor, Stevens, Ginsburg, and Breyer each wrote concurring opinions. See supra notes 201-16 and accompanying text.
\item[221.] See Glucksberg, 117 S. Ct. at 2275 n.24.
\item[222.] See Glucksberg, 117 S. Ct. at 2311 (Breyer, J., concurring).
\item[224.] See id. at 139.
\item[225.] See Gostin, supra note 22, at 1526.
\end{enumerate}
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of life.  

B. Legislative Impact

The Court's decisions in Vacco and Glucksberg defer to the individual states the responsibility of passing legislation which would either permit or prohibit physician-assisted suicide.  

Oregon was the first state to pass legislation legalizing physician-assisted suicide.  

The Supreme Court recently rejected appeals of this statute, thereby affirming its decision to defer to the states on the issue.  

Since Oregon voters passed the Death with Dignity Act, many legislatures have introduced similar proposals to legalize physician-assisted suicide; however, to date, no other state legislature has enacted such a proposal.  

Due to the shifting public and medical attitudes regarding the support for physician-assisted suicide, other state legislatures might "follow the lead of Oregon and enact a law permitting physician-assisted suicide."  

State legislatures can also look to the Netherlands for help in developing appropriate guidelines.  

While the Netherlands experience shows the difficulty in legalizing physician-assisted suicide and euthanasia, the problems the Dutch encountered may be useful tools for state legislatures in drafting effective legislation.  

The various attempts by state legislatures to legalize physician-assisted suicide evidences the American concern for lessening the anguish of terminally ill patients.  

However, the legislation aimed at helping terminally ill patients often

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230. See supra notes 105-10 and accompanying text.

231. See Sitcoff, supra note 72, at 695; Orentlicher, supra note 115, at 475.

232. See Pugliese, supra note 88, at 1324. But see Callahan & White, supra note 125, at 18 (questioning whether the United States can adequately monitor euthanasia and physician-assisted suicide when the Netherlands has failed to do so); Kreimer, supra note 143, at 579 (discussing the consequences of the American system which "reimburses health care on terms that threaten to encourage abuse of assisted suicide and voluntary euthanasia").

233. See Orentlicher, supra note 115, at 460. The evidence from the Netherlands is "decidedly mixed." See Gostin, supra note 22, at 1523.

234. See Sitcoff, supra note 72, at 706.
contains flaws which threaten the rights of terminally ill individuals. For example, the Oregon Act, as well as the Copycat Acts, prohibit third parties from administrating a lethal dosage of medication. Thus, the patients must administer the medication themselves, which presents a potential obstacle for those patients who are unable to carry out the act themselves due to a lack of physical strength or capability of ingesting the medication. Furthermore, the Oregon Act and the Copycat Acts explicitly prohibit lethal injection by a physician, but "they are silent on whether a patient has a right to self administer the lethal injection." The various acts should correct this oversight by allowing patients who cannot orally ingest the dosage to end their lives through lethal injection. Additionally, the absence of any maximum waiting period in any of the various acts presents another problem for terminally ill patients to overcome. For example, if a patient who has requested a lethal dosage to end her life becomes depressed or becomes incompetent while waiting for the prescription, the patient’s request risks nullification. Thus, to ensure that physicians comply with their patient’s wishes, legislation should include a maximum waiting period. Moreover, those in the medical field will have to decide their position on the issue before their patients ask for their assistance. As one author has speculated, "[i]f physician-assisted suicide is sanctioned, some physicians may by law be forced to compromise their values and act against their own conscience." In order to safeguard against making physicians do things to which they are morally opposed, the state legislation should not require a physician to participate, similar to the Oregon Act that allows physicians to decide whether they will participate in physician-assisted suicide. The goal of any death with dignity act should be to "promote more humane living as well as more humane dying for terminally ill patients."
C. Social Impact

The most important social impact of Vacco and Glucksberg is the lack of a uniform statute addressing the legality of physician-assisted suicide because the Supreme Court left the decision to individual state legislatures. Some states could allow physician-assisted suicide while other states will prosecute physicians. The Oregon statute is the first law of its kind in the United States, but it contains various safeguards to protect both the patients and their physicians. Terminally ill patients must "follow a series of steps, including examination by a second physician," a possible psychiatric evaluation if the patient shows signs of depression, and documentation showing that the patient’s actions are voluntary. There is also a residency requirement in Oregon’s statute, although residency is not defined. However, once the residency requirement is met, the law allows physicians to prescribe lethal medication upon a terminally ill patient’s request. The attending physician and a consulting physician must agree that the patient has an incurable disease that will bring about death within six months. There is also a fifteen day waiting period between the first request and the writing of the prescription. Despite these safeguards, the lack of an adequate definition for defining a resident may create the problem of "forum shopping," whereby individuals might cross state lines in order to request physician-assisted suicide. In addition, a lack of residency requirement in the Australian physician-assisted suicide legislation provided a concern that the Northern Territory of Australia might well become the "world’s suicide capital," prompting the Australian government to overturn the law.

Another major concern is the widely accepted fact that physician-assisted suicide already occurs illegally in those states which continue to ban the practice.
There exists a great danger in practicing physician-assisted suicide illegally.\textsuperscript{258} Fearing disapproval among other colleagues, as well as legal consequences, physicians who engage in the practice of assisted suicide infrequently ask their colleagues for second opinions in evaluating a patient's request for suicide.\textsuperscript{259} Thus, the illicit practice of physician-assisted suicide, which will continue to occur with or without Supreme Court support, lacks appropriate safeguards which could result in certain physicians exerting undue pressure on a patient or misdiagnosing a terminal illness.\textsuperscript{260} Moreover, physicians will have wide latitude in interpreting ambiguous and inadequately defined provisions of physician-assisted suicide legislation.\textsuperscript{261} In determining a patient's prognosis, a physician is often confronted with difficulties and uncertainties.\textsuperscript{262} Thus, in deciding if a patient meets the requirement of a terminally ill patient, which is usually defined as a disease that will cause death within six months, physicians must use their best judgment and interpretation of the available scientific literature.\textsuperscript{263} Also, the Oregon Act does not forbid a physician from raising the issue of physician-assisted suicide with a terminally ill patient.\textsuperscript{264} As a result, a physician must take great caution in deciding whether or not to encourage physician-assisted suicide due to the strong fiduciary relationship of a physician and a patient.\textsuperscript{265}

Another problem which exists is the fact that many patients often suffer from extreme pain before they become terminally ill.\textsuperscript{266} Thus, if the "right-to-die reflects the individual's right to be free of inhumane suffering," then it is hard to distinguish between those patients with terminal illnesses and those diagnosed with serious, painful, yet not terminal, illnesses.\textsuperscript{267} Therefore, it is arguable that the right to physician-assisted suicide should extend beyond those patients who suffer from terminal illness.\textsuperscript{268}

\textsuperscript{258} See Anthony L. Back et al., 275 JAMA 919, 919 (1996) (describing how frequently physicians receive requests for physician-assisted suicide and euthanasia, the nature of these requests, and physician responses to these requests).

\textsuperscript{259} See id.

\textsuperscript{260} See id.; Lu, supra note 217, at 8.

\textsuperscript{261} See Alpers & Lo, supra note 243, at 483.

\textsuperscript{262} See id.

\textsuperscript{263} See id. at 484.

\textsuperscript{264} See id.

\textsuperscript{265} See id. (suggesting that suicide is an option rather than a solution to terminal illness).

\textsuperscript{266} See Orentlicher, supra note 115, at 473.

\textsuperscript{267} See id.

\textsuperscript{268} See id.
V CONCLUSION

In Vacco and Glucksberg, the Supreme Court refused to recognize a general right to die or right to physician-assisted suicide.\(^{269}\) However, the Court left the decision of whether to legalize or ban physician-assisted suicide to individual states.\(^{270}\) It appears that the attitude about physician-assisted suicide is changing in the United States.\(^{271}\) For example, the most recent Harris Poll shows that sixty-eight percent of people responded in the affirmative when asked if terminally ill patients should be able to obtain prescriptions from their doctors for lethal dosages of drugs to end their lives.\(^{272}\) Washington and California voters narrowly defeated ballot measures legalizing physician-assisted suicide in the early nineties, but it appears that public opinion regarding physician-assisted suicide has changed since then.\(^{273}\) While Oregon is the first state to pass legislation legalizing the right to physician-assisted suicide, the whole nation will undoubtedly watch Oregon closely to see its trials and tribulations in dealing with such a new area of law. As a result of the Court’s decisions in Vacco and Glucksberg and the subsequent media coverage, pressure rests on individual states to consider the issue of physician-assisted suicide. The American public will cast a watchful eye on Oregon to see how it will implement its experiment and the results that occur. Many questions have been left unanswered, and Oregon will be the guinea pig in the area of physician-assisted suicide. Regardless of what happens in Oregon, there will be much debate between the state legislators and their voters in deciding whether to allow physician-assisted suicide.

JENNIFER BRADFORD