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INSTITUTIONAL ANALYSIS AND PHYSICIANS' RIGHTS AFTER *VACCO V. QUILL*

Larry I. Palmert†

*Calling something a "right" is an institutional statement.*¹

INTRODUCTION

Disagreement about the nature of constitutional rights in our legal system is prevalent. For those who view the Constitution as a set of principles for protecting individual rights, physician-assisted suicide raises the question of whether our rights may be transferable. Or, must we exempt physicians from the criminal prohibitions against aiding suicide in order to realize our sense of autonomy in dying? In other words, can a patient's personal "right of privacy" protect a physician from criminal prosecution for assisting the patient's suicide?

In *Washington v. Glucksberg*² and *Vacco v. Quill*,³ the Supreme Court answered this question in its constitutional form with a "no" by affirming that criminal prosecutions of physicians for assisting patients' deaths remain theoretically possible. In *Quill*, the Court rejected an "equal protection" challenge to New York's assisting or aiding suicide laws.⁴ Chief Justice Rehnquist, for the Court, reasoned that it is "rational" for legislatures to provide immunity from prosecution for those physicians who remove life-sustaining technologies of terminally ill patients in accordance with state law, while at the same time subjecting physicians to criminal liability if they accede to patient requests for lethal doses of barbiturates.⁵ In *Glucksberg*, the unanimous Court used five different reasons to find no "liberty" violation in Washington's statutory provisions against causing or aiding suicide.⁶ In so doing, the Court in-

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¹ NEIL K. KOMESAR, *IMPERFECT ALTERNATIVES: CHOOSING INSTITUTIONS IN LAW, ECONOMICS, AND PUBLIC POLICY* 43 (1994).

² 117 S. Ct. 2258 (1997).

³ 117 S. Ct. 2293 (1997).

⁴ *Id.* at 2296.

⁵ *See id.* at 2302.

⁶ *Glucksberg*, 117 S. Ct. at 2272 (state's interest in life of its citizens); *id.* at 2272-73 (state's interest in treating the causes of suicide); *id.* at 2273 (state's interest in the integrity of

licated that the debate about the appropriate role of physicians in our dying should continue in other policy forums, particularly in state legislatures, regulatory agencies,⁷ professional organizations, commissions,⁸ and religious groups.

Were we to follow the lead of constitutional theorists such as Professors Laurence Tribe⁹ and Ronald Dworkin,¹⁰ the various analyses of "liberty" in *Glucksberg* would frame the debate in state legislatures

the medical profession); *id.* at 2273-74 (state's interest in protecting vulnerable groups); *id.* at 2274-75 (state's interest in preventing the "slippery slope" to euthanasia). Justice O'Connor agreed with the "vulnerable groups" and "slippery slope" bases. *See id.* at 2303 (O'Connor, J., concurring). Justice Stevens agreed with the "preserving life" basis, *see id.* at 2305, and the "vulnerable groups" basis while mentioning the majority's reliance on the "medical integrity" basis. *See id.* at 2308-09 (Stevens, J., concurring). Justice Souter agreed with the "slippery slope" basis. *See id.* at 2290-91 (Souter, J., concurring). Justice Breyer did not mention any of Rehnquist's interests, but considered the lack of infringement of a right to palliative care dispositive. *See id.* at 2312; *see also supra* text accompanying notes 49-51.

⁷ The federal Drug Enforcement Administration recently announced that prescribing medication to assist a patient's death under Oregon's Death with Dignity Act would be in violation of its interpretation of the federal narcotics law which requires a "legitimate medical purpose" for every prescription. *See* Steven Findlay, *DEA Challenges Oregon Doctors; Narcotics Law to be used Against Assisted Suicide*, USA TODAY, Nov. 11, 1997, at 6A.

⁸ At the state level, the New York State Task Force on Life and the Law has been influential in shaping that state's law regarding the ethical issues associated with medicine. The New York Task Force report, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context* (1994), not only recommended no change in New York statutes regarding assisted suicide, but was relied upon by the United States Supreme Court in upholding the constitutionality of those statutes. *See Quill*, 117 S. Ct. 2301. At the national level over the past twenty-five years, we have grown accustomed to legal bodies or officials asking blue-ribbon panels to make recommendations about public and legal responses to ethical dilemmas in science and medicine. Public outcry in 1972, for instance, over the revelations of a forty-year study of untreated syphilis among rural African-American males in Tuskegee was the precipitating event for Congress establishing the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. Since that time, several prominent commissions at both the federal and state levels have made recommendations on policy and legal matters. The most recent example of what Professor David Rothman has labeled "Commissioning Ethics" in his book, *STRANGERS AT THE BEDSIDE: A HISTORY OF HOW LAW AND BIOETHICS TRANSFORMED MEDICAL DECISION MAKING* 168-89 (1991), is President Clinton's appointment of a National Bioethics Advisory Commission, chaired by the President of Princeton University, Harold T. Shapiro, a distinguished economist.

⁹ Advocates for the position that physicians' rights are matters for constitutional adjudication have focused on a final footnote in Chief Justice Rehnquist's opinion and language in some of the concurring opinions in *Glucksberg* to suggest that the Court may hold in a future case, with a different kind of plaintiff, that there is some type of constitutional right to die. As Professor Laurence Tribe, Dr. Quill's lawyer before the Supreme Court, said after *Glucksberg* and *Quill*: "the Court, far from slamming the door, in fact, if you look at it carefully, left it open by a vote of nine to nothing." *NPR Morning Edition: Supreme Court Rulings* (NPR broadcast, June 27, 1997) (statement by Laurence Tribe).

¹⁰ Professor Dworkin, along with five other "leading philosophers," filed a brief on behalf of the physician-respondents in both cases. *See* Brief for Ronald Dworkin et al., as Amici Curiae in Support of Respondents, *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997) (No. 95-1858), and *Vacco v. Quill*, 117 S. Ct. 2293 (1997) (No. 96-110). Dworkin details his views on the issue of assisted death in his book *LIFE'S DOMINION: AN ARGUMENT ABOUT ABORTION, EUTHANASIA, AND INDIVIDUAL FREEDOM* (1993). For a critique of his framing of the constitu-

and administrative bodies.¹¹ Such an approach assumes that legislatures and courts should examine the question of physicians' rights in the same manner—that courts and legislatures are essentially the same kind of institution—at least when it comes to addressing major social values such as how we die. This approach encourages legislators and voters to examine the Court's rhetoric about the nature of "rights" in framing and resolving legislative issues.

Legislatures, however, differ from courts. Both are legal institutions, but they have different procedures and constraints. More significantly, legislators and their staffs are obligated to listen to all of the contentious views, even those that differ from their own views and principles about how law should structure our relationships with our physicians. Courts, on the other hand, are obligated to decide only those cases that litigants bring before them. As a result of these contrasts, in constitutional adjudication, courts must determine which institution should resolve an issue.

I reject *Glucksberg* as a guide for building the analysis for the ensuing legislative debate. Rather, *Quill* provides the institutional framework for delineating the issues we face in legislative forums and other institutional settings.

The institutional analysis embedded in *Quill* is easy to miss for one simple reason: the Second Circuit decided its case a few months before the Supreme Court issued a major opinion on equal protection, *Romer v. Evans*.¹² In *Evans*, the Court held that a Colorado constitutional amendment violated the United States Constitution.¹³ The amendment disabled local municipalities from enacting any legislation prohibiting discrimination on the basis of sexual orientation.¹⁴ The Court struck down the amendment without finding any "fundamental right" or declaring that homosexuals are members of a "suspect class."¹⁵ Once we understand *Evans* as a signal that the Court was going to determine the claims of a

tional issues, see Larry I. Palmer, *Life, Death, and Public Policy*, 81 CORNELL L. REV. 161 (1995) (book review).

¹¹ Other "rights" theorists such as Professor Lois Shepherd are not necessarily unsympathetic to the Court's result, but nonetheless focus on *Glucksberg* and its implications. See Lois Shepherd, *Dignity and Autonomy after Washington v. Glucksberg: An Essay about Abortion, Death, and Crime*, 7 CORNELL J.L. & PUB. POL'Y (forthcoming 1998).

¹² 116 S. Ct. 1620 (1996).

¹³ *Id.* at 1623.

¹⁴ See *id.*

¹⁵ The majority opinion in *Evans*, written by Justice Kennedy, is somewhat remarkable in how it avoids any discussion of the Court's opinion in *Bowers v. Hardwick*, 478 U.S. 186 (1986), which upheld the constitutionality of state statutes making sodomy a crime. Kennedy avoided *Bowers* by framing the question in terms of whether the Colorado amendment was rationally related to a "legitimate governmental purpose." *Evans*, 116 S. Ct. at 1629. Such a statement of the issue allowed the majority of the Court to define the outer boundaries of the legislative process. By invalidating the Colorado amendment, the majority's equal protection

“constitutional right to die” by viewing the matter as one of institutional choice, *Quill* becomes the starting point for interpreting the scope of legislative authority to exempt physicians from legal liability for assisting their patients’ deaths.¹⁶

A particular Justice’s views on abortion, choice in dying, or family formation are informed by how that Justice makes the choice between courts, legislative processes, or “the market” as the appropriate forum for public policy making. Each of the five Justices writing opinions¹⁷ in *Glucksberg* and *Quill* posed different questions about institutional processes. All of the Justices concluded, however, that the legislature is the legal forum for defining which patient actions are self-killing or suicide. In denying the physicians’ claim for a constitutional right, the Court also granted to political processes the job of determining which physician acts constitute legally impermissible assistance in patient deaths.

Part I illustrates that the problem of physician-assisted suicide requires an analysis of two basic social institutions: law and medicine. The different institutional perspectives of the Justices led to variation in their *Quill* opinions. We discover these different theories of comparative institutional analysis by letting the questions each Justice asks frame the analysis. All of these different theories are subsumed by the overall question in law and medicine inherent in *Quill*: when is terminating medical care suicide? Part II demonstrates that interpretations of federal drug laws and Medicare and Medicaid regulations have a role to play in the physician-assisted suicide debate. Finally, Part III suggests that the phy-

analysis provided constitutional protection from “irrational legislation” by providing all individuals with a core right to participate in interest group politics.

In contrast, Justice Scalia’s dissent used *Bowers* to frame the constitutional issue when he stated the overall issue to be whether a majority can preserve “traditional mores” against a politically powerful minority. *See id.* at 1631-32, 1635 (Scalia, J., dissenting). Scalia’s equal protection analysis requires that the plaintiffs be entitled to some “fundamental right” before the Court can invalidate legislation.

The implications of *Evans* for the debate on physician-assisted suicide are apparent if one uses the approach of either the *Evans* majority or dissent to frame the issue. If one asks whether there is a fundamental right in the physician-assisted suicide cases to commit suicide, the *Evans* dissenters would answer with a resounding “no.” If, using the *Evans* majority’s analysis, one asks if physicians or patients in the assisted suicide cases are denied their right to “rational legislation,” the answer is also likely to be “no,” for a number of complex reasons discussed later in this article. The basic point is that the first step in any institutional analysis of problems in law and medicine is the kind of questions one asks.

¹⁶ After Oregon enacted its Death with Dignity Act permitting a form of physician-assisted death, some individuals challenged the constitutionality of the statute on the grounds that it violated the requirement of “equal protection.” The attempt failed. *See Lee v. Oregon*, 107 F.3d 1382 (9th Cir.), *cert. denied sub nom. Lee v. Harclerod*, 118 S. Ct. 328 (1997).

¹⁷ Justice Ginsberg wrote a short concurring opinion joining Justice O’Connor’s opinion, but did not provide any reasoning. *See Glucksberg*, 117 S. Ct. at 2310. Justice Ginsberg’s views are excluded from the analysis which follows.

sician-assisted suicide scheme authorized by Oregon voters is not a model for legislatures in other states because voter initiatives and legislative enactments represent different kinds of institutional processes.

I. IS TERMINATING MEDICAL CARE SUICIDE?

The Supreme Court's unanimous vote rejecting the constitutional claims in *Vacco v. Quill* illustrates how the judges of the Second Circuit Court of Appeals misconstrued the constitutional issues. The premise underlying the Second Circuit's finding of an equal protection violation in the New York statutory scheme was based on an assumption about the allocation of institutional responsibility. Judge Miner, for the Second Circuit majority, interpreted prior Supreme Court cases as implying that federal constitutional courts rather than the New York legislature, had the institutional power to declare that the removal of medical care was the equivalent of suicide.¹⁸ The Supreme Court not only rejected that premise, but used the brief from the American Medical Association and other professional organizations to reject the proposed institutional balance between courts, medicine, and legislatures articulated in Judge Calabresi's Second Circuit concurring opinion.¹⁹

A. IS THE DEFINITION OF SUICIDE A POLITICAL DECISION?

In finding the New York statutory scheme "rational" under equal protection analysis, Chief Justice Rehnquist relied upon *Evans* as stating the appropriate standard for examining the physicians' claims.²⁰ When Rehnquist asserted in *Quill* that the Equal Protection Clause "creates no substantive rights,"²¹ he meant more than simply that the various legislative provisions in question are presumed constitutional. He meant the

¹⁸ Judge Miner assumed that once he had concluded that the plaintiffs had presented a case for judicial resolution, the appropriate Equal Protection Clause analysis allowed him to conclude that the New York legislature had established "two classes" of persons. Later in the opinion, he declared that the New York statute allowing the removal of life sustaining treatment under New York's Health Care Proxy Law was the equivalent of suicide even though the statute provided for civil and criminal immunity for physicians operating under it. See *Quill v. Vacco*, 80 F.3d 716, 729 (2d Cir. 1996), *rev'd*, 117 S. Ct. 2293 (1997). Although Judge Miner might not have been able to "guess" how the Supreme Court would frame the questions of rights in *Evans* a few months later, his opinion is nonetheless an example of how judges fail to view questions in medicine as requiring careful analysis of whether courts or legislatures should determine the degree of social control needed for modern medicine.

¹⁹ Judge Calabresi's concurring opinion concluded that the New York statute that prohibited assisted suicide was at least close to being unconstitutional and thus required a remand to the state legislature for reconsideration of whether the ban on physician-assisted suicide was still appropriate. See *id.* at 742-43. His theory that judges could "update" statutes which no longer enjoy popular support is outlined in his previous scholarship and is cited throughout his opinion. See GUIDO CALABRESI, A COMMON LAW FOR THE AGE OF STATUTES (1982).

²⁰ See *Quill*, 117 S. Ct. at 2297.

²¹ *Id.*

physician-litigants have to demonstrate that the legislation puts physicians, *not* patients, in an institutionally untenable position.

To reject the argument that physicians could rely upon the rights of their patients, Justice Rehnquist had to reject Quill's rhetorically powerful brief and its premises about modern medicine.²² Professor Tribe, Quill's lawyer, had constructed his brief around the suffering and plight of by-then-dead patients. Tribe relied upon the declarations of patients who were dying of cancer and complications associated with AIDS²³ to support his assertion that a patient "in the final stages of dying is not committing suicide when choosing to avoid only unbearable, consciousness-filling pain or suffering."²⁴ Only these patients, Tribe asserted, have a constitutional right.²⁵ In essence, Professor Tribe invited the Court to construct the cases around hypothetical patients instead of his client, Dr. Quill, and his colleagues.

In denying Dr. Quill's claim, Chief Justice Rehnquist's opinion relied heavily upon the brief filed by the American Medical Association and forty-five other professional organizations.²⁶ According to the AMA, physicians generally distinguish between terminating life-sustaining treatment and intending to cause a patient's death.²⁷ Thus, legislation which prohibits physicians from assisting patients' deaths properly classifies situations in which physicians "intend" their patients' deaths. Legislation granting physicians immunity from criminal prosecution when they remove life support properly categorizes such deaths as "unintentional." Furthermore, removal of life support demonstrates the institutionalization of the ethical principle of "respect for patient autonomy" in modern medicine. More significantly, Chief Justice Rehnquist relied upon language in the AMA Brief to assert that "the law has long used intent or purpose to distinguish between two acts with the same result."²⁸ The fundamental point of the AMA Brief was that the distinction made in New York law would help ensure that the medical field would begin to address its inadequacies regarding pain relief.

²² See Brief of Respondents, *Vacco v. Quill*, 117 S. Ct. 2293 (1997) (No. 95-1858).

²³ See *id.* at 5-8.

²⁴ *Id.* at 3. It is worth noting that Professor Tribe assumes that courts have an obligation to relieve the suffering of those patients. See Lois Shepherd, *Sophie's Choices: Medical and Legal Responses to Suffering*, 72 NOTRE DAME L. REV. 103 (1996) (discussing the philosophical and legal reasons underlying this assumption and its effects on the legal and medical realms).

²⁵ See Brief of Respondents at 19-20, *Vacco v. Quill*, 117 S. Ct. 2293 (1997) (No. 95-1858).

²⁶ See *Quill*, 117 S. Ct. at 2298, 2298 n.6.

²⁷ See Brief of the American Medical Association et al., at 19-20, *Vacco v. Quill*, 117 S. Ct. 2293 (1997) (No. 95-1858) [hereinafter "AMA Brief"].

²⁸ *Quill*, 117 S. Ct. at 2299 (citing *United States v. Bailey*, 444 U.S. 394, 403-06 (1980); *Morrisette v. United States*, 342 U.S. 246, 250 (1952)). The latter case was cited and played a central role in the AMA Brief. See AMA Brief, *supra* note 27, at 20.

Finally, the AMA Brief helped Chief Justice Rehnquist dismiss Professor Tribe's suggestion that the Court could determine that "terminal sedation"—the practice of providing pain medication for some terminal patients until they are unconscious—made the prohibition of a lethal dosage upon request constitutionally irrational.²⁹ The AMA's description of pain management in modern medicine allowed Chief Justice Rehnquist to put this practice into a conceptual framework of consent by the patient, the intent of the physician, and the ethical principle of "double effect."³⁰

Holding that legislative distinctions were rational in general, Chief Justice Rehnquist acknowledged differences of opinion in the medical community regarding physician-assisted death³¹ and the possibility of some situations where there might be a constitutional defect in a legislative scheme.³² For Chief Justice Rehnquist, however, defining "suicide" is a political decision and not a task for constitutional adjudication.

Once it had been established in *Glucksberg* that the then-dead plaintiffs had no constitutional right to physician-assisted death, the primary question for Chief Justice Rehnquist in *Vacco v. Quill* was whether the New York legislature had somehow infringed upon the constitutional rights of physicians. For Rehnquist, holding criminal prohibitions against assisted suicide—even when applicable to physicians—to be a constitutional exercise of state legislative authority, effectuates the appropriate institutional balance between legislatures, courts, and the medical community. Underlying Chief Justice Rehnquist's construction of the issues in *Quill*, therefore, is an institutional choice of legislatures, rather than courts, to define suicide.

B. WHEN ARE JUDGES AND JURIES ALLOWED TO INVALIDATE PHYSICIANS' CONVICTIONS FOR ASSISTED SUICIDE?

Justice Stevens's concurring opinion, in which he discussed the constitutional issues in both *Quill* and *Glucksberg*, presented a different view of the appropriate institutional balance between the medical community, legislatures, and courts. Stevens relied upon the briefs of Professor Tribe and others, urging the Court to find a constitutional right to physician-assisted suicide in framing the issues with regard to medicine.³³ Ultimately, however, Justice Stevens rejected the constitutional analysis of

²⁹ See *Quill*, 117 S. Ct. at 2301 n.11.

³⁰ See *id.* at 2298-2301; Timothy E. Quill et al., *The Rule of Double Effect—A Critique of Its Role in End-of-Life Decision Making*, 337 NEW ENG. J. MED. 1768, 1768 (1997) ("According to the ethical principle known as the 'rule of double effect,' effects that would be morally wrong if caused intentionally are permissible if foreseen but unintended.")

³¹ See *Quill*, 117 S. Ct. at 2298 n.6.

³² See *id.* at 2302 n.13.

³³ See *id.* at 2308-10 (Stevens, J., concurring).

these physician-assisted suicide proponents. By suggesting that constitutional questions might arise when the states seek to impose criminal sanctions for the practice of physician-assisted suicide, Justice Stevens, in effect, chose the judiciary as the appropriate forum to resolve the physician-assisted suicide issue.³⁴

Stevens considered the constitutional issue involved in physician-assisted suicide to be similar to the constitutional issues associated with the imposition of the death penalty.³⁵ The Court has become the ultimate arbiter of whether imposition of the death penalty is appropriate since legislatures cannot constitutionally require it for all crimes or even all homicides.³⁶ Thus, in both *Glucksberg* and *Quill*, the issue for Stevens was whether the particular plaintiffs before the Court had, in fact, demonstrated the unconstitutionality of the statutes. According to Stevens, none of the patient-plaintiffs or physician-plaintiffs were "threatened with prosecution for assisting in the suicide of a particular patient."³⁷

In addressing what is essentially the "due process" issue and the most relevant precedent, *Cruzan v. Director, Missouri Department of Health*,³⁸ Justice Stevens asserted that the state's interest in preserving life is limited by "the individual's interest in choosing a final chapter that accords with her life story, rather than one that demeans her values and poisons memories of her."³⁹

In *Quill*, Justice Stevens criticized the basic premise about "intent" in the AMA's Brief.⁴⁰ He used the practice of "terminal sedation," as described by Tribe, to suggest that Chief Justice Rehnquist and the AMA's assertion that legislatures can make distinctions on the basis of physicians' intent is "illusory."⁴¹ Thus, Justice Stevens wants the Court to be open to future constitutional challenges on physician-assisted suicide,⁴² while Chief Justice Rehnquist wants the debate transferred to state legislatures.

³⁴ See *id.* at 2304-05.

³⁵ See *id.*

³⁶ See *id.* at 2304 (citing *Gregg v. Georgia*, 428 U.S. 153 (1976); *Proffitt v. Florida*, 428 U.S. 242 (1976); *Jurek v. Texas*, 428 U.S. 262 (1976)); see also Larry I. Palmer, *The Positions of Justices Stewart and White on the Death Penalty: A Study of Two Perspectives on Discretion*, 70 J. CRIM. L. & CRIMINOLOGY 194 (1979).

³⁷ *Glucksberg*, 117 S. Ct. at 2304 (Stevens, J., concurring).

³⁸ 497 U.S. 261 (1990) (upholding the constitutionality of the refusal of a state court to order the removal of a persistently vegetative patient's life support).

³⁹ *Glucksberg*, 117 S. Ct. at 2308 (Stevens, J., concurring).

⁴⁰ See *id.* at 2310.

⁴¹ *Id.*

⁴² "[O]ur holding today in *Vacco v. Quill* that the Equal Protection Clause is not violated by New York's classification . . . does not foreclose the possibility that some applications of the New York statute may impose an intolerable intrusion upon the patient's freedom." *Id.*

C. ARE LEGISLATIVE DECISIONS NOT TO BAN CERTAIN MEDICAL PRACTICES ARBITRARY EXERCISES OF LEGISLATIVE AUTHORITY?

Justice Souter's short concurring opinion in *Quill* adopted Justice Stevens's view that the state "permits" what he calls "death-hastening pain medication."⁴³ In his attempt to synthesize the Court's complex due process and equal protection cases through a "principled" methodology for determining the constitutionality of statutes,⁴⁴ Justice Souter assumed that the question was whether courts or legislatures should "permit" terminal sedation. He argued that it is appropriate for legislatures to "permit" the practice,⁴⁵ but failed to consider the empirical reality that the practice was, in fact, authorized by the medical community, and not the courts or legislatures.

Souter's common law method of adjudication⁴⁶ assumed that "terminal coma" is what Professor Tribe described, as opposed to the end result of a carefully thought through process of medical intervention. As the patient is gradually given increased doses of pain medication, the patient's tolerance for the medication grows. In other words, an ethical physician does not commence pain medication with the intent of creating a "terminal coma." Rather, physicians determine the amount of sedation a terminally ill patient should receive after careful consideration of the particular patient's condition and consultation with the patient and his or her family.⁴⁷

The significance of Justice Souter's framing of the question is that legislatures can make distinctions between various proposed medical practices without violating the Constitution. Yet, implicit in Souter's *Glucksberg* opinion is the proposition that the Court holds the ultimate authority to determine if a certain legislative distinction is an arbitrary infringement on liberty. Thus, this somewhat complex methodology invites continued constitutional adjudication.

D. DOES MEDICINE CAUSE DEATHS WITHOUT DIGNITY?

Justice Breyer was more explicit about the nature of the constitutional adjudication that might follow *Glucksberg* and *Quill*. He explic-

⁴³ 117 S. Ct. at 2302 (Souter, J., concurring in the judgment).

⁴⁴ See *Glucksberg*, 117 S. Ct. at 2275-93 (Souter, J., concurring in the judgment).

⁴⁵ See *id.* at 2293.

⁴⁶ Justice Souter's method of reasoning bears a close resemblance to the scholarship of the "legal process" tradition. See e.g., Harry H. Wellington, *Common Law Rules and Constitutional Double Standards: Some Notes on Adjudication*, 83 YALE L.J. 221 (1973).

⁴⁷ When students in my spring, 1997 seminar on physician-assisted suicide questioned a colleague from our medical college about terminal coma, many of them assumed the question was: "Doctor, how much pain medication does it take to kill a patient?" The physician pointed out that the amount of pain medication a patient can withstand depends upon the previous amount of pain medication she had been receiving.

itly asserted that there may be some type of constitutional “right to die with dignity.”⁴⁸ Breyer relied upon the briefs of the AMA, the National Hospice Care Organization, and Choice in Dying to frame the issue as one of medicine’s failures:

Medical technology, we are repeatedly told, makes the administration of pain-relieving drugs sufficient, except for a very few individuals for whom the ineffectiveness of pain control medicines can mean, not pain, but the need for sedation which can end in a coma.⁴⁹

According to Justice Breyer, neither state statutes nor judicial rulings prevented patients from obtaining pain relief.⁵⁰ As he stated in his opinion, many terminally ill patients do not receive adequate pain medication “for institutional reasons or inadequacies or obstacles, which would seem possible to overcome, and which do not include a *prohibitive set of laws*.”⁵¹

In his opinion, Justice Breyer attempted to put a “gloss” on Justice O’Connor’s concurring opinion which explicitly joined with Chief Justice Rehnquist’s opinion.⁵² Justice Breyer began his concurrence with the statement, “I believe that Justice O’Connor’s views, which I share, have greater legal significance than the Court’s opinion suggests.”⁵³ By joining Justice O’Connor’s opinion, but refusing to join the opinion of Chief Justice Rehnquist, Breyer implied that Justice O’Connor has a sharper difference with the Chief Justice than she stated in her own concurrence.⁵⁴

E. DO TERMINALLY ILL PATIENTS HAVE A CONSTITUTIONAL RIGHT TO PAIN RELIEF?

The portion of Justice O’Connor’s concurring opinion dealing with *Quill* makes an important assertion: “There is no dispute that dying patients in . . . New York can obtain palliative care, even when doing so

⁴⁸ *Glucksberg*, 117 S. Ct. at 2311 (Breyer, J., concurring in the judgment).

⁴⁹ *Id.* at 2311-12.

⁵⁰ *See id.* at 2311. Some scholars have argued that the statutory framework governing professional discipline for misuse of pain medication needs to be modified. *See e.g.*, Sandra H. Johnson, *Disciplinary Actions and Pain Relief: Analysis of the Pain Relief Act*, 24 J.L. MED. & ETHICS 319 (1996). But none of the litigants in the cases before the Court made out a plausible claim of a realistic fear of prosecution or professional discipline for administering pain medication. The Court did, however, take up the issue of pain relief. *See infra* text accompanying notes 55-56.

⁵¹ *Glucksberg*, 117 S. Ct. at 2312 (Breyer, J., concurring) (emphasis in original).

⁵² *See id.* at 2303 (O’Connor, J., concurring).

⁵³ *Id.* at 2310.

⁵⁴ *See* Robert A. Burt, *The Supreme Court Speaks: Not Assisted Suicide but a Constitutional Right to Palliative Care*, 337 NEW ENG. J. MED. 1234, 1235 (1997).

would hasten their deaths.”⁵⁵ She made it clear that the case does not raise the question of whether those terminally ill patients who are “suffering” can obtain pain relief. O’Connor struck a different institutional balance from Chief Justice Rehnquist. By framing the question in terms of relieving patient suffering, Justice O’Connor narrowed the scope of any future constitutional claims. She shut the door on a claim about suicide, but clearly wanted to provide litigants with greater access to courts on issues of suffering during their terminal illnesses than Chief Justice Rehnquist’s analysis would permit.

Justice O’Connor’s desire to permit future constitutional adjudication on issues of pain relief indicates that she has less confidence than does Justice Rehnquist in the ability of legislatures to control medicine. Review of O’Connor’s earlier opinions supports this conclusion. First, her short concurring opinion in *Cruzan* made clear that she wanted to leave open the question of whether the legislature could prohibit a surrogate from removing medical treatment on behalf of a comatose patient.⁵⁶ Although no state had an explicit prohibition against surrogate removal, O’Connor seemed aware of the potential for other institutional forces, such as religion or medicine, to influence legislation regarding the removal of life support.⁵⁷

More important, Justice O’Connor indicated in *Planned Parenthood v. Casey*,⁵⁸ the most recent abortion case, that she wants the Court to be able to adapt to changing societal concepts of liberty without granting broad definitions of constitutional rights.⁵⁹ Lest anyone assume that she was inviting constitutional litigation, O’Connor asserted—rightly in my opinion—that there are no legal barriers to the administration of pain relief medication.⁶⁰ Or, put more pragmatically, when O’Connor committed the issue of physician-assisted death to the “laboratories” of the states,⁶¹ she provided a context for both legislatures and potential litigants. For the latter, she made it clear that “facial,” as opposed to “as applied,” attacks on regulatory schemes regarding the dispensing of drugs would receive a cool reception.⁶² Moreover, it is apparent that the plaintiff’s identity would make a great deal of difference in the outcome of any future constitutional adjudication. Thus, a physician subject to professional discipline for administering pain medication to a terminally

⁵⁵ *Id.* at 2303 (O’Connor, J., concurring in the judgment).

⁵⁶ 497 U.S. 261, 289-92 (1990) (O’Connor, J., concurring).

⁵⁷ *See id.* at 290-92; *see also* Palmer, *supra* note 10, at 169-71 (discussing Justice O’Connor’s views on terminating medical care and abortion).

⁵⁸ 505 U.S. 833 (1992).

⁵⁹ *Id.* at 847-52.

⁶⁰ *See Glucksberg*, 117 S. Ct. at 2303 (O’Connor, J., concurring).

⁶¹ *See id.* (citing *Cruzan v. Director, Mo. Dep’t of Health*, 497 U.S. 261 (1990)).

⁶² *See id.*

ill patient might be able to raise the liberty claim of her patient to obtain adequate pain relief.

II. THE FEDERAL FRAMEWORK FOR SUBSEQUENT DEBATES

All nine justices agreed with Justice O'Connor's rhetoric about the constitutional right to palliative care.⁶³ As a practical matter, this implies that any legislation prohibiting assisted suicide should have a specific provision exempting physicians who are administering palliative care.⁶⁴ Consequently, the state legislative debate begins by eliminating the policy option of tightening up regulations of pain medication.

None of the major players opposed to physician-assisted suicide in the constitutional and political forums, such as the AMA and the Catholic Church, have any interest in more restrictive regulation of pain medication. On the contrary, the AMA appears on record as being committed to improving patient access to palliative care.⁶⁵ In this respect, Justice Breyer also spoke for the majority of the Court when he indicated that restrictive laws, as opposed to institutional failures in medicine, would lead to a different result in any subsequent constitutional litigation over such matters.⁶⁶

Despite Chief Justice Rehnquist's assertion that legislatures have wide latitude to define suicide, legislative drafters who wish to provide physicians with legal immunity⁶⁷ for some assisted deaths face a new issue—criminal prosecution under federal narcotics laws. The federal Drug Enforcement Agency recently announced that the use of drugs for

⁶³ Professor Robert A. Burt provides essentially the same analysis of the overall effect of the various opinions in the assisted suicide cases. See Burt, *supra* note 54, at 1234-36. On the other hand, Professor David Orentlicher suggests that those same opinions have sanctioned the practice of euthanasia by embracing "terminal sedation." See David Orentlicher, *The Supreme Court and Physician-Assisted Suicide: Rejecting Assisted Suicide but Embracing Euthanasia*, 337 NEW ENG. J. MED. 1236, 1236 (1997). One need not resolve the conflict between these two medical ethicists/lawyers if one remembers that the important public policy choice made by the Court was to determine that legislatures rather than courts are the least detrimental institution for resolving the assisted suicide debate and related issues.

⁶⁴ Several state statutes that prohibit assisting or aiding suicide have explicit provisions exempting pain medication by physicians. See *e.g.*, LA. REV. STAT. ANN. § 14:32.12 (West 1997); S.D. CODIFIED LAWS § 22-16-37.1 (Michie 1997). Of course, Jack Kevorkian has been able to use a similar clause in the now defunct Michigan law to argue successfully before juries that his use of carbon monoxide was meant to relieve the patient's pain rather than kill the patient. From an institutional perspective, we should distinguish what jurors are allowed to do by constitutional design from the different constitutional constraints legislatures might have.

⁶⁵ See AMA Brief, *supra* note 27, at 22.

⁶⁶ See *Glucksberg*, 117 S. Ct. 2312 (Breyer, J., concurring).

⁶⁷ As a practical matter, this means, for instance, that legislatures can regulate medical practice and provide legislative immunity for physicians who follow the statutory scheme. This has already been done with living wills and health care proxy legislation, which usually provide explicit immunity provisions.

assisted suicide under Oregon's Death with Dignity Act constitutes a non-medical use under federal law.⁶⁸ The DEA's position could lead to another round of litigation if a pharmacist or physician were prosecuted under federal narcotics laws.⁶⁹ Although litigants might frame the issue as whether the federal drug law's definition of medical purpose "pre-empts" Oregon's definition of medical purpose, such a prosecution could test the parameters of the constitutional right to palliative care.⁷⁰

Under Rehnquist's constitutional analysis, a state legislature has the institutional competence to define suicide, and thus, to determine whether a medical practice at the end of life is legitimate. On the other hand, Congress has asserted that federal funds should not be used to support the practice of physician-assisted suicide.⁷¹

The actual implementation of any assisted suicide statute in the states faces two possible obstacles. First, whether the federal government's interest in controlling the distribution of drugs—requiring every physician and pharmacist in this country who administers narcotics to have a certificate from the federal government—can override any particular state's political decision to have physician-assisted death. Second, whether the one state where voters, not the legislature, have authorized the practice of physician-assisted death can devise a scheme to pay for the death-hastening drugs without the use of federal Medicaid or Medicare funds.

Given that it was the first state to attempt to "ration" its Medicaid expenditures, Oregon may have enough voter interest in the cost pressures of health care to tackle this problem. Embedded in these questions is the larger institutional issue of Congress's role in medicine.⁷²

Proponents of assisted suicide in the vast majority of states, however, have an uphill battle. The Court's decision was, in some sense,

⁶⁸ See William Claiborne, *Oregon Doctors may Face U.S. Fight on Assisted Suicide; Despite Referendum Upholding Law, DEA Warns that Licenses to Write Prescriptions are at Risk*, WASH. POST, Nov. 13, 1997, at A4.

⁶⁹ See 21 C.F.R. §1306.04(a) ("A prescription for a controlled substance to be effective must be issued for a legitimate medical purpose . . . and the person knowingly filling [any such prescription] . . . shall be subject to . . . penalties."); *United States v. Larson*, 682 F.2d 480, 482 (4th Cir.), cert. denied, 459 U.S. 991(1982); *United States v. Limberopoulos*, 26 F.3d 245, 249-51 (1st Cir. 1994) (affirming convictions of pharmacists for filling "illegitimate" prescriptions).

⁷⁰ Given the debate about the "new textualism" in statutory interpretation, it is possible that the Court could decide this question as one of statutory interpretation rather than one of constitutional law. When the Court is dealing with Congress, it is often a different institutional problem than when dealing with state political decisions. See William N. Eskridge, Jr. & Philip P. Frickey, *Foreword, Law as Equilibrium*, 108 HARV. L. REV. 27, 43-44 (1994).

⁷¹ See Assisted Suicide Funding Restriction Act, 42 U.S.C. §§ 14401-14408 (1997).

⁷² Note for instance, Congress's use of the Medicare and Medicaid funding to impose standards about giving notice about declining treatment, see 42 U.S.C. § 1395cc(f) (1996), and the standards for inpatient discharges. See 42 U.S.C. § 1395d (1996).

made with full knowledge of the views of the various interest groups that are likely to participate in any political debates of physicians' roles in our deaths.⁷³ The Court's "no rights" finding, therefore, has probably swayed the moral debate against mobilizing the kind of political forces necessary to overcome the inertia of doing nothing. In addition, proponents face a national coalition, as indicated by the recent federal administrative rulings and federal statutes, that will oppose the open legalization of physician-assisted death.

III. WHEN THE VOTERS SAY "YES" TO PHYSICIAN-ASSISTED SUICIDE

Now that voters in Oregon have again approved a bill authorizing a form of physician-assisted death,⁷⁴ Oregon may become the first legal "laboratory" for determining whether the hopes of its proponents or the fears of its opponents will become reality. Proponents might look at the 60 percent majority⁷⁵ favoring the retention of the recently-passed initiative in Oregon as evidence that many other states will follow the "Oregon Trail." Opponents have already announced their intention to file a lawsuit to block implementation of the 1994 Oregon Death with Dignity Act.⁷⁶ If, however, we take seriously Chief Justice Rehnquist's invitation in *Glucksberg* to have a true debate about the role of physicians in our dying,⁷⁷ we must be cautious about relying upon the Oregon experience as representative of the entire country.

First and foremost, even though the Oregon voters said "yes" to physician-assisted death in 1994, voters in other western states have recently said "no." In 1991, the voters of Washington rejected a measure that would have "de-criminalized" several forms of physician assistance

⁷³ Bear in mind that over seventy briefs were filed in the recent Supreme Court litigation. Whether a systematic analysis of all these briefs would indicate this was a case of "minoritarian bias" is not of immediate concern. What may be more significant is the fact that when the Court finds itself with limited capacity to solve a problem such as physician-assisted suicide, legislatures may find themselves incapable of resolving the issue. See Einer Elhauge, *Does Interest Group Theory Justify More Intrusive Judicial Review?*, 101 YALE L.J. 31, 66-87 (1991) ("[T]he same interest groups that have an organizational advantage in collecting resources to influence legislators and agencies generally also have an organizational advantage in collecting resources to influence the courts."). In this debate, Compassion in Dying, a non-profit group formed after the defeat of the Washington Referendum in 1991, organized the litigation and was joined by other repeat litigators, such as the American Civil Liberties Union, before the Court. The opponents had the AMA and various religiously-related organizations, among others, as their constitutional allies. See KOMESAR, *supra* note 1, at 123-50.

⁷⁴ See Kim Murphy, *Voters in Oregon Soundly Endorse Assisted Suicide*, L.A. TIMES, Nov. 5, 1997, at A1. Technically, the voters only agreed that the previously-passed measure should not be repealed.

⁷⁵ See Clairborne, *supra* note 68, at A4.

⁷⁶ See William Clairborne & Thomas B. Edsall, *Affirmation of Oregon Suicide Law May Spur Movement*, WASH. POST, Nov. 6, 1997, at A19.

⁷⁷ *Glucksberg*, 117 S. Ct. at 2275.

in patient deaths.⁷⁸ Every interest group imaginable, from the Hemlock Society to religious groups, paid for advertisements to convince voters to adopt or defeat the proposed amendment to Washington's Natural Death Act.⁷⁹ In the end, this media-embedded political process produced a 54 percent majority opposed to the proposed legislation.⁸⁰

Second, Oregon's process for enacting legislation is a form of "direct democracy" limited to a few, mostly western states. Although the initiative process has the same end result—an enacted statute—as the legislative process, the latter is a different kind of institutional process. Some of the constraints on the legislative process—such as passage by two differently-constituted representative chambers and the risk of gubernatorial veto in all states ("veto gates"⁸¹)—are not present in direct democracy schemes.⁸² The role of interest groups further constrains the outcome of the legislative process because, on any given issue, many voters or non-voters are indifferent.⁸³ Despite the media attention paid to the issue of physician-assisted death, it is not clear that most people would necessarily place resolution of this ethical debate at the top of their list of political priorities. As a result, when the issue is broached by legislators, the power of various interest groups to block the enactment of legislation authorizing physician-assisted death is probably greater than the polls indicate. Blocking legislation only requires the institutional capacity to capture one of the "veto gates," be it the failure to move a bill out of committee or a governor's veto. As long as the AMA represents institutionalized medicine's political interests, its opposition to granting physicians the statutory right to assist patient deaths virtually assures that such a bill will not pass in two separate legislative chambers.⁸⁴

⁷⁸ See *Compassion in Dying v. Washington*, 79 F.3d 790, 810 (9th Cir. 1996), *rev'd sub nom. Glucksberg*, 117 S. Ct. 2258 (1997).

⁷⁹ WASH. REV. CODE §§ 70.122.010-.900 (1991). The ballot read: "Shall adult patients who are in a medically terminal condition be permitted to request and receive from a physician aid-in-dying?" William McCord, *Dignity, Choice and Care*, SOCIETY, July/Aug. 1992, at 20.

⁸⁰ See *Compassion in Dying*, 79 F.3d at 810.

⁸¹ See McNollgast, *Legislative Intent: The Use of Positive Political Theory in Statutory Interpretation*, 57 LAW & CONTEMP. PROBS. 3, 16-21 (1994).

⁸² See Jane S. Schacter, *The Pursuit of "Popular Intent": Interpretive Dilemmas in Direct Democracy*, 105 YALE L.J. 107 (1995).

⁸³ The recent Oregon vote on physician-assisted death was by mail-in ballot because of a provision of Oregon law allowing such balloting. See *Voting by Mail*, OR. REV. STAT. § 254.470 (1996). The "cost" of voting to any particular voter was less in the 1997 ballot initiative than in the previous vote in 1994. For a useful analysis of the political process and interest groups, see KOMESAR, *supra* note 1, at 53-97.

⁸⁴ Some might argue that pain relief legislation could be passed because the AMA's Brief in *Quill* indicated its support for adequate pain relief. But the AMA's pain relief efforts might be directed at changing the profession rather than the existing regulatory and legislative structure regarding drugs. Or to put it more plainly, just because the AMA uses the inadequacy of pain relief in its brief before the Court does not necessarily translate into political support for a particular bill.

CONCLUSION

A patient's plea of "let me die" was recently transformed into the idea that the law should protect the patient's ability to determine the timing of his or her death. *Quill's* rejection of this plea in its constitutional form means that proponents of physician-assisted death must return once again to the legislative corridors. As a result of the constitutional adjudication, the legislative debate will take place in a different institutional context where the political processes at both the state and federal levels will have to define their respective relationships to medicine.

The following points are essential to consider in subsequent discussions: 1) *Quill's* equal protection analysis provides the framework for legislative consideration of physician-assisted deaths because it highlights the role of the institution of medicine and its inherent limitations; 2) Any post-*Quill* and *Glucksberg* legislative enactments are constrained by a "constitutional right to pain relief" for patients; and 3) Determining whether to grant physicians legislative exemptions to aid patients' deaths is a function of one's view of the appropriate institutional balance between law, medicine, family, and religion.

The Court has determined that legislatures, as opposed to the federal courts, are the appropriate policy-making bodies to determine whether criminal sanctions, regulatory measures, deregulation of the use of some drugs, or the inherent controls within institutional medicine are the appropriate means of responding to individual desires for control within this legal and medical matrix. Now it seems clear that we need to re-focus our energies, as well as our vision, and concentrate on the real issue. Pain management and relief are issues of life, not death. For most of us, as family members and as prospective patients, how we live the last part of our lives is central and critical.

The more we know about effective pain management by health care professionals, the better we will understand the risks, as well as the benefits, of physician-assisted living in a terminal state. Effective pain management is important not only for those who have terminal illnesses, but also for those living with chronic conditions. Whether legislatures should authorize physician-assisted death for those whose pain cannot be "managed" is the question the Court leaves unanswered.

My own view is that legislatures should encourage physician-assisted living by modifying any laws or regulations which inhibit effective pain management for all patients.⁸⁵

⁸⁵ I take a somewhat pragmatic position on the need for change in existing regulations regarding pain medication. As long as physicians see existing regulations on opiates as "too burdensome," legislatures and regulators may have to change the laws simply to satisfy this political constituency. Other scholars are convinced that physician fears and the actions of disciplinary bodies require new statutes. See Johnson, *supra* note 50, at 320-22.