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The "Right to Die": Constitutional and Statutory Analysis

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September 19, 2005

Abstract. Exercising one or another of these "rights to die" may have drastically different legal consequences: some currently have no legal consequence, some are a violation of common-law, some are a violation of statute, some may have contractual consequences, some may result in an action such as civil confinement, some are currently protected by legislation, and some may be protected by the United States Constitution. This report examines the legal status of the five distinct issues: 1) suicide, 2) passive euthanasia, 3) assisted suicide, 4) active euthanasia, and 5) palliative care. The report examines the history of how each of these issues has been treated and evaluates the constitutional right of a person to pursue these courses of action. It addresses state law regarding living wills, advance medical directives, and how these types of decisions are made regarding persons who have left neither. The report addresses congressional powers and existing federal statutes that are implicated in these issues, such as the Patient Self-Determination Act, the Assisted Suicide Funding Restriction Act, and the Controlled Substances Act. It then addresses bills introduced in the 109th Congress, S. 539 and H.R. 1151, both entitled the "Incapacitated Persons Legal Protection Act of 2005;" a bill passed by the House, H.R. 1332, "The Protection of Incapacitated Persons Act of 2005;" a bill passed by the Senate, "For the Relief of the Parents of Theresa Marie Schiavo;" and a similar bill passed by the House and Senate, S. 686. This last bill was signed by the President and became P.L. 109-3. The report notes that current state regulations prohibiting assisted suicide have been upheld by the Supreme Court, and that similar prohibitions against active euthanasia are likely to be upheld against constitutional challenge. The Due Process Clause of the Fourteenth Amendment, however, appears to limit a state's ability to regulate passive euthanasia (termination of medical treatment). Finally, palliative care may ultimately be found to be protected by the Fourteenth Amendment, but the possible abuse of such care may raise policy concerns.

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Updated September 19, 2005

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Summary

In the spring of 2005, national attention was drawn to a series of court and legislative actions regarding the withdrawal of nutrition and hydration from a Florida patient, Theresa Schiavo, who had suffered severe brain damage. For a summary of relevant factual and legal events surrounding this case, see [<http://www.miami.edu/ethics2/schiavo/timeline.htm>] and CRS Report RL32830, *The Schiavo Case: Legal Issues*. This case brought new scrutiny to the “right to die” issue. Although the popular term “right to die” has been used as a label to describe the current political debate over end-of-life decisions, the underlying issues include a variety of legal concepts, including, suicide, passive euthanasia (allowing a person to die by refusal or withdrawal of medical intervention), assisted suicide (providing a person the means of committing suicide), active euthanasia (killing another), and palliative care (providing comfort care which accelerates the death process).

Exercising one or another of these “rights to die” may have drastically different legal consequences: some currently have no legal consequence, some are a violation of common-law, some are a violation of statute, some may have contractual consequences, some may result in an action such as civil confinement, some are currently protected by legislation, and some may be protected by the United States Constitution. This report examines the legal status of the five distinct issues: 1) suicide, 2) passive euthanasia, 3) assisted suicide, 4) active euthanasia, and 5) palliative care.

The report examines the history of how each of these issues has been treated and evaluates the constitutional right of a person to pursue these courses of action. It addresses state law regarding living wills, advance medical directives, and how these types of decisions are made regarding persons who have left neither. The report addresses congressional powers and existing federal statutes that are implicated in these issues, such as the Patient Self-Determination Act, the Assisted Suicide Funding Restriction Act, and the Controlled Substances Act. It then addresses bills introduced in the 109th Congress, S. 539 and H.R. 1151, both entitled the “Incapacitated Persons Legal Protection Act of 2005;” a bill passed by the House, H.R. 1332, “The Protection of Incapacitated Persons Act of 2005;” a bill passed by the Senate, “For the Relief of the Parents of Theresa Marie Schiavo;” and a similar bill passed by the House and Senate, S. 686. This last bill was signed by the President and became P.L. 109-3.

The report notes that current state regulations prohibiting assisted suicide have been upheld by the Supreme Court, and that similar prohibitions against active euthanasia are likely to be upheld against constitutional challenge. The Due Process Clause of the Fourteenth Amendment, however, appears to limit a state’s ability to regulate passive euthanasia (termination of medical treatment). Finally, palliative care may ultimately be found to be protected by the Fourteenth Amendment, but the possible abuse of such care may raise policy concerns.

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The "Right to Die": Constitutional and Statutory Analysis

I. Introduction

A. Background

In the spring of 2005, national attention was drawn to a series of court and legislative actions regarding the withdrawal of nutrition and hydration from a Florida patient, Theresa Schiavo, who had suffered severe brain damage. The treatment of this patient brought new attention to the “right to die” issue. Although the issue of “right to die” has many common themes, the individual aspects of each case may have a significant affect on the outcome of any proceeding. While a detailed examination of the Schiavo case is beyond the scope of this report, the case is briefly addressed under the topic of “passive euthanasia.”

One of the greatest scientific achievements of this century has been the development of medical technology to cure disease and to prolong lives. Before 1900, most deaths in this country were the result of communicable diseases, such as influenza or pneumonia, which could kill people of all ages.¹ Today, in contrast, deaths due to these illnesses have decreased dramatically, and most people succumb to chronic degenerative diseases related to age such as heart disease, cancer and cerebrovascular disease.²

These advances, however, do not come without burdens. Chronic degenerative diseases tend to be manifested years before death occurs, and because some medical intervention often exists, persons with these conditions tend to die more slowly and often painfully.³ The advent of AIDS has also resulted in an increase in the number of deaths which occur after extended periods of pain and physical disability. Consequently, patients are increasingly being confronted with decisions regarding whether to pursue or decline aggressive medical treatment. Further, there are indications that some patients are making decisions which affirmatively hasten their

¹ G. Steven Needley, *Chaos in the “Laboratory of the States”: The Mounting Urgency in the Call for Judicial Recognition of a Constitutional Right to a Self-Directed Death*, 26 U. TOL. L. REV. 81, 85 (1994).

² *Washington v. Glucksberg*, 521 U.S. 702, 716 (1997) (citation omitted).

³ One in every two Americans dies of a disease diagnosed at least 29 months in advance. G. Steven Needley, *supra* note 1, at 86.

deaths, whether through increasing levels of pain control medications or by other means.⁴

The increase in the number of end-of-life decisions has coincided with the expansion of patients' rights and involvement in medical decision-making. Yet the legal community has not yet come to terms with the implications resulting from this increased patient autonomy. State legislatures have made only piecemeal attempts to confront end-of-life decisions, federal involvement has been minimal, and the courts which have attempted to resolve some of these legal issues are faced with little precedent, inapplicable legislation, murky constitutional theory, and clashing legal doctrines. Prompt resolution of these issues is frustrated by a lack of political consensus among major societal institutions.⁵ For those reasons, the law in this area may be less a reflection of a coherent legal structure than a reaction to the immediate concerns and societal pressures surrounding specific cases.

For example, a majority of patients with terminal illnesses or their guardians will face decisions as to whether life-sustaining medical treatment should be refused or withdrawn, allowing the individual to die.⁶ By design or necessity, most such decisions are made by agreement among interested parties, such as the patient, his or her family, attending doctors and hospital administrators.⁷ On occasion, however, because of fear of legal liability, disagreement between the institutions and individuals involved, or because of moral objections, these decisions are made only after litigation in state, or occasionally federal, courts.

⁴ It is estimated that 6,000 terminal patients a day die as a foreseeable result of pain control medication. *Compassion in Dying v. Washington*, 79 F.3d 790, 811 (9th Cir. 1994)(en banc). A survey by the American Society of Internal Medicine indicated that one in five doctors have participated in assisting a patient's suicide. *Id.*

⁵ While our society has a long-standing moral aversion to suicide of physically healthy persons, attitudes toward hastening death in the cases of seriously ill patients are more complex. Despite existing laws on the books against assisted suicide or intentional killing, there have been few prosecutions under these statutes and many doctors privately admit helping people to die. Richard A. Know, *One in Five Doctors Say They Assisted a Patient's Death, Survey Finds*, BOSTON GLOBE, Feb. 28, 1992, at 5. For instance, in the case of Dr. Jack Kevorkian, who admitted responsibility in assisting over forty ill persons commit suicide (and was eventually convicted of second-degree murder), there were no successful prosecutions for assisted suicide. Jack Lessenberry, *Kevorkian is Arrested and Charged with Suicide*, NEW YORK TIMES, Nov. 8, 1996, at A19. While some argue against societal approvals of such activities, others argue that it is better to regulate this behavior rather than allowing it to flourish underground. Esther B. Fein, *The Right to Suicide, Some Worry, Could Evolve Into a Duty to Die*, NEW YORK TIMES, April 7, 1996, at A24.

⁶ Of the approximately two million people who die in the United States every year, 80% die in hospitals, and perhaps 70% of those die after a decision to forgo life-saving measures is made. *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 302 (1990)(J. Brennan, dissenting).

⁷ Decisions regarding the withdrawal of medical support are generally made, not by courts, but by the individuals or institutions directly involved. Gasner, *Right to Die Lives Locally*, NAT'L L.J., July 23, 1990, at 13, col. 1. Thousands of patients die every day upon withdrawal of medical support; yet since 1976, the number of "right to die" cases number in the low hundreds. *Id.* at 14.

Further, one of the most influential legal doctrines in the area of “right to die” is the constitutional right of privacy and of bodily integrity, the limits of which are anything but clear. Under the so-called privacy cases, the Supreme Court has established certain individual rights regarding the issues of marriage,⁸ contraception⁹ and abortion.¹⁰ The Court has also entered the “right to die” area, provisionally approving of the termination of medical treatment, but setting limits at which the state’s interest in viable life cannot be overridden.¹¹ This decision, however, may be seen as an outgrowth of a line of cases protecting bodily integrity. Other decisions by the court regarding the breadth of the right to privacy, which are now generally called “liberty interests” under the Fourteenth Amendment,¹² bring the establishment of a broader privacy based “right to die” into doubt.

For example, the Supreme Court rejected an argument that statutes prohibiting assisted suicide violate either the Equal Protection Clause or a protected “liberty interest” under the Due Process Clause of the Fourteenth Amendment. Two United States Courts of Appeals had determined that severely ill patients have a right under the Fourteenth Amendment to seek medical assistance to cause their own deaths. Both of these cases, *Quill v. Vacco*¹³ and *Compassion in Dying v. Washington*,¹⁴ were reversed by the Supreme Court. By resolving the issues in *Quill* and *Compassion in Dying*, the Supreme Court effectively ended the likelihood that a significant expansion of the “right to die” will arise through the courts. It did not, however, preclude such expansion by legislatures.

B. How Broad Is the "Right to Die"?

Although the popular term “right to die” has been used as a label to describe the current political debate over end-of-life decisions, the underlying issues include a variety of legal concepts, some distinct and some overlapping. For instance, “right to die” could include, at a minimum, suicide, passive euthanasia (allowing a person to die by refusal or withdrawal of medical intervention), assisted suicide (providing a person the means of committing suicide), active euthanasia (killing another), and palliative care (providing comfort care which accelerates the death process). Recently, a new category has been suggested — physician-assisted suicide — which appears to

⁸ *Loving v. Virginia*, 388 U.S. 1 (1967).

⁹ *Griswold v. Connecticut*, 381 U.S. 479 (1965).

¹⁰ *Roe v. Wade*, 410 U.S. 113 (1973).

¹¹ *Cruzan v. Missouri Dept. of Health*, 497 U.S. 261 (1990).

¹² *See, e.g., Paris Adult Theatre v. Slaton*, 413 U.S. 49 (1973)(obscenity cannot be displayed even to consenting adults).

¹³ *Quill v. Vacco*, 80 F.3d 716 (2nd Cir. 1996), *reversed*, 521 U.S. 793 (1997).

¹⁴ *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir. 1996)(en banc), *reversed*, 521 U.S. 702 (1997).

be an uncertain blend of assisted suicide or active euthanasia undertaken by a licensed physician.¹⁵

Yet, exercising one or another of these “rights to die” may have drastically different legal consequences: some currently have no legal consequence, some are a violation of common-law, some are a violation of statute, some may have contractual consequences, some may result in civil action such as confinement, some are currently protected by legislation, and some may be protected by the United States Constitution. It should also be noted that the legal and moral status of these rights may vary dramatically depending on the medical status of the individual patient. While early legal discussions of the “right to die” were primarily associated with terminal illness, more recent discussions have focused on medical situations involving high levels of pain, futile prognosis, diminished quality of life, or even on mental suffering.¹⁶

While some advocates would find little distinction between these various methods of terminating a person’s life,¹⁷ and would give the patient the discretion to decide what is a sufficient basis for exercising that option, other commentators find that maintaining distinctions between different situations is important to prevent abuses, or to conform to professional, societal or moral concerns.¹⁸ One of the major policy arguments made regarding the “right to die” is the concern that recognizing a “right to die” in one circumstance will be generalized to include other circumstances where different considerations may be relevant; in other words, there is a concern that granting a “right to die” is the first step down a slippery slope.¹⁹

¹⁵ *Compassion in Dying v. Washington*, 79 F.3d at 844, 852 (J. Beezer, dissenting).

¹⁶ STAFF OF THE SUBCOMMITTEE ON THE CONSTITUTION, COMMITTEE ON THE JUDICIARY, *Physician-Assisted Suicide and Euthanasia in the Netherlands*, 104th Cong., 2d Sess. at 2 (Comm. Print 1996)(discussing the development of assisted suicide in Holland).

¹⁷ Note, *Physician-Assisted Suicide and the Right to Die with Assistance*, 105 Harv. L. Rev. 2021 (1992)(noting similarities between withdrawal of medical treatment and assisted suicide).

¹⁸ As Professor Yale Kamisar has said, “how you phrase the question will determine your answer.” Yale Kamisar, *Against Assisted Suicide — Even a Very Limited Form*, 72 U. Det. Mercy L. Rev. 735 (1995). For instance, the United States Court of Appeals for the Ninth Circuit, in reviewing an assisted suicide statute, characterized the constitutional right at stake as the “liberty interest in determining the time and manner of death.” *Compassion in Dying v. Washington*, 79 F.3d at 801. As stated by the court, however, this broader “right” would seem to encompass any of the several ways of choosing death, from termination of medical treatment to euthanasia.

¹⁹ For instance, while some persons would restrict the assisted suicide debate to the terminally ill, the distinction between the terminally ill and persons with incurable conditions was one of the first distinctions to fall when courts considered the issue of termination of medical treatment. See *Cruzan v. Missouri*, 497 U.S. 261 (1990)(constitutional rights to termination of medical treatment apply to persistently vegetative patient); Note, *supra* note 17, at 2026. Thus, one commentator has suggested that if a right to assisted suicide is established for the terminally ill, no principled distinction could be made to prevent similar acts by persons who are handicapped, in physical pain, or even clinically depressed. Yale Kamisar, *supra* note 18, at 748 (1995).

(continued...)

C. The Constitutional Genesis: the Right to Privacy

In *Glucksberg v. Washington*, the Supreme Court evaluated the holding of the United States Court of Appeals for the Ninth Circuit in *Compassion in Dying v. Washington* that the Fourteenth Amendment to the Constitution protects the right of an individual to seek and obtain physician-assisted suicide.²⁰ In doing so, the Court revisited a controversial area of constitutional law, the so-called right to privacy. This relatively amorphous right was first substantively addressed in the contraceptive area, but has subsequently been expanded to include other decisions of a personal nature.

The right of privacy sought a permanent home in the Constitution for a number of years. First proposed in an 1890 article in the *Harvard Law Review* by Samuel Warren and Louis Brandeis,²¹ it reappeared years later in a Supreme Court dissenting opinion regarding the Fourth Amendment.²² However, in 1965, in the landmark case of *Griswold v. Connecticut*,²³ the Court established the concept of a constitutional guarantee of privacy which “emanated” from the Bill of Rights, even if it was not specifically identified in it. In *Griswold*, the Court struck down a law which prevented the use of contraceptives. The Supreme Court ruled that the right of married couples to make decisions regarding procreation was guaranteed by the Constitution.²⁴ This

¹⁹ (...continued)

Concerns have also been raised that once a “right to die” has been legally established, society may begin to expect those who are old, poor or sick to take advantage of this right as a matter of duty. In this context, it is noted that many disabled people withdraw suicide requests when given adequate care. *Id.* at 744. For example, in *McKay v. Bergstedt*, 801 P.2d 617 (Nev. 1990), a thirty-one year old competent, non-terminal quadriplegic obtained a court order permitting the removal of his respirator, despite clear indications that his desire to die was based on the impending death of his primary care-taker, his father, and the presumed attendant lowering in quality of his care.

²⁰ 518 U.S. 1057 (1996)(*cert. granted sub nom.* *Glucksberg v. Washington*).

²¹ Warren and Brandeis, *The Right of Privacy*, 4 Harv. L. Rev. 193 (1890).

²² *See Olmstead v. United States*, 277 U.S. 438 (1928)(J. Brandeis, dissenting)(arguing against the admissibility in criminal trials of secretly taped telephone conversations). In *Olmstead*, Justice Brandeis noted:

The makers of our Constitution undertook to secure conditions favorable to the pursuit of happiness . . . They sought to protect Americans in their beliefs, their emotions and their sensations. They conferred, as against the Government, the right to be let alone - the most comprehensive of rights and the right most valued by civilized men. To protect that right, every unjustifiable intrusion by the Government upon the privacy of the individual, whatever the means employed, must be deemed a violation of the Fourth Amendment.

277 U.S. at 473.

²³ 381 U.S. 479 (1965).

²⁴ The facts of *Griswold*, are relatively straightforward. *Griswold*, the Executive Director of Connecticut Planned Parenthood, was arrested, along with the Medical Director of the organization, and charged as accessory to a crime. The defendants in question were accused
(continued...)

holding was supported, however, by a variety of competing theories set forth by different justices, which left the scope of the right to privacy in an unsettled state.²⁵

In the case of *Roe v. Wade*,²⁶ the Court expanded the theory of the *Griswold* case to the issue of abortion. The opinion of the court in that case focused on the medical and legal history of abortion, and appears to have relied to a large degree on the medical consequence of decisions concerning pregnancy.²⁷ The Court ultimately concluded that the Constitution provided protection for autonomy in reproductive decisions, and set forth a substantive structure to evaluate laws restricting abortion.²⁸ The Court has subsequently established the Due Process Clause of the Fourteenth Amendment as the basis for the protection of these and other “liberty interests,” preferring to avoid the parlance of a generalized constitutional right of privacy. The holding of *Roe v. Wade* was modified by the case of *Casey v. Planned Parenthood of*

²⁴ (...continued)

of having aided and abetted the violation of a Connecticut law which prohibited the use of any drug, medicinal article or instrument for the purpose of preventing conception. The defendants challenged whether such a law could be constitutionally enforced by a state, and the Supreme Court ruled that it could not, as the right of married couples to use contraception was guaranteed by the Constitution.

²⁵ Justice Douglas, in the plurality opinion, noted that the Supreme Court had previously found that fundamental rights could be extended to establish “penumbral” rights, or rights whose enforcement would protect the underlying right. Finding that privacy rights are contained in the First Amendment, the Third Amendment, the Fourth Amendment, the Fifth Amendment, and the Ninth Amendment, Justice Douglas held that the institution of marriage was protected by these “penumbral” rights, and was thus exempt from such regulation. 381 U.S. at 484-485. In concurrence, Justice Goldberg found the right to privacy to be contained in the Ninth Amendment, which states that “the enumeration of rights in the Constitution shall not be construed to deny or disparage those rights retained by the people,” and to be applied to the states through the Fourteenth Amendment. 381 U.S. at 499. Justice Harlan, also in concurrence, found that the contraception statute violated the Fourteenth Amendment as it violated basic values “implicit in the concept of ordered liberty,” 381 U.S. at 500, while Justice White also found the right in the Fourteenth Amendment. It is these last two opinions that would eventually come to be the basis for the modern right to privacy.

²⁶ 410 U.S. 113 (1973).

²⁷ See 410 U.S. at 152.

²⁸ The Court found that in the first trimester, the risks of abortion were less than the risk of childbirth, and thus the mother was to be unrestricted in her ability to choose the less medically risky route of abortion. During the second trimester, the risks to the mother increase, thus allowing the state to intervene for purposes of regulating those aspects of an abortion which may affect a mother’s health and safety. 410 U.S. at 163. Such factors would include the particular qualifications of the physician performing the procedure, the facility where the procedure should take place, and licensing requirements. *Id.* Finally, in the third trimester, when the fetus may be capable of life outside of the mother’s womb, and thus be “viable,” the state may ban abortion completely. *Id.*

Southeastern Pennsylvania,²⁹ but the central holding regarding the existence of a liberty interest in choosing whether or not to terminate a pregnancy is unchanged.³⁰

It is not always clear when the right to privacy is likely to be extended to activities not previously addressed by Supreme Court decisions. If a general test can be discerned as to when a “right of privacy” or “liberty interest” can act as a shield against governmental action, it would appear to require that two basic questions be considered. First, is the activity to be regulated one which is deeply rooted in the history of the nation,³¹ or second, is it so central to personal autonomy that neither liberty nor justice would exist without constitutional protection.³² In the abortion context, however, this protection appears to be subject to an exception if there is a “viable” life being threatened by the activity.³³ When life is at risk because of a protected activity, such as when an abortion is sought in the third trimester, concerns about a “right of privacy” may be outweighed by the need to protect that viable life.

²⁹ 505 U.S. 833 (1992).

³⁰ The Court in *Casey* upheld the provision of information to women seeking abortions, the twenty-four hour waiting period, and the requirement that a minor obtain the consent of a parent or judge. The Court, however, struck down the section of the law which dictates that a woman must notify her husband of her intent to have an abortion. The Court also upheld the medical reporting requirements on clinics and doctors performing abortions, although a requirement that a women report why she did not notify her husband of the abortion was struck down. The core of the plurality opinion is section IV, which upheld the right of a woman to have an abortion, but rejected the trimester structure established by *Roe v. Wade*. Under *Roe*, states were prevented from imposing any restrictions designed to protect “potential life” on abortions performed in the first and second trimesters of pregnancy; only in the third trimester could the state impose restrictions to protect “potential life.” Under *Casey*, however, the Court held that laws restricting abortions to protect “potential life” could be imposed at anytime prior to viability, if such laws did not pose an “undue burden” on the women’s ability to have an abortion. Consequently, the Court found that certain of the above-noted restrictions, which applied during the first and second trimesters of pregnancy and would have been unconstitutional under *Roe v. Wade* and subsequent Supreme Court cases, *see City of Akron v. Akron Center for Reproductive Health*, 462 U.S. 416 (1983); *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747 (1986), were now constitutional on their face.

³¹ *Bowers v. Hardwick*, 478 U.S. 186, 192 (1986) *overturned by* *Lawrence v. Texas*, 123 S. Ct. 2472 (2003)(finding that homosexual activity, historically forbidden by legislation, is not a fundamental liberty implicit in the concept of ordered liberty, and is therefore not protected by the 14th Amendment). In the case of abortion, for example, the interest of individuals in making their own medical decisions and in making their own decisions regarding their family are cited as strong historical reasons for leaving to the individual the decision whether to have an early abortion. Thus, an affirmative answer to this first question will generally serve to inhibit governmental intervention.

³² *Id.*

³³ *See supra* note 28.

II. Five Types of "Right to Die"

This section will examine the legal status of five distinct issues concerning the "right to die:" 1) suicide, 2) passive euthanasia, 3) assisted suicide, 4) active euthanasia, and 5) palliative care. The historical tradition surrounding these will be examined with an eye to the Supreme Court's preference that constitutionally protected liberty interests be "rooted in the nation's history and tradition." This section will also examine present statutory and constitutional implications of each of these areas. It should be noted that some legal doctrines in this area are settled, while others are still evolving.

A. Suicide

1. Historical Precedent.

From the sparse record of ancient times, we can discern that the attitudes of the Greeks and Romans toward suicide were ambiguous.³⁴ By the Middle Ages, however, the influence of the Catholic Church was dominant, and the practice was condemned as a violation of religious and civil law.³⁵ English common law inherited this aversion to suicide and would sometimes impose posthumous deprivation of religious ceremony, and significant penalties were generally directed against the estate of the person committing suicide.³⁶ There are indications, however, that suicide in the face of suffering was treated less harshly.³⁷ The founding fathers of this country, on the other hand, were uninterested in imposing punishment upon the innocent heirs to the estates of persons committing suicide,³⁸ and the legal tradition of punishing suicide was generally abandoned soon after the adoption of the Constitution.³⁹ Consequently, in the American legal tradition, there has been little or no punishment imposed for suicide or attempted suicide.⁴⁰

³⁴ In ancient times, as today, suicide was generally disfavored. Roman law generally forbade suicide and imposed a penalty of forfeiture of property upon the estate of the decedent. Thomas J. Marzan, Mary K. O'Dowd, Daniel Crone & Thomas Balch, *Suicide: A Constitutional Right?*, 24 Duquesne Law Review 26 (1985). However, it appears that suicide in particular circumstance was seen as either acceptable or even commendable. *Compassion in Dying v. Washington*, 79 F.3d at 806-08. In particular, it appears that suicide that was prompted by pain or sickness was generally not punishable under Roman law. Marzan, *supra*, at 22-23.

³⁵ *Compassion in Dying v. Washington*, 79 F.3d at 808.

³⁶ 79 F.3d at 846 (J. Beezer, dissenting).

³⁷ Catherine D. Shaffer, *Criminal Liability for Assisting Suicide*, 86 Colum. L. Rev. 348, 349 (1986); *Compassion in Dying v. Washington*, 79 F.3d at 808-809.

³⁸ *Compassion in Dying v. Washington*, 79 F.3d at 844 (J. Beezer, dissenting).

³⁹ Thomas J. Marzan, *supra* note 34, at 64-69.

⁴⁰ Catherine D. Shaffer, *supra* note 37, at 349 (1986); *Compassion in Dying v. Washington*, 79 F.3d at 809.

2. State Legislation.

Although there are currently no criminal punishments associated with suicide or attempted suicide, this does not mean that these acts are without legal consequence. The trend of modern American law has generally been that a person who is suicidal should not be treated as a criminal, but as mentally ill.⁴¹ Further, a person who assists such a suicide may be prosecuted under the laws of many states.⁴² Thus, while suicide is not punished *per se*, it is not free of significant legal consequence.⁴³

In practice, however, the way in which a person engaged in a suicidal attempt is treated may vary based on context. Where a suicidal attempt appears to be the result of depression or mental problems, the state will generally intervene, and the person will be confined until such time as their suicidal urges have subsided. On the other hand, certain public, political acts, such as fasting, have sometimes been engaged in without government intervention. Nor is it clear that a court is likely to intervene in the cases of terminally ill patients who take their own lives.⁴⁴

3. Constitutional Status.

Although there are no criminal penalties associated with suicide, the threat of confinement might be seen as an infringement on one's personal autonomy as a consequence of making an important and fundamental life decision. Thus, it could be argued that the right to commit suicide should be found to be a liberty interest protected under the Fourteen Amendment. There has been little litigation of this issue in the courts, however, and Supreme Court *dicta* seems to favor the notion that the state has a constitutionally defensible interest in preserving the lives of healthy citizens.⁴⁵ However, the issue of the constitutional status of suicide of the seriously ill has not been squarely faced.

One of the strongest conceptual problems with a constitutional right to suicide for the seriously ill is how such a right would be limited. Suicide is often associated with depression, and certain life events, such as a terminal illness, may trigger depression in some individuals and not in others.⁴⁶ On its face, it is not clear how a constitutional right to act on suicidal impulses related to depression would vary among the terminally ill, the chronically-ill, the disabled, the temporarily-impaired, or the

⁴¹ *Compassion in Dying v. Washington*, 79 F.3d at 847 (J. Beezer, dissenting).

⁴² *See infra* notes 86-89 and accompanying text.

⁴³ For instance, many life insurance contracts include exclusions for suicide. *Compassion in Dying v. Washington*, 79 F.3d at 852 (J. Beezer, dissenting).

⁴⁴ *See Campbell v. Supreme Conclave Improved Order Heptasophs*, 49 A. 550 (1901) (“sometimes self-destruction, humanly speaking, is excusable, as where a man curtails by weeks or months the agony of an incurable disease.”).

⁴⁵ *Cruzan v. Missouri Dept. of Health*, 497 U.S. 261, 280 (1990) (“We do not think that a State is required to remain neutral in the face of an informed and voluntary decision by a physically able adult to starve to death”).

⁴⁶ Catherine D. Shaffer, *supra* note 37, at 356-357. For instance, whether or not a person attempts suicide is often affected by the quality of relationships with others. *Id.* at 357.

physically robust. Further, if the right were only extended to those individuals who were not depressed but who were making a “rational decision” regarding an untenable circumstance, a court would be required to engage in an evaluation of social and psychological factors that are generally alien to the establishment of constitutional rights.⁴⁷

B. Passive Euthanasia: Refusal or Termination of Medical Treatment

1. Historical Precedent: Common Law Battery.

Passive euthanasia, or the refusal or termination of medical treatment by a patient, has historical roots in criminal law. Under common law doctrine, an unauthorized touching was the basis for a charge of battery. In the medical field, this has been applied to prevent and punish the application of medical treatment without the full and informed consent of the individual involved or a suitable representative.⁴⁸ Even when the government seeks to impose unauthorized medical treatment, the courts have generally required that the government show compelling needs to impose such treatment.⁴⁹

2. State Legislation: Treatment Directives.

As the right to refuse medical treatment existed at common law and has, with a few notable exceptions,⁵⁰ generally been honored by the courts, decisions by competent patients to terminate treatment do not appear to have attracted the attention of state legislatures. However, the situation often arises that a patient with a serious medical condition will become so ill that he cannot communicate or he is not competent to make a medical care decision. This situation is prevalent enough that a Model Code entitled Uniform Rights of the Terminally Ill Act was developed, and most states have adopted some procedure by which medical treatment decisions can be made by individuals in advance.

a. The Living Will Option.

Most states have statutes based on the Uniform Rights of the Terminally Ill⁵¹ which authorize an individual to execute a Treatment Directive directing the

⁴⁷ Thomas J. Marzan, *supra* note 34, at 107.

⁴⁸ Note, *supra* note 17, at 2026. *See, e.g.*, *Hershley v. Brown*, 655 S.W.2d 671, 676 (Mo. App. 1983).

⁴⁹ *See* *Washington v. Harper*, 494 U.S. 210 (1990)(state interest in maintaining order overrides a prisoner’s liberty interest in avoiding the forced application of anti-psychotic drugs).

⁵⁰ *See infra* note 71.

⁵¹ *Unif. Rights of the Terminally Ill*, 9B U.L.A. 609 (1989).

withholding or withdrawal of life-sustaining procedures.⁵² These Treatment Directives, referred to as “Living Wills”, are generally only applicable when the individual, sometimes referred to as the “declarant” or “principal,” is terminally ill and death is imminent. The required form of a “Living Will” may vary from state to state, but a properly executed “Living Will” should be easily enforceable in the state in which it was drafted. These “Living Will” statutes also offer significant legal protections. For instance, those involved in termination of medical treatment are generally immunized by statute from liability for allowing a patient to die. Further, life insurance benefits which might be jeopardized by termination of medical treatment are generally protected. Finally, the application of penal laws which might prohibit suicide are generally voided by the operation of these statutes.

b. Appointment Directives.

All states provide that an individual can delegate legally binding authority to another individual. This delegation of authority is sometimes referred to as the delegation of the “power of attorney.” A “durable” power of attorney, which is also provided by state statute, is drafted so as to be effective when a person is incompetent to make decisions for himself. Some states have specifically provided that these durable powers of attorney may be used to delegate the authority to make medical decisions, even where such decisions may lead to the death of the individual. Thus, using a durable power of attorney, a person can appoint another individual to make medical decisions for him if he becomes incapacitated.⁵³

A durable power of attorney, often set forth in an “Appointment Directive,” offers a number of advantages over a Living Will. A person who delegates health-making decisions using this procedure does not have to anticipate every possible medical situation which may arise. By utilizing a power of attorney, the medical treatment decision can be deferred until such time as the medical situation has occurred; in this way, the appointed decision-maker can evaluate the specific details of the medical situation before making a decision. An Appointment Directive can also contain directions to the appointed decision-maker describing what medical treatment should or should not be used, as with a Living Will. The appointed decision-maker need not be a professional attorney; rather, the appointment can be given to any competent adult, with some exceptions, whether they be family, friend or other.

A health proxy is similar to a durable power of attorney, but is generally contained within a Treatment Directive. As with the durable power of attorney, the health proxy may be given specific instructions by the declarant regarding what medical treatment should be provided, or the proxy may be given the discretion to make these decisions. Generally, the only significant difference between a health

⁵² See Marguerite A. Chapman, *The Uniform Right of the Terminally Ill Act: Too Little, Too Late?*, 42 *Arkansas Law Review* 319 (1989). Although many states have authorized “Living Wills” and “durable powers of attorney,” these documents are apparently still relatively uncommon, and the problematic court cases appear to arise most often because patients have not prepared such wills. *Id.*

⁵³ Gregory Gelfand, *Living Will Statutes: The First Decade*, 1987 *Wis. L. Rev.* 737, 794 (1987).

proxy and a durable power of attorney is that a health proxy, like most Treatment Directives, can only be exercised when a patient is terminally ill; a durable power of attorney is usually not so limited.

3. Constitutional Status.

As noted above, the right to refuse medical treatment has been addressed by legislation at the state level. However, even in those cases where no medical directive has been completed, or where the state law does not cover a particular medical circumstance, individuals or their guardians have still sought to make a medical decision which will ultimately cause the death of the patient. In this type of situation, implementation of a patient's wishes might be sought under the Fourteenth Amendment of the Constitution. This was the litigation posture which led to the case of *Cruzan v. Missouri Department of Health*.⁵⁴

At the time of the litigation in *Cruzan*, Nancy Cruzan lay in a hospital bed⁵⁵ in what is called a persistent vegetative state.⁵⁶ In Nancy's case, there was sufficient brain-stem activity to control unconscious activities, such as breathing and heart functioning, and sometimes she would respond to pain or noise. Nancy apparently went through sleep and wake cycles, but when her eyes were open they moved randomly, and she did not seem aware of her environment. Her body was stiff, she lay in a fetal position, and her arms and legs were permanently contracted. Medical opinion was that she would never interact significantly with the world around her again.⁵⁷

Although Nancy was able to take nutrition through spoon-feeding following the accident, it was determined that artificial nutrition and hydration were medically indicated. Thus, approximately three weeks after the accident, with the permission of both her parents and her husband, a feeding tube was surgically implanted in her stomach. It is this medical decision which Nancy's parents sought to reverse. With this feeding tube in place, Nancy Cruzan could have lived up to another thirty years. Without it, she would die, most likely through dehydration. At the time of the litigation, Nancy Cruzan had been in a persistent vegetative state for over six years.

⁵⁴ 497 U.S. 261 (1990).

⁵⁵ In 1983, Nancy Cruzan, 25 years old, was involved in a car accident on a deserted country road. 497 U.S. at 266. She was found face down on a frozen ground with no signs of life. Although an emergency team was able to restore breathing and heartbeat, Nancy Cruzan's brain had been oxygen-starved for too long, and she suffered severe brain damage. *Id.*

⁵⁶ According to the Academy of Neurology, persistent vegetative state patients are permanently unconscious and devoid of thought, emotion and sensation. The state is described as a form of eyes-open permanent unconsciousness in which the patient has periods of wakefulness and physiological sleep/wake cycles. Amicus Brief for Academy of Neurology at 3, *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1989)(No. 88-1503). It was estimated that 10,000 patients were being maintained in a persistent vegetative state in the United States. *Id.*

⁵⁷ 497 U.S. at 267.

Although the State of Missouri has a “Living Will” statute,⁵⁸ it was not in effect at the time of Nancy’s accident, nor did Nancy write out such a will. The statute was relevant, however, because it specifically excluded the possibility that a patient’s Living Will could provide for the withdrawal of nutrition or hydration tubes. Thus, the Missouri legislature appeared to have made a decision that the withdrawal of nutrition and hydration was not within the realm of acceptable conduct even with the written consent of the patient.⁵⁹ Based on this finding, the Missouri Supreme Court held that the state’s interest in protecting life would require a clear and convincing showing of Nancy’s wishes prior to withdrawal of medical treatment.⁶⁰

The *Cruzan* case, because of its facts, presented two legal issues to the Supreme Court: first, whether Nancy Cruzan had the constitutional right, even absent legislative approval, to consent to the withdrawal of nutrition and hydration; second, whether this right could be exercised by a guardian, and what standard of proof would be required to show that such a course of action was the intent of the patient. The Supreme Court ultimately decided that the state may require clear and convincing evidence of her wishes, and as her guardians did not have sufficient proof, the nutrition and hydration could not be withdrawn.⁶¹ The Supreme Court did not technically decide the issue whether the Missouri court could have acted contrary to a clear and convincing expression of Nancy Cruzan to withdraw medical procedures, although, as discussed later, the implication of the case is that it could not.

⁵⁸ Mo. Rev. Stat. § 459.010 *et seq.* (1986).

⁵⁹ The Supreme Court of Missouri graphically pointed out in its opinion how this case differed from many previous medical decision cases. Nancy was not dead, nor was she terminally ill, and she could have lived up to thirty years in her condition. Essentially, the decision, as stated by the court, was whether the hospital should be allowed to cause Nancy Cruzan to die by starvation or dehydration. The Supreme Court of Missouri considered the case as one of first impression for Missouri, and declined to allow the hospital to withdraw nutrition and hydration. *Cruzan v. Harmon*, 760 S.W.2d 408, 427 (Mo. 1989)(en banc).

⁶⁰ *Cruzan v. Harmon*, 760 S.W.2d 408, 426 (1988)(en banc).

⁶¹ The Court found that it was not constitutionally required that guardians or family be allowed to effectuate such a decision. *Cruzan*, 497 U.S. at 284. Rather, the Court determined that not only could a state require that a patient’s own personal wishes be examined, but that absent clear and convincing evidence of such wishes, a state could decline to allow withdrawal of treatment. To bolster this argument, the Court cited other instances in which a state may require certain formalities prior to implementing the wishes of an individual, such as the requirement that a will be in writing. *Id.* However, it does not appear that the Missouri Supreme Court requirement of “clear and convincing” evidence was based on the assumption that most individuals would prefer life to death; rather, the requirement would appear to have been based on a non-individualized state interest in “life” irrelevant of the wishes of the individual. *Id.* at 280-281. As the Court concurred that there was no “clear and convincing” evidence of Nancy Cruzan’s wishes, the Supreme Court held that Missouri’s generalized interest in the preservation of life allowed the State to refuse the guardian’s wishes to terminate treatment. *Id.* at 286-87.

The Court, in deciding the *Cruzan* case, first examined the case of *In re Quinlan*,⁶² one of the first state court cases to examine these issues. Karen Quinlan, similarly to Nancy Cruzan, had suffered severe brain damage as a result of oxygen starvation, and medical opinion agreed that she would not regain cognitive function. Karen Quinlan, unlike Nancy Cruzan, was both attached to a respirator and provided nourishment by a feeding tube, and her guardians sought only removal of the respirator. In *Quinlan*, the New Jersey Supreme Court found that Karen Quinlan had a right of privacy to terminate her life in its vegetative state. This right, however, was not found to be absolute, but was to be balanced against the rights of the state. The *Quinlan* court found that the state's interest in preserving life diminishes as the degree of bodily invasion increases, and as the prognosis dims. Ultimately, there comes a point at which the individual's rights overcome the state's interest. The court further found that the only practical way to give effect to this right would be to let the guardian and the family use their best judgment in making a decision.⁶³

The majority opinion of the *Cruzan* Court, authored by Chief Justice Rehnquist and joined by Justices White, O'Connor, Scalia and Kennedy, appears to have implicitly accepted the primary holding of the *Quinlan* and related state cases, which was that a patient has a constitutional right to refuse medical treatment that sustains life.⁶⁴ However, the language of the opinion did leave some ambiguity as to the general application of this right.⁶⁵ Justice O'Connor, in her concurring opinion, leaves

⁶² 355 A.2d 647 (N.J. 1976), *cert denied*, 429 U.S. 922 (1976).

⁶³ The *Cruzan* Court noted that since the case of *Quinlan*, many other courts have found legal grounds to allow termination of medical treatment. It would appear, however, that these cases have been based on two distinct lines of legal reasoning. The first, consistent with *In Re Quinlan*, is the finding that there is a constitutional right of privacy which protects decisions made concerning life-sustaining treatment. The second line of reasoning is based on the common law right to refuse medical treatment, expressed as the requirement of informed consent. Under common-law, a physician who performs a medical procedure without valid consent is performing a battery, and the law will act to prevent and punish such treatment. *Hershley v. Brown*, 655 S.W.2d 671, 676 (Mo. App. 1983). Thus, the argument is made, individuals who wish to decline medical treatment, even if such will result in their death, have the right to do so.

⁶⁴ 497 U.S. at 280.

⁶⁵ The majority opinion states the following:

Petitioners insist that under the general holdings of our cases, the forced administration of life-sustaining medical treatment, and even of artificially-delivered food and water essential to life, would implicate a competent person's liberty interest. Although we think the logic of the cases discussed would embrace such a liberty interest, the dramatic consequences involved in refusal of such treatment would inform the inquiry as to whether the deprivation of that interest is constitutionally permissible. But for purposes of this case, we assume that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition.

(continued...)

no such ambiguity, and sets forth an extensive opinion of the basis and scope of this right. Further, Justices Brennan, Marshall, Blackmun and Stevens, in dissent, also recognize the existence of this right. Only Justice Scalia, in a concurrence, signals that he would have resisted the Court's acceptance of this constitutional doctrine. Thus, despite the ambiguous language contained in the majority opinion, five justices — O'Connor, Brennan, Marshall, Blackmun and Stevens — appear to support the establishment of a right to termination of medical treatment.

4. Implications of *Cruzan*.

The statutes of the various states do not generally provide for the implementation of any form of Directive other than Living Wills and durable powers of attorney. Yet, there may be other instructions which a person desires to leave regarding his medical treatment,⁶⁶ and *Cruzan* appears to have upheld a person's constitutional right to refuse any medical treatment even if the result will be death. Thus, under *Cruzan*, an individual's right to refuse medical treatment may be broader than the rights which are granted by most state statutes.

For instance, as noted earlier, many states' "Living Will" laws deal only with terminal illness, and thus do not apply where the patient is in a persistent vegetative state, but in no immediate danger of death.⁶⁷ Theoretically, an advance medical directive could be drafted which set forth the procedure to be followed if a patient became persistently vegetative, but it might not qualify under a state's Living Will statute. The holding in *Cruzan*, however, implies that a state may not prohibit a clear advance medical directive, at least regarding life-sustaining technology.⁶⁸ Thus, to be

⁶⁵ (...continued)

The second sentence of this quote appears to hedge the question as to whether refusal of medical treatment by a patient should always be respected, at least when the consequences may be "dramatic". Arguably, this may be because another case could occur where a state interest would outweigh the patient's liberty interest. In fact, in the Supreme Court cases cited in *Cruzan*, medical treatment was imposed over objection of a competent patient based on an overriding state interest. *See* *Washington v. Harper*, 494 U.S. 210 (1990)(state interest in maintaining order overrides a prisoner's liberty interest in avoiding the forced application of anti-psychotic drugs); *Parham v. J.R.*, 442 U.S. 584, 604-08 (1979)(a state's interest in certain administrative procedures used in confining a child to mental institution overrides the child's liberty interest).

⁶⁶ An advance medical directive is a statement by a competent person indicating his wishes regarding medical treatment in the event of future incompetence. LAZAROFF & ORR, *LIVING WILLS AND OTHER ADVANCE DIRECTIVES, ETHICAL ISSUES IN THE CARE OF THE ELDERLY* 523 (1986). Generic advance directives have firmly established legal precedents, but their use in medical contexts has generally not been addressed by statute. Unlike most "Living Will" statutes, advance directives may be used to address medical questions during any period of incompetence, not just those periods association with terminal illness.

⁶⁷ *See* Unif. Rights of the Terminally Ill Act § 3, 9B U.L.A. 615 (1980).

⁶⁸ Generally, states may not act so as to unreasonably burden the exercise of constitutional rights. Thus, a state may not erect procedural barriers for a patient to express his intent to exercise his constitutional right to refuse medical treatment. *Cruzan*, 497 U.S. at 305 (J. Brennan, dissenting). While the Supreme Court was willing to accept a requirement of clear
(continued...)

consistent with *Cruzan*, a state may be required to fully implement an advance medical directive despite its own statute.⁶⁹

A question left unresolved by *Cruzan*, however, is what type of medical treatment may be refused under the Fourteenth Amendment.⁷⁰ While refusing to be attached to a respirator or a heart-lung machine is clearly within a patient's right to refuse treatment, it is not clear that the same can be said for a diabetic who refuses to take insulin, an individual who declines the provision of antibiotics, or an accident victim who refuses attempts to stem arterial bleeding. Of even greater concern is the possibility that an individual can attempt a suicide and leave a suicide note invoking a constitutional right to resist medical treatment.

⁶⁸ (...continued)

and convincing evidence, it did so only after significant analysis. Consequently, the implication of the *Cruzan* case would appear to be that a state may only act to facilitate a patient's desires, and not to restrict or arbitrarily nullify them. For this reason, any state statutes or court opinions which restrict the use of advanced medical directives and durable powers of attorney might be held to overly burden a patient's intent and desire to refuse medical treatment.

⁶⁹ An issue not explicitly addressed by the Court was the type of limitations that may be placed upon an individual appointed by the patient to make medical decisions. Such an appointment, called a durable power of attorney because the appointment remains applicable even after an individual has become incompetent, generally leaves considerable discretion to the appointed individual to make a decision for the principal. Such an appointment may be preferable to a living will, as the appointed surrogate can make a detailed evaluation of the medical situation, and make a determination as to the patient's treatment. What is unclear is whether such a surrogate could be held to a "best interest" of the patient standard, or whether the fact of the appointment of the individual by the patient to exercise his or her constitutional rights would preclude any challenge to the decision made by that individual. The *Cruzan* court stated that "[w]e are not faced with the question of whether a State might be required to defer to the decision of a surrogate if competent and probative evidence established that the patient herself had expressed a desire that the decision to terminate life-sustaining treatment be made for her by that individual". *Cruzan*, 497 U.S. at 287, n.12.

Concerns were raised, prior to *Cruzan*, that a living will or other advance directive executed in one state might not be honored in another state. The *Cruzan* case would appear to dispel most of these concerns. Assuming that an individual had clearly set out his wishes with sufficient detail to cover a particular medical situation, it would appear that any state court would be required to acknowledge the document, and give effect to it. Absent some indication of fraud or changed circumstance, the imposition of specific technical requirements such as to the form or number of witnesses would appear to be inconsistent with an individual's constitutional right to refuse medical treatment as established under *Cruzan*.

It is not yet clear what type of evidence a state can require before it will implement a Directive which is not authorized by its statute. It would appear, however, that a written directive which complied with the procedural requirements of a state's living will or durable power of attorney statutes would be strong evidence of a patient's medical intent, and would ultimately be enforced by a court.

⁷⁰ The Supreme Court opinion in *Cruzan* contained almost no discussion concerning why this particular type of medical technology, provision of nutrition and hydration, could be withdrawn, even though the distinction between nutrition/hydration support and other forms of medical support engendered considerable discussion in the court below. *Cruzan v. Harmon*, 706 S.W.2d at 423-24.

This question may be especially crucial to the lower courts in disposing of cases, such as have arisen in the past, where otherwise healthy individuals have rejected medical treatment for religious or other reasons.⁷¹ There is little indication that the Court considered whether these distinctions would still be valid after *Cruzan*. However, a close scrutiny of the language of the opinion reveals a notion that there is a difference between providing “life-sustaining treatment” to a dying patient, and “life-saving treatment” to a healthy patient.

Life-sustaining treatment does not appear to be a term of art, but is used differently in different contexts.⁷² For purposes of this discussion, however, we will define life-sustaining technologies as those drugs, medical devices, or procedures that by continuous application can keep an individual alive who would otherwise die within the near future.⁷³ Life-saving technology, on the other hand, could be defined to include those treatments which will keep an individual alive, but need not be maintained on a continuous basis because the underlying condition is arrested, reversed or cured. These definitions represent points on a continuum, and some treatments may appear to fall in between depending on the context in which they are provided.⁷⁴

Under common law, the right to refuse medication represents one of the longest standing individual “rights,” bolstering the argument for a constitutional right to refuse life-sustaining intervention. Where a technology is life-saving, however, courts have been less reluctant to override a patient’s wishes, especially when the underlying

⁷¹ Much of the case law in the area of refusal or termination of medical treatment to competent patients involves the refusal of patients to accept medical treatment because of religious beliefs. These often involve Jehovah’s Witnesses who are prohibited by their religion from accepting blood transfusions. Although a court will often weigh religious belief in making its decisions, many of these cases resulted in an order being issued requiring medical treatment. *See* United State v. George, 239 F. Supp. 752 (D. Conn. 1965)(39-year-old father of four children); *Powel v. Columbia Presbyterian Medical Center*, 49 Misc. 2d 215, 267 N.Y.S.2d 450 (1965)(blood required for post-operative caesarian care); *John F. Kennedy Memorial Hospital v. Heston*, 58 N.J. 576, 279 A.2d 670 (1971)(transfusions ordered for 22-year-old woman based on state interest in conservation of life, and need to permit hospital to function according to professional standards).

⁷² *See, e.g.*, Uniform Rights of the Terminally Ill Act § 1, 9B U.L.A. 161 (1989)(1996 Supp.) (defining “life-sustaining treatment” as a medical procedure which serves only to prolong the process of dying).

⁷³ *See* Office of Technology Assessment (OTA), *Life-Sustaining Technologies and the Elderly* 4 (1987).

⁷⁴ For example, the application of antibiotics in an otherwise healthy individual which cures a dangerous infection, and returns that individual to sustained health, would appear to be a life-saving technology. On the other hand, continual doses of antibiotics to fight off recurring infection in an elderly nursing home patient may be seen an life-sustaining technology. *Id.*

condition is medically treatable.⁷⁵ Thus the question arises, what did the Court approve of, and what lines implicitly were drawn.

Let us speculate for the moment that the Court assumed that the administration of artificial nutrition and hydration was found to be a form of life-sustaining technology. As the withdrawal of all nutrition would ultimately kill any patient, and there was no indication that the nutrition and hydration could be successfully withdrawn without threatening the life of Nancy Cruzan, the Court, by inference, appears to be sanctioning refusal of a life-sustaining technology. However, during a general discussion of a state's interest in preserving life and preventing suicide, the Court makes the following statement: “[w]e do not think a State is required to remain neutral in the face of an informed and voluntary decision by a *physically-able adult* to starve to death” (emphasis added). This *dicta* appears to represent some concern that in a different fact situation, such as where a healthy individual attempted suicide by fasting, states may intervene. Such intervention, which might include the use of medical technology, thus appears to be distinguishable from the *Cruzan* case. Thus, the court does appear to recognize that some life-saving, as opposed to life-sustaining, medical technology might be imposed on an individual despite his or her constitutional rights under the Fourteenth Amendment.

5. The *Schiavo* case.

Theresa Schiavo, at the age of 27, suffered a cardiac arrest as a result of a potassium imbalance, and never regained consciousness.⁷⁶ Since 1990, she had lived in nursing homes and a hospice with constant care, where she was fed and hydrated by tubes. Although she had numerous health problems, none were life threatening. A number of courts found that Theresa, whose husband was acting as her guardian, was in a permanent or persistent vegetative state.⁷⁷ Further, Theresa's brain damage was apparently incurable, as much of the cerebral cortex had been replaced by cerebral spinal fluid.

In 2001, the Florida Court of Appeals considered whether to allow the termination of life-prolonging procedures under chapter 765 of the Florida Statutes⁷⁸ and under the constitutional guidelines enunciated by the Florida Supreme Court in

⁷⁵ See *supra* note 71. It should also be noted that there appears to be no common law precedent for “suicide” in our legal system. See Thomas P. Marzan, *supra* note 34 at 1 (1985). Arguably, the refusal of life-saving medical technology may in some cases represent a form of suicide, for instance where a protest fast becomes life-threatening. Thus, arguably, the constitutional right that can be inferred from *Cruzan* would not extend as far as refusal of all life-saving medical technology.

⁷⁶ *In Re Guardianship of Theresa Marie Schiavo*, 780 So. 2d 176 (Fla. App. Ct. 2001).

⁷⁷ Unlike a coma, a person in a persistent vegetative state is not unconscious, but is characterized by cycles of wakefulness and sleep without cognition or awareness. See *supra* note 56 and accompanying text.

⁷⁸ Chapter 765 deals with Health Care Advance Directives.

the case of *In re Guardianship of Browning*.⁷⁹ In the case of *Browning*, the Florida Supreme Court held that, under the Florida Constitution, the guardian of a patient who is incompetent but not in a permanent vegetative state and who suffers from an incurable, but not terminal condition, may exercise the patient's right of self-determination to forego sustenance provided artificially by a nasogastric tube. The case, however, did require that the guardian have clear and convincing proof that the patient would not have wanted food and water provided to them in their present medical circumstance.

In the *Schiavo* case, the trial court had found that, despite conflicting testimony, there was sufficient evidence to support such a finding. Although the testimony only involved a few oral statements to her friends and family about the dying process, the appeals court also found that there was a sufficient basis for the trial court's conclusion. The appeals court finding was apparently influenced by the nature of Theresa Schiavo's medical condition, and whether she would have wanted continued medical care after being in a persistent vegetative state for over ten years.

This court decision, however, was followed by a series of legal proceedings initiated by the parents of Theresa Schiavo⁸⁰ and others,⁸¹ intended to overturn or delay implementation of the appeals court decision. Then, in October of 2003, the Florida Legislature passed a bill granting the Governor the authority to "stay" the withholding of nutrition and hydration in a situation such as existed in the *Schiavo* case,⁸² a power which the Governor promptly exercised.⁸³ This legislative "stay," however, was challenged as a violation of the doctrine of separation of powers and of Theresa Schiavo's due process rights, and the law was subsequently overturned by the Florida Supreme Court.⁸⁴ The trial judge in the case set the date of March 18 for the withdrawal of nutrition and hydration, and the withdrawal occurred on that date.⁸⁵ Theresa Schiavo died on March 31, 2005. For a discussion of congressional and legal actions which occurred on and around that date, see "The Federal Role," *infra*.

⁷⁹ 568 So. 2d 4 (Fla. 1990).

⁸⁰ See e.g., *In Re Guardianship of Theresa Marie Schiavo*, 792 So. 2d 551 (Fla. Ct. App. 2001); *In Re Guardianship of Theresa Marie Schiavo*, 800 So. 2d 640 (Fla. Ct. App. 2001); *In Re Guardianship of Theresa Marie Schiavo*, 851 So. 2d 182 (Fla. Ct. App. 2003).

⁸¹ See, e.g., *Advocacy Center for Persons with Disabilities v. Schiavo*, 2003 U.S. Dist. LEXIS 19949 (M.D. Fla. October 21, 2003).

⁸² See Fla. Stat. § 765.404 note.

⁸³ See Laurie Cunningham, *Legal Experts Say New Law Allowing Governor to Overrule Court Violates Separation of Powers*, Miami Daily Business Review 1 (October 23, 2003).

⁸⁴ *Bush v. Schiavo*, 885 So. 2d 321 (2004).

⁸⁵ For a summary of relevant factual and legal events surrounding this case, see [<http://www.miami.edu/ethics2/schiavo/timeline.htm>] and CRS Report RL32830 (pdf), "The Schiavo Case: Legal Issues."

C. Assisted Suicide

Although suicide is not a crime in this country, assisting another person to commit suicide may, in many states, result in criminal penalties being imposed.⁸⁶ Legal scholars have argued that it is logically inconsistent to punish a person who is “aiding and abetting” the principal actor, here the person committing suicide, when the latter is not punished.⁸⁷ Such laws, however, roughly parallel laws which protect minors and incompetent persons from exploitation, such as laws against statutory rape.⁸⁸ Thus, while a state may decide that treatment would be more effective than punishment for a suicidal person, the state might also reason that punishment would be a more effective deterrent to prevent persons from assisting a suicide. Further, such law can serve as a protection against a person attempting to encourage or coerce a vulnerable person to commit suicide.⁸⁹

1. Historical Precedent.

Assisted suicide, as with suicide generally, has a long history of disfavor.⁹⁰ Unlike legal prohibitions regarding suicide, however, which were not adopted by the American legal system, laws against assisted suicide have been on the books for many years.⁹¹ Thirty-five states currently have statutes with penalties for assisted suicide⁹² and nine more have penalties based on case law.⁹³ It is not clear, however, whether these statutes have ever been vigorously enforced, and for many years the prosecution of such cases appears to have been almost nonexistent.⁹⁴ There are a few examples, however, of convictions for assisted suicide where long sentences have been imposed.⁹⁵

⁸⁶ It is important to distinguish assisting suicide from euthanasia. While assisting a person to commit suicide by providing them the means to commit suicide is a specific crime with mild to moderate criminal penalties, affirmatively killing a person, even with that person’s consent, is murder, and can expose a person to significant jail sentences. Catherine D. Shaffer, *supra* note 37, at 348.

⁸⁷ *Id.*

⁸⁸ An adult who engages in sexual conduct with a minor may be charged with statutory rape, although the minor engaged in the sexual act willingly.

⁸⁹ Catherine Shaffer, *supra* note 37, at 364-65.

⁹⁰ Thomas J. Marzan, *supra* note 34, at 15, 20, 24.

⁹¹ For instance, the two statutes at issue in the cases of *Vacco* and *Glucksberg* before the Supreme Court date from the 19th century. *Id.* at 73.

⁹² Michael Peltier, *U.S. Man Wants Doctors to Help Him Kill Himself*, Reuters World Service (May 8, 1997).

⁹³ *Id.*

⁹⁴ From 1930 through 1985, not one state court decision on assisting suicide appears. Catherine D. Shaffer, *supra* note 37, at 358.

⁹⁵ Thomas J. Marzan, *supra* note 34, at 77.

One of the reasons that few cases have been brought in this area is that where a person is suicidal because of pain or disability, juries appear reluctant to convict persons who assist them in committing suicide. For example, starting in 1990, Jack Kevorkian, a retired pathologist, assisted scores of patients to commit suicide. Various attempts to convict him of assisted suicide, however, were stymied by juries refusing to convict. There are indications that the juries that acquitted Dr. Kevorkian engaged in jury nullification, i.e. the jury found that all the elements of the crime had been established, but failed to convict anyway.⁹⁶ Because jury nullification establishes no precedent and provides no guidelines, however, Dr. Kevorkian's actions remain of dubious legality.⁹⁷

2. State Legislation.

Although there is currently a movement to legalize assisted suicide and active euthanasia legislatively, this movement has little or no precedent in this country⁹⁸ or in others.⁹⁹ The only example of domestic legislation approving of physician-assisted suicide is an initiative passed by Oregon. This initiative allows persons who are terminally ill to seek assistance in committing suicide if they meet certain criteria.¹⁰⁰ A federal district court held that because the referendum failed to distinguish between competent and mentally incompetent persons, depriving the mentally incompetent of the protections of law afforded to the non-terminally ill, the law was a violation of the Fourteenth Amendment.¹⁰¹ This decision, however, was vacated on other grounds.¹⁰² Of more significance, Attorney General Ashcroft has threatened the withdrawal of the controlled substances licenses of doctors who use such substances for the purpose of assisting suicide. This directive, however, was enjoined by the United States Court of Appeals for the Ninth Circuit Court, and is currently before the Supreme Court.¹⁰³

⁹⁶ Jack Lessenberry, *supra* note 5 at A14.

⁹⁷ Dr. Kevorkian was ultimately convicted of second degree murder for directly administering lethal drugs to a terminally ill patient, and was sentenced to 10 to 25 years in prison.

⁹⁸ The cases of *Quill* and *Compassion in Dying* concerned laws which forbid assisted suicide; the case holdings, which approved of assisted suicide, were based on constitutional grounds.

⁹⁹ Holland, the only country which has ventured into this area, has not passed legislation authorizing assisted suicide, but has authorized suicide through a series of court cases. STAFF OF THE SUBCOMMITTEE ON THE CONSTITUTION OF THE COMMITTEE ON THE JUDICIARY, *supra* note 16, at 5. In 1995, the Northern Territory of Australia passed a law authorizing physician-assisted suicide, which has been implemented and utilized. Associated Press, *Suicide Law Divisive in Australia*, Fresno Bee, January 7, 1997, at A9.

¹⁰⁰ Oregon Rev. Stat. 127.800. § 1.01, *et. seq.*

¹⁰¹ See *Lee v. Oregon*, 891 F. Supp. 1429, 1437 (D. Or. 1995), *vacated on other grounds*, 107 F.3d 1382 (9th Cir. 1997).

¹⁰² 107 F.3d. 1382 (9th Cir. 1997).

¹⁰³ See *Oregon v. Ashcroft*, 368 F.3d 1118 (9th Cir. Or., 2004), *cert. granted*, *Gonzales v. Oregon*, 2005 U.S. LEXIS 1453 (2005). The Attorney General's directive was successfully (continued...)

3. Constitutional Status.

In *Glucksberg v. Washington*, the Supreme Court held that the right to assisted suicide is not a fundamental liberty interest protected under the Due Process Clause of the Fourteenth Amendment.¹⁰⁴ In *Quill v. Vacco*, decided the same day, the Court held that enforcement of assisted suicide laws does not unreasonably discriminate, in violation of the Equal Protection component of the Fourteenth Amendment, against persons who are suffering or terminally ill.¹⁰⁵ The ultimate impact of this decision is that the “right to die” is unlikely to be expanded significantly by the courts.

a. Substantive Due Process.

Under the Fourteenth Amendment a “liberty interest” may only be infringed if there is a sufficient state interest to justify such. If a “liberty interest” is deemed to be fundamental, then it may not be infringed except by a narrowly tailored regulation which furthers a compelling state interest.¹⁰⁶ Where a liberty interest is not fundamental, a court will subject an infringement to a much less restrictive analysis.

In *Glucksberg*, the United States Court of Appeals for the Ninth Circuit, struck down an assisted suicide statute, drawing heavily from Supreme Court cases concerning abortion. In particular, the court noted the emphasis on protecting personal autonomy in *Casey v. Planned Parenthood of Pennsylvania*,¹⁰⁷ which reaffirmed that the Fourteenth Amendment protected a woman’s decision to have an abortion. Characterizing laws against assisted suicide as essentially forcing suffering patients to endure torture at the end of life,¹⁰⁸ the court found a generalized right in hastening one’s own death, and consequently struck down the assisted suicide statute as a restriction on a fundamental liberty interest.¹⁰⁹

The Supreme Court rejected this interpretation of the Fourteenth Amendment, noting that the Court moves with “utmost care” before breaking new ground in this area of liberty interests.¹¹⁰ Generally, the Court, which distinguishes between heavily protected “fundamental rights” and less protected “substantive rights,” has indicated an unwillingness to expand the number of “fundamental rights” protected under the Fourteenth Amendment. The Court requires either that such rights must be deeply

¹⁰³ (...continued)

challenged as being outside of the scope of his statutory authority. *Id.* An appeal of this order is pending before the United States Supreme Court. *See* discussion notes 239-249 in “The Controlled Substance Act,” *infra*.

¹⁰⁴ 521 U.S. 702 (1997).

¹⁰⁵ 521 U.S. 793 (1997).

¹⁰⁶ *Collins v. City of Harker Heights*, 503 U.S. 115, 123 (1992).

¹⁰⁷ 505 U.S. 833 (1992).

¹⁰⁸ 79 F.3d at 814.

¹⁰⁹ *Id.* at 839.

¹¹⁰ *Glucksberg*, 521 U.S. at 720.

rooted in history¹¹¹ or so central to personal autonomy that neither liberty nor justice would exist without them.¹¹² An analysis of these two criteria led the Court to reject the broad interpretation of fundamental rights suggested by the circuit court in *Glucksberg*.

I. Whether Assisted Suicide Is a Fundamental Right.

First, the Supreme Court rejected the argument that suicide or assisted suicide is rooted in the nation's history and tradition. As noted above, suicide and assisted suicide have long been disfavored by our judicial system, and even the absence of criminal sanction for suicide has not prevented the legal system from using the civil commitment system as a route to prevent suicide. Further, there is a deep societal resistance to suicide that includes many major religions and many groups associated with health care.¹¹³

The Court easily dismissed the historical approach, noting an almost universal rejection of the practice in the Nation's history.¹¹⁴ As to the second element - whether the right at issue is "so central to personal autonomy that neither liberty nor justice would exist without them" - the Court rejected the application of this broad language, and distinguished cases regarding personal autonomy such as *Casey v. Planned Parenthood of Pennsylvania* and *Cruzan v. Missouri Department of Health*.

The District Court in *Glucksberg*, which struck down the assisted suicide statute, felt that the "right to die" was similar to the right to abortion. That court found many similarities between the two situations, including the intimacy of the decision, and the susceptibility to untoward influence by other persons.¹¹⁵ But, unlike abortion, which involves the competing interests of the mother and the fetus, the court emphasized that assisted suicide involves only the individual and his or her own interests.¹¹⁶ The *en banc* Court of Appeals, which upheld the district court, also relied heavily on language in *Casey* which affirmed the right to abortion as one of the "most intimate and personal choices a person may make in their life-time, choices central to personal dignity and autonomy."¹¹⁷

The Supreme Court rejected this use of *Casey*, noting that while many of the interests protected by the Due Process Clause involved personal autonomy, this did

¹¹¹ See *Bowers v. Hardwick*, 478 U.S. 186, 192, *overturned by Lawrence v. Texas*, 123 S. Ct. 2472 (2003).

¹¹² *Id.*

¹¹³ See *Amicus Curiae* Brief for the American Medical Association, *Vacco v. Quill*, No. 95-1858, at 2 (U.S. 1996)(the American Medical Association, the American Nurses Association, the American Psychiatry Association, and 43 other medical societies oppose a constitutional right to assisted suicide).

¹¹⁴ *Glucksberg*, 521 U.S. at 728.

¹¹⁵ *Compassion in Dying v. Washington*, 850 F. Supp. at 1460-1461.

¹¹⁶ *Id.* at 1460.

¹¹⁷ 79 F.3d at 801, *quoting Casey v. Planned Parenthood*, 505 U.S. at 851 (1992).

not mean that all important, intimate, and personal decisions are so protected.¹¹⁸ The Court, again noting the Nation's historical rejection of assisted suicide, declined to extend the reasoning of *Casey* to cover this practice. This was consistent with the Court's previously expressed reluctance to extend the reasoning of *Roe v. Wade* into other areas of "personal autonomy."¹¹⁹

The Court had even less trouble distinguishing the instant case from *Cruzan v. Missouri Department of Health*,¹²⁰ which addresses the right to terminate medical treatment.¹²¹ In *Cruzan*, the Supreme Court was developing that line of cases which derived from the right to bodily integrity. The *Cruzan* case was important because it dealt with the small but significant subcategory of informed consent cases that involve the refusal of medical treatment when it is apparent that withdrawal of the treatment would result in death. That is a separate issue from whether a person can affirmatively request that another person cause his death. All cases which have dealt with the "right to die" have recognized and maintained the distinction between "active" and "passive" medical intervention,¹²² and the Supreme Court declined to eliminate this distinction.

ii. State Interests in Preventing Assisted Suicide.

If the Court had determined that a fundamental liberty interest exists in assisted suicide, then it would have examined whether there was a compelling governmental interest which was narrowly tailored to justify an infringement on this right. However, as the Court found that there was no fundamental right to assisted suicide, the state needed only to show that its interests were rationally related to any infringement. The Court found numerous state interests, including 1) a general interest in the preservation of life, and a specific interest in maintaining barriers against suicide; 2) an interest in avoiding situations where it would be to the advantage of a third party to influence a person to commit suicide; 3) an interest in maintaining the integrity of the medical profession; and 4) an interest in preventing acts such as voluntary or involuntary euthanasia.

Historically, the state has been found to have a legitimate interest in discouraging physically healthy individuals from committing suicide.¹²³ The district court in *Glucksberg* argued that interest was insufficient when applied to terminally ill persons, and suggested that a legislature could define the appropriate circumstance

¹¹⁸ 521 U.S. at 724.

¹¹⁹ The Court speaking in *Roe* in 1973 made it clear that, despite the importance of its decision, the protection of personal autonomy was limited to a relatively narrow range of behavior, including activities relating to marriage, procreation, contraception, family relationships, and child rearing and education. 419 U.S. at 152.

¹²⁰ 497 U.S. 261 (1990).

¹²¹ 521 U.S. at 725-26.

¹²² Traditionally, the law distinguishes between acts of "omission" and acts of "commission." Thomas J. Marzan, *supra* note 34, at 10.

¹²³ *Compassion in Dying v. Washington*, 850 F. Supp. at 1461.

where assisted suicide could be banned.¹²⁴ The Supreme Court held, however, that a state is not compelled to make such distinctions regarding quality of life.¹²⁵

Unlike termination of medical treatment, which by its nature involves terminal or incurable persons, assisted suicide can be extended to a larger population.¹²⁶ Thus, the argument has been made that societal pressure against devoting resources to the poor, elderly, infirm or disabled would result in subtle or unsubtle pressure for those persons to seek assisted suicide rather than face an uncertain medical or economic future.¹²⁷ Here, the Court held that a state could rationally consider as too high the risk that an assisted suicide statute would be manipulated to encourage a person to commit suicide.¹²⁸

The Court also held that a state may assert an interest in allowing its medical profession to set standards to protect both its integrity and the trust of the populace.¹²⁹ Many medical organizations consider doctor-assisted suicide to be incompatible with a doctor's Hippocratic oath, and would be concerned that such a role for doctors would lead to a conflict with their roles as healers.¹³⁰ There is also a concern that if assisted suicide were considered a treatment option, the progress in the ability of physicians to combat serious disease would be undermined.¹³¹

Finally, the Court held that permitting assisted suicide could start society down the path to active euthanasia, both voluntary and involuntary.¹³² As noted earlier, advocates for physician-assisted suicide often do not distinguish between assisted suicide and euthanasia, despite the potential for abuse where the patient does not control the final administration of the lethal treatment. The Court noted that allowing assisted suicide would create the potential for this line to be crossed without detection, and that it would be extremely difficult to police or contain this distinction.¹³³

¹²⁴ *Id.* at 1455.

¹²⁵ 521 U.S. at 729.

¹²⁶ Yale Kamisar, *supra* note 18, at 755.

¹²⁷ *Compassion in Dying v. Washington*, 49 F.3d at 592. It has also been noted that it may be in the financial interest of a person related to or caring for an ill patient for that patient to die. *Id.* at 592-93.

¹²⁸ 521 U.S. at 732. It should be noted, however, that others have argued that such dire predictions, made with regard to the assertion of other rights, have failed to come true. *Compassion in Dying v. Washington*, 79 F.3d at 825-26 (noting arguments that women would be pressured into abortions if the procedure were legalized).

¹²⁹ 521 U.S. at 731.

¹³⁰ *Compassion in Dying v. Washington*, 49 F.3d at 592.

¹³¹ *Id.* It has been argued, however, that since doctors are already engaged in the unregulated practice of assisted suicide, that the integrity of the profession would be better served by regulation of the practice. *Compassion in Dying v. Washington*, 79 F.3d at 828.

¹³² 521 U.S. at 732.

¹³³ *Id.*

b. Equal Protection.

In *Quill v. Vacco*, a separate argument was made that enforcing a statute banning assisted suicide would discriminate against individuals who are terminally-ill but are not on life support. This argument relies on the fact that individuals with terminal diseases have a constitutional right, and often a statutory right, to request termination of medical treatment, which will ultimately cause their deaths. If terminally-ill patients not on life support are found to be similarly situated, then the denial of the right to assisted suicide is arguably a violation of equal protection.

As with due process fundamental rights analysis, equal protection analysis uses different standards by which to evaluate a law, depending on the class of people being discriminated against. While a high level of scrutiny is reserved for certain “suspect classifications” such as race or religion,¹³⁴ and an intermediate level of scrutiny is applied to certain others such as “gender classifications,”¹³⁵ distinctions based on other characteristics, such as medical condition, would generally be evaluated under a rational basis test. Thus, if a court can ascertain any rational governmental interest in making such a distinction, the law will be upheld.¹³⁶

The Court in *Vacco* noted that the class of individuals being discriminated against here, terminally ill patients not on life support, would not constitute a traditional “suspect classification.”¹³⁷ Consequently, a court would need to look only at whether there was a rational basis to distinguish between the treatment of persons who are on life support and those who are not. The Court noted that the distinction between assisting suicide and withdrawing life-sustaining treatment was widely recognized both legally and medically, and comported with fundamental legal principles of causation and intent.¹³⁸ Thus, the Court held that maintaining a distinction between letting a person die by natural means and causing their death was certainly a sufficient rational basis to preclude a successful equal protection challenge.

D. Active Euthanasia

Active euthanasia, or administering a lethal treatment to a person, could arguably be treated in the same way as assisted suicide. Certainly the line between assisted suicide and active euthanasia has been blurred by commentators and the media in their discussions of the right to die.¹³⁹ For instance, the phrase “physician assisted” suicide has often been used without distinguishing whether a doctor was prescribing a lethal treatment or administering it.¹⁴⁰ Further, the argument can be made that if a person has

¹³⁴ *Quill v. Vacco*, 80 F.3d at 726.

¹³⁵ *Id.*

¹³⁶ *Id.* at 725.

¹³⁷ *Vacco*, 521 U.S. at 799.

¹³⁸ *Id.* at 801.

¹³⁹ 80 F.3d at 747.

¹⁴⁰ *Id.*

the right to self-administer a lethal treatment, then he should have the right to seek such treatment from others.¹⁴¹

The distinction between assisted suicide and active euthanasia is, however, both legally and practically significant, and is maintained in almost all legal jurisdictions. In the case of assisted suicide, the actual fatal procedure is completed by the patient, thus shielding the person assisting from direct legal responsibility for the death. Although, many states have specific statutes that ban assisting in a suicide, the act is not treated as homicide, is rarely prosecuted and has relatively low criminal penalties.¹⁴² The situation is different if another person actually implements the fatal procedure. Since a person cannot generally consent to a crime, killing a patient, even if he asks to be killed, is considered murder, a serious crime in all fifty states.¹⁴³ Even prominent proponents of the right to assisted suicide have been uncomfortable with advocating active euthanasia,¹⁴⁴ although others argue that maintaining a distinction between the two would be difficult.¹⁴⁵

Ultimately, the most significant distinction between assisted suicide and active euthanasia may be the susceptibility of active euthanasia to abuse. While a person who provides a patient the means of committing suicide may be in a position to bring pressure on that person to do so, the decision would ultimately lie with the patient, and thus there is no issue of consent. Where another party commits the act, however, the issue of consent must be addressed, and it may be difficult to establish such consent when the patient is dead. Because active euthanasia appears to be more susceptible to abuse than does assisted suicide, a state could reasonably distinguish between these two practices as a matter of public policy. Enforcement prohibitions on active euthanasia may be difficult, however, as the practice appears to most often occur under the guise of palliative care.¹⁴⁶

E. Palliative Care

Another form of medical treatment which can result in a hastened death is palliative care. Palliative care is medical treatment to relieve pain, but in terminal cases, the escalating levels of pain medication can ultimately reach toxic levels, killing the patient.¹⁴⁷ This type of treatment is less controversial than the other categories, and

¹⁴¹ *Id.*

¹⁴² Catherine D. Shaffer, *supra* note 37 at 352.

¹⁴³ *Id.* at 351.

¹⁴⁴ Yale Kamisar, *supra* note 18, at 747 (noting that Dr. Quill, the named plaintiff in the Quill v. Vacco case, initially resisted arguing for euthanasia because of the risk involved).

¹⁴⁵ *Id.* at 749-750.

¹⁴⁶ Susan Okie, *AIDS Doctors Report Prescribing Lethal Drugs*, WASHINGTON POST, February 11, 1997, Health Section at 5.

¹⁴⁷ *Compassion in Dying v. Washington*, 79 F.3d at 839 (J. Beezer, dissenting).

generally has few legal repercussions.¹⁴⁸ In fact, Justice O'Connor, in a concurring opinion in *Glucksberg*, has indicated that a patient may have a constitutional right to palliative care.¹⁴⁹

Because palliative care can ultimately result in a shortened life-span, however, it would appear to raise policy concerns similar to the other "right to die" issues.¹⁵⁰ Further, the line between palliative care and active euthanasia is extremely difficult to monitor, and it appears that to the extent that unsanctioned euthanasia is being practiced by doctors, much of it may occur under the guise of palliative care. While palliative care by itself may raise few policy issues, its susceptibility to abuse may make it the most likely area where evasion of the law might occur.

III. Who Decides: Individuals, Guardians, and the Court

Medical decision-making regarding terminally or chronically ill persons has the additional complication that many such patients are comatose or so disabled that they are not legally competent to make health care decisions. Consequently, the issue arises as to whether the various "rights to die" can be exercised by others on behalf of the legally incompetent individual, and what standards should apply. While virtually all the law in this area relates to the termination of medical treatment, such situations could also arise if active euthanasia became a legal option.¹⁵¹

Differing standards have been adopted by various courts to address the problem of discerning an unresponsive patient's desires for medical treatment. Some courts attempt to discern the "subjective intent" of the patient, either through (1) written documents such as a Living Will, advance medical directives, or a durable power of attorney; (2) specific oral statements; (3) generalized inquiries regarding a patient's prior attitudes and past statements; or (4) attempts to discern what a patient would decide, if cognizant and given the relevant facts regarding her prognosis.¹⁵² There is also another line of cases which focuses less on the subjective intent of the patient, and more on the objective condition of the patient. Under this "objective test," the issue becomes whether the burdens of a patient's condition are such as to justify a

¹⁴⁸ At least one judge has distinguished palliative care as without legal consequence, because the intent of the act is pain relief, and not to kill. 79 F.2d at 857 (J. Kleinfield, dissenting).

¹⁴⁹ *Glucksberg*, 521 U.S. at 797-98 (O'Connor, J., concurring).

¹⁵⁰ STAFF OF THE SUBCOMMITTEE ON THE CONSTITUTION, COMMITTEE ON THE JUDICIARY, 104TH CONG., *supra* note 16, at 5.

¹⁵¹ As legally incompetent patients would most likely be incapable of committing suicide, surrogate decision-making would appear to either involve termination of medical treatment or active euthanasia.

¹⁵² See *Developments in the Law of Medical Technology and the Law*, 103 Harv. L. Rev. 1519, 1647-49 (1990); Kaenezis, *Patient's Right to Refuse Treatment Allegedly Necessary to Sustain Life*, 93 A.L.R.3d 67 (1979).

withdrawal; the opportunity for oppression and abuse, however, generally leads a court to take a hard look at the facts of such a case.

Using the above standards, many courts have found ways to approve the withdrawal of medical treatment from terminally ill or persistently vegetative patients. Some courts, however, have resisted these efforts, especially in the more difficult cases where there is no clear indication of the intent of the individual. This, for example, was the case when the Missouri Supreme Court refused to allow the parents of Nancy Cruzan to authorize the withdrawal of nutrition and hydration. In *Cruzan*, however, the United States Supreme Court did little more than decide that requiring proof of Nancy's intent by clear and convincing evidence was acceptable. What is unclear is whether there are any alternative tests which may be overly burdensome to this newly identified constitutional right.

A. The Subjective Intent Test

Prior to the Supreme Court's decision in *Cruzan*, many courts had determined that an incompetent patient who did not wish to have life-sustaining medical technology used indefinitely, as evidenced by previous statements made by that patient when competent, should have those wishes given effect.¹⁵³ For instance, in the *Cruzan* case, in order to fulfill this "subjective intent test," the trial court had attempted to discern what Nancy Cruzan's attitude was toward sustained medical intervention. The court found that Nancy Cruzan was a vivacious, active, outgoing and independent person who preferred to do everything for herself. About a year prior to her accident, Nancy apparently had discussions in which she expressed the feeling that she would not wish to continue to live if she couldn't be at least "half-way normal". Based on these two factors, the trial court found that Nancy Cruzan would have rejected her existing medical treatment.¹⁵⁴

As has been discussed previously,¹⁵⁵ the Missouri Supreme Court reversed this decision, holding that Nancy's intent had not been shown by clear and convincing evidence. This standard, which had been utilized previously in other jurisdictions, was ultimately upheld by the Supreme Court, but in doing so, the Court did not indicate whether a more burdensome requirement than clear and convincing evidence could

¹⁵³ See, e.g., *In Re Storar*, 52 N.Y. 2d 363, 420 N.E. 2d 64, *cert denied*, 454 U.S. 858 (1981).

¹⁵⁴ Relying solely on these two factors, the trial court appeared to expand what would normally be considered proof of "consent" under a common-law right to refuse treatment. Generally, for there to be true informed consent to refuse medication, a patient would need to be specifically aware of the possible circumstance of his or her physical condition, and would need to indicate specifically what could or could not be done. Apparently, the trial court, faced with conflicting social mores, was attempting to balance the benefits of continued treatment against the burdens of continued treatment. This attempt at balancing sometimes becomes even more overt under the objective test.

¹⁵⁵ See *supra* notes 58-61 and accompanying text.

be required, and thus did not explicitly address the degree to which a state could hinder this newly recognized right.¹⁵⁶

B. The Objective Test

A more difficult question arises if a patient has left no prior written or oral indications as to his or her medical wishes in the case of a serious illness. A number of lower courts, when confronted with a patient who has left little or no indication as to his intent, have developed rationales to objectively establish what the patient would want, if he were aware of his circumstance. These “objective tests,” or the related “best interest standards,” attempt to move beyond the subjective intent of the patient, and focus instead on the details of the present situation. In the *In the Matter of Conroy* case,¹⁵⁷ the New Jersey Supreme Court, refusing to terminate life-support for an incompetent but conscious patient,¹⁵⁸ established two alternative standards to the subjective test to be used when the patient in question had not made his wishes clear concerning the withdrawal of medical treatment - the limited objective and the purely

¹⁵⁶ In contrast to Missouri’s “clear and convincing” standard, a majority of the states that have considered the issue allowed a form of “substituted judgment,” so that a family member or guardian can make a decision for an incompetent patient. Gasner, *supra* note 7 at 14.

¹⁵⁷ 86 A.2d 1209 (N.J. 1985).

¹⁵⁸ In *In the Matter of Conroy*, 486 A.2d 1209 (N.J. 1985), Claire Conroy was an eighty-two year old resident of a nursing home, and her only surviving relative, a nephew, was appointed as her guardian. Ms. Conroy, because of an organic brain syndrome, had become increasingly confused, disoriented, and physically dependent. As with Nancy Cruzan, a feeding tube had been implanted to provide nutrition and hydration. When her nephew brought suit seeking termination of medical treatment, Ms. Conroy was confined to bed in a semi-fetal position. She suffered from heart disease, hypertension, diabetes, gangrene, and a variety of other infections. On the other hand, she could move her head, neck and arms, could scratch herself, and would attempt to pull at her bandages. Medical doctors testified that Ms. Conroy was not comatose or in a chronic vegetative state, although her mental condition was severely deteriorated. 486 A.2d at 1221.

To resolve the case, the New Jersey Supreme Court tried to balance the interests of the State against the burdens of treatment. The court identified four state interests in such circumstances - preserving life, preventing suicide, safeguarding the integrity of the medical profession, and protecting innocent third parties. *See Satz v. Perlmutter*, 362 So.2d 359, 360 (Fla. 1980). The court indicated that the burden of being maintained on a life-support system could, in some instances, outweigh the interests of the State.

In refusing to allow the withdrawal of Ms. Conroy’s feeding and nutrition, the Supreme Court of New Jersey noted the vulnerability of nursing home populations, and the sometimes grossly inadequate care and concern that they receive. The court further noted that Ms. Conroy, although resistant to medical intervention throughout her life, had not specifically addressed or provided for the contingency of being incapacitated and in need of medical intervention. Ultimately, the court found that there was insufficient evidence to support a finding either that Ms. Conroy’s wishes would be to terminate treatment, or that the burdens imposed by continued treatment outweighed the state interest in life. Consequently, the court declined to condone the removal of the feeding tube, even while contemplating the possibility that absent an expression by the patient as to the withholding of health care, a court might allow the withdrawal of medical care by a guardian.

objective tests.¹⁵⁹ Under the limited objective test, life-sustaining treatment may be withheld when there is trustworthy evidence that the patient would have refused treatment, and where the decision-maker is satisfied that the burdens of continued life outweigh the benefits for the patient.¹⁶⁰ Under a purely objective test, where there is no evidence of subjective intent, not only must the burdens of treatment outweigh the benefits, but the medical treatment must cause such recurring, severe and unavoidable pain that administering the life-sustaining treatment would be inhumane.¹⁶¹ Under these tests, the *Conroy* court found that there was insufficient evidence to allow the withdrawal of Ms. Conroy's feeding tube.¹⁶²

The fate of the "objective intent" tests after *Cruzan* is uncertain. The tests are clearly not overly burdensome to the right of the patient to refuse treatment, as they are only invoked when there is little or no indication of subjective intent. Whether the test is sufficiently attentive to the actual wishes of the patient, or whether the "objective test" instead bypasses the need for an expressed desire by a patient, and merely applies the desires of the guardian, the care-provider, or the court, however, remain valid questions. As the Court pointed out in *Cruzan*, there is as much a Due Process right to "life" as there is to death,¹⁶³ and there may be situations where guardians are not acting to protect the patient. Thus, although unstated, the Court's *Cruzan* decision, by relying almost entirely on individual autonomy, may signal that "objective" decisions, which rely on third party choices, do not have the same constitutional protections. Based on *Cruzan*, therefore, a state might ban its courts from considering any factors except the expressed desires of the individual.¹⁶⁴

¹⁵⁹ 486 A.2d at 1233.

¹⁶⁰ *Id.*

¹⁶¹ Under the limited or purely "objective test", courts appear to be introducing the concept of balancing the benefits of life against the "benefits" of death, albeit still within the context of individual rights. For instance, the *Conroy* court restricted its balancing to the physical pain being felt by the patient because of continuing treatment. Arguably, this would limit the application of the test to the conscious patient, as the value of life in a vegetative state or in a coma is outside of our daily evaluation of "benefits and burdens." Privacy, bodily integrity, pain and suffering would not appear to be of particular relevance to a determination of what was in the best interests of a vegetative or comatose patient.

¹⁶² 486 A.2d at 1243.

¹⁶³ *Cruzan*, 497 U.S. at 281.

¹⁶⁴ Because the Missouri Supreme Court focused on the subjective intent of Nancy Cruzan, the *Cruzan* Court did not have the opportunity to evaluate any "objective" consideration which a court might ultimately weigh in this area. Because these fundamental life decisions regarding dying have been debated primarily in the courts, and not legislatures, the focus has been on individual rights versus the state's interest. The ultimate balancing decisions which society as a whole might make on these issues have been avoided by many states. Ultimately, society may need to reconcile individual wishes, the interests of the immediate family, and the interests of society at large on the use of medical resources, and this would appear to be a role for the legislatures.

C. The Never-Competent Patient

An unaddressed implication of the *Cruzan* opinion is that a state may provide that only “competent” expressions of the desire to resist medical treatment need be honored.¹⁶⁵ Thus, arguably, a minor child or an individual permanently incompetent because of disease or mental disability could be effectively prohibited from exercising his right to have medical treatment withdrawn. Some state courts have allowed such individuals to have medical treatment withheld based on variations of the objective tests.¹⁶⁶ If, however, an incompetent patient were sufficiently lucid to make his or her wishes known, an argument could be made that to deny the right to have treatment withheld would be an Equal Protection violation.¹⁶⁷

IV. The Federal Role

A. Congressional Authority

As discussed above, the vast majority of regulation of the “right to die” has been done at the state level. This regulation is an outgrowth of the states’ authority to legislate generally on all matters within their territorial jurisdiction.¹⁶⁸ The powers of the federal government, on the other hand, are limited to those enumerated in the Constitution.¹⁶⁹ These powers have been interpreted broadly, however, so as to create a large potential overlap with state authority.

For instance, § 5 of the Fourteenth Amendment gives the Congress the power to enforce the guarantees of the Fourteenth Amendment, including the right to due

¹⁶⁵ The *Cruzan* opinion upheld the Missouri Supreme Court, stating that “Missouri . . . has established a procedural safeguard to assure that the action of a surrogate conforms as best it may to the wishes expressed by the patient while competent.” *Cruzan*, 497 U.S. at 280.

¹⁶⁶ See, e.g., *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E. 2d 417 (1977). The reasoning of this court was that the patient, a 67 year old profoundly retarded man, would have refused treatment if he had been competent and aware of his circumstance. This holding has, however, been criticized as circular.

¹⁶⁷ The *Cruzan* court summarily dismissed an equal protection argument that its holding would unjustly discriminate between the rights of competent patients and the rights of incompetent patients. *Cruzan*, 497 U.S. at 261. The Court held this argument inapplicable because the issue being discussed was the choices made *by* a competent person versus the choice made *for* an incompetent person. If a lucid, but incompetent person could make his wishes known, however, the reasoning of the Court in *Cruzan* might be distinguished.

¹⁶⁸ This “police power” does not arise from the Constitution, but is an inherent attribute of the states’ territorial sovereignty.

¹⁶⁹ Article I, §1, of the Constitution provides that “All legislative powers herein granted shall be vested in a Congress of the United States.” Unlike a typical grant of power to states Article I, §1, does not grant to Congress “all legislative power,” but rather grants to Congress only those specific powers enumerated in §8 and elsewhere in the Constitution.

process and equal protection.¹⁷⁰ An argument can be made that since the due process clause applies to cases litigated at the state court level, that Congress can regulate the manner in which courts consider cases involving the termination of medical treatment. As discussed below, however the Supreme Court has imposed significant limitations on Congress' authority under this provision.

The Congress also has broad authority over the commercial interests of the nation, including the power to regulate commerce.¹⁷¹ The Commerce Clause, discussed below, is one of the most far-reaching grants of power to Congress, and would appear to allow the regulation of most commercial enterprises, including hospitals and hospices. However, as discussed below, limits imposed on the commerce clause may prevent the application of such power to all cases of termination of medical treatment.

A final authority that Congress has often relied upon is the spending clause.¹⁷² The purposes for which Congress may tax and spend are very broad, and are not generally limited by the scope of other enumerated powers under which Congress may regulate.¹⁷³ In addition, the courts have found that Congress has broad authority to condition the conferral of federal benefits. While there may be limits to this authority, the conditioning of the spending power is one of the more powerful means by which the Congress can regulate certain beneficiaries of federal dollars.

1. Congress' Authority Under 14th Amendment, § 5.

The 14th Amendment provides that a state may not deprive a person of their right to life, liberty, or property without due process of law.¹⁷⁴ Section 5 of the 14th Amendment provides that Congress has the authority to enforce the provisions of the 14th Amendment.¹⁷⁵ The Supreme Court, however, requires that legislation enacted under § 5 of the Fourteenth Amendment be congruent and proportionate to a pattern and history of constitutional violations.¹⁷⁶ For instance, since only states are limited by restrictions of the 14th Amendment, constitutional violations generally only occur

¹⁷⁰ "No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws." U.S. Const., Amend. XIV, §1. The Congress shall have power to enforce, by appropriate legislation, the provisions of this article. *Id.* at §5.

¹⁷¹ "To regulate commerce with foreign Nations, and among the several States, and with the Indian Tribes." U.S. Const., Article I, § 8, cl. 3.

¹⁷² "The Congress shall have Power To lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defence and general Welfare of the United States; but all Duties, Imposts and Excises shall be uniform throughout the United States." U.S. Const., Art. I, §8, cl. 1.

¹⁷³ *United States v. Butler*, 297 U.S. 1 (1936).

¹⁷⁴ U.S. Const. Amend. XIV, § 1.

¹⁷⁵ U.S. Const. Amend. XIV, § 5.

¹⁷⁶ *See Flores v. City of Boerne*, 521 U.S. 507, 520 (1997).

when the actions are undertaken by state actors. Behavior or activities of private parties acting in their individual capacities are not generally found to violate of the Due Process Clause of the 14th Amendment, and are not generally vulnerable to congressional regulation under § 5.¹⁷⁷

Thus, identifying state actors in the context of the termination of medical treatment becomes important in determining whether particular legislation is congruent and proportionate, as the legislation must be in response to a history and pattern of constitutional violations by such actors. For instance, in *United States v. Morrison*,¹⁷⁸ the Court evaluated 42 U.S.C. § 13981, which provides a federal private right of action for victims of gender-motivated violence against their attackers. The Court considered whether the statute was within the power of the Congress to enact under § 5 of the Fourteenth Amendment, considering that the suit was brought against a private person, not against the state.

The plaintiff attempted to avoid the problem of state action by arguing that there is pervasive bias in various state justice systems against victims of gender-motivated violence, and that providing a federal private right of action was an appropriate means to remedy this "state action." Although the Court found that this bias was supported by a voluminous congressional record,¹⁷⁹ the Court nonetheless rejected this argument, finding that the remedy did not meet the *City of Boerne* test of "congruence and proportionality to the injury to be prevented or remedied and the means adopted to that end."¹⁸⁰ Since the federal private right of action was not aimed at the allegedly discriminatory actions by state officials, but was instead directed against the individual engaging in the violence itself, the Court found that the action could not be supported by reference to the Fourteenth Amendment.¹⁸¹

Thus the power of Congress as regards the termination of medical treatment would appear to be limited based on the nature of the proposal. For instance, consider a proposal that is intended to limit or restricts courts' power to direct that a patient's medical treatment be terminated, such as requiring prove of "clear and convincing evidence" that a patient would want treatment withdrawn. At first glance, such a proposal might seem narrowly focused to address just "state action," as it is limited to disputed cases that are tried before judges, who, as will be discussed later, are state actors. However, a relatively small number of disputed cases involving termination of medical treatment are resolved in court, so it may be difficult to establish a pattern and history of constitutional violations based only on disputed cases. Thus, it may be important for purposes of identifying a pattern and history of constitutional violations to determine if constitutional violations of patient's rights sometimes occur outside

¹⁷⁷ The Court has long held that the Fourteenth Amendment provides that Congress has the authority to regulate states, but not individuals. *See Shelley v. Kraemer*, 334 U.S. 1, 13 (1948).

¹⁷⁸ *United States v. Morrison*, 529 U.S. 598 (2000).

¹⁷⁹ 529 U.S. at 619-620.

¹⁸⁰ 521 U.S. at 526.

¹⁸¹ 529 U.S. at 626.

of the courtroom.¹⁸² The first, step to this process would be identifying likely scenarios outside the courtroom where state actors would be involved in these decisions.¹⁸³

It may also be important, for purposes of congruence and proportionality, to identify any state actors who are involved in these disputed cases apart from the judges, since it can be argued that under *Morrison*, directing a legislative fix against non-state actors is not congruent and proportionate if these actors are not the source of constitutional violations. Arguably, in the hypothetical proposal, the burden of proving a case by clear and convincing evidence will fall upon a patient, health proxy, of guardian. If none of these parties are state actors, however, then it might be argued that they are inappropriate targets for such legislation.

a. State Action.

In *Morrison*, the Court found a voluminous congressional record of bias based on state actions regarding the investigation and prosecution of criminal sex offenses, suggesting the state activities may have been in violation of the 14th Amendment. However, unlike the criminal cases that were at issue in *Morrison*, most termination of medical treatment decisions are not initiated by the state, nor are they generally resolved in a courtroom. Thus, the question arises as to whether the Congress can rely on possible abuses in the termination of medical treatment outside the courtroom to justify the exercise of its 14th Amendment authority, despite the fact that the medical treatment or the termination of such treatment is generally initiated by designated proxies or appointed guardians.

One typical scenario that can be analyzed is where a health proxy or guardian seeks to have treatment withheld from a patient who is being treated in a private hospital or hospice.¹⁸⁴ Private parties can sometimes be state actors if: 1) their actions rely on governmental assistance and benefits, 2) if the actor is performing a traditional governmental function, and 3) if the injury caused is aggravated in a unique way by

¹⁸² Where the right at issue is a fundamental right, the court has allowed the introduction of evidence related to discrimination involving that right in different contexts. *Tennessee v. Lane*, 541 U.S. 509, 528-529 (2004) (considering evidence of unconstitutional discrimination against persons with disabilities in the provision of public services in evaluating discrimination in access to the courts). Although it is unclear that the right to direct medical treatment is a fundamental right, an argument might be made that procedural due process rights, which are implicated by the instant proposal, fall more closely into that category.

¹⁸³ When the rights of a “suspect” class are at issue, which are protected by a higher standard of scrutiny than rational basis, then the Court appears to have been willing to consider a broader array of examples of unconstitutional discrimination, even if they did not involve state action. *Nevada Dep’t of Human Res. v. Hibbs*, 538 U.S. 721, 730-35 (2003) (allowing consideration of the practices of private-sector employers and the federal government). However, it does not appear that any court has found that incapacitated patients are considered a “suspect” class.

¹⁸⁴ Of course, in some instances, state actors can be involved in these decisions. For instance, if a state hospital sought to remove nutrition and hydration from a patient over whom it had guardianship, there would clearly be state action.

the incidents of governmental authority.¹⁸⁵ It does not appear, however, that this standard would be met by any of the typical parties in a decision to withhold medical treatment. Consider, for instance, a health proxy authorized by a patient to make medical decisions. While the parameters of this relationship are certainly amenable to regulation by state law, the decision to appoint a guardian with certain powers would be the act of the patient, and not of the state. Further, the proxy can generally direct the withdrawal of medical treatment without going to court, and it does not appear that the proxy would be performing a traditional governmental function in doing so. Finally, whatever “injury” might be at issue, it does not appear to be aggravated by the incidents of governmental authority. Since no indicia of governmental interest would appear to be present here, a health proxy would not appear to qualify as a state actor.

A closer question is the constitutional status of a guardian who was appointed, not by the patient, but by a court. For instance, courts have held that the appointment of a guardian is state action, and must comply with the dictates of procedural due process.¹⁸⁶ Thus, the parameters of the appointment process by a state would appear amenable to constitutional challenges, or legislative oversight by the Congress. However, once a guardian has been appointed, most courts have held that since a guardian’s legal obligation is to represent the interests of their ward, that the guardian is not a state actor, and thus is only bound by statutory, not constitutional constraints.¹⁸⁷

The next question is whether state action arises if a health proxy, guardian or other party initiates a legal proceeding regarding the termination of medical treatment. It is certainly the case that the behavior of a judge in a case is state action for purposes of due process.¹⁸⁸ Or, a suit brought by a private party in a court room may give rise to state action, if judicial enforcement of the ruling is seen to be in violation of the constitutional rights of another.¹⁸⁹ However, in a typical proceeding to terminate medical treatment for an incompetent patient, it is unlikely that state action would be

¹⁸⁵ *Edmonson v. Leesville Concrete Co.*, 500 U.S. 614, 622-32 (1991).

¹⁸⁶ *In re Guardianship of L.W.*, 167 Wis. 2d 53 (1992) (“Due process . . . is accorded through the guardianship appointment procedures.”).

¹⁸⁷ *Polk County v. Dodson*, 454 U.S. 312 (1981) (dismissing 42 U.S.C. § 1983 suit by a convict for lack of state action because a public defender acted in an adversarial manner to the state); *Taylor v. First Wyoming Bank*, 707 F.2d 388 (9th Cir. 1983) (court-appointed guardian for person declared judicially incompetent did not act under color of state law for purposes of 42 U.S.C. § 1983 for placing ward in convalescent home); *Meeker v. Kercher*, 782 F.2d 153 (10th Cir. 1986) (guardian ad litem representing minor in state proceeding on petition alleging abuse or neglect did not act under color of state law for purposes of 42 U.S.C. § 1983); *Clay v. Friedman*, 541 F. Supp. 500, 503 (N.D. Ill. 1982) (“In all critical respects, the role of the guardian ad litem is almost identical to that of a public defender. He or she is a fiduciary who must act in the minor's best interest.”).

¹⁸⁸ For instance, it is a violation of due process for a biased or partial judge to preside over a trial. *Mayberry v. Pennsylvania*, 400 U.S. 455 (1971); *Tumey v. Ohio*, 273 U.S. 510 (1927).

¹⁸⁹ *Shelley v. Kraemer*, 334 U.S. 1 (1948) (judicial enforcement of racially restrictive covenant found to be violation of 14th Amendment).

ascribed to a health proxy seeking to terminate treatment, since it is the patient's decision to have that person speak for them. Nor, as noted earlier, would the behavior of even an appointed guardian in a court room typically be found to be state action, unless it was determined that the guardian was acting in collusion with the government.¹⁹⁰ Generally, only actions by private parties opposing the exercise of a patient's right to pursue termination of medical treatment would be amenable to such an analysis.¹⁹¹

Thus, it would appear that the only state actor in the court room in these cases would be the judge (although, as noted, certain opposing parties may also take on this character based on judicial enforcement of their legal positions). As noted, § 5 of the 14th Amendment can only be exercised if Congress can establish a pattern and history of constitutional violations. Since only state actors can violate the constitution, this determination would seem to be limited to instances in which the rights of incapacitated patients are being violated in the courtroom by a judge or opposing parties.

The next step in evaluating where there is a history and pattern of constitutional violations would be determining which constitutional rights these state actors are most likely to have violated. In termination of medical treatment cases, the principal constitutional right at issue is the right to direct one's medical treatment. Thus, under this constitutional theory, establishing a basis for exercise of Congress' power under the 14th Amendment would appear to require establishing a record of state judges disregarding an individual's expressed wishes regarding medical treatment, whether based on the petition of the patient or in response to the request of opposing parties.¹⁹² In the alternative, one might consider the patient's right to procedural due process in proceeding regarding termination of medical treatment, and whether such due process rights have been respected by courts.

b. Substantive Due Process Rights of Incapacitated Patients.

The number of reported court decisions regarding the termination of medical treatment, appears to number in the low hundreds.¹⁹³ And, despite the existence of

¹⁹⁰ *Thomas S. v. Morrow*, 781 F.2d 367 (4th Cir. 1986), *cert. denied*, 476 U.S. 1124 (1986) and 476 US 1124 (1986) (guardian appointed by state for incompetent adult acted under color of state law where he acted together with and obtained significant aid from state officials). “[I]n most civil cases, the initial decision whether to sue at all, the selection of counsel, and any number of ensuing tactical choices in the course of discovery and trial may be without the requisite governmental character to be deemed state action.” *Edmonson v. Leesville Concrete Co.*, 500 U.S. 614, 627-28.

¹⁹¹ Thus, for instance, if state law authorized a parent to countermand a decision to terminate medical treatment of an adult patient, an argument might be made that the parent was imbued with the authority of a state actor. *See Shelley v. Kramer*, 334 U.S. 1 (1948).

¹⁹² Since the legal position of opposing parties only becomes state action upon enforcement by the courts, the following analysis will focus on the court as a state actor.

¹⁹³ *See John D. Hodson, Judicial Power to Order Discontinuance of Life-sustaining Treatment*, 48 A.L.R.4th 67 (2005); Kristine Cordier Karnezis, *Patient's Right to Refuse* (continued...)

some high profile cases where the subjective intent of patient was disputed, such as the Theresa Schiavo case,¹⁹⁴ it is not clear that a significant number of these cases involved seriously disputed testimony or other evidence. Thus, for Congress to establish a record of constitutional violations by judges in these cases, it would need to be shown that the courts disregarded the expressed intent of the patient in some significant number of cases.

It may, however, be difficult, at least based on reported decisions, to establish numerous examples of past constitutional violations arising from court orders directing medical treatment be terminated. For instance, a review of these cases does not reveal instances where a court rejected clearly expressed intentions, such as written living wills or advance directives. Instead, the cases principally concern situations where there was some oral or other evidence regarding “subjective intent,” or where the decision was made based on an “objective intent” standard, evaluating the best interests of the patient.¹⁹⁵

There is no case law indicating that application of either a “subjective intent” standard or an “objective intent” standard is, on its face, a violation of the 14th Amendment. Thus, it would appear that, in order for Congress to establish that a significant number of patients’ rights to direct their medical treatment under the 14th Amendment were being violated, it would need to establish that the factual decisions in some portion of these cases were disputed, and that various courts’ evidentiary conclusions were incorrect. It may be difficult, however, for Congress to establish that a significant number of persons’ wishes were disregarded where no written directives were left, since even the courts sitting in these cases generally have a difficult time discerning a person’s intent.

Even if Congress could establish that there is a pattern and history of courts disregarding the wishes of patients, then a court would need to determine whether the hypothetical proposal would be a congruent and proportionate to the problem. Limiting or restricting the ability of a court to order termination of medical treatment would appear to have the effect of increasing the chance that a person’s desire to have medical treatment continued would be honored. However, the legislation would also appear to have the negative effect of burdening the right to direct that medical treatment be discontinued. In order to justify this disparity, Congress might need to establish a record that the courts evaluating such cases are more inclined to incorrectly ascertain the intent of incompetent patients who wish for the continuation of such treatment than they are of patients who wish for termination. Further, the fact that this burden falls on a private party (the patient as represented by the health proxy or guardian) rather than on a state actor may, under *Morrison*, also detract from the

¹⁹³ (...continued)

Treatment Allegedly Necessary to Sustain Life, 93 A.L.R.3d 67 (2005).

¹⁹⁴ See Kenneth R. Thomas, *The Schiavo Case: Legal Issues*, CRS Report RL32830.

¹⁹⁵ See text accompanying notes 153-164, *supra*.

argument that the legislation is congruent and proportional to constitutional violations.¹⁹⁶

c. Procedural Due Process Rights Not to be Deprived of Life, Liberty or Property.

As noted above, an alternative argument has been made that cases involving the termination of medical treatment should not be decided based solely on a patient's substantive due process right to direct their medical treatment, but should also be characterized as involving a right not to be deprived of life by the state without due process of law.¹⁹⁷ Under this argument, to the extent that a guardian is seeking a particular course of medical treatment, and to the extent that the case is being entertained in the court system, such a course of action must be done in accord with due process. Further, the argument can be made that Congress, using its § 5 authority, can act to ensure that due process rights are protected.

Although the Supreme Court has often addressed the requirements of due process as regards deprivation of "liberty or property," there is little case law relating to the requirements of due process as it relates to the deprivation of "life" in the civil context.¹⁹⁸ For instance, the argument might be made that the hypothetical proposal is consistent with due process requirements, since it requires a more careful analysis of a course of action which may lead to death. In other circumstances, the Court has mandated higher levels of standard of proof based on the importance of the underlying right at issue.¹⁹⁹ For instance, the Court has mandated an evidentiary burden of "clear and convincing" be met where individual interests at stake in a state proceeding are

¹⁹⁶ Thus, while federal court review of state termination of medical treatment cases under prevailing state standards might be seen as directed at states not adequately protecting a patient's constitutional rights to direct medical treatment, changing the standard to burden a patient's right to withdrawal of medical treatment might not be seen as directed at states.

¹⁹⁷ *Cruzan*, 497 U.S. at 281. See James Bopp, Jr. and Daniel Avila, *The Due Process "Right to Life" in Cruzan and its Impact on "Right-to-die" Law*, 53 U. Pitt. L. Rev. 193 (1991). But see *In re Guardianship of L.W.*, 167 Wis. 2d 53 (1992) "[W]e do not view the withdrawal of life-sustaining treatment as depriving the patient of life; rather, it 'allows the disease to take its natural course' [cite omitted]. No one can dispute that the withdrawal of treatment, especially artificial feeding, will result in the death of the patient. However, it is equally indisputable that the result is the natural death of the body, as contrasted to the unnatural prolongation of, in this case, a vegetative state. The state does not deprive an individual of life by failing to ensure that every possible technological medical procedure will be used to maintain that life." *Id.* at 83.

¹⁹⁸ Johnny Killian, George Costello, Kenneth Thomas, *THE UNITED STATES CONSTITUTION: ANALYSIS AND INTERPRETATION 1800* (2002). In criminal cases, procedural due process rights regarding the deprivation of life are generally restricted to the context of capital punishment. *Id.*

¹⁹⁹ "The function of a standard of proof, as that concept is embodied in the Due Process Clause and in the realm of factfinding, is to "instruct the factfinder concerning the degree of confidence our society thinks he should have in the correctness of factual conclusions for a particular type of adjudication." *Addington v. Texas*, 441 U.S. 418 (1979) (quoting *In re Winship*, 397 U.S. 358, 370, (1970) (Harlan, J., concurring)).

both “particularly important” and “more substantial than mere loss of money.”²⁰⁰ Examples of cases where a clear and convincing standard is required include deportation proceedings,²⁰¹ denaturalization proceedings,²⁰² civil commitment proceedings,²⁰³ and proceedings for the termination of parental rights.²⁰⁴

It should be noted, however, that the cases in which the Court has held that clear and convincing evidence is required are generally where governments seek to take unusual coercive action against an individual.²⁰⁵ The instant proposal, by contrast, would appear to involve the federal government seeking to protect the due process interests of an individual against the petition of their guardian or other private party. The Supreme Court held in *Cruzan* that a state’s interest in protecting an incapacitated patient could be the basis for the state to raise the level of evidence of the patient’s intent. However, it does not appear that any court has held that states are constitutionally required to raise the standard for withdrawal of medical treatment.

Thus, the question arises as to whether Congress could establish that there is a pattern and history of incapacitated patients being denied procedural due process rights so that Congress can legislate a clear and convincing standard under § 5. As noted previously, state courts currently use a variety of standards in evaluating cases involving withdrawal of medical treatment, including both subjective intent (decided by either preponderance of or clear and convincing evidence) and the objective test²⁰⁶ (often associated with a best interest standard). It does not appear, however, that any court has held that using these standards violates the incompetent patient’s constitutional rights. Thus, it would appear that Congress would have to establish that courts have unconstitutionally ignored the procedural due process rights of individuals in specific cases, thus violating their due process rights. As noted above, it may, however, be difficult to establish that a significant number of patients’ wishes were disregarded by a court in cases where no written directives were left.

Finally, courts would need to determine whether the proposal is congruent and proportional to solving the problem presented by any constitutional violations that are identified. This may be easier to establish for procedural due process than it would be for substantive due process, as the tendency of the hypothetical proposal to favor

²⁰⁰ *Santosky v. Kramer*, 455 U.S. 745, 756, (1982) (quoting *Addington*, 441 U.S. at 424).

²⁰¹ *Woodby v. INS*, 385 U.S. 276, (1966).

²⁰² *Schneiderman v. United States*, 320 U.S. 118 (1943).

²⁰³ *Addington v. Texas*, 441 U.S. 418 (1979).

²⁰⁴ *Santosky v. Kramer*, 455 U.S. 745 (1982).

²⁰⁵ *Price Waterhouse v. Hopkins*, 490 U.S. 228, 253 (1989) (plurality opinion). *But see Gertz v. Robert Welch, Inc.*, 418 U.S. 323, 342 (1974) (requiring clear and convincing evidence standard in defamation suits).

²⁰⁶ The fate of the “objective intent” tests after passage of the instant proposal is unclear. Since the proposal appears to rely exclusively on the subjective intent of the patient, “objective” decisions, which rely on third party choices, do not appear to fit into this decision-making scheme. Therefore, the proposal might prohibit courts from considering any tests except ones based on the expressed desires of the individual.

continued medical treatment is consistent with the fact that deprivation of life without due process would only occur where the treatment is withdrawn.

Certainly, to the extent that constitutional violations were shown to exist in the application of the current standards to particular situations, the raising of the standard of evidence would make such deprivations more unlikely. On the other hand, a court, in evaluating the congruence and proportionality of the proposal might also note that raising the evidentiary standard could lead to more situations where patients' wishes to terminate medical treatment were not implemented. In essence, a proposal such as requiring clear and convincing evidence in order to withdraw treatment would appear to raise the protection for one constitutional right, while limiting the other. This might undercut an argument that the constitutional rights of the incapacitated patients were being protected by the instant proposal.

2. The Commerce Clause.

An alternative constitutional basis for the proposed Act might be the power of the United States Congress to regulate commerce. As noted above, the United States Constitution provides that the Congress shall have the power to regulate commerce with foreign nations and among the various states.²⁰⁷ This power has been cited as the constitutional basis for a significant portion of the laws passed by the Congress over the last fifty years, and it currently represents one of the broadest bases for the exercise of congressional powers.

Starting in 1937, with the decision in *NLRB v. Jones & Laughlin Steel Corporation*,²⁰⁸ the Supreme Court held that the Congress has the ability to protect interstate commerce from burdens and obstructions which "affect" commerce transactions. In the *NLRB* case, the court upheld the National Labor Relations Act, finding that by controlling industrial labor strife, the Congress was preventing burdens from being placed on interstate commerce.²⁰⁹ Thus, the Court rejected previous distinctions between the economic activities (such as manufacturing) which led up to interstate economic transactions, and the interstate transactions themselves. By allowing Congress to regulate activities which were in the "stream" of commerce, the Court also set the stage for the regulation of a variety of other activities which "affect" commerce.

Subsequent Court decisions found that Congress had considerable discretion in determining which activities "affect" interstate commerce, as long as the legislation was "reasonably" related to achieving its goals of regulating interstate commerce.²¹⁰ Thus the Court found that in some cases, events of purely local commerce (such as local working conditions) might, because of market forces, negatively affect the

²⁰⁷ U.S. Const., Art. I, §8, cl. 3.

²⁰⁸ 301 U.S. 1 (1937).

²⁰⁹ 301 U.S. at 41.

²¹⁰ *United States v. Darby*, 312 U.S. 100 (1941)(approving legislation relating to working conditions).

regulation of interstate commerce, and thus would be susceptible to regulation.²¹¹ The Court has also held that an activity which in itself does not affect interstate commerce could be regulated if all such activities taken together in the aggregate did affect interstate commerce.²¹² Under the reasoning of these cases, the Court has upheld many diverse laws, including laws regulating production of wheat on farms,²¹³ racial discrimination by businesses,²¹⁴ and loan-sharking.²¹⁵

More recent cases have found some limits to these powers. In the 1995 case of *United States v. Lopez*,²¹⁶ the Supreme Court struck down the Gun-Free School Zone Act of 1990, in which Congress had made it a federal offense for "any individual knowingly to possess a firearm at a place that the individual knows, or has reasonable cause to believe, is a school zone."²¹⁷ The *Lopez* case was significant in that it was the first time since 1937 that the Supreme Court struck down a federal statute purely based on a finding that the Congress had exceeded its powers under the Commerce Clause.²¹⁸ In doing so, the Court revisited its prior cases, sorted the commerce power into three categories, and asserted that Congress could not go beyond these three categories: 1) regulation of channels of commerce; 2) regulation of instrumentalities of commerce; and 3) regulation of economic activities which "affect" commerce.²¹⁹

Within the third category of activities which "affect commerce," the Court determined that the power to regulate commerce applies to intrastate activities only when they "substantially" affect commerce.²²⁰ Still, the Court in *Lopez* spoke approvingly of earlier cases upholding laws which regulated intrastate credit transactions, restaurants utilizing interstate supplies, and hotels catering to interstate

²¹¹ 312 U.S. at 121.

²¹² *Wickard v. Filburn*, 317 U.S. 111 (1942).

²¹³ *Id.*

²¹⁴ *See Heart of Atlanta Motel v. United States*, 379 U.S. 241 (1964); *Katzenbach v. McClung*, 379 U.S. 294 (1964).

²¹⁵ *Perez v. United States*, 402 U.S. 146 (1971).

²¹⁶ 514 U.S. 549 (1995).

²¹⁷ 18 U.S.C. §922(q)(1)(A).

²¹⁸ Herman Schwartz, *Court Tries to Patrol a Political Line*, *Legal Times* 25 (May 8, 1995).

²¹⁹ The Court failed to note that to some extent, the three categories are intertwined. For instance, the first category, the regulation of "streams" or "channels" of commerce, allows regulation of the creation, movement, sale and consumption of merchandise or services. But the initial extension of the "streams" of commerce analysis by the Court to intrastate trade was justified by the "effect" of these other activities on commerce. *See NLRB v. Jones & Laughlin*, 301 U.S. 1, 31 (1936). Similarly, the second category, which allows the regulation of such instrumentalities of commerce as planes, trains or trucks, is also based on the theory that a threat to these instrumentalities "affects" commerce, even if the effect is local in nature. *Southern Railway Company v. United States*, 222 U.S. 21, 26-27 (1911)(regulation of intrastate rail traffic has a substantial effect on interstate rail traffic). Thus, the final category identified by the Court appears to be a catch-all for all other activities which "substantially affect" commerce.

²²⁰ 514 U.S. at 559.

guests. The Court also recognized that while some intrastate activities may by themselves have a trivial effect on commerce, regulation of these activities may be constitutional if their regulation is an essential part of a larger economic regulatory scheme. Thus, the Court even approved what has been perceived as one of its most expansive rulings, *Wickard v. Filburn*, which allowed the regulation of the production of wheat for home consumption, since the aggregate of the home grown wheat which was regulated, would have a substantial impact on the market for wheat.²²¹ The Court has since noted that the aggregation principal has only been applied to regulation of economic activities.²²²

Regulation of how hospitals and hospices care for incapacitated patients, however, would appear to fall easily into the power of Congress to regulate commerce. The activity, regulation of the care of patients by hospitals, who are providing such care as a commercial service, would clearly be commercial in nature.²²³ The care of patients in a hospital involves the use of a significant amount of goods that travel in interstate commerce²²⁴ and most hospitals treat out-of-state patients.²²⁵ Since the activity of running hospitals and hospices are economic in nature, the substantial effects test can be met by aggregation of these activities by all regulated hospitals. The argument could be made that Congress has a rational basis to find that regulating the termination of medical treatment would preserve the integrity of the medical industry, and consequently the market for such services. Consequently, it would appear that Congress has significant authority to regulate hospitals and hospices.²²⁶

²²¹ *Wickard v. Filburn*, 317 U.S. 111 (1942).

²²² *United States v. Morrison*, 529 U.S. 598, 613 (2000). The Supreme Court confirmed the dictates of *Lopez* in the case of *United States v. Morrison*. 529 U.S. 598 (2000). In *Morrison*, the Court invalidated a portion of the Violence Against Women Act, which specifically created a private right of action against anyone who committed such a crime, allowing an injured party to obtain damages and other compensatory relief. 42 U.S.C. § 13981 (2000). Applying its holding in *Lopez*, the Court concluded that the activity regulated by the act could not be classified as "economic activity," and therefore the aggregation principle established by *Wickard* did not apply.

²²³ *Summit Health, Ltd. v. Pinhas*, 500 U.S. 322 (1991) (exclusion of a single physician from a single hospital affects interstate commerce); *Russell v. United States*, 471 U.S. 858 (1985) (arson of a two-unit apartment building affects interstate commerce); *Wickard v. Filburn*, 317 U.S. 111, (1942) (farmer's consumption of bread baked from own wheat affects interstate commerce).

²²⁴ *Heart of Atlanta Motel v. United States*, 379 U.S. 241 (1964).

²²⁵ *Katzenbach v. McClung*, 379 U.S. 294 (1964).

²²⁶ The Congress has relied on the commerce clause as the basis for significant regulation of the health care industry. *See, e.g.*, Health Insurance Portability and Accountability Act of 1996, 104 Pub. L. 191 (1996), § 195, which finds that

- (1) provisions in group health plans and health insurance coverage that impose certain preexisting condition exclusions impact the ability of employees to seek employment in interstate commerce, thereby impeding such commerce;
- (2) health insurance coverage is commercial in nature and is in and affects interstate commerce;
- (3) it is a necessary and proper exercise of Congressional authority

(continued...)

Thus, for instance, it would appear that Congress would be within its authority to require that hospitals and hospices, in providing services to incompetent patients, follow certain standards regarding how such patients are treated. While such power would still be limited by other constitutional constraints, such as the right to direct one's own medical treatment, it would appear that Congress could still regulate within those constitutional parameters. So, for instance, Congress might have the authority to require that hospitals or hospices, prior to terminating medical treatment for a patient, seek a court order showing by clear and convincing evidence that this was this wish of the patient.

If Congress were to impose such a requirement on hospitals and hospices, however, the guardians of patients might seek to have those people discharged from a hospital, and brought home to avoid these restrictions. Thus, the question arises as to whether such regulation could be extended beyond hospitals and hospices to reach the actions of private individuals. At first impression, regulation of the health care of private individuals who are not being cared for in a commercial setting would not be amenable to federal regulation. Since the activity was not economic, the effects could not be aggregated, and it would be difficult to show that the economic impact of such activity had a substantial impact on commerce.

The question could be asked, however, whether regulation of individuals who sought to terminate medical treatment outside of a hospital or hospice setting could be reached as a "necessary and proper" part of a larger regulatory scheme. In the case of *Gonzales v. Raich*,²²⁷ the Court evaluated an "as applied" challenge to the Controlled Substances Act as regards obtaining, manufacturing or possessing marijuana for medical purposes. The case was brought by two seriously-ill residents of California who used marijuana in compliance with the California Compassionate Use Act of 1996.²²⁸ The challenge was based on the argument that the narrow class of activity being engaged in — the intrastate, noncommercial cultivation and possession of cannabis for personal medical purposes as recommended by a patient's physician pursuant to valid California state law — did not have a substantial impact on commerce, and thus could not be regulated under the Commerce Clause.²²⁹

In upholding the application of the Controlled Substances Act in the *Raich* case, the Court relied on its decision in *Wickard v. Filburn*,²³⁰ which held that "even if appellee's activity be local and though it may not be regarded as commerce, it may still, whatever its nature, be reached by Congress if it exerts a substantial economic

²²⁶ (...continued)

to impose requirements under this title on group health plans and health insurance coverage (including coverage offered to individuals previously covered under group health plans) in order to promote commerce among the States.

²²⁷ 125 S. Ct. 2195 (2005).

²²⁸ Cal. Health & Safety Code Ann §11362.5 (West Supp. 2005) (providing for the legal possession of medical marijuana by a patient or primary care-giver, upon the written or oral recommendation of a physician).

²²⁹ 125 S. Ct. at 2211.

²³⁰ 317 U.S. 111 (1942).

effect on interstate commerce.²³¹ Based on *Wickard*, the Court in *Raich* held that Congress could consider the aggregate effect that allowing the production and consumption of marijuana for medical purposes would have on the illegal market for marijuana.²³² Of even greater concern was that diversion of marijuana grown for medicinal purposes for other uses would frustrate the federal interest in eliminating commercial transactions in the interstate market.²³³ In both cases, the Court found, the regulation was within Congress' commerce power because the Congress had a rational basis to determine that production of a commodity meant for home consumption, be it wheat or marijuana, could have a substantial effect on supply and demand. In addition, since exempting the use of medical marijuana could undercut enforcement of the Controlled Substances Act, the Court found that the application in this case was within Congress' authority to "make all Laws which shall be necessary and proper"²³⁴ to effectuate its powers.

The use of the Commerce Clause to regulate an individual or their guardian seeking to terminate medical care outside of a hospital or hospice setting, however, is not as clear as it was under *Wickard* and *Raich*. Unlike these cases, it is not apparent that the treatment of patients outside of a medical setting has any significant impact on the market for medical services. In general, for Congress to regulate an entire "class of activities," it must find that the "total incidence" of such practice poses a threat to a national market.²³⁵ Here, Congress could arguably exclude patients outside of hospital or hospice settings without undercutting the goal of preserving the integrity of the medical community.

What might be more relevant question is one alluded to by the majority but directly addressed by Justice Scalia in his concurrence in *Raich* – to what extent is the challenged regulation of non-economic activity "necessary and proper" to the larger economic scheme. In *Raich*, the fungibility of marijuana served to make regulation of locally grown marijuana vital to the larger regulatory scheme. In the instant case, however, if a patient is not in a hospital, it does not appear that the regulation would have any effect on enforcement of the larger economic scheme. Although *Raich* held that Congress need only have a rational basis to discern an economic impact from non-economic activities, regulation of this activity may even exceed that lenient

²³¹ *Id.* at 125. The *Wickard* case upheld the application of the Agricultural Adjustment Act of 1938, 52 Stat. 31. which was designed to control prices by regulating the volume of wheat moving in interstate commerce. The Court in *Wickard* held that the Congress could regulate not only the wheat sold into commerce, but also wheat retained for consumption on a farm. *Id.* at 128-29. The Court did so on the theory that the while the impact of wheat consumed on the farm on interstate commerce might be trivial, it was significant when combined with wheat from other farmers similarly situated. *Id.* at 127.

²³² 125 S.Ct.. at 2207.

²³³ *Id.*

²³⁴ U.S. Const., Art. I, § 8.

²³⁵ *See Perez*, 402 U.S. at 154-155 (quoting *Westfall v. United States*, 274 U.S. 256, 259) (1927)("[W]hen it is necessary in order to prevent an evil to make the law embrace more than the precise thing to be prevented it may do so").

standard. Consequently, it would appear that incompetent patients not in a medical setting might not be amenable to federal regulation.

B. Existing Federal Legislation

1. The Patient Self-Determination Act.

In 1990, Congress passed the Patient Self-Determination Act,²³⁶ which requires that providers of health care service²³⁷ under Medicare and Medicaid maintain written policies and procedures related to Living Wills and other advance directives. The providers are required to provide written information to all adult patients of their rights under State law to make decisions about their medical care, including the right to refuse care and to formulate an advance medical directive. The providers must also inquire whether a person has executed an advance directive, and ensure compliance with State law regarding such directives.

2. Assisted Suicide Funding Restriction Act.

In the 105th Congress, the Congress passed the “Assisted Suicide Funding Restriction Act of 1997,”²³⁸ which prohibits the use of federal funds to pay for assisted suicide. Reminiscent of the Hyde Amendments, which prohibit the use of federal funds to pay for abortions, this legislation prevents federal monies from being paid for any goods or services related to assisted suicide, euthanasia or mercy killing. The law also prevents use of federal funding to support legal advocacy. Although there is no indication that any federal monies were being used for such purposes, the legislation appears to be a constitutional exercise of Congress’ spending power to regulate in the area of the “right to die.”

3. The Controlled Substances Act.

As noted, the state of Oregon allows persons who are terminally ill to seek assistance in committing suicide if they meet certain criteria.²³⁹ In November of 1997, a Drug Enforcement Agency staff report concluded that prescribing a controlled substance with the intent of assisting a suicide would not be a legitimate medical purpose and therefore would violate the Controlled Substances Act (CSA). Consequently, the Drug Enforcement Agency issued a warning that under the Controlled Substances Act, doctors could lose their licenses to prescribe drugs if they helped someone commit suicide. On June 5, 1998, however, the Department of Justice (DOJ) issued a press release rejecting this conclusion.

The DOJ press release reads, in part, as follows:

²³⁶ 42 U.S.C. § 1395cc(f).

²³⁷ This includes hospitals, nursing homes, home health agencies, hospices, HMOs and other prepaid organizations.

²³⁸ Pub. L. 105-12 (1997).

²³⁹ Oregon Rev. Stat. 127.800. § 1.01, *et. seq.*

Physicians . . . are authorized to prescribe and distribute scheduled drugs only pursuant to their registration with the DEA, and the unauthorized distribution of drugs is generally subject to criminal and administrative action. The relevant provisions of the CSA provide criminal penalties for physicians who dispense controlled substances beyond “the course of professional practice,” and provide for revocation of the DEA drug registrations of physicians who have engaged either in such criminal conduct or in other “conduct which may threaten the public health and safety.” Because these terms are not further defined by the statute, we must look to the purpose of the CSA to understand their scope.

The CSA was intended to keep legally available controlled substances within lawful channels of distribution and use. It sought to prevent both the trafficking in these substances for unauthorized purposes and drug abuse. . . . There is no evidence that Congress, in the CSA, intended to displace the states as the primary regulators of the medical profession, or to override a state’s determination as to what constitutes legitimate medical practice in the absence of a federal law prohibiting that practice. Indeed, the CSA is essentially silent with regard to regulating the practice of medicine that involves legally available drugs except for certain specific regulations dealing with the treatment of addicts.

The state of Oregon has reached the considered judgment that physician-assisted suicide should be authorized under narrow conditions and in compliance with certain detailed procedures. Under these circumstances, we have concluded that the CSA does not authorize DEA to prosecute, or to revoke the DEA registration of, a physician who has assisted in a suicide in compliance with Oregon law. . .

The DOJ press release noted that physicians who dispense controlled substances beyond “the course of professional practice” may be subject to criminal penalties, and that those who engage in “conduct which may threaten the public health and safety” may have their authority to prescribe controlled substances revoked. Although the press release did not provide citations for these standards, the phrase “the course of professional practice” may be found in 21 C.F.R. § 1306.04, which provides that:

A prescription for a controlled substance to be effective must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice. . . . An order purporting to be a prescription issued not in the usual course of professional treatment . . . is not a prescription within the meaning and intent of section 309 of the Act (21 U.S.C. 829) and the person . . . issuing it shall be subject to the penalties provided for violations of the provisions of law relating to controlled substances.

Some variation of the other phrase used in the DOJ press release, “conduct which may threaten public health and safety,” was relevant to two different sections of the code: 21 U.S.C. §§ 823 and 824. Under § 823, the Attorney General shall “register” or authorize a physician to prescribe or dispense controlled substances if it is consistent with the “public interest.” In determining the public interest, a variety of factors may be considered, including whether such registration is “consistent with the public health and safety.” Under 21 U.S.C. § 824, a registration “may” be revoked for

a number of reasons,²⁴⁰ including whether the physician has committed such acts as would render his registration inconsistent with the “public interest” as evaluated under factors as defined in § 823(f).²⁴¹

On November 9, 2001, newly appointed Attorney General John Ashcroft reversed the DOJ position and issued a Directive indicating that physician assisted suicide serves no “legitimate medical purpose” under 21 C.F.R. § 1306.04 and that specific conduct authorized by Oregon’s Death With Dignity Act may “render [a practitioner’s] registration . . . inconsistent with the public interest” and therefore subject to possible suspension or revocation.”²⁴² The Directive specifically focused on health care practitioners in Oregon and instructed the DEA to enforce this determination “regardless of whether state law authorizes or permits such conduct by practitioners.”

A doctor, a pharmacist, several terminally ill patients, and the State of Oregon challenged this Directive as a violation of the CSA.²⁴³ The United States Court of Appeals for the Ninth Circuit, in the case of *Oregon v. Ashcroft*, held that the Directive violates the plain language of the CSA, contravenes Congress’ express legislative intent, and oversteps the bounds of the Attorney General’s statutory authority.²⁴⁴ This case is currently on appeal to the Supreme Court.²⁴⁵

The Ninth Circuit, citing a number of federalism cases,²⁴⁶ first noted that “unmistakably clear” statutory authorization is needed for the Attorney General to exercise control over an area of law traditionally reserved for state authority, such as regulation of medical care. According to the court, the CSA expressly limits federal

²⁴⁰ Factors to be considered are whether a registrant (1) has materially falsified an application required by the act; (2) has been convicted of a felony relating to controlled substances; (3) has lost his State license or registration relating to controlled substances; (4) has committed an act inconsistent with the public interest; or (5) has been excluded from participation in a Medicare or state health program pursuant to 42 U.S.C. § 1320a-7(a).

²⁴¹ The five factors specified under 21 U.S.C. § 823(f) are (1) the recommendation of the appropriate State licensing board or professional disciplinary authority; (2) the applicant’s experience in dispensing, or conducting research with respect to controlled substances; (3) the applicant’s conviction record under Federal or State laws relating to the manufacture, distribution, or dispensing of controlled substances; (4) compliance with applicable State, Federal, or local laws relating to controlled substances; (5) such other conduct which may threaten the public health and safety.

²⁴² 66 Fed. Reg. at 56,608.

²⁴³ 21 U.S.C. §§ 801-904.

²⁴⁴ *Oregon v. Ashcroft*, 368 F.3d 1118 (9th Cir. Or., 2004), *cert. granted*, *Gonzales v. Oregon*, 2005 U.S. LEXIS 1453 (2005).

²⁴⁵ *Gonzales v. Oregon*, 2005 U.S. LEXIS 1453 (2005).

²⁴⁶ *See, e.g.*, *Gregory v. Ashcroft*, 501 U.S. 452, 461 (14th Amendment); *Atascadero State Hosp. v. Scanlon*, 473 U.S. 234, 242 (11th Amendment).

authority under the act to the field of “drug abuse,”²⁴⁷ which does not include physician-assisted suicide. Thus, the court suggested, the lack of an “unmistakably clear” indication that Congress intended to authorize the Attorney General to regulate the practice of physician assisted suicide precluded regulation of this practice.

The court further found that the Attorney General’s authorization to revoke prescription privileges from physicians for conduct deemed “inconsistent with the public interest” could not be invoked based solely on a physician participating in a physician-assisted suicide under the Oregon regime. The court noted that when determining what conduct is inconsistent with the public interest under 21 U.S.C. § 823(f), the Attorney General must consider five factors.²⁴⁸ These factors include the recommendation of the appropriate State licensing board; the applicant’s experience with controlled substances; the applicant’s conviction record regarding controlled substances; compliance with applicable State, Federal, or local laws relating to controlled substances; and such other conduct which may threaten the public health and safety. Here, the court found that the Attorney General had only considered whether the conduct was such as would “threaten public health and safety.”²⁴⁹ Consequently, the court struck down the promulgation of the Directive as being outside of the Attorney General’s authority under 21 U.S.C. § 823(f).

4. “For the Relief of the Parents of Theresa Schiavo”.

On March 17, 2005, the Senate passed S. 653, a bill “For the relief of the parents of Theresa Marie Schiavo.” On March 20, the Senate passed S. 686, an almost identical bill with the same name, which the House then passed and the president signed on March 21.²⁵⁰ The law provided that either parent of Theresa Marie Schiavo

²⁴⁷ 21 U.S.C. § 801(2)-(6) (congressional findings and declarations).

²⁴⁸ *See* 21 U.S.C. § 823(f).

²⁴⁹ *Oregon v. Ashcroft*, 368 F.3d. at 1127.

²⁵⁰ Public Law 109-3, 119 Stat. 15 (2005). The only difference between S. 653 and S. 686 appears to be the addition of the following language:

It is the Sense of Congress that the 109th Congress should consider the status and legal rights of incapacitated individuals who are incapable of making decisions concerning the provision, withholding, or withdrawal of foods, fluid, or medical care.

would have standing²⁵¹ to bring a suit in federal court.²⁵² Under the law, the federal courts would determine *de novo*²⁵³ any claim of a violation of any right of Theresa Marie Schiavo under either the Constitution or laws of the United States, as related to the withholding or withdrawal of food, fluids, or medical treatment necessary to sustain her life.²⁵⁴ The suit was to be filed within 30 days of the enactment of the proposed bill. Despite passage of this law, the federal courts declined to order that the feeding tube of Theresa Schiavo be reinserted.²⁵⁵

A number of issues appeared to be raised by the law. First, as discussed previously, there was a question as to under what circumstance a federal court would find sufficient state action to invoke constitutional concerns. Secondly, it is not clear what laws of the United States would be implicated by this issue. In general, the federal courts have jurisdiction over violations of federal constitutional provisions and statutes under federal question provisions. Thus, it was unclear how this law would change existing law.²⁵⁶

²⁵¹ P.L. 109-3, § 2 provides that:

Any parent of Theresa Marie Schiavo shall have standing to bring a suit under this Act. The suit may be brought against any other person who was a party to State court proceedings relating to the withholding or withdrawal of food, fluids, or medical treatment necessary to sustain the life of Theresa Marie Schiavo, or who may act pursuant to a State court order authorizing or directing the withholding or withdrawal of food, fluids, or medical treatment necessary to sustain her life.

²⁵² P.L. 109-3, § 1 provides that

The United States District Court for the Middle District of Florida shall have jurisdiction to hear, determine, and render judgment on a suit or claim by or on behalf of Theresa Marie Schiavo for the alleged violation of any right of Theresa Marie Schiavo under the Constitution or laws of the United States relating to the withholding or withdrawal of food, fluids, or medical treatment necessary to sustain her life.

²⁵³ A *de novo* trial is a hearing on a case as if it had not been heard before and no previous decision had been rendered. Blacks Law Dictionary 435 (2004).

²⁵⁴ P.L. 109-3, § 2 provides that:

In such a suit, the District Court shall determine *de novo* any claim of a violation of any right of Theresa Marie Schiavo within the scope of this Act, notwithstanding any prior State court determination and regardless of whether such a claim has previously been raised, considered, or decided in State court proceedings.

²⁵⁵ For a summary of relevant factual and legal events surrounding this case, see [<http://www.miami.edu/ethics2/schiavo/timeline.htm>] and CRS Report RL32830 (pdf), "The Schiavo Case: Legal Issues."

²⁵⁶ 28 U.S.C. § 1331.

a. Bill of Attainder.

There was also a concern that the specificity of this law might raise constitutional concerns. Article I of the Constitution prohibits passage of Bills of Attainder.²⁵⁷ Under this provision, Congress is prohibited from passing legislation which “appl[ies] either to a named individual or to easily ascertainable members of a group in such a way as to inflict punishment on them without a judicial trial.”²⁵⁸ Generally, the prohibition on Bills of Attainder is intended to prevent the Congress from assuming judicial functions and conducting trials.²⁵⁹ The two main criteria which the courts will look to in order to determine whether legislation is a Bill of Attainder are 1) whether specific individuals are affected by the statute, and 2) whether the legislation inflicts a punishment on those individuals.²⁶⁰

An argument might be made that the Schiavo law was a bill of attainder, but the precedent for this is very limited. Although the bill itself specifically addressed providing a benefit to the parents of Theresa Schiavo, it could have theoretically affected the reputation of Michael Schiavo, and could be seen as interfering with his role as legal guardian of his wife. Although Michael Schiavo was not named in the law, the Supreme Court has held that legislation meets the criteria of specificity if it applies to a person or group of people who are described by past conduct.²⁶¹

By specifying Theresa Schiavo’s parents, limiting the law to facts which related to a pending case, and providing that the suit must be filed within 30 days, the law seemed to establish criteria which only applied to the case regarding Theresa Schiavo. However, the Supreme Court has found that a piece of legislation which is narrowly focused is not a Bill of Attainder merely because the statute might have been set at a higher level of generality.²⁶² In order to find that legislation is a Bill of Attainder, a court would have to establish that the legislation was intended to inflict punishment on this individual or individuals.

While it is true that the law had the potential to disrupt the proceedings in the particular state court case, the mere fact that focused legislation imposes burdensome consequences does not require that a court find such legislation to be an unconstitutional of Bill of Attainder. Rather, the Court has identified three types of

²⁵⁷ U.S. Const. Art. 1, Sec. 9, cl. 3 provides that “No Bill of Attainder or ex post facto Law shall be passed.”

²⁵⁸ United States v. Brown, 381 U.S. 437, 447 (1965).

²⁵⁹ Id.

²⁶⁰ Nixon v. Administrator of General Services, 433 U.S. 425, 472-484 (1977).

²⁶¹ Selective Service System v. Minnesota Public Interest Group, 468 U.S. 841, 847 (1984).

²⁶² 433 U.S. at 470. In fact the Court has upheld a law which specifically affected only one named individual. In Nixon v. Administrator of General Services, the Congress passed the Presidential Recordings and Materials Preservation Act, which directed that the General Services Administration take custody of the presidential papers of a named individual, Richard M. Nixon. The Court held that if there is a rational basis for a legislative classification and no punitive intent, then the Congress may go so far as to legislate against one named individual. 433 U.S. at 472.

“punitive” legislation which are barred by the ban on Bills of Attainder: 1) where the burden is such as has traditionally been found to be punitive; 2) where the type and severity of burdens imposed cannot reasonably be said to further non-punitive legislative purposes; and 3) where the legislative record evinces a congressional intent to punish. Thus, questions could have arisen as to whether the potential burdens on Michael Schiavo’s right to act as her guardian fit into one of these three categories.

The Supreme Court has identified various types of punishments which have historically been associated with Bills of Attainder. These traditionally have included capital punishment, imprisonment, fines, banishment, confiscation of property, and more recently, the barring of individuals or groups from participation in specified employment or vocations.²⁶³ There are no indications by the Court that harming a person’s reputation or intervening in guardianship rights is a type of “punishment” traditionally engaged in by legislatures as a means of punishing individuals for wrongdoing.

The Supreme Court has also indicated that some legislative burdens not traditionally associated with Bills of Attainder might nevertheless “functionally” serve as punishment.²⁶⁴ The Court has stated, however, that the type and severity of a legislatively imposed burden should be examined to see whether it could reasonably be said to further a non-punitive legislative purpose.²⁶⁵ Intervening in guardianship rights does not appear to have been addressed, but there has been legislation regarding affecting a person’s position of responsibility.

Various Supreme Court decisions have invalidated as Bills of Attainder legislation barring specified persons or groups from pursuing various professions, where the employment bans were imposed as a brand of disloyalty.²⁶⁶ For instance, in *Cummings v. Missouri*,²⁶⁷ the Supreme Court noted that “disqualification from the pursuits of a lawful avocation, or from positions of trust, or from the privilege of appearing in the courts, or acting as an executor, administrator, or guardian, may also, and often has been, imposed as punishment.”

An opinion by the United States Court of Appeals for the District of Columbia has specifically addressed the issue of whether a congressional bill limiting custodial rights was a Bill of Attainder. In *Foretich v. United States*,²⁶⁸ the court considered a legislative rider to the 1997 Department of Transportation Appropriations Act entitled “The Elizabeth Morgan Act.” This act provided for specific procedures to be followed in resolving child custody cases in the District of Columbia Superior Court, but was

²⁶³ 433 U.S. at 474-75.

²⁶⁴ 433 U.S. at 475.

²⁶⁵ *Kennedy v. Mendoza-Martinez*, 372 U.S. 144, 168-69 (1963); *Nixon v. Administrator of General Services*, 433 U.S. at 476.

²⁶⁶ *Nixon v. Adm’r of Gen. Servs.*, 433 U.S. 425, 474-75 (1977).

²⁶⁷ *Cummings v. State of Missouri*, 71 U.S. 277, 320 (1867).

²⁶⁸ 351 F.3d 1198 (2003).

written so narrowly as to apply to just one case.²⁶⁹ This case involved a protracted custody battle, where allegations of sexual abuse by the husband had been made. Because the child in the case was no longer a minor, the issue of removal of custodianship was declared by the court to be moot. However, the court found that act imposed “punishment” under the functional test because it harmed the father’s reputation, and because it could not be said to further a non-punitive purpose. To the extent that the proposed law would harm Michael Schiavo’s reputation, these arguments could have been found applicable.

b. Due Process.

Although it was not considered by the courts reviewing this statute, a Due Process argument could have been made that the bill required that Theresa Schiavo comply with an additional set of procedural requirements in order to effectuate constitutional rights. The bill would appear to require a named individual to comply with a set of procedural rules that are not required of any other individuals. This may raise issues of whether a substantive due process right, the right to terminate medical treatment, can be specifically burdened. Further, it could have raised the issue of Equal Protection, as seen in the context of the substantive due process right to terminate medical treatment.

For instance, in *News America Publishing, Inc. v. FCC*,²⁷⁰ the United States Court of Appeals for the District of Columbia applied heightened scrutiny to an act of Congress that singled out “with the precision of a laser beam,” a corporation controlled by Rupert Murdoch. Murdoch’s corporation had applied for, and received, temporary waivers from the FCC’s cross-ownership rules, so that the corporation

²⁶⁹ The act provided:

(a) In any pending case involving custody over a minor child or the visitation rights of a parent of a minor child in the Superior Court which is described in subsection (b)

(1) at anytime after the child attains 13 years of age, the party to the case who is described in subsection (b)(1) may not have custody over, or visitation rights with, the child without the child’s consent; and

(2) if any person had actual or legal custody over the child or offered safe refuge to the child while the case (or other actions relating to the case) was pending, the court may not deprive the person of custody or visitation rights over the child or otherwise impose sanctions on the person on the grounds that the person had such custody or offered such refuge.

(b) A case described in this subsection is a case in which -

(1) the child asserts that a party to the case has been sexually abusive with the child;

(2) the child has resided outside of the United States for not less than 24 consecutive months;

(3) any of the parties to the case has denied custody or visitation to another party in violation of an order of the court for not less than 24 consecutive months; and

(4) any of the parties to the case has lived outside of the District of Columbia during such period of denial of custody or visitation.

²⁷⁰ 844 F.2d 800, 814 (D.C. Cir. 1988).

could acquire two TV licenses, one in Boston, and the other in New York.²⁷¹ Subsequently, Congress passed a law that prevented the FCC from extending any existing temporary waivers; at the time, Murdoch's corporation was the only current beneficiary of any such temporary waivers. The corporation sued, arguing a violation of Equal Protection in the context of the First Amendment. Based on this argument, the court evaluated the law under a heightened scrutiny standard, and struck it down.²⁷²

C. Proposed Legislation

1. "Incapacitated Persons Legal Protection Act of 2005".

The proposed "Incapacitated Persons Legal Protection Act of 2005"²⁷³ (hereinafter proposed Act) amends existing federal *habeas corpus* procedures to deem that an incapacitated person is in the "custody" of any court if such court "authorizes or directs the withholding or withdrawal of food, fluids, or medical treatment necessary to sustain the person's life." Further, that person shall also be deemed to be in the custody of those parties "authorized or directed by the court order to withdraw or withhold food, fluids, or medical treatment." The apparent intent of this language is that an incapacitated person who fits in the described category would be given the opportunity to challenge such withdrawal of nutrition, hydration, or medical treatment in a federal court.

The ultimate impact of this legislation is not clear. The existing federal *habeas corpus* procedure is a federal remedy available to persons in the custody of a state or the federal government.²⁷⁴ It is "available to effect discharge from any confinement contrary to the Constitution or fundamental law, even though imposed pursuant to conviction by a court of competent jurisdiction."²⁷⁵ For instance, 28 U.S.C. § 2254, provides for *habeas corpus* review of persons who are in the custody of state government. This provision, however, has not generally been applied to medically incapacitated persons.

The courts have construed "custody" liberally to include not only actual physical custody but restraints on personal liberty as well, such as parole conditions.²⁷⁶ It appears, however, that 28 U.S.C. § 2254 is limited to situations where the person bringing the petition is in custody pursuant to legal processes initiated by the state,

²⁷¹ *Id.* at 804.

²⁷² *Id.* at 815.

²⁷³ S. 539, 109th Cong., 1st Sess.; H.R. 1151, 109th Cong., 1st Sess.

²⁷⁴ *See* David P. Saybolt, *Habeas Relief for State Prisoners*, 85 Geo. L.J. 1507 (1997).

²⁷⁵ *Preiser v. Rodriguez*, 411 U.S. 475, 485 (1973). Generally, *habeas corpus* proceedings are limited to a review of allegations that an individual has been deprived of a constitutional or fundamental right as a result of state action. *See Hickock v. Crouse*, 334 F.2d 95, 100 (10th Cir. 1964), cert. denied, 379 U.S. 982, 13 L. Ed. 2d 572, 85 S. Ct. 689 (1965).

²⁷⁶ *Jones v. Cunningham*, 371 U.S. 236 (1963).

such as criminal prosecutions, immigration detentions, or juvenile hearings.²⁷⁷ It does not appear that 28 U.S.C. § 2254 has generally been construed to apply to restraints on personal liberty pursuant to court proceedings where a person is solely in the custody of private parties.²⁷⁸

For example, although certain state laws dealing with child custody are called “habeas” statutes, the Supreme Court has found that the federal *habeas* statute has no general application to child custody cases. In *Lehman v. Lycoming County Children’s Services Agency*,²⁷⁹ a mother voluntarily placed three boys in the legal custody of a county agency, which placed the children in foster homes. Subsequently, a state court terminated the mother’s parental rights over the children, and the Pennsylvania Supreme Court affirmed. The mother then sought a writ of *habeas corpus* under 28 U. S. C. § 2254, arguing that the sons were “in custody” pursuant to a state-court judgment in alleged violation of the Federal Constitution.

The mother argued that *habeas corpus* should be available to her in this case because *habeas* is a procedure used in child-custody cases in various states and in England. The Court, however, noted that “Federal habeas when applied to persons under state control is a procedure of unique potency within the federal-state framework, having far different and more far-reaching consequences than a state’s utilization of *habeas* within its own system. State utilization of *habeas* to test the legal custody of a child is part of the fabric of its reserved jurisdiction over child custody matters. If a *habeas* remedy were not provided, some other procedure would be needed to effectuate the state’s substantive interest in these relationships. It is purely a matter of procedural detail whether the remedy is called ‘habeas’ or something else. The federal government, however, has no parallel substantive interest in child custody matters that federal *habeas* would serve.”²⁸⁰

It should be noted that in the above case, the custody of the children had at least briefly passed through the state’s legal control. This would not appear to be the case with most incapacitated persons in a hospital setting. In order for “custody” to arise in such a situation, it would appear that the state would either have to have physical custody and control over the patient’s settings, or that a state would need to act to limit the legal rights of that individual. As discussed in a previous section, most relevant state statutes and state case law regarding the “right to die” are directed to the

²⁷⁷ Andrea G. Nadel, *When Is a Person in Custody of Governmental Authorities for Purpose of Exercise of State Remedy of Habeas Corpus — Modern Cases*, 26 A.L.R.4th 455 (2004).

²⁷⁸ *S.U. v. Youth Care of Utah, Inc.*, 345 F. Supp. 2d 1269, 1271 (2004); See William H. Danne, Jr., *Modern Status of “In Custody” and Live-controversy Requirements for Asserting Federal Habeas Corpus Challenge to Custody Pursuant to State Court Judgment*, 176 A.L.R. Fed. 189 (2004).

²⁷⁹ 458 U.S. 502 (1982). “It is true that habeas has been used in child-custody cases in England and in many of the States. . . .” *Id.* at 514.

²⁸⁰ 458 U.S. at 515, *citing* *Sylvander v. New England Home for Little Wanderers*, 584 F.2d 1103, 1111 (1st Cir., 1978).

implementation of individual rights, not to their limitation.²⁸¹ Thus, it would appear even less likely that an incapacitated person would generally be considered to be in custody of a state, even if a court order had been issued regarding their medical treatment.

The proposed Act would appear to avoid these issues by providing that for purposes of the *habeas corpus* statute, a court that authorizes or directs the withholding of nutrition or hydration is deemed to be the custodian of the patient. Thus, the act would appear to bring such a patient within the ambit of the *habeas corpus* provision. However, even if an incapacitated person was found to be in custody of a state, the questions would arise as to what constitutional authority would exist to review the state court's holding.

The findings of the proposed Act suggest that the constitutional basis for the bill is section 5 of the Fourteenth Amendment. As was noted previously, in *Flores v. City of Boerne*, the Supreme Court held that section 5 of the Fourteenth Amendment is available as a basis for a statute when such law is a "congruent and proportional response" to a pattern and history or constitutional violations.²⁸² This raises two issues: 1) can Congress establish a pattern or history violations of the constitutional rights of incapacitated persons who are subject to a court order withdrawing nutrition or hydration; and 2) is the proposed Act a "congruent and proportional" response?

In order to address the first issue, one must postulate what constitutional violation the proposed Act is intended to remedy. As was noted above, it would appear that the constitutional right at issue is either the right of a patient to direct one's own medical treatment (as was at issue in the case of *Cruzan v. Missouri Dept. of Health*),²⁸³ or a concern about procedural due process. There is no indication that state legislation and case law which is currently on the books regarding advance directives or guardianship significantly limits the exercise of either the right to direct medical treatment or denies incompetent patient's procedural due process rights.²⁸⁴ Thus, it would appear that Congress would need to establish that there is a pattern of courts using neutral laws to disguise an effort to deny the constitutional rights of incapacitated person to direct their own medical treatment.

As discussed above, under *United States v. Morrison*, Congress would also need to establish that such violation of constitutional rights occurred as a result of actions attributable to the state, not as a result of private activity.²⁸⁵ The Court has long held that the Fourteenth Amendment provides the Congress the authority to regulate states,

²⁸¹ See text accompanying notes 50-53, *supra*.

²⁸² *Flores v. City of Boerne*, 521 U.S. 507 (1997). Section 5 provides that "The Congress shall have power to enforce, by appropriate legislation, the provisions of this article."

²⁸³ 497 U.S. 261, 302 (1990).

²⁸⁴ See *United States v. Raines*, 362 U.S. 17, 25 (1960)(state action is found when a legislature passes a bill which violates the constitution).

²⁸⁵ See discussion *supra*.

but not individuals.²⁸⁶ Thus, evidence regarding the treatment of patients who had nutrition and hydration withheld outside of the court context might not be deemed relevant. Rather, the Congress would need to establish that there was a pattern and history of court cases directing either the application or withdrawal of medical treatment in contravention to the incompetent patients' desires.

Also, as discussed above, an alternative constitutional basis for the proposed Act might be the power of the United States Congress to regulate commerce. This power has been cited as the constitutional basis for a significant portion of the laws passed by the Congress over the last fifty years, and it currently represents one of the broadest bases for the exercise of congressional powers. The proposed Act, however, does not address channels or instrumentalities of commerce: it contains no requirement that interstate commerce be affected; it is not part of a larger regulatory scheme to regulate commerce; nor does it regulate an economic activity. Rather, it is a law designed to regulate the activity of state courts in evaluating incapacitated patients regarding medical decisions. Consequently, in order for the Commerce Clause to be established as a basis for the proposed Act, the Congress may need to take additional steps to establish a relationship between the activity to be regulated and interstate commerce.

2. "Protection of Incapacitated Persons Act of 2005".

On March 16, 2005, the House of Representatives passed H.R. 1332,²⁸⁷ the "Protection of Incapacitated Persons Act of 2005" (hereinafter "Protection Act"). This bill would amend the removal provisions of Title 28 to provide for the removal to federal court of state cases involving the withdrawal of nutrition or hydration from an incapacitated person, where that person did not leave a written advance directive regarding their treatment.²⁸⁸ These claims can only be brought after all state remedies have been exhausted, and the case may be brought by the incapacitated person or a

²⁸⁶ See *Shelley v. Kraemer*, 334 U.S. 1, 13 (1948).

²⁸⁷ 109th Cong., 1st Sess.

²⁸⁸ H.R. 1332(b) provides for removal of cases where a:

state court authorizes or directs the withholding or withdrawal of food or fluids or medical treatment necessary to sustain the incapacitated person's life, but does not include a claim or cause of action in which no party disputes, and the court finds, that the incapacitated person, while having capacity, had executed a written advance directive valid under applicable law that clearly authorized the withholding or withdrawal of food or fluids or medical treatment in the applicable circumstances.

“next friend.”²⁸⁹ A “next friend” includes anyone who has a significant relationship with the incapacitated person, including his or her parents.²⁹⁰

The proposed Protection Act provides that a federal court may hear a claim or cause of action regarding a directive to withhold food, fluids or medical treatment necessary to sustain the incapacitated person’s life. Such a review may only extend to whether there is a deprivation of a constitutional right or federal statutory right.²⁹¹ Such a determination will be made *de novo*, and the litigation of previous issues at the state level will not bar relitigation of these issues.²⁹²

These provisions appear to differ significantly from other federal removal provisions. Generally, removal is a doctrine which is reserved for defendants who have been sued,²⁹³ while this bill would allow removal of cases involving incapacitated persons, who are likely to be in court under guardianship proceedings. Second, the bill requires that all state proceedings be exhausted, while removal provisions must be made within 30 days of the filing of the case.²⁹⁴ In addition, removal to federal court would not generally eliminate issues of abstention and issue preclusion, as is done by the present bill.

There appear to be no apparent constitutional issues raised on the face of the bill. For instance, an incapacitated person could be in the care of a Veteran’s Administration Hospital, and a decision made by the administration of that hospital

²⁸⁹ H.R. 1332(b) provides that removal is available:

not later than 30 days after available State remedies have been exhausted, an incapacitated person, or the next friend of an incapacitated person, may remove any claim or cause of action described in subsection (b) to the United States district court for the district in which the claim or cause of action arose, or was heard.

²⁹⁰ H.R. 1332(e)(2) provides that a “next friend” is:

an individual who has some significant relationship with the real party in interest, and includes a parent.

²⁹¹ H.R. 1332(b) provides:

hearing and determining a claim or cause of action removed under this section, the court shall only consider whether authorizing or directing the withholding or withdrawal of food or fluids or medical treatment necessary to sustain the incapacitated person’s life constitutes a deprivation of any right, privilege, or immunity secured by the Constitution or laws of the United States.

²⁹² H.R. 1332 (d) provides that the:

United States district court shall determine *de novo* any claim or cause of action considered under subsection (c), and no bar or limitation based on abstention, res judicata, collateral estoppel, procedural default, or any other doctrine of issue or claim preclusion shall apply.

²⁹³ Charles Alan Wright, Mary Kay Kane, LAW OF THE FEDERAL COURT 225 (2002).

²⁹⁴ *Id.* at 243.

to withhold medical treatment despite an advance medical directive directing otherwise. In that case, an argument could be made that an agency of the United States was acting so as to violate the constitutional rights of that individual to direct their own medical treatment. Or, if a state passed a law which had the effect of requiring termination of medical treatment against the direction of an individual, this may also be a violation of constitutional rights.

There also appears to be no constitutional problem on the face of the bill regarding the provision of “next friend” status for purposes of litigation. The practice of allowing a “next friend” to bring such a suit is well-established,²⁹⁵ and a person with a significant enough relationship with the patient, such as a parent,²⁹⁶ would appear to be able to take advantage of its provisions despite issues of standing.²⁹⁷

A question does arise, however, whether this bill would have practical application to situations where an individual is not in a government facility and is not challenging a state law. In such a context, the question arises as to what constitutional rights are at issue. In general, actions by private individuals or entities are not of constitutional significance; only actions by a government lead to the violation of constitutional rights.²⁹⁸ So, if a hospital or facility caring for an incapacitated individual moved to terminate medical treatment of an individual patient, no constitutional rights appear to be implicated.

As noted previously, a more complicated issue arises when a court has become involved in such a situation, and has directed or authorized the withdrawal of medical treatment. In the case of *Shelley v. Kraemer*,²⁹⁹ the Supreme Court found that state action could arise based on the contractual and property rights of a private individual, if the court, in the act of enforcing those rights, violated the Equal Protection Clause. Specifically, the Court held that a state court could not enforce restrictive covenants in deeds of residential property by which the owners would agree that the property should not be used or occupied by any person except a Caucasian.

It is not apparent, however, that a guardian automatically becomes a state actor, since, where appropriate, a legal guardian is expected to stand in the place of the

²⁹⁵ Caroline Nasrallah Belk, *Next Friend Standing and the War on Terror*, 53 Duke L.J. 1747 (2004). “The doctrine of next friend standing permits persons unable to prosecute their own actions to have third persons litigate in their stead. In U.S. courts, next friend standing is authorized by common law and, in the context of habeas corpus proceedings, by statute.”

²⁹⁶ The existence of a relationship generally creates a presumption of standing that may be rebutted by other information. Although having a family relationship, or being hired or appointed as counsel, may be strong evidence of the “best interests” prong, in practice most courts are willing to look at other evidence. *Id.* at 1775.

²⁹⁷ Next friend standing constitutes an exception to traditional standing rules, which generally require that litigants bring suit only for their own injuries and prohibit suits on behalf of third parties. *Id.* at 1750.

²⁹⁸ See *Shelley v. Kraemer*, 334 U.S. 1, 13 (1948).

²⁹⁹ *Id.*

patient, not in opposition to her. In *Kraemer*, the Court noted, “these are cases in which the States have made available to such individuals the full coercive power of government to deny to petitioners, on the grounds of race or color, the enjoyment of property rights in premises which petitioners are willing and financially able to acquire and which the grantors are willing to sell.”³⁰⁰ Thus, it is not clear that the doctrine of *Shelley v. Kraemer* would be extended without a showing that the guardian was seeking the approval of the court to act against the interests of his or her charge.

D. Congressional Subpoenas and Congressional Requests

On March 17, 2005, Senator Mike Enzi (R-WY), Chairman of the Senate Health, Education, Labor and Pensions Committee sent a letter to Terri Schiavo and her husband requesting their presence at a hearing before his Committee on Monday, March 28. According to a committee press release, the purpose of the hearing, “Health Care Provided to Non-ambulatory Persons,” was to review health care policies and practices relevant to the care of non-ambulatory persons such as Mrs. Schiavo. It was further noted that federal criminal law protects witnesses called before official congressional committee proceedings from anyone who may obstruct or impede a witness’ attendance or testimony. More specifically, the law protects a witness from anyone who — by threats, force, or by any threatening letter or communication — influences, obstructs, or impedes an inquiry or investigation by Congress.

On March 18, the House Committee on Government Reform issued subpoenas to Michael Schiavo, Victor Gambone, Stanton Tripodis, Annie Santamaria and Theresa Schiavo. The subpoenas required the recipients to testify at a Committee field hearing and to produce “all medical and other equipment that provides nutrition and hydration to Theresa Schiavo — in its current and continuing state of operations — and all data, information, and records relating to the functioning of such medical and other equipment, subject only to such routine and necessary maintenance as is necessary to ensure its continued proper functioning to provide such nutrition and hydration to Theresa Schiavo.” The field hearing at which the subpoena recipients were required to testify and produce the listed items was scheduled for March 25, 2005 at the Hospice of the Florida Suncoast, where Theresa Schiavo was located.

On March 18, the House Office of General Counsel filed a motion in the Circuit Court for Pinellas County, Florida, Probate Division to modify the court’s order directing Michael Schiavo to remove nutrition and hydration from Theresa Schiavo on March 18,³⁰¹ so that such removal would occur on March 29. This motion was made in order to allow the recipients of the House subpoenas to comply with the Committee subpoena, and to give the Committee the opportunity to fulfill its investigative function at its field hearing on March 25. Although a brief stay was issued, the presiding judge in this case denied the motion, and subsequently the nutrition and feeding tubes were removed.

³⁰⁰ *Id.* at 19.

³⁰¹ *See* Order, *Schiavo v. Schindler* at 3, Case No. 90-2908-GD-003 (Feb. 25, 2005)(“Ordered and Adjudged that absent a stay from the appellate court, the guardian, Michael Schiavo, shall cause the removal of nutrition and hydration from the ward, Theresa Schiavo, at 1:00 p.m. on Friday, March 18, 2005”).