No. 95-1858

IN THE
# Supreme Court of the United States
OCTOBER TERM, 1996

DENNIS C. VACCO, Attorney General of the State of New York; GEORGE E. PATAKI, Governor of the State of New York; and ROBERT M. MORGENTHAU, District Attorney of New York County,

*Petitioners,*

v.

TIMOTHY QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; and HOWARD A. GROSSMAN, M.D.,

*Respondents.*

**On Writ of Certiorari to the United States Court of Appeals for the Second Circuit**

## BRIEF *AMICI CURIAE* OF THE UNITED STATES CATHOLIC CONFERENCE; NEW YORK CATHOLIC CONFERENCE; WASHINGTON STATE CATHOLIC CONFERENCE; OREGON CATHOLIC CONFERENCE; CALIFORNIA CATHOLIC CONFERENCE; MICHIGAN CATHOLIC CONFERENCE; CHRISTIAN LIFE COMMISSION OF THE SOUTHERN BAPTIST CONVENTION; NATIONAL ASSOCIATION OF EVANGELICALS; THE LUTHERAN CHURCH-MISSOURI SYNOD; WISCONSIN EVANGELICAL LUTHERAN SYNOD-LUTHERANS FOR LIFE; THE EVANGELICAL COVENANT CHURCH; AND THE AMERICAN MUSLIM COUNCIL IN SUPPORT OF PETITIONERS

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## INTEREST OF *AMICI*

In this extraordinary case, this Court must decide whether, consistent with the Equal Protection Clause, New York may apply its laws against assisted suicide equally to everyone, including physicians who provide persons in the final stages of a terminal illness with lethal drugs to commit suicide. The Court below held it may not, resting its opinion on an erroneous construction of the Equal Protection Clause, New York law, and medical evidence. Representatives of diverse religious communities, *amici curiae* here, share grave concerns about these unprecedented conclusions. As New York law and medical practices recognize, there is a great difference between letting nature take its course for a gravely ill patient, and intervening in that course by intentionally providing a lethal agent to cause death. All citizens are entitled to laws that protect their lives, even from those who may wish to "assist" their suicides. The common good of our society requires that the life of each person be treated as having inherent worth. Individual statements of interest follow.

The United States Catholic Conference is a nonprofit corporation organized under the laws of the District of Columbia. Its members are the active Roman Catholic Bishops in the United States. The Catholic Bishops of New York, Washington, Oregon, California, and Michigan are, in addition, members of the State Catholic Conferences of those respective states. The Conferences are vehicles through which the Bishops speak cooperatively and collegially on matters affecting the Catholic Church and its people. Roman Catholicism is the largest religious denomination in the United States, with over 60 million members in this country. The Conferences advocate and promote the pastoral teaching of the Church on diverse issues, including the protection of human rights and the sanctity and dignity of human life. Each Conference has been active in supporting state laws that protect persons from assisted suicide.

The Christian Life Commission is the moral concerns and public policy agency for the Southern Baptist Convention, the nation's largest Protestant denomination, with over 15.2 million members in over 38,000 autonomous local churches. The Commission is charged with addressing public policies affecting the sanctity of human life.

The National Association of Evangelicals ("NAE") is a nonprofit association of evangelical Christian denominations, churches, organizations, institutions and individuals. It includes some 42,500 churches from 75 denominations, and 300 parachurch ministries. NAE has joined in this and many other *amicus* briefs in the defense of human rights, including the right to life.

The Lutheran Church-Missouri Synod is the second-largest Lutheran denomination in the United States. It has about 6,000 member congregations and about 2.6 million individual members. In 1995, as a result of their deeply-held religious beliefs on the sanctity of life, the congregations of the Synod passed a resolution expressing the Synod's objection "to medical personnel having any part in actively inducing death, even at the patient's request." The Synod resolved "to speak against any attempt to legalize physician-assisted suicide."

The Wisconsin Evangelical Lutheran Synod-Lutherans for Life is a para-synod organization in fellowship with the 400,000 member Wisconsin Evangelical Lutheran Synod ("WELS") and the 10,000 member Evangelical Lutheran Synod. WELS-Lutherans for Life is a specialized ministry seeking to make known God's will on life and to provide assistance to others on life issues. God's will concerning euthanasia and suicide is clear, recognizing that God acknowledges the absolute value of human life despite its varying or diminished quality. WELS-Lutherans for Life stands by the conviction that it is contrary to the will of God to take one's own life or to assist in such a task.

The Evangelical Covenant Church ("ECC") is a Protestant denomination with 92,000 members in 600 churches

throughout the United States. It operates a university, two hospitals, twelve continuing care retirement communities, and twelve nursing homes as a Christian ministry. ECC has adopted an ethical guideline on death and euthanasia. The guideline affirms the ECC's commitment to provide "the best palliative measures we can to relieve the pain, discomfort and suffering of our patients. . . . We do not act in any way intentionally to cause, assist, or accelerate the death of patients."

The American Muslim Council ("AMC") is a nationally recognized organization representing the interests of the American Muslim community. AMC is a committed advocate of human rights. It participates in interfaith and multiethnic dialogue with the hope of promoting an environment in which tolerance and justice will thrive. AMC's opposition to assisted suicide is rooted in Islamic belief, which strongly affirms the sanctity of human life.

Through their counsel, the parties have consented to the appearance of these *amici*.

## SUMMARY OF ARGUMENT

In this case, this Court is asked to reverse an extraordinary ruling—that "terminally ill persons" in the "final stages of dying," as a class, constitutionally must be *excluded* from the mandatory protection of generally applicable homicide laws. This conclusion contravenes the very principle of equal protection under law upon which the Second Circuit below purported to ground its decision. Excluding people from the protection of the homicide laws based on the condition of their health is a particularly serious departure from the principle of equal justice for all. It is a grave injustice to deprive any person of the protections against deadly harm that are extended to all others under the criminal law. Indeed, withholding such protections is an injustice of unspeakable magnitude, for it leads to the literal destruction of the very lives that government is charged with protecting.

The decision below is based on at least five erroneous assertions. First, the court erred by subjecting to equal

protection scrutiny New York homicide laws that create no classification whatsoever. Second, contrary to this Court's declaration that the Equal Protection Clause is not a source of substantive rights, the court below created a new "right to hasten death" that has never been recognized by the New York legislature or New York courts. Third, disregarding precedent and common sense, the court erroneously declared that there is no rational difference between complying with a person's decision to decline medical treatment and providing that person with a lethal poison to commit suicide. Fourth, disregarding this Court's own admonitions, the court below incorrectly found that New York has a "greatly reduced" interest in protecting the lives of persons who are in the "final stages of a terminal illness," thereby removing this ambiguously-defined and vulnerable class of persons from the protections of an unambiguous and generally applicable homicide statute. Fifth, by concluding that persons who fall within this ambiguous category can choose only between self-destruction or continued "agony," the court erroneously suggested, as a matter of law and for the entire Nation, that this class of citizens is simply and unalterably beyond the reach of modern-day medical and palliative care—a suggestion that is as false as it is cynical.

This case is not about respecting a person's desire to be free of an unwanted or burdensome medical treatment. It is about providing those who appear to be terminally ill with a death-producing agent for the express purpose of causing their death. The Second Circuit erroneously concluded that the Constitution forbids States to recognize a difference between the two. The court thus cast aside as "irrational" a distinction that has achieved nearly universal recognition in the common law, statutory law, the medical profession, and countless court decisions, including the law of New York. A 1994 Task Force appointed by the Governor of New York cited the distinction between declining medical treatment and administering a lethal agent with the intentional purpose of causing death, as one of many reasons for retaining the State's

laws prohibiting assisted suicide. On this basis, the New York legislature acted reasonably in leaving its law unchanged.

In the last analysis, the ruling below manufactures a "right" that would radically alter society. The rule of law reflects the idea of "ordered liberty." There is no right for one person to provide another with the means of taking his or her life. The decision below must be reversed.

## ARGUMENT

This Term, the Court confronts what, without exaggeration, may be the most profound and far-reaching federal constitutional question ever to have demanded its attention. At issue is whether a centuries-old tradition and prohibition—*we will not take the life of another even if asked*—should be abandoned. No departure from that proscription should be allowed by this Court. Indeed, the very uniformity of that tradition suggests a serious and fundamental error at the heart of the lower court's analysis.[1]

### I. THE NEW YORK HOMICIDE LAWS COMPLY WITH THE EQUAL PROTECTION CLAUSE BECAUSE THEY APPLY EQUALLY TO EVERYONE.

The New York homicide statutes struck down in this case create no classifications whatsoever. In New York, no one may assist another person to commit suicide or obtain another person's "assistance" in committing suicide. Since the statutory prohibition against assisted suicide applies to everyone equally, it clearly complies with the Equal Protection Clause. *New York City Transit Authority v. Beazer*, 440 U.S. 568, 587 (1979) (laws that apply evenhandedly to all persons "unquestionably comply" with the Equal Protection Clause).

What is more, the Second Circuit's decision *creates* an equal protection problem where none had existed before.

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[1] This Court has agreed to hear *State of Washington v. Glucksberg*, No. 96-110, raising the same conceptual questions but from a different legal perspective.

The court's conclusion that the Equal Protection Clause requires *unequal* application of a generally applicable criminal law, depending on the health condition of the victim and whether the defendant has a medical license, contradicts the very principle of equal protection upon which the court below purported to ground its decision. It is abhorrent to the principle of equal justice under law to withhold from terminally ill patients "the same protections from suicide the majority enjoys." *Lee v. Oregon*, 891 F. Supp. 1429 (D. Or. 1995), *appeal pending*, No. 95-35804 (9th Cir.) (*sub judice*).

There is a second and equally fundamental problem with the Second Circuit's decision. The court relied upon the Equal Protection Clause to create what it called a "right to hasten death"—a new substantive right that is not recognized by the New York legislature or the New York courts. As this Court has declared, "[i]t is not the province of [the federal courts] to create substantive constitutional rights in the name of guaranteeing equal protection of the laws." *San Antonio Independent School District v. Rodriguez*, 411 U.S. 1, 33 (1973). There is, moreover, a contradiction between New York law and this judicially invented "right to die" or "right to hasten death"—a "right" which, stripped of euphemism, would more aptly be called a "right to assisted suicide" because that is the conduct at issue here. The contradiction is obvious: assisted suicide is *proscribed* by the very New York legislature that the Second Circuit claimed had implicitly *created* a "right to hasten death." Conduct cannot be explicitly banned under state criminal law and at the same time constitute a state-created "right" subject to "equal application" under the Equal Protection Clause.[2]

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[2] New York law rejecting a "right to hasten death" is clear. *Matter of Storar*, 420 N.E.2d 64, 71 n.6 (N.Y. App.), *cert. denied*, 454 U.S. 858 (1981). But for the Second Circuit's declaration of such a "right," which is contrary to New York's view, there would be no equal protection problem. In *Leavitt v. Jane L.*, 116 S. Ct. 2068 (1996), this Court summarily reversed the Tenth Circuit's invalidation of the entire Utah statute regulating abortion based

For the Second Circuit to declare who may be charged with a homicide in New York and under what circumstances is a radical departure from the proper judicial role. A declaration by a court that assistance in self-destruction is a "benefit" or "right" for one particular class of citizens, while remaining a crime when inflicted upon all other citizens, would be tantamount to deciding that some persons are truly better off dead than alive. How such a mandate could be rooted in the Constitution defies reasoned explanation. Our Constitution does not mandate that state-licensed healing professionals be permitted to assist in the self-destruction of any class of citizens.

## II. EVEN IF THE EQUAL PROTECTION CLAUSE WERE IMPLICATED, THERE IS A PROFOUND DISTINCTION BETWEEN WITHDRAWING MEDICAL TREATMENT AND ASSISTING IN A SUICIDE.

The Second Circuit, substituting its judgment for that of the New York legislature, erred by denying that there is any rational difference between assisting a suicide and acceding to a decision to forego medical treatment. The legislature saw the distinction clearly. Under New York law, everyone is permitted to accept or refuse his or her own medical treatment, yet no one is permitted to enlist another person's assistance in committing suicide. *See, e.g., Matter of Storar,* 420 N.E.2d 64, 71 n.6 (N.Y. App.) (distinguishing a natural death from self-inflicted killing), *cert. denied,* 454 U.S. 858 (1981); *id.* at 74 (Jones, J., dissenting) ("I explicitly disclaim any intention, expressly or by implication, to invite consideration of . . . the deliberate use of a life shortening agent for the termination of life").

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on the court of appeal's failure to apply a clear legislative severability clause. *Id.* at 2070. By disregarding clear state law and creating the classification, the Second Circuit's action is analogous and calls for the same remedy here. *See id.* at 2073.

The distinction between withdrawing treatment and assisting a suicide is supported by both authority and reason. Courts and legislatures, including those of New York, have uniformly and consistently recognized the distinction.[3] When courts began to extend the right to forego treatment to incompetent and comatose patients, they did so precisely *because* it was different from committing suicide, and they cautioned explicitly that these decisions were not to be taken as blurring or violating that distinction. *Matter of Quinlan*, 355 A.2d 647, 665 (N.J. 1976) ("We would see . . . a real distinction between the self-infliction of deadly harm and a self-determination against artificial life support"), *cert. denied sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976). The difference between foregoing treatment and assisting

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[3] *Barber v. Superior Court*, 195 Cal. Rptr. 484, 487 (Cal. App. 1983) ("Euthanasia, of course, is neither justifiable nor excusable in California"); *Superintendent of Belchertown v. Saikewicz*, 370 N.E.2d 417, 426 n.11 (Mass. 1977) (distinguishing a "competent, rational decision to refuse treatment when death is inevitable" from an act of intentional self-destruction); *Bartling v. Superior Court*, 209 Cal. Rptr. 220, 225-26 (Cal. App. 1984) (suicide is distinguishable from death from natural causes which results from disconnecting a respirator from a comatose, terminally ill patient); *Matter of Conroy*, 486 A.2d 1209, 1224 (N.J. 1985) (declining life-sustaining medical treatment is distinguishable from suicide because it "merely allows the disease to take its natural course; if death were eventually to occur, it would be the result, primarily, of the underlying disease, and not the result of a self-inflicted injury"); *Bouvia v. Superior Court*, 225 Cal. Rptr. 297, 306 (Cal. App. 1986) (a "decision to allow nature to take its course is not equivalent to an election to commit suicide with . . . parties aiding and abetting therein"); *Brophy v. New England Sinai Hospital*, 497 N.E.2d 626, 635 n.29, 638 (Mass. 1986) ("the law does not permit suicide," which is distinguishable from the decision to remove life-sustaining treatment from a patient who is in a persistent vegetative state and unlikely to regain cognitive functioning); *Donaldson v. Van de Kamp*, 4 Cal.Rptr.2d 59, 63 (Cal. App. 1992) ("Here there are no life-prolonging measures to be discontinued. Instead, a third person will simply kill [the plaintiff]"). *See also* Edward R. Grant & Paul Benjamin Linton, *Relief or Reproach?: Euthanasia Rights in the Wake of Measure 16*, 74 Oregon L. Rev. 449, 465-66 n.59 (1995) (citing additional cases).

suicide is explicitly recognized by 45 state legislatures, including New York, and the District of Columbia, in the living will and power of attorney laws of these jurisdictions.[4]

The American Medical Association ("AMA") likewise recognizes a "fundamental difference between refusing life-sustaining treatment and demanding a life-ending treatment." AMA Council on Ethical and Judicial Affairs, *Report I-93-8*, at 2.[5] So do other medical associations.[6] To state the AMA position:

> When a life-sustaining treatment is declined, the patient dies primarily because of an underlying disease. The illness is simply allowed to take its natural course. With assisted suicide, however, death is hastened by the taking of a lethal drug or other agent. Although a physician cannot force a patient to accept a treatment against the patient's will, even if the treatment is life-sustaining, it does not follow

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[4] Edward R. Grant & Paul Benjamin Linton, *Relief or Reproach?: Euthanasia Rights in the Wake of Measure 16*, 74 Oregon L. Rev. at 462-3 (listing statutes).

[5] Individual health care professionals understand the difference as well, with 87% of physicians and nurses in a recent study agreeing that "to allow patients to die by forgoing or stopping treatment is ethically different from assisting in their suicide." Mildred Z. Solomon, *et al., Decisions Near the End of Life: Professional Views on Life-Sustaining Treatments*, 83 Am. J. of Pub. Health 14, 17-18 (Jan. 1993).

[6] The World Medical Association, American Nurses Association, National Hospice Organization, American Geriatrics Society, Canadian Medical Association, and British Medical Association oppose physician-assisted suicide. Edward R. Grant & Paul Benjamin Linton, *Relief or Reproach?: Euthanasia Rights in the Wake of Measure 16*, 74 Oregon L. Rev. at 469 n.70; Leah L. Curtin, *Nurses Take a Stand on Assisted Suicide*, 26 Nursing Management 71 (May 1995); Bill Wallace, *The Right to Die Rightly*, 3 Hospice 10-11, 28 (Summer 1992). According to the National Hospice Organization's position statement: "Euthanasia is different in kind, not degree, from treatments that allow death to occur or even those which unintentionally hasten it." Wallace, *supra* at 11.

> that a physician ought to provide a lethal agent to the patient. The inability of physicians to prevent death does not imply that physicians are free to help cause death.

*Id.* The Second Circuit's elimination of this distinction therefore overrides not only a legislative judgment but the medical profession's own longstanding ethical judgment, thus undermining the profession's "unqualified opposition to physician-assisted suicide." Brian McCormick, *Continued Opposition: House Refuses to Open Door on Physician-Assisted Suicide*, Am. Med. News, Dec. 20, 1993, at 7; American Medical Association Press Release, "AMA Soundly Reaffirms Policy Opposing Physician-Assisted Suicide" (June 25, 1996).

The American Bar Association's Commission on Legal Problems of the Elderly also recognizes that decisions to refuse treatment are "legally and ethically distinct" from decisions to provide "a lethal agent with the intentional purpose of terminating life." American Bar Association ("ABA"), Commission on Legal Problems of the Elderly, Memorandum of Jan. 17, 1992, *reprinted in* 8 Issues in Law & Med. 117, 118 (Summer 1992). Assisted suicide, as one commentator on the law has observed, "involves not letting the patient die, but making the patient die. . . ." Stephen L. Carter, The Culture of Disbelief 236 (1993).[7]

Like the AMA, ABA, and countless courts, New York knows (and argued below) that there is a material difference between declining medical treatment and assisting a suicide. In 1994, a 25-member Task Force on Life and the Law appointed by the Governor of New York concluded that the distinction was one of many reasons for retaining the existing New York ban on assisted suicide. The Task Force wrote:

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[7] *See also* Robert Byrn, *Compulsory Lifesaving Treatment for the Competent Adult*, 44 Fordham L. Rev. 1 (1975) ("suicide means something quite different in the law" from refusing lifesaving treatment).

> As . . . courts have recognized, the fact that the refusal of treatment and suicide may both lead to death does not mean that they implicate identical constitutional concerns. The imposition of life-sustaining medical treatment against a patient's will requires a direct invasion of bodily integrity and, in some cases, the use of physical restraints, both of which are flatly inconsistent with society's basic conception of personal dignity. . . . It is this right against intrusion—*not a general right to control the timing and manner of death*—that forms the basis of the constitutional right to refuse life-sustaining treatment. Restrictions on suicide, by contrast, entail no such intrusions, but simply prevent individuals from intervening in the natural process of dying.

New York State Task Force on Life and the Law, When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context 71 (1994) (emphasis added).

The distinction between declining treatment and assisting suicide is likewise supported by reason. There are at least four critical differences. Assisted suicide (1) does not implicate the interest in being free of bodily invasion, an interest that is central to the refusal of medical treatment, (2) has been consistently criminalized under the common law and by statute, (3) does not involve death from natural causes, and (4) involves a direct and unambiguous intention to cause death. *Any one of these differences is sufficient* to demonstrate the rationality of the distinction.

### A. Assisted Suicide Does Not Implicate the Interest in Being Free of Bodily Invasion.

The interest of a competent adult in being free of bodily invasion at the hands of another has been a mainstay of English and American law for centuries. The law protects this interest by imposing a duty upon everyone to refrain even from touching another, absent his or her consent. Doctors who violate this duty by administering medical treatment to unwilling patients are subject to civil damages, even if the treatment might have been thought

beneficial or life-saving to the patient. *E.g., Matter of Storar,* 420 N.E.2d at 71 (New York imposes "civil liability on those who perform medical treatment without consent, although the treatment may be beneficial or even necessary to preserve the patient's life"). An assisted suicide, by contrast, posits a right to *insist* upon a bodily invasion—one so radical that it invariably and deliberately causes death.

It was precisely the interest in being free of bodily invasion—not any right to self-destruction—that was at issue in *Cruzan v. Director, Missouri Department of Health,* 497 U.S. 261 (1990). In deciding that Missouri could require clear and convincing evidence of an incompetent patient's past wishes before allowing the discontinuation of artificially administered nutrition and hydration, this Court observed that a liberty interest "in *refusing unwanted medical treatment* may be inferred from our prior decisions." *Cruzan,* 497 U.S. at 278 (emphasis added); *id.* at 279 (petitioner claimed that "the forced administration of life-sustaining medical treatment . . . would implicate a competent person's liberty interest"); *id.* at 287 (O'Connor, J., concurring) ("I agree that a protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions"). As Justice O'Connor observed, the liberty interest in refusing medical treatment "flows from decisions involving the State's invasions into the body." 497 U.S. at 287 (O'Connor, J., concurring). It was "state incursions into the body," Justice O'Connor wrote, that were repugnant to the Due Process Clause. *Id.*[8] At the same time, this Court recognized that

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[8] Other decisions of this Court also recognize the interest in being free of bodily invasion. *Washington v. Harper,* 494 U.S. 210, 221-22 (1990) (liberty interest in avoiding the unwanted administration of anti-psychotic drugs); *Jacobson v. Massachusetts,* 197 U.S. 11, 24-30 (1928) (liberty interest in declining an unwanted smallpox vaccine is outweighed by the common good); *Rochin v. California,* 342 U.S. 165, 172 (1952) ("forcible extraction of . . . stomach's contents" in criminal search offends due process);

> As a general matter, the States—indeed, all civilized nations—demonstrate their commitment to life by treating homicide as a serious crime. Moreover, the majority of States in this country have laws imposing criminal penalties on one who assists another to commit suicide.

*Id.* at 280. The fact that one may forego medical treatment "even if" treatment might have prolonged life suggests how misleading it is to speak of a "right to die." Patients have a right to refuse treatment *despite* the fact that treatment might have extended their lives, not *because* the refusal will shorten their lives.

The difficulty in speaking of a "right to die" or a "right to hasten death" is also demonstrated by the relation between the principle of informed consent and the overarching aim of tort law to protect people from harm. The principle of informed consent historically provided a remedy for people who were injured when their physicians failed to adequately disclose relevant risks and dangers, or failed to obtain any consent at all, before carrying out a medical procedure. This was the foundation of the common law principle of informed consent.

> Ordinarily, where the patient is in full possession of all his mental faculties and in such physical health as to be able to consult about his condition without the consultation itself being fraught with dangerous consequences to the patient's health, and when no emergency exists making it impracticable to confer with him, it is manifest that his consent should be a prerequisite to a surgical operation.

*Pratt v. Davis*, 79 N.E. 562, 564 (Ill. 1906). That the principle of informed consent is grounded in concern for the preservation of bodily health is evident from its exceptions. When its application does not serve the goal of preserving life and health, the principle of informed consent may give way to exceptions that will. This occurs,

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*Winston v. Lee*, 470 U.S. 753, 759 (1985) ("compelled surgical intrusion into an individual's body for evidence" implicates the Constitution).

for example, (1) when, in an emergency, immediate remedial treatment must be undertaken to preserve the patient's life or health and the patient's decision on the treatment cannot be obtained, or (2) when it is apparent that full disclosure regarding the proposed treatment or procedure will only harm the patient's health. *Canterbury v. Spence*, 464 F.2d 772, 788-89 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); *Pratt v. Davis*, 79 N.E. at 564; *see Schloendorff v. Soc. of N.Y. Hosp.*, 105 N.E. 92 (N.Y. 1914). That patients may refuse treatment (over the objection of a physician who believes treatment would be beneficial) is simply a corollary of the rule that the patient has ultimate responsibility to decide the direction of his or her health care. That the power to resolve disagreements about whether to accept health care resides with the patient does not mean that the patient has a constitutional right to obtain from a physician something which is the very antithesis of health care—the means of inflicting deadly self-harm.

### B. Assisted Suicide Has Consistently Been Treated as a Criminal Offense Under English and American Law.

As the Second Circuit itself observed, it cannot be said that a right to assisted suicide is rooted in the nation's traditions or history:

> Indeed, the very opposite is true. The Common Law of England, as received by the American colonies, prohibited suicide and attempted suicide. Although neither suicide nor attempted suicide is any longer a crime in the United States, 32 states, including New York, continue to make assisted suicide an offense. Clearly, no "right" to assisted suicide ever has been recognized in any state in the United States.

*Quill v. Vacco*, 80 F.3d 716, 724 (2d Cir. 1996) (citations omitted). Today a "majority of States in this country have laws imposing criminal penalties on one who assists another to commit suicide." *Cruzan v. Director, Missouri Department of Health*, 497 U.S. at 280. In re-

cent years, in fact, that number has increased. In 1996, Iowa and Rhode Island joined the ranks of states with specific statutes against assisting a suicide.[9] Since 1994, at least seventeen states have considered and rejected proposals to legalize assisted suicide.[10]

"American law has always accorded the State the power to prevent . . . suicide," let alone assisted suicide. *Cruzan*, 497 U.S. at 293 (Scalia, J., concurring). The right to decline medical treatment, by contrast, has a long pedigree in the common law and is recognized in every state.

### C. In an Assisted Suicide, Death Does Not Result From Natural Causes.

A patient's death by assisted suicide is caused not by any underlying disease, but by an intervening lethal act.

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[9] Iowa S.F. 2066, to be codified at Iowa Code § 707A.2 (Supp. 1996); R.I. Pub. Act 96-133, to be codified at R.I. Gen. Stat. tit. 11, ch. 60.

[10] Alaska, HB 371 (died in House State Affairs Committee, 1996); Arizona, S.B. 1007 (negative vote in Senate Health Committee, Jan. 1996); California, A. 1080 (withdrawn by sponsor in 1995) and A. 1310 (died without a hearing, Jan. 1996); Colorado, H.B. 1308 (tabled by House Committee on Health, Environment, Welfare and Institutions, Feb. 1995) and H.B. 1185 (defeated 7-to-4 in the same committee, Feb. 1996); Connecticut, S.B. 361 (died in committee, April 1995); Maine, L.D. 748 (rejected by House Judiciary Committee 10-to-3 and by full House 105-to-35, June 1996); Maryland, H.B. 933 (rejected by House Environmental Affairs Committee 15-to-4 in 1995) and H.B. 474 (rejected by same committee 16-to-5 in 1996); Massachusetts, H.B. 3173 (died in House Judiciary Committee, May 1995); Michigan, H.B. 4134 (died in committee, 1995); Mississippi, H.B. 1023 (died in House Judiciary Committee, 1996); Nebraska, L.B. 1259 (died in Judiciary Committee, 1996); New Hampshire, H.B. 339 (rejected by House of Representatives 256-to-90, Jan. 1996); New Mexico, S.B. 446 (tabled 6-to-1 by Senate Judiciary Committee, Feb. 1995); New York, S. 1683, S. 5024-A, A. 6333 (died without a hearing in 1995); Vermont, H.B. 335 (died in House Committee on Health and Welfare, 1995); Washington, S.B. 5596 (died in committee, March 1995); Wisconsin, S.B. 90 and A.B. 174 (died in committee).

If, for example, a doctor does not put a patient on a respirator or feeding tube because the patient has decided to forego such treatment, death may occur if the patient's disease or injury prevents adequate respiration or nutrition. But American courts have long recognized that what impedes the patient's ability to breathe or eat adequately on his or her own is the underlying disease, not an intervening act by the physician.[11]

On this point, the Second Circuit was simply mistaken. It wrote:

> [T]here is nothing "natural" about causing death by means other than the original illness or its complications. The withdrawal of nutrition brings on death by starvation, the withdrawal of hydration brings on death by dehydration, and the withdrawal of ventilation brings about respiratory failure. By ordering the discontinuance of these artificial life-sustaining processes or refusing to accept them in the first place, a patient hastens his death by means that are not natural in any sense. It certainly cannot be said that the death that immediately ensues is the natural result of the progression of the disease or condition from which the patient suffers.

80 F.3d at 729. The court's analysis is faulty and, not surprisingly, the court offered no supporting authority. "Nat-

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[11] Again, New York law on this point is clear. *Delio v. Westchester County Medical Center*, 516 N.Y.S.2d 677, 692 (N.Y. S. Ct. 1987) (death following withdrawal of a patient's feeding tube "will be the end result of his inability to chew and swallow spontaneously and not the result of a self-inflicted injury"). *See also Matter of Conroy*, 486 A.2d 1209, 1226 (N.J. 1985) (death following removal of feeding tube "would result, if at all, from [the patient's] underlying medical condition, which included her inability to swallow"); *In re Estate of Longeway*, 549 N.E.2d 292, 296 (Ill. 1989) (withdrawal of feeding tube "does not deprive the patient of life; rather the inability of the patient to chew or swallow, as a result of his illness, is viewed as the ultimate agent of death"); *In re Gardner*, 534 A.2d 947, 955-56 (Me. 1987) (patient's death following removal of feeding tube is caused by "his accident and his resulting medical condition, including his inability to ingest food and water").

ural" means "produced or existing in nature, not artificial or manufactured." Webster's New World Dictionary 903 (3d College ed. 1988). A respirator or feeding tube is an *artificial* or manufactured device that is intended to overcome a *natural* incapacity to breathe or eat adequately on one's own. Thus, the law recognizes that one who dies because of a natural incapacity to breathe or eat adequately dies of natural causes.

A death that may or may not *follow* after a patient's refusal of ventilator assistance,[12] for example, is plainly different from a death that is *caused* by placing a pillow over a patient's face and deliberately smothering him (even if he consents). The first is natural, for in that case one dies because of a disease or injury that was not brought on by the physician's intervention.[13] Strangling

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[12] Of course, death does not always occur following the removal of a respirator or feeding tube. For example, Karen Ann Quinlan lived for nine years after her respirator was removed. Yale Kamisar, *The Real Quinlan Question Lives On*, Minneapolis Star Tribune, June 18, 1985. Likewise, a patient capable of ingesting even small amounts of food or water on his or her own may continue to live. Ronald E. Cranford, *The Persistent Vegetative State: The Medical Reality (Getting the Facts Straight)*, 18 Hastings Center Report 27, 28, 31 (Feb./March 1988).

[13] *McKay v. Bergstedt*, 801 P.2d 617, 627 (Nev. 1990) (refusing medical intervention merely allows the disease or effects of an injury to take its natural course); *Matter of Conroy*, 486 A.2d 1209, 1224 (N.J. 1985) (assisted suicide is different from refusing medical intervention because the latter "merely allows the disease to take its natural course"); *Brophy v. New England Sinai Hospital, Inc.*, 497 N.E.2d 626, 638 (Mass. 1986) (death following refusal of medical intervention "merely allows the disease to take its natural course"); *McConnell v. Beverly Enterprises-Connecticut, Inc.*, 553 A.2d 596, 605 (Conn. 1989) ("death [following removal of feeding tube] will be by natural causes underlying the disease, not by self-inflicted injury"); *Bartling v. Superior Court*, 209 Cal.Rptr. 220, 225 (Cal. App. 1984) (disconnection of respirator merely allows "death by natural causes"); *In re Browning*, 568 So.2d 4, 14 (Fla. 1990) ("suicide is not an issue when . . . the discontinuation of life support 'in fact will merely result in death, if at all, from natural causes'") (citation omitted), *aff'd*, 379 So.2d 359 (Fla. 1980); *Leach v. Akron Gen. Medical Ctr.*, 426 N.E.2d 809, 815 (Ohio Ct.

or poisoning a patient, on the other hand, even if he consents, is not by any means natural. One must therefore reject the Second Circuit's conclusion that withholding or withdrawing medical treatment is an "unnatural" cause of death.

To hold otherwise leads to absurd results. In most cases of illness, some form of modern medical technology could be found which may briefly extend life.[14] If a failure to initiate or continue such technology cannot rationally be distinguished from causing an "unnatural" death, then there is no such thing as death by "natural" causes.[15] Or rather, the *only* "natural" death would be one in which every possible *artificial* life-sustaining treatment was aggressively maintained but unable to delay death.

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Common Pleas 1980) ("Withdrawal of a respirator . . . allows the processes of nature to run their course"); *In re Colyer*, 660 P.2d 738, 743 (Wash. 1983) ("A death which occurs after the removal of life sustaining systems is from natural causes"); *Superintendent of Belchertown v. Saikewicz*, 370 N.E.2d 417, 426 n.11 (Mass. 1977) (in case of withdrawing treatment, "the cause of death [is] from natural causes"); *Matter of Quinlan*, 355 A.2d at 669-70 (death following withdrawal of medical treatment "would not be homicide but rather expiration from existing natural causes").

[14] One commentator has noted that "where humans were once helpless onlookers in the presence of death, we are now increasingly able to intervene in the process, using technological resources to direct or delay the inevitable." Robert M. Veatch, Death, Dying, and the Biological Revolution 2 (Yale Univ. Press. 1989).

[15] The Second Circuit is on solid ground, however, in treating the withholding and withdrawal of treatment as similar. To establish a special obligation to continue treatment once begun would have "serious adverse consequences" for many patients. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Deciding to Forego Life-Sustaining Treatment: A Report on the Ethical, Medical, and Legal Issues in Treatment Decisions 75 (March 1983). For example, physicians would fail to offer or initiate many potentially beneficial treatments if there were a chance that treatment might later become futile or burdensome, thus placing them in an impossible ethical and legal situation.

### D. Assisted Suicide Involves an Intention to Cause Death.

If a patient should die after refusing treatment, the attending physician is not liable for homicide for he or she did not intend death. When a doctor accedes to a patient's request to provide the means of committing suicide, however, death is always the intention. *Matter of Storar,* 420 N.E.2d 64, 71 (N.Y. 1981) (doctor cannot be held criminally liable "when he honors the right of a competent adult patient to decline medical treatment"). The absence of a deadly intention in the former case is most obvious when treatment is merely *withheld* at the patient's request rather than provided to the patient and then later *withdrawn.* In withholding treatment, a physician need not "intend" anything, for he or she has not acted at all, lacking authorization from the patient to do so. His or her intention is simply to respect the patient's informed decision to decline medical treatment, as the physician legally must. But the absence of a deadly intention is also clear when treatment is withdrawn. When, for example, a patient unexpectedly survives following withdrawal of life-sustaining treatment, families and courts do not then seek a way of ensuring the patient's death, for that was not the intention.[16] Rather, the intent was simply to discontinue a treatment considered to be futile, invasive, or burdensome.[17]

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[16] *Karen Ann Quinlan Still Lingers On,* Newsweek, March 3, 1980, at 14 (parents' only intent was to forego one invasive procedure).

[17] By contrast, the intent to ensure death is absolutely clear in assisted suicide. Some proponents, conceding that attempts to commit suicide by orally ingesting drugs may sometimes fail to achieve that result, have declared that the law should also authorize lethal injections so that a physician can always be standing by "to administer the *coup de grace* if necessary." D. Humphry, *Oregon's Assisted Suicide Law Gives No Sure Comfort to Dying,* N.Y. Times, Dec. 3, 1994, at 22 (letter to the editor). The Ninth Circuit accommodated this concern by refusing to find any "principled distinction" between assisted suicide and active euthanasia. *Compassion in Dying v. State of Washington,* 79 F.3d 790, 831 (9th Cir. 1996).

A request to withdraw treatment generally involves a judgment by that patient about the positive and negative effects *of that particular treatment* on that patient in light of his or her ability to benefit from it and endure its burdens. "Both as a matter of law and as a matter of medical ethics, the right to refuse unwanted medical intervention is properly seen not as part of a right to become dead but rather of a *right protecting how we choose to live,* even while we are dying." Leon Kass, *Dehumanization Triumphant,* 65 First Things 16 (August/Sept. 1996). For example, in rejecting a final round of chemotherapy, the effectiveness of which is in doubt, a cancer patient chooses how to spend the rest of his or her life (*e.g.,* in relative comfort, at home with family), not that he or she is better off dead. By contrast, the clear purpose of assisted suicide is to cause the patient's death.

To be sure, there are extreme cases in which a refusal of treatment may seem tantamount to the implementation of a suicidal wish. It is precisely in such cases that the right to refuse treatment reaches its legal and logical limit, as noted by this Court. *Cruzan,* 497 U.S. at 279 (stating that the "dramatic consequences" involved in refusing artificially-delivered nutrition and hydration "would inform the inquiry as to whether the deprivation of that interest is constitutionally permissible").[18] At times such a decision can justify a judgment that the person is not fully competent and requires protection from self-harm. When the malicious intent to cause death is clear, even withdrawal of a respirator may be prosecuted as a

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[18] In recent years, an ethical debate has arisen as to whether medically assisted nutrition and hydration is best seen as a form of care generally owed to helpless patients. The Catholic moral tradition, in particular, opposes "euthanasia by omission"—that is, a withdrawal of sustenance or other basic support that disregards the benefits and burdens of a particular procedure and aims simply at ensuring the death of a patient. Sacred Congregation for the Doctrine of the Faith, *Declaration on Euthanasia* 8 (Boston: St. Paul Books 1980).

homicide.[19] But such cases are extreme and rare, and certainly do not render the general distinction between withdrawing treatment and assisting suicide either invalid or irrational. If there is any "twilight" in the category of decisions to decline medical treatment, it should not lead this Court to conclude that there is no difference between the day and night of declining treatment and assisting suicide.

Some argue that assisted suicide is indistinguishable from the depression of respiration that may be a side-effect of large dosages of pain control medication.[20] In fact, when dosages are properly calibrated to relieve pain, this side-effect is extremely rare,[21] if it occurs at all. Those

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[19] Linda Miller Terman, *Triple Murderer Gets Death Sentence*, The Washington Times, Oct. 17, 1995, at C3 (man sentenced to death for killing a disabled boy by disconnecting his respirator).

[20] According to the president-elect of the American Academy of Hospice and Palliative Medicine, that assertion is "out of touch with biologic and pharmacologic reality" because morphine given to control pain "simply does not hasten someone's death." Diane M. Gianelli, *Assisted Suicide or Pain Relief?: Recent Court Rulings Discount Age-Old Ethical Distinction*, American Med. News, July 1, 1996, at 3.

[21] "Addiction among patients who receive narcotics for pain is exceedingly unlikely; the incidence is probably no more than 0.1 percent . . . . The incidence of serious respiratory depression in patients who receive narcotics for pain is similarly low. As tolerance develops to the analgesic effects of narcotics, so it does to respiratory effects. No more than 1 percent of patients who receive narcotics for pain develop serious respiratory depression." Marcia Angell, *The Quality of Mercy*, 306 New Eng. J. Med. 99 (Jan. 14, 1982). *See also* American Pain Society, Principles of Analgesic Use in the Treatment of Acute Pain and Cancer Pain 23 (3d ed. 1992) ("[R]espiratory depression is rare in patients who have been receiving chronic opioid treatment"); Michael H. Levy, *Pharmacologic Treatment of Cancer Pain*, 335 New Eng. J. Med. 1124, 1129 (Oct. 10, 1996) ("Appropriate titration of the opioid dose rarely results in respiratory depression or cardiovascular collapse"); E. Cassidy, *et al.*, *As Life Ends: Professional Care Givers on Terminal Care and Euthanasia*, in I. Gentles, ed., Euthanasia and Assisted Suicide: The Current Debate 52 (Stoddart 1995) ("[I]t is well

very rare cases in which pain medication may risk an earlier death from respiratory depression are distinguishable from assisted suicide because the intent in administering these drugs is not to cause death, but to relieve pain. In the very unlikely event that death may occur, it is an *unintended* consequence, not the intended result. Assisted suicide and euthanasia, on the other hand, involve an intention to cause death. Thus, a doctor who suddenly administers a massive dose of barbiturates with the *intention* of causing death is liable for a homicide.[22] On the other hand, a doctor who administers medication only with the intention of relieving pain and whose conduct is not reckless, would not be liable for a homicide if death occurs any more than he or she would be criminally liable under the same conditions if death resulted from a risky surgery.[23]

The difference between intention and foreseeability is central to our system of criminal and civil law:

> The distinction between what is intended and what is not intended but brought about as a side-effect is

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known by practitioners in the field of terminal care that deaths from narcotics are extremely rare in terminal patients").

[22] Michael Berry, *Doctor Found Guilty in Patient's Death*, The Wichita Eagle, Jan. 27, 1996, at 1A; Robert D. McFadden, *Hospital Patient's Fatal Overdose is Ruled a Homicide*, N.Y. Times, July 2, 1993, at B3; *Nurse Pleads Guilty to Killing Three Patients*, N.Y. Times, Apr. 10, 1992, at A23; *Nurse's Death Sentence Upheld*, American Med. News, Sept. 14, 1992, at 2; *Nurse's Aide Gets 20 to 40 Years for Helping Kill Elderly Patients*, The Washington Times, Oct. 2, 1989, at A-7.

[23] This analogy to potentially life-saving surgery is especially valid in light of modern medical knowledge that unrelieved pain can itself weaken a patient and even undermine his or her immune system, thus hastening death. A "new development" in the field of pain management is "the idea of killing pain before it kills the patient." Marsha F. Goldsmith, *Pain Speaking—And Anesthesiologists Answer*, 267 J. of the Am. Medical Association 1578 (March 25, 1992). "Unrelieved agony will shorten a life more surely than adequate doses of morphine." Catholic Health Association, Care of the Dying: A Catholic Perspective 30 (1993).

> at the basis of the vast modern law of tortious liability in negligence; it is the focus, too, of the criminal law's long accepted distinction between murder and manslaughter. As those facts suggest, it is not the esoteric preserve of some sectarian moral teaching, but a morally significant distinction which is intrinsic to practical reasonableness.[24]

The Second Circuit's decision is based on the radical notion that the intended/unintended distinction is not a meaningful one, a notion that this Court should resoundingly reject.

## III. NEW YORK HAS A RATIONAL BASIS FOR APPLYING ITS UNIFORM PROHIBITION OF ASSISTED SUICIDE TO PERSONS WHO ARE TERMINALLY ILL.

New York acted rationally in prohibiting assisted suicide for persons in the final stages of a terminal illness who are not on life support, just as it does in prohibiting such assisted suicide generally. Conceptualizing clearly the category of persons who are in the "final stages of a terminal illness but not receiving life-sustaining treatment" is inherently problematic. That category would seem to encompass persons who *are* sick enough to be thought of as "terminally ill"—a term almost impossible to define in itself[25]—but *not* sick enough to require life-sustaining treatment. Curiously, none of the named terminally ill plaintiffs in this lawsuit appear to fall into the "protected" category, for all of them were receiving life-extending treatment which they could have declined but chose to accept. *Quill v. Vacco*, 80 F.3d at 720-21.

Furthermore, since the right to refuse medical treatment applies to everyone, it is unclear why the claimed "right" to assisted suicide would or could be confined to persons who are terminally ill. Indeed, this newly crafted

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[24] John Finnis, *Intention and Side-Effects*, in R.G. Frey and Christopher Morris, eds., Liability and Responsibility: Essays in Law and Morals 32 (Cambridge University Press 1991).

[25] *See* notes 26 and 27, *infra*.

"right" arguably creates a new quagmire of equal protection problems, *Lee v. Oregon*, 891 F. Supp. 1429 (D. Or. 1995), *appeal pending*, No. 95-35804 (9th Cir.), and may also violate other laws, including the Americans with Disabilities Act. *Lee v. Oregon*, 869 F. Supp. 1491 (D. Or. 1994) (preliminary injunction).

Finally, as experience has taught, there is no clear-cut definition of terminal illness,[26] and even if there were, such diagnoses are notoriously inaccurate.[27] As this Court has observed, "it is often impossible to identify a patient as terminally ill except in retrospect. . . . Even critically ill individuals may have unexpected remissions and may respond to conventional treatment." *United States v. Rutherford*, 442 U.S. 544, 556-57 (1979) (upholding federal regulations restricting use of unsafe drugs by terminally ill patients and noting the particular vulnerability of such patients to "resourceful entrepreneurs" peddling such drugs).

Even if these several difficulties could be surmounted, the Second Circuit's analysis of the rationality of New York's prohibition of assisted suicide is seriously flawed. Empirically there is no rational relationship among (a) terminal illness, (b) suicide requests, and (c) pain. Most people who request or attempt suicide are not terminally ill.[28] The vast majority of people who are terminally ill

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[26] "[S]eventeen years of experience with State Living Will statutes that have used 'terminal condition' as a prerequisite to patient directives have demonstrated that 'terminal' lacks any truly objective, operational definition. The terminal requirement is an . . . unworkable requirement." American Bar Association, Commission on Legal Problems of the Elderly, Memorandum of January 17, 1992, *reprinted in* 8 Issues in Law & Med. 117 (Summer 1992).

[27] Joanne Lynn, *et al., Defining the "Terminally Ill": Insights from SUPPORT*, 35 Duq. L. Rev. 311 (1996); Eric Chevlen, *The Limits of Prognostication*, 35 Duq. L. Rev. 337 (1996).

[28] "The major studies all agree in showing that the fraction of suicide victims struggling with a terminal illness at the time of their death is in the range of 2% to 4%." David Clark, *"Rational"*

do not request or attempt suicide for any reason.[29] In the vast majority of cases, people who request suicide—terminally ill or not—do so for reasons other than pain.[30]

Thus, there is no reasonable correlation among these three categories of terminal illness, pain, and suicide requests. Even if there were, suicide would *not* be a rational answer to the problem of pain. The reasonable response to human needs or problems is to address the need or the problem, *not to destroy the person.* Suicide is neither a "solution" to a problem, nor a "benefit"; it takes away the one good—life itself—that makes all other goods possible. Death itself is not a benefit or a "right," but simply a fact of the human condition. Life, however, *is* a right. U.S. Const., amend. 14 (no state shall deprive any person of life without due process of law). It is, according to the Declaration of Independence, an inalienable right.

Moreover, for terminally ill patients who are in pain, the choice is not the specious one between death and the "continuation of agony" (80 F.3d at 370) that the Second Circuit posits.[31] The president-elect of the American

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*Suicide and People with Terminal Conditions or Disabilities*, 8 Issues in Law & Med. 151 (Fall 1992). Two major studies suggest that more people commit suicide under the *mistaken* belief that they have cancer than commit suicide and really have cancer. *Id.* at 159.

[29] *Id.* at 160-61; *see also* Ezekiel J. Emanuel, *et al.*, *Euthanasia and Physician-Assisted Suicide: Attitudes and Experiences of Oncology Patients, Oncologists, and the Public*, 347 The Lancet 1805 (June 29, 1996).

[30] A 1990 study showed that in the Netherlands, the only Western nation currently to permit euthanasia, pain was the only reason for requesting euthanasia in only 10 of 187 cases, and a contributing factor in less than half of the cases. P.J. van der Maas, *et al.*, *Euthanasia and Other Medical Decisions Concerning the End of Life* 44 (Elsevier Science Publishing 1992).

[31] The same unfounded and uninformed negative assumptions about persons who are terminally ill appear throughout the Ninth Circuit's opinion in *Compassion in Dying*. Such persons, the Ninth

Academy of Hospice and Palliative Medicine emphatically writes:

> As a doctor who has been involved in hospice care for more than 14 years, I can state without equivocation that the physical sources of suffering associated with dying all can be controlled. Most often, such symptoms as pain, shortness of breath and nausea, yield to routine evaluation and straightforward interventions. Even the pain of end-stage cancer commonly can be managed with oral medications. In a small percentage of cases, pain or other bothersome symptoms do require advanced interventions. Rarely, sedation is required to effectively alleviate pain, breathlessness or terminal agitation.
>
> Symptom management is not always easy. Effective therapy may require the efforts of a physician with special interest in palliative medicine and a team of hospice-trained nurses, consultant pharmacists and others. Yet I want to state again clearly that in *all* cases the physical distress of the dying can be controlled.

Ira Byock, *Kevorkian: Right Problem, Wrong Solution*, The Washington Post, January 17, 1994, at A23 (original emphasis). Pain medication is available even in the end stages of cancer.[32] Experts agree that unmanaged pain is generally due not to the unavailability of effective pain relief, but to the failure of health care providers to learn and use available techniques. New York State Task Force on Life and the Law, *supra* at 43-44. These tech-

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Circuit supposed, face a "painful, undignified and inhumane ending to their lives," 79 F.3d at 810, are "reduced at the end . . . to a childlike state of helplessness, diapered, sedated, incontinent," *id.* at 814, and "can only be maintained in a debilitated and deteriorating state." *Id.* at 821. It is as if the court had decided that making demands upon one's community ("a childlike state of helplessness") or losing certain bodily functions ("diapered . . . incontinent") make life unworthy of being lived.

[32] "No patient with cancer needs to live or die with unrelieved pain." Michael H. Levy, *Pharmacologic Treatment of Cancer Pain*, 335 New Eng. J. Med. 1124 (Oct. 10, 1996).

niques are being more fully disseminated. *Id.* at 46-47. But such progress could be forestalled if physicians were licensed to facilitate a patient's suicide rather than ease his or her pain.

Permitting physicians to prescribe drugs so patients can take their own lives has an especially grotesque twist when contrasted with the Second Circuit's desire to relieve the dying of their "agony." Supporters of assisted suicide concede that in a large number of cases (25%) an intentional overdose of prescription medication does not result in an immediate death but only leaves the patient in *greater* agony than if suicide had not been attempted. A well-known advocate of assisted suicide has admitted that a law facilitating an overdose of such drugs could have "disastrous" consequences. D. Humphry, *Oregon's Assisted Suicide Law Gives No Sure Comfort to Dying*, New York Times, Dec. 3, 1994, at 22 (letter to the editor). Humphry relied upon a Dutch study in which over 20 out of 90 people given barbiturates by mouth "lingered as long as four days." *Id.* In "15 instances the doctor gave a lethal injection because the oral drugs were causing protracted suffering to the patient, the family, and himself." *Id.*[33] Thus, permitting physicians to prescribe lethal drugs for their patients may only create suffering, not relieve it, and lead physicians to take an even more active role in causing the deaths of their patients. *See also* American Association of Suicidology, *Report of the Committee on Physician-Assisted Suicide and Euthanasia*, 26 Suicide & Life-Threatening Behavior 15 (1996 Supp.) (patients attempting physician-assisted suicide by oral medication can choke to death on their own vomitus,

[33] Twenty-five percent of those who try to kill themselves with an oral overdose prescribed by a physician are "likely to experience a lingering death that could go on for hours, maybe days." M. O'Keefe, *Dutch Researcher Warns of Lingering Deaths*, The Oregonian, Dec. 4, 1994, at A1. Dutch physician and euthanasia practitioner Pieter Admiraal says that witnessing such a death presents an "agonizing dilemma" for relatives, who will be "tempted to suffocate loved ones by putting plastic bags over their heads" when the drugs do not work quickly enough. *Id.*

"experience terror, panic, or become assaultive" as a result of intoxication from the ingested drugs, or change their mind altogether and "beg for rescue").

Finally, there is no basis for the Second Circuit's claim (80 F.3d at 729-30) that New York has a "greatly reduced" interest in protecting the lives of sick people when the state prohibitions in question are against intentional acts of killing. Judicial decisions that speak of the state's interest in preserving life as being "reduced" or "weakened," including *Quinlan*, concerned disputes about the extent to which the state could insist on affirmative efforts to prolong life despite a patient's wish to be free of unwanted medical treatment and physical intrusions. It was in *that* context that *some* courts considered the state's interest in actively prolonging life to be less serious *when weighed against the patient's wishes to be free of unwanted treatment. See, e.g., Matter of Quinlan*, 355 A.2d at 664 ("We think that the State's interest . . . weakens and the individual's right to privacy grows *as the degree of bodily invasion increases* and the prognosis dims") (emphasis added). In fact, even in the withdrawal of treatment context, this Court has completely rejected the notion that the state must have a "reduced interest" in protecting a person's life, or that this interest fluctuates with the patient's health. The state may assert "an *unqualified* interest in the preservation of human life"—that is, an interest that does not vary with the person's health condition or "quality of life." *Cruzan*, 497 U.S. at 282 (emphasis added). If, as this Court declared in *Cruzan*, the interest in protecting life is *unqualified*, then it cannot at the same time be "greatly reduced" even when the patient's medical condition is as debilitated as Nancy Cruzan's.

Moreover, any notion that the state has *less* interest in protecting a person's life against a lethal intervention when that person is very sick would itself do violence to the principle of equal justice under the law. It would mean that the law has a greater interest in protecting those who are "fit" and "healthy" than those who are sick and dependent. This is simply another way of saying that

(a) the state may decide in the first place whose life warrants greater or lesser protection (a dangerous proposition by any standard), and (b) as a matter of constitutional law, sick people, in particular, have lives less worth protecting than others. Such a governmental determination would be a direct assault on the fundamental equality and dignity of each and every person. Excluding people from the protection of the criminal law based on the condition of their health is an abdication of the Court's responsibility to ensure equal justice for all.[34] To graft such a result into the *Constitution* is simply unthinkable.

The New York State Task Force, *supra*, expressed grave reservations about the impact legalization of assisted suicide would have on those who lie on the fringes of society. The Task Force concluded that the poor and socially marginalized would most likely be pressured to resort to physician-assisted suicide if such conduct were legalized. These are precisely the people whom the Constitution was intended to protect from majoritarian impulses. Others have noted the disproportionate impact that legalization of assisted suicide would have on women.[35]

> In the United States more elderly women than elderly men are poor, widowed, live alone, suffer from chronic illness, and have limited access to medical insurance and family care. They would appear to be at great risk either to be pressured, or to feel pressured, into

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[34] The poor condition of a person's health does not remove criminal liability for his or her homicide. "The lives of all are equally under the protection of the law . . . to their last moment." *Cruzan*, 497 U.S. at 296 (Scalia, J., concurring), *quoting Blackburn v. State*, 23 Ohio St. 146, 163 (1873). In fact, under the federal sentencing guidelines, crimes against the sick and vulnerable warrant an *enhanced* sentence. United States Sentencing Commission, Guidelines Manual, Pt. A, ch. 3, § 3A1.1.

[35] Sidney Callahan, *A Feminist Case Against Self-Determined Dying in Assisted Suicide and Euthanasia*, 1 Studies in Pro Life Feminism 303-317 (Fall 1995); Nancy J. Osgood & Susan A. Eisenhandler, *Gender and Assisted and Acquiescent Suicide: A Suicidologist's Perspective*, 9 Issues in Law & Med. 361 (Spring 1994).

> suicide or euthanasia to relieve others of the financial and emotional burden of caring for them.

American Association of Suicidology, 26 Suicide & Life-Threatening Behavior at 9.[36]

Thus, far from bringing about equal justice under the law, the Second Circuit's decision creates a fundamental inequity in which citizens who are most socially and economically marginalized will be least protected from their own and others' deadly intentions. Our Constitution does not require such a tragic result.

## CONCLUSION

For the foregoing reasons, the judgment of the Second Circuit should be reversed.

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[36] Most of Jack Kevorkian's victims, for example, have been women. Suicide & Life Threatening Behavior, at 8-9. Because most physicians are men, and because men tend to have a more favorable view of suicide than women, there is a real danger that physicians will be "likely to take at face value a woman's request for assistance in death. . . ." *Id.* at 9.