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ABORTION, PHYSICIAN-ASSISTED SUICIDE AND THE CONSTITUTION: THE VIEW FROM WITHOUT AND WITHIN

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INTRODUCTION

The theme of this symposium, "The Beginning and End of Life," has led me to undertake an examination of how abortion and physician-assisted suicide have been "taken into our constitutional system"[1] and of the societal impact of the Supreme Court's constitutional treatment of these issues. This examination will be based in considerable part on my own experiences, nearly a quarter century apart, in litigating constitutional challenges to bans on abortion and bans on physician-assisted suicide.[2] In the 1970's, while on the law faculty at the University of Kentucky, I litigated the "Kentucky version" of *Roe v. Wade*,[3] in asserting the Kentucky ACLU's challenge to the state's "life only" abortion

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1. This expression is borrowed from Robert Dixon, Bakke: *A Constitutional Analysis*, 67 CAL. L. REV. 69,70 (1979).

2. Because of my litigation involvement in abortion and physician-assisted suicide, my discussion and analysis will lack the purported impartial and dispassionate perspective of the pure legal scholar. But I believe that there is an existential as well as an objective component to legal scholarship, and that participation and involvement might thus yield insights that detached observation could not possibly supply. In addition to assisted suicide, *see* Robert A. Sedler, *Constitutional Challenges to Bans on "Assisted Suicide": The View from Without and Within*, 21 HASTINGS CONST. L.Q. 777 (1994) [hereinafter Sedler, *Constitutional Challenges*]; Robert A. Sedler, *Are Absolute Bans on Assisted Suicide Constitutional? I Say No*, 72 U. DET. L. REV. 725 (1995) [hereinafter Sedler, *Absolute Bans*], I have approached a number of legal questions from the dual perspective of an academic commentator and a litigating lawyer. *See, e.g.*, Robert A. Sedler, *The Unconstitutionality of Campus Bans on "Racist Speech": The View from Without and Within*, 53 U. PITT. L. REV. 631 (1992); Robert A. Sedler, *The Summary Contempt Power and the Constitution: The View from Without and Within*, 51 N.Y.U. L. REV. 34 (1976); Robert A. Sedler, *Metropolitan Desegregation in the Wake of* Milliken*—On Losing Big Battles and Winning Small Wars: The View Largely from Within*, 1975 WASH. U. L.Q. 535 (1975); Robert A. Sedler, *The Procedural Defense in Selective Service Prosecutions: The View from Without and Within*, 56 IOWA L. REV. 1121 (1971).

3. 410 U.S. 113 (1973).

prohibition,[4] and, following the Supreme Court's decision in *Roe*, to Kentucky's "round two" anti-abortion law,[5] which was essentially the same law invalidated by the Court in *Planned Parenthood v. Danforth*.[6] In the 1990's, now on the law faculty at Wayne State University in Detroit, I litigated the Michigan ACLU's unsuccessful challenge to Michigan's ban on physician-assisted suicide.[7] As I litigator, then, I have strongly advocated recognition of a woman's constitutional right to a safe and legal abortion and recognition of a terminally ill person's constitutional right, in the end stages of that person's terminal illness, to make the choice to hasten inevitable death by the use of physician-prescribed medications. As an academic commentator, however, I must now deal with the fact that while the Supreme Court has recognized in *Roe* and reaffirmed in *Casey*[8] that a woman does have a constitutional right to a safe and legal abortion, in *Vacco*[9] and *Glucksberg*[10], the Court held that a terminally ill person does not have a constitutional right to make the choice to hasten inevitable death by the use of physician-prescribed medications, and that no one, including a terminally ill person in the end stages of terminal illness, has a constitutional right to "commit suicide." In this article I will discuss the legal, social and political context in which these two fundamental constitutional and societal issues were litigated and resolved by the Supreme Court. I will also discuss the societal impact that has followed from recognition of a woman's constitutional right to a safe and legal abortion, and what I believe will be the societal impact of the Court's refusal to recognize a constitutional "right to die," while at the same time recognizing that every person does have a right, assumedly protected by the Constitution, to refuse or discontinue life-saving medical treatment, and that a terminally ill person has a similar right to

4. *See* Crossen v. Attorney Gen., 344 F. Supp. 587 (E.D. Ky. 1972) (three-judge). I was spectacularly unsuccessful in this challenge, losing the case before the then-required statutory three-judge court, 3-0. Upon remand following *Roe*, the district judge reluctantly declared the Kentucky anti-abortion law unconstitutional, but refused to issue an injunction against its enforcement.

5. Wolfe v. Schroering, 388 F. Supp. 631 (W.D. Ky. 1974), *aff'd in part, rev'd in part*, 541 F. 2d 523 (6th Cir. 1976).

6. 428 U.S. 52 (1976).

7. Hobbins v. Attorney Gen., *decided with and reported as* People v. Kevorkian, 527 N.W.2d 714 (Mich. 1994), *cert. denied*, 115 S. Ct. 714 (1995).

8. Planned Parenthood v. Casey, 505 U.S. 833 (1992).

9. Vacco v. Quill, 117 S. Ct. 2293 (1997).

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

receive all the medication necessary to alleviate pain and suffering even if this has the effect of hastening the person's death.[11]

THE CONSTITUTIONAL RIGHT TO A SAFE AND LEGAL ABORTION

Constitutional cases do not just "happen," as one might think if one were only to look at the cases decided by the Supreme Court, as they appear in constitutional law casebooks and are discussed in academic commentary. There are reasons why particular kinds of constitutional cases are brought at particular times, and these reasons are best understood in terms of their legal, social, and political context. The constitutional challenges to legal prohibitions on abortion that culminated in the Supreme Court's 1973 decisions in *Roe v. Wade*[12] and the companion case of *Doe v. Bolton*[13] (which we will hereinafter refer to collectively as "*Roe*") were precipitated by the 1960's "sexual revolution" and the emergence of the women's rights movement, and were facilitated by the Supreme Court's recognition of a so-called constitutional "right of privacy" in *Griswold v. Connecticut*.[14]

At the beginning of the 1960's, in virtually every state, abortion was prohibited except where the abortion was necessary to save the life of the mother. The organized medical profession also opposed abortion, and those few physicians who were willing to perform abortions, if discovered, were not only subject to criminal prosecution, but were likely to lose their licenses as well.[15] Such abortions as were performed at that time then were illegal "back-alley" abortions, often performed by non-physicians, and putting the woman at serious risk. Then as now, there were

11. In saying that a person has a constitutionally protected right to refuse or discontinue life-saving medical treatment and to receive all the medication necessary to alleviate pain, I am referring, of course, to a constitutional requirement that the state cannot interfere with the person's exercise of that right, such as by requiring physicians to provide or continue life-saving medical treatment against the patient's will or prohibiting physicians from providing all the medication necessary to alleviate the patient's pain if this will hasten the patient's death.

12. 410 U.S. 113 (1973).

13. 410 U.S. 179 (1973).

14. 381 U.S. 479 (1965).

15. The American Medical Association had been opposed to abortion since the late 19th century. In 1967, the AMA took the position that therapeutic abortion was ethically permissible in certain circumstances. In 1970, the AMA took the position that abortion was a medical procedure that should be performed by a licensed physician in an accredited hospital only after consultation with two other physicians and in conformity with state law, and that no party to the procedure should be required to violate personally held moral principles. See the discussion of the AMA's position in *Roe*, 410 U.S. at 141-44.

a large number of unwanted pregnancies resulting from the lack of contraceptive use or from contraceptive failure, and for most women abortion was not a feasible option. The end result was that large numbers of women were compelled to carry unwanted pregnancies to term.

The unavailability of safe and legal abortion had significant social consequences. Married women and their husbands would have an additional child to raise, with the attendant impact on the family's economic well-being. For the woman who was unmarried, the choice was to enter into a "shotgun marriage" with the putative father if he was willing to do so, to undergo the stigma of bearing an out-of-wedlock child (and admit to having had non-marital intercourse, which in many circles was socially and morally unacceptable at that time), or to conceal the pregnancy as best as she was able and to surrender the child for adoption upon birth. While the number of unwanted pregnancies was not easily measurable, they clearly contributed to the "population explosion" that was identified as a major social problem in the United States in the early 1960's.[16] The large number of unwanted pregnancies to unmarried women also meant that large numbers of healthy newborn babies were available for adoption, and middle-class families, at least, had no difficulty in adopting one or more children.

The "sexual revolution" of the 1960's and the increasing acceptability among young people of "sex without marriage" also presumably increased the number of unwanted pregnancies and the desire of many unmarried women to terminate those pregnancies by a safe and legal abortion. The 1960's also saw the emergence of the women's rights movement and the demand for recognition of a woman's "ability to control her destiny and her ability to participate equally in the economic and social life of the Nation."[17] In the forefront of this movement was the assertion of a woman's right to control over own body, and to terminate an unwanted pregnancy by a safe and legal abortion.

One part of the effort to provide a woman with the right to a safe and legal abortion was directed at obtaining some legislative modification of the existing laws prohibiting abortion. In many states this effort was unsuccessful. Some states, however, did "lib-

16. *See, e.g.*, PAUL EHRLICH, THE POPULATION BOMB (1968).

17. In *Casey*, the Court noted that, "[t]he destiny of the woman must be shaped to a large extent on her own conception of her spiritual imperatives and her place in society", Planned Parenthood v. Casey, 505 U.S. 833, 852, and that, "[t]he ability of women to participate in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives." *Id.* at 856.

eralize" their abortion laws to allow abortions in certain circumstances, such as where the pregnancy was the result of rape or incest, or where the pregnancy threatened the woman's health. At the time of *Roe v. Wade* and *Doe v. Bolton*, these efforts had succeeded to some degree, but as the Georgia law at issue in *Doe* indicated, this liberalization was usually accompanied by regulatory restrictions, such as the need for two-doctor concurrence.[18] It was not until 1970 that one of the nation's largest states, New York, completely removed all legal prohibitions against abortion.[19] And, as the Right to Life movement and other opponents of abortion became better organized politically, efforts at legislative reform faltered badly in most states.[20]

The other part of this effort was directed at asserting a constitutional challenge to state anti-abortion laws. This effort was possible because of the Supreme Court's 1965 decision in *Griswold v. Connecticut*,[21] where the Court, in invalidating a nineteenth-century Connecticut law that prohibited the use of contraceptives, including presumably their use by married couples, held that the prohibition violated the married couple's so-called constitutional "right of privacy." Like all other areas of law, constitutional law develops in a *line of growth.* The Supreme Court's decisions in prior cases serve as precedents for the resolution of future cases presenting the same or similar issues. The doctrine that the Court promulgates in these cases and the rationale for its decisions are applicable in future cases, where that doctrine can be extended or limited. The meaning of a constitutional provision thus develops incrementally over a period of

18. The Georgia "liberalized" abortion law was patterned after the American Law Institute *Model Penal Code*, which served as the model for the fourteen "liberalized" abortion laws that had been adopted at the time of *Roe*. *See* MODEL PENAL CODE § 230.3 (1985). See also the discussion in *Roe*, 410 U.S. at 140-41. The Georgia law is set forth as Appendix A and the Model Penal Code as Appendix B to the *Doe v. Bolton* opinion. *See Doe*, 410 U.S. at 202-07.

19. By the end of that year, Alaska, Hawaii and the State of Washington also had repealed criminal penalties for abortions performed by a physician in the early stages of pregnancy. *See Roe*, 410 U.S. at 140-141 n.37. With the removal of all substantial legal restrictions on abortion in New York, middle-class women, who could afford to travel to New York, were able to terminate unwanted pregnancies by a safe and legal abortion. After 1970, the supply of healthy newborns available for adoption began to decrease, since many pregnant unmarried women were now able to obtain a safe and legal abortion.

20. At the time of *Roe*, 30 states, including Texas, had in effect laws that prohibited an abortion except where necessary to save the life of the mother. Fourteen states had "liberalized" abortion laws, and four states prohibited abortion without restriction. The status of abortion was not clear in a few states. *See id.* at 118 n.2, 138-40.

21. 381 U.S. 479 (1965).

time, and the line of growth of that constitutional provision strongly influences its application in particular cases.[22]

For the litigating lawyer, the "stuff of constitutional litigation" is the Supreme Court's precedents and the constitutional doctrine that has been promulgated by the Court in prior cases. In deciding whether or not to assert a constitutional challenge to a particular law or governmental action, and in deciding on the basis of that challenge, the lawyer must look to the precedents and doctrine. This examination of precedents and doctrine will determine the viability of a particular constitutional challenge and the basis on which that challenge should be made.

As I have discussed more fully elsewhere,[23] the development of the constitutional protection of personal autonomy traces back to the 1920's, where the Court used substantive due process to invalidate laws interfering with parents' rights to control the education of their children.[24] As part of this development, the Court in 1942 decided *Skinner v. Oklahoma ex rel. Williamson*,[25] in which it invalidated on equal protection grounds an Oklahoma law providing for the compulsory sterilization of persons who had been convicted of three felonies involving moral turpitude, but exempting "white-collar" crimes. In *Skinner*, the Court justified a higher level of scrutiny for the equal protection challenge by saying that the compulsory sterilization requirement implicated the fundamental rights of marriage and procreation (which at that time were assumed to go together—only married

22. *See generally* Terrance Sandalow, *Constitutional Interpretation*, 79 MICH. L. REV. 1033, 1054 (1981) (discussing the development of constitutional doctrine in a line of growth); *see also* Robert A. Sedler, *The Legitimacy Debate in Constitutional Adjudication: An Assessment and a Different Perspective*, 44 OHIO ST. L.J. 93, 118-20 (1983).

23. *See* Robert A. Sedler, *The Constitution and Personal Autonomy: The Lawyering Perspective*, 11 T.M. COOLEY L. REV. 773 (1994) [hereinafter Sedler, *Personal Autonomy*]. This article was an expanded version of the Fifth Annual Krinock Lecture that it was my privilege to deliver at the Thomas M. Cooley Law School on November 23, 1993. A number of the points that I am now discussing in connection with a woman's right to a safe and legal abortion were first developed in that article.

24. *See* Pierce v. Society of Sisters, 268 U.S. 510 (1925) (invalidating a state law requiring all parents to enroll their children only in private schools); Meyer v. Nebraska, 262 U.S. 390 (1923) (invalidating a state law prohibiting the teaching of schoolchildren in any language other than English and prohibiting the teaching of any language at all to elementary schoolchildren). While Justice Douglas in *Griswold* tried to explain these cases as First Amendment cases, they were not decided as First Amendment cases, but were expressly decided on due process grounds. The First Amendment realistically was not available as a basis of challenge to state laws at the time these cases were decided. *See* Sedler, *Personal Autonomy*, *supra* note 23, at 776-79.

25. 316 U.S. 535 (1942).

persons were supposed to be procreating). Thus, in *Skinner*, the Court recognized procreation—reproductive freedom—as a fundamental right, and while the Court had not yet specifically articulated a two-tier standard of review, once it did, reproductive freedom came within the category of "fundamental rights," interference with which would be tested under the compelling governmental interest standard of review.[26]

Since *Skinner* had held that marriage and reproductive freedom were fundamental rights, *Skinner* served as a precedent for the lawyers in *Griswold* to support their argument that the ban on contraceptive use by married persons interfered with the fundamental right of married persons to engage in intimate marital relationships without risking procreation—in essence that the right to procreate also included the right to avoid procreation, so that the right for constitutional purposes was a right of reproductive freedom.

In *Griswold*, the Court found the Connecticut ban on contraceptive use by married couples unconstitutional as violating the married couple's constitutional "right of privacy." However, only two of the seven Justices comprising the majority, Justices Harlan and White, explicitly found this "right of privacy" to inhere in substantive due process; the other opinions went off on "penumbras" and the Ninth Amendment.[27] In *Roe v. Wade*, the Court simply stated that the "right of privacy" was founded in the Fourteenth Amendment's concept of personal liberty,[28] thereby in effect adopting the Harlan-White due process analysis in *Griswold*. In point of fact, as subsequent developments reflected in the physician-assisted suicide opinion in *Glucksberg* make clear, there is no generalized constitutional "right of privacy." Rather, it is that certain privacy-type interests, such as marriage and reproductive freedom, have been held to constitute fundamental rights, while other privacy-type interests, such as sexual freedom,[29] and physician-assisted suicide, have not. Once the Court holds that the asserted "privacy-type" interest is not a fundamental right, the less demanding rational basis standard of review applies, and the challenged restriction interfering with that interest is likely to be upheld.

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26. *See* Sedler, *Personal Autonomy*, *supra* note 23, at 780-82 (discussing *Skinner* within the context of personal autonomy case law).

27. *See id.* at 782-83 (placing *Griswold* within the context of personal autonomy case law).

28. *See* Roe v. Wade, 410 U.S. 110, 153 (1973).

29. *See* Bowers v. Hardwick, 478 U.S. 186 (1986) (sustaining the validity of a Georgia statute prohibiting consensual sodomy).

But regardless of the existence of any generalized constitutional right of privacy, or the theoretical basis for the Court's finding a "right of privacy" in *Griswold*, the significance of *Griswold* for purposes of the constitutional challenge to anti-abortion laws in the late 1960's was that in *Griswold* the Court had held that there *was* a constitutional "right of privacy," and that reproductive freedom was included within the ambit of that right. The lawyers for the women claiming a constitutional right to a safe and legal abortion could rely on *Griswold* as the source of constitutional doctrine and precedent to support that challenge. If it had not been for the Court's decision in *Griswold*, which incidentally revived the vitality of the *Skinner* precedent, a viable constitutional basis for challenging anti-abortion laws simply would not have existed at that time.

My own involvement in the "Kentucky version" of *Roe v. Wade* did not begin until 1970, well after most of the other challenges to state anti-abortion laws, including those that culminated in *Roe*, had been litigated in the lower courts. So, I had the benefit of the work that had been done by the lawyers for the plaintiffs in those cases, as my opponents, including Kentucky Right to Life, had the benefit of the work that had been done by the opposing side. The essential argument for the plaintiffs was that abortion differed little from contraception and that both procedures were related to implementation of a woman's fundamental right of reproductive freedom. The argument went on that since the constitutional "right of privacy" included reproductive freedom, and since anti-abortion laws, which directly interfered with that right, could not be justified under the exacting compelling governmental interest standard of review, those laws were unconstitutional. My own argument in the Kentucky case focused on the virtually absolute ban of Kentucky's "life only" anti-abortion law, and I argued that the law was unconstitutional because it was "extreme," and did not allow an abortion in at least some circumstances where an abortion was "medically indicated," such as where it was necessary to protect the pregnant woman's health.

The opposing argument was that abortion was very different from contraception, because abortion "destroyed human life," so that the state's interest in protecting human life "from the moment of conception" justified a complete ban on abortion except where it was necessary to protect the life of the mother. In connection with this argument, it was argued, particularly by Right to Life, that a fetus was a "person" for constitutional purposes. If this argument had been accepted by the Court instead

of being decisively rejected,[30] not only would the laws prohibiting abortion be constitutionally permissible, but laws permitting abortion, such as New York's 1970 law, could be declared unconstitutional as violating the "right to life" of the fetus.[31] But totally apart from whether a fetus was a "person" for constitutional purposes, the state argued that anti-abortion laws could be sustained as being necessary to advance the state's compelling interest in protecting human life—even potential human life—from the moment of conception.

After most of the lower court cases had been decided, but the year before the Court decided *Roe*, it decided *Eisenstadt v. Baird*,[32] in which the Court clearly separated marriage from reproductive freedom, and held that unmarried persons, like married persons, also had a constitutionally protected right to reproductive freedom. The Court did so in the context of invalidating a Massachusetts law that allowed only married couples to have access to contraception when prescribed by a physician, holding that as a matter of equal protection, unmarried persons must have the same access to contraception as married persons, because a ban on contraception interfered with their reproductive freedom.[33]

The stage was now set for what turned out to be the Court's monumental decision in *Roe*. With the passage of time and now somewhat removed from my advocacy perspective, I have said that the Court, consistent with existing constitutional doctrine, could have upheld the constitutionality of the challenged Texas

30. *See Roe*, 410 U.S. at 157-58. As the Court stated, "[b]ut in nearly all of these instances [references to "person" in the Constitution], the use of the word is such that it has application only postnatally. None indicates, with any assurance, that it has any possible prenatal application. . . .[and] the word, 'person,' as used in the Fourteenth Amendment, does not include the unborn." *Id.*

31. After the New York law permitting abortion was enacted in 1970, a Fordham Law School professor brought an action in a state court, seeking to have himself declared the guardian of all unborn fetuses in New York, and seeking a declaration that the New York law was unconstitutional as violating the "right to life" of the unborn fetus. His claim was rejected by the New York state courts. *See* Byrn v. New York City Health & Hosps. Corp., 286 N.E.2d 887 (N.Y. 1972), *appeal dismissed*, 410 U.S. 949 (1973).

32. 405 U.S. 438 (1972).

33. The Court emphasized that the "right of privacy" recognized in *Griswold* was an individual right, not the right of the married couple, and stated that, "[i]f the right of privacy means anything, it is the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child." *Id.* at 453. For a discussion of this case at greater length, see Sedler, *Personal Autonomy*, *supra* note 23, at 786-87.

and Georgia anti-abortion laws. Applying the compelling governmental interest standard of review, the Court could have held that *this* interference with reproductive freedom could be justified even under that exacting standard. The Court could have held that the state's interest in protecting potential human life from the moment of conception was a compelling interest, and that since a prohibition against abortion was the only effective way of advancing that interest, it was necessarily the "least drastic means" of doing so.[34]

Instead, the Court, adopting a "stages of pregnancy" formulation, which it retained in regard to the constitutional impermissibility of abortion prohibition in *Casey*,[35] held that the state's interest in protecting potential human life did not become "compelling" until the stage of viability had been reached, so that the state could not constitutionally prohibit pre-viability abortions. After the stage of viability had been reached, the state could prohibit abortion except where the abortion was necessary to protect the health of the mother.[36] Since medical considerations dictate that post-viability abortions not be performed unless this is necessary to protect the woman's life or health (close to 90% of the abortions in this country are performed during the first trimester

34. The Court could have distinguished *Skinner*, *Griswold* and *Eisenstadt* on a constitutionally principled basis in that in those cases the particular interference with reproductive freedom could not have been shown to be rationally related to the advancement of any legitimate governmental interest, let alone the least drastic means of advancing a compelling governmental interest. See the discussion of these cases and how they could have been distinguished by the lawyers for the state in *Roe* in Sedler, *Personal Autonomy*, *supra* note 23, at 785-88.

35. The "central holding" of *Roe* was that the state could not prohibit an abortion prior to viability. It was this "central holding" of *Roe* that the Court reaffirmed in *Casey*. As the Court stated in *Casey*:

> We have seen how time has overtaken some of *Roe*'s factual assumptions: advances in maternal health care allow for abortions safe to the mother later in pregnancy than was true in 1973, and advances in neonatal care have advanced viability to a point somewhat earlier. But these facts go only to the scheme of time limits on the realization of competing interests, and the divergences from the factual premises of 1973 have no bearing on the validity of *Roe*'s central holding, that viability marks the earliest point at which the State's interest in fetal life is constitutionally adequate to justify a legislative ban on nontherapeutic abortions. . . . Whenever it may occur, the attainment of viability may continue to serve as the critical fact, just as it has done since *Roe* was decided: which is to say that no change in *Roe*'s factual underpinning has left its central holding obsolete, and none supports an argument for overruling it.

Planned Parenthood v. Casey, 505 U.S. 833, 861 (1992) (citations omitted).

36. *See* Roe v. Wade, 410 U.S. 110, 162-65 (1973).

of pregnancy), the practical effect of *Roe* was indeed to make abortion "available on demand."

In holding that the state's interest in protecting potential human life was not "compelling" until the stage of viability had been reached, the Court was obviously engaging in *constitutional balancing*. It was making a value judgment about the *relative constitutional importance* of the woman's interest in reproductive freedom and the state's interest in protecting potential human life, and it made that value judgment in favor of the woman's reproductive freedom interest. In effect, the Court held that the woman's reproductive freedom interest was *constitutionally more important* than the state's interest in protecting potential human life, in the context of state laws prohibiting pre-viability abortions.

The Court's sweeping decision in *Roe* was a complete surprise to me and I strongly suspect to many of the most ardent advocates of a woman's right to reproductive freedom. The sweeping nature of that decision was inconsistent with the principle that a constitutional decision should not be rendered "in broader terms than are required by the precise facts to which the ruling is to be applied."[37] The lawyers who were asserting the constitutional challenges in these cases were primarily concerned with striking down the draconian "life only" Texas law and the still highly restrictive Georgia law that allowed abortion only in limited circumstances and with a number of restrictions.[38] All that the Court had to decide in *Roe* was that these kinds of laws constituted an improper interference with a woman's fundamental right of reproductive freedom. Instead, the Court came down with this sweeping decision, invalidating all the anti-abortion laws then in existence, as well as any other law that would prohibit a woman from having a pre-viability abortion, and also imposing significant constitutional restrictions on a state's efforts to regulate the abortion procedure. It was a complete and unexpected victory for advocates of a woman's reproductive freedom.

Supreme Court Justice Ruth Bader Ginsburg has criticized the Court's decision in *Roe* not only for going beyond invalidating the challenged laws in issue and "fashion[ing] a set of rules that displaced virtually every state law then in force," but also for not focusing sufficiently on the impact that anti-abortion laws

37. Rescue Army v. Municipal Court, 331 U.S. 549, 569 (1947).

38. As I said, my essential argument in the Kentucky case was that Kentucky's "life only" law was unconstitutional because it was "extreme" and did not allow for an abortion at least in some circumstances where an abortion was "medically indicated," such as where necessary to protect a woman's health.

had on the "ability [of a woman] to control her [own destiny] . . . and her ability . . . to participate equally in the economic and social life of the Nation," a focus that she found in the Court's decision in *Casey*.[39] Justice Ginsburg concludes that "[t]he *Roe* decision might have been less of a storm center had it both honed in more precisely on the woman's equality dimension of the issue and, correspondingly, attempted nothing more bold at that time than the mode of decisionmaking the Court employed in the 1970's gender classification cases."[40] In those cases, a number of which were litigated by Justice Ginsburg herself as she was developing the constitutional protection of gender equality under the Fourteenth Amendment's Equal Protection Clause, the Court proceeded on a case by case basis. The Court invalidated all of the traditional gender-based classifications that had disadvantaged women, and also invalidated gender-based classifications disadvantaging men, except where the classification could be shown to be substantially related to overcoming the present consequences of past discrimination against women as a group.[41]

Given the extent of opposition to *Roe* by the pro-life movement, I seriously doubt that the decision would have been any "less of a storm center" if it had been limited to invalidating the challenged anti-abortion laws in issue. I also doubt that the decision would have been any less opposed by the pro-life movement if it had "honed in more precisely on the woman's equality dimension of the issue." The pro-life movement strongly disputes the contention that a concern for women's equality justifies a woman's "destruction of the life of her unborn child." Be that as it may, Justice Ginsburg is clearly correct in emphasizing that, as the Court recognized in *Casey*, the social and political context in which *Roe* was litigated was the context of women's equality. As we have said, the 1960's saw the emergence of the women's rights movement, and in the forefront of this movement was the assertion of a woman's right to control over her own body, and to terminate an unwanted pregnancy by a safe and legal abortion. It is this right that the Supreme Court

39. Ruth Bader Ginsburg, *Speaking in a Judicial Voice*, 67 N.Y.U. L. REV. 1185, 1199-2000 (1992) (quoting Planned Parenthood v. Casey, 505 U.S. 833, 856 (1992)).

40. *Id.* at 2000.

41. *See* JOHN E. NOWAK & RONALD D. ROTUNDA, CONSTITUTIONAL LAW 772-90 (5th ed. 1995) (analyzing and discussing cases involving gender-based classifications).

emphatically recognized in *Roe* and effectively made abortion "available on demand."[42]

However, while the social and political context in which *Roe* was litigated was indeed a context of women's equality, the *legal* context in which *Roe* was litigated was a context of personal autonomy and reproductive freedom, rather than a legal context of women's equality. The right of a woman to reproductive freedom was involved in *Roe* simply because of the biological fact that only women can become pregnant and so are in need of a safe and legal abortion in order to terminate an unwanted pregnancy. But the doctrinal basis of the challenge to anti-abortion laws in *Roe* was the interference with the woman's right to reproductive freedom, and the precedents supporting that challenge were the reproductive freedom precedents of *Skinner*, *Griswold* and *Eisenstadt*, precedents that involved the reproductive freedom of both men and women. Thus, the fact that anti-abortion laws impacted only on women and so "interfered with [her] ability to control her own destiny and to participate equally in the economic and social life of the Nation" was logically and doctrinally irrelevant to the basis of the constitutional challenge in *Roe*.[43]

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42. A woman's constitutional right of reproductive freedom also includes her right not to be compelled to have an abortion. Thus, just as the state cannot give parents the power to prevent their minor daughter from having an abortion, the state cannot give parents the power to compel their minor daughter to have an abortion either. *See* Planned Parenthood v. Danforth, 428 U.S. 52 (1976).

The government's effort to compel a woman to have an abortion against her will was at issue in *Struck v. Secretary of Defense*, 460 F.2d 1372 (9th Cir. 1971), *cert. granted*, 409 U.S. 942, *vacated*, 409 U.S. 947 (1972). Captain Struck was an Air Force career officer who became pregnant in Vietnam. Her religious views precluded her from having an abortion. She declared her intention to place her child for adoption immediately after birth, and did so. At the time, Air Force regulations required the discharge of any woman officer who became pregnant. *Roe v. Wade* had not yet been decided, and while Captain Struck asserted a reproductive freedom challenge, her primary challenge was based on "Fifth Amendment equal protection," focusing on the discrimination between male officers who became fathers, and female officers who became mothers, and between female officers who chose to have an abortion and female officers who chose to continue their pregnancy. Captain Struck's constitutional challenge was rejected by the lower courts, but after the Supreme Court granted certiorari, the Air Force backed off and permitted her to remain in the service.

43. As to why it would not have been doctrinally possible to mount a gender discrimination challenge to anti-abortion laws in the 1960's and as to why such a challenge would not have been as effective as a challenge based on the interference with reproductive freedom, see Sedler, *Personal Autonomy*, *supra* note 23, at 794-96.

The primary significance of *Casey* in regard to a woman's constitutional right to a safe and legal abortion is that the Court, although badly divided and only by a single vote, reaffirmed the "central holding" of *Roe*, that the state may not *prohibit* a woman from having an abortion until the stage of viability has been reached.[44] Although the Court doctrinally replaced the "stages of pregnancy" formulation of *Roe* with the "undue burden" formulation[45] that had long been advocated by Justice O'Connor,[46] the practical effect of this doctrinal change is only to permit the state to impose "harassing-type" regulations that had been held unconstitutional under *Roe* and other pre-*Casey* cases, such as a twenty-four hour wait and state-required information designed to discourage the woman from having an abortion.

The existence of "harassing-type" regulations and other regulations of the abortion procedure, such as a ban on so-called "partial birth" abortions, is *peripheral* to recognition of a woman's constitutional right to a safe and legal abortion. While the pro-choice and the pro-life forces portray every controversy over the enactment of abortion regulation as a titanic struggle for a woman's freedom of choice or for the right to life of the unborn child, the fact remains that no abortion regulation, "harassing" or otherwise, will have the effect of denying a woman the right to have a safe and legal abortion. If the woman has to wait twenty-four hours before having the abortion, this means a second trip to the doctor's office, which, while inconvenient, does not prevent her from having the abortion when she gets there. If a phy-

44. *See* Planned Parenthood v. Casey, 505 U.S. 833, 860-61, 878-79 (1992).

45. In *Casey*, Justices O'Connor, Kennedy and Souter promulgated this test in a joint opinion. The joint opinion was joined in by Justices Blackmun and Stevens, who favored retention of the "stages of pregnancy" test, in order to keep intact what the joint opinion called the "central holding" of *Roe*, that the state cannot prohibit pre-viability abortions. In any event, where five Justices join in the judgment, but differ in their reasons for doing so, the holding of the Court is based on the narrowest ground of agreement among the Justices who joined in the judgment. *See* Marks v. United States, 430 U.S. 188, 193 (1977). Since the "undue burden" formulation is narrower than the "stages of pregnancy" formulation, it becomes the basis for the holding that the state cannot prohibit pre-viability abortions. The "undue burden" formulation was also the basis for the Court's holding that the spousal notification requirement was unconstitutional, as well as for the Court's holding that the other regulatory provisions of the challenged law were constitutionally permissible. The four dissenting Justices would have upheld all the regulatory provisions on the same basis as they would have upheld a pre-viability prohibition on abortion—that a woman does not have a constitutionally protected right to a safe and legal abortion.

46. *See* Akron v. Akron Ctr. for Reprod. Health, 462 U.S. 416, 452-66 (1983) (O'Connor, J., dissenting).

sician cannot use a so-called "partial birth" abortion to perform a medically-indicated abortion late in the pregnancy, the physician can use a different procedure, and the medically-indicated abortion will be performed. I do not wish to minimize the significance of abortion regulations and the legitimate concerns of both the pro-choice and the pro-life forces in this area. My point is that the constitutional right of a woman to have a safe and legal abortion is firmly established, and no kind of abortion regulation can prevent her from exercising that right.[47]

This brings me finally to the societal impact of the Supreme Court's decisions in *Roe* and *Casey* recognizing a constitutional right to a safe and legal abortion. The societal impact of these decisions is that abortion is now *operationally acceptable* in American society. Despite the public controversy over abortion and the unremitting opposition to abortion by the pro-life forces, the availability of safe and legal abortions for women who wish to have them has become a permanent feature of American life. There is now an "abortion industry," and most of the nearly 90% of abortions that are performed in the first trimester of pregnancy[48] are performed in abortion clinics. Well over a million abortions are performed each year, and while there has been a slight drop in abortions in recent years, according to the Center for Disease Control and Prevention (CDC), in 1994, a total of 1,267,415 legal abortions were reported to the CDC, down from about 1.3 million in 1993. The statistics showed that in 1994 there were 321 abortions per 1,000 live births, and that twenty-

47. The most serious interference with a woman's right to have a safe and legal abortion is the denial of public funding for abortions for indigent women, which the Supreme Court has long held is constitutionally permissible. *See* Harris v. McRae, 448 U.S. 297 (1980); Maher v. Roe, 432 U.S. 464 (1977). I seriously doubt, however, that most indigent women who want to terminate an unwanted pregnancy are in practice prevented from doing so by the absence of public funding. Rather, these women and their families are likely somehow to come up with the money to pay for the abortion, even if this means that they must suffer further economic deprivation, and it may be that non-profit abortion providers, such as Planned Parenthood, have taken actions to facilitate the provision of abortions for indigent women. I do not have any sense that at the present time most indigent women who want to have an abortion are in practice unable to obtain it.

48. According to the Center for Disease Control and Prevention (CDC), in 1994, the last year for which statistics are available, about 54% of abortions were performed during the first eight weeks of pregnancy, and about 88% were performed during the first twelve weeks. *See generally* AMERICAN POLITICAL NETWORK, ABORTION REPORT (1997).

one of every 1000 women ages fifteen to forty-four had an abortion in 1994.[49]

The primary reason why so many abortions are being performed in the United States today is contraceptive failure. A survey of 10,000 abortion patients in 1994-95 conducted by the Alan Guttmacher Institute found that 57.5% of the women who had abortions were using contraception during the month in which they became pregnant, up from 51.3% who answered a similar question in the late 1980's. According to the Institute's President, "Our study clearly shows that the large majority of women are motivated to prevent an unwanted pregnancy and avoid abortion in the first place."[50]

The survey also exploded the myth that most abortion patients are low-income patients. Although the Institute said that abortion rates are relatively high for teenagers and those with low incomes, 78.5% of the abortion patients were over age twenty, and 45.6% were over age twenty-four. More than half of the abortion patients reported annual family incomes higher than $30,000.[51] The final point that the survey made was that abortion was more widespread than generally believed and that even women who belong to groups traditionally opposed to abortion are likely to seek abortions. The survey found that one in every five abortion patients were evangelical or born-again Christians, and that Catholic women actually had a slightly higher abortion rate than their representation in the population as a whole: 31.3% of the abortion patients surveyed gave their religion as Roman Catholic, although Roman Catholics account for 30.9% of the United States childbearing population. The Institute estimated that half of all American women are likely to have an abortion at some point during their lives.[52]

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49. *See id.* The thrust of the news story was that the 1994 abortion rate was the lowest since 1976, when there was 312 abortions per 1,000 live births. The operational acceptance of abortion in American society today is illustrated by the fact that it is newsworthy that the abortion rate is dropping slightly from 1.3 million abortions per year, and that with this drop, there were still 321 abortions per 1,000 live births.

In 1995, 1,210,883 abortions were reported to the Center. In 1996, the number was 1,221,585. The number of abortions had peaked in 1990 at 1,429,577. In 1996, the rate of abortions per 1000 women ages fifteen to forty-four had declined to 20 from 21 in 1994. *See* Tamar Levin, *Slight Increase in Abortions Reported*, N.Y. TIMES, Dec. 4, 1998, at 21.

50. *U.S. Abortion Survey Produces Surprise Statistics*, THE LANCET, Aug. 17, 1996, at 469.

51. *See id.*

52. *See id.* A New York Times-CBS News poll taken in connection with the 25th anniversary of the *Roe v. Wade* decision showed strong public acceptance of a woman's right to have an abortion during the first three months of

The widespread prevalence of abortion in American society in the 1990's was not something that was anticipated by myself and the other abortion rights advocates that I knew at the time of *Roe*. As I said at the time, none of us—the physicians who wanted to perform abortions, the women who wanted to have a constitutional right to a safe and legal abortion, the lawyers who litigated the cases—"liked" abortion. We all recognized that abortion interrupted a viable pregnancy: in the great majority of cases, the pregnancy will not "spontaneously abort," and so will result in a life birth. By interrupting the viable pregnancy and preventing the eventual life birth, abortion did amount to the destruction of potential human life, and none of us denied this. For this and other reasons, it was assumed that abortion would be stressful for the woman, and physicians performing abortions were expected to provide counseling for their patients, both about accepting their decision to have an abortion and about preventing an abortion in the future by the proper use of contraception. We saw abortion as a temporary expedient that would be largely unnecessary after the pharmaceutical industry developed a contraceptive that was safe, effective, acceptable and available. We did not anticipate that a quarter of a century later, well over a million abortions would be performed each year.

But this contraceptive was not developed. There are problems and side effects with every kind of contraceptive use, and all too often contraception fails or is not used at all. Thus, abortion, which we saw as a temporary expedient, has now become a permanent expedient to deal with unwanted pregnancy caused by contraceptive failure. The Supreme Court has held that the Constitution recognizes a woman's right to a safe and legal abortion, and the societal impact of this decision, coupled with continuing contraceptive failure, is that women exercise this right in large numbers in American society today. Abortion then is an accepted feature of American life today, and this is because the Supreme Court held a quarter of a century ago that a woman has a constitutional right to a safe and legal abortion.

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pregnancy, but equally strong resistance to her having an abortion after that time. The survey showed that the respondents supported a woman's right to have an abortion during the first three months of pregnancy by 61 percent to 28 percent, but opposed her having that right during the second three months by 66 percent to 15 percent and during the third three months by 79 percent to 7 percent. *See* Carey Goldberg & Janet Elder, *Public Still Backs Abortion, But Wants Limits, Poll Says*, N.Y. TIMES, Jan. 16, 1998, at 1. As pointed out previously, close to 90 percent of abortions in the United States are performed during the first trimester of pregnancy.

THE REJECTION OF A CONSTITUTIONAL RIGHT TO PHYSICIAN-ASSISTED SUICIDE

In the companion cases of *Washington v. Glucksberg*[53] and *Vacco v. Quill*,[54] the Supreme Court has unanimously held that the Constitution does not recognize as a "fundamental right" the asserted right to "commit suicide" and to have assistance in doing so.[55] This includes the asserted right of a terminally ill person, in the end stages of that person's terminal illness, to make the choice to hasten inevitable death by the use of physician-prescribed medications.[56] Since no fundamental right was implicated by bans on physician-assisted suicide, the rational basis standard applied, and under that standard, the state's ban on physician-assisted suicide was found to be rationally related to the advancement of "unquestionably important and legitimate interests."[57] The Supreme Court then has definitively determined that there is no constitutional right to physician-assisted suicide.[58]

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53. 117 S. Ct. 2258 (1997).

54. 117 S. Ct. 2293 (1997).

55. *See Glucksberg*, 117 S. Ct. at 2271.

56. *See id.* at 2262. The plaintiffs in *Glucksberg* and *Vacco* were not asserting a general right to "commit suicide," but only the right of the terminally ill, in the end stages of their terminal illness, to make the choice to hasten inevitable death. *See id.*; *see also* Sedler, *Constitutional Challenges*, *supra* note 2, at 793-94.

57. *Glucksberg*, 117 S. Ct at 2275.

58. *Glucksberg* was the more important case, since it directly presented the issue of whether, as the Ninth Circuit had held, the Due Process Clause protects as a fundamental right, the right of terminally ill persons, in the end stages of their terminal illness, to make the choice to hasten inevitable death by the use of physician-prescribed medications. In *Vacco*, the Second Circuit rejected the contention that the right of the terminally ill to make the choice to hasten inevitable death was a fundamental right for constitutional purposes, and rested its decision on an equal protection ground that had not specifically been argued by the plaintiffs in that case. The plaintiffs had argued, on the assumption that the right of the terminally ill to make the choice to hasten inevitable death was a fundamental right, that the New York ban on physician-assisted suicide also violated equal protection in that it improperly distinguished between terminally patients who were permitted to choose to hasten inevitable death by refusing or withdrawing life-saving medical treatment and those who were not permitted to make that choice by the use of physician-prescribed medications. The Second Circuit held that this distinction failed the rational basis standard of review. In *Vacco*, the Supreme Court, to the contrary, held that the distinction was a rational one as "comport[ing] with fundamental legal principles of causation and intent," and that New York's ban on physician-assisted suicide was rationally related to the advancement of the legitimate state interests that the Court identified in *Glucksberg*. *Vacco*, 117 S. Ct. at 2298-2302. Since *Glucksberg* turned out to be the more important case, we will refer to it as including both decisions in the same way as we have referred to

Like the constitutional challenges to legal prohibitions on abortion that culminated in *Roe v. Wade*, the constitutional challenge to legal prohibitions on physician-assisted suicide that culminated in *Glucksberg* is best understood in terms of legal, social and political context. Let us look first to the social context in which this challenge arose. The social context is best described as a conflict between the wishes of terminally ill people to be free from pain and to "die with dignity" and the traditional insistence of the organized medical profession that its responsibility was to keep people alive at all costs, coupled with a general disinterest in "death and dying" and in providing palliative care for the terminally ill. In other words, the terminally ill have too often suffered from both overtreatment and undertreatment. The overtreatment takes the form of medical efforts to keep them alive at all costs, and the undertreatment takes the form of failing to deal adequately with their pain and with their anxiety about death. In graphic terms, terminally ill people, in the end stages of their terminal illness, have all too often found themselves "hooked up to machines" that keep them alive, while their physicians refuse to prescribe adequate pain medication for fear that "too much medication will kill them."[59]

A recent Report of the Institute of Medicine has analyzed at length the twin problems of overtreatment and undertreatment and the general disinterest of the medical profession in "death and dying."[60] A number of the observations in the Report make it clear why terminally ill people have asserted a constitutional right to physician-assisted suicide. We will set out just a few:

> [T]oo many people suffer needlessly at the end of life, both from errors of omission (when caregivers fail to provide palliative and supportive care known to be effective) and from errors of commission (when caregivers do what is known to be ineffective and even harmful). Studies have repeatedly indicated that a significant proportion of dying patients and patients with advanced disease experience serious pain, despite the availability of effective and other options for relieving most pain . . . . In perverse counter-

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Roe v. Wade as including the Court's decision in the companion case of *Doe v. Bolton*.

59. My wife, Rozanne Sedler, M.S.W., is a geriatric social worker who has helped me very much in understanding the social context of physician-assisted suicide. As she has put it succinctly: "Old people want an easy exit. They don't want to be kept alive and suffer great pain. They just want to die in peace."

60. *See generally* DIVISION OF HEALTH CARE SERVICES, INSTITUTE OF MEDICINE, APPROACHING DEATH: IMPROVING CARE AT THE END OF LIFE (Marilyn J. Field & Christine K. Cassel eds., 1997) [hereinafter APPROACHING DEATH].

> point to the problem of undertreatment, the aggressive use of ineffectual and intrusive interventions may prolong and even dishonor the period of dying . . . .[61]
>
> Outdated and scientifically-flawed drug-prescribing laws, regulations, and interpretations by state medical boards continue to frustrate and intimidate physicians who wish to relieve their patients' pain. Addiction to opiods appropriately prescribed to relieve pain and other symptoms is virtually nonexistent, whereas underuse of those medications is a well-documented problem.[62]
>
> [T]he education of physicians and other health care professionals fails to provide them with the attitudes, knowledge, and skills required to care well for the dying patient. Many deficiencies in practice stem from fundamental prior failures in professional education. Undergraduate, graduate and continuing education do not sufficiently prepare health professionals to recognize the final phases of illnesses, understand and manage their own emotional reactions to death and dying, construct effective strategies for care, and communicate sensitively with patients and those close to them.[63]
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> It is a dual perversity that interest in assisted suicide sometimes reflects anxiety about overly aggressive medical treatment, sometimes dread about abandonment, and sometimes fear that dying people may suffer simultaneously or sequentially from both misfortunes.[64]

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61. APPROACHING DEATH, *supra* note 60, at Sum-4.

62. *Id.* The Report goes on to point out that "[n]umerous studies indicate that dying patients and patients with advanced illnesses experience considerable amounts of pain and other physical and psychological symptoms." *Id.* at 5-6.

63. *Id.* at Sum-5. As the Report went on to observe "[d]eficiencies in undergraduate, graduate and continuing education for end-of-life care reflect a medical culture that defines death as failure and ignores care for dying people as a source of professional accomplishment and personal meaning." *Id.* at 8-1.

> The Report concluded that health professions education can do better in (1) conferring a basic level of competence in the care of the dying patient for all practitioners; (2) developing an expected level of palliative and humanistic skills considerably beyond this basic level; and (3) establishing a cadre of superlative professionals to develop and provide exemplary care for those approaching death, to guide others in the delivery of such care, and to generate new knowledge to improve care of the dying.

Id. at 8-2. Chapter 8 of the Report, entitled *Educating Clinicians and Other Professionals*, puts much emphasis on this problem.

64. *Id.* at 1-2. The Report also observed that:

> [i]n the context of end-of-life care, overtreatment involves both care that is clinically inappropriate and care that is not wanted by the

> [P]eople in this country have not yet discovered how to talk realistically but comfortably about the end of life, nor have they learned how to value the period of dying as it is now experienced by most people . . . . One result is an unhelpful combination of fear, misinformation, and oversimplification that contributes to a public perception of misery as inescapable, pain as unavoidable, and public spending as misdirected for people approaching death.[65]
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> [A] *good death* is one that is: free from avoidable distress and suffering for patients, families and caregivers; in general accord with patients' and families' wishes; and reasonably consistent with clinical, cultural, and ethical standards. A *bad death*, in turn, is characterized by needless suffering, dishonoring of patient or family wishes or values, and a sense among participants or observers that norms of decency have been offended. Bad deaths include those resulting from or accompanied by neglect, violence, or unwanted and senseless medical treatments.[66]

The desire of many terminally ill persons to have a "good death" and to avoid a "bad death" was a major factor behind the development of constitutional challenges to bans on assisted suicide.

Another major factor behind the development of constitutional challenges to bans on assisted suicide, as it turned out, was the widely-publicized activity of Dr. Jack Kevorkian in assisting terminally ill persons and other persons in great pain to end their lives. Dr. Kevorkian has a very clear philosophy of death related to an individual's control of his or her own destiny. Kevorkian's focus has been on an individual's right to be liberated from unbearable pain and suffering and the right to end "a life no longer worth living" because of the effects of debilitating illness. Given this focus, some of the persons that Dr. Kevorkian has assisted in ending their lives have not been terminally ill, and Dr. Kevorkian's constitutional defense to prosecutions in Michigan has been based on an asserted constitutional right of his patients to be free from unbearable pain and suffering. It may also be noted that Dr. Kevorkian has provided assistance in ending their lives to only a very few persons—somewhere between 50

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patient, even if some clinical benefit might be expected. Fear of unwanted treatment at the end of life is an important factor in initiatives promoting advance care planning. Such fear—and the loss of control it implies—may also contribute to interest in assisted suicide.

Id. at 5-13 (citations omitted).

65. *Id.* at 1-2.

66. *Id.* at 1-8.

and 100[67]—out of the thousands who have sought that assistance.[68]

Because Dr. Kevorkian's activity in assisting suffering people to end their lives has been so visible and because he has been a such strong advocate for physician-assisted suicide, the matter of "death with dignity" came to public attention in a way that it had never done before. This was not a situation like that presented in the *Quinlan*[69] and *Cruzan*[70] cases, where the question involved the ending of artificial life support for a person in a persistent vegetative state. Now it was competent adults who had made the deliberate choice to end their lives, and Dr. Kevorkian was using his skills as a physician to enable them to do so. American society was now forced to come to grips with the policy question of whether physician-assisted suicide should be permissible in that society.

For some years before Kevorkian came on the scene, various groups had been advocating for legal recognition of a person's right to make the decision to end life and to have the assistance of a physician in carrying out that decision. Fueled in part by public awareness of the issue in the early 1990's, proponents succeeded in getting initiatives authorizing assisted suicide in specified circumstances on the ballot in California, Washington and

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67. Dr. Kevorkian has acknowledged assisting in 50 suicides, but his attorney, Geoffrey Fieger, has said that other cases, not made public, push the total closer to 100. *See Note Found Near Body Mentions Kevorkian*, DET. FREE PRESS, Oct. 4, 1997, at 11.

68. Dr. Kevorkian's activities, and those of his associate, Janet Good, have been chronicled by Jack Lessenberry, a free-lance writer and journalism instructor at Wayne State University. *See, e.g.*, Jack Lessenberry, *Death Becomes Him*, VANITY FAIR, July 1994, at 105; Jack Lessenberry, *Death and the Matron*, ESQUIRE, Apr. 1997, at 80. A highly critical assessment of Dr. Kevorkian is found in Michael Betzold, NEW REPUBLIC, May 26,1997, at 22.

A personal disclaimer is necessary. I am not an "objective observer" about Dr. Kevorkian. In the process of litigating the Michigan ACLU's challenge to Michigan's ban on assisted suicide and commenting extensively on the matter both in Michigan and the national media, I have come to know Dr. Kevorkian and his attorneys, Geoffrey Fieger and Michael Schwartz, very well. Jack Lessenberry is also a personal friend. I have high regard for Dr. Kevorkian's commitment to the cause that he has so strongly advocated and respect for him as an individual. So does my wife, who is more directly involved with issues of death and dying than I am. I also have high regard for the legal abilities of Mr. Fieger and Mr. Schwartz, and for the journalistic ability of Mr. Lessenberry. Stated simply, I "am at one" with all of them, and some of my observations are based on personal knowledge. As stated in the title of the article, this article is written "from within," and the "within" part includes my involvement with "the Kevorkian circle."

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

70. Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261 (1990).

Oregon. The voting was very close in all three states, with the initiatives failing in California and Washington, and narrowly passing in Oregon.[71] As the ballot initiatives indicate, the political context in which the constitutional challenge to bans on assisted suicide was litigated was one of extreme controversy. Although public opinion surveys show support for the general proposition that in some circumstances persons should be able to end their life with the assistance of a physician,[72] there is great disagreement on what these circumstances should be and on the conditions in which physician-assisted suicide should be permitted. And as will be discussed subsequently, the opponents of physician-assisted suicide have marshaled very credible arguments about the dangers of abuse and about the "slippery slope" that would follow from legal recognition of physician-assisted suicide.

Because the matter of physician-assisted suicide is so politically controversial, there is understandably considerable legislative resistance to confronting it. Most of the states have long-standing prohibitions against assisted suicide, which reflected a policy against assisting in the taking of a human life.[73] Prosecutions under these laws have been exceedingly rare. While these laws for the most part were not enacted to deal specifically with physician-assisted suicide, by their terms they are necessarily applicable to physician-assisted suicide, and can be invoked against it. And insofar as legislatures are disposed to act, it is to prohibit physician-assisted suicide, as some states have done in recent years. No proposal to permit physician-assisted suicide has passed in any legislature.[74]

It is in this social and political context that constitutional challenges to bans on assisted suicide have been asserted. Compassion in Dying, an organization "dedicated to changing the climate and experience of dying in America, to allow mentally competent patients to experience a choice in the manner of their dying,"[75] brought the challenges to the Washington and

71. See the discussion of the ballot initiatives in *Washington v. Glucksberg*, 117 S. Ct. 2258, 2266 (1997). The Oregon law did not go into effect because of legal challenges, and a proposal to repeal it on the ballot for the November, 1997 election. *See* Carey Goldberg, *Oregon Braces for New Fight on Helping the Dying to Die*, N.Y. TIMES, June 17, 1997, at 1.

72. Survey research on attitudes toward death and dying is summarized in APPROACHING DEATH, *supra* note 60, at 2-11-13.

73. A list of state laws prohibiting assisted suicide is set forth in *Glucksberg*, 117 S. Ct. at 2287 n.14.

74. *See Glucksberg*, 117 S. Ct. at 2266.

75. Letter from Kathryn L. Tucker, Director of Legal Affairs, Compassion in Dying, to Robert A. Sedler, Professor of Law, Wayne State University (Oct. 8,

New York laws that culminated in *Glucksberg* and *Vacco*. Dr. Kevorkian's activity prompted the enactment of a ban on assisted suicide in Michigan, one of the few states that did not have an extant law, and led to the unsuccessful constitutional challenge to that ban that I litigated for the Michigan ACLU in the Michigan state courts.[76]

The primary constitutional argument that was made both by Compassion in Dying and the by Michigan ACLU[77] was that the right of the terminally ill, in the end stages of their terminal illness, to make the choice to hasten inevitable death, was a "fundamental right," protected by the Fourteenth Amendment's Due Process Clause, and that an absolute ban on physician assistance imposed an "undue burden" on that right, which could not be justified under the compelling governmental interest standard of review.[78] There were two doctrinal bases to this argument. The first basis involved what we contended was a "logical extension" of the assumed constitutional right to refuse or discontinue life-

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1997) (on file with author). Ms. Tucker was lead counsel in the *Glucksberg* and *Vacco* cases from their inception and argued *Glucksberg* before the Supreme Court. Ms. Tucker goes on to say in her letter:

> Our chief mission has always been to provide information, consultation and emotional support to terminally ill patients and their families who are facing end of life choices. We offer consultations regarding every end-of-life option, including pain management, palliation and hospice care. For mentally competent people who make an enduring and voluntary request, we also provide information about hastening death when suffering cannot be adequately addressed.

Id.

Compassion in Dying, as might be expected, also seeks to "change the law to improve care of the dying and to allow physicians to participate fully and openly in a hastened death." *Id.* It has "made a long term commitment to the legal work necessary to bring the laws on assisted dying into accord with current needs." *Id*; *see also* Kathryn L. Tucker, *The Death With Dignity Movement: Protecting Rights and Expanding Options After* Glucksberg *and* Quill, 82 MINN L. REV. 923 (1998).

76. The ACLU challenge, *Hobbins v. Attorney-General*, was decided with and reported as *People v. Kevorkian*, 527 N.W.2d 714 (Mich. 1994), *cert. denied*, 115 S. Ct. 714 (1995).

77. Counsel for Compassion in Dying, Kathryn L. Tucker, and myself shared our arguments and cooperated with each other. While we developed our cases separately, and while the cases took different turns in the lower courts, our primary constitutional argument was essentially the same.

78. The argument, as I developed it in *Hobbins*, is set forth in Sedler, *Constitutional Challenges*, *supra* note 2, at 780-90. As noted above, it was essentially the same argument as was made by counsel for Compassion in Dying in litigating the *Glucksberg* and *Vacco* cases.

saving medical treatment that had been recognized in *Cruzan*.[79] This doctrinal basis of the argument was similar to the "abortion as a logical extension of contraception" argument that had been advanced in *Roe*: since abortion differed little from contraception and since both procedures were related to implementation of a woman's fundamental right to reproductive freedom, the constitutional right to reproductive freedom included the right to a safe and legal abortion. In regard to physician-assisted suicide, the argument was that since there was no essential difference between ending life by refusing or discontinuing life-saving medical treatment and ending life by the use of physician-prescribed medications, the right of the terminally ill, in the end stages of their terminal illness, to hasten inevitable death, should be given the same constitutional protection as the right to refuse or discontinue lifesaving medical treatment.

The second doctrinal basis of the argument looked to the broad definition of "liberty" in *Casey*, and contended that, under that definition, the right of the terminally ill, in the end stages of their terminal illness, to make the choice to hasten inevitable death, like the right of a woman to have a pre-viability abortion, qualified as a "fundamental right" for constitutional purposes. In *Casey*, the Supreme Court had stated:

> It is a promise of the Constitution that there is a realm of personal liberty which the government may not enter . . . . It is settled now . . . that the Constitution places limits on a State's right to interfere with a person's most basic decisions about family and parenthood, as well as bodily integrity. . . . 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.[80]

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79. Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261 (1990). Chief Justice Rehnquist, writing for the Court stated that "we assume that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition." *Id.* at 279. In her separate opinion in *Cruzan*, Justice O'Connor fully developed the reasons why the right of a person to refuse life-saving medical treatment is encompassed within the liberty protected by the Fourteenth Amendment's Due Process Clause. As she stated: "The liberty guaranteed by the Due Process Clause must protect, if it protects anything, an individual's deeply personal decision to reject medical treatment, including the artificial delivery of food and water." *Id.* at 289 (O'Connor, J., concurring).

80. Planned Parenthood v. Casey, 505 U.S. 833, 851 (1992).

The argument attempted to bring the decision to hasten inevitable death within the ambit of *Casey*'s broad definition of "liberty" and to liken that decision to other decisions about personal autonomy that the Court had heretofore recognized as "fundamental rights." The argument, as I developed it in *Hobbins*, was as follows:

> A person's entitlement to bodily integrity and control over that person's own body protects the person's right to refuse unwanted medical treatment, including the right of a competent adult person to make the personal decision to discontinue lifesaving medical treatment. It protects the right of a woman to have an abortion and the right of men and women to use contraception in order to prevent pregnancy. For the same reasons, a terminally ill person's right to control that person's own body must include the right to make decisions about the voluntary termination of that person's life. Terminally ill persons must have the right to make the 'most basic decisions about . . . bodily integrity,' 'the right to define [their] own concept of existence,' and 'the attributes of their personhood,' without the 'compulsion of the [s]tate.' Thus, logically, they must have the right to decide whether to undergo unbearable suffering until death comes naturally, or to hasten their inevitable death by the use of physician-prescribed medications.[81]

Once it was established that the right to make the choice to hasten inevitable death was a "fundamental right," the argument went on, it could not be denied that an absolute ban on the use of physician-prescribed medications to hasten death was an "undue burden" on that right, which could not be justified under the exacting compelling governmental interest standard of review.[82]

It was clear during the litigation as it certainly is clear in retrospect that the success of the constitutional challenge depended on the Court's acceptance of the argument that the right of terminally ill persons, in the end stages of their terminal illness, to make the choice to hasten inevitable death was a "fundamental right" for constitutional purposes. If the Court were to hold, as it ultimately did, that this was not a "fundamental right," then the various interests asserted by the state to justify the absolute ban, such as "preserving life" and avoiding possible abuse and "slippery slope" problems, would be sufficient to sustain its constitutionality under the rational basis standard of review. But if the

81. Sedler, *Constitutional Challenges*, *supra* note 2, at 787.
82. *Id.* at 789.

Court had held that this was a "fundamental right," then the absolute ban on physician-assistance, which imposed an "undue burden" on that right, could not be shown to be precisely tailored to advance a compelling governmental interest.

The structural problem with this argument was that its acceptance by the Court would have required the Court to recognize specifically a *new* fundamental right, which the Court had been unwilling to do for some twenty years. The last time the Court found a fundamental right that it had not expressly recognized previously was in *Moore v. City of East Cleveland*,[83] where it held that extended family relationships were included in the previously-recognized fundamental right of marriage and the family. The Court has rejected the contention that sexual freedom was a fundamental right,[84] and in the context of equal protection challenges to legislative classifications, had held that neither education[85] nor housing[86] was a fundamental right for constitutional purposes. And *Casey*'s broad definition of "liberty," on which the argument put so much reliance, was part of the Court's explication as to why abortion had been held to be a fundamental right in *Roe*. In other words, the Court, consistent with the line of growth of constitutional doctrine applicable to recognition of fundamental rights, could hold that the right to hasten inevitable death was not a fundamental right for constitutional purposes, and, applying the rational basis standard of review, could uphold the constitutionality of an absolute ban on "assisted suicide." This is exactly what the Court did in *Glucksberg*.

I have explained *Roe v. Wade* as a case where the Court was engaging in constitutional balancing and making a value judgment about the relative constitutional importance of the woman's interest in reproductive freedom and the state's interest in protecting potential human life, and it made that value judgment in favor of the woman's reproductive freedom interest. Without getting into a detailed discussion of the doctrinal and other differences in the various opinions in *Glucksberg*, the fact remains that all of the members of the Court in *Glucksberg* agreed that the right of the terminally ill, in the end stages of their terminal illness, to make the choice to hasten inevitable death, and to have the assistance of a physician in doing so, was not a funda-

83. 431 U.S. 494 (1977).

84. *See* Bowers v. Hardwick, 478 U.S. 186 (1986).

85. *See* San Antonio Sch. Dist. v. Rodriguez, 411 U.S. 1 (1973).

86. *See* Lindsey v. Normet, 405 U.S. 56 (1972).

mental right for constitutional purposes, and so upheld the constitutionality of the challenged laws.[87]

Using the same constitutional balancing-value judgment explanation of *Glucksberg* as I did of *Roe v. Wade*, I would have to say that in *Glucksberg* the Court made the value judgment that the various interests that the state asserted to justify a ban on physician-assisted suicide were *constitutionally more important* than the interest of the terminally ill person, in the end stages of that person's terminal illness, in making the choice to hasten inevitable death by the use of physician-prescribed medications. I will now discuss some of the factors that may have influenced the Court to make the value judgment that it did.

In constitutional litigation, as a distinguished constitutional scholar has observed, "[i]t is critically important that we get the

87. Chief Justice Rehnquist wrote the opinion for the Court in both cases. In arguing for a narrow interpretation of the "liberty" protected by the Due Process Clause, the Chief Justice insisted that the Due Process Clause protected only those liberties that were "deeply rooted in this Nation's history and tradition," or that were "implicit in the concept of ordered liberty." *See* Washington v. Glucksberg, 117 S. Ct. 2258, 2268 (1997). He then went on to demonstrate that "assisted suicide" did not fall into either of these categories. *See id.* at 2269-71. Taking issue with the Chief Justice on this point, Justice Souter invoked the "legitimacy of the modern justification for judicial review [under the Due Process Clause]," as set forth in Justice Harlan's dissent in *Poe v. Ullman*, 367 U.S. 497, 542 (1961) (Harlan, J., dissenting), which Justice Souter said had been adopted by the Court in *Casey* and other decisions. *See Glucksberg*, 117 S. Ct. at 2277 n.4 (Souter, J., concurring). According to Justice Souter, this approach "avoids the absolutist failing of many older cases without embracing the opposite pole of equating reasonableness with past practice described at a very specific level." *Id.* at 2281. While recognizing the importance of the asserted individual interests of the terminally ill patients, Justice Souter concluded that in the circumstances of this case, that interest was not "fundamental," since the state's asserted interests were "sufficiently serious to defeat the present claim that the law is arbitrary or purposeless." *Id.* at 2290. Justice O'Connor, emphasizing that the plaintiffs in this case were not asserting that there were any legal barriers to their obtaining adequate pain-killing medication, agreed with Justice Souter that "the state's interests in protecting those who are not truly competent or facing imminent death, or those whose decisions to hasten death would not truly be voluntary, are sufficiently weighty to justify a prohibition against physician-assisted suicide." *Id.* at 2303 (O'Connor, J., concurring). Justice Ginsburg concurred in Justice O'Connor's opinion, and Justice Breyer took essentially the same position. *See id.* at 2310-12 (Breyer, J., concurring). Justice Stevens, while concurring in the judgment, argued that "there is room for further debate about the limits that the Constitution places on the power of the States to punish the practice [of physician assisted suicide]," *id.* at 2304 (Stevens, J., concurring), and that "it is clear that the 'unqualified interest in the preservation of human life' is not itself sufficient to outweigh the interest in liberty that may justify the only possible means of preserving a dying patient's dignity and alleviating her intolerable suffering." *Id.* at 2310.

questions right and the answers right, because constitutional law is written in concrete and is not easily washed out by rain or tears."[88] Throughout the constitutional litigation that culminated in *Glucksberg*, the proponents and the opponents of a constitutional right to physician-assisted suicide sharply disagreed as to the formulation of the issue that ultimately would be decided by the Court. The proponents of recognition of this constitutional right argued that the issue was whether terminally ill persons, in the end stages of their terminal illness, had a constitutionally-protected right to make the choice to hasten inevitable death with the assistance of a physician. They argued that the case only involved the constitutional rights of the terminally ill, and that the terminally ill, in the end stages of their terminal illness, should have the choice to hasten inevitable death instead of "undergoing unbearable suffering until death comes naturally."[89] The opponents of recognition of a constitutional right to physician-assisted suicide, such as Professor Yale Kamisar, insisted that there was no principled way to limit the claimed right to the terminally ill or to those suffering unbearable physical pain, and that what the proponents were really contending for was a broader right to "commit suicide."[90]

The Court in *Glucksberg* defined the issue as it was defined by the opponents of a right to physician-assisted suicide. The Court noted that "we have a tradition of carefully formulating the interest at stake in substantive-due-process cases," and stated 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."[91]

In the same vein, proponents of a constitutional right to physician-assisted suicide argued that there was no issue in the cases before the Court as to possible abuses that could result from recognition of such a right or with the problem of the "slippery slope." The case, it was argued, only involved the constitutionality of an absolute ban on physician-assisted suicide for the terminally ill, that possible abuses could be dealt with by reasonable regulation, and that recognition of a constitutional right to assisted suicide for the terminally ill would not lead us down the "slippery slope" to something like involuntary euthanasia.[92]

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88. Dixon, *supra* note 1, at 70.

89. Sedler, *Constitutional Challenges*, *supra* note 2, at 787.

90. *See* Yale Kamisar, *Against Assisted Suicide—Even a Very Limited Form*, 72 U. DET. MERCY L. REV. 735, 735-45 (1995).

91. *Glucksberg*, 117 S. Ct. at 2258.

92. *See* Sedler, *Constitutional Challenges*, *supra* note 2, at 790-94.

The opponents of a constitutional right to physician-assisted suicide, to the contrary, insisted that the Court could not avoid concerns with possible abuses and with the problems of the "slippery slope."[93] Possible abuses had been identified by a New York State Task Force, which unanimously recommended that existing law should not be changed to permit assisted suicide. The Task Force found that permitting assisted suicide would create serious risks for the elderly, the poor and the socially disadvantaged:

> [I]t must be remembered that assisted suicide and euthanasia will be practiced through the prism of social inequality and prejudice that characterizes the delivery of services in all segments of society, including health care. Those who will be most vulnerable to abuse, error or indifference are the poor, minorities, and those who are least educated and least empowered. . . . [Many patients] in large, overburdened facilities serving the urban and rural poor . . . will not have the benefit of skilled pain management and comfort care. Indeed, a recent study found that patients treated for cancer at centers that care predominantly for minority individuals were three times more likely to receive inadequate therapy to relieve pain. Many patients also lack access to psychiatric services. Furthermore, for most patients who are terminally or severely ill, routine psychiatric consultation would be inadequate to diagnose reliably whether the patient is suffering from depression.[94]

For these persons, then, the contention was that there would be a serious question as to whether any decision to hasten death would be truly "voluntary."

The Court expressly took these concerns into account in *Glucksberg*. In the context of holding that the Washington law was rationally related to advancing legitimate state interests, the Court quoted at length from the Task Force Report, noting that those who attempt suicide, terminally ill or not, often suffer from depression or other mental disorders, that the state has an interest in protecting vulnerable groups, such as the poor, the elderly and disabled persons, from abuse, neglect, and mistakes, and from overt and subtle coercion to hasten their deaths. The state's assisted-suicide ban, said the Court, also reflects and

93. *See generally* Kamisar, *supra* note ; *see also* Thomas Marzen et al., *Suicide: A Constitutional Right*, 24 DUQ. L. REV. 1, 100-47 (1985).

94. NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE IN THE MEDICAL CONTEXT 125, 143 (1994) (footnotes omitted) [hereinafter WHEN DEATH IS SOUGHT].

enforces its policy that the lives of terminally ill, disabled and elderly people must be no less valued than the lives of the young and healthy.[95] Finally, the Court joined the opponents of assisted suicide in a journey down the "slippery slope," saying that the state "may fear that permitting assisted suicide will start it down the path to voluntary and perhaps even involuntary euthanasia."[96]

Finally, and perhaps most importantly, the Court, especially in the opinions of the concurring Justices, rejected the attempt of the proponents of physician-assisted suicide to cast the constitutional claim in terms of a right to hasten death in order to be free from unbearable suffering. Proponents of physician-assisted suicide argued that terminally ill persons, in the end stages of their terminal illness, "must have the right to decide whether to undergo unbearable suffering until death comes naturally, or to hasten their inevitable death by the use of physician-prescribed medications."[97] As discussed earlier, the social context in which the constitutional challenges to bans on physician-assisted suicide arose included the failure of the terminally ill to receive adequate pain medication to alleviate their pain and suffering. It will be recalled that, according to the Report of the Institute of Medicine, "[s]tudies have repeatedly indicated that a significant proportion of dying patients and patients with advanced disease experience serious pain, despite the availability of effective and other options for relieving most pain," and that, "[o]utdated and scientifically-flawed drug-prescribing laws, regulations, and interpretations by state medical boards continue to frustrate and intimidate physicians who wish to relieve their patient's pain."[98]

However, while the constitutional challenges were wending their way through the lower courts, the American Medical Association expressly recognized that physicians had the ethical responsibility to prescribe all the pain medication that was necessary to alleviate the patient's suffering, even if this would hasten the patient's death.[99] Assuming that terminally ill patients, in fact receive all the pain medication necessary to alleviate their suffer-

95. *See Glucksberg*, 117 S. Ct. at 2273.

96. *Id.* at 2274. See also the discussion of these concerns in Justice Souter's concurring opinion, *see id.* at 2290-93 (Souter, J., concurring).

97. Sedler, *Constitutional Challenges*, *supra* note 2, at 787.

98. APPROACHING DEATH, *supra* note 60, at Sum-4.

99. *See* COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, AMERICAN MEDICAL ASSOCIATION, REPORT, *reprinted in* 10 ISSUES IN L. & MED. 90, 94-95 (1994) [hereinafter REPORT] ; COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, AMERICAN MEDICAL ASSOCIATION, DECISIONS NEAR THE END OF LIFE, *reprinted in* 267 JAMA 2229, 2231 (1992) [hereinafter DECISIONS NEAR THE END OF LIFE].

ing, their claim of a constitutional right to make the choice to hasten inevitable death can no longer be founded on the need to avoid "unbearable suffering."

In her *Glucksberg* concurrence in which Justice Ginsburg joined, Justice O'Connor, stated that the proponents of a constitutional right to assisted suicide were not asking the Court to recognize a generalized right to "commit suicide," but instead were asking the Court to address "the narrower 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."[100] Justice O'Connor went on to say, however, that there was no need for the Court to reach that question in the context of the facial challenge to the Washington and New York laws, because, "there is no dispute that dying patients in Washington and New York *can obtain palliative care even when doing so would hasten their deaths.*"[101] Justice Breyer also emphasized that the laws of Washington and New York "do not prohibit doctors from providing patients with drugs sufficient to control pain despite the risk that those drugs themselves will kill," and said that the right to be free from unbearable pain would be central to any constitutional claim of a right to hasten inevitable death. If such a situation were presented, said Justice Breyer, "the Court might have to revisit its conclusions in these cases."[102] Justice Stevens likewise emphasized that where palliative care was inadequate to alleviate all pain and suffering, the state's interest in preventing potential abuse and mistake would only be minimally implicated, and that he would not "foreclose the possibility that an individual plaintiff seeking to hasten her death, or a doctor whose assistance was sought, could prevail in a more particularized challenge."[103] And in his opinion for the Court in *Vacco*, Chief Justice Rehnquist noted that New York permitted physicians to provide aggressive palliative care, and stated that in this situation, the physician's intent was only to ease his patient's pain. For this reason he concluded that a distinction between permitting physicians to provide aggressive palliative care and prohibiting them from assisting in the patient's suicide was reasonable,[104] a point that Justice Souter also made in his *Vacco* concurrence.[105]

100. *Glucksberg*, 117 S. Ct. at 2303 (O'Connor, J., concurring).
101. *Id.* at 2303 (emphasis added).
102. *Id.* at 2311-12 (Breyer, J., concurring).
103. *Id.* at 2308-09 (Stevens, J., concurring).
104. *See* Vacco v. Quill, 117 S. Ct. 2293, 2302 n.12 (1997).
105. *See id.* at 2302 (Souter, J., concurring).

My point here is that the Court's holding in *Glucksberg* that the right of the terminally ill to make the choice to hasten inevitable death was not a fundamental right for constitutional purposes was clearly predicated on the assumption that the terminally ill person was not being denied adequate pain medication. In effect then, the issue in *Glucksberg* was formulated in terms of whether a terminally ill person, in the end stages of that person's terminal illness, *who was not suffering unbearable pain*, had a fundamental right to make the choice to hasten inevitable death, and the Court held that the person did not. The Court's formulation of the issue, relating to the facts of those cases, and to the current approved medical practice of providing adequate pain medication to terminally ill persons, even at the risk of hastening inevitable death, made the constitutional claim significantly less cogent than it was when the issue was formulated in terms of an entitlement to be free from unbearable pain and suffering.

Since the issue in *Glucksberg* was formulated by the Court in this way, and since as the Court emphasized, neither Washington nor New York had a law that prohibited physicians from prescribing adequate pain medication, it can now be contended that a terminally ill person should have a constitutionally-protected right to receive adequate pain medication, even though this may have the effect of hastening inevitable death. As discussed above, at least five of the Justices in *Glucksberg*, O'Connor, Ginsburg, Stevens, Souter and Breyer, indicated that they were open to recognizing the existence of such a right. If such a right is recognized, this means, as Justice Breyer pointed out in *Glucksberg*, that the state cannot "prohibit doctors from providing patients with drugs sufficient to control pain despite the risk that those drugs themselves will kill."[106] It also would mean that state laws prohibiting "assisted suicide," whether they expressly say so or not, must be interpreted as not including within the definition of "assisted suicide" a physician's furnishing of death-hastening pain medication to a terminally ill patient.

I think it highly unlikely that the Court will ever have to confront this question directly. It is difficult to imagine any state legislature today enacting a law that would prohibit physicians from providing adequate pain medication for the terminally ill, or any state court interpreting the state law on "assisted suicide" to include such a prohibition. In the absence of a legal prohibition, physicians are ethically required to provide death-hastening

106. *Glucksberg*, 117 S. Ct. at 2311 (Breyer, J., concurring).

pain medication.[107] Operationally then, we may say that the terminally ill do have a legally-protected right, constitutionally-based or not, to receive adequate pain medication, even though this may have the effect of hastening their inevitable death.

In *Glucksberg*, the Court also appeared to explicitly affirm what it had assumed in *Cruzan*, that all persons have a constitutionally protected right to refuse or discontinue life-saving medical treatment. Chief Justice Rehnquist noted that, "[g]iven the common-law rule that forced medication was a battery, and the long legal tradition protecting the decision to refuse unwanted medical treatment, our assumption [in *Cruzan*] was entirely consistent with this Nation's history and constitutional traditions."[108] It may be assumed, therefore, that the Constitution protects a person's right to refuse or discontinue life-saving medical treatment. And in any event, it is impossible to imagine any state enacting a law denying this right. Operationally then, we may say that the terminally ill, like all other persons, have a legally-protected right to refuse or discontinue life-saving medical treatment.

We thus see that one of the consequences of the constitutional controversy over assisted suicide that culminated in the *Glucksberg* decision *has been some substantial degree of legal protection to the claimed right of terminally ill persons to have a "good death."*[109] It will be recalled that the Institute of Medicine Report identified "in perverse counterpoint" the two most common components of a "bad death": "the aggressive use of ineffectual and intrusive interventions that may prolong and even dishonor the period of dying," and "experiencing serious pain, despite the availability of effective and other options for relieving most pain."[110] The legal system now clearly protects the right of the terminally ill to avoid both of these components of a "bad death." Specifically, terminally ill persons clearly have a legally-protected right to refuse or discontinue lifesaving medical treatment, and with it, the right to prevent the "aggressive use of ineffectual and intrusive interventions."[111] Likewise, they have the legally protected right to be

107. *See supra* text accompanying note 95.

108. *Glucksberg*, 117 S. Ct. at 2270.

109. *See* APPROACHING DEATH, *supra* note 60, at 1-8.

110. *Id.* at Sum-4.

111. For constitutional purposes, of course, this right can only be implicated by "state action," such as by a law changing the common law rule that a person has the right to refuse or discontinue life-saving medical treatment. It is difficult to imagine any state enacting such a law, and if a state did so, the law would be declared unconstitutional. By the same token, if a physician refused to discontinue lifesaving medical treatment when directed to do so by the patient, the physician would be liable for a common-law battery.

free from unbearable pain and to receive all the medication necessary to alleviate pain even though this may have the effect of hastening their inevitable death.

Of equal importance is societal acceptance of both of these propositions. Unlike the controversy over abortion, the controversy over physician-assisted suicide is not a controversy between sharp antagonists (even though both proponents and opponents of physician-assisted suicide sometimes try to portray it that way). In the abortion context, the woman's claim of entitlement to an abortion is a claim of entitlement to control over her own body, which can only be recognized by permitting her to have an abortion. But if the woman does have an abortion, she will be destroying the potential life of the fetus she is carrying, which to the opponents of abortion is the destruction of human life in the same manner as if she had killed an infant child. The conflicting claims of the proponents and opponents of abortion cannot be reconciled, and any "compromise," such as allowing an abortion only in certain circumstances, will not resolve the underlying conflict.

Both the proponents and opponents of assisted suicide, however, share a common goal, the protection of the terminally ill in the process of dying and concern for their being able to have a "good death." The disagreement is over whether a "good death" for the terminally ill should include the right to physician-assisted suicide. But the opponents of physician-assisted suicide, no less than the proponents, seemingly agree both that the terminally ill should have the right to refuse or discontinue life-saving medical treatment and that they should have the right to receive death-hastening pain medication. This point was emphasized by the states and by all the amici opposed to assisted suicide in *Glucksberg* and *Vacco*. The crucial point of disagreement between the proponents and the opponents of physician-assisted suicide then turned out to be whether there was a constitutionally significant distinction between a patient's refusal or discontinuance of lifesaving medical treatment and a physician's prescription of death-hastening medications, on the one hand, and the physician's providing the patient with lethal medications that the patient could take in order to hasten inevitable death, on the other hand. The Supreme Court agreed with the opponents of physician-assisted suicide that there was a constitutionally significant distinction, and that is the end of the matter. The Constitution does not protect the right of the terminally ill, in the end stages of their terminal illness, to make the choice to

hasten inevitable death by the use of physician-prescribed medications.[112]

In American society today then terminally ill persons no longer face the fearful prospect of being kept alive against their will while at the same time being forced to suffer unbearable pain. They have the right to make the choice to refuse or discontinue lifesaving medical treatment. They have the right to receive all the medication that is necessary to alleviate their pain even if this will have the effect of hastening their deaths. They have the right to terminal sedation. What they do not have is the right to make the choice to "die at once" by the use of physician-prescribed medications, even in the end stages of their terminal illness. If they are not receiving lifesaving medical treatment, but are receiving all the medication necessary to alleviate their pain, they do not have a constitutionally protected right to decide that they are "ready to die" now, and with the assistance of a physi-

112. It will be recalled that the basis of the Court's equal protection holding in *Vacco* was that it was rational for the state to make a distinction between a physician's complying with a person's decision to refuse or withdraw life-saving medical treatment, and a physician's affirmatively assisting a terminally ill person to "commit suicide." The distinction, said the Court, "comports with fundamental legal principles of causation and intent." Vacco v. Quill, 117 S. Ct. 2293, 2298 (1997). When the patient refuses treatment, the cause of death is the underlying disease, but when the patient ingests lethal medication prescribed by a physician, the patient is killed by that medication. And when the physician complies with the patient's decision to refuse treatment, the physician is honoring the patient's wishes and is not acting with the intent to kill the patient. The Court went on to make the same point about causation and intent in the context of a physician's providing aggressive palliative care: while painkilling drugs may hasten death, the physician's purpose is to ease the patient's pain rather than to bring about the patient's death. *See id.* at 2298-99.

The American Medical Association has strongly defended the distinction as a matter of medical ethics:

> Assisted suicide and euthanasia should not be confused with the provision of palliative treatment that may hasten the patient's death ("double effect"). The intent of the palliative treatment is to relieve pain and suffering, not to end the patient's life, but the patient's death is a possible side effect of the treatment. It is ethically acceptable for a physician to gradually increase the appropriate medication for a patient, realizing that the medication may depress respiration and cause death. Assisted suicide also must be distinguished from withholding or withdrawing life-sustaining treatment, in which the patient's death occurs because the patient or the patient's proxy, in consultation with the treating physician, decides that the disadvantages of treatment outweigh its disadvantages and therefore that treatment is refused.

REPORT, *supra* note 99, at 92; *see also id.* at 93-96; DECISIONS NEAR THE END OF LIFE, *supra* note 99, at 2229-31.

cian, to "die at once." In other words, for the terminally ill, in the end stages of their terminal illness, there is a "right to die" slowly and under sedation, but there is no "right to die all at once."[113]

The likely political effect of the Supreme Court's decision in *Glucksberg* will be to entrench existing laws against physician-assisted suicide. Because the matter is so politically controversial, it would not be expected that most legislatures would be disposed to enact laws authorizing physician-assisted suicide, even in limited circumstances. In some states, it may be possible to launch a successful petition drive to legalize physician-assisted suicide, but this effort would face formidable obstacles, as the opponents of physician-assisted suicide would raise concerns about possible abuse and the specter of the "slippery slope."[114]

The terminally ill who want to make the choice to hasten inevitable death and to "die all at once" are now effectively deprived of this choice and likely will continue to be so deprived in the foreseeable future. Just as prior to *Roe v. Wade*, physicians were deterred from performing abortions by state anti-abortion laws, today physicians will be deterred from providing their terminally ill patients with lethal medications and instruction in their use by state laws prohibiting assisted suicide. And even if a physician is willing to risk a criminal prosecution because of the unlikelihood of a jury voting to convict, the physician still faces the loss of his or her medical license in disciplinary proceedings. The prudent physician, therefore, will stay far away from physician-assisted suicide. Unlike abortion, therefore, physician-

113. For press discussions of current medical practice and the terminally ill, see Gina Kolata, *'Passive Euthanasia' Is the Norm in Today's Hospitals, Doctors Say*, N.Y. TIMES, June 28, 1997, at 1; Sheryl Gay Stolberg, *Cries of the Dying Awaken Doctors to a New Approach*, N.Y. TIMES, June 30, 1997, at 1.

114. I commented on this matter immediately after the *Glucksberg* decision:

> 'It entrenches the existing laws against assisted suicide,' said Robert Sedler, a professor of constitutional law at Wayne State University in Detroit who has argued in favor of legalizing assisted suicide before the State Supreme Court in Michigan, which became a focal point for the debate after Dr. Jack Kevorkian began helping terminally ill patients die. 'The proponents of assisted suicide will have a heavy burden getting legislatures to repeal them.'

Janny Scott, *An Issue That Won't Die*, N.Y. TIMES, June 29, 1997, at 1. Professor Yale Kamisar, a strong opponent of physician-assisted suicide, has recently argued that there should not be legal recognition of a right to physician-assisted suicide, even in the most "compelling, heartwrenching case." *See* Yale Kamisar, *Physician-Assisted Suicide: The Problems Presented by the Compelling, Heartwrenching Case*, 88 NW. U. L. REV. 1121 (1998).

assisted suicide is not now *operationally acceptable* in American society.

CONCLUSION

In this article, I have undertaken an examination of how abortion and physician-assisted suicide have been "taken into our constitutional system," and of the societal impact of the Supreme Court's constitutional treatment of these issues. We see that in American society today, a woman's right to have a safe and legal abortion is operationally acceptable, but the right of the terminally ill, in the end stages of their terminal illness, to make the choice to hasten inevitable death with the assistance of a physician is not. The difference between the operational acceptability of the woman's right to a safe and legal abortion and the absence of operational acceptability of the terminally ill person's right to make the choice to hasten inevitable death is explainable, in my opinion, by Supreme Court decisions, a quarter-century apart, reflecting different value judgments about the meaning of Constitution as it relates to the beginning and end of life.