

FOREWORD:
CAN GLUCKSBERG SURVIVE LAWRENCE?
ANOTHER LOOK AT THE END OF LIFE AND
PERSONAL AUTONOMY

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In Washington v. Glucksberg, the Court declined to find a right to physician-assisted suicide (“PAS”) in the Constitution. Not a single Justice dissented. One would expect such a ruling to be quite secure. But Lawrence v. Texas, holding that a state cannot make consensual homosexual conduct a crime, is not easy to reconcile with Glucksberg. Lawrence certainly takes a much more expansive view of substantive due process than did Glucksberg. It is conceivable that the five Justices who made up the Lawrence majority—all of whom still sit on the Court—might overrule Glucksberg. For various reasons, however, this seems improbable.

Unlike the situation with respect to the pre-Lawrence era, Glucksberg does not stigmatize any politically vulnerable group. When there is no democratic defect in the political process, there is much to be said for courts deferring to reasonable legislative judgments. Moreover, unlike the developments preceding Lawrence, there has been no emerging awareness of a right or liberty to enlist the assistance of a physician in committing suicide. No state supreme court has found a right to PAS in its own state constitution. Nor, in the decade since Glucksberg, has any state legislature legalized PAS. And attempts have been made to do so in some twenty states.

In addition, various considerations might cause a court to balk at constitutionalizing PAS for the terminally ill. Such a right is not easily cabined. If personal autonomy extends to the time and manner of one’s death, why doesn’t it also apply whenever a competent person believes that death is better than continued life? Once the right to PAS is grounded on self-determination or personal autonomy in controlling one’s own life and death, it no longer seems plausible to limit it to the terminally ill. Why should people who have to endure pain, suffering, or indignity for a much longer time than the terminally ill (often defined as those with six months or less to live) be denied this right? The argument made by many proponents of PAS that the right to forgo medical treatment and the

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right to PAS are merely subcategories of the same broad right is not convincing. Most of the two million people who die every year in this country do so in hospitals and long-term care institutions and do so after a decision to forgo life-sustaining treatment has been made. If medical treatment could not be rejected, vast numbers of patients would be at the mercy of every technological advance. (For example, Nancy Cruzan could have been kept alive in her persistent vegetative state for thirty years.) Allowing a patient to die at some point is a practical condition upon the successful operation of medicine. The same can hardly be said of PAS.

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INTRODUCTION

A decade ago, in *Washington v. Glucksberg*,¹ the Court declined to find a right to physician-assisted suicide (“PAS”) in the Constitution. Not a single Justice dissented.² One would expect such a ruling to be quite secure. But *Glucksberg* faces an uncertain future.

1. 521 U.S. 702 (1997).

2. *But see infra* text accompanying notes 67–78.

The Court also declined to find a right to PAS in the companion case of *Vacco v. Quill*.³ In *Quill*, the Court rejected the argument that because New York permitted competent persons to refuse lifesaving medical treatment but prohibited competent persons not on life support from doing “essentially the same thing,” the state’s assisted-suicide ban violated equal protection. As in *Glucksberg*, there was no dissenting opinion.

Despite the apparently clear signal sent by these opinions, ten years later it remains uncertain whether *Glucksberg* and *Quill* are in fact still good law. This Symposium will explore many of the issues surrounding the two cases: their place in constitutional doctrine,⁴ the ways in which they highlight problems in constitutional theory⁵ and contemporary moral theory,⁶ and their practical effect for physicians and patients.⁷ Before turning to these pieces, I will lay out the arguments why these cases—especially *Glucksberg*—could conceivably be overturned, but why, in the end, they are likely to remain good law.

I. WHY THE COURT MIGHT OVERRULE *GLUCKSBERG*

Recent decisions, an expansive recognition of personal autonomy, and the complicated opinions in *Glucksberg* all undermine *Glucksberg*’s continuing vitality.

A. *The Potential Impact of Lawrence*

The principal reason *Glucksberg* stands on shaky ground is *Lawrence v. Texas*,⁸ which overruled *Bowers v. Hardwick*⁹ and held that “[t]he State cannot demean [the] existence [of homosexuals] or control their destiny by making their private sexual conduct a crime.”¹⁰ As Brian Hawkins has observed, “Although the *Lawrence* majority opinion never cited *Glucksberg*, the aspersions *Lawrence* cast on *Bowers* inevitably fell with equal force on

3. 521 U.S. 793 (1997).

4. Randy E. Barnett, *Scrutiny Land*, 106 MICH. L. REV. 1479 (2008); Steven G. Calabresi, *Substantive Due Process After Gonzales v. Carhart*, 106 MICH. L. REV. 1517 (2008); Erwin Chemerinsky, *Washington v. Glucksberg Was Tragically Wrong*, 106 MICH. L. REV. 1501 (2008).

5. Cass R. Sunstein, *Due Process Traditionalism*, 106 MICH. L. REV. 1453 (2008).

6. Steven D. Smith, *De-Moralized: Glucksberg in the Malaise*, 106 MICH. L. REV. 1571 (2008); Marc Spindelman, *Death, Dying, and Domination*, 106 MICH. L. REV. 1641 (2008).

7. Herbert Hendin & Kathleen Foley, *Physician-Assisted Suicide in Oregon: A Medical Perspective*, 106 MICH. L. REV. 1613 (2008); Kathryn L. Tucker, *In the Laboratory of the States: The Progress of Glucksberg’s Invitation to States to Address End of Life Choice*, 106 MICH. L. REV. 1593 (2008).

8. 539 U.S. 558 (2003).

9. 478 U.S. 186 (1986).

10. *Lawrence*, 539 U.S. at 578.

Glucksberg”¹¹—especially the narrow view of substantive due process *Glucksberg* shared with *Bowers*.

Mr. Hawkins is not the only commentator to call attention to the fact that, despite the heavy damage *Lawrence* seems to have inflicted on *Glucksberg*, it failed to so much as cite the earlier case. Two of *Lawrence*’s strongest critics have called this failure a “striking manifestation of *Lawrence*’s haughtiness toward the kind of legal analysis that had become conventional in the case law.”¹² “The rejection of the *Glucksberg* test,” they continue, “is not only unacknowledged and unexplained, but it is a total rejection.”¹³

Glucksberg had insisted, as had *Bowers*, that in order for a right or liberty to come within the substantive reach of the Due Process Clauses it had to be (1) “deeply rooted in this Nation’s history and tradition” and “implicit in the concept of ordered liberty” and (2) susceptible of a “careful description”¹⁴ (whatever that means).¹⁵ Although the *Lawrence* Court did conclude that the historical grounds relied on by the *Bowers* majority were somewhat doubtful,¹⁶ it could not, and did not, claim that the right or liberty at issue was “deeply rooted in this Nation’s history and tradition.”¹⁷

As long as *Bowers* remained on the books, it served as a buffer between the implications of the line of cases originating with *Griswold v. Connecticut*¹⁸ and any alleged constitutional right to PAS. As Jed Rubenfeld noted almost two decades ago, “The laws struck down under the rubric of privacy

11. Brian Hawkins, Note, *The Glucksberg Renaissance: Substantive Due Process Since Lawrence v. Texas*, 105 MICH. L. REV. 409, 410 (2006). Mr. Hawkins goes on to say, however, that his scrutiny of 102 post-*Lawrence* lower court cases “indicates that the *Glucksberg* Doctrine has not only survived *Lawrence*, but has flourished.” *Id.* at 411. Indeed, “[m]ost cases from [the survey] ignore *Lawrence* completely.” *Id.*

12. Nelson Lund & John O. McGinnis, *Lawrence v. Texas and Judicial Hubris*, 102 MICH. L. REV. 1555, 1578 (2004).

13. *Id.* at 1579; see also Calabresi, *supra* note 4, at 1525.

14. *Washington v. Glucksberg*, 521 U.S. 702, 720–21, 723, 727 (1997). For the view that O’Connor, one of the four other Justices who joined Rehnquist’s opinion, did not even agree with Rehnquist that a fundamental liberty interest—one that requires the state to come forward with a strong justification for intruding on that interest—has to be “deeply rooted in this Nation’s history and tradition,” see Ronald Dworkin, *Assisted Suicide: What the Court Really Said*, N.Y. REV. BOOKS, Sept. 25, 1997, at 40, and Cass R. Sunstein, *Supreme Caution: Once Again, the High Court Takes Only Small Steps*, WASH. POST, July 6, 1997, at C1.

As to whether Chief Justice Rehnquist’s *Glucksberg* framework accurately describes substantive due process cases preceding *Glucksberg*, compare, in this Symposium, Chemerinsky, *supra* note 4, at 1504–06, and Smith, *supra* note 6, at 1572, with Sunstein, *supra* note 5, at 1544–45.

15. See Barnett, *supra* note 4, at 1489–91, which maintains that there is always more than one way to plausibly define the particular liberty at issue.

16. *Lawrence v. Texas*, 539 U.S. 558, 571 (2003).

17. *Glucksberg*, 521 U.S. at 721.

18. 381 U.S. 479 (1965). *Griswold* was followed by *Loving v. Virginia*, 388 U.S. 1 (1967), *Eisenstadt v. Baird*, 405 U.S. 438 (1972), *Roe v. Wade*, 410 U.S. 113 (1973), *Moore v. City of East Cleveland*, 431 U.S. 494 (1977), and *Carey v. Population Services International*, 431 U.S. 678 (1977).

have had a peculiar tendency to gravitate around sexuality”¹⁹ If the Court were to build on these cases, the next one was likely to be a case establishing the right of homosexual persons, no less than heterosexual ones, to choose the sexual intimacy they share with adult partners in private. Unless and until such a ruling was handed down, any constitutional right to PAS seemed far away.²⁰

Bowers seemingly brought the development of privacy to an abrupt halt. Indeed, it threatened to do even more than that. The Court’s prior cases had recognized three protected areas—marriage, procreation, and family relationships. The *Bowers* Court, however, thought it “evident” that none of the protected categories “bears any resemblance to the claimed constitutional right of homosexuals to engage in acts of sodomy.”²¹ Moreover, the Court did not even see any unifying principle connecting the three recognized privacy categories. To quote Rubinfeld a final time:

[A]fter [*Bowers*], we know that the right to privacy protects some aspects of marriage, procreation, and child-rearing, but we do not know why. By identifying three disparate applications ungrounded by any unifying principle, the majority effectively severed the roots of the privacy doctrine, leaving only the branches, which will presumably in short order dry up and wither away.²²

As long as *Bowers* remained good law—as long as the Court considered itself “com[ing] nearest to illegitimacy when it deals with judge-made constitutional law having little or no cognizable roots in the language or design of the Constitution”²³—there was no chance that a right to PAS would be found in the Constitution. But *Bowers* has been overruled—and all five members of the *Lawrence* majority are still on the Court.

One will search the *Lawrence* opinion in vain for any indication that the Court believed expanding the substantive reach of the Due Process Clauses is an act to be strongly resisted. If anything, the *Lawrence* Court indicated the contrary:

[T]hose who drew and ratified the Due Process Clauses . . . knew times can blind us to certain truths and later generations can see that laws once thought necessary and proper in fact serve only to oppress. As the Constitution endures, persons in every generation can invoke its principles in their own search for greater freedom.²⁴

19. Jed Rubinfeld, *The Right of Privacy*, 102 HARV. L. REV. 737, 738 (1989).

20. See Yale Kamisar, *Against Assisted Suicide—Even a Very Limited Form*, 72 U. DET. MERCY L. REV. 735, 763–64 (1995).

21. *Bowers v. Hardwick*, 478 U.S. 186, 190–91 (1986).

22. Rubinfeld, *supra* note 19, at 749.

23. *Bowers*, 478 U.S. at 194.

24. *Lawrence v. Texas*, 539 U.S. 558, 578–79 (2003).

B. *The Revivification of the “Mystery of Life” Passage*

No treatment of *Lawrence*'s impact on *Glucksberg* would be complete without some discussion of the significance of *Planned Parenthood v. Casey*'s²⁵ “mystery-of-life” passage:

Our law affords constitutional protection to personal decisions relating to marriage, procreation, contraception, family relationships, child rearing, and education. . . . These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State.²⁶

This sweeping language did not make much of an impression on Chief Justice Rehnquist, author of the “opinion of the Court” in *Glucksberg*. As Rehnquist viewed the passage, all it did was “describe[, in a general way and in light of our prior cases, those personal activities and decisions that this Court has identified as . . . protected by the Fourteenth Amendment.”²⁷ He added, “That many of the rights and liberties protected by the Due Process Clause sound in personal autonomy does not warrant the sweeping conclusion that any and all important, intimate, and personal decisions are so protected, and *Casey* did not suggest otherwise.”²⁸

If the Court revisits the question(s) presented in *Glucksberg*, a number of Justices, perhaps a majority, are likely to take the mystery-of-life passage a good deal more seriously. When the *Lawrence* Court quoted the mystery-of-life passage with approval, it prefaced the quotation with the comment that this language “explain[s] the respect the Constitution demands for the autonomy of the person in making [various] choices,” such as “personal decisions relating to marriage, procreation . . . family relationships, [and] child rearing.”²⁹ The *Lawrence* Court seemed to be trying to provide the “unifying principle” for the “privacy” or “autonomy” cases that the Court did not—or could not—find in *Bowers*.³⁰ And if we take the stirring words of the mys-

25. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992).

26. *Id.* at 851, quoted in *Lawrence*, 539 U.S. at 574.

27. *Washington v. Glucksberg*, 521 U.S. 702, 727 (1997).

28. *Id.* at 727–28 (citation omitted).

29. *Lawrence*, 539 U.S. at 574.

30. *Cf.* Brief for the American Civil Liberties Union & the ACLU of Texas as Amici Curiae Supporting Petitioner at 3, *Lawrence*, 539 U.S. 558 (No. 02-102), 2003 WL 164132. The ACLU argued:

[I]t is only a unifying principle of personal autonomy that serves to limit an otherwise boundless, tyrannical state power over every detail of personal life. And only such a unifying principle renders this Court's privacy decisions a coherent whole, instead of a series of disjointed pin-points of constitutional protection unconnected by principle or logic.

Id. “Counsel of Record” for the ACLU brief was Professor Laurence H. Tribe, who also represented the plaintiffs in *Quill*.

tery-of-life passage seriously, as *Lawrence* did, how can we ignore the desire of competent people to seek assistance in ending their lives? Indeed, the decision to “shuffle[] off this mortal coil”³¹ because one has arrived at the conclusion that continued life is worse than immediate death would seem to fit some of the wording in the *Casey* passage better than any decision one can imagine.³²

Decisions whether (and whom) to marry and with whom to share sexual intimacy are important. So is the decision whether to have children or to get an abortion. But is not controlling the time and manner of one’s own death the most evident way—the most profound way—to “define one’s own concept of existence, of meaning, of the universe, and of the mystery of human life”?³³

C. *Despite the Lack of a Single Dissent, Glucksberg Was a Shaky Ruling from the Outset*

Another reason the *Glucksberg* decision faces an uncertain future is the discordant note struck by five concurring opinions—especially Justice O’Connor’s, who purported to join Chief Justice Rehnquist’s four-Justice opinion but really did not. These five concurring opinions make for frustrating reading and a shaky ruling.

A decade ago, Kathryn Tucker, a contributor to this Symposium, was the lead lawyer for the plaintiffs in the *Glucksberg* case. Ms. Tucker and her colleagues formulated the question presented as “[w]hether the Fourteenth Amendment’s guarantee of liberty protects the decision of a mentally competent, *terminally ill adult* to bring about impending death in a certain, humane, and dignified manner.”³⁴ Moreover, Ms. Tucker began her oral argument by telling the Supreme Court that “[t]his case presents the question whether *dying* citizens in full possession of their mental faculties *at the*

31. WILLIAM SHAKESPEARE, *HAMLET* act 3, sc. 1.

32. This provides support for the view that the challenged restriction on PAS implicates a fundamental right, but it does not end the inquiry. If the state’s countervailing interests are powerful enough, they may override the “liberty interest” in PAS. See Cass R. Sunstein, *The Right to Die*, 106 *YALE L.J.* 1123, 1124 (1997) (arguing that even if there is a fundamental right to PAS, there are state interests sufficiently compelling to render prohibitions on PAS constitutional). *But see* Chemerinsky, *supra* note 4 (arguing that the *Glucksberg* Court should have applied strict scrutiny and struck down the prohibition on PAS).

For the view that *Lawrence* points the way to an alternative to the modern doctrine of fundamental rights that would require the government to justify its restriction on liberty instead of requiring the individual to establish that the liberty being restricted is “fundamental,” see Randy Barnett, *Justice Kennedy’s Libertarian Revolution: Lawrence v. Texas*, 2002–03 *CATO SUP. CT. REV.* 21, 35–36.

33. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 851 (1992); *see also* LAURENCE H. TRIBE, *AMERICAN CONSTITUTIONAL LAW* 1337–38 (2d ed. 1988); *cf.* Chemerinsky, *supra* note 4, at 1506–07.

34. Brief of Respondents at i, *Washington v. Glucksberg*, 521 U.S. 702 (1997) (No. 96-110), 1996 WL 708925 (emphasis added).

threshold of death due to terminal illness have the liberty to choose to cross that threshold in a humane and dignified manner.”³⁵

Similarly, Professor Laurence Tribe, who argued the companion case of *Vacco v. Quill*, told the Court that the liberty at stake in that case was the “liberty, when facing imminent and inevitable death, not to be forced by the government to endure . . . pain and suffering.”³⁶ He also emphasized that the freedom he was advocating was “the freedom, at this threshold at the end of life, not to be a creature of the state but to have some voice in the question of how much pain one is really going through.”³⁷

It is no secret why the lawyers for the plaintiffs in the *Glucksberg* and *Quill* cases insisted that the right they were asserting was limited to the terminally ill. The best chance they had of prevailing in the courts—perhaps the only chance—was to ask for a narrow right to PAS, one confined to the terminally ill. Such a limited right would cause less alarm and command more support than a general right to assisted suicide.

Thus, as I expressed it a decade ago, if all that the Supreme Court decided in *Glucksberg* and *Quill* was that there is no general right to enlist the aid of a physician in committing suicide, “the Court decided virtually nothing—because everybody agreed that there was no such right.”³⁸ After rereading *Glucksberg* many times, especially in light of what other commentators have had to say about it, I have come to the unhappy conclusion that it is possible to read the physician-assisted suicide cases as having decided “virtually nothing.”

Indeed, the more I reread the various opinions in *Glucksberg*, the more I get the feeling that this may be the most confusing and the most fragile 9–0 decision in Supreme Court history.

Chief Justice Rehnquist is not blameless. He contributed to the uncertainty about the holding by stating the question presented in different ways. At one point he told us that “the question before us is whether the ‘liberty’ specially protected by the Due Process Clause includes a right to commit suicide which itself includes a right to assistance in doing so.”³⁹ This is incorrect on two counts. First, nobody was asking for “a right to commit suicide”—only a right to a physician’s assistance in doing so. Neither suicide nor attempted suicide is a criminal offense in Washington (or any other state)—only aiding another in committing suicide is criminally proscribed.⁴⁰

35. Transcript of Oral Argument at 26–27, *Glucksberg*, 521 U.S. 702 (No. 96-110), 1997 WL 13671 (emphasis added).

36. Transcript of Oral Argument at 55–56, *Vacco v. Quill*, 521 U.S. 793 (1997) (No. 95-1858), 1997 WL 13672 (emphasis added).

37. *Id.* at 56 (emphasis added).

38. Yale Kamisar, *On the Meaning and Impact of the Physician-Assisted Suicide Cases*, 82 MINN. L. REV. 895, 912 (1998).

39. *Glucksberg*, 521 U.S. at 723. Elsewhere, however, Rehnquist does make it clear that the issue to be resolved was not whether the Court’s “liberty jurisprudence” supported a right to suicide, but whether it supported a right to *assisted* suicide. *Id.* at 724.

40. N.Y. STATE TASK FORCE ON LIFE & THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT, at xi (1994) [hereinafter TASK FORCE REPORT].

And second, nobody was claiming a right to a physician's assistance in committing suicide generally—only a right to a physician's help in very special circumstances.

Whatever Rehnquist's reasons for framing the question presented this way,⁴¹ at other places in his opinion he framed the issue more specifically. For example, at one point he called attention to the fact that the Ninth Circuit had “held that [Washington] State's assisted-suicide ban was unconstitutional ‘as applied to terminally ill competent adults who wish to hasten their deaths with medication prescribed by their physicians.’”⁴² Moreover, in the penultimate paragraph of his opinion, Rehnquist concluded that the Court was “hold[ing] that [Washington's assisted-suicide ban] does not violate the Fourteenth Amendment, either on its face or ‘as applied to competent, terminally ill adults who wish to hasten their deaths by obtaining medication prescribed by their doctors.’”⁴³

When one reads Rehnquist's opinion in its entirety, there is little doubt, if any, that he believed he was rejecting the contention that Washington State's assisted-suicide ban violated due process insofar as it prevented terminally ill people from obtaining a physician's assistance in bringing about death. He believed he was holding that a state could, consistently with the Fourteenth Amendment, reject a “sliding-scale approach” to protecting lives, whereby the “weight” of the state's interest “depends on the ‘medical condition and the wishes of the person whose life is at stake.’”⁴⁴

Nevertheless, a concurring Justice O'Connor seized on Rehnquist's broadest description of the question before the Court and announced that she was “join[ing] the Court's opinion[] because [she] agree[d] that there is no generalized right to ‘commit suicide.’”⁴⁵ This also permitted her to say that in light of the “facial challenge[]” to the Washington statute (as opposed to an “as applied” challenge), she saw “no need to reach” the question of “whether a mentally competent person who is experiencing great suffering has a constitutionally cognizable interest in controlling the circumstances of his or her imminent death.”⁴⁶

41. Perhaps deliberately avoiding the terms “suicide” and “assisted suicide” (terms that carry strongly negative associations), the Ninth Circuit had used such synonyms as “right to die,” “controlling the time and manner of one's death,” “choosing a dignified and humane death,” and “individuals' right to determine their own destiny.” *Compassion in Dying v. Washington*, 79 F.3d 790, 801, 814, 816 (9th Cir. 1996) (en banc), *rev'd sub nom. Glucksberg*, 521 U.S. 702; *see also id.* at 798–99. As I have suggested elsewhere, Rehnquist may have been annoyed at what he may have considered the Ninth Circuit's emotive and euphemistic language for “suicide” and believed that the statement of the “question presented” should feature that term prominently. *See Kamisar, supra* note 38, at 913.

42. *Glucksberg*, 521 U.S. at 709 (quoting *Compassion in Dying*, 79 F.3d at 837). Rehnquist referred to this language again later in the opinion. *Id.* at 709 n.6, 732–33.

43. *Id.* at 735 (quoting *Compassion in Dying*, 79 F.3d at 838). He then dropped a footnote which added, “We emphasize that we today reject the [Ninth Circuit's] specific holding that the statute is unconstitutional ‘as applied’ to a particular class.” *Id.* at 735 n.24.

44. *See id.* at 729 (quoting *Compassion in Dying*, 79 F.3d at 817).

45. *Id.* at 736 (O'Connor, J., concurring).

46. *Id.*

Justice O'Connor's approach is problematic in several respects. First, "generalized right to commit suicide" is O'Connor's phrase, not Rehnquist's. He never spoke of a "general" or "generalized" right to commit suicide. Second, Rehnquist's statement that the issue involved a "right to commit suicide" was itself flawed, as described above. Finally, as already noted, nobody claimed a general right to obtain the active intervention of a physician (or anyone else) to help bring about one's suicide—only a particularized right to do so when one is experiencing great suffering and facing imminent death. This particularized right—the only right asserted by the plaintiffs in the *Glucksberg* and *Quill* cases—was the one Justice O'Connor saw no need to reach.

Although formally Justice O'Connor provided the much-needed fifth vote, it is highly doubtful that she really did. Although she stated that she was "join[ing]" Rehnquist's opinion,⁴⁷ she certainly didn't "join" the decision Rehnquist believed he had arrived at.⁴⁸ Thus, although Rehnquist's opinion is called "the opinion of the Court," it does not seem to deserve that designation.

Justice Ginsburg, meanwhile, concurred in the Court's judgments "substantially for the reasons" stated in Justice O'Connor's concurring opinion.⁴⁹ Justice Breyer joined O'Connor's opinion as well, "except insofar as it joins the majority."⁵⁰ He, no less than Justice O'Connor, was concerned about the need of terminally ill patients to avoid pain.⁵¹ Breyer described the asserted right at stake as a "right to die with dignity,"⁵² one that would have at its core "personal control over the manner of death, professional medical assistance, and the avoidance of unnecessary and severe physical suffering—combined."⁵³ However, Justice Breyer saw no need to decide whether such an asserted right should be classified as "fundamental."⁵⁴ For "the avoidance of severe physical pain (connected with death) would have to constitute an essential part of any successful claim and . . . as Justice O'Connor points

47. *Id.*

48. However, Justice O'Connor certainly didn't dissent from Rehnquist's opinion either. There is no indication, for example, that she interprets the stirring language in *Casey* any more expansively than did Chief Justice Rehnquist or that she has any more difficulty than he did accepting the distinction between forgoing life-sustaining medical treatment and actually intervening to bring about death. Moreover, she does say that "[t]here is no reason to think the democratic process will not strike the proper balance between the interests of terminally ill, mentally competent individuals who would seek to end their suffering and the State's interests in protecting those who might seek to end life mistakenly or under pressure." *Id.* at 737. It is also possible to read Justice O'Connor's opinion as indicating that she is inclined to agree with Rehnquist that the state's interests are sufficient to justify a ban on assisted suicide even for terminally ill patients suffering great pain, *so long as* dying patients can obtain palliative care.

49. *Id.* at 789 (Ginsburg, J., concurring).

50. *Id.* (Breyer, J., concurring).

51. *Id.* at 790.

52. *Id.*

53. *Id.*

54. *Id.* at 791.

out, the laws before us do not *force* a dying person to undergo that kind of pain.”⁵⁵

Since Justices Stevens and Souter, who also wrote concurring opinions in *Glucksberg*, seemed to favor a right to PAS even more than Justices O’Connor, Ginsburg, and Breyer did, at least for compelling circumstances,⁵⁶ there is reason to believe that five members of the *Glucksberg* Court were inclined to recognize a right to effective pain medication even if it might hasten death and to resist any legislative efforts to restrict the ability of terminally ill patients to obtain such pain relief.⁵⁷

Justice Souter concluded that the challenged statute did not set up “one of those ‘arbitrary impositions’ or ‘purposeless restraints’ at odds with the Due Process Clause of the Fourteenth Amendment.”⁵⁸ One of the interests the state put forward to justify the challenged statute was “dispositive” for

55. *Id.*

56. See Richard H. Fallon, Jr., *The Supreme Court, 1996 Term—Foreword: Implementing the Constitution*, 111 HARV. L. REV. 54, 138–39 (1997); see also *infra* text accompanying notes 61–64, 72–78.

57. See Robert A. Burt, *The Supreme Court Speaks—Not Assisted Suicide but a Constitutional Right to Palliative Care*, 337 NEW ENG. J. MED. 1234 (1997); Kamisar, *supra* note 38, at 908–09. This point implicates a concept known as the “double effect” principle, which, in the context of pain relief, means that a physician (a) may not administer a lethal dose of drugs for the very purpose of killing the patient, but (b) may administer increasing dosages of drugs to relieve the patient’s increasing pain—even though doing so will foreseeably hasten or increase the risk of death—so long as the dosage was not intended to produce death but to relieve pain. For a helpful discussion of the “double effect” principle, see, in this Symposium, Smith, *supra* note 6, at 1578–79.

As I have discussed elsewhere, the view that pain relief must be permitted even when the level of medication is high enough to bring about death helps PAS *opponents*, for one of their principal arguments is that health professionals can effectively meet their patients’ need for compassionate end-of-life care without yielding to requests for assisted suicide. Kamisar, *supra* note 38, at 909–10.

In rare instances, it should be noted, nothing will relieve great pain and suffering except terminal sedation, a technique which renders a dying patient unconscious or stuporous until the end finally comes. See Norman L. Cantor, *Twenty-Five Years after Quinlan: A Review of the Jurisprudence of Death and Dying*, 29 J.L. MED. & ETHICS 182, 187 (2001). I share Professor Cantor’s view that some forms of terminal sedation take us into “legally uncharted territory.” *Id.*; see also David Orentlicher, *The Supreme Court and Terminal Sedation: Rejecting Assisted Suicide; Embracing Euthanasia*, 24 HASTINGS CONST. L.Q. 947, 956–60 (1997) (likening some forms of terminal sedation to active euthanasia). I also agree with Professor Cantor that it is “doubtful” that any of the concurring Justices in *Glucksberg* who made favorable references to the use of analgesics at high enough levels to cause unconsciousness were endorsing all forms of terminal sedation. Cantor, *supra*, at 187.

It appears that pain or the fear of pain is less often a decisive factor when patients seek assisted suicide than a feeling of “indignity,” “degradation,” or loss of control. See, e.g., Arthur E. Chin et al., *Legalized Physician-Assisted Suicide in Oregon—The First Year’s Experience*, 340 NEW ENG. J. MED. 577, 581 tbl.3 (1999); Peter J. Hammer, *Assisted Suicide and the Challenge of Individually Determined Collective Rationality*, in LAW AT THE END OF LIFE: THE SUPREME COURT AND ASSISTED SUICIDE 239, 263–64 (Carl E. Schneider ed., 2000); Eric A. Johnson, *Assisted Suicide, Liberal Individualism, and Visceral Jurisprudence: A Reply to Professor Chemerinsky*, 20 ALASKA L. REV. 321, 324–27 (2003); see also Hendin & Foley, *supra* note 7, at 1635–36. Some patients, therefore, will undoubtedly be appalled by the helplessness and indignity brought about by some forms of terminal sedation, and strongly resist these procedures (especially when they have several weeks to live). They will do so even though there is no alternative way to ease their pain. This small category of cases probably constitutes the strongest set of circumstances for PAS (or for active euthanasia).

58. *Glucksberg*, 521 U.S. at 752 (Souter, J., concurring) (quoting *Poe v. Ullman*, 367 U.S. 497, 543 (1961) (Harlan, J., dissenting)).

Justice Souter—a justification, he noted, that opposed the respondents’ claim “not with a moral judgment” contrary to those of the respondents,⁵⁹ but with “a recognized state interest . . . in protecting patients from mistakenly and involuntarily deciding to end their lives, and in guarding against both voluntary and involuntary euthanasia.”⁶⁰

However, Justice Souter was quite sympathetic to the respondents’ arguments.⁶¹ He was well aware that PAS proponents had an answer to the concerns that all sorts of mistakes and abuses might occur if PAS were decriminalized: “state regulation with teeth.”⁶² For example, the state might require two qualified physicians to confirm the patient’s diagnosis and mandate that the patient make repeated requests for PAS in the presence of at least two witnesses over a specified timespan.⁶³ But, he continued,

at least at this moment there are reasons for caution in predicting the effectiveness of the teeth proposed. Respondents’ proposals . . . sound much like the guidelines now in place in the Netherlands There is, however, a substantial dispute today about what the Dutch experience shows. . . . *The day may come* when we can say with some assurance which side is right, *but for now* it is the substantiality of the factual disagreement, and the alternatives for resolving it, that matter. They are, for me, dispositive of the due process claim *at this time*.⁶⁴

Justice Souter ended his opinion by observing that he was not deciding the respondents’ claim “for all time,” but “acknowledg[ing] the legislative institutional competence as the better one to deal with that claim at this time.”⁶⁵

I have saved Justice Stevens for last because his opinion, although described as “concurring in the judgment,”⁶⁶ is primarily a dissent. Stevens managed to accomplish this by the way he viewed the procedural nature of the case. As spelled out earlier, it is fairly clear that Chief Justice Rehnquist’s four-person opinion concluded that the challenged statute was constitutional *both* “on its face” *and* “as applied” to competent terminally ill people.⁶⁷ But Justice Stevens maintained that Rehnquist had only decided that the challenged statute was constitutional “on its face.”⁶⁸

59. *Id.* at 782. As to whether a moral judgment is a valid state interest, compare the views of two contributors to this Symposium, Barnett, *supra* note 32 at 36–38, and Smith, *supra* note 6, at 1584–88.

60. *Glucksberg*, 521 U.S. at 782 (Souter, J., concurring).

61. *See id.* at 778–79, 781–82, 785.

62. *Id.* at 785.

63. *Id.*

64. *Id.* at 785–86 (emphasis added).

65. *Id.* at 789.

66. *Id.* at 738 (Stevens, J., concurring).

67. *See supra* text accompanying notes 39–44. For a helpful discussion of “on its face” and “as applied” challenges in the *Glucksberg* context, see Sonia M. Suter, *Ambivalent Unanimity: An Analysis of the Supreme Court’s Holding, in LAW AT THE END OF LIFE: THE SUPREME COURT AND ASSISTED SUICIDE*, *supra* note 57, at 25, 29–32.

68. *See Glucksberg*, 521 U.S. at 739, 740 (Stevens, J., concurring).

Justice O'Connor had also read Rehnquist's opinion as addressing only a facial challenge to the Washington statute.⁶⁹ But Justice Stevens went a step further. He said, in effect, that none of the remaining plaintiffs had standing to make an "as applied" challenge. He thought it significant that all the *patient*-plaintiffs had died by the time the case reached the appellate federal court.⁷⁰ As for the *physician*-plaintiffs, none were "threatened with prosecution for assisting in the suicide of a particular patient."⁷¹

Although Chief Justice Rehnquist did not fully address Justice Stevens's procedural argument, concurring Justice Souter did. He observed that "[a]lthough the terminally ill original parties have died during the pendency of this case, the four physicians who remain . . . continue to request declaratory and injunctive relief for their own benefit in discharging their obligations to other dying patients who request their help."⁷²

There is no reason to think that the three members of the Court who joined Rehnquist's opinion (Justices Scalia, Kennedy, and Thomas) disagreed with him about the procedural nature of the challenge to the Washington statute. If they agreed, Souter's opinion means that on this issue Rehnquist did speak for a majority of the Court.

As we have seen, Justice Stevens took a different, and narrower, view of the challenge to the Washington statute. This enabled him to (a) "fully agree with the Court" that the Due Process Clause "does not include a categorical 'right to commit suicide which itself includes a right to assistance in doing so' "⁷³ yet (b) maintain that "there are times when [PAS] is entitled to constitutional protection."⁷⁴

Stevens's claim that the Washington statute was only being challenged "on its face" may have been quite weak, but his statement of a competent, terminally ill person's need for—and right to—PAS when she seeks such relief was quite powerful. Reading the *Cruzan* case⁷⁵ broadly (too broadly, I

69. See *supra* text accompanying notes 45–48.

70. *Glucksberg*, 521 U.S. at 739 (Stevens, J., concurring).

71. *Id.* If, as Justice Stevens maintained, physicians lacked standing to challenge laws prohibiting assisted suicide, how could appellate courts *ever* consider a challenge as applied to terminally ill patients? All terminally ill patients (often defined as those who will die within six months) *necessarily* will die before completion of the litigation. In the *Glucksberg* case itself all but one of the patient-plaintiffs had died even by the time the district court had issued its decision. Moreover, the view that "physicians have standing to assert the legal rights of their patients has been established in many cases." Michael W. McConnell, *The Right to Die and the Jurisprudence of Tradition*, 1997 UTAH L. REV. 665, 677.

72. *Glucksberg*, 521 U.S. at 752–53 (Souter, J., concurring); see also *id.* at 753 ("I take it to be true, as [the physician-plaintiffs] say, that the Washington statute prevents the exercise of a physician's 'best professional judgment to prescribe medications to [mentally competent, terminally ill] patients in dosages that would enable them to act to hasten their own deaths.'").

73. *Id.* at 741 (Stevens, J., concurring) (quoting *id.* at 723 (majority opinion)).

74. *Id.* at 742.

75. *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990). This case, ably discussed in Louis Michael Seidman, *Confusion at the Border: Cruzan, "The Right to Die," and the Public/Private Distinction*, 1991 SUP. CT. REV. 47, involved a woman (Nancy Beth Cruzan) who had been in a persistent vegetative state for many years and was being kept alive by means of a feeding tube. Her parents sought to discontinue the tubal feeding, but were rebuffed by hospital officials and

submit),⁷⁶ and making proficient use of *Casey*'s mystery-of-life language (too much, I submit),⁷⁷ Justice Stevens asserted as follows:

Given the irreversible nature of her illness and the progressive character of her suffering, Nancy Cruzan's interest in refusing medical care was incidental to her more basic interest in controlling the manner and timing of her death. . . . [T]he source of Nancy Cruzan's right to refuse treatment was not just a common-law rule . . . [but] an aspect of a far broader and more basic concept of freedom that is even older than the common law. This freedom embraces . . . a person's . . . interest in dignity, and in determining the character of the memories that will survive long after her death.

. . . [S]ome state intrusions on the right to decide how death will be encountered are . . . intolerable. The now-deceased plaintiffs in this action may in fact have had a liberty interest even stronger than Nancy Cruzan's because, not only were they terminally ill, they were suffering constant and severe pain. Avoiding intolerable pain and the indignity of living one's final days incapacitated and in agony is certainly "[a]t the heart of [the] liberty . . . to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life."⁷⁸

In the course of overruling *Bowers*, the *Lawrence* Court quoted Justice Stevens's dissent in *Bowers* with approval,⁷⁹ declaring that "Justice Stevens' analysis [in the earlier case] should have been controlling . . . and should control here."⁸⁰ Someday, when the Court revisits *Glucksberg*, as it inevitably will, it may quote from Stevens's opinion in that case with approval and say, once again, that his analysis then "should have been controlling . . . and should control here."⁸¹

II. WHY THE COURT IS UNLIKELY TO ESTABLISH A RIGHT TO PAS

That *Lawrence* may lead the Court someday to find a right to PAS in the Constitution is certainly conceivable. Despite the flaws in the various

turned to the courts. The state supreme court ruled that, in the absence of a living will, they had to show "clear and convincing" evidence of their daughter's wish to be free of life support. The U.S. Supreme Court affirmed five to four, per Chief Justice Rehnquist, but assumed for purposes of the case that a competent person would have a "constitutionally protected right to refuse lifesaving hydration and nutrition." *Cruzan*, 497 U.S. at 279. As noted elsewhere in this Symposium, five members of the *Cruzan* Court—concurring Justice O'Connor and the four dissenters—seemed to go further than the Chief Justice and to assert that the right of competent persons to reject lifesaving medical treatment does exist. Chemerinsky, *supra* note 4, at 1507–08. For the dramatic aftermath of the *Cruzan* case, see Carl E. Schneider, *The Road to Glucksberg*, in *LAW AT THE END OF LIFE: THE SUPREME COURT AND ASSISTED SUICIDE*, *supra* note 57, at 11, 18.

76. See *infra* Section II.D.

77. See *infra* Section II.C.

78. *Glucksberg*, 521 U.S. at 742–43, 745 (quoting *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 851 (1992)).

79. *Lawrence v. Texas*, 539 U.S. 558, 577–78 (2003).

80. *Id.* at 578.

81. *Id.*

Glucksberg opinions, however, that ruling is likely to remain unchanged for the foreseeable future. A number of considerations support this prediction.

Unlike the situation with respect to *Bowers*, *Glucksberg* did not demean any politically vulnerable group. Moreover, unlike developments preceding *Lawrence*, there has been no emerging awareness of a right or liberty to enlist the assistance of a physician in committing suicide. No state court has found a right to PAS in its own state constitution. Nor has any state legislature legalized PAS in the decade since *Glucksberg*.

In addition, various considerations might cause a court to balk at constitutionalizing PAS for the terminally ill. Such a right is not easily cabined. If personal autonomy extends to the time and manner of one's death, why doesn't it also apply *whenever* a competent person believes that death is better than continued life? And why shouldn't personal autonomy apply when a patient is unable to commit the final act herself, but needs a health professional to administer a lethal injection? (Such an act would constitute euthanasia, not simply assisted suicide.)

A. *The Rights of a Politically Vulnerable Group Are Not at Stake*

"[W]hatever [its] rhetoric about sexual freedom in general," Cass Sunstein has observed, one can view *Lawrence* as "really a case about the social subordination of gays and lesbians."⁸² *Lawrence*'s words, he continues, "sound in due process, but much of its music involves equal protection."⁸³ One might add that, although the majority chose to decide the case on due process grounds,⁸⁴ some of the words in Justice Kennedy's majority opinion sound in equal protection as well: "[*Bowers*'s] continuance as precedent demeans the lives of homosexual persons."⁸⁵

It is hard to see, however, how the prohibition against physician-assisted suicide subordinates or demeans any politically vulnerable group. After all, "[d]ying people are clearly not a discrete and insular minority in the same, sure way as are black people subject to race discrimination laws [or] women subject to abortion restrictions."⁸⁶

82. Cass R. Sunstein, *What Did Lawrence Hold? Of Autonomy, Desuetude, Sexuality, and Marriage*, 2003 SUP. CT. REV. 27, 30; see also Pamela S. Karlan, *Foreword: Loving Lawrence*, 102 MICH. L. REV. 1447, 1457 (2004).

83. Sunstein, *supra* note 82, at 30.

84. "Were we to hold the statute invalid under the Equal Protection Clause," observed Kennedy, "some might question whether a prohibition would be valid if drawn differently, say, to prohibit the conduct both between same-sex and different-sex participants." *Lawrence*, 539 U.S. at 575.

85. *Id.* at 575; see also Karlan, *supra* note 82, at 1453–54; Miranda Oshige McGowan, *From Outlaws to Ingroups: Romer, Lawrence, and the Inevitable Normativity of Group Recognition*, 88 MINN. L. REV. 1312, 1313 (2004) ("Gays and lesbians win in *Lawrence* . . . because the challenged legislation explicitly targeted gays, and gays constituted a group that, in the Court's eyes, is socially salient.").

86. Robert A. Burt, *Constitutionalizing Physician-Assisted Suicide: Will Lightning Strike Thrice?*, 35 DUQ. L. REV. 159, 179 (1996).

During the oral arguments in *Glucksberg*, three members of the Court, Justices O'Connor, Souter, and Ginsburg, made essentially the same point.⁸⁷ Justice O'Connor reiterated this point in her concurring opinion:

Every one of us at some point may be affected by our own or a family member's terminal illness. There is no reason to think the democratic process will not strike the proper balance between the interests of terminally ill, mentally competent individuals who would seek to end their suffering and the State's interest in protecting those who might seek to end life mistakenly or under pressure.⁸⁸

That prohibiting assisted suicide and euthanasia does not subordinate or demean any distinct groups is not all that one can say. One can go a large step further and note that a ban on PAS *protects* the poor and the socially disadvantaged. Consider the observations, findings and conclusions of the twenty-four member, ongoing, blue-ribbon New York State Task Force on Life and the Law, which unanimously recommended that New York laws prohibiting assisted suicide and euthanasia not be changed.⁸⁹ In the preface to its 181-page report, the task force expressed its belief that (a) "the practices would be profoundly dangerous for large segments of the population, especially in light of the widespread failure of American medicine to treat pain adequately or to diagnose and treat depression in many cases," and (b) the risks "would be most severe for those whose autonomy and well-being are already compromised by poverty, lack of access to good medical care, or membership in a stigmatized social group."⁹⁰

87. Transcript of Oral Argument, *supra* note 35, at 39–42.

88. *Washington v. Glucksberg*, 521 U.S. 702, 737 (1997) (O'Connor, J., concurring); *see also* Sunstein, *supra* note 32, at 1146 (observing that when the issue is close and "there is no democratic defect in the underlying political process, [courts] should not strike down reasonable legislative judgments").

89. TASK FORCE REPORT, *supra* note 40, at vii. The task force, convened by Governor Mario Cuomo in 1985, was made up of eight medical doctors (two of whom were deans of medical schools), two bioethicists who were not medical doctors, four lawyers, six clergymen (one of whom was also a law professor), the state commissioner of health, the state commissioner on the quality of care for the mentally disabled, and a member of the New York Civil Liberties Union. In addition, three medical doctors and a nurse served as consultants. Neither PAS nor euthanasia were on the agenda initially presented to the task force, but it decided to grapple with these issues when public debate about the practices intensified. *Id.*

90. *Id.* at vii–viii; *see also id.* at 125, 143; *Glucksberg*, 521 U.S. at 719, 732 (quoting TASK FORCE REPORT, *supra* note 40, at 120).

Consider, too, UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE (Brian D. Smedly et al. eds., 2001), especially the summary at pages 2–3. Consider, as well, a recent study detailing how "[d]eeply imbedded attitudes about race influence the way doctors care for their African-American patients." Stephen Smith, *Tests of ER trainees find signs of race bias in care: Study seeks root of known disparity*, BOSTON GLOBE, July 20, 2007, at A1 (reporting on Alexander R. Green et al., *Implicit Bias Among Physicians and its Predictions of Thrombolysis Decisions for Black and White Patients*, 22 J. GEN. INTERNAL MED. 1231 (2007)).

As pointed out elsewhere in this Symposium, however, reports from Oregon indicate that "the option of physician-assisted dying has not been unwillingly forced upon those who are poor, uneducated, uninsured, or otherwise disadvantaged." Tucker, *supra* note 7, at 1604. Indeed, one recent annual report "found that a higher level of education is strongly associated with the use of physician-assisted dying." *Id.*

B. *There Is No “Emerging Recognition” of a Right or Freedom to Practice PAS*

The *Lawrence* majority downplayed the debate over whether, as the *Bowers* Court had claimed, proscriptions against homosexual conduct had “ancient roots.”⁹¹ Instead, it emphasized that the past half century had seen “an emerging awareness that liberty gives substantial protection to adult persons in deciding how to conduct their private lives in matters pertaining to sex.”⁹²

The first evidence cited of this “emerging awareness” was an event that occurred in 1955: when promulgating its Model Penal Code, the American Law Institute “made clear that it did not recommend or provide for ‘criminal penalties for consensual sexual relations conducted in private.’”⁹³ Six years later, “Illinois changed its laws to conform to the Model Penal Code” and “[o]ther states soon followed.”⁹⁴

Nothing comparable, however, has occurred with respect to PAS. Indeed, almost the exact opposite has taken place. The same Model Penal Code that decriminalized homosexual conduct declined to do the same for assisted suicide. Instead, it “create[d] a separate offense of aiding or soliciting suicide,”⁹⁵ explaining that “[t]he fact that penal sanctions will prove ineffective to deter [a suicidal individual from committing the act himself] does not mean that the criminal law is equally powerless to influence the behavior of those who would aid or induce another to take his own life.”⁹⁶

The second piece of evidence cited by the *Lawrence* Court to support its view of an “emerging awareness” was an event that took place in 1957: a committee advising the British Parliament recommended the repeal of laws punishing homosexual conduct.⁹⁷ The substance of these recommendations was enacted ten years later.⁹⁸

However, PAS proponents did not fare well when, almost four decades after this recommendation, another British committee, the House of Lords Select Committee on Medical Ethics, concluded that it could “identify no circumstances in which assisted suicide should be permitted, nor do we see any reason to distinguish between the act of a doctor or of any other person in this connection.”⁹⁹

91. See *Lawrence v. Texas*, 539 U.S. 558, 567–70 (2003).

92. *Id.* at 572.

93. *Id.* (quoting MODEL PENAL CODE § 213.2 cmt. 2 (1980)).

94. *Id.*

95. MODEL PENAL CODE § 210.5 cmt. (Proposed Official Draft 1962), reprinted in 2 AM. LAW INST., MODEL PENAL CODE AND COMMENTARIES 100 (1985).

96. MODEL PENAL CODE § 210.5 cmt.

97. *Lawrence*, 539 U.S. at 572–73 (referring to the Wolfenden Report).

98. *Id.* at 573. For a critique of the Court’s citation to foreign sources of law, see, in this Symposium, Calabresi, *supra* note 4, at 1539–41.

99. SELECT COMMITTEE ON MEDICAL ETHICS, REPORT, 1993–94, H.L. 21–1 para. 262, at 54. This report is sometimes called the Walton Report, after the Chair of the Committee, Lord Walton.

The *Lawrence* Court deemed it significant that five years before *Bowers* was decided the European Court of Human Rights had ruled that a law prohibiting consensual homosexual conduct infringed the European Convention for the Protection of Human Rights and Fundamental Freedoms (sometimes called the European Convention on Human Rights).¹⁰⁰ But two decades later, the same European court concluded that a ban on assisted suicide did not violate any provision of the same European Convention.¹⁰¹

The *Lawrence* majority also seemed to be impressed by the fact that “[t]he courts of five different States have declined to follow [*Bowers*] in interpreting provisions in their own state constitutions parallel to the Due Process Clause of the Fourteenth Amendment.”¹⁰² But no comparable development has occurred with respect to PAS.

When the case that came to be known as *Washington v. Glucksberg* was working its way up to the Supreme Court, a panel of the Court of Appeals for the Ninth Circuit observed that “[in all the years] of our existence no constitutional right to aid in killing oneself has ever been asserted and upheld by a court of final jurisdiction.”¹⁰³ That statement is still valid today. Not a single state supreme court has relied on any of its own state constitutional provisions¹⁰⁴ or on any U.S. Supreme Court decision to declare PAS a protected right.

The *Lawrence* Court also deemed it noteworthy that “[t]he 25 states with laws prohibiting the relevant conduct referenced in the *Bowers* decision are reduced now to 13, of which 4 enforce their laws only against homosexual conduct.”¹⁰⁵ The trend in the political arena regarding PAS, however, has been *strongly against* legalizing it.

In the decade immediately preceding *Glucksberg*, interest in PAS and the controversy over it intensified greatly. The principal reasons were (a) the Washington and California initiatives to legalize PAS (which failed) and the Oregon initiative (which succeeded), (b) the rulings by the two federal courts of appeals in *Glucksberg* and *Quill* that PAS was a constitutionally protected right (rulings ultimately overturned by the U.S. Supreme Court), and (c) the exploits of Jack Kevorkian. During this eventful era, sixteen bills

The report is noted in *Washington v. Glucksberg*, 521 U.S. 702, 718 n.16 (1997), and substantial extracts are set forth in EUTHANASIA EXAMINED: ETHICAL, CLINICAL AND LEGAL PERSPECTIVES 96 (John Keown ed., 1995).

100. *Lawrence*, 539 U.S. at 573 (citing *Dudgeon v. United Kingdom*, 45 Eur. Ct. H.R. (ser. A) at 21 (1981)).

101. *Pretty v. United Kingdom*, 2002-III Eur. Ct. H.R. 157.

102. *Lawrence*, 539 U.S. at 576.

103. *Compassion in Dying v. Washington*, 49 F.3d 586, 591 (9th Cir. 1995), *rev'd en banc*, 79 F.3d 790 (9th Cir. 1996), *rev'd sub nom. Glucksberg*, 521 U.S. 702 (Noonan, J.).

104. Since *Glucksberg*, it is worth noting, the highest courts of two states have rejected the argument that the people of these states are entitled to PAS under state constitutions that contain special provisions expressly safeguarding privacy. See *Sampson v. State*, 31 P.3d 88 (Alaska 2001); *Krischer v. McIver*, 697 So. 2d 97 (Fla. 1997). For more on the Alaska case, compare Erwin Chemerinsky, *Privacy and the Alaska Constitution: Failing to Fulfill the Promise*, 20 ALASKA L. REV. 29 (2003), with Johnson, *supra* note 57.

105. *Lawrence*, 539 U.S. at 573.

expressly prohibiting assisted suicide were enacted into law.¹⁰⁶ On the other hand, although bills to legalize PAS were introduced in more than twenty state legislatures during the same time period, not a single one passed.¹⁰⁷

To be sure, Oregon voters did approve a “death with dignity” initiative in 1994 (a vote Oregon reaffirmed three years later), but Oregon is still the only state in the union to have legalized PAS. A decade later, the Oregon vote looks like a striking exception to PAS proponents’ lack of success generally in the political arena.¹⁰⁸

C. No Obvious Stopping Point¹⁰⁹

Though proponents claim a new right may be limited to PAS for terminally ill patients, the limits they impose appear difficult to defend both in principle and in practice.

1. Once Established, Can (Will) PAS Be Limited to the “Terminally Ill”?

The first difficulty comes in the limitation of PAS to the “terminally ill.”¹¹⁰ If personal autonomy or “the right to define one’s own concept of existence” and “the mystery of human life”¹¹¹ extends to the time and manner of one’s death—if “the right not to be killed, like other rights, should be

106. Ezekiel J. Emanuel & Linda L. Emanuel, *Assisted Suicide? Not in My State*, N.Y. TIMES, July 24, 1997, at A21.

107. Timothy Egan, *Assisted Suicide Comes Full Circle, to Oregon*, N.Y. TIMES, Oct. 26, 1997, at A1; Emanuel & Emanuel, *supra* note 106; *see also infra* note 108.

108. The failure of PAS proponents to achieve success in any state legislature continues. A Michigan ballot initiative legalizing PAS failed in 1998, and between 1994 (the year the Oregon initiative was approved) and 2007, bills to legalize PAS failed in twenty-one states. Such bills failed *five or more times* in six states: Arizona, California, Hawaii, New York, Vermont, and Wisconsin. Kathi Hamlon, Int’l Task Force on Euthanasia & Assisted Suicide, *Failed Attempts to Legalize Euthanasia/Assisted-Suicide in the United States*, <http://www.internationaltaskforce.org/usa.htm> (last visited Feb. 10, 2008).

109. *See* Brief for the United States as Amicus Curiae Supporting Petitioners at 26, *Washington v. Glucksberg*, 521 U.S. 702 (1997) (No. 96-110), 1996 WL 663185 (“Once a legislature abandons a categorical prohibition against physician assisted suicide, there is no obvious stopping point.”), *quoted in Glucksberg*, 521 U.S. at 734 n.23.

110. “Terminal illness” is frequently defined as a condition or illness that will result in death within six months’ time. *See* Daniel Callahan & Margot White, *The Legalization of Physician-Assisted Suicide: Creating a Regulatory Potemkin Village*, 30 U. RICH. L. REV. 1, 44 (1996). However, “[t]he few studies that have been done indicate that the designation of six months as a terminal period is entirely arbitrary and that physicians vary drastically in their interpretation of what constitutes this terminal phase of illness.” *Id.* at 45; *see also* 2 ALAN MEISEL, *THE RIGHT TO DIE* § 11.9, at 96 (2d ed. 1995); Thomas J. Marzen, “*Out, Out Brief Candle*”: *Constitutionally Prescribed Suicide for the Terminally Ill*, 21 HASTINGS CONST. L.Q. 799, 814–18 (1994).

I have assumed, as have most commentators, that “terminal illness” is a manageable classification. However, according to a five-hospital empirical study by Professor Joanne Lynn and five other health professionals, this assumption is quite shaky. Joanne Lynn et al., *Defining the “Terminally Ill”*: *Insights from SUPPORT*, 35 DUQ. L. REV. 311, 334 (1996) (“Deciding who should be counted ‘terminally ill’ will pose such severe difficulties that it seems untenable as a criterion for permitting [PAS].”); *see also* Hendin & Foley, *supra* note 7, at 1633–34.

111. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 851 (1992).

waivable when the person makes a competent decision that continued life is no longer wanted . . . but is instead worse than no further life at all"¹¹²—why should this right be limited to the “terminally ill”?

It seems strange that someone in the early stages of Alzheimer’s disease, anticipating and fearing mental deterioration some years down the road, would be ineligible for PAS because the disease has not progressed far enough to render her “terminally ill.” Why does a victim of Alzheimer’s disease have to wait until the final phase of the disease to request PAS, when she will no longer be competent to make the request? And what of the person who is paralyzed from the neck down, but has twenty years to live? The mangled survivor of a car accident? One suffering from not yet “terminal” amyotrophic lateral sclerosis (Lou Gehrig’s disease) or AIDS?

The argument that personal autonomy or the liberty to “define one’s own concept of existence” and “the mystery of life” leads to a constitutional right to PAS—but only for the terminally ill—troubled Justice Ginsberg. At one point during the oral arguments, when the lawyer for the *Glucksberg* plaintiffs had spoken of the need for PAS for terminally ill people who wanted to be free of pain and suffering, Justice Ginsberg retorted, “[A] lot of people would fit the category.”¹¹³ How, she wondered, “do you . . . leave out the rest of the world who would fit the same standards?”¹¹⁴

As Kathryn Tucker observes elsewhere in this Symposium, there is a good deal of distance between terminally ill patients who enlist the assistance of a physician to end their lives in order to avoid further suffering or loss of dignity and the typical suicide, who, “in a moment of despair, commits a completely senseless and utterly tragic act.”¹¹⁵ But there are many suicides committed by individuals who are neither mentally ill nor terminally ill that can hardly be called “senseless.” As one proponent of assisted suicide has observed, “[s]urely under a variety of circumstances life may be unendurable to a reasonable person, even though he does not face the prospect of immediate and painful death.”¹¹⁶

Once a right to PAS is established, it is difficult to believe it will be confined to the terminally ill for very long. It will be difficult to justify drawing

112. Dan W. Brock, *Voluntary Active Euthanasia*, HASTINGS CENTER REP., Mar.–Apr. 1992, at 10, 14.

113. Transcript of Oral Argument, *supra* note 35, at 50.

114. *Id.* Justice Scalia made a similar point. *Id.* at 27; *Excerpts From the Supreme Court Oral Argument on Physician-Assisted Suicide*, WASH. POST, Jan. 9, 1997, at A16.

115. Tucker, *supra* note 7, at 1596 n.7 (quoting James E. Dallner & D. Scott Manning, *Death with Dignity in Montana*, 65 MONT. L. REV. 309, 314 (2004)).

116. Alan Sullivan, *A Constitutional Right to Suicide*, in SUICIDE: THE PHILOSOPHICAL ISSUES 229, 241 (M. Pabst Battin & David J. Mayo eds., 1980). According to a survey of ancient attitudes about suicide undertaken by the Ninth Circuit in *Glucksberg*, suicide has been deemed a rational and sensible act if, among other things, it is caused by “weariness of life,” “fear of dishonor,” if “your existence is hateful to you,” or “if you are overwhelmed by fate” or “bowed with grief.” Compassion in *Dying v. Washington*, 79 F.3d 790, 807 (9th Cir. 1996) (en banc), *rev’d sub nom.* *Washington v. Glucksberg*, 521 U.S. 702 (1997). For a list of situations which “various writers have regarded as good and sufficient reasons for ending life,” see Richard B. Brandt, *The Rationality of Suicide*, in SUICIDE: THE PHILOSOPHICAL ISSUES, *supra*, at 117, 123.

a line between (a) the terminally ill and (b) other seriously ill or impaired persons, when those in the second category may have to endure pain or suffering or indignity *for a much longer time*. And if the *Casey* language does apply to assisted suicide, it would be disingenuous to permit only a few people to define their own concept of existence. Why should only a small fraction of the population be allowed to exercise a right that is “at the heart of liberty”? Once the right to PAS is grounded on “self-determination” in making one’s most intimate choices and controlling one’s own life and death, it no longer appears plausible to limit it to the terminally ill.¹¹⁷

2. *Once the Right to PAS is Established, Will (Should) the Thin Line
Between Assisted Suicide and Active Euthanasia Hold?*

PAS is seen by many as offering more protection against potential abuse than active euthanasia, “since the final act is in the patient’s hands.”¹¹⁸ Thus, PAS causes less alarm than euthanasia and commands more support. Moreover, although the term “euthanasia” “apparently first appeared in the English language in the early seventeenth century in its original meaning—a gentle, easy death,”¹¹⁹ somewhere along the way it has become for many a dirty word.¹²⁰

It would hardly be surprising, therefore, if a goodly number of PAS proponents believed that *at this point* in the development of the law governing death and dying, the less talk about euthanasia the better. They may fear, understandably, that few legislatures, if any, are likely to legalize PAS—and the Supreme Court is unlikely to give the asserted right constitutional protection—if it is linked to active voluntary euthanasia “before its time.”¹²¹

117. Cf. DANIEL CALLAHAN, *THE TROUBLED DREAM OF LIFE: LIVING WITH MORALITY* 107–08 (1993) (“How can self-determination have any limits? Why are not the person’s desires or motives, whatever they be, sufficient?”).

118. HERBERT HENDIN, *SEDUCED BY DEATH: DOCTORS, PATIENTS, AND ASSISTED SUICIDE* 49 (rev. ed. 1998) (criticizing this distinction as a justification for legalization of PAS); see also Callahan & White, *supra* note 110, at 6–7 (arguing that the distinction is baseless because the “power differential” between physician and patients is essentially the same in both cases).

119. Yale Kamisar, *Some Non-Religious Views Against Proposed “Mercy-Killing” Legislation*, 42 MINN. L. REV. 969, 969 n.3 (1958). Euthanasia has its origin in the Greek words *eu* (happy, painless) and *thanatos* (death). *Id.*

120. One commentator has put it more gently: Proponents of physician-assisted death are well aware that “euthanasia” is a term that has “strong emotionally laden connotations.” DAN W. BROCK, *LIFE AND DEATH* 170 (1993).

121. Surely this explains in part why the nine physicians, lawyers, and ethicists who drafted a “Model State Act” authorizing and regulating PAS—and wrote an accompanying article—did not address active voluntary euthanasia. “Members of the public and the medical community disagree,” they observed, “and we disagree among ourselves, as to whether there is an important difference between the two concepts.” Charles H. Baron et al., *A Model State Act to Authorize and Regulate Physician-Assisted Suicide*, 33 HARV. J. ON LEGIS. 1, 10 (1996).

In *Gonzales v. Carhart*, the Court recalled that it has “confirmed the validity of drawing boundaries to prevent certain practices that extinguish life and are close to actions that are condemned. *Glucksberg* found reasonable the State’s ‘fear that permitting assisted suicide will start it down the path to voluntary and perhaps even involuntary euthanasia.’” 127 S. Ct. 1610, 1634 (2007)

However, Professor Dan Brock, one of the most respected and eloquent proponents of both PAS and active voluntary euthanasia,¹²² has concluded that the moral arguments for one apply to the other:

In physician-assisted suicide the patient acts last . . . whereas in euthanasia the physician acts last by performing the physical equivalent of pushing the button. In both cases, however, the choice rests fully with the patient. In both the patient acts last in the sense of retaining the right to change his or her mind until the point at which the lethal process becomes irreversible. . . .

If there is no significant, intrinsic moral difference between the two, it is hard to see why public or legal policy should permit one but not the other; worries about abuse or about giving anyone dominion over the lives of others apply equally to either.¹²³

The distinction between PAS and euthanasia is difficult to defend as a matter of principle. The Ninth Circuit en banc majority did not try. Rather, it only “agree[d] that it may be difficult to make a principled distinction” between the two practices.¹²⁴

If the claim that terminally (or seriously) ill people have a right to control the time and manner of their death is well founded, how can this right be denied them—even though they otherwise “qualify”—because they lack the capacity to place the lethal pills into their mouths or the capacity to swallow them?

This point did not escape Justice Ginsburg. At one point during the oral arguments, she suggested that the person who is helpless or in so much agony that she “is not able to assist in her own suicide,” but must have a health professional administer a lethal injection, is “in a *more sympathetic* situation” than one who is able to end her life merely with the preliminary assistance of a physician.¹²⁵

As we have seen, the lawyers for Doctors Glucksberg and Quill insisted that the only question presented was the asserted right to PAS for the terminally ill. The narrow way these lawyers framed the issue is quite understandable. I would have done the same if I had been in their place. After

(quoting *Glucksberg*, 521 U.S. at 732–35 & 733 n.23). *Gonzales* is discussed extensively elsewhere in this Symposium by Calabresi, *supra* note 4.

122. Some evidence of the high regard in which Professor Brock is held is that when Professor Sunstein wrote *The Right to Die*, he quoted or referred to Brock’s writings seven times—more than he did any other proponent of assisted suicide or active euthanasia. Sunstein, *supra* note 32.

123. Brock, *supra* note 112, at 10. To the same effect is BROCK, *supra* note 120, at 203–04.

124. *Compassion in Dying v. Washington*, 79 F.3d 790, 831 (9th Cir. 1996) (en banc), *rev’d sub nom. Glucksberg*, 521 U.S. 702. The distinction would also be difficult to maintain in practice. Compare Lawrence O. Gostin, *Drawing a Line Between Killing and Letting Die: The Law, and Law Reform, on Medically Assisted Dying*, 21 J.L. MED. & ETHICS 94, 96 (1993), with Yale Kamisar, *Physician-Assisted Suicide: The Last Bridge to Active Voluntary Euthanasia*, in EUTHANASIA EXAMINED: ETHICAL, CLINICAL AND LEGAL PERSPECTIVES, *supra* note 99, at 225, 230–33.

125. Transcript of Oral Argument, *supra* note 35, at 29 (emphasis added).

all, as Justice Frankfurter once observed, “The function of an advocate . . . is to seduce.”¹²⁶

The function of a court, however, is to resist seduction. It should rest its judgment on a principle of general significance that may be consistently applied, and it should produce an intellectually coherent reason which in like cases will produce a like result. If I may quote Justice Frankfurter a second time, a court must decide the case before it but this does not mean that the case should be decided without “due regard for what went before” and without equal regard “for what may come after.”¹²⁷

D. *The Right to Forgo Medical Treatment and the Right to PAS Are Not Merely Subcategories of the Same Broad Right*¹²⁸

Few rallying cries or slogans are more stirring than the “right to die.” But few are more fuzzy or misunderstood. The phrase has been used loosely by many people to embrace at least four different rights: (1) the right to forgo unwanted medical procedures, including lifesaving treatment; (2) the right to commit suicide; (3) the right to the assistance of another in committing suicide; and (4) the right to active voluntary euthanasia, i.e., the right to authorize another to kill you intentionally and directly.

The right or liberty that the famous Karen Ann Quinlan case¹²⁹ established and the *Cruzan* Court¹³⁰ recognized is the right under certain circumstances to forgo life-sustaining medical treatment. Indeed, the *Quinlan* case explicitly distinguished between letting die on the one hand, and both direct killing and assisted suicide on the other.¹³¹

Nevertheless, many proponents of PAS have maintained that the same ethical values, or the same constitutional doctrines, that support the right to forgo life-sustaining treatment also support PAS.¹³² I call this the basic argument of PAS proponents.¹³³

For reasons spelled out elsewhere in this Symposium by my colleague Steve Smith,¹³⁴ I do not deny that *some* of the arguments by PAS opponents

126. Felix Frankfurter, *Mr. Justice Jackson, in FELIX FRANKFURTER ON THE SUPREME COURT* 509, 511 (Philip Kurland ed., 1970).

127. *Bd. of Educ. v. Barnette*, 319 U.S. 624, 661 (1942) (Frankfurter, J., dissenting).

128. See Alexander Morgan Capron, *Liberty, Equality, Death!*, *HASTINGS CENTER REP.*, May–June 1996, at 23, 23–24, so characterizing the reasoning in *Compassion in Dying*, 79 F.3d 790, but expressing his strong disagreement with this view.

129. *In re Quinlan*, 355 A.2d 647 (N.J. 1976).

130. For discussion of *Cruzan*, see *supra* note 75.

131. See *Quinlan*, 355 A.2d at 665, 670 & n.9.

132. *E.g.*, Brock, *supra* note 112, at 11; Ronald Dworkin, *Euthanasia, Morality, and Law*, 31 *LOY. L.A. L. REV.* 1147, 1152–55 (1998); Robert A. Sedler, *Are Absolute Bans on Assisted Suicide Constitutional? I Say No*, 72 *U. DET. MERCY L. REV.* 725, 729 (1995).

133. One might also view this as the principal component of what another contributor to the Symposium calls “the now-standard liberal case for the right to die” (using the right in its broadest sense). Spindelman, *supra* note 6, at 1642.

134. See Smith, *supra* note 6, at 1575–82.

for distinguishing between PAS and the forgoing of life-sustaining medical treatment are not convincing. I submit, however, that upon reflection the same may be said for *the basic argument* of PAS proponents.

Justice Stevens, the Second and Ninth Circuits, and the commentators who argue that PAS is a constitutionally protected right have read a good deal more into the well-established right to forgo medical treatment than is really there.¹³⁵ As Justice O'Connor underscored in her pivotal concurring opinion in *Cruzan*, "Requiring a competent adult to endure such procedures [as the insertion of a nasogastric tube into her nose, throat, esophagus and stomach] against her will burdens [her] liberty, dignity, and freedom to determine the course of her own treatment."¹³⁶ As the New York State Task Force pointed out, "It is [the] right against intrusion—not a general right to control the timing and manner of death—that forms the basis of the constitutional right to refuse life-sustaining treatment. . . . [This right] has a well-established history in the laws of informed consent and battery."¹³⁷

Not only would a prohibition against forgoing life-sustaining treatment impose a more onerous burden on affected persons than does a ban on PAS, but it would impair the autonomy of a great many people. As Justice Brennan noted in his *Cruzan* dissenting opinion, most of the two million who die every year in this country do so in hospitals and long-term care institutions, and most of them do so "after a decision to forgo life-sustaining treatment has been made."¹³⁸ If medical treatment could not be rejected, vast numbers of patients would be "at the mercy of every technological advance."¹³⁹ Moreover, if patients could refuse potentially life-sustaining treatment at the outset, but not discontinue the treatment once it started, many patients probably would not avail themselves of the treatment in the first place.¹⁴⁰

Allowing a patient to die at some point, I think it fair to say, is a practical condition upon the successful operation of medicine. The same can hardly be said of PAS. Moreover, "the practice of forgoing treatment is by now so deeply embedded in our social and medical practices that a reversal

135. See also the quotation from the "Philosophers' Brief" (an amicus brief filed by Ronald Dworkin, John Rawls, and other prominent philosophers on behalf of the *Glucksberg* plaintiffs) set forth elsewhere in this Symposium. Smith, *supra* note 6, at 1576 (quoting Brief for Ronald Dworkin et al. as Amici Curiae in Support of Respondents at 45, *Washington v. Glucksberg*, 521 U.S. 702 (1997) (No. 96-110), 1996 WL 708956).

136. *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 289 (1990) (O'Connor, J., concurring).

137. TASK FORCE REPORT, *supra* note 40, at 71–72 (footnote omitted).

138. *Cruzan*, 497 U.S. at 302–03 (Brennan, J., dissenting).

139. TASK FORCE REPORT, *supra* note 40, at 75; see also CALLAHAN, *supra* note 117, at 77–81. It is worth recalling that "[a]lthough there was no possibility that her condition would improve, [Ms. Cruzan] could be kept 'alive' in her [persistent vegetative] state for as long as thirty years through artificial feeding and hydration." Seidman, *supra* note 75, at 50.

140. See TASK FORCE REPORT, *supra* note 40, at 75; Giles R. Scofield, *Exposing Some Myths About Physician-Assisted Suicide*, 18 SEATTLE U. L. REV. 473, 481 (1995); see also CASS R. SUNSTEIN, ONE CASE AT A TIME: JUDICIAL MINIMALISM ON THE SUPREME COURT 101–02, 106 (1999) ("It is reasonable to think that the risks of abuse are far greater in [PAS cases] than in cases of withdrawal of life support.").

of policy on this point would throw most of our major medical institutions into a state approaching chaos.”¹⁴¹ Again, the same can hardly be said of refusals to comply with requests for PAS.¹⁴²

In short, when Art Buchwald tried dialysis twelve times and decided—despite “tremendous pressure” to continue it—that he “didn’t like it” and didn’t “want to do it anymore,”¹⁴³ I submit it was his choice to make and that his doctors did not assist him in committing suicide when he made it. Would it have mattered if staying on dialysis could have kept Mr. Buchwald alive for another ten or fifteen years? So far as the law and the medical ethics governing end-of-life care is concerned, no, not at all.

It is noteworthy that the right to forgo life-sustaining medical treatment is not limited to the terminally ill (regardless of how that term is defined). As the leading treatise-writer on the subject has put it, “the right of a competent person to refuse medical treatment is virtually absolute.”¹⁴⁴

If, as many PAS proponents tell us, actively intervening to bring about death and forgoing medical treatment are (or at least ought to be) “on an equal footing before the law,”¹⁴⁵ and we are also told that the right to forgo medical treatment is “virtually absolute,” how can we be expected to believe that, once established, the right to PAS will be limited to the terminally ill?

III. THE OREGON EXPERIENCE

This Foreword has explored the contours of the doctrinal debate surrounding PAS, a debate that will be fleshed out in greater detail in the following articles. Yet the doctrinal debate tells only part of the story. For example, Professor Sunstein maintains elsewhere in this Symposium that *Glucksberg* was “rightly decided, because the argument for a right to [PAS] was too fragile in light of empirical realities; [PAS] might not, in fact, promote patient autonomy.”¹⁴⁶ Surely Sunstein is not alone. More than a few observers believe that when the Court revisits the questions presented by *Glucksberg*, the experience in Oregon—the only state that has legalized

141. John Arras, *News from the Circuit Courts: How Not to Think about Physician-assisted Suicide*, BLOLAW (SPECIAL SECTION), July–Aug. 1996, at S:171, S:183.

142. Some commentators worry that the arguments of PAS proponents may “work backwards” and lead to new restrictions on “the hard-won rights that the great majority of patients can and do now exercise to refuse medical treatments.” George J. Annas, *The Promised End—Constitutional Aspects of Physician-Assisted Suicide*, 335 NEW ENG. J. MED. 683, 686 (1996); see also Susan M. Wolf, *Holding the Line on Euthanasia*, HASTINGS CENTER REP. (SPECIAL SUPPLEMENT), Jan.–Feb. 1989, at 13.

143. ART BUCHWALD, TOO SOON TO SAY GOODBYE 15–16 (2006).

144. I MEISEL, *supra* note 110, § 8.2, at 470. Another leading commentator has been equally emphatic on this point. See Cantor, *supra* note 57, at 193.

145. Alan Meisel, *Physician-Assisted Suicide: A Common Law Roadmap for State Courts*, 24 FORDHAM URB. L.J. 817, 849 (1997). As we have seen, in the context of equal protection the Court has told us that these two practices do *not* stand on an equal footing before the law. See *supra* text accompanying note 3.

146. Sunstein, *supra* note 5, at 1547.

PAS¹⁴⁷—will have an important bearing on the outcome. What has been the Oregon experience? It seems that depends on whom you ask.

According to one contributor to this Symposium, Kathryn Tucker, the director of legal affairs for Compassion and Choices¹⁴⁸ and the lawyer who argued the case for the *Glucksberg* plaintiffs in the U.S. Supreme Court, the Oregon record demonstrates that fears that various abuses might occur if PAS were legalized can be (and have been) dispelled so long as a state establishes “regulation with teeth”¹⁴⁹ (to use Justice Souter’s phrase).¹⁵⁰ Professor Erwin Chemerinsky, another contributor to this Symposium, and a strong critic of *Glucksberg*, also paints a rosy picture of the Oregon experience. According to him, the situation in Oregon strengthens the case for PAS both as a matter of policy and as a matter of substantive due process.¹⁵¹

On the other hand, two other contributors to this Symposium, Herbert Hendin (a professor of psychiatry and executive director of Suicide Prevention International) and Kathleen Foley (a professor of neurology and pain relief expert), take a much less sanguine view of the Oregon experience.¹⁵²

Many people, and at least some Supreme Court Justices, would welcome a consensus on how well or how poorly the Oregon law is working. But if the contributions to this Symposium are any indication, a consensus about Oregon’s experience may not emerge for quite a while. Indeed, disagreement about the Oregon experience appears to be, and is likely to continue to be, as vigorous as disputes over other aspects of PAS.

147. Oregon’s Death with Dignity Act was approved via a ballot initiative in 1994, but did not go into effect until after the Court’s decision in *Glucksberg*. See Tucker, *supra* note 7, at 1600.

148. This organization is the successor to Compassion in Dying, the organization which instituted the lawsuit that led to the *Glucksberg* decision.

149. *Washington v. Glucksberg*, 521 U.S. 702, 785 (1997) (Souter, J., concurring).

150. See Tucker, *supra* note 7.

151. See Chemerinsky, *supra* note 4, at 1513–15.

152. See Hendin & Foley, *supra* note 7.