Analysis and Commentary

Physician-Assisted Suicide and the Supreme Court: The *Washington* and *Vacco* Verdicts

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In June 1997, the Supreme Court decided that statutes proscribing physicians from providing lethal medication for use by competent, terminally ill patients do not violate the Due Process or Equal Protection Clauses of the Constitution. The Court returned the question of physician-assisted suicide to the states, but did not foreclose future review of state laws that may be too restrictive of care at the end of life. The conceptual distinctions between assisted suicide, refusal of life-sustaining treatment, and administration of pain medication to terminally ill patients were endorsed as important guideposts for future analyses.

In June 1997, the U.S. Supreme Court announced decisions in two cases addressing the controversial issue of physician-assisted suicide. Two appellate circuits, the Second and Ninth, had struck down state statutes in New York and Washington that prohibited assistance to those seeking to end their lives. The originators of the lawsuits included physicians, their gravely ill patients, and in Washington state, the nonprofit advocacy group Compassion in Dying. Prominent among the New York physicians was Timothy Quill, whose personal accounts of caring for terminally ill patients were now a seminal part of the debate surrounding assisted suicide.[1,2]

Against the backdrop of certain states passing laws against assisted suicide while others introduced legislation to legalize it, voters approving a death with dignity act in Oregon only to have it held up in district court, and juries refusing to convict retired pathologist Jack Kevorkian despite concerns with his methods, the Supreme Court was afforded an unprecedented opportunity to guide public discussion and set standards in this difficult area. Although few expected the Court to enumerate a previously unknown "right to die," prior decisions on marital privacy, contraception, and child-rearing offered fertile ground

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for rigorous commentary on the bounds of individual claims against society. The Court's logic and argumentation on physician-assisted suicide ultimately suggested an important set of guideposts for the ongoing debate. We examine each decision from the appellate level to the high court's response and place the reasoning in the context of the greater moral debate on physician-assisted suicide.

Ninth Circuit Decision: *Compassion in Dying v. State of Washington*

The ninth circuit, in finding Washington's statute unconstitutional,[3] concluded that there was a "constitutionally-protected liberty interest in determining the time and manner of one's own death, an interest that must be weighed against the state's legitimate and countervailing interests, especially those that relate to the preservation of human life" (at 793). The court identified certain oft-described state's interests as (1) preserving life, (2) preventing suicide, (3) preventing the influence of third parties, (4) protecting the interests of vulnerable populations, (5) protecting the integrity of the medical profession, and (6) protecting against adverse consequences (i.e., the "slippery slope"). However, after weighing the state's interests against the individual's liberty interest, the court concluded "by answering the narrow question before us: we hold that insofar as the Washington statute prohibits physicians from prescribing life-ending medication for use by terminally ill, competent adults who wish to hasten their own deaths, it violates the Due Process Clause of the Fourteenth Amendment" (at 793–794). Having decided the case on the grounds of substantive due process, the court did not address equal protection arguments raised at the district court level.

Circuit Judge Reinhardt in writing the *en banc* opinion drew on prior Supreme Court decisions in *Planned Parenthood v. Casey*[4] and *Cruzan v. Director*[5] to establish the overriding liberty interest. From *Casey*, the constitutional protection afforded to decisions in marriage, procreation, and child-rearing was construed as applicable to the "most intimate and personal choices a person may make," which by extension included the decision how and when to die. From *Cruzan*, the refusal of unwanted life-sustaining treatment was further construed as "necessarily recognizing a liberty interest in hastening one's death." The opinion also drew on a perceived parallel between refusal of nutrition and hydration and the "administration of pain-relieving medications that nonetheless induce death," arguing that both were permissible in modern practice. This blurring of distinctions between assisted suicide, refusal of medical treatment, and administration of pain medications to terminally ill patients would play an important role in the Supreme Court's response. The Supreme Court would have variable success in negotiating these definitional vagaries, however, despite rejecting the particular balancing approach undertaken by the circuit court.

Supreme Court Decision: *Washington v. Glucksberg*

Chief Justice Rehnquist responded to the decision of the ninth circuit.[6] Al-

though joined by Justices O'Connor, Scalia, Kennedy, and Thomas, the opinion drew separate concurring opinions from Justice O'Connor and the remaining justices, which provided a sense of where the Court might stand in different factual circumstances. Far from being an absolute ban on physician-assisted suicide or even an unanimous opinion, despite the nine to zero vote, the opinion allowed states to establish their own approaches and permitted a certain leeway in its discussion.

The Court's introductory description of the case offered a hint of what was to come. The Court began by noting that an 1854 act of Washington's first Territorial Legislature outlawed "assisting another in the commission of self-murder," and that promoting a suicide remains a felony under current state law. In a case in which definitions would ultimately determine the outcome, the Court was already telegraphing the legal and moral sanction that the term "murder" would affix to the question of physician-assisted suicide. The Court nonetheless succeeded in drawing a distinction between suicide and the withholding or withdrawing of medical treatment, finding language in Washington's Natural Death Act to clarify the point blurred by the court of appeals.

The body of the opinion began with an approach common to due process analyses: an examination of the nation's historical and legal traditions. Noting that assisted-suicide bans are not "innovations" but longstanding commitments by states to protect and preserve life, including treating homicide as a serious crime, the Chief Justice again juxtaposed assisted suicide and homicide, presaging his conclusion. Describing punishments for assisted suicide dating to the Colonial era, he traced a historical connection to this century's Model Penal Code that also prohibited "aiding" suicide and observed "interests in the sanctity of life." Although the Court would ultimately eschew making quality of life judgments, the historical review did little to address whether the sanctity of even poor qualities of life was preferable to having no life at all.

Bolstering the argument from tradition with evidence that the majority of states currently impose penalties for assisting suicide, the court invoked the Federal Assisted Suicide Funding Restriction Act of 1997 (P.L. 105–12, codified at 42 U.S.C. §14401 *et seq.*), which prohibited federal funds supporting physician-assisted suicide, to emphasize the nation's distaste for the practice. Although moral philosophers might argue, as did the appeals court, that tradition is not moral warrant, the Court could not be faulted for a time-honored approach consistent with its standing as a social institution grounded in precedent and legal tradition.

In fact, the Supreme Court cited work by a multidisciplinary panel, the New York State Task Force on Life and the Law,[7] to strengthen its view that the nation in general and the states in particular were already "engaged in serious, thoughtful examinations of physician-assisted suicide." The Task Force, composed of 24 religious, medical, and legal scholars, had published an opinion in May 1994 now quoted by the Court: "legalizing assisted suicide and euthanasia

would pose profound risks to many individuals who are ill and vulnerable. . . [T]he potential dangers of this dramatic change in public policy would outweigh any benefit that might be achieved" (at 2266).

The New York Task Force had fashioned its opinion not simply on broad theoretical argumentation but on a classic distinction in medical and legal ethics: the distinction between private acts and public policy. Whatever the disagreement surrounding an individual act of assisted suicide, a permissive public policy, they argued, would leave in place the undertreatment of physical pain, mental illness, and lack of communication at the end of life. Furthermore, those socially marginalized groups treated inequitably by current social biases would be at greatest risk from a new policy. Most medical care was not ideal, they reasoned, but flawed by the usual influences of bias, arbitrariness, and even financial incentive. Moreover, there was a slippery slope toward involuntary euthanasia, a slope already traveled by The Netherlands in its practice of permissive, but illegal, active voluntary euthanasia.* The Supreme Court would echo these arguments throughout the remainder of its decision.

The Court resumed its discussion with an acknowledgment that the Due Process Clause did indeed protect certain rights from state interference: the rights to marry, to have and rear children, to marital privacy, and to abortion, among others. The Court also noted that its decision in *Cruzan* "assumed, and strongly suggested, that the Due Process Clause protects the traditional right to refuse unwanted life-saving medical treatment." The Court expressed reluctance, however, to expand constitutional protection to new rights, thus precluding "public debate and legislative action." Traditional due process would be viewed as protecting rights rooted in the nation's history and implicit in the concept of liberty such that "'neither liberty nor justice would exist if they were sacrificed,'" a strict view indeed. In addition, the Court's own tradition lay in establishing a *threshold* requirement that state intervention implicate a fundamental right before embarking on the complex balancing of interests favored by the appeals court.

The Supreme Court would consequently underscore its disagreement with the ninth circuit by redefining the case before it not as a "right-to-die" case, with its attendant uncertainties of definition, but as a case of whether the liberty protected by the Due Process Clause included a "right to commit suicide which in itself includes a right to assistance in doing so." This was not the right to determine the time and manner of one's death described by the ninth circuit but a far more discerning and, ultimately, accurate focus.

Reading *Casey* and *Cruzan* as reflective of a "general tradition of self-sovereignty" was too broad, argued the high court. Nancy Cruzan's proxy request to withdraw life-sustaining treatment had been decided as a case of informed con-

*Dutch physicians are generally granted immunity from prosecution if they fulfill certain conditions and notify the coroner about euthanasia cases. These conditions include competent patient-initiated requests, unrelieved suffering, and consultation with a second physician.

sent and unlawful touching: physicians could be sanctioned for battery should they force medical treatment on unwilling and competent patients, regardless of context. As the New York Task Force would point out in its April 1997 revisitation of the case, "while patients who refuse treatment may become sicker, and sometimes will die, that result has always been regarded as an unavoidable *consequence* of applying the doctrine of informed consent consistently and without exception, not as a *reason* to recognize individuals' right to refuse treatment capable of prolonging life."[8] The Court stated unequivocally that a right to assisted suicide, although similarly related to the general principle of patient autonomy, could not conceptually or legally be equated with the right to refuse unwanted treatment.

Even *Casey*, which recognized that a woman's right to an abortion was a highly "intimate and personal choice. . . central to personal dignity and autonomy," could not be extended to assisted suicide. Although the decision how and when to die was among the most intimate and personal one might experience, it did not follow that *all* important, intimate, and personal decisions were protected by the Due Process Clause. The Supreme Court would argue that although the state's interests may wane as the individual's condition deteriorated, the states could decline to make quality of life judgments along a sliding scale. The Court held instead, as did Washington state, that all persons' lives, regardless of condition, were under protection of law. This refusal to apply a sliding scale of diminishing state dominion over personal decisions was in keeping with the qualitative distinction the Court was seeking to make between those refusing life-sustaining treatment and those seeking assisted suicide. Even the most intimate decisions could be open to state scrutiny under the right conditions. The Court would not be drawn into the morass of deciding which qualities of life were worth protecting, choosing instead to concentrate on the manner in which the two groups were conceptually distinct.

The degree of physician involvement in patient deaths is the downfall of most conceptualizations of assisted suicide. Whether physicians withdraw or withhold treatment (treatment refusal/passive euthanasia), provide the means for a patient to take her own life (assisted suicide), or inject consenting patients with medication (active voluntary euthanasia as tolerated in The Netherlands) determines the justifications used to construct the argument. These distinctions often become blurred as analysts attempt to tease apart whether discontinuing treatment is action or inaction, whether the result of intervention preserves life or prolongs dying, and whether intent is to kill or relieve suffering. The Supreme Court would, in *Washington*, simply agree with those who, even while recognizing similarities between the forms that death might take, find value in distinguishing them. Beauchamp,[9] for example, is among those who, although unconvinced of the ethical distinction between active and passive involvement in patients' deaths, believe that preserving the distinction remains socially useful. His argument, like

that of the New York Task Force, depends on social considerations and justifications similar to those the Court would now address.

Having distinguished a physician's obligation to respect a patient's right to refuse treatment from a physician's involvement in assisted suicide, the justices turned to the fundamental question of what otherwise hastening death would mean to the physician's role. Arguing that, as a matter of public health, patients with clinical depression or uncontrolled pain would be at greater risk under legalized physician-assisted suicide, the high court cited both conditions as well-established risk factors in requests for assisted suicide. In addition to invoking physicians' public health role, the Court revived a classic state interest in protecting the integrity and ethics of the medical profession. Here, the justices cited the Council on Ethical and Judicial Affairs of the American Medical Association who condemned assisted suicide as incompatible with the role of healer. Physician-assisted suicide, they reasoned, could "undermine the trust that is essential to the doctor-patient relationship by blurring the time-honored line between healing and harming." The Court did not rebut arguments from those like Task Force consultant Diane Meier[10] who argue that "the social costs of abandoning patients (costs such as loss of faith in doctors, acceptance of callousness toward the suffering of the dying, and fear of modern medical practice) far outweigh the costs of easing constraints on physician-assisted dying."

The Court agreed rather with the New York Task Force that vulnerable populations in particular would be at greater risk for subtle coercion at the end of life. The Task Force considered the risk of harm greatest for those "whose autonomy and well-being are already compromised by poverty, lack of access to good medical care, advanced age, or membership in a stigmatized social group."[7] Neither deliberative body addressed the concern that current practice leaves such coercion beyond the reach of regulatory scrutiny.

Finally, the Supreme Court looked down the slippery slope. Finding merit in the state's concern that assistance to commit suicide might not be limited to physicians, the Court cited reasoning by the ninth circuit that surrogate decision makers, family members, and loved ones had a constitutional right to assist incapacitated patients. This "expansive reasoning," a tactical error from the lower court, did not merely leave open the possibility of a slippery slope, but defined one explicitly. This, for the high court, provided "ample support for the State's concerns."

Data from The Netherlands would also serve to make the slippery slope argument. Citing the existence of cases in which patients were euthanized without explicit consent, the Court observed that a permissive policy of euthanasia had not been limited as originally intended: "regulation of the practice may not have prevented abuses in cases involving vulnerable persons, including severely disabled neonates and elderly persons suffering from dementia" (at 2258).

Yet the lesson of The Netherlands data is far from settled, as noted by Justice Souter in his concurring opinion. Data

regarding a possible slide from voluntary to involuntary euthanasia may not be predictive of one in assisted suicide, although the comparison appears inevitable. In fact, follow-up analysis by the Dutch government (and available to the Court) had shown that patients who did not give explicit consent fell into two categories: those who could not physically give consent, and consequently exercised their rights through a surrogate decision maker, and those whose wishes were known to physicians from prior discussions.[11] Whatever one's stance on physician-assisted suicide, this familiarity with patient wishes is in stark contrast to empirical data characterizing medical practice in the United States. The multicenter, multiyear Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT), for example, showed poor correlations among U.S. physicians and patients in knowledge of end-of-life wishes.[12–14] Furthermore, Dutch physicians who had participated in euthanasia were less, rather than more, willing to participate in a case again.[15] The Netherlands data, rather than supporting a wholesale unprincipled slide toward involuntary euthanasia could be interpreted as proper use of alternative decision makers and prior knowledge of patient wishes—weaknesses in current U.S. medical culture.

Concurring Opinions

Justice O'Connor's brief concurrence, joined by Justices Ginsburg and Breyer, echoed the five-justice majority that included her: there is no generalized right to commit suicide. O'Connor saw no need to address the narrower question of whether a competent person experiencing great suffering had a constitutional interest in controlling the circumstances of her imminent death. She explained that there was no legal barrier to obtaining medication that may in the course of treating pain cause unconsciousness or even death. Given this freedom, the state's interests were weighty enough to prohibit the broader practice of physician-assisted suicide.

Here, Justice O'Connor demonstrated the same logical conflation as the appeals court: since pain medications are available that may hasten death, there is a point of congruence between the two concepts. The position that relief for suffering, to the point of death, is available implies that the difference from physician-assisted suicide is one of degree rather than of kind—a departure from the perceived view of the two concepts. It is the distinction between primary and secondary effect that usually governs the use of pain medications at the end of life: where death is the foreseen but unintended secondary consequence of pain relief, it is permissible to administer potentially lethal doses. This principle of double effect, challenged by some for the small logical and ethical distance between the primary effect of relieving pain and the secondary effect of hastening death, as well as for the difficulty in ascertaining a physician's intent, remains a useful paradigm. It is not best used, as is often thought, as a practicable policy requiring reliable application, but rather as a tool for moral actors themselves to determine whether an action is ethically permissible.

In this view, it is not an argument from motivation (e.g., after all, how can others tell what motivates the physician in using large doses of pain medication?), but a reflective method for individuals to address deeper questions of intent and even character. A physician intending to act primarily to hasten death in an assisted suicide would consequently cross the line set by this principle. O'Connor's view of the relationship between pain control near death and physician-assisted suicide leaves the conflation with pain relief unresolved, while putting the weight of her opinion behind the plurality.

Justice Breyer, writing separately, was also influenced by the availability of palliative care at the end of life. The difficulties in obtaining pain relief, he argued, are for "institutional reasons or inadequacies or obstacles, which would seem possible to overcome, and which do *not* include a *prohibitive set of laws*" (emphasis in original; at 2312). Given that state laws do not infringe on administration of pain relief even to the point of coma, Breyer reasoned that the laws consequently did not infringe on "the core of the interest in dying with dignity." He did leave open, however, the possibility that the Supreme Court might revisit cases in which state laws did become too restrictive on end-of-life pain relief.

But Justice Breyer went even further. He would not reject the possibility of a specific "right to die with dignity," a right that would involve "personal control over the manner of death, *professional medical assistance* [emphasis added], and the avoidance of unnecessary and severe physical suffering—combined" (at 2311). It was unnecessary to enunciate the right at this point, however, because of the availability of pain control medications. Breyer appeared to be influenced by an ethics committee report from the English parliament indicating that the "number of palliative care centers in the United Kingdom where physician-assisted suicide is illegal, significantly exceeds that in The Netherlands, where such practices are legal" (at 2312). Leaving aside the incorrect assertion that physician-assisted suicide is legal in The Netherlands, this analysis still side-steps the question raised by the patients and their physicians: what of the competent requests of patients whose pain could not be controlled by available methods? Here, as in the O'Connor opinion, appeal to the availability of pain medications did not distinguish assisted suicide as a qualitatively different moral action.

Justice Stevens agreed that hastening death alone may legitimately be constitutionally protected in some situations. As in the Court's past assessment of state capital punishment cases, some applications of state statutes could ultimately be held unconstitutional. The "room for further debate" that remained could be viewed as a limit on state intrusions "on the right to decide how death will be encountered." Indeed, the state's interests in preventing abuse would not apply to individuals who were not victimized. Even the integrity of the medical profession could be preserved because patients may view their doctor's refusal to hasten death as an abandonment. This opinion, too, would not foreclose the possibility that in future some applications of the

state statute "may impose an intolerable intrusion on the patient's freedom."

A thread common to the five concurring opinions would be best articulated by Justice Souter. The sense that the democratic political process itself would strike the appropriate balance brought all the opinions into line. State legislatures, argued Souter, had superior resources and "more flexible mechanisms" for obtaining the facts necessary to resolve the controversy. Determining the danger of the putative slide toward involuntary euthanasia, the accuracy of assessments of terminality, and even the vulnerability of dying patients to the financial influences of managed care, would be premature. Souter too, in describing superior legislative competence for deciding the issue, would "not decide for all time that respondents' claim should not be recognized."

Second Circuit Decision: *Quill v. Vacco*

The second circuit court of appeals addressed both due process and equal protection arguments for physician-assisted suicide.[16] In this civil rights action under 42 U.S.C. Sec. 1983, physician plaintiffs, led by Timothy Quill, argued that the Fourteenth Amendment guarantees the liberty of competent terminally ill adults to make decisions about the end of their lives. They also argued that the Fourteenth Amendment guarantees the liberty of physicians to practice medicine consistent with their best professional judgment, including prescribing lethal medication for self-administration by competent, terminally ill patients. Furthermore, equal protection was denied because patients on life support could terminate treatment while non-life support patients could not similarly end their lives. The removal of life support resulting in death involved direct medical involvement, Quill argued, much like physician-assisted suicide.

The Court of appeals made a due process analysis similar to that of the Supreme Court in *Washington*. Protected rights with no textual support in the Constitution had to be such that liberty and justice would not exist without them. Moreover, they must be deeply rooted in the nation's history. Although privacy rights, for example, had been recognized by the Supreme Court, cases such as *Bowers v. Hardwick*[17] (upholding Georgia's sodomy laws) suggested for this court where the line should be drawn in protecting unenumerated rights. Following this kind of analysis, the second circuit would not identify physician-assisted suicide as a new fundamental right.

The second circuit did, however, find that the New York statute sanctioning physician-assisted suicide as second-degree manslaughter violated equal protection because it did not treat all competent persons equally. Citing *Schloendorff v. Society Hospitals*,[18] *Rivers v. Katz*,[19] as well as *Cruzan*, the court recognized the well-established right to refuse treatment. But, the second circuit observed, discontinuation of treatment hastened death "by means that are not natural in any sense" and requires removal of equipment and, often, administration of palliative drugs which may "contribute to death." This was "nothing more nor less than assisted

suicide." Here again was the conflation of refusing treatment, administering pain medications, and assisting suicide.

The court did argue persuasively that the criticism of The Netherlands' policy lay in the presumed move from voluntary toward involuntary euthanasia, whereas the present case involved assisted suicide. Indeed, the Dutch appeared to be moving back up the slippery slope (toward assisted suicide and away from active voluntary euthanasia) by requiring patients to self-administer lethal medication whenever possible.

Supreme Court Decision: *Vacco v. Quill*

Justice Rehnquist again delivered the opinion of the Supreme Court.[20] The Court observed that the Equal Protection Clause, although prohibiting states from denying equal protection of the laws, created no substantive rights. Indeed, as noted by the lower court, the New York statutes infringed no fundamental rights. Furthermore, even though specific laws may affect certain groups unevenly it did not follow that the law itself treated them differently: "*Everyone*, regardless of physical condition, is entitled, if competent, to refuse unwanted lifesaving medical treatment; *no one* is permitted to assist a suicide" (emphasis in original; at 2295).

Rehnquist's brief opinion maintained the conceptual distinction between withdrawing life-sustaining treatment and assisting suicide even more clearly than had the opinion in *Washington*. The distinction "widely recognized and endorsed in the medical profession and in our legal traditions" was based in "fundamental legal principles of causation and intent" and echoed mainstream views in bioethics and moral philosophy. Contrary to Quill's assertion, death after withdrawal of treatment follows a withdrawal or inaction and is usually ascribed to the underlying disease. Death in assisted suicide follows the provision of lethal medication—although, of course, the ultimate act is the patient's.[21, 22]

Intent again played a distinguishing role. A physician's intent in removing treatment is primarily to respect the patient's autonomy. Death would follow as the consequence of honoring informed consent doctrine, as argued by the New York Task Force.[8] The same is true, argued the Court, when a physician provides "agressive palliative care." Primary intent is not to kill but to relieve suffering. This is not the case in assisted suicide: "a doctor who assists a suicide, however, 'must, necessarily and indubitably, intend primarily that the patient be made dead'" (at 2299). Distinguishing the different forms of medical involvement at the end of life in this way corrected the conflations of the lower court and made the final logical distinctions side-stepped in *Washington*. Clarifying the distinctions between "killing and letting die" and "primary and secondary effect," as they are usually described, would set the argumentation of both decisions back into proper alignment. The Court's opinion concluded with the observation that New York mirrored most state legislatures in protecting rights to refuse treatment while including language that explicitly disapproved assisted suicide. This distinction was not "arbitrary" or "irrational," even if

the line between them was occasionally unclear. Indeed, the public policy interests served by the distinction had already been described to the Court's satisfaction in *Washington*.

Concurring Opinions

The separate opinions filed for *Washington* essentially served as concurrences for *Vacco*. Only Justice Souter abbreviated his opinion to reemphasize that although assisted suicide was not a fundamental right "at this time," the claims raised in the suits were of a "high degree of importance, requiring a commensurate justification." Furthermore, he did provide a fifth voice for distinguishing assisted suicide from termination of life support and administration of "death-hastening pain medication." Justice Stevens' opinion that intent and causation were not sufficient to distinguish the three concepts would stand in stark relief now against the analysis of the majority, as would Justice O'Connor's view that availability of pain medications obviated further legal discussion of assisted suicide.

Conclusions

The Supreme Court has decided that statutes proscribing physicians from providing lethal medication for competent, terminally ill patients do not violate the Due Process or Equal Protection Clauses of the Constitution. In returning the question of physician-assisted suicide to the states, however, the Court does not foreclose future review of state laws that may be too restrictive of care at the end of life. In choosing a conservative path among the available interpretations of language on the topic, the Court is in step with mainstream views hesitant to make broad policy changes in an area of unsettled opinion and scholarship. The conceptual distinctions between assisted suicide, refusal of life-sustaining treatment, and administration of pain medication to terminally ill patients are endorsed as important guideposts for future analyses.

References

1. Quill TE: "Doctor I want to die: will you help me?" JAMA 270:870–3, 1993
2. Quill TE: "You promised me I wouldn't die like this!" Arch Intern Med 155:1250–54, 1995
3. Compassion in Dying v. Washington, 79 F.3d 790 (9th Cir. 1996)
4. Planned Parenthood v. Casey, 505 U.S. 833 (1992)
5. Cruzan v. Director, Missouri Dept. of Health, 497 U.S. 261 (1990)
6. Washington v. Glucksberg, 117 S. Ct. 2258 (1997)
7. New York State Task Force on Life and the Law: When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context. New York: New York State Task Force on Life and the Law, 1994
8. New York State Task Force on Life and the Law: When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context (suppl. to report). New York: New York State Task Force on Life and the Law, 1997
9. Beauchamp TL: A reply to Rachels on active and passive euthanasia, in Ethical Issues in Death and Dying. Edited by Beauchamp TL, Perlin S. Englewood Cliffs, NJ: Prentice-Hall, pp 246–58, 1978
10. Meier DE: Physician-assisted dying: theory and reality. J Clin Ethics 3:35–7, 1992
11. Pijnenborg L, van der Maas PJ, van Delden JJM, Looman CWN: Life-terminating acts without explicit request of patient. Lancet 341:1196–9, 1993
12. Hofmann JC, Wenger NS, Davis RB, *et al*: Patient preferences for communication with physicians about end-of-life decisions. Ann Intern Med 127:1–12, 1997
13. Lynn J, Teno JM, Phillips RS, *et al*: Percep-

tions by family members of the dying experience of older and seriously ill patients. Ann Intern Med 126:97–106, 1997
14. Teno JM, Licks S, Lynn J, *et al*: Do advance directives provide instructions that direct care? J Am Geriatr Soc 45:508–12, 1997
15. van der Maas PJ, van Delden JJM, Pijnenborg L, Looman CWN: Euthanasia and other medical decisions concerning the end of life. Lancet 338:669–74, 1991
16. Quill v. Vacco, 80 F.3d 716 (2d Cir. 1996)
17. Bowers v. Hardwick, 478 U.S. 186 (1986)
18. Schloendorff v. Society of New York Hospitals, 211 N.Y. 125 (1914)
19. Rivers v. Katz, 67 N.Y. 2d 485 (1986)
20. Vacco v. Quill, 117 S. Ct. 2293 (1997)
21. Emanuel EJ: Euthanasia: historical, ethical, and empiric perspectives. Arch Intern Med 154:1890–1901, 1994
22. Wilson JW: Handbook for Hospital Ethics Committees. American Hospital Association, 1986