Navigating the Maze of End-of-Life Decisions Regarding the Rejection of Life Sustaining Treatment, Medical Futility, Physician-Assisted Death, and Abortion

Philip Kim
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INTRODUCTION

Personal autonomy is arguably one of the most sacred protected rights of an individual under the United States Constitution, which provides, in part, that no state shall "deprive any person of life, liberty, or property, without due process of law." This essential constitutional right has become a topic of controversy in medicine and various end-of-life decisions. This essay will examine topics ranging from the rejection of life-sustaining treatment and medical futility to physician-assisted suicide and abortion. Each end-of-life subject is unique and divisive; however, analyzing these topics together and comparing the laws regarding each area may help untangle the web of confusion over these ever-important medical determinations.

Perhaps it would be most appropriate to begin with a broader perspective on end-of-life decisions concerning terminal illnesses. Such scenarios create a host of issues concerning not only medicine, but also society as a whole, ethics, politics, and the law of the jurisdiction in question. Behind every situation involving terminal illnesses, there are several complexities that surface when making two necessary determinations: "(1) who should be authorized to resolve the problem, and (2) what substantive principles should apply."2

I. "RIGHT TO DIE"

The phrase "right to die" concerns the basic concept of an individual having full autonomy over the choice between continuing or discontinuing life-supporting treatment when faced with a terminal illness. One typical situation involves the incapacitated patient's family refusing life-sustaining treatment, opting instead to remove life support after years of hope that the patient's condition would improve. The seminal case regarding the right-to-

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die setting is *Cruzan v. Director, Missouri Department of Health.* However, the media coverage surrounding Terry Schiavo from 2001 to her death in 2005 was perhaps one of the most well-known examples in recent history highlighting this ethical dilemma. Both of these cases involved a family's willingness to remove life-sustaining treatment from a dying patient, and both will be discussed at length in this essay.

A. Medical Futility

The converse concept, the "reverse right to die," is the less-publicized notion of medical futility pertaining to the rare circumstance in which physicians have provided their expert opinions that further treatment is medically futile, yet the family desires to continue the treatment. It goes without saying that the decision-making process becomes complicated. Medical futility involves novel and complex issues, and some refer to the concept as "reverse right to die," which is a play on the aforementioned notion of the "right to die." Medical futility is a highly controversial topic dealing with the limits on personal autonomy at the end of an individual's life. One suggested definition of the term is "interventions that are unlikely to produce any significant benefit for the patient." A more authoritative and detailed characterization describes medical futility as the conflict that arises "[w]hen the medical professional and the patient, through a surrogate, disagree on the worth of pursuing life" where the former considers medical intervention to be futile and the latter desires to delay the inevitable.

B. Physician-Assisted Deaths

Physician-assisted death is generally the most controversial end-of-life issue, as society has by and large admonished such undertakings in the field of medicine. This essay will examine this topic through two of the highest court's decisions in the cases of *Washington v. Glucksberg* and *Vacco v. Quill.* Of course, the most infamous poster child for this subject is Dr. Jack Kevorkian, who pushed the limits of the law by helping patients accelerate their own deaths and was incarcerated for his actions. This essay will examine the Supreme Court's rulings on an individual's constitutional right in this controversial situation, which is often known as "physician-assisted sui-

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cide" or euthanasia. The law has proven to be quite firm and consistent on this issue. Also worth noting is the legislation of certain states such as Oregon, which has passed legislation to support physician-assisted deaths through “Death with Dignity” initiatives. This state statute specifically “allows terminally ill Oregonians to end their lives through the voluntary self-administration of lethal medications, expressly prescribed by a physician for that purpose.”

C. Abortion

Perhaps it is not exactly an end-of-life decision, but abortion is discussed in this essay primarily for the purpose of comparing the United States Supreme Court’s description of constitutional rights regarding personal autonomy. This narrowly drawn comparison is specifically between how the Supreme Court has treated decisions regarding physician-assisted deaths and abortions. It seems logical and necessary to include abortion in the totality of the conversation of end-of-life determinations even though many uncertainties remain as to the question of the viability of an unborn fetus. Although this essay will entertain the prominent debate of fetus viability, said debate is by no means the focal point of this conversation. Rather, abortion appears to be an obligatory component to any general dialogue involving the constitutional rights pertaining to physician-assisted deaths; therefore, it will be discussed here as well.

II. Background

A. “Right to Die”

In 1976, the California Natural Death Act was passed and immediately became the precedent and template for living will statutes. These living wills were created for individuals with terminal illnesses where death was imminent, and they were intended “to avoid unwanted life-sustaining treatment that would merely prolong the moment of death.” It was certainly a contentious piece of legislation at the time in California, as detractors of the new statute in the late 1970s worried about the moral questions regarding the possible overstepping of boundaries by the judicial system. Some critics

9. The Oregon Death With Dignity Act, OR. REV. STAT. ANN. § 127.805 (West 2005); see also Furrow et al., supra note 2, at 1556.


13. Redleaf, supra note 11 at 918.
contended that legal solutions to the problem were impracticable, as “statutory standards [would] be either so vague that they provide no guidance or so rigid that they eliminate necessary flexibility.”

Interestingly, even individuals who supported the California Natural Death Act in principle diverged in their opinions regarding timing of the decision to end life-sustaining treatment and the degree of control the patient should have in the decision-making process.

In the many contemporaneous debates over the California statute, there was an underlying fear that this state legislation, if passed, would lend itself to further discussions on the legality of euthanasia. There appears to have been some foreshadowing in these fears, as will be evidenced later in this essay’s discussion. Since 1976, more recent and advanced directives have been implemented in various states, accounting for the expanded scope of circumstances in which a mentally incapacitated individual, such as one who suffers from a persistent vegetative state, may forgo life-sustaining treatment through a surrogate decision-maker.

The right-to-die issue was raised in the famous 1990 United States Supreme Court case *Cruzan v. Director, Missouri Department of Health*. At the center of the case was Nancy Cruzan, a young woman who had suffered massive, permanent brain damage from a car accident. Consequently, Nancy entered into a persistent vegetative state, rendering her incompetent, and it “had become apparent that Nancy Cruzan had virtually no chance of regaining her mental faculties.” At this point, her parents requested that she be taken off life support, knowing that this would cause her death. The hospital employees refused to follow through with the family’s request until it received court approval, so the Cruzan family sought authorization from a court and the case eventually ended up before the U.S. Supreme Court. This particular case invoked the Fourteenth Amendment of the U.S. Constitution, bringing up the issue of whether this amendment provided “a right under the United States Constitution which would require the hospital to withdraw life-sustaining treatment from her under these circumstances.”

The Court acknowledged that this was “the first case in which we have been

14. **Id.** at 918 n.22.
15. **Id.** at 918–19.
16. **Id.** at 919.
17. See [Jecker et al.](supra note 11), at 427.
19. **Id.** at 266.
20. **Id.** at 266-68.
21. **Id.** at 268.
22. **Id.** at 269.
squarely presented with the issue whether the United States Constitution grants what is in common parlance referred to as a ‘right to die.’”

In holding the State’s interest in the preservation of life to be more vital than the quality of life, the majority assumed that a competent patient’s right to die was indeed a protected liberty interest. However, the Court did not grant the surrogate of an incompetent patient with this same constitutional right. In a long, convoluted opinion, the majority ruled that the Fourteenth Amendment permitted a state to erect the highest evidentiary barrier for a decision regarding an incompetent patient’s right to die; the Court specifically allowed for a state to impose “heightened evidentiary requirements” such as clear and convincing evidence of the patient’s desire to refuse life-sustaining treatment.

This decision essentially gave states like Missouri the ability to create the highest evidentiary hurdle possible in a civil case of this kind, as the state could maintain an unqualified interest in the protection of life. Rather than being completely clear on the issue of a surrogate decision-maker in such scenarios, the Court carefully constructed its language in stating that “for purposes of this case, we assume that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition.” The Court stopped just short of recognizing an overly broad constitutional right to die. The question of whether a surrogate held such a right remained unanswered, leaving the question to the discretion of the states. So naturally, the topic of medical futility— or the “reverse right to die”— was even more unclear.

B. Medical Futility

In the past several decades, the physician-patient relationship has drastically changed from medical paternalism to strong patient autonomy, as patients displayed a desire to participate fully in the medical decision process for themselves. Along with this shift there has been a gradual increase in patients and/or their families who claim the right to receive any and all aggressive, high-tech medical interventions, even if their physicians determine the interventions to be futile because there is “no realistic chance of achieving the goals of medicine.” However, it has long been noted that it is not

23. Id. at 277.
24. Id. at 279.
25. See generally id.
26. See id. at 281.
27. Id. at 279 (emphasis added).
29. Id.
always possible for medicine to realize its desired goals, as words that are fundamental to health care "such as ‘heal’ (which means ‘to make whole’) and ‘patient’ (which comes from the Latin ‘to suffer’) suggest that the goal of medicine is not merely to achieve a means, such as restoring heartbeat, unless that means leads to the end of healing the patient."\textsuperscript{30}

Regarding these particular goals, the argument begins with the principle that physicians are duty-bound to offer “only those treatments that have a reasonable chance of achieving a therapeutic benefit for the patient.”\textsuperscript{31} One argument supporting the discretion of health care providers is that a physician’s goal is not merely to treat some part of the body, but rather to benefit the patient as a whole; the patient should at least have the ability to appreciate such benefits.\textsuperscript{32} Some argue that this appreciation is inherently impossible if the patient remains in a persistent vegetative state.\textsuperscript{33}

Sparse litigation obstructs clarity on the issue of medical futility; it is rarely litigated in courts throughout the nation for several reasons—the most obvious being the eventual death of the patient. When a terminally ill patient is incapacitated and cannot decide for herself whether to continue medically futile treatment, the laws of most states are vague and unclear as to the necessary steps in deciding for the patient. Herein lies the problem—because it is not only a matter of choice but also a matter of whether the patient is enduring any physical pain by the maintenance of life-sustaining treatment that may only prolong the patient’s suffering.

These situations become quite contentious because family members are often understandably distraught by the idea of being responsible for removing life-sustaining treatment from a loved one. Such a monumental determination may come with the heavy burden of guilt if the family believes it did not do everything possible to bring about a cure for the patient. Regardless of the medical facts of the situation, emotions run high and can overwhelm the surrogate decision-maker’s conscience in a way that ignores reason and common sense. Thus, when consent becomes difficult or impossible to obtain from the family members of the patient, directives become all the more necessary to assist the medical professionals in doing what is, in their expert opinions, essential and beneficial for the patient. The question then becomes when such directives should control.

Only a modicum of case law regarding medical futility exists and, as recently as the early 1990s, courts have usually found in favor of the patient when a physician objects to a patient’s request for additional treatment in an alleged medically futile situation.\textsuperscript{34} Examples of these judicial tendencies of

\textsuperscript{30} Id. at 673.
\textsuperscript{31} Id. at 669.
\textsuperscript{32} Id.
\textsuperscript{33} Id.
\textsuperscript{34} Judith F. Daar, Medical Futility & Implications for Physician Autonomy, 21 AM. J. L. & MED. 221, 223 (1995).
the time arise in cases such as *In re Jane Doe*, where a hospital was enjoined from de-escalating medical treatment it considered “medical abuse” of a thirteen-year-old girl suffering from an irreversible, degenerative neurological disorder. There the parents of the patient disagreed with the doctors over the child’s course of treatment, as the doctors urged for the treatment to be terminated.\(^35\)

Likewise, in the case *In re Conservatorship of Wanglie*, the patient was in a persistent vegetative state, and it was clear that she would not recover.\(^36\) The physicians treating the patient suggested to the family that the aggressive treatment they were providing the patient was of no medical benefit and should be discontinued.\(^37\) The family rejected the physicians’ advice, and the court ultimately ruled in favor of the family. The decision appointed the husband as the conservator of a permanently unconscious patient over the objections of the attending physicians.\(^38\) Some viewed this case, based on its practical outcome, as a warning sign marking “the erosion of physician autonomy” in medically futile situations.\(^39\)

In 1994, *In re Baby K* involved a similar set of facts to *Wanglie* in that the infant patient’s family opposed the medical judgment of the physicians, who had opined that aggressive treatment was inappropriate and futile.\(^40\) The hospital in this case specifically requested for the court to declare that the hospital had no duty to provide life-sustaining treatment because such care was “medically and ethically inappropriate.”\(^41\) The court ruled in favor of the patient’s family in a rather roundabout fashion by relying on the Emergency Medical Treatment and Active Labor Act (EMTALA) to conclude that immediate medical attention in the form of respiratory support was a mandatory duty of the hospital.\(^42\) This reliance on EMTALA would serve only to complicate the issue of medical futility because such a position would seem to require medical treatment in virtually every emergency room scenario regardless of the patient’s overall prognosis.\(^43\)

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37. See id.
38. See id.
39. Daar, supra note 34, at 225.
40. See generally *In re Baby K*, 16 F.3d 590 (4th Cir. 1994).
41. Id. at 593.
42. Id. at 594–95.
There are plenty of other examples from this period where courts have favored families demanding medically futile treatment. A prime example is the case of a quadriplegic, deaf, blind, and respirator-dependent infant girl whose mother successfully objected to the physicians' recommendations that aggressive treatment be withheld. Thus, the courts appeared to be leaning in the same direction in these cases.

However, cases such as *Gilgunn v. Massachusetts General Hospital* seem to indicate a possible shift in judicial philosophy. In that case, the jury found the hospital and doctors were not negligent in issuing a do-not-resuscitate (DNR) order for a comatose patient suffering from irreversible brain damage even though the patient's family member objected to the DNR order. This seemed to be a new kind of decision concerning medical futility in which the court ruled that doctors no longer needed to provide medical care when they deemed such care to be futile.

This back-and-forth game of consent and autonomy in the difficult decision-making process of this era was well depicted in a cartoon by Gahan Wilson in the *New Yorker Magazine*, where Wilson drew a scene showing:

A browbeaten physician kneeling before a tombstone in a cemetery, anxiously fiddling with his stethoscope over the grave. Standing behind and over him with an intimidating expression is someone we take to be the wife of the deceased, seemingly demanding that the physician perform a miracle. All the physician can do is submissively look back over his shoulder and apologetically explain, "I'm afraid there is really very little I can do . . . ."

Since the early 1990s, there have been new laws enacted in various states concerning medical futility; however, the nation as a whole has yet to reach a consensus as to how to deal with this rare dilemma in which family members desire to continue medically futile care when faced with the opposition of expert health care providers.

C. Physician-Assisted Deaths

The highly unpopular notion of physician-assisted death, also referred to as physician-assisted suicide (PAS), received great notoriety through the in-
famous character of Dr. Jack Kevorkian, who was not shy in lending his medical support to individuals desiring to end their own lives. Oftentimes, Dr. Kevorkian (sometimes called “Dr. Death”) did not have a preexisting relationship with the patients that sought his assistance, and it was not always clear that these patients had terminal illnesses. However, Kevorkian’s greatest misstep with the law, which led to his ultimate downfall, actually came through his injection of lethal doses to patients on videotape and sending the recording to media outlets such as the investigative television program 60 Minutes. This led to the highly publicized trial of Kevorkian and many national debates on the subject.

Two major United States Supreme Court cases from 1997 provide background and a constitutional framework for this issue: Washington v. Glucksberg and Vacco v. Quill. In Glucksberg, the Court held that “the asserted ‘right’ to assistance in committing suicide is not a fundamental liberty interest protected by the Due Process Clause [because] Washington’s assisted-suicide ban implicates a number of state interests.” Therefore, the majority was clear in establishing that a state ban of any physician assisting in suicide “does not violate the Fourteenth Amendment, either on its face or ‘as applied to competent, terminally ill adults who wish to hasten their deaths by obtaining medication prescribed by their doctors.’”

Justice O’Connor’s concurrence, however, was more deliberate in differentiating between the state’s interest concerning an individual wishing to commit suicide and a terminally ill patient “faced not with the choice of whether to live, only of how to die.” The Associate Justice continued to elaborate on her stance by stating that “the State’s legitimate interest in preventing abuse does not apply to an individual who is not victimized by abuse, who is not suffering from depression, and who makes a rational and voluntary decision to seek assistance in dying.”

In Vacco v. Quill, the Supreme Court ruled in the same way, reversing the Second Circuit Court of Appeals. The Supreme Court “disagree[d] with respondents’ claim that the distinction between refusing lifesaving medical


50. *Id.*


55. *Id.* at 735.

56. *Id.* at 746 (emphasis added).

57. *Id.* at 747.

58. See Quill, 521 U.S. at 809.
treatment and assisting suicide [was] 'arbitrary' and 'irrational.'”

Rather, the Court upheld the right of the state of New York to treat these two acts differently, as the Court recognized that “permitting everyone to refuse unwanted medical treatment while prohibiting anyone from assisting a suicide [was] a longstanding and rational distinction.” The Court was clear in establishing that “[t]hese valid and important public interests easily satisfy the constitutional requirement that a legislative classification bear a rational relation to some legitimate end.” Thus, by way of Glucksberg and Quill, the nation received a clear ruling from the highest court that states had the power and the right to deny individuals the self-initiated process of undergoing physician-assisted deaths.

With regard to “Death with Dignity” statutes, the lone, radical state that is unique from every other state in the country is Oregon, as evidenced by its version of the “Death with Dignity” legislation. Although “Death with Dignity” initiatives were narrowly defeated in the states of California and Washington, the voters of Oregon approved their version of the initiative in 1994, allowing The Oregon Death with Dignity Act to become a state statute.

Provided for within the same chapter as the laws concerning powers of attorney, advance directives for health care, and declarations for mental health treatment, this particular act regarding “death with dignity” eventually drew the ire of many people beyond the borders Oregon, including federal government officials.

There were many challenges brought against Oregon's Death with Dignity Act, but United States Attorney General John Ashcroft brought forth the most powerful and controversial objection when he “issued a directive which reinterpreted the Controlled Substances Act as to invalidate Oregon's assisted-suicide law. This was the first time in history that the Controlled Substances Act was used to preempt state law.” Attorney General Ashcroft specifically attempted to reinterpret the Controlled Substances Act by relying on the “legitimate medical purpose” regulation, something the Executive Branch had never done before, in order to deem any prescriptions issued and filled for the purpose of assisting suicide as an illegitimate medical purpose,

59. Id. at 807.
60. Id. at 808.
61. Id. at 809.
63. Furrow et al., supra note 2, at 1556.
65. Lindsay R. Kandra, Comment, Questioning the Foundation of Attorney General Ashcroft's Attempt to Invalidate Oregon's Death with Dignity Act, 81 Or. L. Rev. 505, 505 (2002).
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“effectively nullifying the Oregon Act.”66 This, in turn, led to a contentious dispute that went all the way to the United States Supreme Court in Gonzales v. Oregon, which stands as the current law and will be discussed below.67

D. Abortion

The landmark case of Roe v. Wade hardly needs an introduction; however, in the interest of being thorough, it is worth reviewing the Supreme Court’s 1973 decision in detail.68 The majority held that there is a constitutional right of privacy, and further elaborated that such a right, “whether it be founded in the Fourteenth Amendment’s concept of personal liberty and restrictions upon state action [or] in the Ninth Amendment’s reservation of rights to the people . . . is broad enough to encompass a woman’s decision whether or not to terminate her pregnancy.”69

This constitutional right, of course, could not adequately or logically be discussed until dealing with the question of the unborn fetus’s viability. As the first step in the debate, if it was established that the fetus was not viable, then it could be considered as a part of the mother’s own body; however, if the fetus was viable, then it would have be treated as a separate human being. The appellee and certain amici made the argument that “the fetus is a ‘person’ within the language and meaning of the Fourteenth Amendment” based on established medical facts of fetal development.70 The Court even acknowledged—and the appellant aptly conceded—that if such a “suggestion of personhood [was] established, the appellant’s case, of course, collapses, for the fetus’ right to life would then be guaranteed specifically by the Amendment.”71

However, the Court refused to redefine the Constitution’s interpretation of personhood by stating that the United States Constitution only narrowly refers to the term “person” in Section 1 of the Fourteenth Amendment.72 Since this section has been discussed throughout this essay, it is worthwhile to examine it in its entirety, as the critical term “person” is used throughout:

All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, lib-

66. Id. at 518.
69. Id. at 153.
70. Id. at 156.
71. Id. at 156–57.
72. Id. at 157.
property, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.73

The Court in Roe v. Wade mentioned that the Fourteenth Amendment, "in defining 'citizens,' speaks of 'persons born or naturalized in the United States' . . . [and] the word also appears in the Due Process Clause and in the Equal Protections clause."74 After considering other places within the Constitution in which "person" is mentioned, the Court decidedly remarked that "in nearly all these instances, the use of the word is such that it has application only postnatally [and] none indicates, with any assurance, that it has any possible prenatal application."75 Therefore, the Court was clear in observing that "the word 'person,' as used in the Fourteenth Amendment, does not include the unborn."76 The Supreme Court established the legal principle that a fetus within a pregnant woman could not be seen as its own person, meaning it was ultimately still a natural part of the mother.

So it was determined that the right of personal privacy, albeit a right that the Court noted was "not unqualified," included the right of a woman to abort the fetus, as this was her constitutional right regarding medical treatment to her own body.77 The Court further held that only a "compelling state interest" could justify any state regulation limiting the right of privacy of a woman desiring to undergo an abortion.78 This opinion still stands as binding precedent today.

III. CURRENT LAW

A. "Right to Die"

The holding and impact from the United States Supreme Court case of Cruzan v. Director, Missouri Department of Health remains good law today.79 The Cruzan family suffered a great deal in the process of the highly publicized case, and the heavy burdens and moral dilemmas proved to be too much for Nancy Cruzan’s father, Joe, who committed suicide in 1996 after suffering bouts of depression.80

Of course, the case also has had an impact in the decisions of courts throughout the country, as the case has often been cited in discussions of end-of-life determinations following the Supreme Court’s finding that a pa-

73. U.S. CONST. amend. XIV, § 1.
75. Id. at 157.
76. Id. at 158.
77. Id. at 154.
78. Id. at 155.
80. Peter Annin & Mark Peyser. A Father’s Sorrow: Joe Cruzan’s Struggle Ends with Suicide, NEWSWEEK, Sept. 2, 1996, at 54.
tient has the right to forgo medical treatment. And although some courts have turned to the United States Constitution, the Supreme Court's interpretation of the Fourteenth Amendment has given lower courts the confidence to look elsewhere for the same right, such as in state statutes, state common law, or even state constitutions.

Since Chief Justice Rehnquist noted in *Cruzan* that "the informed consent doctrine has become firmly entrenched in American tort law," nearly every state court that recognizes a right to refuse life-sustaining treatment has recognized that particular right of an individual in state common law, typically in the form of informed consent. Examples of states finding such a right in their state statutes can be seen in Connecticut and Illinois. But perhaps the strongest type of support for the right to die that one could locate is in a state constitution because it likely cannot be reviewed by the United States Supreme Court, and it is not subject to alteration by the state's legislature. Various examples of these provisions in state constitutions can be found in Florida, Arizona, and California.

B. Medical Futility

Current case law on the topic of medical futility is still quite muddled. One of the most recent cases on point is the case of *Bernstein v. Superior Court*, which serves as a prime example of a typical sequence of events when the jurisdiction lacks a clear directive under which physicians may operate. The California Superior Court recently dealt with the idea of medical futility from the perspective of a family dispute "regarding the level of appropriate care that should be provided" to the patient. The court found that the family member pursuing life-prolonging measures was "not acting in good faith


82. *Furrow*, et al., *supra* note 2, at 1435.

83. *Cruzan*, 497 U.S. at 269.

84. *Furrow*, et al., *supra* note 2, at 1435.


86. *Furrow*, et al., *supra* note 2, at 1436.


or in [the patient]’s best interests [because he] had not based his health care decisions on medical advice.”

Much can be learned from a more detailed look into this particular case. The 79-year-old patient, Karl Bernstein, had two sons, Ilya and Nicholas, through his marriage of 28 years with Olga Bernstein, and one son, Scot Bernstein, by a prior marriage. Doctors officially diagnosed Karl, who had suffered degenerative symptoms for a number of years, with Alzheimer’s disease in April of 1999. Following the initial diagnosis, Karl’s condition worsened during the next few years as he was transferred from one health care facility to another, only to return to one of the first hospitals he had visited—Los Robles Hospital. At Los Robles, the family members began to dispute “the level of appropriate care that should be provided to Karl concerning orders to or not to resuscitate (DNR).”

Scot officially became Karl’s temporary conservator in April of 2003 after reaching a settlement with Olga, who agreed to turn over the conservatorship to Scot because she was unable to pay for the expense of opposing him as conservator and was unable to “cope with the stress of litigation and Karl’s illness.” Among the express requirements set forth in the agreement was the condition “that Scot would adhere to physician recommendations.” Soon thereafter, Karl became “completely bedridden, non-communicative, fully contracted in a fetal position, incontinent, unable to eat or swallow, and . . . unable to undertake any volitional act.” The doctors found him to be in a persistent vegetative state, or PVS, and for “the last six years, while unable to consent to medical treatment, Karl received a number of invasive procedures to keep him alive.”

During this time, Karl suffered from a lack of “meaningful rest or sleep” due to the distortion of his legs underneath his body, an inability to “process the nutrition provided through the feeding tube rendering him extremely thin and wasted,” recurring infections such as pneumonia due to the tracheostomy tube, and intramuscular antibiotic injections that the physicians determined were “too painful to continue given their lack of therapeutic value.” Ilya and Nicholas “contended that Scot had abused his authority as conservator

90. Id. at *12.
91. Id. at *1.
92. Id.
93. Id.
94. Id.
95. Id. at *2.
96. Id.
97. Id.
98. Id.
99. Id.
by . . . demanding a series of painful and invasive treatments having no medical or therapeutic value for Karl."  

This led to their request for the trial court to change the conservatorship from Scot to Olga, because Scot was not acting in the best interests of Karl, who "spoke of his own death in his handwritten journal [w]anting 'some pleasure and comfort out of life, as well as to add to the pleasure and comfort of others.'"  

Various doctors involved in Karl's treatment unanimously concluded that "Karl [was] in a persistent vegetative state . . . [, and] most, if not all, of the medical staff believe[d] that Karl experience[d] some amount of pain." Furthermore, the court-ordered report showed "that the doctors have determined a number of procedures and treatments are futile . . . [and] essentially all of the treatments Karl is currently receiving are inappropriate and the family should withdraw support altogether . . . [because] there is minimal, if anything, that can be done to change his condition."  

The trial court ruled in favor of the respondents as it "appointed Ilya as conservator and [simultaneously] denied Scot's request for a further hearing" on the issue. The court rejected Scot's argument that there was "no evidence that his behavior negatively impacted Karl's care." The court also rejected Scot's further argument that "through his diligence, Karl [had] received excellent care," because he made the decision as the conservator, at the time, to ignore the medical advice of the treating physicians. The trial court based its decision largely on the evidence that "Scot was not acting in good faith or in Karl's best interest," and that Karl's stated desires were not being met because his "present condition was uncomfortable and painful, not pleasurable for him, and his suffering causes stress for all his family . . . [while] the Bioethics Committee concluded there was no treatment that had therapeutic value for Karl's condition."  

The respondents primarily focused on a request to "prohibit medical treatments that are painful and medically futile, such as intramuscular antibiotic injections, discontinue feeding methods that are painful and futile, and remove the tracheostomy tube." The court also "rejected the 'clear and convincing standard,' stating that the 'preponderance test' applied in this

100. Id.
101. See id. at *3.
102. Id. at *4.
103. Id.
104. See id. at *11.
105. Id.
106. Id.
107. Id. at *3.
108. Id.
case.”109 In response to the trial court’s ruling, Scot appealed contending “the trial court abused its discretion in removing him as conservator.”110

The appellate court found that the trial court “applied the proper burden of proof and properly found that Scot was not acting in good faith or in Karl’s best interests because Scot’s judgment and objectivity were impaired.”111 The basic rationale for this finding is the idea that Scot went against the medical advice of the treating doctors when making health care decisions for Karl since the physicians unanimously agreed that “Karl has been in a persistent or chronic vegetative state for several years with no hope of recovery, the painful and futile medical procedures should be terminated, he should be placed on a DNR order, and he should be moved to a sub-acute care facility.”112

The court rejected any application of the Conservatorship of Wendland case “in determining whether or not to allow removal of nutrition, hydration, and respiratory care” because Karl was not “conscious,” and the evidence was undisputed that Karl had no hope of recovery due to his PVS.113 Although Karl did show some type of “awareness,” it was only “in response to certain medical treatments . . . [and a] showing of discomfort [did] not render Karl ‘conscious’ within the meaning of Wendland.”114 Moreover, the Court rejected any theory that “a person could be both in a persistent vegetative state and conscious at the same time . . . [because] the terms are mutually exclusive.”115

The court denied Scot’s request for a further hearing based on the Probate Code Section 2355, which clearly states that it “does not require a further hearing for the court to give its approval of a conservator’s decision to withdraw medical treatment, or guarantee an interested party the right to have a hearing should the interested party take issue with a decision as the conservator.”116 The court then further elaborated its stance by explaining, “[c]ourts have held that judicial intervention in right-to-die cases should be minimal [as they] are not the proper place to resolve the agonizing personal problems that underlie these cases.”117

Thus, the court agreed that “[n]ot only [was] there no useful purpose in having a further hearing on the subject of the removal of life sustaining treat-

109. Id. at *11.
110. Id.
111. Id. at *12.
112. Id.
113. Id. (comparing Conservatorship of Wendland, 28 P.3d 151 (Cal. 2001)).
114. Id. at *13.
115. Id. at *13 n.2.
116. Id.
117. Id. at *14 (citing Conservatorship of Morrison, 206 Cal. App. 3d 304, 312 (1988)).
ment . . . [but] such a hearing would only compound the damage done to [Karl] and this family . . . by [Scot].”118 Moreover, the court declared that the Bernstein family had “suffered enough.”119

The current controlling law in the state of Texas is found in the Texas Advance Directives Act of 1999, which is “groundbreaking and unique.”120 Also colloquially referred to as the “Texas Futility Statute,” this landmark act has been influential in the surrogate decision-making process when there is a dispute over end-of-life treatment for an incapacitated patient.121 The statute lays out a step-by-step procedure, and below is a notable subsection of the statute describing the necessary steps to follow:

(e) If the patient or the person responsible for the health care decisions of the patient is requesting life-sustaining treatment that the attending physician has decided and the review process has affirmed is inappropriate treatment, the patient shall be given available life-sustaining treatment pending transfer under Subsection (d). The patient is responsible for any costs incurred in transferring the patient to another facility. The physician and the health care facility are not obligated to provide life-sustaining treatment after the 10th day after the written decision required under Subsection (b) is provided to the patient or the person responsible for the health care decisions of the patient unless ordered to do so under Subsection (g).122

The reference to subsection (g) is significant because it indicates that the state legislature actually acknowledges and understands the sensitive nature of medically futile scenarios:

(g) At the request of the patient or the person responsible for the health care decisions of the patient, the appropriate district or county court shall extend the time period provided under Subsection (e) only if the court finds, by a preponderance of the evidence, that there is a reasonable expectation that a physician or health care facility that will honor the patient’s directive will be found if the time extension is granted.123

The arduous and straining litigation process in medical futility circumstances can only make the process more difficult for the family involved—which is perhaps one reason there is little case law on the issue.124

118. Id.
119. Id.
121. See generally TEX. HEALTH & SAFETY CODE ANN. § 166.046 (Vernon 2003).
122. Id. § 166.046(e).
123. Id. § 166.046(g) (emphasis added).
124. Id. § 166.046.
nately, statutes such as the one in Texas have clarified a blurry issue by defining a specific number of days that a medically futile patient may receive life-sustaining treatment. During this ten-day period, there are several things that can happen, such as the family’s eventual acquiescence to the doctors’ opinions, the death of the patient, or a continued impasse period. Although it is far from an ideal statute, it appears to be a step in the right direction as it provides the proper procedure if a physician is not effectuating a patient’s directive or treatment decision.

C. Physician-Assisted Deaths

The two United States Supreme Court cases of Washington v. Glucksberg and Vacco v. Quill have yet to be overturned. So generally speaking, states continue to maintain the constitutional right and ability to deny individuals the self-initiated process of undergoing physician-assisted deaths, or PAS, if the state desires to do so. In Glucksberg, the Supreme Court determined that the Fourteenth Amendment did not protect the rights of an individual regarding physician-assisted suicide. Looking closely and carefully at the nation’s long “history, legal traditions, and practices . . . that direct and restrain [the Court’s] exposition of the Due Process Clause,” the Court cited a “consistent and almost universal tradition that has long rejected the asserted right, and continues explicitly to reject it today, even for the terminally ill, mentally competent adults.”

It was true then, and it remains true today, that physician-assisted death is controversial and unpopular, as typified by President Clinton during his term, when he “signed the Federal Assisted Suicide Funding Restriction Act of 1997, which prohibits the use of federal funds in support of physician-assisted suicide.” This legislation passed by Clinton helps to identify a concrete foundation in the current law of the United States in general. This sentiment is not restricted to the federal level, but also “the overwhelming majority of States explicitly [prohibit] assisted suicide.” Although the

125. Id. § 166.046(e).
126. Id.
127. Id. § 166.046(a).
129. Glucksberg, 521 U.S. at 721.
130. Id.
131. Id. at 721, 723.
132. Id. at 718.
133. Id. at 718–19.
134. Id. (citing IOWA CODE ANN. §§ 707A.3 (1997); R.I. GEN. LAWS §§ 11-60-1, 11-60-3 (1996)).
Navigating the Maze of End-of-Life Decisions

The Supreme Court has recognized that an individual has a right to refuse unwanted medical treatment, the Court generally favors the countervailing state interests, including the deep-rooted public disapproval of suicide, to prohibit PAS.135

Likewise, in Quill, the Court essentially distinguished between physician-assisted suicide and the more passive approach of euthanasia, which was manifest through the differences in causation and intent of the two circumstances.136 Specifically, the Court explained that "when a patient refuses life-sustaining medical treatment, he dies from an underlying fatal disease or pathology; but if a patient ingests lethal medication prescribed by a physician, he is killed by that medication."137 As to the intent, the Court noted that a form of passive euthanasia by refusing life-sustaining treatment would be to respect the wishes of the patient, whereas a drug-induced death would be to cause the patient’s death.138 Thus, prohibiting PAS has long been and continues to be the precedent.139

Of course, referring to the law regarding PAS as “general” implies that there are exceptions, and in this case that would be the state of Oregon.140 Section 127.085(1) of the Oregon Death with Dignity Act holds that:

An adult who is capable, is a resident of Oregon, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner . . . .141

This remarkable shift away from the national trend regarding physician-assisted suicide is a great rarity among the states.142 The fact that Oregon’s statute is completely contrary to the general law of the nation may help explain why Attorney General John Ashcroft made an effort to invalidate Oregon’s assisted suicide statute.143 As discussed above, Ashcroft, using the powers of the Executive Branch, attempted to reinterpret the Controlled Substances Act by relying on the “legitimate medical purpose” regulation so that

135. Id. at 773; Vacco v. Quill, 521 U.S. 793, 809 (1997).
136. Quill, 521 U.S. at 800–801.
137. Id. at 801 (emphasis added).
138. Id. at 801–802.
139. See Washington, 521 U.S. at 718.
141. Id. § 127.805(1).
142. Washington, 521 U.S. at 718.
143. Kandra, supra note 65, at 518.
any prescriptions issued and filled for the purpose of assisting suicide, or anything similar, would be viewed as an illegitimate medical purpose.\textsuperscript{144}

However, Ashcroft’s attempts were foiled as seen in the case of Gonzales v. Oregon, where the United States Supreme Court held in its majority opinion that the Controlled Substances Act’s “prescription requirement does not authorize the Attorney General to bar dispensing controlled substances for assisted suicide in the face of a state medical regime permitting such conduct . . . [because] Congress did not have this far-reaching intent to alter the federal-state balance and the congressional role in maintaining it.”\textsuperscript{145} Even Justice Scalia’s dissenting opinion acknowledged that the “prohibition or deterrence of assisted suicide is certainly not among the enumerated powers conferred on the United States by the Constitution, and it is within the realm of public morality (bonos mores) traditionally addressed by the so-called police power of the States.”\textsuperscript{146} Thus, Oregon’s unique statute remains to stand as controlling law in the state for purposes of physician-assisted suicide.

\section*{D. Abortion}

Roe v. Wade was decided almost four decades ago; however, it remains controversial today, and it is heavily debated in political discussion, especially during election season. In the many years since the case was decided, Harris Poll results indicate that although general attitudes towards the decision have fluctuated over time, the 2006 poll shows that it is now almost an even split in public opinion:\textsuperscript{147}

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\caption{Poll results showing public opinion on Roe v. Wade from 1973 to 2006.}
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\textsuperscript{*}The Harris poll was conducted by telephone within the U.S. on 4-10-06, among a random sample of 1,016 adults. In theory, with a probability sample of this size, one can say with 95\% certainty that the results have a sampling error of \pm 3 percentage points of what they would be if the entire U.S. adult population had been polled with complete accuracy.

\textsuperscript{**}Note: Percentages may not add up to 100\% due to rounding.
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\textsuperscript{144} Id.


\textsuperscript{146} Id. at 298.

Subsequent decisions to *Roe v. Wade* have been equally contentious. The Supreme Court had the opportunity to change its prior ruling when it heard the case of *Webster v. Reproductive Health Services*. Justice Scalia was clear in his desire to “reconsider and explicitly overrule *Roe v. Wade*,” however, he was in the minority.\footnote{Webster v. Reprod. Health Servs., 492 U.S. 490, 496 (1989).} Justice Rehnquist, who authored the majority opinion, considered it moot to reconsider *Roe v. Wade*, thus the crux of the original decision did not change.\footnote{Id. at 512.} The issue arose again in *Planned Parenthood of Southeastern Pennsylvania v. Casey* in 1992; however, *Roe v. Wade* again emerged unchanged as the Court applied the doctrine of *stare decisis* in reaffirming its original decision.\footnote{Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 833-34 (1992).} Although many attempts have been made to overturn *Roe v. Wade*, the 1973 case continues to remain as binding precedent today.\footnote{See generally *Roe v. Wade*, 410 U.S. 113 (1973).} Regardless, there have been very different views from the various states. If the power to regulate abortion is returned to the states by a reversal of *Roe v. Wade*, some states would be able to enforce related laws they have since passed, which range from making abortion illegal to ensuring it is legal.\footnote{Christine Vestal, *States Probe Limits of Abortion Policy*, STATERLINE, (June 11, 2007), http://www.stateline.org/live/ViewPage.action?siteNodeId=136&languageId=1&contentId=121780.}

IV. **Analysis**

A. “Right to Die”

In evaluating the case law regarding the right to die, this essay looks specifically to the case of *Cruzan*.\footnote{See generally *Cruzan v. Dir. Mo. Dep’t of Health*, 497 U.S. 261 (1990).} Rather than raising the issue of privacy, in which the level of scrutiny tends to be very strict, the United States Supreme Court classified the competent person’s interest in the preservation of life as a protected liberty interest under the Due Process Clause.\footnote{Id. at 262.} Chief Justice Rehnquist explained the importance of preserving life as an interest that outweighs the quality of life.\footnote{Id. at 335–36.} In fact, Missouri was held to have an unqualified interest in the protection of life.\footnote{Id. at 282.}

But it cannot be overlooked that the majority opinion only assumed that a competent patient’s right to die was indeed a protected liberty interest, while a surrogate decision-maker of an incompetent patient was not granted
the same constitutional right. Even though the Court recognized what seemed to be a constitutional right to die, there were still unanswered questions remaining as the Court did not specifically answer whether a surrogate held the same right, which consequently leaves the problem to the discretion of each individual state without uniformity.

The four dissenting judges did well to highlight the perspective that the right to die was the most intimate decision a person could make. And just as issues of privacy are under strict scrutiny, this issue should be the same. Still, considering patient autonomy and the notion that there are fundamental rights, it was valuable for the Court to come to a general consensus on the issue of a competent patient’s right to refuse medical treatment. However, this conclusion (or rather, assumption) by the Court only scratched the surface of the right-to-die issue. The most litigious controversy arises when the patient is effectively incompetent, incapacitated, and/or incapable of making his/her own decisions regarding current and future medical treatment. It would help the lower courts if, in addition to a competent patient’s right to die, the Supreme Court also decisively explained the constitutional rights of surrogate decision-makers. This would certainly resolve many of the uncertainties that torture families involved in “Catch-22” scenarios, such as in the cases of the families of Nancy Cruzan and Terry Schiavo.

B. Medical Futility

Using the case of Bernstein v. Superior Court as a platform to discuss some of the problematic ways in which courts have ruled, one obstacle to clarity is that the court was deferential to the trial court’s opinion, as it simply borrowed language from the lower court to explain its holding. The facts of this case happened to be advantageous for the respondents, whom the court noted had the benefit of “undisputed and overwhelming evidence presented at the evidentiary hearing” in their favor. The court even admitted that it wanted to remain deferential and relatively quiet on this highly sensitive right-to-die issue.

The court’s level of silence on medical futility was disappointing at best. The court did well to cite to past cases within its own jurisdiction to

157. Id. at 279.
158. Id. at 303–05.
159. Id. at 279.
160. See generally id.; Schiavo ex rel. Schindler v. Schiavo, 403 F.3d 1289 (11th Cir. 2005).
162. Id. at *15.
163. Id. at *14.
determine perspectives and definitions regarding the topic. But the court also missed a golden opportunity to enhance the dialogue regarding medical futility. This court could have had a greater impact on the rarely litigated subject of medical futility for future courts to look to, not only within the state of California, but also around the nation since there is very little case law on the issue. Yet the court chose the minimalist route.

The court failed to refer to cases like Causey v. St. Francis Medical Center, even through a simple footnote could have shined more light on the topic. California would likely have been well-served had this court gleaned more from the sensitive rendering of the medical futility problem provided by the Causey court. In this particular Louisiana case, the court looked to the “subjective value judgments” used to determine futility “in terms of personal values, not in terms of medical science.” The court seemed to understand the very sensitive nature of such a “conflict over values, i.e., whether extra days obtained through medical intervention are worth the burden and costs.”

This was in stark contrast to the Bernstein court, which took the less controversial route of looking only at the specific situation at hand, where the facts clearly painted a picture of an end-of-life patient in great pain and without hope. While the Causey court looked to a myriad of issues such as a “physician’s obligation to obtain informed consent [which] is both an ethical requirement and a legal standard of care derived from principles of individual integrity and self determination,” the Bernstein court merely stated “judicial intervention in ‘right to die’ cases should be minimal,” effectively shying away from addressing persuasive cases from other jurisdictions that might be of benefit to future medical futility cases in the state and country. The court could also have chosen to examine statutes from other states dealing with medical futility, such as the landmark Texas Advance Directives Act of 1999. However, the court in Bernstein failed to do anything of the sort when drafting its recent decision.

164. See id.
165. See generally id.
167. See generally id.
168. Id. at 1074.
169. Id. at 1075.
171. Causey, 719 So. 2d at 1075.
The topic of informed consent providing a discussion on the issue of individual autonomy is also lacking in the Bernstein court’s decision. The Cruzan decision is a binding decision by the U.S. Supreme Court that this court could have referred to for a discussion on individual autonomy. Although the facts in Cruzan are different from Bernstein, it is beneficial in terms of examining the constitutional rights associated with permitting a state to create a high evidentiary barrier for an incompetent patient’s right to die.

In Cruzan, the patient suffered a massive brain injury from an automobile accident, which led to her entering into a persistent vegetative state. There was evidence in “Cruzan’s expression to a former housemate that she would not wish to continue on with her life if sick or injured unless she could live at least halfway normally suggested that she would not wish to continue on with her nutrition and hydration.” However, the Missouri Supreme Court disagreed with the idea that her surrogate decision-makers were ultimately permitted to determine her end-of-life choices, “concluding that no person can assume that choice for an incompetent in the absence of the formalities required by the Living Will statute or clear and convincing evidence of the patient’s wishes.”

The debate hinged on the question of whether the Fourteenth Amendment of the U.S. Constitution allowed a state to create a high, “clear and convincing evidence standard” in determining an incompetent patient’s right to die. The petitioners in Cruzan “insist[ed] that under the general holdings of [the Court’s] cases, the forced administration of life-sustaining medical treatment and even of artificially delivered food and water essential to life, would implicate a competent person’s liberty interest.” They also argued “an incompetent person should possess the same right [of refusing life-saving hydration and nutrition] as is possessed by a competent person.”

The majority of the justices assumed that the right to die is a protected liberty interest of a competent patient. Although the Supreme Court has proven to be somewhat elusive in these controversial right-to-die cases, this

174. See generally Bernstein, 2009 WL 224942.
176. See id. at 286–87.
177. See id. at 261.
178. Id. at 261.
179. Id.
180. Id. at 263.
181. Id. at 279.
182. Id.
183. Id.
does not excuse the California court from addressing medical futility to the fullest, because a healthy discussion in an opinion would be beneficial to all.

The topic of medical futility is nebulous and as medical technology advances, the question of whether medical intervention is ever medically futile will increasingly become a subject of heated debate. Texas is still one of only a few states with such a specific statute concerning medical futility, but even Section 166.046 of the Texas Health & Safety Code falls short in many respects. As the statute currently stands, there are many situations where a person with neither an irreversible nor terminable condition can have the statute used against them. Society as a whole can only benefit when there is greater dialogue on controversial topics such as medical futility. Cases like Bernstein provide very little aid when much is needed. There seems to be little regard for guidance in the opinions of such important and rare cases. Simply put, the Bernstein court fell short when there was great opportunity to clarify the law.

As there has yet to be an established, clear consensus on the question of who exactly has the power to demand medical treatment—and who has the power to refuse treatment—both the patients' and physicians' perspectives must be properly framed by asking the two following questions:

[1] Do patients and families have a right to force doctors to squander scarce time and resources on therapies that have no benefit in order to satisfy their irrational wishes? [and 2] Do doctors have a right to arbitrarily ignore the values and preferences of patients and families using their own value systems to make life and death decisions for others?

It is in the response to these questions that we see the varying perspectives on the dilemma of medical futility. As irreconcilable as the two queries appear to be, they must be posed in conjunction because the breadth of the medical futility problem cannot be touched without a full examination of the issues. Texas has taken a step toward this type of proposition by including not only specific directives for transferring a patient that desires to continue medically futile treatment against the will of that patient's doctor, but also provisions within the statute to account for the difficult decision-making process, as the Texas medical futility statute has allows for the possibility of reasonable extensions.

C. Physician-Assisted Deaths

There is not an end-of-life determination more scrutinized in the United States than the physician-assisted death. The commonly used phrase, "physician-assisted suicide (PAS)," connotes a whole new level of negativity in that

it implies that the decision to follow through with a physician-assisted death is no longer a medical decision, but rather something much worse, perhaps a morally wrong one. This essay does not attempt to agree with or attack this end-of-life decision. Rather, it is a useful academic exercise to compare this particular category of end-of-life determinations with others that are more accepted, or at least viewed with less disfavor.

Additionally, Dr. Jack Kevorkian is regarded by some as one of the most reviled physicians of our time. In fact, “Dr. Death” actually prevailed as a defendant in cases before the Supreme Court of Michigan, where he was on trial for the murder of two women.\textsuperscript{187} In \textit{People v. Kevorkian}, Kevorkian appealed the two counts of murder for which he was charged in assisting two people in committing suicide.\textsuperscript{188} Each woman was suffering from a condition that caused “great pain or was severely disabling,” so Dr. Kevorkian met them at a cabin in 1991 and set up machines that allowed the individuals to end their lives.\textsuperscript{189} The Supreme Court of Michigan held that a defendant could be charged for murder “[o]nly where there is probable cause to believe that death was the direct and natural result of defender’s act”, not “[w]here a defendant merely is involved in the events leading up to the death, such as providing the means.”\textsuperscript{190} The court reversed and remanded in favor of Dr. Kevorkian but the state of Michigan was more successful in a jury trial in 1999, where Kevorkian was convicted and sentenced to 10 to 25 years in prison for the murder of Thomas Youk.\textsuperscript{191}

Kevorkian’s eventual conviction may have been due to his arrogance in the physician-assisted suicides, going so far as to dare the legal system to stop him from continuing with the procedures.\textsuperscript{192} However, some might argue that he never stood a chance in a jury trial of this magnitude, as his good fortune may have inevitably run out. Although PAS is just as painless and achieves the same end as the procedures pertaining to an individual’s right to die or even in cases of medical futility, it has never been well-received in the public eye. As has been already mentioned, the only state with a legitimate statute termed “Death with Dignity Act” is Oregon, where a terminally ill patient may request in writing medication to end his or her life.\textsuperscript{193} Interestingly enough, this statute rings a completely different tone from the rest of

\textsuperscript{187} People v. Kevorkian, 527 N.W.2d 714 (Mich. 1994).

\textsuperscript{188} Id.

\textsuperscript{189} Id. at 733.

\textsuperscript{190} Id. at 738–39.


\textsuperscript{192} Id.

\textsuperscript{193} The Oregon Death with Dignity Act, OR. REV. STAT. § 127.805 (West 2005).
the nation with the last few words of the Section 127.805(1) stating that the ending of life is performed “in a humane and dignified manner.”194 While “physician-assisted suicide” carries a pessimistic tenor, Oregon turns the procedure into something almost glorious. The dichotomy is nothing short of astonishing.

Even the state of Oregon does not wholly agree with PAS, as Oregon voters approved the statute by the narrowest of margins at 51%-49%.195 And there were several challenges to the controversial statute, as Attorney General Ashcroft attempted to invalidate the state legislation for all intents and purposes.196 In addition, there were many obstacles to implement the act initially, as evidenced by a federal district judge issuing a preliminary injunction in an effort to bar the statute’s provisions, only to be followed by Oregon’s own legislature challenging the act one last time in a House Bill.197 After finally becoming law in the state of Oregon, there has been substantial criticism of the statute, but there have also been efforts by other states to enact similar statutes, albeit without much success.198

It is also worth contemplating the constitutional rights, or lack thereof, concerning an individual’s desire to engage in a physician-assisted death or euthanasia when confronted with unbearable pain. The question must be asked: when a competent person’s right to make decisions about life and death was clearly recognized in cases such as Cruzan199 what is the extent of such a right, by way of substantive due process, to make similar end-of-life decisions when the patient is not under a form of life-sustaining treatment such as a respirator? It can be argued that oftentimes, patients seeking PAS are in even greater pain and might be solely surviving on a feeding tube. And technicalities classify some patients as individuals facing right-to-die end-of-life decisions, while others are not. For public policy reasons, the Supreme Court has determined that suicide, for federal purposes, is not a fundamental right even though it deals with the same end-of-life determination that Cruzan and Schiavo had faced.200 Whether such determinations are similar to these two classes of patients is perhaps a futile effort in and of itself, since the general public opinion, based on state laws, show that the vast majority of states agree with keeping these two categories distinct from each other.

194. § 127.805(1).
195. Kandra, supra note 65, at 508.
196. Id. at 505.
197. Id. at 511.
198. Furrow et al., supra note 2, at 1565 n.6.
200. See generally id.; Schiavo ex rel. Schindler v. Schiavo, 403 F.3d 1289 (11th Cir. 2005).
D. Abortion

Finally, in analyzing the topic of abortion in relation to other end-of-life decisions, this essay examines the relatively longstanding rule that a woman has the right over her own body and the fetus during pregnancy.\textsuperscript{201} Tied to the constitutional right to privacy, a woman holds a qualified right to terminate her pregnancy even though the state has “legitimate interests in protecting both the pregnant woman’s health and the potentiality of human life, each of which grows and reaches a ‘compelling’ point at various stages of the woman’s approach to term.”\textsuperscript{202}

In this heated debate, the popular terms representing the opposing sides are labeled as “pro-life” vs. “pro-choice.” The supporters of the latter enjoy a level of protection of the Due Process clause in making their argument, for it was in providing a constitutional right to privacy to pregnant women that the Supreme Court effectively established a very strict level of scrutiny, making it quite difficult to overcome a pregnant woman’s individual private interest in making a determination for her body and fetus up to a certain point in the pregnancy. The Court was adamant in stating that where “certain ‘fundamental rights’ are involved, the Court has held that regulation limiting these rights may be justified only by ‘compelling state interest.’”\textsuperscript{203} This places a high burden on those that take the “pro-life” stance, and the Court used this language despite several amici referring to medical data arguing that “the fetus is a ‘person’ within the language and meaning of the Fourteenth Amendment.”\textsuperscript{204}

Therefore, despite contentious medical data set before the Court, the powerful and broad constitutional right of privacy was provided to pregnant women who wanted personal autonomy over their own body and the potential body of the fetus.\textsuperscript{205} Some “pro-life” advocates would even argue that the \textit{Roe v. Wade} decision was based on a technicality of the term “person” in the Fourteenth Amendment, and the absence of a reference to the unborn carried great weight in the eventual decision of the Court.\textsuperscript{206}

In stark contrast to the \textit{Roe v. Wade} opinion, even when medical data has been used to speak \textit{not} to the \textit{viability} of a fetus, but rather the pain and suffering an individual endures under certain terminal illness conditions, there has been no constitutional right afforded to these patients. There appears to be an inherent logical flaw in how an individual holds the constitutional right regarding one’s own body and that of an unborn fetus, while that

\textsuperscript{201} Roe v. Wade, 410 U.S. 113, 154 (1973).
\textsuperscript{202} \textit{Id.} at 114.
\textsuperscript{203} \textit{Id.} at 155.
\textsuperscript{204} \textit{Id.} at 156.
\textsuperscript{205} \textit{Id.} at 153.
\textsuperscript{206} \textit{Id.} at 158.
same right is withheld from a medical patient in great physical anguish when attempting to make a decision on his or her own body alone.

How can the two divergent opinions on the same of constitutional right be reconciled? Some women make the decision to undergo an abortion to protect their quality of life, not necessarily for the preservation of life. However, some terminally ill patients face more dire circumstances when desiring to protect the quality of life due to the fact that their physical pains outweigh the value of their own life. Some may argue that PAS is the “taking away” of a life, while an abortion of a fetus is simply a personal decision since the fetus is not a viable “person;” however, these distinctions between the two decisions become more questionable when cautiously examining the quality of life issue.

V. CONCLUSION

It may seem unfair to take all four end-of-life determinations into consideration together, as each end-of-life decision rightfully warrants its own discussion as a unique category in and of itself. However, for the sake of comparison in the whole discussion of personal autonomy by way of well-protected constitutional rights, it is helpful to weigh the judicial decisions and state statutes from a more horizontal perspective. As the mores of society constantly evolve, these topics of self-initiated medical determinations are increasingly important so long as humans continue to be bound by mortality.

In evaluating the topic of one’s right to die, a competent individual is considered to enjoy full autonomy over his or her own life when faced with a terminal illness while on some kind of life-sustaining treatment. The Supreme Court’s assumption of this constitutional right in Cruzan has been useful in establishing a type of base for various end-of-life decisions. Conversely, when dealing with the issue of medical futility, there are limits imposed on personal autonomy by way of “reverse right to die.” In effect, expert physicians in some states have the ability to refuse medical life-sustaining treatment when it is rendered to be medically futile. Regrettably, the recognition or denial of a constitutional right is not the focus of the discussion concerning the harsh reality that some families must face. Rather, medical futility represents a gap in the role of the judiciary, as courts have failed to clarify the rights and countervailing interests involved in the decision-making process. Thus, state legislation is necessary in resolving the problems of medical futility, but the laws in this area are lacking as well.

In the conflict-ridden topic of physician-assisted deaths, or physician-assisted suicides, the vast majority of states have decidedly taken a clear stance against such methods for end-of-life decisions. Oregon remains distinct from all other states in that no other state legislature has effectively

passed anything like the Oregon Death with Dignity Act.\footnote{The Oregon Death With Dignity Act, \textit{Or. Rev. Stat. Ann.} § 127.805 (West 2005).} For the most part, the citizens of the forty-nine other states have not budged enough from their moral positions regarding this topic, and even if they were to do so, there would be several challenges from within the state and the federal government. The constitutional right regarding anything related to the concept of suicide does not exist in the American legal system, and this trend does not seem to be changing any time soon based on the lack of legislative enactments in even the country's most liberal states.

And for the benefit of comparative analysis, a look into the constitutional rights afforded to pregnant women to procure an abortion is valuable in constructing a working paradigm of the distinguishing factors, which make abortion more amenable to the mores of society than PAS. For the foreseeable future, the abortion issue seems as though it will continue to be an important platform on which politicians run their campaigns. But regardless of differing stances on the topic, the Supreme Court's decision in \textit{Roe v. Wade} from almost four decades ago continues to be binding precedent today, though some may argue that the decision has become more complicated since then. Nevertheless, it is clear that the Court found it important enough to recognize a constitutional right of privacy, which requires careful scrutiny if an attempt is made to compromise that right. The identification of this constitutional right is unique when observed against the lack of rights provided for pain-ridden patients searching for personal autonomy in making their respective decisions based on the quality of their lives.

However, this important issue continues to gain momentum in the discussions of palliative care for terminally ill patients. Even as reasonable minds differ on the topic, some states have activists and advocates on both sides of the PAS issue combining efforts to support intractable pain relief statutes, which could be seen as optimistic attempts to reach a reasonable compromise in the interest of suffering patients.\footnote{See generally Sandra H. Johnson, \textit{Disciplinary Actions and Pain Relief: Analysis of the Pain Relief Act}, 24 \textit{J. L. Med. \\& Ethics} 317 (1996), available at http://www.painandthelaw.org/aslme_content/24-4c/24.4c.html.} In supporting the creation of intractable pain relief acts, several states are looking to provide acceptable models or guidelines in providing aggressive pain medication.\footnote{\textit{Id.}} This may only be a consolation to true personal autonomy, but collective efforts such as these are necessary to translate good intentions and negative perceptions into hope for what is supposed to be the primary focus—the patient. It is in this very regard that all of these end-of-life decisions may be connected. Af-
ter all, the end goal is to avoid depriving "any person of life, liberty, or property, without due process of law (while providing) the equal protection of the laws."211

211. U.S. Const. amend. XIV, § 1.