Constitutionalizing Physician-Assisted Suicide: Will Lightning Strike Thrice?

Robert A. Burt*

The necessary conjunction of caution with wisdom has been the very definition of judicial conduct in American law. The common law methodology, deferring to precedent and deciding only what is necessary to resolve the specific dispute at hand, exemplifies this conjunction. Constitutional adjudication has traditionally followed this course.

Courts do, of course, overrule precedent and sometimes announce spacious principles intended to have general applicability. Brown v. Board of Education\(^1\) is the preeminent example of the wisdom of this course in constitutional adjudication. Brown also exemplifies the conjunction of caution with wisdom. Of the nine Justices in 1954 who unanimously proclaimed that “separate is inherently unequal,” notwithstanding the authority of Plessy v. Ferguson,\(^2\) five had served on the Court together since 1941.\(^3\) During these thirteen years, the Justices addressed the constitutional validity of racial segregation laws in many different contexts, including graduate school public education,\(^4\) voting practices,\(^5\) public transportation,\(^6\) and judicial enforcement of restrictive housing covenants.\(^7\) Brown was the climax of a cautiously incremental judicial course and, even then, Brown’s bold-

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* Alexander M. Bickel Professor of Law, Yale University.
2. 163 U.S. 537 (1896).
3. Justice Hugo Black was appointed to the Court by Franklin Roosevelt in 1937, followed by Stanley Reed in 1938, Felix Frankfurter and William Douglas in 1939 and Robert Jackson in 1941.
ness was significantly tempered by the cautious incrementalism that the Court adopted in Brown II.8

This judicial caution has costs, as many critics have observed.9 In its prolonged struggle against racially discriminatory practices in the decades following Brown, the Court displayed increasing impatience. In 1968, the Court finally repudiated the incremental enforcement directive of Brown II.10 Perhaps chastened by the gap between its enunciation of constitutional principle and the resistant state practices, the Court became visibly bolder in attacking state racially discriminatory practices after 1968 and its boldness was immediately extended to other state practices.

Decisions concerning abortion and the death penalty were the most notable and publicly visible examples of a more abrupt style of judicial intervention. In 1973, Roe v. Wade effectively overturned abortion restrictions then in force in all but four states.11 Unlike the carefully measured progression of judicial decisions that preceded Brown, the Supreme Court had previously adjudicated only one case involving abortion restrictions. The previous decision had given virtually no hint of doubt concerning the constitutional status of restrictive abortion laws.12 Similarly, in 1972, the Court abruptly and unexpectedly invalidated the death penalty statutes then extant in forty-one states. Before its decision in Furman v. Georgia,13 the Court had found constitutional problems only in jury selection practices, a narrow though important aspect of the administration of state death penalties.14 The sweeping condemnation in Furman appeared suddenly, like a stroke of lightning, the metaphor that Justice Stewart invoked to describe the capricious unpredictability that he found constitutionally offensive in the administration of the death penalty generally.15 And like lightning, Furman disappeared almost as quickly as it had arrived. Just four years later, after thirty-five states had quickly enacted new death penalty laws, the Court

8. Brown v. Board of Education, 349 U.S. 294 (1955) (declining to mandate immediate enforcement of the apparently sweeping principle that the Court had announced the preceding year).
15. 408 U.S. at 309-10 (Stewart, J., concurring).
reversed direction with minimal advance warning or coherent explanation of its new course.\(^\text{16}\)

*Roe* and *Furman*, viewed as examples of the reaction to the measured pace of and adamant resistance to *Brown*, may denote that the traditionally accepted judicial virtue of caution joined with wisdom no longer has self-evident normative force in constitutional adjudication.\(^\text{17}\) If judges are more tempted today, however, to enunciate sweeping principles, the recent rulings of the Second and Ninth Circuit Courts of Appeals on physician-assisted suicide\(^\text{18}\) go a considerable distance beyond even *Roe* and *Furman* in their abruptness, their lightning-like appearance from nowhere.

I. FINDING CONSTITUTIONAL PRINCIPLE

Although *Roe* was an unexpected invocation of judicial authority on behalf of freely-chosen abortions, state legislatures had been moving toward this result for more than a decade. In 1959, the American Law Institute had proposed substantial liberalization of the grounds for abortion in its Model Penal Code, most notably permitting abortion to protect the pregnant woman's future “mental health.”\(^\text{19}\) This liberalization had been adopted by “about one third of the states” when *Roe* was decided.\(^\text{20}\) Although these statutes still required physician boards to approve a woman's request for abortion, retrospective studies in California show that in practice, these liberalized standards amounted to abortion on demand. It is likely that this same practical impact occurred in other liberalizing states.\(^\text{21}\) More sig-


\(^{17}\) For speculation about generational differences in the understanding of constitutional adjudication from *Brown* to *Roe* and *Furman*, see Robert A. Burt, *Alex Bickel's Law School and Ours*, 104 Yale L.J. 1853 (1995).


\(^{20}\) Roe, 410 U.S. at 139 \& n.37.

\(^{21}\) Luker, *supra* note 19, at 94. Luker stated:

In 1968, the first full year under the new [liberalized California] law, 5,018 abortions were performed. In the next year, however, the number of abortions tripled, to 15,952. The following year that number itself quadrupled, and 65,389 abortions were performed. In 1971 it almost doubled again, and 116,749 abortions were performed. In 1972 the rate stabilized at a little over 100,000 abortions and has remained at that level to the present. In four short years, therefore, the number of abortions sought and performed in California increased by 2,000 percent. Moreover, by 1970, it was becoming apparent that what had been proposed as a “middle-\(^{21}\) way” solution had in fact become “abortion on demand.” It is possible that the mechanisms of medical review (and psychiatric review in the case of those using
nificantly, in 1971, New York, Washington, Alaska and Hawaii repealed all restrictions on first-trimester abortions. Thus, when the Supreme Court decided Roe, four state legislatures had already explicitly approved freely-chosen abortions, and, in some fifteen additional states, this legal regime was already available in practice.

Judicial abolition of the death penalty in Furman had been more extensively anticipated by state legislatures. By 1972, the death penalty had been completely abolished in nine states, as early as 1853 in Wisconsin and 1846 in Michigan. Moreover, by 1972, four additional states had so narrowly limited the application of their death penalties as to amount to virtual abolition.

Accordingly, although both Roe and Furman were unexpected exercises of judicial authority and imposed a rule on every state which had been in effect in only a minority of states, the actual impact of both cases was not unprecedented. Many states had already accumulated considerable experience in the practical administration and the cultural implications of the legal regimes made generally applicable in Roe and Furman. Large, controversial questions remained about the legitimacy of the Court's rulings in both cases and the moral acceptability of the judicially-commanded results. Nonetheless, the likely consequences of freely-available abortions and an abolished death penalty were predictable because of the prior state experience.

No one knows what to expect, however, regarding legally recognized physician-assisted suicide, since there is no directly relevant past experience. No state now recognizes, nor has ever recognized, the legitimacy of physician-assisted suicide. In 1992, Oregon voters approved by referendum a measure that would, for the first time in any American jurisdiction, authorize physicians to prescribe (but not administer) lethal medication for voluntary, mentally competent, terminally ill people. This measure
has not yet gone into effect. A federal district court held it unconstitutional\textsuperscript{24} and, though the Ninth Circuit Court of Appeals explicitly disapproved this ruling in its opinion overturning the Washington state ban on physician-assisted suicide,\textsuperscript{25} the Oregon law remains stalled. Although it seems likely that the constitutional challenge to the Oregon law will ultimately be dismissed,\textsuperscript{26} the rulings by the Second and Ninth Circuit overturning state laws explicitly forbidding physician-assisted suicide were not merely novel exercises of constitutional authority. These rulings startlingly impose a legal result that was without precedent in any prior state or federal legislative action.

This fact has several implications. First, it raises questions concerning the sources of principle on which judges have relied in interpreting constitutional commands. This is a complex issue. In our constitutional tradition, judges are meant to protect minorities against majoritarian overreaching. Thus, simply observing that a judge has constitutionally invalidated a law approved by majorities in all but one state does not in itself demonstrate that the judge has erred. Nonetheless, life-tenured judges have customarily worried, and should always worry, about succumbing to the temptation of confusing their personal moral views with constitutional norms. As Justice Brandeis classically observed, “in the exercise of this high power [of constitutional invalidation], we must be ever on our guard, lest we erect our prejudices into legal principles.”\textsuperscript{27} If the Supreme Court unanimously affirms the judgments of the Ninth and Second Circuits, this would mean that a total of twenty-one people (nine on the Supreme Court, eight on the Ninth Circuit en banc


\textsuperscript{25} Compassion in Dying, 79 F.3d at 839 & nn.138-39.

\textsuperscript{26} The district court had invalidated the Oregon statute on the ground that it violated equal protection guarantees by providing insufficient safeguards to assure that its application would be limited to those who were truly voluntary and mentally competent. It is, however, difficult to understand the jurisprudential theory by which these possible insufficiencies become transformed into constitutional infirmities. The district court maintained that, because the Oregon statute authorized assisted suicide only for terminally ill people, the non-terminally ill were given more effective protections and this distinction wasconstitutionally irrational. While it may not be good public policy, however, it does not seem wholly irrational to permit people who are diagnosed as terminally ill and mentally competent to obtain lethal medication which they must self-administer, thus providing an added measure of assurance for voluntariness. One might argue that there is a “fundamental right” against involuntary euthanasia that is so powerful that no imaginable legislative safeguards could ever be sufficient to assure voluntariness. That appears to be the underlying argument of the district court in Lee v. Oregon, supra note 24, but the district court did not explicitly make this argument and it is difficult to identify constitutional law precedent for doing so.

\textsuperscript{27} New State Ice Co. v. Liebmann, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting).
Panel plus one dissenting judge on the original panel, two on the Second Circuit panel, and the District Judge in the Ninth Circuit case) will have imposed on every state a legal conclusion that had been endorsed by the voters of only one state in the Union.

Judges have properly invalidated widely-enacted laws to vindicate constitutional values. Yet, notwithstanding the judicial boldness expressed in such decisions as Brown, Roe, Furman, Lochner v. New York, or even Dred Scott v. Sandford, there is no judicial decision in our entire tradition that has constitutionally imposed a result on all states which had been previously approved in only one. The constitutional invalidations by the Ninth and Second Circuits of state laws prohibiting physician-assisted suicide are, in this sense, utterly unprecedented.

Many individuals have criticized these rulings for employing prior precedents in substantive constitutional law, asking whether the "privacy" or "liberty" interest proclaimed in Roe can logically be extended to physician-assisted suicide, as the Ninth Circuit held, or whether equal protection rationality standards prohibit state law distinctions between deaths resulting from refusing as opposed to demanding medical treatment, as the Second Circuit held. This author's concern is not with the courts' substantive interpretations themselves; indeed, this author believes it was a larger substantive leap from Griswold to Roe, from the privacy right for two consenting adults to use contraception to the claim that abortion is a "private choice," notwithstanding the plausibility of state claims to protect fetal life, than from Roe to the Ninth Circuit's ruling regarding physician-assisted suicide. This author's concern is with the abruptness of the judicial process by which that substantive interpretation occurred. It is in this sense that the physician-assisted suicide rulings are without precedent.

II. TRANSLATING CONSTITUTIONAL PRINCIPLE INTO PRACTICE

Even if a federal court could justifiably find the existence of a constitutional principle requiring the legal authorization of physician-assisted suicide, the absence of any state experience in this matter means that no one knows how, or even whether, the constitutional principle could be effectively vindicated in practice.

Both the Ninth and Second Circuits held that physician assistance must be limited to terminally ill people who voluntarily

28. 198 U.S. 45 (1905).
29. 60 U.S. 393 (1857),

choose suicide and are mentally competent to do so.31 The centrality of voluntariness and mental competence in these rulings arises from the internal logic of the constitutional principle that the Ninth Circuit most explicitly invoked as the basis for its ruling: the principle of individual liberty “involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy.”32 The Second Circuit held that the New York law irrationally distinguished between authorizing physicians to withhold life-saving medical treatment and forbidding them actively to assist in hastening death;33 but this is not a coherent invocation of equal protection analysis unless there is some special reason for heightened scrutiny of the state legislative distinctions, such as the “liberty interest” on which the Ninth Circuit relied.

There are, however, peculiar difficulties in assuring both the voluntariness and mental competence of gravely ill people who might choose hastened death, difficulties that are more troubling and intractable than choice-making in most other contexts, including such emotionally charged matters as abortion. Unless these difficulties can be overcome in actual practice, it is a hollow pretense to proclaim respect for an individual’s right to choose hastened death.34

31. See Compassion in Dying, 79 F.3d at 793; Quill, 80 F.3d at 718.
32. Compassion in Dying, 79 F.3d at 813 (quoting Planned Parenthood v. Casey, 505 U.S. 833, 851 (1992)).
33. Quill, 80 F.3d at 727.
34. These difficulties also afflict an individual faced with a decision to decline life-prolonging treatment offered by the individual’s physician, a decision which the Supreme Court has already implied rests within a constitutionally protected “liberty interest.” Cruzan v. Director, Missouri Dep’t of Health, 497 U.S. 261, 277 (1990). The context of an individual’s decision to refuse life-prolonging treatment, in itself, provides significant checks for voluntariness, if not mental competence, that are lacking for a decision in favor of physician-assisted suicide. In the former context, a physician’s offer to provide life-prolonging treatment presents a counterweight to the patient’s apparently contrary inclinations; whereas, when physicians offer to assist suicide, which, by the Ninth Circuit’s hypothesis, physicians must remain free to do, this counterweight is not only removed, but the individual patient’s choice for suicide is likely to be implicitly validated and facilitated.

Even if the psychological pressures accompanying decisions to decline treatment are the same, however, as the pressures experienced in decisions to enlist physician assistance for suicide, this is a reason for judicial caution in pressing forward with proclamations of constitutional rights to decline treatment. This caution was reflected in the Supreme Court’s tentative approach in Cruzan, where the Court refused to impose a uniform constitutional rule on all states but deferred to their diverse “sources available” in resolving “a perplexing question with unusually strong moral and ethical overtones.” Cruzan, 497 U.S. at 278.
A. Voluntariness

1. Pain

The most powerful and poignant argument on behalf of legalizing physician-assisted suicide is to provide release for terminally ill people from intense, intractable pain.\textsuperscript{35} For anyone forced to choose between continued life with such pain and the release of death, the pain obviously exerts an enormous and even overwhelming coercive impact. Obviously, this impact alone cannot justify characterizing a choice for death as "involuntary." If, however, this pain is actually avoidable but the suffering individual is neither informed of this fact nor given the opportunity to alleviate this terrible pain, then this individual is not acting voluntarily in choosing death as the only or even the preferred way to end suffering.

Many dying people in this country today are suffering from insufficiently treated pain.\textsuperscript{36} Medically effective techniques for completely alleviating this pain are available for almost all of these people. According to knowledgeable physicians and researchers, this is possible in as many as 98% of cancer cases.\textsuperscript{37} The medical profession generally, however, is neither informing patients of this possibility nor providing this palliative care.\textsuperscript{38}

\textsuperscript{35.} Both the Second and Ninth Circuits repeatedly relied on this proposition to justify their rulings. \textit{Compassion in Dying,} 79 F.3d at 820, 825, 827, 834 ("debilitating pain and humiliating death ... unusual and protracted suffering ... slow and agonizing death ... unmitigated tortures"); \textit{Quill}, 80 F.3d at 719, 730 ("chronic, intractable pain and/or intolerable suffering"... "continuation of agony").

\textsuperscript{36.} American Medical Ass'n Council on Scientific Affairs, \textit{Good Care of the Dying Patient,} 275 JAMA 474, 475 (1996). The council stated:

How commonly pain marks the actual experience of dying is uncertain, and estimates vary substantially across institutions, whether hospices or hospitals. Coyle et al reported that three of every four cancer patients had pain. Bonica's review of published reports indicates that more half of cancer patients have severe pain. Saunders has claimed that one fourth of cancer patients have inadequate pain control when dying.

\textit{Id.} (citations omitted). \textit{See also} C. S. Cleeland et al., \textit{Pain and its Treatment in Outpatients with Metastic Cancer,} 330 NEW ENG. J. MED. 592 (1994).

\textsuperscript{37.} American Med. Ass'n, 275 JAMA at 475 (citations omitted). The Council further stated:

Only 2% of patients in hospice care experience pain that is difficult for a skilled team to manage. With the exception of one study, other investigators confirm this low rate of serious pain persisting in systems of care that emphasize pain management. The rates of pain in persons who are dying of diseases other than cancer are not [however] well described.

\textit{Id.}

\textsuperscript{38.} \textit{Id.}

The potential for management of pain has recently improved, both through the development of better techniques and through enhanced care delivery through hospice and palliative care efforts. ... Although guidelines and a curriculum on pain management have been developed, oncologists and others report serious perceived shortcomings in management of cancer pain.
The reasons for this failure by the medical profession are not adequately understood, nor is an effective remedy for this failure known. There are many possible explanations, such as: insufficient knowledge among physicians about pain management because of inadequate professional training; state and federal legal restrictions on availability of controlled substances for pain relief and/or physician misconceptions about the legal restrictions; failure to acknowledge a patient's pain because of unwillingness or inability of physicians and other medical personnel to engage in more than perfunctory conversation, or, in many cases, any conversation with patients who are perceived as dying.\(^{39}\)

The explanation for this failure cannot plausibly be cruelty or callousness of the medical profession. There is widespread acknowledgment and dismay within the profession about the failure to provide even minimally adequate pain palliation for most dying people. Not enough is known about the causes of this failure, however, to confidently prescribe effective remedies for it. The most recent and disturbing indication of the profession's ignorance are the research results of the so-called SUPPORT project (Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments). This four-year study, involving over nine thousand dying adult patients in five United States teaching hospitals, was designed "to improve end-of-life decision making and reduce the frequency of a mechanically supported, painful, and prolonged process of dying."\(^{40}\) Phase I of the study, establishing the empirical base-line of practices current in 1989-91, documented that, overall, "50% of all conscious . . . patients who died in the hospital experienced moderate or severe pain at least half the time during their last 3 days of life," although there was "substantial variation" among the five hospitals.\(^{41}\) In Phase

Other distressing symptoms of dying patients, in addition to pain, are also inadequately treated by physicians. See Susan Block & Andrew Billings, Patient Requests to Hasten Death: Evaluation and Management in Terminal Care” 154 ARCH.INTERN.MED. 2039, 2040 (1994) (“Other symptoms [beyond pain] (eg., dyspnea, anorexia, nausea, constipation, insomnia, and anxiety) regularly plague terminally ill patients and are often inadequately controlled by physicians who lack expertise in palliative care or fail to take an aggressive stance toward assuring patient comfort”).


40. Alfred F. Connors et al, A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients: the Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment (SUPPORT), 274 JAMA 1591 (1995).

41. Id. at 1594. This base-line result was consistent with numerous other prior research reports. See WORLD HEALTH ORG., REPORT OF A WORLD HEALTH ORG. EXPERT COMMITTEE: CANCER PAIN RELIEF AND PALLIATIVE CARE 19 (1990).
II, conducted in 1992-94, patients were divided into intervention and control groups, with the intervention group receiving intensive services from a "specially trained nurse" who, among other functions, facilitated communication and "encouraged attention to pain control" between the medical care team and the patients and their families. Unfortunately, this "phase II intervention failed to improve care or patient outcomes." In particular, reports of untreated pain during the last three days of life actually somewhat increased among intervention group patients in comparison to control group patients.

The SUPPORT study was the most comprehensive research on the experience of dying patients ever conducted in this country. The failure of its intervention, not simply to correct, but to measurably affect the problem of unnecessary but untreated pain among dying patients, is a puzzling result. Much more extensive changes in physician education and institutional structural arrangements may be necessary in order to make generally available the existing well-documented techniques of pain relief that, when actually implemented, are effective for almost all dying patients. Alternatively, perhaps relatively modest changes, untested by the SUPPORT researchers, including amendments to restrictive state drug control laws recently proposed by the National Conference of Commissioners on Uniform State Laws and currently being considered in many states, may have a substantial impact.

As long as substantial numbers of dying people are unnecessarily suffering from treatable pain, however, no one can claim that an individual's choice to end his or her life rather than endure pain is an adequately voluntary act. States cannot design adequate safeguards to assure that every suffering person has access to available pain control treatment when the reasons why such

42. Connors, supra note 40, at 1591.
43. Id. at 1595.
44. As the researchers observed,

The study certainly casts a pall over any claim that, if the health care system is given additional resources for collaborative decision making in the form of skilled professional time, improvements will occur. . . . [T]he overall results of this study are not encouraging. No pattern emerged that implied that the intervention was successful for some set of patients or physicians or that its impact increased over time. The five hospitals had been chosen for their diversity and their willingness to undertake a substantial and controversial challenge. Yet none showed a tendency toward improvement in these outcomes.


treatment is not being provided to large numbers of patients is not yet understood.

Moreover, recognition of a right to physician-assisted suicide is likely to create barriers to the provision of effective pain control and other symptomatic relief to dying patients. This paradoxical result could arise because some pharmacologic measures that are medically necessary to relieve intense pain or other symptoms can also have the unintended effect of hastening death. Even though such measures violate neither legal nor ethical proscriptions, some physicians are currently reluctant to administer adequate palliative medications because of their potential life-shortening effect. If physician-assisted suicide were legalized and accompanied by stringent procedural safeguards, many more physicians might conclude that even their current practices of pain control might require observance of these stringent new procedures. The net result would be the imposition of new barriers to the provision of currently recognized palliative care measures, thus increasing the already large number of patients who suffer needlessly from inadequate pain control. This paradoxical result would not inevitably follow from legalized physician-assisted suicide but it seems likely to do so and, in any event, carefully designed implementation measures would be required to guard against this possibility. In common, however, with all of the current barriers to adequate medical provision of palliative measures, we do not yet know enough about the underlying reasons for these barriers in order to design effective remedies to overcome them.

2. Undue Financial Pressures

Prolonged dying from chronic illness, which is the increasingly common mode of death in this country, can be extremely expensive for patients and their families, and for private and public health insurers. The Ninth Circuit explicitly recognized that the “risk of undue influence is real - and it exists today,” and that patients would choose suicide based on their own or others’ concerns about “astronomical medical bills.” Though Judge Reinhardt, in his opinion for the court, specifically mentioned the prospect of “undue pressure from callous, financially burdened, or self-interested relatives,” he minimized this concern as a significant factor in pressures for physician-assisted suicide on the

46. See World Health Org., supra note 41, at 52-53.
47. See generally K. E. Covinsky et al., The Impact of Serious Illness on Patients’ Families, 272 JAMA 1839 (1994); Anne Scitovsky, 'The High Cost of Dying' Revisited, 72 Milbank Q. 561 (1994).
ground “that the person will die shortly in any event.” Thus, Judge Reinhardt reasoned that grasping relatives will have little to gain in pressing for hasty decisions and, moreover, that direct involvement of a “professional third party in the decision-making process would more likely provide an important safeguard.”

Judge Reinhardt ignored the most potent new social force whose financial self-interest would not be thus tempered. Institutional arrangements in the delivery of health care are now in the midst of a fundamental transformation, as increasingly large numbers of patients are choosing, or are being forced by their employers or by state agencies to accept, the provision of medical treatment through managed care organizations. “The most troubling issue for end-of-life care in managed care is the possibility that clinicians are changed from being patients’ advocates to having a personal stake in withholding treatment that would be in the patients’ interests.”

Because the dominance of managed care organizations in American health care is relatively recent, there has been little systematic study of the extent of inappropriate cost-cutting pressures on patients. If physician-assisted suicide suddenly becomes a constitutionally-sanctioned option for all patients, however, it is certainly plausible and perhaps even likely that budget-minded health care organization managers and their physician-employees would press all of their dying patients toward exercising this option. Judge Reinhardt’s dismissive observation that grasping heirs would have little financial incentive to pressure a soon-dead relative toward a quicker suicide has no relevance to the motivations of managed care physicians who would realize substantial financial gains if many of their soon-dead patients chose quicker deaths. Perhaps traditional patient-centered medical ethics would guard against this improper pressure; perhaps external regulation of the new health care organizations would adequately protect dying patients against undue influence. Our experience of managed care, however, is too new

48. Compassion in Dying, 79 F.3d at 826.
49. Id.
50. Steven Miles et al., End-of-Life Treatment in Managed Care: The Potential and the Peril, 163 WESTERN J. MED. 302, 304 (1995). As Miles et al. observe:

Health maintenance organizations (HMOs), preferred provider plans, and managed indemnity insurance cover 80% of the privately insured persons in the United States. Recent large-scale extensions of managed care to public programs of Medicare and Medicaid ensure the continued rapid growth of managed care. The raison d’etre of managed care is to contain the growth of the cost of health care for groups of enrollees . . . . Managed care plans cannot afford to ignore the cost of end-of-life care. About 10% of health care resources are used for the care of persons in their last year of life.

Id. at 302.
for any confident claims on this score. Yet, as Judge Reinhardt's opinion for the Ninth Circuit explicitly recognized, without carefully designed safeguards to counteract "the risk of undue influence" for financial gain, a dying person's choice of physician-assisted suicide would not truly be a voluntary act.

Unjustified financial pressures would have an even more powerful effect on the large proportion of the American public without any health insurance, who number some forty million according to recent estimates.51 Once again Judge Reinhardt's opinion noted the problem ("[w]e would be inclined to agree that the country's refusal to provide universal health care, and the concomitant suffering so many Americans are forced to undergo, demonstrates a serious flaw in our national values."52), but nonetheless failed to acknowledge the central relevance of this problem to the constitutional legitimization of physician-assisted suicide. Unless there can be adequate assurances that no person chooses physician-assisted suicide because of poverty, this choice cannot be considered sufficiently voluntary. The judiciary is, however, not institutionally capable nor constitutionally authorized to create a system to guarantee health care regardless of income.53

If physician-assisted suicide is to be based on truly voluntary choice, it must only be offered as one part of a general social arrangement which ensures that no one is forced to choose suicide because he or she is too impoverished to obtain generally available medical services. If there should be a right to physician-assisted suicide, in other words, it must be accompanied by general social recognition of a right to adequate health care. The judiciary acting alone cannot achieve this goal. Two years ago, Congress intensely deliberated the establishment of a national health insurance program and, for many complex reasons, failed to act. The question is still being openly debated both in Congress and in individual state legislatures. The Ninth Circuit opinion observed that "as members of the judicial branch . . . we are compelled to stand aside from that battle."54 The proper way to "stand aside" is for courts to withhold any judgment regarding

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51. See President Finds He Has Gained Even If He Lost on Health Care, N.Y. TIMES, July 30, 1996, p. A1, col. 5.
52. Compassion in Dying, 79 F.3d at 826.
54. Compassion in Dying, 79 F.3d at 826.
the existence of a constitutional right to physician-assisted suicide while Congress and state legislatures are engaged in considering whether and how to implement a general right to health care, actions that alone could adequately eliminate the "undue influence" of poverty from any patient's deliberation about whether his or her chosen treatment should be physician-assisted suicide.

B. Mental Competence

1. Judgment-Impairing Confusion

"Confusional states are common" among dying people and, accordingly, "obtaining a truly informed consent is problematic."55 Regarding patients with advanced cancer, "the brain . . . is subject to many insults, including multiple drug effects, metastatic involvement, sepsis, and a plethora of metabolic abnormalities."56 After these factors have been excluded, "for unknown reasons a substantive number of cancer patients will remain delirious."57

It may seem self-evident that such confusional states would be readily detected by physicians or even by lay observers such as family members and that requests for assisted suicide would be appropriately disregarded. In actual practice, however, the detection of judgment-impairing confusion among dying people is surprisingly difficult.58 Based on several studies of dying patients, one researcher concluded that "our clinical observations miss profound confusional episodes in [20%] of our patients."59 Eduardo Bruera, a Canadian palliative care specialist with extensive experience treating dying patients, described one of these studies as follows:

56. Id.
57. Id.

Physicians frequently fail to recognize cognitive impairment in hospitalized patients and may miss delirium because of its fluctuating features and subtle presentation. When physician diagnosis is required to identify cases of delirium, reported rates have been quite low . . . . In this study of elderly patients on medical services, delirium occurred in over one-fifth of subjects and was usually evident within 48 hours of admission. Our prospective surveillance identified many more patients with delirium than were seen by psychiatric consultants or diagnosed by physicians.

We looked at 45 patients that we had approached to participate in clinical trials... Of the 38 patients who signed the consent form we later determined, based on the administration of a Mini-Mental Status Questionnaire that six (21 percent) had severe cognitive impairment. These findings are open to many interpretations. One that raised a great deal of concern among us is that we believe that palliative care doctors and nurses spend more time talking to patients than the average physician and nurse and [yet] in our conversations with these patients we did not perceive them as being profoundly impaired.60

Bruera studied an additional sixty-one patients, administering the Mini-Mental Status Questionnaire three times each week until the patient had been discharged or had died. Based on this testing, he found that “thirty-four percent had cognitive failure upon admission and [83%] had it before death,” but when physicians and nurses not involved in this testing were asked for their independent observational assessments, “an episode of confusion identified by testing was not detected by the doctor on the same day in [23%] of cases, and was missed by the nurse in [22%] of cases.” Attempting to explain these counter-intuitive results, the researcher speculated, “[w]hat we may be observing among patients is an effort on their part to compensate for their cognitive failure because nobody likes to be viewed as not knowing where they are, what day it is or who they are talking to.”61

These results are consistent with more general observations in the SUPPORT study about shortcomings in communications between physicians and dying patients. The SUPPORT study found in Phase I that, of the patients who had expressed preferences for withholding cardiopulmonary resuscitation, “only 47% of their physicians accurately reported this preference.”62 In Phase II, for the intervention group in which a specially trained nurse talked with both physicians and patients on a regular basis regarding patient preferences, the SUPPORT study found essentially no improvement in physicians’ understanding of patients’ preferences.

It appears, then, that dying patients and their physicians are generally reluctant to talk with one another about matters of profound importance (“discussions and decisions substantially in advance of death were uncommon”63), and that there are substantial misperceptions between physicians and patients when conversations do occur. These profound silences and miscom-

60. Id. at 12.
61. Id. at 13.
62. Connors, supra note 40, at 1594.
63. Id. at 1595.
Communications between physicians and dying patients are often mirrored in general doctor-patient interactions. 64

This pattern of persistently missed communications appears to confirm the finding that physicians and nurses regularly overstate dying patients' decision-making competence. The explanation for this is not clear. Perhaps it occurs because of medical professionals' reluctance to intensively engage in painful conversations with dying people; perhaps because many dying patients are strongly motivated to disguise their own confusions.

Whatever the reasons, it is clear that state authorities and medical professional groups face a very difficult task and currently have inadequate experience or research data to design reliable safeguards to ensure the lucidity of dying patients who might claim a right to assisted suicide.

2. Judgment-Impairing Depression

Distinguishing between a dying person's profound sadness and an appropriate psychiatric diagnosis of clinical depression is exceedingly difficult. 65 For many reasons, however, drawing this distinction with accuracy and sensitivity is important in designing appropriate treatment for all dying people in order to provide the greatest possible satisfactions (for conversations, for reconciliations, for good leave-takings) for them and for their families.

Identifying clinical depression is even more important when crucial decisions, such as refusing further medical treatment or requesting assisted suicide, is at stake. Clinical depression, which commonly carries deep feelings of personal worthlessness and hopelessness, distorts an individual's rational capacity to make choices.

There has been little systematic research regarding the mental status of dying people who request assisted suicide or

65. Susan Block & Andrew Billings, Patient Requests for Euthanasia and Assisted Suicide in Terminal Illness: The Role of the Psychiatrist, 36 PSYCHOSOMATICs 445, 451-52 (1995). The article states:

Depression and organic mental disorders are commonly seen among patients who request assistance in dying. These disorders can both impair patient autonomy and coexist with autonomous wishes for hastened death. . . . Determination of competence in this setting is often extraordinarily challenging, requiring subtle evaluations of thought processes and complex assessments of the patient's cognitive understanding, affective and emotional appreciation, and character limitations in understanding the implications of alternative choices.

Id. See also William Breitbart et al, Interest in Physician-Assisted Suicide among Ambulatory HIV-Infected Patients, 153 Am.J.PSYCHIATRY 238, 241-2 (1996); Nathan Cherny et al., The Treatment of Suffering When Patients Request Elective Death, 10 J.PALLIATIVE CARE 71, 73 (1994) (“Undertreatment [of depression among terminally ill patients] derives largely from the problems of recognition and assessment and from the misconception that depression is a normal response to cancer”).
refuse life-prolonging treatment. The limited available investigations suggest two propositions: first, that among terminally ill patients, “the desire for death could be quite variable over time;” and second, that clinical differentiation between a “psychologically stable” and a distorted decision is “in practice . . . a difficult distinction to make without actually initiating a course of treatment.”

Safeguards could be designed for the administration of physician-assisted suicide to take account of these considerations. The Ninth Circuit observed that, consistent with its finding of a constitutional right to physician-assisted suicide, states may adopt regulations requiring “reasonable, though short, waiting periods to prevent rash decisions.” As the underscored directive makes clear, however, the Ninth Circuit would exercise independent judgment about the requisite length of the waiting period, as it must, if it takes constitutional command of the question.

The problem, however, is that there is not yet enough practical experience or systematic empirical research to give an adequate answer to this question. The new Oregon statute requires a waiting period of “no less than 15 days . . . between a patient’s initial request and the writing of a prescription.” A two-week waiting period would not, however, be sufficient to account for the “temporal instability of the desire for death” that has been documented in the existing, limited empirical studies.

The existence of doubts about the appropriate waiting period between a request for suicide and facilitative action by a physi-

It has been reported that depression in the terminally ill can be responsive to both antidepressant medications and psychotherapeutic interventions, although admittedly there is no well-developed body of controlled research on this issue. Nevertheless, our findings indicate that a substantial proportion of terminally ill patients who express a desire to die could potentially benefit from a trial of treatment for depression. Although concurrent depression does not necessarily imply that a desire for death is implicitly “irrational,” the reasoning processes of depressed patients are characteristically biased by negative mental sets that may affect their capacity to make well-considered life-and-death decisions. Furthermore, demoralization and lack of assertiveness may render the depressed terminally ill patient more vulnerable to the suggestions of others, thereby increasing the potential for abuse.

Id. at 1190 (citations omitted).
67. Compassion in Dying, 79 F.3d at 833 (emphasis added).
68. OR. REV. STAT. ANN. ch. 127.850 § 3.08 (Supp. 1996).
69. Referring to the Dutch experience, currently the only country with any experience of legally recognized physician-assisted suicide, Chochinov et al observe: “Although the Dutch guidelines are explicit with respect to the requirement that the request for an assisted death must be persistent over time, it has been reported that in practice, 65% of all euthanasia deaths occur within [two] weeks of the initial request,” a time span which would be too brief to take account of the “temporal instability of the desire for death that was observed in our group” of patients. Chochinov, supra note 66, at 1190.
cian does not mean that the Oregon statute is constitutionally invalid, though it does point to substantial risks inherent in its implementation, not only on this matter, but on the entire range of concerns about ensuring the voluntariness and mental competence of gravely ill people who request assisted suicide. As Justice Brandeis observed in another context:

> The objections to the [state law] are obvious and grave. The remedy might bring evils worse than the present disease. The obstacles to success seem insuperable. The economic and social sciences are largely uncharted seas. . . . Merely to acquire the knowledge essential as a basis for the exercise of this multitude of judgments would be a formidable task; and each of the thousands of these judgments would call for some measure of prophecy. Even more serious are the obstacles to success inherent in the demands which execution of the project would make upon human intelligence and upon the character of men. Man is weak and his judgment is at best fallible.70

Justice Brandeis made this observation in dissenting from his colleagues’ decision to overturn a state economic regulatory law during the heyday of the Court’s substantive due process interventions. The effect of this constitutional ruling, Brandeis said, was to “stay experimentation in things social and economic.” This result, he warned, however, “may be fraught with serious consequences to the nation. It is one of the happy incidents of the federal system that a single courageous state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.”71

The voters of Oregon have just recently resolved to embark on an unprecedented course in legitimizing physician-assisted suicide. The only guidance available for this action is the experience of the Netherlands, where physician-administered euthanasia, including assisted suicide, has been legally recognized under judicially-crafted guidelines for twenty years. Until very recently, however, there have been no systematic studies of the Dutch experience and it is still difficult to know what lessons, either encouraging or cautionary, can be gathered from that experience or, indeed, whether any lessons directly applicable to the United States can be drawn from this small homogeneous country with its generously funded, universal health insurance.72

71. 285 U.S. at 311.
Perhaps other states will follow Oregon's lead. Perhaps Oregon itself will find, after some practical experience with its novel policy, that, in Brandeis' words, their imagined remedy has inflicted "evils worse than the present disease." It is unjustified, even arrogant, however, to imagine that enough is known about the possible balance of virtues and evils in physician-assisted suicide for judges to command its legalization in every state at this moment. This sweeping imposition would effectively end free experimentation about the feasibility and desirability of this course, as much as the imperious interventions of the 1930s Supreme Court blocked social and economic regulatory experimentation in its day. Justice Brandeis was right then and is right now:

This Court has the power to prevent an experiment. We may strike down the statute which embodies it on the ground that, in our opinion, the measure is arbitrary, capricious, or unreasonable. . . . But, in the exercise of this high power, we must be ever on our guard, lest we erect our prejudices into legal principles. If we would guide by the light of reason, we must let our minds be bold. 73

### III. JUDICIOUS INITIATION OF A DELIBERATIVE PROCESS

This author's objection to the constitutionalizing of physician-assisted suicide does not rest on the conventionally debated ground that there either "is" or "is not" a "right to die" already implanted in the Constitution. This author's conclusion is that it is premature for any court to reach a final resolution of this issue because society has virtually no experience on which a judgment that is both morally and practically informed can be reached. Justice Brandeis' acknowledgment of the virtues of state experimentation and his conclusion that judges should withhold constitutional judgment to promote such experimentation is precisely the resolution that this author would adopt in this context. Although some scholars have expounded on the jurisprudential implications of Brandeis' position 74 and some judicial decisions have drawn on this jurisprudence, 75 this position does not fit

74. See, most notably, Alexander Bickel's praise for the "passive virtues" in his well-known but little observed book, The Least Dangerous Branch: The Supreme Court at the Bar of Politics (1962).
75. See, e.g., Penry v. Lynaugh, 492 U.S. 302 (1989)(refusing either to constitutionally prohibit capital punishment for mentally retarded offenders or to rule out the possibility of such a future constitutional ruling); Chandler v. Florida, 449 U.S. 560 (1981)(withholding final constitutional judgment regarding televised state criminal trials notwithstanding the defendant's objections); Mapp v. Ohio, 367 U.S. 643 (1961)(adopting constitutional exclusionary rule for illegally seized evidence only after extensive prior state regulatory experience and endorsements).
comfortably into the more conventional posture of judicial
authoritativeness, of "finality" in rendering judgments based on
high moral abstractions.

Judge Guido Calabresi, one of the members of the Second Cir-
cuit panel that invalidated New York's ban on physician-assisted
suicide, directly addressed this jurisprudential issue in a concur-
ring opinion in which he offered an unusual, and unusually inter-
esting, response. Calabresi concluded that the New York state
law was "neither plainly unconstitutional . . . nor plainly constitu-
tional"\(^\text{76}\) in the light of past substantive precedents, but that
the law itself had been "born in a different age,"\(^\text{77}\) and that the
state "legislature - for many, many years - has not taken any rec-
ognizably affirmative step reaffirming the prohibition" of physi-
cian-assisted suicide.\(^\text{78}\) Accordingly, Calabresi was prepared to
overturn the existing law in order to assure that the legislature
"really want[s] and [is] prepared to defend laws that are constitu-
tionally suspect."\(^\text{79}\) Calabresi insisted, however, that this dispo-
sition would "leave open the question of whether, if the state of
New York were to enact new laws prohibiting assisted suicide
(laws that either are less absolute in their application or are
identical to those before us), such laws would stand or fall."\(^\text{80}\)

Calabresi's approach is virtually unprecedented. Though he
invoked a few prior court rulings, these rulings provide only sug-
gestive support for him. The novelty of this approach is not an
indication that it violates the implicit prescriptions of caution
and moral humility that underlie traditional judicial canons in
constitutional as well as common law interpretive practice. To
the contrary, Calabresi's approach is a self-conscious attempt to
devise an explicit adaptation of these virtues to contemporary
judicial practices that pitch constitutional interpretation at such
a high level of moral abstraction and such elevated hierarchic
authority as to offer no alternative between unjustified authori-
tarianism by courts or by legislative majorities.\(^\text{81}\) Calabresi's
search for a technique in judicial interventions is properly guided
by the underlying constitutional imperative to find some mediating
ground where legislatively expressed majority will and judi-

\(^{76}\) Quill, 80 F.3d at 739.
\(^{77}\) Id. at 732.
\(^{78}\) Id. at 735.
\(^{79}\) Id. at 742.
\(^{80}\) Id. at 732.
\(^{81}\) For a general critique that the dominant schools of contemporary constitu-
tional jurisprudence offer only these unacceptable alternatives, see Robert A. Burt, The
cially protected minority rights can each claim their just portions.

The conventional constitutional doctrine of judicial supremacy has, of course, held that courts are authorized to strike this balance by authoritative proclamation. In actual practice, this conception has most commonly veered between the unjustified polar extremes of judicial authoritarianism (as epitomized by the judicial deployment of substantive due process to invalidate state and federal economic and social regulations from the late nineteenth century almost until World War II)\textsuperscript{82} and equally unjustified, supine judicial deference to majority impositions (epitomized, and explicitly justified as a reaction to "wrongful judicial authoritarianism," by the Supreme Court's utter disregard for the rights of a scorned sexual minority in \textit{Bowers v. Hardwick}\textsuperscript{83} and its resolute turning away from constitutional scrutiny of capital punishment after its premature authoritarian strike in \textit{Furman}).\textsuperscript{84}

As much as Calabresi's approach offers a better alternative than conventional accounts of the process of constitutional interpretation, however, this author believes it is misplaced in its application to the specific context of adjudicating the constitutionality of physician-assisted suicide laws. This author comes to this conclusion for two reasons. First, the functional justification for Calabresi's approach, judicially mandating a "constitutional remand" to the legislature, gives heightened moral force and public importance to substantive interests which are unlikely to be given serious attention in legislative assemblies. This justification does not apply clearly enough to the minority rights at stake in physician-assisted suicide laws. Dying people are clearly not a discrete and insular minority in the same, sure way as are black people subject to race discrimination laws, women subject to abortion restrictions, convicted criminals condemned to death or criminally prosecuted homosexuals. This is not to say that "dying people", as such, have no difficulty in obtaining a legislative hearing. Though we all will die, the prospect is sufficiently unsettling that most people are constantly tempted to deny their common bonds with "dying people." This psychological force, combined with the adamant moral opposition of some politically powerful social groups, can effectively keep the issues surrounding physician-assisted suicide from serious legislative deliberation.

\textsuperscript{82} See id. at 232-67.
\textsuperscript{83} 478 U.S. 186 (1986).
\textsuperscript{84} See Burt, supra note 81, at 327-44.
There is a second, and more clearly dispositive, reason for withholding the kind of intermediating judicial intervention that Calabresi espoused. This reason is the current, dramatic public ferment regarding physician-assisted suicide, which in itself shows that no judicial intervention is now necessary to give visibility and moral salience to the minority claims at stake. If Calabresi were a state court judge with dispositive authority in only a single state jurisdiction, the absence of sustained legislative debate within his jurisdiction might be sufficient justification for a “constitutional remand” that effectively invalidates the antique but extant assisted suicide prohibition. Judge Calabresi, however, sits as a federal judge with jurisdiction over several states at once. Moreover, he is charged with interpreting national standards in our single constitutional document, unlike state judges who draw their authority and substantive principles from specific state sources as well as from the federal Constitution. Legislative actions and popular political movements in other states are thus relevant for all federal judges, even if those states are not direct parties to the litigation at hand.

It is accordingly relevant for Judge Calabresi, though sitting in the Second Circuit, to consider that Oregon voters had authorized physician-assisted suicide in 1992, and that voters in both Washington and California had specifically rejected such authorizations by popular referenda in the preceding two years.\(^85\) By his criteria, these actions would appear to be “current and clearly expressed statements, by the people or by their elected officials, of the state interests involved,”\(^86\) thus mooting his predicate for a constitutional remand to state legislatures, at least in those states. The justification for a federal tribunal overturning the New York state law, not, by Calabresi’s hypothesis, because it is unconstitutional but because the people of New York or their legislative representatives have not recently articulated the state interests at stake, seems too narrowly constricted in its focus, too contrived in light of the contemporaneous actions of closely situated sister states.

The fact is that an intense, vibrant national debate about physician-assisted suicide and the social and medical treatment generally of dying people has recently erupted in this country. In the absence of any such debate, it would be injudicious, in the sense of being incautious and even morally arrogant, for a federal court to impose on the entire country a constitutionally-based resolution that has been approved in only one state. Calabresi's decision to remand the case to the state courts is warranted by the current public ferment regarding physician-assisted suicide.

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85. See Compassion in Dying, 79 F.3d at 810.
86. Quill, 80 F.3d at 738.
bresi's innovative approach is not subject to this critique; indeed, its mediating character is a self-conscious attempt to adapt traditional virtues of judiciousness to contemporary forms of constitutional adjudication. For Calabresi's more modest approach, the absence of any debate would be a justification for judicial intervention, but in the specific context of contemporary popular and legislative consideration of physician-assisted suicide, his approach is unsuitable. To invalidate the laws in most states, where physician-assisted suicide barriers have not been "currently" reaffirmed, would give an unjustified advantage to the proponents of this practice in a currently raging debate in which neither proponents nor opponents of the practice are clearly dominant in competing for public and legislative attention or sympathy.

The basic goal of judicial response to the constitutional claims regarding legalization of physician-assisted suicide should be to avoid sweepingly dispositive resolutions while the moral and practical issues involved are freely and widely debated and ultimately brought into clearer focus. Some boldness is needed for devising an adequate judicial technique to accomplish this goal. This boldness, though, would be in the service of an appropriate judicial modesty in approaching "a perplexing question with unusually strong moral and ethical overtones."87
