
Tales of Death: Storytelling in the Physician-Assisted Suicide Litigation

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I. INTRODUCTION: DEBBIE'S STORY

“The call came in the middle of the night,”¹ noted a 1988 letter to the editor of the prestigious *Journal of the American Medical Association* (“*JAMA*”) from an anonymous gynecology medical resident at a large private hospital. “A nurse informed me that a patient was having difficulty getting rest, could I please see her.”² The letter went on:

I grabbed the chart from the nurses station on my way to the patient's room, and the nurse gave me some hurried details: a 20-year old girl named Debbie was dying of ovarian cancer. She was having unremitting vomiting, apparently as the result of an alcohol drip administered for sedation. Hmmm, I thought. Very sad. . . . I entered and saw an emaciated, dark-haired woman who appeared much older than 20. . . . She had not responded to chemotherapy and was being given supportive care only. It was a gallows scene, a cruel mockery of her youth and unfulfilled potential. Her only words to me were, “Let's get this over with.”³

The medical resident described his decision to administer a lethal dose of pain-killing morphine sulfate.⁴ “Debbie looked at the syringe, then laid her head on the pillow with her eyes open, watching what was left of the world,”⁵ he recalled. “I injected the morphine intravenously and watched to see if my calculations on its effects would be correct.”⁶ They were. First the patient's labored respiration calmed to normal.⁷ “[W]ithin four minutes the breathing rate slowed even more, then became irregular, then ceased,”⁸ the young doctor concluded. “It's over,

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1. *It's Over Debbie*, 258 *JAMA* 272 (1988).
2. *Id.*
3. *Id.*
4. *See id.*
5. *Id.*
6. *Id.*
7. *See id.*
8. *Id.*

Debbie.”⁹

But the story was not over so far as the law was concerned, and it was just the beginning for our society as a whole. After the letter was published, local prosecutors served a grand jury subpoena on *JAMA* demanding all of its documents relating to the letter. Among other things, the prosecutors wanted to know the letter writer’s identity and whether he had acted within their jurisdiction. If so, a criminal indictment for murder or assisted suicide might result. Even though the American Medical Association (“AMA”) opposes physician-assisted suicide and euthanasia, its journal resisted the subpoena on the basis of a state law protecting journalists from being forced to reveal their sources.¹⁰ Without further evidence, the criminal investigation floundered. Yet the prosecutors’ response foreshadowed the litigation over euthanasia and physician-assisted suicide that would arise with increasing frequency across America in the years to come.

Debbie’s story raises many questions for prosecutors and society. Was it against the law for the doctor to relieve the suffering of a patient like Debbie? And if so, should the law be enforced? Of course such questions are not new, but Debbie’s story cast them in a new, more compelling light that focused renewed attention on some very old laws. No American state outlaws either suicide or attempted suicide.¹¹ Yet most states maintain laws against assisting others to commit suicide and every state outlaws murder.¹² In Debbie’s story, these latter laws could be invoked, but should the laws apply when the victim is dying anyway and the doctor is acting to alleviate pain? And if they do apply, are they constitutional? In a variety of different contexts, courts and legislatures across America have been grappling with these questions ever since the furor over the *JAMA* letter refocused public attention on them. At the time, University of Chicago physician and ethicist Mark Siegler commented about *JAMA*’s decision to publish the letter, “[t]his could change medicine profoundly and irreversibly. It undermines the profession if the public believes that doctors have the power to kill people and occasionally do.”¹³ But in Debbie’s story, maybe that is what the public wants.

Most of the legal, legislative, and public battles over this issue center on laws against assisted suicide. Debbie’s story may have gone beyond that, crossing into the realm of euthanasia and murder, but propo-

9. *Id.*

10. See Isabel Wilkerson, *An Essay on Euthanasia*, PORTLAND OREGONIAN, Feb. 29, 1988, at A2.

11. For a comprehensive analysis of American law on suicide and attempted suicide, see Thomas J. Marzen et al., *Suicide: A Constitutional Right?*, 24 DUQ. L. REV. 1, 63-100 (1985).

12. See *id.*

13. Wilkerson, *supra* note 10, at A2.

nents of change in this area typically frame the issue more narrowly by focusing on the right or liberty of competent, terminally ill patients to obtain medical assistance in committing suicide. "On the question you ask depends the answer you get,"¹⁴ Justice Felix Frankfurter once observed about judicial proceedings. On this issue, proponents are most likely to get what they want by presenting compelling stories of dying patients asking their physicians for means to avoid the seemingly meaningless pain and indignity of terminal illnesses.¹⁵ These stories directly implicate statutes against assisted suicide. These laws, and the stories for and against their constitutionality, have become the focal point of the debate over whether or not physicians should legally participate in hastening or causing death. Both of them, statutes and stories, merit closer examination, beginning with the former.

II. THE LAWS AGAINST ASSISTED SUICIDE

Criminal penalties have been imposed for assisted suicide from the dawn of the Anglo-American legal system.¹⁶ It was a felony to commit suicide under traditional English common law, and it always has been unlawful to aid and abet the commission of a felony.¹⁷ These common law crimes were carried over to the thirteen original American colonies, and generally remained good law after they became states in 1776.¹⁸ Acting under the influence of Enlightenment thinking, however, most states decriminalized suicide following the American Revolution either by legislative enactment or judicial decree.¹⁹ This left the prohibition against assisted suicide in doubt.²⁰ Courts in some states continued to punish assisted suicide as a common law crime while courts in other states did not.²¹

New York became the first state to address this issue legislatively when, in 1828, it enacted a criminal statute providing: "Every person deliberately assisting in the commission of self-murder shall be deemed guilty of manslaughter in the first degree."²² As new states and territo-

14. Henry Friendly, *Mr. Justice Frankfurter and the Reading of Statutes*, in *BENCHMARKS* 318-19 (1967).

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

16. See *Washington v. Glucksberg*, 521 U.S. 702, 711 (1997) ("[F]or over 700 years, the Anglo-American common-law tradition has punished or otherwise disapproved of both suicide and assisting suicide.").

17. See *id.* at 710-11; Marzen et al., *supra* note 11, at 56-63.

18. See Marzen et al., *supra* note 11, at 63-68.

19. See *id.* at 66-70.

20. See *id.* at 78. "In the absence of a statute or a direct killing, however, the courts were faced with a dilemma regarding the assistance of a suicide that one commentator called as 'confusing a question as the law can present.'" *Id.* (quoting Comment, *The Crime of Aiding a Suicide*, 30 YALE L.J. 408, 408 (1921)).

21. See *id.* at 71-75.

22. Act of Dec. 10, 1828, ch. 209, § 4, 1828 N.Y. Laws 19, 19.

ries were carved out of the American west during the mid-1800's, most of their legislatures used New York criminal law as a model in enacting statutes against assisted suicide.²³ The legislature of the new Washington Territory did so in 1854, as part of its second legislative act.²⁴ In 1997, the legacy of these two early enactments became the object of constitutional challenges to laws against assisted suicide before the United States Supreme Court.²⁵ As such, they hold special significance for constitutional law in general and this article in particular.

A. New York State Law

The New York statute against assisted suicide has changed little over the years.²⁶ In 1881, it was included in the state's new penal code even though that code expressly decriminalized suicide.²⁷ New York's 1881 code was the work of David Dudley Field, a giant in American legal history. Inspired by what Napoleon had done for French law in the early 1800's, the New York Legislature appointed a commission led by Field to reorganize the entire body of state civil and criminal law into a systemic code. Field and his commission labored from 1857 to 1865. All or part of the resulting "Field Codes" were adopted in territories and states throughout the American west.²⁸ Regarding suicide, Field's penal code provided: "Although suicide is deemed a grave public wrong, yet from the impossibility of reaching the successful perpetrator, no forfeiture [or penalty] is imposed."²⁹ With regard to assisted suicide, however, his code maintained: "Every person, who willfully, in any manner, advises, encourages, abets or assists another person in taking his own life, is guilty of aiding suicide."³⁰ Further, in a section seemingly speaking to the situation of physician-assisted suicide, the code added: "Every person who willfully furnishes another person with any deadly weapon or poisonous drug, knowing that such person intended to use such weapon or drug in taking his own life, is guilty of aiding suicide, if such person thereafter employs such instrument or drug in taking his

23. See Marzen et al., *supra* note 11, at 74.

24. See 1854 Wash. Laws p. 78, § 17 (incorporating the same language as the 1828 New York statute against assisted suicide).

25. See *Quill v. Koppell*, 870 F. Supp. 78 (S.D.N.Y. 1994), *rev'd sub nom. Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996), *rev'd*, 521 U.S. 793 (1997); *Compassion in Dying v. Washington*, 850 F. Supp. 1454 (W.D. Wash. 1994), *rev'd*, 49 F.3d 586 (9th Cir. 1995), *rev'd en banc*, 79 F.3d 790 (9th Cir. 1996), *rev'd sub nom. Washington v. Glucksberg*, 521 U.S. 702 (1997).

26. For an analysis of the history of laws against assisted suicide in New York, see Marzen et al., *supra* note 11, at 205-10 (appendix).

27. Compare COMMISSIONERS OF THE CODE, PROPOSED PENAL CODE OF THE STATE OF NEW YORK § 229 (1865) ("Although suicide is deemed a grave public wrong, yet from the impossibility of reaching the successful perpetrator, no forfeiture is imposed.") [hereinafter FIELD PENAL CODE] with FIELD PENAL CODE § 231 ("Every person, who willfully, in any manner, advises, encourages, abets or assists another person in taking his own life, is guilty of adding suicide.").

28. See Marzen et al., *supra* note 11, at 76-77.

29. FIELD PENAL CODE § 229.

30. *Id.* § 231.

life.”³¹ When New York finally adopted its version of Field’s penal code in 1881, it classified assisted suicide as “manslaughter in the first degree.”³² Ten other American states or territories enacted laws against assisted suicide modeled on the Field penal code, including the State of Washington in 1909.³³

By the late 1800’s, most American states had statutes or clear judicial precedent establishing assisted suicide as a crime.³⁴ During that era, apparently no court even considered a claim that such a statute might violate the federal constitution, much less hold that it did so. Indeed, the constitutional provision now claimed by some to protect a person’s right to assisted suicide—the Fourteenth Amendment (which guarantees to all U.S. citizens a certain measure of liberty and equal protection under state law)—was ratified just as Field’s commission was completing work on its penal code. There is no indication that anyone at that time perceived any conflict between the two. Quite to the contrary, based on state-by-state analysis, a team of scholars led by Thomas J. Marzen concluded that, when the Fourteenth Amendment was ratified following the Civil War, “twenty-one of the thirty-seven states, and eighteen of the thirty ratifying states prohibited assisting suicide.”³⁵ All of these twenty-one states maintained their laws against assisted suicide in the years to come, and other states joined them by adopting the Field penal code.³⁶ At the very least, this suggests that the legislators who ratified the Fourteenth Amendment did not see it as creating constitutional protection for assisted suicide.³⁷

New York did not again tamper with its laws relating to suicide until 1965. At that time, it deleted its statutory declaration that suicide was a “grave public wrong,” but retained its law against assisted suicide.³⁸ The classification of the crime was reduced, however, to second-degree manslaughter.³⁹ The issue was re-examined two decades later at the instigation of then Governor Mario Cuomo, who appointed a blue-ribbon task force of doctors, ethicists, and religious leaders to examine public policy regarding the right to die.⁴⁰ After a ten-year investigation,

31. *Id.* § 232.

32. Act of July 26, 1881, ch. 676, § 175, 1881 N.Y. Laws 1, 42.

33. See Marzen et al., *supra* note 11, at 77.

34. See generally *Washington v. Glucksberg*, 521 U.S. 702, 714 (1997) (“By the time the Fourteenth Amendment was ratified, it was a crime in most States to assist a suicide.”).

35. Marzen et al., *supra* note 11, at 78.

36. See *id.* at 76-77. For a current list of state laws against assisted suicide, see *Washington v. Glucksberg*, 521 U.S. 702, 775 n. 14 (Souter, J., concurring). See also Marzen et al., *supra* note 11, at 148-242 (appendix) (analyzing state laws in regard to assisted suicide).

37. See Marzen et al., *supra* note 11, at 75-76.

38. See Penal Law, Ch. 1030, § 500 & Table II, 1965 N.Y. Laws 2343, 2482.

39. See Penal Law, Ch. 1030, § 125.15(3) & Table II, 1965 N.Y. Laws 2387, 2516.

40. See generally NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT (1994) [hereinafter NEW YORK STATE TASK FORCE].

in 1994, the task force concluded that patients should be allowed to refuse life-sustaining medical treatment (including artificially administered nutrition and hydration), but that physician-assisted suicide and euthanasia should not be allowed.⁴¹ No changes were recommended in the law against assisted suicide.⁴² The law remained unchanged until it was challenged in *Quill v. Koppell*,⁴³ one of the two cases ultimately reviewed by the U.S. Supreme Court in 1997.

B. Washington State Law

The appeal also involved the Washington law against assisted suicide, which was challenged in the companion case of *Washington v. Glucksberg*.⁴⁴ Like most states, Washington does not outlaw suicide or attempted suicide. Rather, the law at issue proscribes aiding or causing the suicide of another. It provides: "A person is guilty of promoting a suicide attempt when he knowingly causes or aids another person to attempt suicide."⁴⁵ This is a broad prohibition. Nothing in the statute focuses on physicians as actors or on the elderly, terminally ill, or those in pain as recipients. The law was intended to protect life and discourage suicide without regard to the victim's condition.⁴⁶

As noted, restrictions against assisted suicide were in place in Washington even before the region became a state. The second bill passed by the first territorial legislature for Washington, in 1854, provided: "Every person deliberately assisting another in the commission of self-murder, shall be deemed guilty of manslaughter."⁴⁷ That law or one similar to it has remained on the books in Washington ever since. Of course, this long history for Washington's bar of assisted suicide does not, in and of itself, make it a good rule. As the progressive jurist Oliver Wendell Holmes once observed, "[i]t is revolting to have no better reason for a rule of law than that so it was laid down in the time of Henry IV."⁴⁸ Yet Washington's age-old stance against assisted suicide does not run afoul of this dictum. Quite to the contrary, in its present form, the Washington law reflects the relatively recent influence of the Model Penal Code, which was crafted by the leading criminal law scholars of the mid-twentieth century. The drafters of the Model Penal Code considered the arguments in favor of legalizing assisted suicide, but ultimately decided to retain that traditional feature of Anglo-American

41. See *id.* at 142-46.

42. See *id.*

43. 870 F. Supp. 78 (S.D.N.Y. 1994).

44. 521 U.S. 702 (1997).

45. Wash. Rev. Code § 9A.36.060(1) (1997).

46. See *infra* note 49.

47. 1854 Wash. Laws p.78, § 17.

48. Oliver Wendell Holmes, Jr., *The Path of the Law*, 10 HARV. L. REV. 457, 469 (1897).

criminal law.⁴⁹ In the past thirty years, following the publication of the Model Penal Code, eight states passed new statutes specifically outlawing assisted suicide and eleven other states, including Washington in 1975, revised their existing statutes.⁵⁰

The people of Washington reconsidered their law against assisted suicide in the current medical context during the 1991 initiative campaign. At that time, after extensive public discussion of the issues on both sides of the question, Washington voters rejected the initiative measure that would have legalized physician-assisted suicide.⁵¹ A year later, the Washington Legislature added a provision expressly excluding physician-assisted suicide from the practices permitted under that state's living will statute.⁵² Thus, like the New York statute, the Washington law has been re-examined in light of recent developments in terminal health-care practices. And like such statutes throughout the country, its constitutionality was never seriously questioned until the litigation leading up to the 1997 Supreme Court rulings. That litigation, and the legal stories told by both sides, lies at the heart of the public-policy debate over physician-assisted suicide in America. It offers a classic illustration of the power of stories in constitutional litigation and lawmaking.

III. STORYTELLING AND THE LAW

"No set of legal institutions or prescriptions exists apart from the narratives that locate it and give it meaning,"⁵³ Robert Cover once observed. "Every prescription is insistent in its demand to be located in discourse—to be supplied with history and destiny, beginning and end, explanation and purpose."⁵⁴ Cover used this observation to introduce his analysis of the 1982 United States Supreme Court term, and to weave that Court's work into the American narrative.⁵⁵ For him, that narrative—consisting of stories and historical events—locates and gives meaning to constitutional provisions.⁵⁶

A legal tradition is hence part and parcel of a complex normative world. The tradition includes not only a corpus juris, but also a language and a mythos—narratives in which the corpus juris is located by those whose wills act upon it. These myths establish the paradigms for behav-

49. See MODEL PENAL CODE § 210.5(2) cmt. 5 (1980).

50. See Marzen et al., *supra* note 11, at 95.

51. See, e.g., Jane Gross, *Voters Turn Down Mercy Killing Idea*, N.Y. TIMES, Nov. 7, 1991, at B16.

52. Wash. Rev. Code § 70.122.010 (1997).

53. Robert M. Cover, *The Supreme Court 1982 Term—Foreward: Nomos and Narrative*, 97 HARV. L. REV. 4, 4 (1983).

54. *Id.* at 5.

55. See *id.*

56. See *id.* at 9.

ior.⁵⁷

Cover's thinking anticipated the growing interest of scholars in the role that stories play in shaping legal discourse. In 1989, Richard Delgado wrote about that developing legal scholarship.

Everyone has been writing stories these days. And I don't just mean writing about stories or narrative theory, important as those are. I mean actual stories, as in "once-upon-a-time" type stories. Derrick Bell has been writing "Chronicles," and in the Harvard Law Review at that. Others have been writing dialogues, stories, and metastories. Many others have been daring to become more personal in their writing, to inject narrative, perspective, and feeling—how it was for me—into their otherwise scholarly, footnoted articles and, in the case of the truly brave, into their teaching.⁵⁸

Delgado went on to explain why storytelling plays such a significant role in litigation and lawmaking, an explanation that directly points to its importance in the legal debate over physician-assisted suicide.⁵⁹

Stories, parables, chronicles, and narrative are powerful means for destroying mindset—the bundle of presuppositions, received wisdoms, and shared understandings against a background of which legal and political discourse takes place. These matters are rarely focused on. They are like eyeglasses we have worn a long time. They are nearly invisible; we use them to scan and interpret the world and only rarely examine them for themselves. Ideology—the received wisdom—makes current social arrangements seem fair and natural. Those in power sleep well at night—their conduct does not seem to them like oppression.

The cure is storytelling (or as I shall sometimes call it, counterstorytelling).⁶⁰

Certainly, the taboo against physician-assisted suicide and euthanasia represents a longstanding part of the received wisdom of Western law and medical ethics and is integral to traditional mindsets.⁶¹ As Delgado suggests, stories and counterstories can help to destroy (or reinforce) such mindsets.⁶²

According to Delgado, both stories and counterstories serve the community-building function of forging consensus and social values.⁶³ Counterstories have the added function of challenging received wisdom, for "[t]hey can open new windows into reality, showing us that there are possibilities for life [or, in this instance, death] other than the ones we live [or die]."⁶⁴ Further, he stresses:

57. *Id.* Cover offers examples of how such narratives give rise to constitutional meaning. See *id.* at 15-40. See also, Robert M. Cover, *The Folktales of Justice: Tales of Jurisdiction*, 14 CAP. U. L. REV. 179, 180 (1985) (describing law as rooted in "the sacred narratives of our world").

58. Richard Delgado, *Storytelling for Oppositionists and Others: A Plea for Narrative*, 87 MICH. L. REV. 2411, 2411-12 (1989).

59. See *id.* at 2413-14.

60. *Id.*

61. See generally *Washington v. Glucksberg*, 521 U.S. 702, 708-19 (1997).

62. See Delgado, *supra* note 58, at 2411-12.

63. See *id.* at 2414.

64. *Id.*

Counterstories can quicken and engage conscience. Their graphic quality can stir imagination in ways in which more conventional discourse cannot.

....

... They invite the reader to suspend judgment, listen for their point or message, and then decide what measure of truth they contain. They are insinuating, not frontal; they offer a respite from the linear, coercive discourse that characterizes much legal writing.⁶⁵

Stories about death, such as Debbie's story, and their potential impact on legal, ethical, and societal discourse about physician-assisted suicide and euthanasia, represent powerful illustrations of Delgado's thesis.

Toni M. Massaro puts the matter of legal storytelling into a broader context that speaks to the issue of laws against assisted suicide and euthanasia. She writes:

American legal scholarship of the past several decades has revealed deep dissatisfaction with the abstract and collective focus of law and legal discourse. The rebellion against abstraction has, of late, been characterized by a "call to context." One strand of this complex body of thought argues that law should concern itself more with the concrete lives [or, in this instance, deaths] of persons affected by it. One key word in the dialogue is the term "empathy," which appears frequently in the work of critical legal studies, feminist, and "law and literature" writers.⁶⁶

Massaro goes on to assert: "One problem underscored in this scholarship is that individual, concrete human voices and abstract, general legal rules often conflict."⁶⁷ Of course, proponents of physician-assisted suicide argue that just such a conflict exists between the individual, concrete human voices calling for relief through physician-aided death and the abstract, general legal rules against assisted suicide. Stories (or what Delgado might call counterstories) could help resolve this conflict. "Empathy, human stories, and different voices should be woven into the tapestry of legal scholarship, legal training, law formulation, legal counseling and advocacy, and law application and enforcement,"⁶⁸ Massaro writes.

By way of illustration, she applied this analysis to the landmark Supreme Court decisions in *Brown v. Board of Education*⁶⁹ and *Bowers v. Hardwick*⁷⁰ as follows:

Brown, which abolished separate-but-equal schools, may be read simply as a long-overdue realization that separate is not equal: a straightforward constitutional analysis. Or it may have been an emotional, adverse response to the harsh effects of discrimination on school-aged black chil-

65. *Id.* at 2415.

66. Toni M. Massaro, *Empathy, Legal Storytelling, and the Rule of Law: New Words, Old Wounds?*, 87 MICH. L. REV. 2099, 2099 (1989).

67. *Id.* at 2101.

68. *Id.*

69. 347 U.S. 483 (1954).

70. 478 U.S. 186 (1986).

dren. *Hardwick*, which upheld the Georgia sodomy statute, may be read simply as a refusal to include in our catalogue of individual rights the right to engage in certain types of sexual activity—also routine constitutional analysis. Or it may have been an emotional, adverse response to homosexuality. The opinion cites history and scripture, suggesting still other bases for the result. “Traditional legal thinking” thus was not necessarily the villain in *Hardwick*, and “empathetic understanding” was not necessarily the hero in *Brown*.

Explaining these results or analyzing what “really” determines the ruling of the United States Supreme Court or of lower court judges is a confounding and complicated endeavor, as the depth and variety of legal scholarship on this topic proves.⁷¹

In short, she suggests, storytelling and counterstorytelling probably influenced these Supreme Court decisions, both of which involved fundamental matters of received wisdom, social values, and cultural mindset. Constitutional challenges to laws against physician-assisted suicide and euthanasia also involve such matters of mindset.

As the differing results in *Brown* and *Hardwick* illustrate, how the story (or counterstory) is told and heard can profoundly impact the legal result. In an article about legal storytelling, Kim Lane Scheppelle notes:

Yet, it matters a great deal how stories are framed. The same event can be described in multiple ways, each true in the sense that it genuinely describes the experience of the storyteller, but each version may be differently organized and give a very different impression of “what happened.” And different legal consequences can follow from the choices of one story rather than another.⁷²

The constitutional litigation over physician-assisted suicide that culminated in the paired 1997 Supreme Court decisions, *Quill*⁷³ and *Glucksberg*,⁷⁴ exemplify the power of storytelling and counterstorytelling—with proponents of legal change first capturing the advantage through their stories and then defenders of the status-quo effectively countering with stories of their own. In the end, it mattered a great deal how these stories were framed.

IV. THE PLAINTIFFS’ STORIES

The two cases challenging state laws against assisted suicide came from different ends of the country, but their plaintiffs told similar stories. This should not be surprising. The cases involved different plaintiffs but the same lead attorney, Kathryn L. Tucker of Seattle, Washington, litigated both controversies,⁷⁵ and she organized the facts into

71. Massaro, *supra* note 66, at 2108-09.

72. Kim Lane Scheppelle, *Foreward: Telling Stories*, 87 MICH. L. REV. 2073, 2085 (1989).

73. *Vacco v. Quill*, 521 U.S. 793 (1997).

74. *Washington v. Glucksberg*, 521 U.S. 702 (1997).

75. See Petitioners’ Brief, app. at JA21, *Vacco v. Quill*, 521 U.S. 793 (1997) (No. 95-1858) (appending Complaint for Declaratory Judgment and Injunctive Relief, in *Quill v. Koppell*, 870 F.

compelling stories.

A. Vacco v. Quill

The legal challenge to the New York law against assisted suicide commenced on July 20, 1994, with the filing of a complaint by six individual plaintiffs—three dying patients and three physicians for dying patients.⁷⁶ From this initial filing, they began telling their stories—compelling stories of physical pain, terminal illness, and the prayer for relief through physician-assisted death.

The first patient plaintiff was identified simply as Jane Doe. The complaint tells her story as follows:

Jane Doe is a 76-year-old retired physical education instructor who is dying of thyroid cancer. Jane Doe has been advised and understands that her illness is a terminal one, that she is in the terminal phase of her disease, and that there is no chance of recovery. Jane Doe is fully aware of the ravages the disease wreaks and the prospect she faces of progressive loss of bodily function and integrity and increasing pain and suffering. Jane Doe seeks necessary medical assistance in the form of medications prescribed by her physician to be self-administered for the purpose of hastening her death. Without such assistance Jane Doe cannot hasten her death in a certain and humane manner.⁷⁷

The complaint contains similarly compelling stories of the other two patient plaintiffs, both of whom were dying from painful AIDS related illnesses.⁷⁸ It also relates the stories of the three physicians who, based on their professional experience treating terminally ill patients, assert their willingness “to assist these patients in their decisions to hasten death through the prescription of medications.”⁷⁹

Three months later, the plaintiffs moved for a preliminary injunction. In support of the motion, the six plaintiffs submitted declarations elaborating their stories.⁸⁰ These stories served as powerful arguments for physician-assisted suicide. Indeed, their power was such that the Second Circuit Court of Appeals, in its decision ruling for the plaintiffs, began its written opinion by quoting at length from these declarations.⁸¹

Jane Doe’s declaration is representative of the declarations filed by the patients. As edited by the appellate court, it states:

Supp. 78 (S.D.N.Y. 1994)); Petitioners’ Brief, app. at 1, *Washington v. Glucksberg*, 521 U.S. 702 (1997) (No. 96-110) (appending Complaint for Declaratory Judgment and Injunctive Relief, in *Compassion in Dying v. Washington*, 850 F. Supp. 1454 (W.D. Wash. 1994)).

76. See *Quill v. Koppell*, 870 F. Supp. 78 (S.D.N.Y. 1994).

77. Petitioners’ Brief, app. at JA24, *Vacco v. Quill*, 521 U.S. 793 (1997) (No. 95-1858) (appending Complaint for Declaratory Judgment and Injunctive Relief, in *Quill v. Koppell*, 870 F. Supp. 78 (S.D.N.Y. 1994)).

78. See *id.* at JA24-25.

79. *Id.* at JA25.

80. *Id.* at JA42-109 (appending Declarations, in *Quill v. Koppell*, 870 F. Supp. 78 (S.D.N.Y. 1994)).

81. See *Quill v. Vacco*, 80 F.3d 716, 720-21 (2d Cir. 1996).

I have a large cancerous tumor which is wrapped around the right carotid artery in my neck and is collapsing my esophagus and invading my voice box. The tumor has significantly reduced my ability to swallow and prevents me from eating anything but very thin liquids in extremely small amounts. The cancer has metastasized to my plural [sic] cavity and it is painful to yawn or cough. . . . In early July 1994 I had the [feeding] tube implanted and have suffered serious problems as a result. . . . I take a variety of medications to manage the pain. . . . It is not possible for me to reduce my pain to an acceptable level of comfort and to retain an alert state. . . . At the point at which I can no longer endure the pain and suffering associated with my cancer, I want to have drugs available for the purpose of hastening my death in a humane and certain manner. I want to be able to discuss freely with my treating physician my intention of hastening my death through the consumption of drugs prescribed for that purpose.⁸²

The other two patient plaintiffs filed declarations setting forth similarly compelling stories of their own dying conditions.⁸³

Such stories force judges to confront the very personal and individual impact of laws against assisted suicide in tragic cases. They strip away legal abstractions. Certainly laws against assisted suicide make

82. *Id.* at 720 (alterations in original).

83. *See id.* at 720-21. The other two patient plaintiffs were identified as George A. Kingsley and William A. Barth. *See id.* As edited and printed in the appellate court decision, those declarations state as follows:

Mr. Kingsley subscribed to a declaration that included the following:

At this time I have almost no immune system function. . . . My first major illness associated with AIDS was cryptosporidiosis, a parasitic infection which caused me severe fevers and diarrhea and associated pain, suffering and exhaustion. . . . I also suffer from cytomegalovirus ("CMV") retinitis, an AIDS-related virus which attacks the retina and causes blindness. To date I have become almost completely blind in my left eye. I am at risk of losing my sight altogether from this condition. . . . I also suffer from toxoplasmosis, a parasitic infection which has caused lesions to develop on my brain. . . . I . . . take daily infusions of cytovene for the . . . retinitis condition. This medication, administered for an hour through a Hickman tube which is connected to an artery in my chest, prevents me from ever taking showers and makes simple routine functions burdensome. In addition, I inject my leg daily with neupogen to combat the deficient white cell count in my blood. The daily injection of this medication is extremely painful. . . . At this point, it is clear to me, based on the advice of my doctors, that I am in the terminal phase of [AIDS]. . . . It is my desire that my physician prescribe suitable drugs for me to consume for the purpose of hastening my death when and if my suffering becomes intolerable.

In his declaration, Mr. Barth stated:

In May 1992, I developed a Kaposi's sarcoma skin lesion. This was my first major illness associated with AIDS. I underwent radiation and chemotherapy to treat this cancer. . . . In September 1993, I was diagnosed with cytomegalovirus ("CMV") in my stomach and colon which caused severe diarrhea, fevers and wasting. . . . In February 1994, I was diagnosed with microsporidiosis, a parasitic infection for which there is effectively no treatment. . . . At approximately the same time, I contracted AIDS-related pneumonia. The pneumonia's infusion therapy treatment was so extremely toxic that I vomited with each infusion. . . . In March 1994, I was diagnosed with cryptosporidiosis, a parasitic infection which has caused severe diarrhea, sometimes producing 20 stools a day, extreme abdominal pain, nausea and additional significant wasting. I have begun to lose bowel control. . . . For each of these conditions I have undergone a variety of medical treatments, each of which has had significant adverse side effects. . . . While I have tolerated some [nightly intravenous] feedings, I am unwilling to accept this for an extended period of time. . . . I understand that there are no cures. . . . I can no longer endure the pain and suffering . . . and I want to have drugs available for the purpose of hastening my death.

Id. (alterations in original).

sense in the abstract—they discourage suicide and protect against duress, abuse, mistake, and undue influence. Yet how can they apply in such compelling cases where there can be no risk of duress, abuse, mistake, or undue influence?⁸⁴

To complete the story, declarations filed by the physician plaintiffs and other doctors explained the need for trained medical assistance in such situations.⁸⁵ The appellate court quoted at length from these declarations as well.⁸⁶ One such declaration provided:

Physicians can determine whether a patient's request to hasten death is rational and competent or motivated by depression or other mental illness or instability. . . . Terminally ill persons who seek to hasten death by consuming drugs need medical counseling regarding the type of drugs and the amount and manner in which they should be taken, as well as a prescription, which only a licensed medical doctor can provide. . . . Knowing what drug, in what amount, will hasten death for a particular patient, in light of the patient's medical condition and medication regimen, is a complex medical task. . . . It is not uncommon, in light of present legal constraints on physician assistance, that patients seeking to hasten their deaths try to do so without medical advice. . . . Very often, patients who survive a failed suicide attempt find themselves in worse condition than before the attempt. Brain damage, for example, is one result of failed suicide attempts.⁸⁷

With this, the basic story is complete—rational suicide and irrational restrictions against assisted suicide. Variations on this theme appeared in the other declarations. Certainly the attorneys for the plaintiffs proceeded to offer technical legal arguments for physician-assisted suicide, but it is telling that the appellate court chose to lead with these stories in its written opinion finding for the plaintiffs.⁸⁸ In striking contrast, when it found against the plaintiffs, the district court had hardly mentioned the plaintiffs' stories.⁸⁹ Instead, its opinion stressed general, abstract matters of constitutional law.⁹⁰

B. Washington v. Glucksberg

The legal challenge to the Washington law against assisted suicide proceeded in a similar fashion, except the plaintiffs in that case prevailed at the district court level.⁹¹ There were nine plaintiffs in all—three dying patients, five physicians who treat such patients, and one organization, Compassion in Dying, that supports mentally competent,

84. See, e.g., *Compassion in Dying v. Washington*, 850 F. Supp. 1454, 1464-66 (W.D. Wash. 1994) (setting forth standard justifications for outlawing assisted suicide and concluding that they do not apply in the physician-assisted suicide context).

85. See *Quill v. Vacco*, 80 F.3d 716, 721 (2d Cir. 1996).

86. See *id.*

87. *Id.* (alterations in original).

88. See *id.* at 720-21.

89. See *Quill v. Koppell*, 870 F. Supp. 78 (S.D.N.Y. 1994).

90. See *id.* at 81-85.

91. See *Compassion in Dying v. Washington*, 850 F. Supp. 1454 (W.D. Wash. 1994).

terminally ill adults considering suicide.⁹² Here too, the plaintiffs began telling their story from the beginning of their case. The initial complaint set forth the story of each plaintiff in compelling detail.⁹³

The first-named patient plaintiff was Jane Roe, a mentally competent, 69-year-old physician who was dying of cancer. The complaint went on to describe her condition as follows:

Her cancer has metastasized into her bones and is growing rapidly throughout her entire skeleton. She has undergone surgery, chemotherapy, and radiation therapy, but the cancer is incurable. Jane Roe has been almost entirely confined to bed for the past seven months. Movement is intensely painful and her muscles have become so weak they cannot support her. To attempt to alleviate the extreme pain associated with bone cancer, Jane Roe relies on increasing doses of morphine. Even so, she is frequently in severe pain. Jane Roe has been advised and understands that her illness is a terminal one, that she is in the terminal phase of disease and that there is no chance of recovery. Jane Roe is fully aware of the ravages the disease wreaks and the prospect she faces of progressive loss of bodily function and integrity and increasing pain and suffering. Jane Roe seeks necessary medical assistance in the form of medications prescribed by her doctor to be self-administered for the purpose of hastening her death.⁹⁴

The complaint also sets forth the physical conditions of the other two patient plaintiffs in similarly tragic detail.⁹⁵

92. *See id.* at 1456.

93. Petitioners' Brief, app. at 1-8, *Washington v. Glucksberg*, 521 U.S. 702 (1997) (No. 96-110) (appending Complaint for Declaratory Judgment and Injunctive Relief, in *Compassion in Dying v. Washington*, 850 F. Supp. 1454 (W.D. Wash. 1994)).

94. *Id.* at 3.

95. *See id.* at 3-5. These two plaintiffs are identified as John Doe and James Poe. *See id.* The paragraphs of the complaint describing them follow:

John Doe is a 44-year-old artist, living in King County, Washington suffering from AIDS. Mr. Doe has a T-cell count of four, leaving him vulnerable to all manner of infections with almost no natural ability to fight them. Mr. Doe has cytomegalovirus retinitis, which has caused him to lose approximately 70% of his vision to date and will result in blindness. Loss of vision is fatal to Mr. Doe's vocation and avocation, painting. Mr. Doe has been hospitalized for AIDS-related pneumonia on several occasions. Mr. Doe suffers from chronic skin infections, sinusitis and grand mal seizures related to AIDS. Mr. Doe experiences extreme fatigue and his ability to care for himself is rapidly diminishing. Mr. Doe served as the primary caregiver for his long-term companion who recently died of AIDS at home in Mr. Doe's care. Mr. Doe witnessed firsthand the pain, suffering and loss of bodily function, integrity and personal dignity the disease causes. John Doe has been advised and understands that his illness is a terminal one, that he is in the terminal phase of the disease and that there is no chance of recovery. John Doe desires medical assistance in the form of medications prescribe by his doctor to be self-administered for the purpose of hastening his death.

James Poe is a mentally competent, terminally ill adult. James Poe is a 69-year-old resident of King County, Washington, who suffers from chronic obstructive pulmonary disease ("COPD") involving emphysema, bronchitis, and asthma. James Poe also suffers from heart failure caused in part by his COPD. The COPD makes it extremely difficult for James Poe to get enough air. He is connected to an oxygen tank at all times and is required to aspirate medications for hours each day to assist his breathing. He regularly experiences panic attacks associated with the sensation of suffocating and must take medication to calm this terror. James Poe's heart failure causes swelling of his lower extremities, resulting in lost mobility and pain. James Poe's only comfortable moments in life are when he is asleep; however, he can only sleep for two to three hours at a time. James Poe saw his mother die a slow, agonizing death and desires to avoid such a death himself.

The complaint then broadens out the story through its description of the plaintiff physicians.⁹⁶ The account of Dr. Peter Shalit is representative. About Dr. Shalit, the complaint notes:

Approximately thirty percent of his patients suffer from AIDS, an incurable disease. AIDS patients typically suffer from recurrent infections that wear the body down. Many AIDS patients develop cancer. Cancer of the lungs is common among AIDS patients, causing extreme shortness of breath and the terrifying sensation of suffocating. AIDS patients have typically witnessed the deaths of other persons from AIDS and are aware of the course the disease takes. Many of Dr. Shalit's competent, terminally ill patients express interest in voluntary self-termination of life. Under certain circumstances, it would be consistent with Dr. Shalit's medical practice standards to assist these patients' decision to hasten death through the prescription of medication.⁹⁷

The other plaintiff physicians, all of whom treat the terminally ill, joined in asserting their willingness to help some of their patients hasten their own deaths.⁹⁸ In such cases, to do otherwise hardly seems humane.

In connection with their successful motion for summary judgment, the plaintiffs filed additional declarations that related their story of death. The declaration of one plaintiff physician, Dr. Harold Glucksberg, added in part:

Cancer usually progresses steadily and slowly. The cancer patient is fully aware of his or her present suffering and anticipates certain future suffering. The terminal cancer patient faces a future that can be terrifying. Near the end, the cancer patient is usually bedridden, rapidly losing mental and physical functions, often in excruciating, unrelenting pain. Pain management at this stage often requires the patient to choose between enduring unrelenting pain or surrendering an alert mental state because the dose of drugs adequate to alleviate the pain will impair consciousness. Many patients will choose one or the other of these options; however, some patients do not want to end their days either racked with pain or in a drug induced stupor. For some patients pain cannot be managed even with aggressive use of drugs.⁹⁹

In this story, the judge becomes the potential hero—saving these patients by permitting physician-assisted suicide.¹⁰⁰ Absent powerful countervailing considerations, the plaintiffs have all but made their case through their facts.

The written opinion of the lower court underscores the importance of these stories in the lawmaking process. In her written opinion

James Poe has been advised and understands that his illness is a terminal one, that his illness is incurable, and that he is, or soon will be, in the terminal phase of the disease. When death is imminent and his suffering too great, James Poe wants the right to choose to hasten his inevitable death with medications prescribed by his doctor for that purpose.

Id.

96. *See id.* at 5-7.

97. *Id.* at 6.

98. *See id.* at 5-6.

99. *Compassion in Dying v. Washington*, 850 F. Supp. 1454, 1457 (W.D. Wash. 1994).

100. *See id.* at 1467-68.

granting the plaintiffs' motion for summary judgment, the trial judge began by retelling in their entirety the stories of the patient plaintiffs, as originally set forth in the complaint.¹⁰¹ She then repeated Dr. Glucksberg's declaration as quoted in the preceding paragraph.¹⁰² In contrast, these stories wholly disappear from the written opinion of the Ninth Circuit panel that reversed the trial court judgment.¹⁰³ In this opinion, abstract rules of law predominate.¹⁰⁴ Significantly, the stories reappear at length (including the full account of each patient plaintiff) in the majority opinion of the Ninth Circuit, sitting en banc, that reversed the panel ruling and affirmed the original trial court judgment for the plaintiffs.¹⁰⁵

Indeed, the final appellate opinion stressed the importance of these stories from the outset. The opinion began as follows:

This case raises an extraordinarily important and difficult issue. It compels us to address questions to which there are no easy or simple answers, at law or otherwise. It requires us to confront the most basic of human concerns—the mortality of self and loved ones—and to balance the interest in preserving human life against the desire to die peacefully and with dignity.¹⁰⁶

Abstract legal principles are not enough. The stories are vital, and so the opinion properly relates those stories. The opinion followed this opening and laid the foundation for the ruling that certain dying patients have a constitutionally protected liberty interest in access to physician-assisted suicide.¹⁰⁷ This ruling, coupled with a similar ruling from the Second Circuit on equal-protection grounds,¹⁰⁸ represented a potentially landmark development in constitutional law that stretched existing precedent and invited Supreme Court review. Just how much that development relied on the factual context (or the plaintiffs' stories) rather than abstract constitutional principles becomes apparent when examining these rulings in relation to those principles.

C. Due Process and Equal Protection

In both lawsuits, *Glucksberg* and *Quill*, the plaintiffs originally challenged the constitutionality of laws against assisted suicide (at least as applied to the plaintiff patients and physicians) on two abstract legal bases, both derived from the Fourteenth Amendment—substantive due

101. See *id.* at 1456-58.

102. See *id.* at 1456-57.

103. See *Compassion in Dying v. Washington*, 49 F.3d 586 (9th Cir. 1995).

104. See *id.*

105. See *Compassion in Dying v. Washington*, 79 F.3d 790, 794-95 (9th Cir. 1996) (en banc).

106. *Id.* at 793.

107. See *id.* at 794-95.

108. See *Quill v. Vacco*, 80 F.3d 716, 725-31 (2d Cir. 1996) (discussing plaintiffs' equal protection argument).

process and equal protection.¹⁰⁹ Although the Ninth Circuit accepted the substantive due process basis in *Glucksberg*,¹¹⁰ its weakness as a basis for physician-assisted suicide is suggested by its rejection in *Quill*¹¹¹ by the otherwise friendly Second Circuit panel. The *Quill* court set out the recognized tests for determining whether a claimed right (such as, in this case, to physician-assisted suicide) constitutes a constitutionally protected fundamental liberty interest under the substantive component of the Due Process Clause.¹¹² Of course, unlike free speech or other matters expressly protected in the Bill of Rights, no right to any form of suicide has direct textual support in the language of the Constitution. With respect to such non-textual rights, the Second Circuit quoted from established Supreme Court precedent as follows:

Rights that have no textual support in the language of the Constitution but qualify for heightened judicial protection include fundamental liberties so “implicit in the concept of ordered liberty” that “neither liberty nor justice would exist if they were sacrificed.” Fundamental liberties also have been described as those that are “deeply rooted in this Nation’s history and tradition.”¹¹³

The Second Circuit concluded that neither of these tests were satisfied regarding a right to assisted suicide.¹¹⁴ “Indeed, the very opposite is true,”¹¹⁵ the *Quill* court wrote, adding as follows:

The Common Law of England, as received by the American colonies, prohibited suicide and attempted suicide. Although neither suicide nor attempted suicide is any longer a crime in the United States, 32 states, including New York, continue to make assisted suicide an offense. Clearly, no “right” to assisted suicide ever has been recognized in any state in the United States.¹¹⁶

Based on this historical record, the Second Circuit declined the invitation to create a substantive due process right to assisted suicide.¹¹⁷ In doing so, it quoted the Supreme Court’s warning from a 1986 decision: “The Court is most vulnerable and comes nearest to illegitimacy when it deals with judge-made constitutional law having little or no cognizable roots in the language or design of the Constitution.”¹¹⁸ That could have settled the matter. Ultimately, in a unanimous Supreme Court ruling, it did.¹¹⁹

109. See *Compassion in Dying v. Washington*, 850 F. Supp. 1454, 1467 (W.D. Wash. 1994); *Quill v. Koppell*, 870 F. Supp. 78, 80 (S.D.N.Y. 1994).

110. See *Compassion in Dying v. Washington*, 79 F.3d 790, 816 (9th Cir. 1996) (en banc).

111. See *Quill v. Vacco*, 80 F.3d 716, 723-25 (2d Cir. 1996).

112. See *id.* at 723-24.

113. *Id.* at 723 (quoting *Palko v. Connecticut*, 302 U.S. 319, 325-26 (1937); *Moore v. City of East Cleveland*, 431 U.S. 494, 503 (1977)).

114. See *id.* at 724.

115. *Id.*

116. *Id.* at 724 (citations omitted).

117. See *id.* at 724-25.

118. *Id.* at 724 (quoting *Bowers v. Hardwick*, 478 U.S. 186, 194 (1986)).

119. See *Washington v. Glucksberg*, 521 U.S. 702 (1997). Writing for the Court, Chief Justice Rehnquist addressed this point as follows:

As an abstract legal principle, the Equal Protection Clause offers scarcely more support for the plaintiffs' claims than the Due Process Clause. Having found that laws against assisted suicide unconstitutionally restricted the liberty interests of terminally ill persons, the Ninth Circuit never reached the equal protection issue.¹²⁰ Having found no such constitutional violation, however, the Second Circuit turned to the equal protection challenge.¹²¹

In *Quill*, the Second Circuit identified rational basis scrutiny as the applicable standard of judicial review under the Equal Protection Clause,¹²² and proceeded to reason as follows:

Applying the foregoing principles to the New York statutes criminalizing assisted suicide, it seems clear that: 1) the statutes in question fall within the category of social welfare legislation and therefore are subject to rational basis scrutiny upon judicial review; 2) New York law does not treat equally all competent persons who are in the final stages of fatal illness and wish to hasten their deaths; 3) the distinctions made by New York law with regard to such persons do not further any legitimate state purpose; and 4) accordingly, to the extent that the statutes in question prohibit persons in final stages of terminal illness from having assistance in ending their lives by the use of self-administered, prescribed drugs, the statutes lack any rational basis and are violative of the Equal Protection Clause.¹²³

In particular, on the crucial issue of equating types of terminally ill persons, the court wrote:

[T]hose in the final stages of terminal illness who are on life-support systems are allowed to hasten their deaths by directing the removal of such systems; but those who are similarly situated, except for the previous attachment of life-sustaining equipment,¹²⁴ are not allowed to hasten death by self-administering prescription drugs.

Yet the court's opinion offered no medical, ethical, or historical authority—indeed, no authority of any type other than its own reasoning from prior decisions—for equating the two groups.¹²⁵

The absence of authority on this point is telling because it deals with a central issue in medical ethics—the act/non-act distinction in terminal health care. Although some medical ethicists and physicians agree with the Second Circuit's position,¹²⁶ the great weight of authority

The history of the law's treatment of assisted suicide in this country has been and continues to be one of the rejection of nearly all efforts to permit it. That being the case, our decisions lead us to conclude that the asserted "right" to assistance in committing suicide is not a fundamental liberty interest protected by the Due Process Clause.
Id. at 728.

120. See *Compassion in Dying v. Washington*, 79 F.3d 790, 838 (9th Cir. 1996) (en banc).

121. See *Quill v. Vacco*, 80 F.3d 716, 725 (2d Cir. 1996).

122. See *id.* at 725-26.

123. *Id.* at 727.

124. *Id.* at 729.

125. See *id.* at 725-31.

126. See, e.g., Marcia Angell, *Euthanasia*, 319 NEW ENG. J. MED. 1348, 1350 (1988).

maintains that there is a fundamental difference between allowing patients to die by withholding or withdrawing medical treatment and hastening death through a medical intervention.¹²⁷ Thus, for example, the American Medical Association's current Code of Medical Ethics condemns physician-assisted suicide as "fundamentally inconsistent with the physician's professional role" and states that it "must be distinguished from withholding or withdrawing life-sustaining treatment, in which the patient's death occurs because the patient or the patient's proxy, in consultation with the treating physician, decides that the disadvantages of treatment outweigh its advantages and therefore treatment is refused."¹²⁸

Leading medical ethicists also accept this distinction. For example, a committee of medical ethicists working under the auspices of the prestigious Hastings Center concluded in a 1987 report: "Medical tradition and customary practice distinguish in a broadly acceptable fashion between the refusal of medical interventions and intentionally causing death or assisting suicide."¹²⁹

Similarly, in a joint statement on the issue published in *JAMA*, four of America's premier physician-ethicists, Willard Gaylin, Leon R. Kass, Edmund D. Pellegrino, and Mark Siegler, declared: "Generations of physicians and commentators on medical ethics have underscored and held fast to the distinction between ceasing useless treatments (or allowing to die) and active, willful, taking of life . . ."¹³⁰ At the very least, such positions and statements provide a rational basis for the distinction rejected as irrational by the Second Circuit panel.¹³¹ Ultimately, in its

127. This distinction dates at least as far back in Western medical tradition as the famous Hippocratic Oath, which is attributed to the ancient Greek physician Hippocrates and is still widely recognized today. That oath permits physicians to refrain from treating any patient but absolutely enjoins them from ever assisting in a person's suicide or euthanasia. See *Hippocratic Oath*, in 12 COLLIER'S ENCYCLOPEDIA 137 (1994) (text of oath and commentary).

128. AMERICAN MEDICAL ASSOCIATION COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, 5 CODE OF MEDICAL ETHICS REPORTS 269, 269-71 (1994) (Rept. #59, Physician-Assisted Suicide). The British Medical Association took a similar position in its 1988 *Euthanasia Report*, which concluded: "There is a distinction between an active intervention by a doctor to terminate life and a decision not to prolong life (a nontreatment decision)." *Conclusions of a British Medical Association Review of Guidelines on Euthanasia*, in EUTHANASIA: THE MORAL ISSUES 115 (Robert M. Baird & Stuart E. Rosenbaum eds., 1989).

129. THE HASTINGS CENTER, GUIDELINES ON THE TERMINATION OF LIFE-SUSTAINING TREATMENT AND THE CARE OF THE DYING 128-29 (1987).

130. Willard Gaylin et al., *Doctors Must Not Kill*, 259 JAMA 2139 (1988).

131. See *Quill v. Vacco*, 80 F.3d 716, 725-31 (2d Cir. 1996) (rejecting the distinction between the removal of life-support and self-administered prescription drugs). An exhaustive study of the issue by the 24-member New York State Task Force of Life and the Law reached a conclusion contrary to the Second Circuit in 1994, after a decade of careful deliberation. See generally NEW YORK STATE TASK FORCE, *supra* note 40. In its 200-page report, this broad-based, expert panel (which included physicians) unanimously recommended maintaining the very law that the Second Circuit struck down as unconstitutional only a year later. See *id.* "Few states have ever provided a more cogent explanation for any public policy, and none has ever furnished a more coherent defense of the ban against assisted suicide," one legal commentator noted. Michael M. Uhlmann, *The Legal Logic of Euthanasia*, 22 HUM. LIFE REV. 23, 31 (1996). "If the Task Force Report couldn't pass muster with the Second Circuit, it is virtually impossible to think of a rationale that would." *Id.*

unanimous ruling, the Supreme Court so held.¹³²

As shown by the plaintiffs' successes in the Second and Ninth Circuits, getting courts to recognize the weakness of the abstract legal bases for challenging laws against assisted suicide required their defenders to counter the strength of the plaintiffs' stories against them. Whatever principles support those laws, they proved inadequate to justify withholding physician-assisted suicide from these patient plaintiffs. By leading with these stories, the appellate court opinions in *Glucksberg*¹³³ and *Quill*¹³⁴ suggest their importance. Indeed, unchallenged, they alone fully support the holdings. As if recognizing as much, the defenders countered with stories of their own in their appeals to the Supreme Court.

V. THE DEFENDERS' STORIES

Stung by their defeats in the circuit courts, the New York and Washington attorneys general adopted the tactics of their opponents. In their Supreme Court briefs, the states met compelling story with compelling story and clearly stated their reason for doing so. For example, a representative passage from the brief filed by the State of Washington argues:

The decision below is replete with anecdotal recitations of the toll that terminal illness has inflicted on some individuals as they approach the end of life. These accounts cannot be read without evoking at least two strong emotional reactions—sympathy for those afflicted, and apprehensiveness that—some day a similar fate may befall the reader or a loved one. The proposition advanced by Respondents and apparently subscribed to by the Ninth Circuit—that such suffering would be alleviated by finding a constitutional right to assisted suicide—is unquestionably inviting.

There are, of course, stories that make a different point:

The story of a New York woman, a multiple sclerosis victim, who committed suicide with the encouragement of her husband. Excerpts from her husband's diary, which came to light after her death, suggested that his encouragement of her suicide was motivated, at least in part, by his own wish to be free of the burden of taking care of his ailing wife. . . .

Similarly, Yale Kamisar sighed: "To be sure, any American legislature remains free to reject the Task Force report as a matter of public policy. But how can it be said that a legislature that is impressed by the same *nonreligious* arguments against assisted suicide that influenced the Task Force and arrives at the same conclusions the Task Force did has acted *unconstitutionally*?" Yale Kamisar, *Physician-Assisted Suicide: The Last Bridge to Active Voluntary Euthanasia*, in EUTHANASIA EXAMINED: ETHICAL, CLINICAL AND LEGAL PERSPECTIVES 250 (John Keown ed., 1995) (emphasis in original).

132. See *Vacco v. Quill*, 521 U.S. 793 (1997). Writing for the Court, Chief Justice Rehnquist concluded that "New York's reasons for recognizing and acting on this distinction . . . easily satisfy the constitutional requirement that a legislative classification bear a rational relation to some legitimate end." *Id.* at 808-09.

133. *Compassion in Dying v. Washington*, 79 F.3d 790, 794-95 (9th Cir. 1996) (en banc).

134. *Quill v. Vacco*, 80 F.3d 716, 720-21 (2d Cir. 1996).

The story of a Seattle man who, though diagnosed with terminal pancreatic cancer, was able with modern pain management techniques to be active until shortly before his death. . . .

The story of a Virginia woman who was born with cerebral palsy and, among other things, needed several surgeries to connect her malformed esophagus to her stomach. She survived one suicide attempt, and her doctor resisted her thinly-veiled requests that he assist her in another, instead persuading her to undergo yet another surgery. Two weeks after the surgery she was eating on her own, planning a new wardrobe, and contemplating a return to college.¹³⁵

By putting a human face on the abstract principles supporting laws against assisted suicide, these stories finally began making an effective legal case for those statutes.

At other points, the states call the plaintiffs on their storytelling tactics and offer their own alternative endings in which everyone does not live (or die) happily ever after. In challenging the plaintiffs' equation of physician-assisted suicide with the termination of life-sustaining treatment, for example, the State of Washington's reply brief notes:

Respondents describe tragic individual stories that are close to the line that now separates "letting the patient die from making the patient die." Respondents appear to hope that these terrible stories will evoke an emotional reaction that will lead this Court to mandate moving that line.

But Respondents do not offer a workable stopping point along the continuum where a new line can be established—in effect, their argument provides the "slippery slope." If refusing medical care equals assisted suicide for the terminally ill, why not for the chronically ill or just plain unhappy, who have the same right to refuse treatment? If assisted suicide is equivalent to health care, can allowing a guardian to consent to one and not the other pass the equal protection test Respondents suggest?¹³⁶

Similarly, the reply brief filed by the New York attorney general baldly asserts: "The prevalence of managed care increases the risk of error by and abuse of patients who choose suicide relative to those who withdraw from treatment. . . . To put it bluntly, it is cheaper to kill patients at once than to treat them at length."¹³⁷

Both passages suggest story endings quite at odds with those of-

135. Petitioners' Brief at 16-17, *Washington v. Glucksberg*, 521 U.S. 702 (1997) (No. 96-110) (citation omitted).

136. Petitioners' Reply Brief at 15, *Washington v. Glucksberg*, 521 U.S. 702 (1997) (No. 96-110) (citation omitted).

137. Petitioners' Reply Brief at 16, *Vacco v. Quill*, 521 U.S. 793 (1997) (No. 95-1858). The New York petitioners tell similar stories in their initial brief. See Petitioners' Brief at 27-28, *Vacco v. Quill*, 521 U.S. 793 (1997) (No. 95-1858). New York petitioners assert regarding assisted suicide and euthanasia: "We believe that the practices would be profoundly dangerous for large segments of the population, especially in light of the widespread failure of American medicine to treat pain adequately or to diagnose and treat depression in many cases. The risks would extend to all individuals who are ill." *Id.* at 28 (quoting NEW YORK STATE TASK FORCE, *supra* note 40, at vii-viii). Similarly, they add, with respect to physician-assisted suicide: "Moreover, it is not difficult to imagine that, given the inherent imbalance of power in the doctor-patient relationship, a doctor's suggestion of physician assisted suicide may be viewed not as the presentation of an option but as encouragement." *Id.* at 29.

ferred by the plaintiffs. These alternative endings about unwanted death by physician-assisted suicide are just as compelling, just as personal, and perhaps just as frightening as those told by the plaintiffs about unwanted life without physician-assisted suicide.

Amici opposed to physician-assisted suicide joined in the storytelling, and not just those amici associated with the right-to-life movement. Thus, for example, in its amicus brief, the United States, which joined in arguing the case before the Supreme Court, warned with respect to physician-assisted suicide:

Another area of concern is that terminally ill patients are often extremely vulnerable and susceptible to influence by physicians, family members, and others on whom they depend for support. A terminally ill person may have a strong desire to remain alive. But if that person perceives that those around him disapprove of that choice, it may be difficult to remain steadfast in that choice. The problem is even greater if the patient begins without a strong resolve to cling to life. The point is not that physicians or family members will attempt to coerce persons into committing suicide, although there may be some cases of that. The real dangers are much more subtle and extremely difficult to monitor and address.

For example, physicians may offer lethal medications based on their own judgments concerning the quality of the person's life and their own belief that any rational person in that condition would want assistance in committing suicide. . . . Pressures to cut costs can also affect judgment. When the choice is between suicide and an expensive and prolonged course of treatment, physicians may feel pressured to suggest the former.¹³⁸

This compelling account directly counters proponents' claim that the legalization of physician-assisted suicide promotes patient autonomy. Indeed, it suggests that precisely the opposite would result in many real, individual cases.

In other briefs, several amici describe how legalized physician-assisted suicide could reduce (rather than enhance) patient autonomy in many cases. For example, the American Medical Association brief warns that "poor and minority individuals are at the greatest risk for receiving inadequate care and thus may feel the greatest pressure to request physician-assisted suicide."¹³⁹ This brief identifies the health-insurance industry as potential culprits:

Pressure to contain health care costs exacerbates the problem. Even if, as one would expect, health care insurers would consciously seek to avoid suggesting to patients or physicians that they consider financial costs in making a decision to hasten death, the continuing pressure to reduce costs can only constrain the availability and quality of palliative care

138. Brief for the United States at 20-21, *Washington v. Glucksberg*, 521 U.S. 702 (1997) (No. 96-110) (citing NEW YORK STATE TASK FORCE, *supra* note 40, at 124-25).

139. Brief for the American Medical Association et al. at 14, *Washington v. Glucksberg*, 521 U.S. 702 (1997) (No. 96-110).

and support services that patients and families need.¹⁴⁰

Similarly, an amicus brief filed on behalf of several interested members of Congress stresses: “The harsh reality is that a more expeditious death for terminally ill patients would often serve the interests of others, especially in this era of managed care and exploding medical costs.”¹⁴¹ Such reasoning led to the obvious conclusion: “For every suffering person who makes a rational, informed choice to die, there will be others—perhaps many times as many—on whom that ‘choice’ is effectively imposed. And there will be no way to tell the difference.”¹⁴² This, in short, summarizes the alternative story that the defenders of laws against assisted suicide seek to tell—when it comes to compelling cases, our stories check your stories. Relating these stories helped to swing the tide of the litigation and to lay the foundation for the unanimous Supreme Court rulings reversing the Second and Ninth Circuits.¹⁴³

VI. CONCLUSION: THE SUPREME COURT DECISION

Buffeted by stories from both sides, the Supreme Court largely relied on abstract legal principles in its written opinions upholding the New York and Washington laws against assisted suicide.¹⁴⁴ None of the Justices, in their opinions, related the compelling stories offered by the plaintiffs. But none of them denied those stories either.¹⁴⁵ The competing stories effectively canceled each other out.

In the opinion of the Court, Chief Justice Rehnquist often drew on the states’ stories to support their interests in maintaining laws against assisted suicide. For example, noting that one such interest involves protecting those who might mistakenly commit suicide, Rehnquist draws on the states’ stories to note that “[t]hose who attempt suicide—terminally ill or not—often suffer from depression or other mental disorders.”¹⁴⁶ Reasoning that such depression and mental disorders are difficult to diagnose, he concludes that “legal physician-assisted suicide could make it more difficult for the State to protect depressed or mentally ill persons, or those who are suffering from untreated pain, from suicidal impulses.”¹⁴⁷ Further reflecting the influence of the states’ pres-

140. *Id.*

141. Brief for Senator Orrin Hatch et al. at 4, *Vacco v. Quill*, 521 U.S. 793 (1997) (No. 95-1858).

142. *Id.*

143. See *Vacco v. Quill*, 521 U.S. 793 (1997); *Washington v. Glucksberg*, 521 U.S. 702 (1997).

144. See generally *Vacco v. Quill*, 521 U.S. 793 (1997); *Washington v. Glucksberg*, 521 U.S. 702 (1997).

145. Chief Justice Rehnquist, however, did seem to diminish the stories of the physician plaintiffs in describing those plaintiffs as follows: “These doctors *occasionally* treat terminally ill, suffering patients, and declare that they would assist those patients in ending their lives if not for Washington’s assisted-suicide ban.” *Washington v. Glucksberg*, 521 U.S. 702, 707 (1997) (emphasis added).

146. *Washington v. Glucksberg*, 521 U.S. 702, 730 (1997).

147. *Id.* at 731.

entation, Rehnquist adds:

Next, the State has an interest in protecting vulnerable groups—including the poor, the elderly, and disabled persons—from abuse, neglect, and mistakes. The Court of Appeals dismissed the State's concern that disadvantaged persons might be pressured into physician-assisted suicide as "ludicrous on its face." We have recognized, however, the real risk of subtle coercion and undue influence in end-of-life decisions.¹⁴⁸

In their briefs, of course, opponents of legalized physician-assisted suicide effectively related these risks in individual cases.¹⁴⁹

The concurring opinion of Justice Souter underscores the neutralizing impact of the stories for and against legalized physician-assisted suicide. Souter notes that "[t]he mere assertion that the terminally sick might be pressured into suicide decisions by close friends and family members would not be very telling."¹⁵⁰ But the states did more than this, he adds.¹⁵¹ They countered the respondents' claim that legal safeguards could prevent such abuses with stories from the Netherlands, where such safeguards appear ineffective.¹⁵² The respondents countered with stories claiming that the Dutch safeguards were effective.¹⁵³ Justice Souter concludes that "[t]his factual controversy is not open to a judicial resolution with any substantial degree of assurance at this time."¹⁵⁴ "The principal enquiry at the moment is into the Dutch experience, and I question whether an independent front-line investigation into the facts of a foreign country's legal administration can be soundly undertaken through American courtroom litigation."¹⁵⁵ At least for now, Justice Souter concludes on the basis of these conflicting stories, that the matter should be left to state legislatures, which "are not so constrained,"¹⁵⁶ and their laws against assisted suicide upheld.¹⁵⁷

Although he also concurred in the Court's holding, Justice Stevens expressed even greater concern regarding the stories of patients seeking physician-assisted suicide.¹⁵⁸ Upholding the New York and Washington laws against assisted suicide did not necessarily resolve all individual cases.¹⁵⁹ Justice Stevens states that how cases are decided "will depend on their specific facts."¹⁶⁰ In general, abstract legal principles should not

148. *Id.* (quoting *Compassion in Dying v. Washington*, 79 F.3d 790, 825 (9th Cir. 1996) (en banc)).

149. *See supra* Section V and accompanying notes.

150. *Washington v. Glucksberg*, 521 U.S. 702, 783 (Souter, J., concurring).

151. *See id.* at 783-86.

152. *See id.* at 785-86 (citation omitted).

153. *See id.* at 786 (citations omitted).

154. *Id.* at 787.

155. *Id.*

156. *Id.* at 789.

157. *See id.*

158. *See id.* at 752 (Stevens, J., concurring).

159. *See id.*

160. *Id.*

control in all cases.¹⁶¹ In particular, he concludes “that the so-called ‘unqualified interest in the preservation of human life’ is not itself sufficient to outweigh the interest in liberty that may justify the only possible means of preserving a dying patient’s dignity and alleviating her intolerable suffering.”¹⁶² He thus extends the invitation for further storytelling to the courts.

161. *Id.*

162. *Id.* (quoting *Cruzan v. Director, Mo. Dept. of Health*, 497 U.S. 261, 282 (1990)).