



1997

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12 St. John's J. Legal Comment. 599-609 (1997)

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THE CONSTITUTIONAL RIGHT TO DIE: ETHICAL CONSIDERATIONS

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Thank you. I should begin by mentioning my conflicts of interest. Not only did I co-author one of the amicus briefs before the Supreme Court,¹ but I have also been writing with Timothy Quill and others in support of physician-assisted suicide dying.²

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Professor Gostin is the Editor of the Health Law and Ethics section of the *Journal of the American Medical Association (JAMA)*. He is also on the editorial board of scholarly journals, including the *Yale Journal on Regulation*, the *International Journal of Bioethics*, and the *International Journal of Health and Human Rights*. Formerly, Professor Gostin was Editor-in-Chief of the *Journal of Law, Medicine & Ethics*, Executive Editor of the *American Journal of Law & Medicine*, and Western European Editor of the *International Journal of Law and Psychiatry*.

As a member of the President's Task Force on National Health Care Reform, Professor Gostin's principal areas of work included the ethical foundations of the health care system, public health, and privacy and health information (Chair).

Professor Gostin was formerly Executive Director of the American Society of Law, Medicine & Ethics and Adjunct Professor of Law and Public Health at Harvard University. In the United Kingdom, Professor Gostin was the Chief Executive of the National Council for Civil Liberties, Legal Director of the National Association of Mental Health, and a member of the faculty of Oxford University. Professor Gostin received the Rosemary Delbridge Memorial Award from the National Consumer Council (U.K.) as the person "who has most influenced Parliament and Government to act for the welfare of society." He also received the Key to Tokyo University (Japan) for distinguished contributions to human rights in mental health.

¹ See Amicus Brief of Law Professors for Respondents, *Vacco v. Quill*, Washington v. Glucksberg (Nos. 95-1858, 96-110), Dec. 10, 1996, available in 1996 WL 709330.

² See Lawrence O. Gostin, *Deciding Life and Death in the Courtroom: From Quinlan to Cruzan, Glucksberg, and Vacco—A Brief History and Analysis of Constitutional Protec-*

I believe that constitutional law really cannot be separated from the morals and ethics involved in this discussion.³ Consequently, I will address three primary areas.

First, I am going to look at some ethical reasoning supporting physician-assisted dying. Second, I will examine some of the lines that have been drawn between withdrawing and withholding life sustaining treatment⁴ on the one hand and physician-assisted dying on the other.⁵ Finally, I will relate both of these matters to constitutional reasoning beginning with *Cruzan*⁶ and ending with the cases currently before the Supreme Court.⁷

Let us begin with a discussion at the ethical level by looking at some of the principles that might help guide us through our inquiries. We need to remind ourselves that we do not need to be judges, lawyers or law professors to understand this issue. This is an issue that exists at the deepest human level, and involves a far reaching social debate which involves us all.⁸ We will all face this issue whether we are young, old, male, female, healthy, sick. Therefore, we have to try to understand what kinds of ethical principles might guide this kind of fundamentally important decision in all of our lives.

We ought to start with the ethical principle of respect for persons. That is, everyone who is competent has an autonomy interest in deciding what will happen with their lives, and what

tion of the 'Right to Die', 278(18) JAMA 1523, 1523-28 (1997); Frank G. Miller & Timothy E. Quill, et. al., Regulating Physician-Assisted Death, 331(2) NEW ENG. J. MED. 119, 119-23 (1994).

³ See generally DEREK HUMPHRY & ANN WICKETT, *THE RIGHT TO DIE: AN HISTORICAL AND LEGAL PERSPECTIVE OF EUTHANASIA* (1987) (providing overview of right to die controversy).

⁴ See THOMAS A. RAFFIN, *WITHHOLDING AND WITHDRAWING LIFE SUPPORT: MEDICAL ASPECTS IN LEGAL ASPECTS OF MEDICINE* (James R. Vevain et al. eds., 1989) (discussing removal of life support as non-culpable option).

⁵ See T. Howard Stone & William J. Winsdale, *Physician-Assisted Suicide and Euthanasia in the United States*, 16 J. LEGAL MED. 481, 482 (1995) (noting that majority of states do not permit physician-assisted suicide).

⁶ See *Cruzan v. Missouri Dep't of Health*, 497 U.S. 261, 278 (1990) (recognizing existence of right to refuse medical treatment as inherent in liberty interest of Fourteenth Amendment).

⁷ See *Quill v. Vacco*, 80 F.3d 716, 731 (2d Cir. 1996) (finding New York Statute banning physician-assisted suicide unconstitutional), *rev'd*, 117 S. Ct. 2293 (1997); *Compassion in Dying v. Washington*, 79 F.3d 790, 793-94 (9th Cir. 1996) (holding that prohibition against physician-assisted suicide violated Equal Protection Clause of Fourteenth Amendment), *rev'd sub nom.*, *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997).

⁸ See generally GERALD A. LARUE, III, *PLAYING GOD - 50 RELIGIONS' VIEWS ON YOUR RIGHT TO DIE* (1996) (offering differing views on individual right to choose when to die).

people can or cannot do with their lives.⁹ Given our human sense of respect for persons, I think that each individual ought to have a sense of control. This sense of control should encompass our entire life span, including the dying process. Therefore, it ought to give us the right to determine the manner and timing of our own death, so that we have some voice in this final chapter in human life.¹⁰

The dying process, after all, is the most intimate, private and fundamental of all parts of life.¹¹ It is the voice that we, as humans, assert in influencing this autonomous part of our life. At the moment of our death, this right of autonomy ought not to be taken from us simply because we are dying.¹²

An autonomous person should not be required to have a good reason for the decision that he or she will make; that is the nature of autonomy. We do not judge for other competent human beings what may be in their best interest, but instead allow them to determine that for themselves.

As such, an autonomous person does not need to have a good understanding or even good reasons. All they need is an understanding of what they are confronting.¹³ There is no reason to believe that when a person faces imminent death that they have less human understanding, or less ability to fathom what they will face, than other people.

Of course, death is a mystery. But death is what we will all confront sooner or later, and we all may wish to assert our interests in how we may die. It doesn't matter how we assert those interests. Some of us may believe passionately in the sanctity of life. If a person holds this belief, he or she will choose not to expedite the natural dying process. Others, however, may believe

⁹ See *Cruzan*, 497 U.S. at 278 (holding competent person has constitutionally protected liberty interest in refusing medical treatment).

¹⁰ See generally MARGARET C. JASPER, *THE RIGHT TO DIE 1* (1996) (suggesting that primitive societies viewed assisting dying as act of mercy and respecting ill people and modern society views assisting dying as compassionate and merciful).

¹¹ See generally RITA MARKER, *DEADLY COMPASSION* (1995) (discussing personal and public sides of euthanasia debate).

¹² See Rachel D. Kleinberg & Toshiro M. Mochizuki, *The Final Freedom: Maintaining Autonomy and Valuing Life in Physician-Assisted Suicide Cases*, 32 HARV. C.R.-C.L. L. REV. 197, 197 (1997) (explaining that federally recognized ban on assisted suicide constituted equal protection violation).

¹³ See *Schloendorff v. Society of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914) (stating that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his body").

that living in anguish is not meaningful. If a person holds this view, he or she may seek assistance in dying at some point. It should not matter which choice a person makes, provided that choice is free and informed.

Although we may not need any reasons for making autonomous decisions, the reasons asserted by most patients are understandable. They are fathomable on a human level. People may confront unendurable pain, mental anguish, emotional anguish, suffering, indignity and knowledge of the inevitability of the result.

This is a person who neither wants to die nor seeks to die. Therefore, I think that physician-assisted suicide is not the right term because the person is not seeking suicide. They know they will die soon, and their only decision is to decide how best they can make that death as peaceful, as humane, and respectful of their own integrity as possible.¹⁴

In *Cruzan*, in a wonderful dissent by one of my heroes Justice Brennan, he asked who should make the decision about withdrawing life sustaining treatment.¹⁵ Should it be the government or the state? Or should it be the person's family? He then paused and said, "To ask that question is to answer it."¹⁶ I think that is the answer today. Who is best to decide the timing and manner of one's own death than oneself, without state interference?

I also believe that the ethical principle of beneficence militates in favor of permitting physician-assisted dying. We seek a physician's help in relieving suffering and affording comfort. We may never choose that physician's assistance in our death and to me, that is one of the most important parts of physician-assisted dying. It is the comfort that we give each other by knowing that at the moment of our death, our physician will not turn his or her back on us. We may never want to use the physician's assistance and the overwhelming majority of us do not wish to use

¹⁴ See generally Cheryl K. Smith, *What About Legalized Assisted Suicide*, 8 ISSUES L. & MED. 503, 513 (1993) (noting that assisted death is exercise of free will and is not to be viewed as taking of life).

¹⁵ See *Cruzan v. Missouri Dep't of Health*, 497 U.S. 261, 303 (1990) (Brennan, J., dissenting) (stating relatively narrow question before Court).

¹⁶ See *id.* at 303-05 (Brennan, J., dissenting) (offering answer to question before Court).

it.¹⁷ But one day, if we are in unendurable pain and facing certain death, we would like the comfort of knowing that we will not be abandoned when we need help the most.¹⁸

A third kind of ethical reasoning is consequentialist reasoning. Oddly enough, it is the consequentialist, rather than the normative area, that concerns me most about my decision on physician-assisted dying. I am not one who feels absolutely certain in the correctness of my position in this debate. My greatest concern is the idea of the vulnerability and the potential for exploitation and abuse in physician-assisted dying. Some people put it rhetorically as follows: How can we, in a society that does not give the right to healthcare, give the right to have a physician's assistance in the dying process? I think that is a powerful rhetorical statement.

I would answer it in the following way: I believe that we ought to have a right to healthcare, and have the kind of palliative remedial treatment that may be needed. At the same time, I also believe that the state ought not interfere in a physician-patient relationship, where both the physician and patient agree that they would wish assistance to hasten death.

I realize that this could be problematic for those who are elderly, poor and disenfranchised in society.¹⁹ I also worry greatly that, in a society where healthcare costs are so monumental, such a burden on individuals and families might result in individuals hastening their death because of the financial responsibility borne by their families if they continue to live.²⁰ This is something that worries me a great deal, and it is something that I know we, as a society, must discuss.

I do believe that while physician-assisted dying has certain problems from a consequentialist point of view, there is no reason why we cannot have careful, precise and thoughtful safe-

17 See *Abstracts*, 13 ISSUES L. & MED. 105, 107 (1997) (stating that clear majority of persons do not support physician-assisted suicide).

18 See Marshall B. Kapp, *Old Folks on the Slippery Slope: Elderly Patients and Physician-Assisted Suicide*, 35 DUQ. L. REV. 443, 444 (1996) (noting that public opinion polls show America's youth are more supportive of physician-assisted suicide than elderly Americans).

19 See ALAN MEISEL, *THE RIGHT TO DIE* 76 (2d ed. 1995) (suggesting safeguards needed to successfully implement aid in dying process).

20 See Scott FitzGibbon & Kwan Kew Lai, *The Model Physician-Assisted Suicide Act and the Jurisprudence of Death*, 20 HARV. J.L. & PUB. POL'Y 126, 141-42 (1996) (discussing economic benefits of physician-assisted suicide).

guards to ensure that only competent individuals make these decisions.²¹ We must also ensure that no undue burden exists or coercion is exercised upon these individuals. I do not think this will make these problems go away, but I do think that it will ease it.

My next point related to both ethics and law is the question of line drawing. Most of you will remember that society went through very much the same thing that we are going through now when it looked at the questions of withdrawing and withholding life sustaining treatment.²² It took more than a decade of ethical and judicial reasoning for us to now accept that it is ethically, constitutionally and legally appropriate for physicians to withdraw or withhold life sustaining treatment.²³

There are powerful ethical reasons that have been offered for this. Philosophically, there is another inquiry that we need to make: Are there any morally relevant distinctions between seeking a physician's assistance at the end of life and the abatement of treatment, the withdrawal or withholding of treatment?²⁴

Therefore, I want to posit two similarly situated cases to you. First, a person is under life support and she is seeking to hasten her death by withdrawal of life support, whether it be a nasal gastric tube, respirator or the like. The second is a person who is not on life support, but is similarly dying, seeking to hasten her death by self-administration of prescription medication.

There are several reasons why people believe that a rational distinction can be drawn between those two cases. However, I think that those distinctions are not morally relevant. The first is that physician-assisted dying requires an active physician's

21 See Edward J. Larson, *Prescription for Death: A Second Opinion*, 44 DEPAUL L. REV. 461, 482 (1995) (discussing state interest in deterring undue influence upon competent, terminally ill patients).

22 See, e.g., Rebecca L. Rosnack, *Termination of Life-Sustaining Treatment: The Decision-Making Process After Cruzan v. Missouri Dep't of Health*, 43 BAYLOR L. REV. 842, 862 (1991) (continuing debate regarding health care legislation which permits withdrawing of life-sustaining medical treatment).

23 See Lonnie R. Bristow, *Report of the Board of Trustees of the American Medical Association: Euthanasia/Physician-Assisted Suicide: Lessons in the Dutch Experience*, 10 ISSUES L. MED. 81, 89-90 (1994) (discussing physician-assisted suicide and concluding that physicians should avoid assisted suicide as it is contrary to practice of medicine).

24 See Daniel Callahan & Margo White, *Legalization of Physician-Assisted Suicide Creating a Regulatory Potemkin Village*, 30 U. RICH. L. REV. 1, 73 (1996) (recognizing active and passive distinctions between both procedures).

role. This distinction is based on the difference between an act and an omission—a distinction that most moral philosophers have long ago relinquished.²⁵

The physician acts affirmatively in hastening death in both cases.²⁶ In fact, it is plausible to say that the physician must do more in withdrawing treatment. It is a complicated procedure to withdraw a nasal gastric tube and prescribe palliative medication for the patient. Is it not much less active for the physician simply to write a prescription? In both cases, the result is the same and in both cases there is a clear affirmative act that results in the death.²⁷

The second moral reason that has been proffered is that physician-assisted dying causes death that would not otherwise result from the underlying disease. In both cases, death is not a result of the underlying disease, but a consequence of the physician's behavior.²⁸ When a physician withdraws a feeding tube, the person does not die from her underlying disease, but rather from starvation. The same is true with a ventilator. Patients do not die from the underlying disease, they die from a lack of respiration. There is an affirmative relationship between what the physician does and the certain death that follows.²⁹

My analysis does warrant a caveat. For example, when a person is under artificial respiration, it is possible to argue that absent the ventilator, the person would die of the underlying disease that prevents respiration. The same thing would be true for a comatose person who has a nasal gastric tube. The underlying

25 See James S. Reitman, M.D., *The Debate on Assisted Suicide—Redefining Morally Appropriate Care for People with Intractable Suffering*, 11 ISSUES L. & MED. 299, 299-300 (1995) (discussing physician's role in relieving patient's suffering).

26 See Amicus Brief of the American Medical Student Association and a Coalition of Distinguished Medical Professionals in Support of Respondents, *Vacco v. Quill*, Washington v. Glucksberg (Nos. 95-1858, 96-110), available in 1996 WL 709332, at *7 (explaining that physician's removal of life support from dependent patient is affirmative act and causally no different than physician's affirmative act in assisting in suicide of terminal patient).

27 See George P. Smith, II, *Symposium on Law and Medicine, All's Well That Ends Well: Toward a Policy of Assisted Rational Suicide or Merely Enlightened Self-Determination*, 22 U.C. DAVIS L. REV. 275, 350 (1989) (discussing omissions to act and resulting liability).

28 See generally BARRY FURROW, *BIOETHICS: HEALTH CARE AND ETHICS* 320 (1991) (discussing passive and active conduct).

29 See generally Paul J. Zwier, Allen Chair Symposium, *Looking for a Nonlegal Process: Physician-Assisted Suicide and the Care Perspective*, 30 U. RICH. L. REV. 199, 208 (1996) (acknowledging that withdrawal of medical technology "includes an affirmative act of doing something, whether it be removing a tube or turning off the respirator").

disease prevents the patient from taking in food. Although the distinctions may have some moral differences, they are negligible because, in both cases, the doctor's intervention is so closely related to the death itself.³⁰

A third distinction, and this is one that has been expressed significantly and powerfully in the Jesuit tradition, is the idea of intention. That is, in physician-assisted dying, the doctor and the patient intend the patient's death. This intent is what is considered morally wrong. In both cases, I think there is a very strong moral claim that the intent is the same. In both cases, both the physician and the doctor do intend the same result, the patient's death. The patient wants to die in both cases. Given the current state of their disease and their dying process, the patient chooses to die. To be sure, it is not that the patients want to die; indeed they would like to live if they had a decent quality of life. It is only that they want to be free from pain, physical, mental, emotional suffering, and indignity. Therefore, in both cases, withdrawing life sustaining treatment and physician-assisted dying, the patient's intent is the same. Furthermore, the doctor and the patient realize and know that death will be the consequence of the decision that they make. Given this context, in terms of what we know and what we intend, there is very little difference.

We often speak of terminal sedation. This is often called in medical jargon "the double effect."³¹ The double effect has been something that has been going on in medicine for many years. In such a circumstance, the patient is dying and the patient and doctor know the inevitable result. Although they both know what each wants, they know that there is a criminal proscription against affirmatively killing the patient. In order to circumvent the criminal liability, the doctor gives so much sedation that it impedes or impairs respiration and the patient stops breathing.

30 See James Bopp, Jr., *Nutrition and Hydration for Patients: The Constitutional Aspects*, 4 ISSUES L. & MED. 3, 14 (1988) (discussing whether death from removal of feeding tube results in underlying natural death).

31 See Peter Blanck et al., *Socially-Assisted Dying and People with Disabilities: Some Emerging Legal, Medical, and Policy Implications*, 21 MENTAL & PHYS. DISABILITY L. REP. 538, 539 (1997) (discussing "double effect" of palliative care which may result in death of patient); see also Alycia C. Regan, *Regulating the Business of Medicine: Models for Integrating Ethics and Managed Care*, 30 COLUM. J.L. & SOC. PROBS. 635, 648n.62 (1997) (defining principle of "double effect" as being used "to evaluate whether action involving more than one effect is moral").

Both patient and doctor know what is going on, and there is a double effect.³² The effect is to give sedation in the sense that we want to ease pain, but the knowledge is that the person will die.

Finally, let me relate this to the Constitution. I think that the substantive due process question is the stronger claim.³³ The difficult question that arises is whether there is a liberty interest. Justice Scalia has observed, I think correctly, that the existence of a liberty interest is not a casual issue. On the other hand, I would say to Justice Scalia that one thing I do notice is that virtually every time the Supreme Court declares a liberty interest, the state wins and the individual loses. That is, the state interest seems to always override the liberty interest unless the liberty interest is of a fundamental nature, a fundamental right.³⁴

The Supreme Court stated in *Cruzan* that it was asked to answer one particular question: When should a person have a right to die?³⁵ If we were to take the Supreme Court literally, and I do believe that the Supreme Court will regret and retract that statement in the upcoming case, then it would be interesting to see how the Supreme Court could do anything other than to find a liberty interest in this case.³⁶ Clearly, the person is seeking the right to choose the manner and timing of their death.³⁷ If so, they have a liberty interest in the right to die no less than Nancy Cruzan had a liberty interest.³⁸

32 See David Van Biema, *Fatal Doses Assisted Suicide Soars in an Afflicted Community*, TIME, Feb. 17, 1997, at 72, available in 1997 WL 8543150 (noting that, in general, it is understood that between seven and nine percent of American doctors assist their patients in dying).

33 See, e.g., *Compassion in Dying v. Washington*, 79 F.3d 790, 798 (9th Cir. 1996) (holding state ban on assisted suicide impinges upon liberty interest protected by due process), *rev'd sub nom.*, *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997); see also Sylvia A. Law, *Physician-Assisted Death: An Essay on Constitutional Rights and Remedies*, 55 MD. L. REV. 292, 304 (1996) (arguing that laws prohibiting physician assistance in dying violate liberty interest protected by due process).

34 See *Reno v. Flores*, 507 U.S. 292, 301-02 (1993) (explaining that Fourteenth Amendment "forbids the government to infringe certain 'fundamental' liberty interests at all . . . unless the infringement is narrowly tailored to serve a compelling state interest").

35 See *Cruzan v. Missouri Dep't of Health*, 497 U.S. 261, 269 (1990) (stating one question Court was to answer).

36 See *id.* at 280 (holding competent person has constitutionally protected interest in refusing medical treatment).

37 See Steven J. Wohlander, *Voluntary Active Euthanasia for the Terminally Ill and the Constitutional Right to Privacy*, 69 CORNELL L. REV. 363, 363 (1984) (suggesting that terminally ill patients have constitutionally protected right to determine time and manner of death).

38 See *Cruzan*, 497 U.S. at 278 (noting constitutionally protected liberty interest to

What I think, however, is that the Supreme Court will have a much more limited reading of *Cruzan*. It will find from *Cruzan* that there is no liberty interest in the right to die, but simply the freedom from restraint, the freedom to say "no" to medical treatment. This freedom has a long common law tradition and a constitutional tradition, particularly at the state court level. If this reading of *Cruzan* is accurate, it is possible that the Court would make a distinction between a person having a liberty interest in refusing treatment imposed upon him on the one hand, and, on the other hand, making the affirmative request for help in the dying process.

Recently, of course, the Supreme Court has been particularly adverse to the idea that constitutional rights are affirmative, or positive, in nature. In this instance, however, I think the best argument would be that the doctor is the state's gatekeeper to the administration of medication. Because medication cannot be purchased over the counter, it cannot be used effectively and humanely without the physician's prescription and the physician's advice. Effectively, the state is preventing the patient from doing what the patient seeks.³⁹

Let us just suppose that the Supreme Court finds that there is a liberty interest.⁴⁰ It seems to me that if there is a liberty interest, the one thing the state cannot do is snuff that liberty interest out completely. Unfortunately, physician-assisted suicide is completely banned in most of these cases.⁴¹ Therefore, I think

refuse medical treatment may be inferred from Supreme Court's prior decisions).

39 See *Compassion in Dying v. Washington*, 79 F.3d 790, 816 (9th Cir. 1996) (discussing that court cannot ignore patients' individual interests and must balance relevant state interest against individual's liberty interest in seeking physician aid in dying), *rev'd sub nom.*, *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997); see also *Zweir*, *supra* note 29, at 224 (noting that state interest in preserving life and prevention of suicide must be balanced against terminally ill individual's liberty interest).

40 See *Vacco v. Quill*, 117 S. Ct. 2293, 2295 (1997) (holding that New York State may distinguish between assisted suicide and withholding life-sustaining treatment and find former criminal).

41 See ALA. CODE § 22-8A-10 (1990); ALASKA STAT. §§ 18.12.080(a), (f) (Michie 1996); ARIZ. REV. STAT. ANN. § 36-3210 (West 1996); ARK. CODE ANN. §§ 20-13-905(a), (f), 20-17-210(a), (g) (Michie 1991 and Supp. 1995); CAL. HEALTH & SAFETY CODE §§ 7191.5(a), (g) (West Supp. 1997); CAL. PROB. CODE ANN. § 4723 (West Supp. 1997); COLO. REV. STAT. ((15-14-504(4), 15-18-112(1), 15-18.5-101(3), 15-18.6-108 (1987 and Supp. 1996); CONN. GEN. STAT. § 19a-575 (Supp. 1996); DEL. CODE ANN., Tit. 16, § 2512 (Supp. 1996); D.C. CODE ANN. §§ 6-2430, 21-2122 (1995 & Supp. 1996); FLA. STAT. §§ 765.309(1), (2) (Supp. 1996); GA. CODE ANN. §§ 31-32-11(b), 31-36-2(b) (1996); HAW. REV. STAT. § 327D-13 (1996); IDAHO CODE § 39-152 (Supp. 1996); ILL. COMP. STAT., ch. 755, §§ 35/9(f), 40/5, 40/50, 45/2-1 (West 1992); IND. CODE §§ 16-36-1-13, 16-36-4-19, 30-5-5-17 (1994 & Supp. 1996); IOWA CODE §§ 144A.11.1-144A.11.6, 144B.12.2 (1997); KAN. STAT. ANN. § 65-28-109

the Supreme Court should find that a liberty interest exists. The Court should also state that there are some fundamental and important state interests. Consequently, the state could safeguard or regulate this practice, but could not completely prohibit or ban it.

Finally, I simply will end on a personal and human level. When I was young, my mother died, and she died a long death. She was in and out of a comatose medical condition for a long period of time. My father reminded me this morning, that, at the time, he went to his physician and said, "Well, she is clearly going to die. There is clearly nothing that you can do to help her. She is clearly never again going to be in a sentient human state in the sense that she can interact. Why just let her lie here in bed? Why can't you do anything to help her?"

His answer to my father then was a simple one. The law, the state, the government will not allow it.

(1995); KY. REV. STAT. ANN. § 311.638 (Banks-Baldwin 1992); LA. REV. STAT. ANN. 40: §§ 1299.58.10(A), (B) (West 1996); MASS. GEN. LAWS 201D, § 12 (1997); MD. CODE HEALTH ANN. § 5-611(c) (1994); ME. REV. STAT. ANN., tit. 18-A, §§ 5-813(b), (c) (West Supp. 1996); MICH. COMP. LAWS ANN. § 700.496(20) (West 1995); MINN. STAT. §§ 145B.14, 145C.14 (Supp. 1997); MISS. CODE ANN. §§ 41-41-117(2), 41-41-119(1) (Supp. 1992); MO. REV. STAT. §§ 459.015.3, 459.055(5) (1992); MONT. CODE ANN. §§ 50-9-205(1), (7), 50-10-104(1), (6) (1995); NEB. REV. STAT. §§ 20-412(1), (7), 30-3401(3) (1995); NEV. REV. STAT. § 449.670(2) (1996); N.H. REV. STAT. ANN. §§ 137-H:10, 137-H:13, 137-J:1 (1996); N.J. STAT. ANN. §§ 26:2H-54((d), (e), 26:2H-77 (West 1996); N.M. STAT. ANN. §§ 24-7A-13B(1), (C) (Michie Supp. 1995); N.Y. PUB. HEALTH LAW § 2989 (McKinney 1997); N.C. GEN. STAT. §§ 90-320(b), 90-321(f) (1993); N.D. CENT. CODE §§ 23-06.4-01, 23-06.5-01 (1991); OHIO REV. CODE ANN. §§ 2133.12(A), (D) (Anderson Supp. 1996); OKLA. STAT. ANN., tit. 63, §§ 3101.2(C), 3101.12(A), (G) (West 1996); 20 PA. CONS. STAT. § 5402(b) (Supp. 1996); R.I. GEN. LAWS §§ 23-4.10-9(a), (f), 23-4.11-10(a), (f) (1996); S.C. CODE ANN. §§ 44-77-130, 44-78-50(A), (C), 62-5-504(O) (Law Co-op. Supp. 1996); S.D. CODIFIED LAWS §§ 34-12(D)-14, 34-12(D)-20 (Michie 1994); TENN. CODE ANN. §§ 32-11-110(a), 39-13-216 (Supp. 1996); TEX. HEALTH & SAFETY CODE ANN. §§ 672.017, 672.020, 672.021 (West 1997); UTAH CODE ANN. §§ 75-2-1116, 75-2-1118 (1997); VT. STAT. ANN., tit. 18, § 5260 (1997); VA. CODE ANN. §§ 54.1-2990 (Michie 1994); WASH. REV. CODE §§ 70.122.070(1), 70.122.100 (Supp. 1997); W. VA. CODE §§ 16-30-10, 16-30A-16(a), 16-30B-2(b), 16-30B-13, 16-30C-14 (1996); WIS. STAT. §§ 154.11(1), (6), 154.25(7), 155.70(7) (Supp. 1996); WYO. STAT. ANN. §§ 3-5-211, 35-22-109, 35-22-208 (Michie 1994 & Supp. 1996).