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Essay

The Right to Die

Cass R. Sunstein[†]

In a number of cases, people with terminal illnesses are seeking to end their lives with the aid of a physician.¹ Many such people suffer from hopeless conditions of increasing debilitation, sometimes accompanied by periods of excruciating pain. It was inevitable that circumstances of this kind would raise constitutional questions. Two recent cases have turned the “right to die”—or, more precisely, the right to physician-assisted suicide—into the next great arena for the struggle to define the scope of fundamental rights under the Due Process Clause. In *Quill v. Vacco*,² the Court of Appeals for the Second Circuit rejected the due process claim but held, somewhat astonishingly, that New York had acted “irrationally” and hence in violation of the Equal Protection Clause because it prohibited physician-assisted suicide while simultaneously permitting patients to withdraw life-saving equipment. In *Compassion in Dying v. Washington*,³ the Court of Appeals for the Ninth Circuit held straightforwardly that a prohibition on the right to physician-assisted suicide violates the Due Process Clause.

In this Essay, I argue that the Supreme Court should not invalidate laws forbidding physician-assisted suicide. My basic claim is institutional: The Court should be wary of recognizing rights of this kind amid complex issues of fact and value, at least if reasonable people can decide those issues either way, and if the Court cannot identify malfunctions in the system of deliberative democracy that justify a more aggressive judicial role.⁴ The issues

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1. Dr. Jack Kevorkian has been the doctor in many of the most famous cases. See, e.g., *People v. Kevorkian*, 527 N.W.2d 714 (Mich. 1994); Tamar Lewin, *Doctor Cleared of Murdering Woman with Suicide Machine*, N.Y. TIMES, Dec. 14, 1990, at B6.

2. 80 F.3d 716 (2d Cir.), cert. granted, 117 S. Ct. 36 (1996).

3. 79 F.3d 790 (9th Cir.) (en banc), cert. granted, 117 S. Ct. 37 (1996).

4. For the classic treatment, see JOHN HART ELY, *DEMOCRACY AND DISTRUST* (1980). I urge a cautious judicial role partly because judicial judgments may be wrong and partly because judicial judgments

presented by a right to physician-assisted suicide are especially well-suited to a federal system, where appropriate experiments may be made, and where such experiments are likely to provide valuable information about underlying risks. It is particularly important that the issue of physician-assisted suicide is facing not neglect or indifference but intense discussion in many states.⁵ It is far too early for courts to preempt these processes of discussion, especially if we consider the fact that there is no systematic barrier to a fair hearing of any affected group. Despite appearances, the Court's current doctrines reflect this point. Thus a general theme of this Essay is that many cases involving "fundamental rights"—including the key privacy cases and the key equal protection cases—are best seen not as flat declarations that the state interest was inadequate to justify the state's intrusion, but more narrowly as democracy-forcing outcomes designed to overcome problems of discrimination and desuetude.

In short, the Court should say that even if it assumes that the right to physician-assisted suicide qualifies as "fundamental" under the Due Process Clause, a legal ban on physician-assisted suicide is constitutionally permissible in light of the state's legitimate and weighty interests in preventing abuse, protecting patient autonomy, and avoiding involuntary death. The Court should reach this conclusion partly because of appropriate judicial modesty in the face of difficult underlying questions of value and fact;⁶ it should emphasize these institutional concerns in explaining its conclusion.

To present the argument in more specific and somewhat more technical terms, it does not seem especially controversial to say that the state needs a strong justification if it seeks to intrude on the decision of a competent adult to terminate his life under medically hopeless and physically painful conditions.⁷ But it is extremely difficult either to describe the standard for "fundamental rights" that emerges from the existing cases or to tell whether

may cause serious social problems even if they are right. *See infra* text accompanying notes 129–33. By "recognizing rights," I mean invalidating legislation; as suggested below, I do think these cases are an appropriate setting for recognizing a presumptive right, in the sense that the state should be required to bring forward a strong justification for any intrusion.

5. Washington, for example, enacted its governing law in 1992, and Governor Cuomo of New York sponsored a widely discussed Task Force report in 1994 that rejected legalization of physician-assisted suicide. *See Quill*, 80 F.3d at 734–35 (Calabresi, J., concurring) (describing New York background); *Compassion in Dying v. Washington*, 49 F.3d 586, 591–92 (9th Cir. 1995) (describing discussion in New York and Michigan), *rev'd*, *Compassion in Dying*, 79 F.3d 790.

6. There is an extensive philosophical literature on the right to die. A particularly illuminating discussion is DAN W. BROCK, *LIFE AND DEATH* 202–30 (1993), which argues for autonomy right and challenges the distinction between withdrawal of treatment and active euthanasia. *See also* RONALD DWORKIN, *LIFE'S DOMINION* 218–41 (1993) (arguing for autonomy right); John Keown, *Euthanasia in the Netherlands: Sliding down the Slippery Slope?*, in *EUTHANASIA EXAMINED* 261, 261–62 (John Keown ed., 1995) (collecting various positions about whether voluntary euthanasia will lead to involuntary euthanasia). As will become apparent, the philosophical issue is far from coextensive with the constitutional issue, and there is a limit to how much progress can be made through philosophical discussion alone; many of the key questions are empirical, involving the real-world effects of the relevant right.

7. For the moment I put to one side some of the definitional issues.

the right to physician-assisted suicide qualifies as “fundamental” under those cases. We might want to read current law to say that there is a presumptive right⁸ *against government intrusion into a decision whether to terminate one’s life under hopeless conditions* or, alternatively and more broadly, a presumptive right *against nontrivial government-imposed intrusions into the physical space of one’s own body*. In some cases, the right to physician-assisted suicide certainly meets the former standard, and while it does not quite meet the latter—it is a right “to” invasion, not a right “from” invasion—that right should probably be taken as close enough to the rights established by the existing case law to qualify as “fundamental” for constitutional purposes when the patient faces medically hopeless conditions. At the very least, it would be reasonable for the Court to make this assumption for purposes of decision. But—and this is the central point—the state has an array of strong justifications for intruding on that right. These justifications involve the risk of abuse by doctors and others and the danger that a right to physician-assisted suicide would, in practice, decrease rather than increase patient autonomy.

The state may believe, for example, that recognition of the right would allow people suffering from depression and distorted judgment to terminate their lives when their judgments should not readily be trusted; that a right to physician-assisted suicide would discourage people from dealing more productively with their distress and with the fact of death; that the line between hopeless and hopeful conditions is too thin in practice and that any right to physician-assisted suicide would thus produce premature deaths; that at least some doctors, carrying a great deal of authority and faced with multiple demands on their time, would present death as an option in such a way that some patients would have a hard time refusing; that some well-meaning families would impose irresistible pressures on terminal patients to “choose” death; or that any such right would have harmful effects on the performance and norms of the medical profession and perhaps on the norms of the citizenry in general. On some of these counts, the right to remove life-sustaining equipment is quite different from the right to physician-assisted suicide, because the latter creates far more serious risks of abuse.⁹ At least relevant in this regard is the fact that numerous doctors—aware of the underlying risks—oppose a right to physician-assisted suicide.¹⁰ In these circumstances, the Supreme Court should decline to impose a national solution.

8. It is presumptive in the sense that government can overcome the right with a showing of a sufficiently strong interest.

9. See *infra* text accompanying notes 143–45.

10. See *A Review of Assisted Suicide*, WASH. POST, Oct. 3, 1996, at A28; *Plus News*, CHI. SUN-TIMES, June 25, 1996, at 3 (noting American Medical Association members voted “overwhelmingly” not to change AMA’s opposition to physician-assisted suicide); see also Willard Gaylin et al., *Doctors Must Not Kill*, 259 JAMA 2139 (1988) (arguing against active euthanasia). But see Judy Foreman, *Assisted Suicide Seen Gaining Favor*, BOSTON GLOBE, Feb. 1, 1996, at 3.

This is emphatically not an argument against physician-assisted suicide as a matter of public policy. Many of the individual cases present powerful arguments for respecting the patient's wishes. A reader of those cases and the relevant literature may well conclude (as I would) that, in the end, states should probably allow physician-assisted suicide—because strong autonomy interests favor the right, social and familial interests support the right, the risks that trouble opponents of the right may not be as severe as they appear, and those risks can be handled through procedural safeguards short of denying the right.¹¹ Eventually, it may be predicted that the United States and other nations will indeed come to recognize a right to physician-assisted suicide under appropriate conditions, accompanied by procedural safeguards.¹² While any judgment must be tentative, I believe that this is likely to be a salutary development.¹³ What I am suggesting is that these claims do not support recognition of such a judgment as a matter of constitutional law.

I. SOME CLARIFICATIONS

The “right to die” might be asserted in a number of circumstances.¹⁴ Of course, the term might refer to the interest in withdrawing life-sustaining equipment. The interest in doing so appears to have been recognized as having presumptive constitutional status in *Cruzan v. Director, Missouri Department of Health*,¹⁵ in the sense that the state must come forward with a strong

11. See RICHARD A. POSNER, *AGING AND OLD AGE* 235–45 (1995) (arguing on behalf of right to physician-assisted suicide); see also Keown, *supra* note 6, at 263–66 (describing controversial safeguards in Netherlands). Keown identifies safeguards requiring that the request must come from the patient and be free and voluntary; the request must be well-considered, durable, and persistent; the patient must be intolerably suffering, with no hope of improvement; euthanasia must be the last resort, after other alternatives have failed; euthanasia must be performed by the physician; the physician must consult with another physician trained in the field; and the death record should not indicate death of “natural causes.” These safeguards are controversial because it is not clear that they are respected in practice. See *id.*; see also HERBERT HENDIN, *SEDUCED BY DEATH* 47–95 (1997).

12. A recent referendum in Oregon has produced a right of this sort, accompanied by procedures whose constitutional adequacy is in doubt. See *Lee v. Oregon*, 891 F. Supp. 1429 (D. Or. 1995). In 1988, there was a failed effort to produce a referendum on this topic in California; in November 1991, Washington voters rejected a highly publicized referendum proposal to legalize active euthanasia. See BROCK, *supra* note 6, at 203.

13. It is most unfortunate that American constitutional law lacks a kind of “democratic political question doctrine”—a doctrine that would allow the Court to decline to validate or invalidate legislation, and to suspend its judgment about constitutionality until a certain period of democratic deliberation (and clarification of relevant issues) has passed. The Court can deny certiorari, of course, and there are analogues in American law to such a doctrine, see *infra* Section IV.C (discussing desuetude and associated doctrines), but the idea has no explicit constitutional foundation. Such a doctrine would be especially well-suited to the right to physician-assisted suicide.

14. A helpful discussion can be found in DWORKIN, *supra* note 6, at 218–41, which argues on behalf of an autonomy right.

15. 497 U.S. 261 (1990). The Court said:

The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions. . . . Although we think the logic of the cases . . . would embrace such a liberty interest [in resisting the forced administration of life-sustaining medical treatment], the dramatic consequences involved in

justification for intruding on that interest. In any case, many states allow citizens to decline medical treatment.¹⁶

The distinction between the right to withdraw life-sustaining equipment and the right to physician-assisted suicide is problematic in many ways,¹⁷ but here I am speaking of cases that involve more than the withdrawal of treatment. Consider the following possibilities, designed to give a sense of the range of factual contexts in which the right might be claimed. (1) A competent patient seeks death under conditions that are both medically hopeless, in the sense that the best medical judgment is that there is a fixed and relatively short time to live, and physically difficult and debilitating, in the sense that the patient will experience some intense pain.¹⁸ (2) A competent patient seeks death under conditions that are medically hopeless, but do not involve much physical pain. (3) A competent patient with a disease that will produce a long period of deterioration and a long span of life—Alzheimer's disease is the most familiar example—seeks to terminate her life at some stage before the deterioration becomes serious. (4) A patient may be unconscious or otherwise incompetent and also in a medically hopeless state; his family or guardian seeks death, with or without evidence that this would be the patient's desire. These might be called cases of nonvoluntary euthanasia, as distinguished from voluntary and involuntary euthanasia. (5) A competent patient may be facing a severe medical problem. Though his condition is not utterly hopeless, he may seek death because he is generally depressed or no longer considers life worth living. (6) A patient may be facing a period of sustained medical difficulty without knowing whether or not some improvement is eventually possible. His condition is therefore considerably better than in (5), but he seeks death because he no longer considers life worth living. (7) Any of the above conditions might involve a person who seeks death, not with the assistance of a physician, but with the assistance of a friend or family member.

refusal of such treatment would inform the inquiry as to whether the deprivation of that interest is constitutionally permissible. But for purposes of this case, we assume that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition.

Id. at 278–79. Justice O'Connor was much clearer on this point. *See id.* at 289 (O'Connor, J., concurring) (“[T]he liberty guaranteed by the Due Process Clause must protect, if it protects anything, an individual's deeply personal decision to reject medical treatment, including the artificial delivery of food and water.”)

16. *See, e.g.,* Quill v. Vacco, 80 F.3d 716, 727–28 (2d Cir.), *cert. granted*, 117 S. Ct. 36 (1996) (describing New York statutes allowing patients to decline treatment).

17. *See infra* text accompanying notes 73–74.

18. It has been suggested that modern pain management techniques make this an unlikely event. For example, Brock writes:

There are not great numbers of patients undergoing severe suffering that can only be relieved by directly killing them. Modern methods of pain management enable physicians and nurses to control the pain of virtually all such patients without the use of lethal poisons, though often at the cost of so sedating the patient that interaction and communication with others is limited or no longer possible.

BROCK, *supra* note 6, at 170.

These various situations present quite different issues. In case (4), there is a question about whether we have sufficient reason to believe the third party's judgment about the patient's desires. In case (5), the problem is not so different from that of ordinary suicide: The patient has some decent life prospects but nonetheless seeks to terminate his life. In some of the highly publicized recent cases, it has been feared that doctors have brought about death simply because the patient is suffering from intense depression.¹⁹ Case (6) is close to case (5), with even more features of ordinary suicide. In case (7), we may fear that medical judgments are playing an insufficiently large role in the outcome, that the case is in that sense close to ordinary suicide, or that there is too large a risk of abuse because of the absence of professional norms and professional involvement.²⁰

For present purposes, let us accept the following propositions. First, it can sometimes be hard to know, in the real world, whether a case qualifies as (1), (2), (3), (4), (5), or (6). The difficulty of making such distinctions bears on the desirability of a constitutional ruling: If apparent category (1) cases actually fall in category (6), perhaps a flat ban on physician-assisted suicide, accompanied by the good-faith exercise of prosecutorial discretion (protecting against arrests and indictments in the most excusable cases), makes a good deal of sense. Second, the state has a legitimate reason to make sure that any third party representation about the patient's wishes is actually reliable. When the patient has not consented, we have involuntary or nonvoluntary euthanasia, and it is safe to assume that the state has an especially strong interest in ensuring against involuntary or nonvoluntary deaths.²¹

Third, and perhaps most importantly and more contentiously, let us assume that there is no constitutional barrier to laws forbidding ordinary suicide and ordinary assisted suicide, and hence that in categories (5) and (6) there is no constitutional problem.²² Let us accept this conclusion partly because of precedent²³ and partly on the theory that the state has extremely strong

19. See, e.g., Seth F. Kreimer, *Does Pro-Choice Mean Pro-Kevorkian? An Essay on Roe, Casey, and the Right to Die*, 44 AM. U. L. REV. 803, 824-25 (1995) (noting New York State Task Force on Life and the Law's opposition to physician-assisted suicide based in part on fact that majority of individuals who commit suicide suffer from depression and most doctors are not adequately trained to diagnose depression in complex cases such as terminal illness).

20. See BROCK, *supra* note 6, at 229-30.

21. See *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 280 (1990). Note that there is a pervasive concern that if physician-assisted suicide is permitted, there will inevitably be physician-chosen death instead. See *infra* Sections III.C-D.

22. This is a legal claim, not a philosophical one. There has been a long debate about the philosophical issues raised by suicide. See Miriam Griffin, *Philosophy, Cato, and Roman Suicide: II*, 33 GREECE & ROME 192 (1986).

23. See *Cruzan*, 497 U.S. at 280 ("[T]he majority of States in this country have laws imposing criminal penalties on one who assists another to commit suicide. We do not think a State is required to remain neutral in the face of an informed and voluntary decision by a physically able adult to starve to death."); *Paris Adult Theatre I v. Slaton*, 413 U.S. 49, 68 n.15 (1973) (suggesting that laws banning suicide are constitutionally unproblematic).

interests in encouraging a general commitment to the continuation of life and in protecting people from engaging in behavior that may be myopic or a product of short-term depression or distortions in judgment. Some of the strongest cases for public interference with private judgments involve myopia, cognitive error or motivational problems, or similar distortions. It is easy to imagine cases in which people facing severe temporary (or not so temporary) distress are inclined to seek a way out, and there is extremely good reason for social norms—and laws both expressing and fortifying those social norms—discouraging such people from terminating their lives. Suicide may seem the only solution to the experience of intolerable suffering, perhaps occasioned by some disastrous or life-transforming event (death of a loved one, involuntary separation, divorce); but the suffering may be far more short-term and far more remediable than it seems.²⁴ The norms directed against suicide and assisted suicide have a salutary function in encouraging people to deal with even the most severe problems in a more constructive fashion; part of the salutary function of the relevant norms and laws is to block serious thought of suicide in cases where it appears to be the only or the simplest solution. In fact, it is possible that in many cases those who are “assisting” suicide are actually urging or at least legitimating it.²⁵ A decent society seeks to inculcate a strong norm in favor of preserving life even when things seem extremely bad. It does so especially in view of the fact that suicide seems remarkably contagious. Highly publicized suicides can create bandwagon or cascade effects.²⁶

Of course we can also imagine cases in which a suicide may be warranted and in which assistance in suicide is morally acceptable and perhaps morally responsible, even in category (5). But in such cases, criminal prosecutions are quite unlikely, and even if there are such prosecutions, the relevant laws are generally acceptable on constitutional grounds, and that proposition is sufficient for my purposes here. I will deal, then, principally with cases falling in categories (1) and (2), for these are the most insistent ones for a constitutional “right to die.” They also provide the factual settings behind both *Quill* and *Compassion in Dying*.

These points suggest a possible problem with right-to-die litigation, one that points to the distorting lens of adjudication. The particular cases brought to a court’s attention will certainly be the most compelling ones. They will involve competent patients facing horrible life prospects and perhaps intense pain. A focus on the particular cases will make the right seem particularly insistent, and this will be a fully reasonable reaction to those cases. But a

24. See HENDIN, *supra* note 11, at 216; HERBERT HENDIN, *SUICIDE IN AMERICA* (1995)

25. See HENDIN, *supra* note 11, at 80–95.

26. See David P. Phillips, *The Influence of Suggestion on Suicide: Substantive and Theoretical Implications of the Werther Effect*, 39 AM. SOC. REV. 340 (1974).

decision in these particular patients' favor will undoubtedly affect other people not before the court, and those cases will be much more difficult. Very poignant and compelling particular cases should not be allowed to stand for the whole of the problem.

An additional point by way of clarification: Medical practice will operate in the shadow of the law and will be influenced by the law without, however, simply tracking the law. Thus a legal system lacking an actual or formally recognized "right to die" may well make space (even quasi-official space) for physician judgments about whether to prolong life or hasten death in some quiet, not widely advertised way, usually made in close consultation with the patient and family members. For example, a doctor may administer painkillers that will make death come sooner, allow a patient not to take life-sustaining medicines or even food and water, or avoid "extraordinary" measures.²⁷ The line between these steps and physician-assisted suicide seems thin and it is undoubtedly breached in practice. It is imaginable that patients often exercise an informal "right to die" regardless of the illegality of physician-assisted suicide. Of course the technical illegality is important; no one should feel entirely comfortable in committing an unlawful act. But the fact that social practice can outrun law is important for courts to keep in mind; it suggests that informal practice may already be creating a right where it is especially insistent, even if the law is otherwise.²⁸ The content of law depends not merely on the statute books but also on prosecutorial practice, and it is safe to say that in many cases prosecutors do not and will not devote their limited resources to the most benign cases of voluntary active euthanasia. The availability of informal practice and informally agreed-upon "rights" should relieve some of the pressure for a constitutional guarantee,²⁹ at least if it appears that those rights will be recognized in some or many cases in category (1) and (2) contexts. With these notes let us now turn to the constitutional issue.

27. See POSNER, *supra* note 11, at 236.

28. Cf. ROBERT C. ELLICKSON, *ORDER WITHOUT LAW* (1991) (discussing people's capacity to order their lives without reference to law).

29. Abortion is an interesting analogy along this dimension. Even without *Roe v. Wade*, 410 U.S. 113 (1973), and even in places where abortion is unlawful, abortions occur, sometimes in large numbers. See CASS R. SUNSTEIN, *THE PARTIAL CONSTITUTION* 278 (1993). But this is not much of an argument against *Roe*, since the relevant abortions tend to be extremely dangerous. See *id.* The term "back-alley butchers" reflects the point. In the case of physician-assisted suicide, there is a weaker parallel in the informal processes I am describing. No one should deny, however, that the ban on physician-assisted suicide can produce some ugly informal outcomes. *Compassion in Dying* presents an example:

When he realized that my family was going to be away for a day, he wrote us a beautiful letter, went down to his basement, and shot himself with his 12 gauge shot gun. He was 84 . . . My son-in-law then had the unfortunate and unpleasant task of cleaning my father's splattered brains off the basement walls.

Compassion in Dying v. Washington, 79 F.3d 790, 834-35 (9th Cir.) (en banc) (citation omitted), *cert. granted*, 117 S. Ct. 37 (1996).

II. A FUNDAMENTAL RIGHT?

Under the Court's cases, the first question is whether the right to die, understood as a right to physician-assisted suicide in category (1) and (2) cases, qualifies as a "fundamental right" or "liberty interest,"³⁰ such that a state must show an especially strong reason for interfering with it. My ultimate suggestion is that the Court would do best to assume, without holding, that the relevant right so qualifies. Hence the discussion to follow is in a sense gratuitous; I will be arguing that the Court should put to one side the extraordinary complexities and proceed directly to the issue of justification. But the underlying issue is important, difficult, and of great intrinsic interest, and if the Court does answer the question, I suggest that it should conclude that the right to physician-assisted suicide is presumptively protected either (a) because there is a presumptive right to choose whether to live or die under medically hopeless conditions; or (b) because the cases establish a presumptive right to prevent physical invasions of one's own body, and the right to physician-assisted suicide is close enough to this established right to qualify as presumptively protected as well.

The source of the doctrinal difficulty is that the Court has not—to say the least—given clear criteria for deciding when a right qualifies as a liberty interest. The cases leave a great deal of ambiguity and the doctrine lacks much coherence. Consider Table 1.

Is it possible to make sense of this set of results? There are two common ways of reading the cases. One reading, which played a large role in *Quill* and in the *Compassion in Dying* dissent, is that the Court has issued a firm "no more" and is unwilling to recognize additional fundamental rights unless they find specific and extremely strong recognition in Anglo-American traditions.³¹ The other reading, reflected in the majority opinion in *Compassion in Dying*, is that the cases should be taken to establish a presumptive right to noninterference with decisions that are "highly personal and intimate,"³² especially if those decisions involve the use of one's body. Unfortunately,

30. I will use the two terms interchangeably. There is, however, a technical difference. If the Court finds a "fundamental right," the state may intrude only on a showing that it has chosen the least restrictive means of promoting a compelling state interest. See, e.g., *Roe*, 410 U.S. at 155. It is unclear whether the identification of a "liberty interest" has the same consequence. It is notable that in *Cruzan v. Director, Missouri Department of Health*, the Court spoke of a "liberty interest" rather than a fundamental right, see 497 U.S. 261, 278–79 (1990), though it is not clear that this was intended as a distinction.

31. The plurality opinion in *Michael H. v. Gerald D.*, 491 U.S. 110 (1989), strongly supports this view: "We refer to the most specific level at which a relevant tradition protecting, or denying protection to, the asserted right can be identified." *Id.* at 127 n.6. Interestingly, the plurality found consistency with *Griswold v. Connecticut*, 381 U.S. 479 (1965), and *Eisenstadt v. Baird*, 405 U.S. 438 (1972), by saying that such cases did not acknowledge "a longstanding and still extant societal tradition withholding the very right pronounced to be the subject of [the] liberty interest." 491 U.S. at 127. Thus, in those cases, there was no tradition of state enforcement of laws withholding the liberty interest "continuing to the present day." *Id.* This idea bears on the notion of desuetude. See *infra* text accompanying notes 150–52.

32. 79 F.3d 790, 813 (9th Cir.) (en banc), cert. granted, 117 S. Ct. 37 (1996).

TABLE 1. HOLDINGS OF SUBSTANTIVE DUE PROCESS AND FUNDAMENTAL RIGHTS CASES

SUBJECT OF CASE	QUALIFIES AS FUNDAMENTAL INTEREST	DOES NOT QUALIFY AS FUNDAMENTAL INTEREST
Use of Contraceptives	Griswold v. Connecticut; ³³ Eisenstadt v. Baird ³⁴	
Access to Contraceptives	Carey v. Population Servs. Int'l ³⁵	
Abortion	Roe v. Wade ³⁶	
Heterosexual Sodomy	[Bowers v. Hardwick] ³⁷	[Bowers v. Hardwick]
Prevention of Compulsory Sterilization	Skinner v. Oklahoma ³⁸	
Homosexual Sodomy		Bowers v. Hardwick ³⁹
Avoidance of Life-Saving Medical Treatment	Cruzan v. Director, Missouri Dep't of Health ⁴⁰	
Avoidance of Administration of Antipsychotic Drugs	Washington v. Harper ⁴¹	
Paternal Visits to Child Conceived Out of Wedlock		Michael H. v. Gerald D. ⁴²
Live with Family Members	Moore v. City of East Cleveland ⁴³	
Live with Friends		Village of Belle Terre v. Boraas ⁴⁴
Marriage	Loving v. Virginia; ⁴⁵ Zablocki v. Redhail ⁴⁶	Califano v. Jobst ⁴⁷

neither of these readings holds out much promise; both are far too crude. As we will see, the "no-more-except-for-tradition" reading does not fit the cases very well, and it also lacks much appeal in principle. On the other hand, the terms "personal" and "intimate" are far too broad; they create too many

33. 381 U.S. 479 (1965).

34. 405 U.S. 438 (1972).

35. 431 U.S. 678 (1977).

36. 410 U.S. 113 (1973).

37. 478 U.S. 186 (1986). The Court did not resolve the issue of heterosexual sodomy.

38. 316 U.S. 535 (1942) (holding fundamental right under Equal Protection Clause).

39. 478 U.S. 186 (1986).

40. 497 U.S. 261 (1990).

41. 494 U.S. 210 (1990).

42. 491 U.S. 110 (1989).

43. 431 U.S. 494 (1977).

44. 416 U.S. 1 (1974).

45. 388 U.S. 1 (1967).

46. 434 U.S. 374 (1978) (holding fundamental right under Equal Protection Clause).

47. 434 U.S. 47 (1977).

ambiguities and lead in too many unhelpful directions. This is not the occasion for a full discussion of these points—I cannot attempt to sort out the modern doctrine of substantive due process in this space⁴⁸—but a few notations will be helpful.

A. *Tradition*

On occasion, influential Justices and the Court as a whole have said that fundamental rights under the Due Process Clause qualify as such largely because of their origins in Anglo-American traditions, understood at a level of considerable specificity.⁴⁹ Let us for the moment assume that this is the case. If the right to physician-assisted suicide must emerge from such traditions, the case is relatively simple: There is no such right. The right to physician-assisted suicide is not something that Anglo-American law traditionally protects.⁵⁰ Of course suicide and assisted suicide have been banned by tradition.⁵¹ Perhaps we could say that Anglo-American practice with respect to suicide is complex, not simple, because enforcement has often been lacking and because physician-assisted suicide is a novel phenomenon;⁵² perhaps we could say that tradition yields no clear judgment that suicide is to be banned in the distinctive circumstances that we are discussing. But even if this is true, and hence the tradition does not speak with clarity, it would be implausible to suggest that our tradition affirmatively supports a right to terminate one's life with the help of a doctor. From the standpoint of Anglo-American traditions, a ban on the use of contraceptives within marriage may well count as anomalous;⁵³ so too

48. For relevant discussions, see LAURENCE H. TRIBE & MICHAEL C. DORF, *ON READING THE CONSTITUTION* (1991), which challenges traditionalism in constitutional law; J.M. Balkin, *Tradition, Betrayal, and the Politics of Deconstruction*, 11 *CARDOZO L. REV.* 1613 (1990), which argues that traditions are indeterminate; and Jed Rubenfeld, *The Right of Privacy*, 102 *HARV. L. REV.* 737 (1989), which argues for broad privacy right not rooted in tradition.

49. See *Michael H. v. Gerald D.*, 491 U.S. 110, 127–28 n.6 (1989) (plurality opinion of Scalia, J.) (discussing right of adulterous natural father as not rooted in specific tradition); *Bowers v. Hardwick*, 478 U.S. 186, 192–95 (1986) (White, J.) (discussing lack of specific tradition supporting right to consensual sodomy); *Moore v. City of East Cleveland*, 431 U.S. 494, 503–06 (1977) (plurality opinion of Powell, J.) (discussing need to ground rights in tradition and sanctity of family tradition); *Griswold v. Connecticut*, 381 U.S. 479, 501–02 (1965) (Harlan, J., concurring) (discussing need to ground fundamental rights in “continual insistence upon respect for the teachings of history, solid recognition of the basic values that underlie our society”).

50. See, for example, Justice Scalia's discussion in *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261, 294–95 (1990), of the historical English legal reason for the prohibition on suicide, and a similar discussion in *Compassion in Dying v. Washington*, 79 F.3d 790, 806–10 (9th Cir.) (en banc), cert. granted, 117 S. Ct. 37 (1996).

51. See *Cruzan*, 497 U.S. at 294–95 (discussing Anglo-American reasoning against prohibition), *Compassion in Dying*, 79 F.3d at 808–10 (discussing Greco-Roman and Anglo-American reasoning).

52. See POSNER, *supra* note 11, at 236–37 (discussing rarity of reporting); *id.* at 251–52 (discussing rarity of enforcement).

53. See *Griswold*, 381 U.S. at 500 (Harlan, J., concurring) (citing *Poe v. Ullman*, 367 U.S. 497, 522, 539–45 (1961) (Harlan, J., dissenting) (arguing that ban on use of contraceptives within marriage should be invalidated partly because it is so anomalous and so at odds with tradition)).

may a ban on the right of a grandparent to live with her child;⁵⁴ but the same cannot be said about the right to physician-assisted suicide.

If the right to die must be rooted in tradition, then it does not qualify as a fundamental interest.⁵⁵ But there are severe problems with understanding fundamental interests solely by reference to tradition, specifically described. The first problem is that many of the Court's cases cannot be understood in purely traditionalist terms, and hence the traditionalist understanding of the privacy cases fits poorly with existing law. *Roe v. Wade*⁵⁶ is the clearest example; there is no clear tradition establishing a right to abortion.⁵⁷ But this is true not only of abortion. From the standpoint of tradition, a large number of the Court's cases make little sense. The cases establishing a right to contraceptives outside of marriage⁵⁸ do not vindicate a longstanding tradition. Nor is there any general right to marry within Anglo-American traditions; hence *Loving v. Virginia*⁵⁹ and *Zablocki v. Redhail*⁶⁰ fit poorly with due process traditionalism. Traditions, taken at a level of great specificity and as brute facts, do not support the right to physician-assisted suicide, but they also explain few of the key cases, and hence traditionalism does not make sense of existing law.

Should the Court consider its own decisions doubtful and use traditionalism in the future notwithstanding its inconsistency with past decisions? This course, suggested by both *Bowers v. Hardwick*⁶¹ and the plurality opinion in *Michael H. v. Gerald D.*,⁶² might be deemed reasonable if traditionalism were extremely appealing in principle and if the alternatives were unacceptable. Perhaps a firm "no more!" would make sense despite its failure to fit with existing law; *Hardwick's* cavalier treatment of precedent in particular implies a judgment of this sort. But if we assume that at least some kind of substantive due process is legitimate,⁶³ as all of the Justices appear

54. See *Moore*, 431 U.S. 494 (plurality opinion).

55. See *Quill v. Vacco*, 80 F.3d 716, 724–25 (2d Cir.) (rejecting view that right to die qualifies as "fundamental" on ground that tradition does not recognize that right), cert. granted, 117 S. Ct. 36 (1996).

56. 410 U.S. 113 (1973).

57. The Court's own discussion in *Roe* establishes as much. See *id.* at 130–41 (discussing conflicting and unclear historical rules on abortion).

58. See *Carey v. Population Servs. Int'l*, 431 U.S. 678 (1977) (striking down law prohibiting sale of contraceptives to minors); *Eisenstadt v. Baird*, 405 U.S. 438 (1972) (striking down as irrational law forbidding sale of contraceptives to unmarried people).

59. 388 U.S. 1, 6 (1967) (invalidating antimiscegenation law that had historical roots in colonial period).

60. 434 U.S. 374 (1978) (invalidating law forbidding people to marry unless they have met their support obligations).

61. 478 U.S. 186, 192–96 (1986) (discussing lack of historical basis for right to consensual sodomy).

62. 491 U.S. 110, 127–28 n.6 (1989) (plurality opinion of Scalia, J.) (defending use of specific historical traditions relating to adulterous natural father rather than parenthood more generally).

63. Of course the whole idea of "substantive due process" is quite doubtful as a matter of text and history. See ELY, *supra* note 4, at 14–18 (arguing that interpretation of Due Process Clause as incorporating general mandate to review substantive merits of government action "not only was not inevitable, it was probably wrong"). But we might see that idea as doing the work of the Privileges and Immunities Clause, which could plausibly have been used for an enterprise of this kind. See Charles Fairman, *Does the*

to assume, we will find large problems with using traditions, narrowly and specifically conceived, as the sole source of rights under the Due Process Clause. To be sure, such a use of tradition does help to discipline judicial discretion, and that is an important gain.⁶⁴ And if traditions were systematically reliable as sources of rights, and if judges thinking more independently about the appropriate content of rights were systematically unreliable, due process traditionalism might be justified on rule-utilitarian grounds. That is, due process traditionalism might be justified as a way of minimizing aggregate judicial errors⁶⁵ even if it were quite imperfect as a source of rights.

But this is not a very plausible view, for there is no reason to think that traditions, understood at a level of great specificity, are systematically reliable or so close to systematically reliable as to exclude a somewhat more reflective and critical judicial role.⁶⁶ Anglo-American traditions, so understood, include a great deal of good but also significant confusion and injustice (consider, for example, bans on racial intermarriage); it is appropriate for courts to engage in at least a degree of critical scrutiny of intrusions on liberty even if those intrusions do not offend tradition. Nor is there sufficient reason to think that judges will inevitably do very badly if they think critically about rights. Of course judges should be very cautious about rejecting judgments made by elected officials; of course judges should avoid hubris in examining the past. Certainly it is plausible to think that judges should generally proceed incrementally and in good common law fashion from previous decisions.⁶⁷ It also makes sense to say that substantive due process should be used sparingly.⁶⁸ Understandings of this kind provide important constraints on judicial power under the Due Process Clause. But at the very least it is right to ask whether the interest said to qualify as a fundamental right is, in principle, at all different from rights that have been sanctified by tradition. If, for example, there were no relevant difference, in principle, between a traditionally unrecognized right to physician-assisted suicide and (let us suppose) a traditionally recognized right to resist treatment, courts should not say that the latter is constitutionally protected and the former is not.

Fourteenth Amendment Incorporate the Bill of Rights?, 2 STAN. L. REV. 5, 9–15 (1949) (discussing historical development of limited Privileges and Immunities Clause).

64. See *Michael H.*, 491 U.S. at 127–28 n.6 (plurality opinion of Scalia, J.) (arguing that traditions should be characterized at level of greatest specificity).

65. Due process traditionalism might be thought to minimize decision costs too, at least if it is relatively simple to identify traditions.

66. See Cass Sunstein, *Against Tradition*, 13 SOC. PHIL. & POL'Y 207 (1996) (challenging idea that tradition is good source of rights).

67. See generally David A. Strauss, *Common Law Constitutional Interpretation*, 63 U. CHI. L. REV. 877 (1996) (defending idea that constitutional law is form of common law).

68. See *infra* Section IV.A.

B. *Dignity, Bodily Integrity, Intimacy*

If tradition is not decisive, what is the source of fundamental rights for purposes of substantive due process? This is one of the largest unanswered questions in American jurisprudence, and it would be foolish to attempt a full answer here. But terms such as “intimate” and “personal” provide too little help. They tend to be conclusions masquerading as analytic devices. In any case, some of the cases deny protection to interests that seem highly intimate and highly personal; consider both *Hardwick* and *Village of Belle Terre v. Boraas*.⁶⁹ Thus the Court’s cases refuse to accept the view that intimate and personal decisions deserve constitutional protection as such.

Putting previous cases to one side, we can see that some decisions that seem intimate and personal are not strong candidates for constitutional protection; consider the decision to work longer than the maximum hour laws allow in order to provide for one’s family, the decision to take medicines or drugs of a certain sort, the decision to marry one’s cousin or aunt, or for that matter, the decision to commit suicide. Thus a reference to “intimacy” or “control of one’s body” seems unhelpful. The Court of Appeals for the Ninth Circuit placed emphasis on the interest in promoting death “with dignity.”⁷⁰ There is indeed a strong political argument for a right to physician-assisted suicide grounded in this concern. But it is unclear what the notion adds to the due process argument.

C. *Life and Death Decisions Under Narrowly Defined Conditions*

As we will see, the relevant cases seem to depend not simply on deciding that an interest has considerable importance, but also on at least implicit problems of procedural due process or equal protection, problems that suggest an underlying defect in democratic processes themselves.⁷¹ It is extremely difficult to produce any verbal formula that is satisfactory, consistent with current law, and adequate to resolve the issue of physician-assisted suicide. For this reason, it would be best for the Court simply to assume that the right qualifies as fundamental and to proceed from there to the question of justification;⁷² at least this course would make sense if the justification is sufficient, as I will argue.

69. 416 U.S. 1 (1974) (upholding New York village ordinance as valid land-use legislation addressed to family needs).

70. *Compassion in Dying v. Washington*, 79 F.3d 790, 793 (9th Cir.) (en banc), cert. granted, 117 S. Ct. 37 (1996).

71. See text accompanying notes 113–33.

72. See Cass R. Sunstein, *Leaving Things Undecided*, 110 HARV. L. REV. 4 (1996) (defending judicial minimalism in midst of complex issues of fact and value).

But if the Court wanted to be more ambitious, it might venture a tentative alternative. The Court might say very narrowly that *Cruzan* should be read to recognize a presumptive right *to make a choice about whether to live or die when one is suffering from a medically hopeless condition*. Such a right would recognize that this choice is as central to individual self-determination as any that one can imagine; and if conditions are medically hopeless, it is harder, at least, to say that a state prohibition helps counteract individual irrationality. The existence of such a right would be important not only for people who are now dying but also for people not facing such conditions, who would be able to rest secure that if their condition became unbearable, they would have power to end it.⁷³ Thus the Court might put to one side the issues raised by “dignity” and “intimacy” and rely instead on self-determination as the source of constitutional doctrine; it might conclude that whatever may fall in that category, the right to die when one is facing a terminal illness certainly does so. Such a right would also recognize that it is hard, in principle, to distinguish between withdrawal of life-saving equipment and category (1) and (2) cases,⁷⁴ if we put to one side the risks of abuse discussed below. Those risks go not to the question of whether there is a right in the first instance, but to the separate issue of whether government has an adequate justification for intruding on the right.

A narrow right of this kind would avoid many of the problems created by a general right to suicide. A large advantage of defining the presumptive right in this narrow way is that it would avoid the various puzzles created by any broader reading of the privacy cases. Perhaps the principal difficulties with such a definition are that the term “medically hopeless” is vague, the notion of “self-determination” leaves many open questions, and the line between terminal and nonterminal illnesses can be indistinct in practice.

D. *Bodily Invasion*

Suppose that the Court sought to be more ambitious and to introduce somewhat more order to the cases. It could find a principle of some appeal, and considerable consistency with the cases, if it said that there is a presumptive right against *government authorization of nontrivial physical invasions into a person's body*. A government authorization may be found when the law allows invasions by government officials or when law forbids people from fending off physical invasions by private persons. This basic idea—intended as a statement of a sufficient, if not necessary, condition for a fundamental interest—explains the notion that people have a presumptive right

73. See POSNER, *supra* note 11, at 239–40 (characterizing value of right of suicide as “option”).

74. Interestingly, Justice Scalia made this very argument in his separate opinion in *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261, 296–97 (1990) (Scalia, J., concurring). This claim does not, however, mean that the distinction fails rationality review. See *infra* Subsection IV B 1

to resist the involuntary administration of drugs.⁷⁵ It accounts for the widespread intuition that there would be serious constitutional issues if the government undertook medical experiments on people against their will or required them to have operations for their own good. It helps account for *Cruzan* as well, though the Court did not announce a general right against physical invasions of a person's body.

Less obviously, the standard helps explain both *Roe v. Wade* and the cases involving governmental efforts to prevent people from diminishing risks of pregnancy. In these cases, the government is preventing people from taking steps to prevent a physical invasion of their bodies via pregnancy. The key point, then, is that a pregnancy is a physical invasion, and if government wants to prevent people from fending off that invasion, it needs a special justification.⁷⁶ A particular advantage of the standard is that it helps explain why the Court has struck down laws involving contraception and abortion without saying that there is a right to engage in sexual activity as such; the Court has been careful to say that the Constitution does not prohibit laws forbidding fornication and adultery,⁷⁷ and it has restricted its holdings to state efforts to control fornication and adultery indirectly by creating a risk of pregnancy. The suggested standard thus distinguishes *Hardwick*, on the ground that there is no prohibition on the regulation of sexual conduct if pregnancy and childbirth are not at risk. In any event, the standard seems to provide a sufficient if not necessary condition for constitutional concern; there do not appear to be any cases that fail to find a constitutionally protected interest in cases in which the standard is met.⁷⁸

Of course this standard does not answer all imaginable questions, and this fact argues against its judicial adoption in a case that does not require the Court to attempt to make sense of its privacy doctrine, which undoubtedly consists of a number of incompletely theorized judgments⁷⁹ not easily reconciled with one another. The notion of "physical invasion" is vague. We

75. Cf. *Washington v. Harper*, 494 U.S. 210, 219–27 (1990) (holding that Due Process Clause permits state to administer antipsychotic drugs to prisoner against his will despite significant liberty interest in avoiding such administration of drugs).

76. This point is intended as a description, not as a full defense of the cases and especially not of a full defense of *Roe v. Wade*. See EILEEN L. MCDONAGH, *BREAKING THE ABORTION DEADLOCK* (1996), for an effort to defend *Roe* in these terms. Note also that it is possible to think that any physical invasion is legitimate either because the invasion is the product of the woman's voluntary actions or because protection of the fetus counts as sufficient justification. These points bear on the question of whether government may intrude on the right as I have understood it.

77. See *Eisenstadt v. Baird*, 405 U.S. 438, 448 (1972); see also *Griswold v. Connecticut*, 381 U.S. 479, 498–99 (1965) (Goldberg, J., concurring).

78. Criminal law sanctions might be thought to raise difficulties for this standard, but the appearance is misleading. The suggested standard is about literal invasion, not about confinement. In any case, it is well understood that the state needs a strong justification for depriving people of liberty; violations of the criminal law ordinarily provide that justification.

79. On incompletely theorized judgments, see CASS R. SUNSTEIN, *LEGAL REASONING AND POLITICAL CONFLICT* 35–61 (1996); and Cass R. Sunstein, *Incompletely Theorized Agreements*, 108 *HARV. L. REV.* 1733 (1995).

can start with core or defining cases in which government officials or private actors are authorized literally to invade bodily space—*Cruzan* and *Washington v. Harper*⁸⁰ are examples—but hard questions can easily be imagined, in which it is unclear whether there is a physical invasion.⁸¹ Some of the modern due process cases finding fundamental rights do not meet the standard; the right to marry⁸² and the right to live with one's grandchild⁸³ are examples. Moreover, I have not explained what is special about the physical invasion of one's own body. The best answer might begin with an understanding of the time-honored nature of that right in Anglo-American law; tradition affords a special place to the individual's right to prevent invasion of his body. The right to self-defense can itself be understood in these terms. Even if tradition is not decisive, for reasons suggested above, it plainly matters under existing law, and it tends to support the right described here. Tradition aside, protection of one's body against external intrusion provides the most primitive and basic sense of personal security and independence. In this way, the right to prevent physical invasions can be seen as the most central and defining case of a series of familiar rights, including the right to private property itself.⁸⁴

Does this standard support the right to physician-assisted suicide? Understood minimally, the standard seems not to create any such right. In such cases, the state is attempting to *prevent* a physical invasion. It is not itself undertaking a physical invasion, or making it impossible for people to stop a physical invasion from other private parties. Instead, the government is attempting to forbid people from allowing their bodies to be physically invaded. Thus the suggested standard seems to create a right to withdraw life-saving equipment without creating a right to physician-assisted suicide. But there are two problems with this conclusion. First, as discussed above, some cases find a fundamental right even without a bodily invasion. Second, the distinction between withdrawal of life-saving equipment and physician-assisted suicide raises some serious conceptual issues, involving perhaps intractable distinctions between actions and omissions. Does it make sense to say that people have a constitutional right to resist physical invasions without also saying that they have a constitutional right to bring about physical invasions? In other words, we might say that the former implies the latter, so that people have a *presumptive right to decide whether or not their bodies will be*

80. 494 U.S. 210 (1990).

81. It would follow from what I have said that a grant of permission to rape or assault would be constitutionally suspect. By contrast, a broad right of sexual autonomy need not follow; by preventing various sexual relations, the state certainly does not *allow* invasions of the body in the way I am describing here.

82. See *Zablocki v. Redhail*, 434 U.S. 374 (1978); *Loving v. Virginia*, 388 U.S. 1 (1967).

83. See *Moore v. City of East Cleveland*, 431 U.S. 494 (1977).

84. See JEREMY WALDRON, *THE RIGHT TO PRIVATE PROPERTY* 177–83 (1990) (discussing private property and self-ownership).

physically invaded. A strong commitment to autonomy might well lead in this direction.⁸⁵ But this idea seems far too broad as a matter of both settled law and basic principle. It would draw into question, for example, much of the activity of the Food and Drug Administration, which is precisely in the business of deciding what sorts of things may be ingested. Much criminal law also forbids people from allowing certain invasions of their body; consider laws forbidding use of addictive substances. The broader standard also appears to imply an expansive right to sexual autonomy, one that extends far beyond existing doctrine. We may conclude that the right to *prevent* physical invasions has some appeal but has the disadvantage of leaving open many questions, while the right to *decide whether to allow* physical invasions lacks both consistency with precedent and much appeal on the merits.

E. *Summary and Alternatives*

From these points, several alternatives are available to the Court. First and simplest, the Court might say that it need not decide whether the right to physician-assisted suicide qualifies as fundamental for constitutional purposes and proceed from that point to assess the state's justifications. Second, the Court might hold that its decisions protect rights vindicated by tradition and at most involve a right to prevent physical invasions and do not extend to other kinds of decisional autonomy, even when the body is directly involved. But this approach has the disadvantage of failing to account for some key cases. It also fails to explain why so sharp a distinction should be drawn between removing life-sustaining equipment and administering a drug that hastens death. As we shall see, a distinction of this kind is reasonable if we focus on the potential for abuse; but at the level of presumptive rights, it is much harder to defend. In any case, it seems odd to say that this vexed and controversial distinction can support the momentous difference between rational basis review and something like the "compelling interest" standard.

Third, the Court might say more narrowly that there is, under medically hopeless conditions, a presumptive right to decide whether one will continue to live. Fourth, and more broadly, the Court might say that the cases recognize a presumptive right to protection against physical invasion of one's body. It might add that it is not easy, in principle, to distinguish between the right to prevent bodily intrusions and the right to physician-assisted suicide, because that latter right is so obviously central to a person's most fundamental and apparently self-regarding judgments about the ultimate direction of his life, and because it is hard to explain why a person should have a constitutionally protected interest in withdrawing life-saving equipment without also having

85. See RICHARD A. EPSTEIN, *MORTAL PERIL* (forthcoming 1997) (defending even broader conception of autonomy as matter of policy).

such an interest in terminating his life through "more active" means.⁸⁶ On this view, the state must therefore meet a severe burden if it seeks to intrude on those judgments. Because of the difficulties associated with the various alternatives, it would probably be best for the Court to take the first route, to assume that the right to physician-assisted suicide qualifies as fundamental, and to proceed from there with the issue of justification. This is the course suggested by *Cruzan*.⁸⁷

III. STATE JUSTIFICATIONS

Suppose that the right to physician-assisted suicide does or is assumed to qualify as a fundamental interest for constitutional purposes. From this point it should not be concluded, in mechanical fashion, that any state intrusion is unacceptable. The Court should say, as it did in *Adarand Constructors, Inc. v. Peña*,⁸⁸ that "strict scrutiny" need not be "fatal in fact."⁸⁹ The Court should require a strong demonstration that the interference is reasonable, without having to be persuaded that it actually agrees with the enacting legislature.⁹⁰ Does the state have a sufficient reason to interfere with that interest? There are several possible grounds.⁹¹ I outline them here, not to endorse them, but to suggest what reasonable people might say on behalf of the ban on physician-assisted suicide. The broadest point is that autonomy, rightly conceived, does not entail respect for all "choices"; sometimes the right to choose can diminish autonomy by subjecting people to novel pressures and influences.

A. *Depression, Distress, and Distorted Judgment*

People who are in intense pain or emotional distress, and who face a bleak future, may well be unlikely to think clearly. They may be deeply depressed or myopic; short-term distress may overwhelm their judgment. We could easily imagine that people who are or appear to be terminally ill might be facing the equivalent of duress. In these circumstances, a right to die might be denied as a way of protecting people against their own distorted judgment. As I have suggested, the ban on suicide itself is best justified in these terms.

86. See BROCK, *supra* note 6, at 210–13 (rejecting distinction between passive and active euthanasia)

87. 497 U.S. 261, 277–79 (1990) (assuming right to withdraw treatment qualifies as liberty interest but noting that state may nonetheless have sufficient grounds to interfere with that interest)

88. 115 S. Ct. 2097 (1995).

89. *Id.* at 2117 (quoting *Fullilove v. Klutznick*, 448 U.S. 448, 519 (1980) (Marshall, J., concurring))

90. I defend this standard below. See *infra* Section IV.A.

91. I am putting to one side the idea that the state has an interest in protecting life as such. In many forms, that view is rooted in considerations that are essentially religious in nature and therefore an illegitimate basis for upholding a law. In nonreligious forms, the idea is hard to understand independently of the considerations discussed in the text.

It is intended to signal the gravity of the act and the importance of self-preservation, with an understanding that people might, under the stress of extremely difficult times, be tempted to end their lives.

When people's prospects are uncertain, this argument has considerable force. It appears weaker if we are dealing with genuine category (1) cases—in which, say, a patient faces six months of deterioration and almost certain death thereafter. We might conclude that the argument relating to distorted judgment does not justify state interference in such cases. But in practice, those cases can be hard to separate from other, quite different cases, and the difficulty of separating them argues in favor of a general prohibition. In any case, it is a relevant point in favor of such a prohibition that current medical technology allows a wide range of means by which to reduce or eliminate intense pain.⁹²

There is a related issue. Sometimes physician-assisted suicide may seem the easiest way to deal with extreme and understandable distress, but in many of these cases, there are more productive alternatives, which may lead patients to deal better with their fears. People who face medically difficult circumstances and a bleak prognosis may (like anyone else facing a difficult life event) seek the simplest solution, even though a more difficult approach may enable them to find some degree of peace or resolution. There are cases in which physician-assisted suicide appears to have prevented this process; it seems to have encouraged people to respond to their distress through death rather than through seeking assistance from professionals and loved ones.⁹³ On this view, a prohibition on physician-assisted suicide is not so different from the general ban on suicide. It is part of an effort to see death as a part of life—to encourage distressed people and their families to come to terms with their fears, including the fear of death itself, in a way that can be productive, and to ensure that distressed, sick, or dying people are not treated, and do not treat themselves, as objects to be eliminated from the scene.

B. *Protecting the Patient Against External Pressure*

A ban on physician-assisted suicide may seem to intrude on the autonomy of the patient; this is in fact the strongest argument against the ban. Ironically, however, the ban may have the opposite effect. A vulnerable person with perhaps a short time to live might be subject to various psychological pressures from family, certainly if (as is likely) family members are feeling great distress and also if (as is possible) nontrivial sums of money are at stake. The closing stages of life can, in short, create conflicts of interest between a patient and the patient's family members.⁹⁴ The patient may wish to live as

92. See *supra* note 18.

93. This is the argument of Herbert Hendin. See HENDIN, *supra* note 11, at 127–34, 155–59.

94. See *id.* at 114–20. There is a similar concern with the right to abort. Women may be under intense pressure from boyfriends, parents, or husbands to have an abortion, even when they would prefer not to

long as possible; family members may believe that this is a situation of great tragedy, difficulty, and expense, and that it will be much better when it is over. Here too a right to die may seem the simplest solution while more difficult approaches would be better for all concerned.

Of course we can imagine situations in which the patient freely agrees with the family on this point. But it is also possible to foresee situations in which the patient, having been granted a "right to die," bows to the family's wishes and hence very much regrets the fact that he has that right.⁹⁵ If there is a right to physician-assisted suicide, the social meaning of a refusal to terminate one's life would be very different from what it now is. Perhaps this would be an acceptable situation. But since it is, after all, the patient's life that is on the line, we can imagine reasonable people thinking that the right to die should be rejected because it actually threatens to decrease patient autonomy in too many cases.

C. *Protecting the Patient Against Pressure from Physicians*

Physician-assisted suicide may in practice increase the authority of physicians rather than the autonomy of patients.⁹⁶ Suppose that a patient is confronted with a list of options from a doctor, one of which includes physician-assisted suicide. In some such cases the patient—confused or not—might feel actual or implicit pressure to accept the option of death. This is not because this option is, all things considered, the patient's preferred one, but because the physician explicitly or implicitly favors it and because, under the circumstances, the physician has assumed the role of an authority figure. Once a right is granted, real-world physicians may (consciously or unconsciously) favor death for any number of reasons, including financial pressures and the need to allocate scarce time to other, more promising cases. People who are poor, undereducated, or otherwise disadvantaged may be especially vulnerable to pressure. Here, too, we have a case in which a ban on physician-assisted suicide supports rather than undermines autonomy. It is relevant here that in the Netherlands, the only nation to legalize physician-assisted suicide, there are many allegations that patient consent is not always the precondition for medical decisions.⁹⁷ One observer claims, "Euthanasia,

do so, and in such cases the right might undermine their autonomy. It is unlikely, however, that a large percentage of abortions results from these pressures as a matter of fact. If the percentage were in fact large, the argument for the right to abort would be undermined.

95. Compare the situation of restaurants under Title VII. Many restaurants sought a ban on race discrimination, on the apparent theory that a legal barrier enabled them to do what they wanted to do and in that way increased their autonomy. See Lawrence Lessig, *The Regulation of Social Meaning*, 62 U. CHI. L. REV. 943, 965–67 (1995) (discussing how Civil Rights Act of 1964 protected desires of restaurants by changing "social meaning" of nondiscrimination). Like a right to discriminate, a right to die could decrease autonomy, by pressuring patients to submit to social norms and familial desires.

96. See HENDIN, *supra* note 11, at 214.

97. See *id.* at 52–54, 75–84; *infra* text accompanying notes 101–07.

advocated and instituted to foster patient autonomy and self-determination, has actually increased the paternalistic power of the medical profession."⁹⁸

D. *Nonvoluntary Euthanasia*

Many critics of the "right to die" believe that there is an easy slippage from voluntary to nonvoluntary euthanasia. Their argument has two forms.⁹⁹ Some people believe that the safeguards designed to ensure a trustworthy expression of the patient's will cannot be held in place—that in a number of cases, those safeguards will, as an empirical matter, prove inadequate, and the patient will be killed despite his wishes. Other people do not stress this empirical possibility but urge instead that if doctors are put in a position to honor the suicide requests of (autonomous) patients, the doctors will also inevitably be making some evaluation of whether those patients' lives will be worth living. Once doctors begin to make that evaluation, they will, in practice, be making judgments about the competence of patients and the value of their lives, and in some number of cases will ultimately terminate lives partly or mostly on the basis of their own judgments rather than those of their patients.¹⁰⁰

The experience in the Netherlands is complex, but it is taken by reasonable people to signal a warning on this front.¹⁰¹ A comprehensive survey suggested that of 130,000 people who died each year, 49,000 raised issues of whether to withdraw life-saving equipment or hasten death, and about 400 cases amounted to assisted suicide.¹⁰² There were 9000 annual requests for euthanasia; of these, voluntary euthanasia—"any action that intentionally ends the life of someone else, on the request of that person"—was allowed in 2300 cases, or about one-quarter. In 8100 cases, doctors intended to hasten deaths via pain-killing drugs.¹⁰³ Some people believe that abuse has been extensive, in the form of deaths that did not receive adequate consent.¹⁰⁴ Thus, of the 8100 cases involving pain-killing drugs designed to hasten death,

98. HENDIN, *supra* note 11, at 94.

99. See Keown, *supra* note 6, at 261–62.

100. See HENDIN, *supra* note 11, at 50 (arguing that under Dutch system "the patient has no autonomy because the doctor has decided that the quality of the patient's life is such that it is time for the patient to die").

101. See, e.g., CARLOS F. GOMEZ, REGULATING DEATH: EUTHANASIA AND THE CASE OF THE NETHERLANDS 104–11, 135 (1991) (claiming that some deaths have not been voluntary); HENDIN, *supra* note 11, at 75–84 (discussing involuntary and nonvoluntary deaths); Keown, *supra* note 6, at 262–63, 271–73 (discussing allegedly large number of involuntary deaths).

102. See Henk A.M.J. ten Have & Jos V.M. Welie, *Euthansia: Normal Medical Practice?*, HASTINGS CENTER REP., Mar.-Apr. 1992, at 34 (describing study: Commissie Onderzoek Medische Praktijk inzake euthanasie, *Medische Beslissingen rond het Levenseinde* [Medical Decisions Concerning the End of Life] (The Hague: S.D.U. Uitgeverij, 1991)); see also Keown, *supra* note 6, at 267–75 (reporting findings of study).

103. See Keown, *supra* note 6, at 271.

104. See GOMEZ, *supra* note 101, at 104–13, 135; HENDIN, *supra* note 11, at 75–84.

5508 involved no explicit request on the patient's part.¹⁰⁵ One observer suggests that "the Dutch euthanasia experience lends weighty support to the slippery slope argument Within a decade, the so-called strict safeguards against the slide have proved signally ineffectual; non-voluntary euthanasia is now widely practiced and increasingly condoned in the Netherlands."¹⁰⁶ Others disagree.¹⁰⁷ The existence of uncertainty on the question suggests that there is at least a significant possibility of abuse.

E. *Systemic Effects, Expressive Values, and the Role of the Physician*

Some people undoubtedly support the prohibition on suicide and assisted suicide because of the expressive value of the prohibition.¹⁰⁸ That is, a ban on suicide may be supported as an intrinsic good insofar as it reflects social attitudes about the sanctity of life.¹⁰⁹ Perhaps it is inadequate to defend a law intruding so deeply on patient autonomy on purely expressive grounds. But less controversially, it might be suggested that the ban has expressive value insofar as it has salutary effects on social norms—helping to create a culture in which life is seen with a degree of reverence, and in which the termination of life, by self or others, is taken to be a tragic event. This point has special importance insofar as a prohibition on suicide and assisted suicide, even in the most compelling cases, helps express and fortify norms in favor of dealing with difficult conditions in more constructive ways. A right to physician-assisted suicide might be taken to compromise the general social norm against suicide and assisted suicide, even if, as a technical matter, it applies only in a restricted and compelling context. We have seen that acts of suicide can be contagious.¹¹⁰ The state may want to disallow physician-assisted suicides for fear that a few highly publicized cases may spur a wide range of additional cases, with harmful effects on norms against suicide in general.¹¹¹

It is also possible that a right to physician-assisted suicide would have adverse effects on the norms and role of physicians. Physicians are now faced with an entrenched norm in favor of the preservation of life. A right to physician-assisted suicide might have harmful effects on that norm. It is possible, for example, that such a right would make doctors more willing to hasten death whether or not this is actually the patient's choice. Such a right

105. See HENDIN, *supra* note 11, at 76; Keown, *supra* note 6, at 277

106. Keown, *supra* note 6, at 289.

107. See EPSTEIN, *supra* note 85 (manuscript ch. 16, at 12–14) (arguing that significant abuse has not been demonstrated); POSNER, *supra* note 11, at 242 & n.23 (same)

108. See Cass R. Sunstein, *On the Expressive Function of Law*, 144 U PA L REV 2021 (1996) (discussing norms and official "statements"); Cass R. Sunstein, *Social Norms and Social Roles*, 96 COLU M L. REV. 903, 964–65 (1996) (same).

109. *But see supra* note 91.

110. See ELLIOT ARONSON, *THE SOCIAL ANIMAL* 63–64 (7th ed 1995) (discussing copycat suicides). Phillips, *supra* note 26, at 341–42 (discussing relation between suicides and knowledge of other suicides)

111. See ARONSON, *supra* note 110, at 63–64.

may encourage physicians to make personal or cost-benefit judgments that disserve many patients' interests. The ban on physician-assisted suicide is, on this view, intended to serve an expressive function, fortifying social norms associated with the proper role of the physician.

IV. CONSTITUTIONAL OPTIONS

We have now seen that the state can invoke some powerful justifications to oppose the right to physician-assisted suicide. In light of these considerations, how might the Court resolve the question of whether there is a constitutionally guaranteed right to die? I believe that the Court should reject the constitutional challenge, partly for institutional reasons connected with the limited place of the Supreme Court in American government:¹¹² When the issue is very close in light of the underlying issues of fact and value, and when there is no democratic defect in the underlying political process, the Court should not strike down reasonable legislative judgments. I consider substantive due process, equal protection, and (following the lead of Judge Guido Calabresi in *Quill*) the form of procedural due process involving the defect known as "desuetude."

A. *Substantive Due Process*

1. *Narrowly Vindicating the Right*

Like the Court of Appeals for the Ninth Circuit, the Supreme Court might say that there is a fundamental liberty interest in deciding whether to live or die and that the various state justifications are not sufficient to overcome that interest. It might support this view with the plausible suggestion that the various risks can be counteracted through less restrictive alternatives. A state concerned about those risks might take steps to make sure that the patient really wants to die by requiring a certain burden of proof, ensuring that the circumstances meet certain constraints, imposing procedural safeguards of various kinds, and using the criminal law against doctors who pressure patients and do not simply follow their wishes. This approach would be reminiscent of *Roe* in the sense that it would follow the familiar two-step process of finding a fundamental right and declaring that the state does not have a "compelling" interest that it is unable to support with less restrictive means.

This route would not be entirely indefensible. At least if we have a category (1) or category (2) case—the patient's wishes are clear, the condition is genuinely hopeless, and the patient is facing physically difficult circumstances—reasonable people might believe that the state's interests are

112. See *infra* Subsection IV.A.3.

not overriding. Perhaps the basic risks could be adequately handled through procedural safeguards (as I believe is likely true as a matter of policy). Indeed, it is possible to think that such a route would be stronger than that in several of the privacy cases, including *Roe* itself. Here the individual interest may be at least as insistent and the countervailing interests might seem weaker insofar as the individual in question has extremely poor life prospects. There is no direct argument, as there is in the abortion context, about preventing harm to third parties. The Court has almost never said that a state can intrude on a right that qualifies as fundamental, and unlike the procedural rules upheld in *Cruzan*, the barrier to physician-assisted suicide is a total ban.

But vindication of the right would not, all things considered, be a good resolution. The privacy cases are actually far narrower than this two-step process suggests, and the Court might reasonably seek to cabin those cases by taking account of their distinctive features. Those features very much involve problems with democratic deliberation. First, equal protection dimensions—themselves calling up democratic concerns connected with political inequality—were present in many of these cases. *Roe* was in important part a case of gender equality, as then-Judge Ruth Bader Ginsburg suggested in 1985¹¹³ and as the Court has since explicitly acknowledged.¹¹⁴ If that decision is to be made acceptable, it must be partly because of the connection between sex equality and the abortion right.¹¹⁵ Nor was this only true of *Roe*. In privacy cases involving a right of use or access to contraceptives,¹¹⁶ there was at least a tacit equal protection dimension as well, for women were particularly at risk in the event of an unwanted pregnancy. It does not require much imagination to see this point. When discrimination of this kind is involved, the interest in democratic deliberation legitimately calls for a larger judicial role so as to counteract predictable problems with ordinary majoritarian processes.

Second, as Alexander Bickel suggested long ago, the early cases raised questions of procedural due process, for they involved laws that were practically unenforced and unenforceable.¹¹⁷ Thus the ban on the use of

113. See Ruth Bader Ginsburg, *Some Thoughts on Autonomy and Equality in Relation to Roe v. Wade*, 63 N.C. L. REV. 375, 385–86 (1985) (suggesting that *Roe* should have been decided more narrowly and as equality case).

114. See *Planned Parenthood v. Casey*, 505 U.S. 833, 896–98 (1992) (plurality opinion) (referring to interest in sex equality); *id.* at 918–19 (Stevens, J., concurring in part and dissenting in part) (same); *id.* at 928 (Blackmun, J., concurring in part, concurring in the judgment in part, and dissenting in part) (same).

115. See SUNSTEIN, *supra* note 29, at 270–85; Reva Siegel, *Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection*, 44 STAN. L. REV. 261, 380 (1992); David A. Strauss, *Abortion, Toleration, and Moral Uncertainty*, 1992 SUP CT REV. 1, 18–22, Kenneth L. Karst, *Book Review*, 89 HARV. L. REV. 1028, 1036–37 (1976) (noting relevance of equality concerns to abortion question).

116. See *Carey v. Population Servs. Int'l*, 431 U.S. 678 (1977); *Eisenstadt v. Baird*, 405 U.S. 438 (1972); *Griswold v. Connecticut*, 381 U.S. 479 (1965).

117. See ALEXANDER M. BICKEL, *THE LEAST DANGEROUS BRANCH* 148–56 (2d ed. 1986) (discussing concept of desuetude).

contraceptives within marriage was not a simple invasion of privacy; it involved a statute enacted long ago, not plausibly representing the considered judgments of the relevant electorate, and enforced only in a selective and discriminatory manner.¹¹⁸ In this sense, the ban presented a case of desuetude.¹¹⁹ The other privacy cases did not vindicate a broad right to control one's body. They suggested more narrowly that if a state is going to regulate sexual activity, it must do so directly and not through the indirect, at best modestly effective means of making pregnancy the price of that activity. We may thus conclude that the privacy cases did not involve a simple identification of a fundamental right and a judgment that the state lacked sufficient justification to intrude. There were important issues relating to procedural due process and equal protection as well. And these issues suggest that there were problems in the system of democratic deliberation that contributed to the outcomes in the relevant cases. Thus the Court did not announce a broad right to sexual autonomy. It said more narrowly that any intrusion on that right must be direct, nondiscriminatory, and supported by actual public judgments, rather than indirect, discriminatory, and reflecting no actual judgment from the democratic public.

Along these dimensions, the right to physician-assisted suicide is quite different. In many cases, that right has been considered very recently in the relevant states.¹²⁰ Moreover, there is no serious equal protection dimension in these cases.¹²¹ No politically vulnerable group is at risk, at least not in any constitutionally pertinent sense. It does make sense to assume or say that the decision whether to live in category (1) and (2) cases implicates a fundamental interest for constitutional purposes. But the state has very strong reasons to intrude on that interest. The closest analogy may be to third-trimester abortions, where the Court did not deny that women retain a fundamental interest, but found the state's justification sufficient to support intrusion on that interest, even in the context of a near-total prohibition.¹²² It is perfectly reasonable for citizens, in their capacity as voters, to conclude that state law should allow a right to physician-assisted suicide. But a decision by the Court, foreclosing diverse solutions in diverse states, would intrude into ongoing

118. *See id.*; *see also* RICHARD A. POSNER, *SEX AND REASON* 326–28 (1992) (discussing role of Catholic Church in preventing statutory change).

119. *See infra* note 152 and accompanying text. *See generally* BICKEL, *supra* note 117, at 148–56.

120. *See infra* text accompanying notes 162–64.

121. Perhaps it might be thought that politically weak groups are most vulnerable in a system lacking a formal right to physician-assisted suicide; many (wealthy, well-educated) people may have something like that right even in a system in which the right is not formally recognized. But politically weak people would also be at special risk in a system recognizing such a right; the risks of abuse might well operate most strongly against members of disadvantaged groups. Hence the interest in political equality does not seem to argue in any particular direction. Note in this regard that while a slight majority of whites favor physician-assisted suicide, African Americans oppose it by more than two to one. *See* HENDIN, *supra* note 11, at 180.

122. *See* *Roe v. Wade*, 410 U.S. 113, 162–64 (1973).

deliberative processes in circumstances in which reasonable people may differ. This is so especially insofar as the relevant judgments depend on factual issues not well-suited for judicial judgment.

2. *Rejecting the Due Process Claim*

The Court might simply uphold the relevant laws. It might hold that there is no fundamental interest, for reasons discussed above. Far more promisingly, it might say that even if there is a fundamental interest, the state has sufficient reason to interfere with the choice. There is a great deal to be said on behalf of this conclusion. The distinction between withdrawing treatment and active euthanasia may not be supportable at the level of first principles; but it reflects widely held intuitions and, more fundamentally, the state's justifications for rejecting a right to physician-assisted suicide are stronger at least in degree.¹²³ Thus the Court might say that the risks of abuse and misapplication are not so serious in the case of withdrawal of treatment, but that a state could reasonably decide that those risks are decisive against physician-assisted suicide.

Moreover, recognition of the importance of the state's countervailing interests would free up state legislatures to do as they wish with a problem that is very much on the public agenda. As we have seen, the state does have powerful interests with which to counterpose the claim from decisional autonomy.¹²⁴ Notably, those interests are more powerful than in any of the privacy cases vindicating the underlying right. In *Roe*, the state's justification—protection of fetal life—seemed (and seems) to many quite strong; but at least there is a serious question whether, on secular grounds, fetal life deserves the same respect and concern as human life post-viability. By contrast, the potential abuses introduced by any right to physician-assisted suicide have considerable weight whatever one's convictions about foundational issues. The Court is not in a good position to know whether the likely risks are serious and whether they can be reduced sufficiently through less restrictive means. For this reason, the question is admirably well-suited to a federal system that can conduct a range of experiments.

3. *Institutional Notes*

It should be clear that the argument I am making depends on the controversial suggestion that when there is no palpable defect in the system of

123. See *infra* text accompanying notes 143–45.

124. A suggestion to this effect is made by a defender of the right to active euthanasia. See BROCK, *supra* note 6, at 172 (“Different persons can reasonably reach different conclusions . . .”).

democratic deliberation,¹²⁵ courts should respect very reasonable legislative judgments even if a “fundamental interest” is at stake.¹²⁶ This view depends on two assumptions. The first is that judicial judgments about how to balance the relevant interests, especially in light of factual and predictive uncertainties, are not always reliable. Judges are aware of this point and they devise doctrines accordingly. Of course, judges have certain advantages by virtue of their insulation and their ability, perhaps, to be especially careful with respect to underlying issues of both fact and political morality. But with respect to issues of both fact and value, judicial insulation can be a disadvantage too; it can make it harder for courts to obtain relevant information, and it can make it less legitimate for judges to choose what to do in the face of factual uncertainty. Judicial insulation suggests that courts should not be too sure that they are right,¹²⁷ in the sense that they should be reluctant to overturn a legislative judgment when the balance is quite close and when there is no problem in democratic deliberation.¹²⁸

The second assumption is that even if judges are right, they should be aware that their (by hypothesis correct) moral judgments, once announced, may not receive immediate social vindication and may instead produce something very different from what they intended.¹²⁹ This is because judicial judgments may truncate ongoing processes of democratic deliberation, and by so doing, may prove futile or even counterproductive. In the context of abortion, this is a plausible view, for the nation may well have been moving reasonably amicably toward a solution not far from *Roe* and reflecting deliberative

125. I am referring here to the general view of constitutional interpretation set out in ELY, *supra* note 4; see also JÜRGEN HABERMAS, *BETWEEN FACTS AND NORMS* 266 (William Rehg trans., Polity Press 1996) (1992) (arguing against judicial paternalism); SUNSTEIN, *supra* note 29, at 123–61 (embracing same general view). On this view, a democratic problem exists if a right central to democracy is at issue (for example, the right to free political speech) or if a group is being fenced out of political processes through formal exclusions or, more controversially, prejudice or “animus.” See *Romer v. Evans*, 116 S. Ct. 1620, 1627 (1996) (striking down state constitutional amendment partly because it reflects “animus”).

It might be thought that there is such a defect in light of the fact that religious groups can block change for religious reasons, and perhaps this accounts for current practice in some states. The short answer is that this is not the sort of defect that would justify a more aggressive judicial role. Religious groups of course are entitled to participate in democratic processes, and even if there are constraints on the kinds of arguments that they are entitled to make, the arguments typically invoked against physician-assisted suicide do not run afoul of those constraints. The case is different from *Griswold v. Connecticut*, 381 U.S. 479 (1965), where a well-organized religious minority, invoking a purely religious argument, was able to block a repeal that was very generally favored of a prohibition that was never directly enforced through the criminal law. See POSNER, *supra* note 118, at 324–28.

126. This is not to say that courts should defer to any minimally plausible legislative judgment; the critical fact here is that fully reasonable people might decide this issue either way, even though the Court might find one view more reasonable than the other as a matter of policy.

127. Cf. LEARNED HAND, *The Spirit of Liberty*, in *THE SPIRIT OF LIBERTY* 189, 190 (Irving Dillard ed., 3d ed. enlarged 1960) (suggesting that spirit of liberty is spirit which “is not too sure that it is right”).

128. Accord EPSTEIN, *supra* note 85 (manuscript ch. 17, at 2). Professor Epstein’s view is notable insofar as he is a strong defender of the right to physician-assisted suicide as a matter of policy, see *id.* (manuscript ch. 16, at 2–3), and insofar as he is not reluctant to urge a strong judicial role in other areas, see RICHARD A. EPSTEIN, *TAKINGS* (1985) (arguing for aggressive protection of property rights).

129. See GERALD N. ROSENBERG, *THE HOLLOW HOPE* 175–201 (1991) (discussing limits of courts in producing social reform and complex effects of *Roe v. Wade*).

compromises in various states.¹³⁰ Currently, the same may well be true with respect to physician-assisted suicide (or, to take an issue that is in some ways similar, the right to same-sex marriage).¹³¹ In these circumstances, a constitutional ruling may embroil the Court in decades of political conflict. This consideration should not be decisive; if the argument for the constitutional right were compelling, as in for example *Brown v. Board of Education*,¹³² a majority or minority that rejects the right should not be allowed to exercise any kind of heckler's veto. In *Brown*, the existence of political inequality and racial animus suggested that possible disagreement among apparently reasonable people should not be decisive in court. But where there is no such inequality and the issue is otherwise very close, institutional considerations of this kind are relevant.¹³³ They suggest that if democratic processes are not malfunctioning, judges should be cautious about invoking their own moral judgments partly because of the risk of producing unfortunate and unintended consequences.

This is not the occasion to attempt a full account of the appropriate occasions for exercising judicial power under the rubric of "substantive due process." It should be clear from what I have said thus far that most past substantive due process cases had some other element involving a democratic failure of some kind: excessive role for religious convictions in the public sphere, insufficient connection with considered public judgments, or problems of inequality and prejudice. Certainly we could imagine cases calling for substantive due process even without these elements. Suppose, for example, that government imposed a general "one family, one child" policy, or required people to have abortions, or said that randomly chosen people must give their kidneys to those who need them. The fact that these cases are so bizarrely unlikely suggests that the occasions for "pure" substantive due process will be rare indeed. Ordinarily, political safeguards are sufficient against such gross abuses, and if they are not sufficient, circumstances (underlying facts and values) are likely to be so entirely different from our own that our present (outraged, uncomprehending) view of them does not yield a strong defense of substantive due process. For present purposes the central point is that while there may be some cases in which states have no sufficiently powerful grounds

130. *Cf. id.* at 182–84 (discussing growing popular support for repeal of abortion laws prior to *Roe*). *But see* DAVID J. GARROW, *LIBERTY AND SEXUALITY* 616–17 (1994) (contending that states would not have moved in direction set by *Roe*). Whether or not *Roe* is a good example, the point certainly holds in general.

131. This right is vigorously urged in WILLIAM N. ESKRIDGE, JR., *THE CASE FOR SAME-SEX MARRIAGE* 123–82 (1996), which claims that the Constitution forbids laws banning same-sex marriage.

132. 347 U.S. 483 (1954).

133. *Cf.* Lawrence Gene Sager, *Fair Measure: The Legal Status of Underenforced Constitutional Norms*, 91 HARV. L. REV. 1212, 1220–28 (1978) (discussing rights that courts, for institutional reasons, underenforce).

for interfering with what is properly characterized as a fundamental interest, the right to physician-assisted suicide is not such a case.

In the context at hand, there is a further point. As least as much as *Roe* itself, a decision on behalf of a right to physician-assisted suicide would put the Court in the exceedingly difficult business of specifying appropriate procedures and boundary lines. It is inevitable that a judicially recognized right would have to be accompanied by guarantees designed to ensure that the patient genuinely wants to die. States that are skeptical of the underlying right would predictably devise correspondingly elaborate procedures, and hence the Court would be in the business of distinguishing between justified and unjustified measures designed to produce certainty about the patient's wishes. If a ban on suicide is permissible, the Court would have to make fine distinctions between those cases in which physician-assisted suicide is a constitutional right and those in which it is not. These considerations ought not to be decisive if the case for a constitutional guarantee is otherwise compelling. But they suggest that any such guarantee would produce not one judgment but a long line of judgments, not well-suited to judicial competence. The Court's difficulties with *Roe* in this regard counsel against a duplication of that experience.

B. *Equal Protection*

1. *Rationality Review*

In *Eisenstadt v. Baird*,¹³⁴ the Court struck down as irrational a law forbidding the distribution of contraceptives to unmarried people. The Court said that it was irrational to prohibit the distribution of contraceptives among unmarried people if such distribution was not prohibited to married people.¹³⁵ Many questions might be raised about the Court's reasoning; the state's decision was hardly irrational in the technical sense. But *Eisenstadt* can be understood as a rather cautious and modest ruling, one that vindicates a claim that the Court thought convincing without going so far as to announce a general "substantive due process" right to purchase contraceptives.

Perhaps the Court might attempt to do something like this and seek a more modest approach via the generality-requiring commands of the Equal Protection Clause. The Second Circuit attempted a route of just this sort in *Quill v. Vacco*.¹³⁶ The court noticed that New York allowed patients to order the removal of life support systems, but did not otherwise allow patients to take action to terminate their lives. This inequality, the court said, violated the

134. 405 U.S. 438 (1972).

135. *See id.* at 454-55.

136. 80 F.3d 716 (2d Cir.), *cert. granted*, 117 S. Ct. 36 (1996).

Equal Protection Clause because it was “not rationally related to any legitimate state interest.”¹³⁷ On this view, there is no sufficiently good reason to allow people to terminate their lives in one way while banning them from doing so in another way. Under the decision of the court of appeals, New York might be able to ban both physician-assisted suicide and removal of life support systems (though the latter step would raise substantive due process questions under *Cruzan*), but it may not discriminate.

The equal protection/rationality approach has an advantage of comparative modesty; it also has a plausible antecedent in *Eisenstadt*. But the argument is nonetheless weak. Longstanding traditions, and many reasonable people, have distinguished between killing and letting die.¹³⁸ This distinction finds a particular instantiation in the idea that people should be allowed to remove life-saving equipment but not to kill themselves. Certainly the action/omission distinction raises many puzzles, and it is far from clear that the distinction makes ultimate sense in this context,¹³⁹ but a holding that it is “irrational” runs afoul of both ordinary law and ordinary intuitions. If the distinction in this context is unconstitutional because it is irrational, it is unconstitutional in many other contexts as well. Consider, for example, criminal law’s distinction between killing and letting die,¹⁴⁰ tort law’s absence of liability for bad samaritans,¹⁴¹ and indeed due process law’s own distinction between government actions and omissions.¹⁴²

There is also theoretical support for the distinction. Here are some possible grounds. Without endorsing the distinction for all purposes, we can say that someone who jumps off a building expresses contempt for his own life, whereas someone who disconnects life-saving equipment, and allows nature to take its course, expresses no such contempt. The attitude expressed by what are conventionally labelled “acts” may well be different from the attitude expressed by what are conventionally labelled “omissions.” Similarly, it might seem that a doctor who assists in suicide is different from a doctor who withdraws life-saving equipment, because of the different attitudes expressed by the two acts. In any case, the right to remove life support might be rooted in a desire to allow people to prevent the government from restraining and invading their bodies against their will. The right to physician-assisted suicide is at least plausibly different on this score. I do not mean to

137. *Id.* at 731.

138. For a philosophical discussion of this distinction, see, for example, BROCK, *supra* note 6, at 202–13.

139. *See id.*

140. Murder is, of course, prohibited in various forms, but states do not impose criminal penalties on the general failure to assist people who will die without help.

141. *See* WILLIAM L. PROSSER, HANDBOOK OF THE LAW OF TORTS § 56, at 338–43 (4th ed. 1971).

142. *See* *DeShaney v. Winnebago County Dep’t of Soc. Servs.*, 489 U.S. 189, 195–203 (1989) (holding that there is no affirmative right to action by state).

endorse these points as a matter of basic principle. But if rationality review is genuinely at work, a state could allow people to terminate life support while disallowing them from asking doctors to administer life-terminating drugs.

In my view, the more important points are empirical and pragmatic. It is reasonable to think that the risks of abuse are far greater in cases of physician-assisted suicide than in cases of withdrawal of life support. The latter set of cases is far easier to cabin; the former set raises in far more imaginable contexts the various difficulties discussed in Part III. A central reason is that the withdrawal of life-saving equipment is as a general rule far less likely to be unjustifiable—far less likely to reflect an irrational judgment by a competent patient—than is resort to assisted suicide. In the ordinary case, the withdrawal of life-saving equipment will involve a life that a patient reasonably and with adequate information wants to terminate; the act of assisted suicide far more commonly can involve a form of involuntary euthanasia, short-run distortions in judgment, or familial or physician pressure. For this reason, the distinction is an imperfect but fully reasonable proxy for (costly, imperfect) case-by-case inquiries into the reasonableness of the grounds for choosing death in particular instances.¹⁴³

This is not to deny that withdrawal of life support raises risks of abuse as well. We can certainly imagine instances in which very dependent patients feel pressured, by family or doctors, to misstate their true wishes in the face of exceptionally expensive medical treatments. But at least some safeguard against widespread abuse comes from the very possibility that the withdrawal would produce death; these are relatively rare cases, mostly involving terrible and terminal illnesses, and allowing the withdrawal of treatment does not risk the sheer number of conceivable instances in which a right to physician-assisted suicide would produce nonautonomous or involuntary deaths, or deaths that more nearly resemble ordinary suicide. The withdrawal of treatment produces death only if the patient suffers from a fatal illness, whereas the right to physician-assisted suicide may well, in either theory or practice, apply far more broadly even if we attempt to restrict its domain.¹⁴⁴ It is for this reason that this distinction is fully plausible as a way of attempting to protect patient autonomy and to combat risks of abuse.¹⁴⁵ So long as rationality review is genuinely at work, the equal protection challenge is unconvincing.

143. See David Orentlicher, *The Legalization of Physician-Assisted Suicide*, 335 *NEW ENG. J. MED.* 663, 665 (1996).

144. See Daniel Callahan, *When Self-Determination Runs Amok*, *HASTINGS CENTER REP.*, Mar.-Apr. 1992, at 52, 53-55.

145. See HENDIN, *supra* note 11, at 47-95. Recall that my suggestion is that the distinction is sufficiently plausible for constitutional purposes; the policy issue is different. See *supra* text accompanying notes 11-13; see also Orentlicher, *supra* note 143, at 665-66 (arguing that permitting assisted suicide in "limited" cases will bring law closer to society's moral values).

2. *Equal Protection "Fundamental Rights"*

The equal protection argument might be rooted in the "fundamental rights" branch of equal protection doctrine. In a number of cases, the Court has said that it will look skeptically at classifications that involve fundamental rights. It might be concluded that there is a fundamental interest here and that any discrimination with respect to that interest must be given a compelling justification. The distinction between refusing treatment and physician-assisted suicide is rational, to be sure, but perhaps it does not have a compelling argument on its behalf. Thus understood, the case would be like *Skinner v. Oklahoma ex rel. Williamson*¹⁴⁶ and *Zablocki v. Redhail*,¹⁴⁷ involving sterilization and marriage, respectively, and using the fundamental rights branch of equal protection doctrine.

But this branch of the doctrine raises many puzzles. At least at first glance, the Equal Protection Clause creates a right to nondiscrimination; it does not create any independent "fundamental rights." The key equal protection "fundamental rights" cases involve voting,¹⁴⁸ and thus should be seen as part of democracy-reinforcing judicial review, not as a kind of junior-varsity substantive due process. It remains to be explained why *Skinner* and *Zablocki* are treated as equal protection rather than due process cases. If they are to be so treated, it is because they involve issues of discrimination as well as issues of "fundamental rights." *Skinner* is probably best understood as a case in which criminals of a certain social class were peculiarly subjected to the punishment of sterilization; *Zablocki* is best understood as a case informed and influenced by the fact that the relevant law prohibited poor people from marrying. Thus both cases can be seen as part of the general line of cases increasing judicial scrutiny where politically weak groups are at risk. The right to physician-assisted suicide does not raise problems of this sort.

Nor is it clear what might be gained by holding some rights to be fundamental for equal protection purposes but not for purposes of substantive due process. Perhaps the idea is that the fundamental rights branch of equal protection doctrine is less intrusive than substantive due process because it leaves states more room to maneuver by permitting them to invade the relevant right so long as they do so on a nondiscriminatory basis. This is not entirely implausible; for purposes of physician-assisted suicide, the analysis in *Skinner* would be less intrusive than a rerun of *Roe*. But from the analytic point of view, it is very untidy. The state has fully reasonable grounds for allowing withdrawal of life-saving equipment while fearing the risks of abuse that might

146. 316 U.S. 535 (1942) (invalidating law requiring sterilization of certain criminals).

147. 434 U.S. 374 (1978) (invalidating law forbidding people to marry unless they have met their support obligations).

148. See, e.g., *Harper v. Virginia Bd. of Elections*, 383 U.S. 663 (1966) (striking down poll tax); *Reynolds v. Sims*, 377 U.S. 533 (1964) (articulating one person, one vote principle).

follow from a right to physician-assisted suicide. If the substantive due process argument is not convincing, the equal protection argument is unconvincing as well.

C. *Desuetude*

The Court might strike down such laws unless they are a product of recent legislative deliberation on the particular issues raised by physician-assisted suicide. This is the solution favored by Judge Calabresi in his intriguing if somewhat adventurous concurring opinion in *Quill*.¹⁴⁹ Judge Calabresi's solution identifies an important and salutary theme in constitutional law, one that raises complex issues and deserves considerable attention. A large advantage of Judge Calabresi's approach is institutional. It ensures that interferences with important forms of liberty will not be based on law that lacks current political support; in that way, the approach is democracy-supporting. Moreover, it does not preempt but instead catalyzes democratic processes, and in that sense reflects the courts' appropriate caution in dealing with complex ethical and factual issues. The principal problem with Judge Calabresi's approach is that the case of physician-assisted suicide does not easily fit the case of desuetude, for the "right to die" has received ample recent consideration in most of the relevant states. I conclude that the idea of desuetude is extremely important and valuable, and deserves a more prominent and explicit place in constitutional law, but that it ought not to be used to call for new legislation in Washington or New York.

1. *The General Idea*

The basic argument is simple. Suppose that the relevant laws—banning people from helping in the commission of suicide—were written long ago, and suppose too that they were not specifically addressed to the problem of physician-assisted suicide. Indeed, that problem is a recent one, made available by new technologies and practices. In light of the novelty of the relevant practice, and (let us assume) the lack of legislative attention to that practice, we could imagine a state court ruling that state law bans on assisting suicide do not even cover physician-assisted suicide, on the ground that criminal statutes should be construed narrowly and not applied to a case that is so far afield from the understandings of the enacting legislature.¹⁵⁰ If a state court

149. *Quill v. Vacco*, 80 F.3d 716, 731 (2d Cir.), cert. granted, 117 S. Ct. 36 (1996) (Calabresi, J., concurring in the result).

150. Cf. *Industrial Union Dep't v. American Petroleum Inst.*, 448 U.S. 607, 639–59 (1980) (plurality opinion of Stevens, J.) (construing statute against ordinary language so as to avoid perceived unintended outcome); *Church of the Holy Trinity v. United States*, 143 U.S. 457, 472 (1892) (interpreting statute contrary to its plain meaning so as not to reach outcome likely disfavored by enacting legislature).

has not so held, a federal court, faced with a due process challenge, might say something like this:

We do not hold that a state may never forbid physician-assisted suicide. But if a state is going to forbid a decision of this kind, it must demonstrate that it has focused with some particularity on the problem and concluded that its rationale is weighty enough to override the individual's decision. An old statute banning assistance in suicide, enacted long ago in a time of different values and facts, is not sufficient.

This may seem an exotic argument. But it has roots in the old notion of "desuetude," in accordance with which citizens may not be prosecuted under laws that were enacted long ago, are regularly violated in practice, may not connect with existing public convictions, and are enforced only on a sporadic and highly selective basis.¹⁵¹ The notion of desuetude does not have explicit support in the decisions of the Supreme Court. But it makes a good deal of constitutional sense. Notably, it is a form of procedural rather than substantive due process; the basic concerns are that there has been no focused legislative deliberation about the particular matter at hand and that rule of law principles are being violated in the enforcement process. A ruling of this kind is far less intrusive than one based on ordinary substantive due process principles, for it leaves open the possibility that a current legislature might resolve the matter as it chooses. And the principle does have antecedents. Many commentators have suggested that it provides a simpler and more compelling basis for *Griswold v. Connecticut*,¹⁵² and Justice White's opinion in *Griswold* can be understood to point to concerns of this sort.

Other judge-made doctrines have, without using the name, pointed to desuetude-related concerns. In some cases, for example, the Court will uphold a statute only on the basis of a rationale actually at work in the process leading to its enactment. A merely hypothetical purpose is not enough. This was a central part of the Court's reasoning in *United States v. Virginia*,¹⁵³ where the Court invalidated a same-sex program at the Virginia Military Institute on the ground that no legislature had in fact adopted single-sex education as a

151. See BICKEL, *supra* note 117, at 148–56.

152. 381 U.S. 479 (1965); see Guido Calabresi, *Foreword Antidiscrimination and Constitutional Accountability (What the Bork-Brennan Debate Ignores)*, 105 HARV L REV 80, 122 n 136 (1991)

153. 116 S. Ct. 2264, 2277–79 (1996) (striking down law in part on ground that there was no actual purpose of promoting educational diversity and equal opportunity), see also *Thompson v. Oklahoma*, 487 U.S. 815, 857–58 (1988) (O'Connor, J., concurring) (voting to strike down law imposing death penalty with no minimum age provision on grounds that statute did not reflect actual and recent legislative judgments in light of subsequent statute allowing minors to be dealt with as adults in some cases), *Califano v. Goldfarb*, 430 U.S. 199, 223 n.9 (1977) (Stevens, J., concurring) ("Perhaps an actual, considered legislative choice would be sufficient to allow this statute to be upheld, but that is a question I would reserve until such a choice has been made.").

way of promoting equality of opportunity and educational diversity.¹⁵⁴ The Court left open the possibility that a legislature that actually operated with this purpose might be proceeding constitutionally. We can even understand *Virginia* as a case of desuetude, for the Court treated the relevant statute as embodying an obsolete judgment, one that had not been reaffirmed by a recent legislature operating on the basis of constitutionally legitimate principles. In cases of this kind, the Court leaves open the possibility that a statute calling for same-sex schooling, enacted on the basis of a legitimate and sufficiently weighty rationale, will in fact be upheld.

The Court also construes ambiguous statutes so as to avoid raising serious constitutional doubts.¹⁵⁵ This idea has roots in the nondelegation doctrine; indeed, it can be seen as a narrow and more targeted version of the nondelegation doctrine, designed to say that the national legislature (rather than the bureaucracy) must focus specifically on the problem at hand. There is a close link with the doctrine of desuetude insofar as both doctrines are designed to ensure that the coercive power of law will be brought to bear on citizens only on the basis of a specific and focused legislative judgment to this effect.

The void-for-vagueness doctrine is rooted in the same basic concern.¹⁵⁶ When the Court strikes down a statute as unacceptably vague, it leaves open the possibility that a more specific version of the legislative judgment—regulating speech or conduct—may be valid. A void-for-vagueness holding leaves that question undecided; it demands a focused legislative determination. It is notable in this regard that *Roe* itself was originally conceived as a void-for-vagueness case,¹⁵⁷ a holding that would have been far more cautious and modest than the opinion that emerged.

In its intriguing decision in *Hampton v. Mow Sun Wong*,¹⁵⁸ the Court similarly held that if aliens are going to be deprived of all federal employment, it must be because of a judgment from Congress or the President, not the Civil Service Commission. The Court said that the Due Process Clause renders invalid a wholesale deprivation of employment unless a constitutionally specified official has decided that such a drastic step is desirable.¹⁵⁹ The

154. 116 S. Ct. at 2265.

155. *See, e.g.*, *NLRB v. Catholic Bishop*, 440 U.S. 490, 507 (1979) (holding NLRB without jurisdiction over teachers in church-operated schools under the National Labor Relations Act so as to avoid First Amendment difficulties); *Kent v. Dulles*, 357 U.S. 116, 129 (1958) (construing statute so as to avoid constitutional doubts).

156. *See, e.g.*, *Papachristou v. City of Jacksonville*, 405 U.S. 156, 162 (1972) (striking down vagrancy law for vagueness). A similar idea underlies the development of death penalty doctrine. In *Furman v. Georgia*, 408 U.S. 238 (1972), Justice White and Justice Stewart did not hold that death penalties were unconstitutional per se, but only that the death penalty had to be administered nonarbitrarily. *See id.* at 306–14 (White and Stewart, JJ., concurring). Once the public reaffirmed its commitment to capital punishment under more specific criteria after this form of “constitutional remand,” the Court retreated. *See Gregg v. Georgia*, 428 U.S. 153, 179–81 (1976).

157. *See* GARROW, *supra* note 130, at 547–49.

158. 426 U.S. 88 (1976).

159. *See id.* at 116.

problem with the relevant regulation was that it faced a "legitimacy deficit" because it had not been embraced by someone with adequate political accountability.¹⁶⁰

All of these cases have close connections with the notion of desuetude. They suggest that a less intrusive alternative to a substantive due process holding is a conclusion that the state must show sufficient grounds, in actual democratic judgments, for an intrusion on certain interests and rights.

2. *Problems*

As I have noted, an idea of this kind is not a version of substantive due process; it suggests instead that there is a procedural defect in the laws at hand. What would be wrong with an opinion of this sort? There is an obvious slippery slope problem. Many statutes now in operation were enacted long ago, when facts and values were different; are all such statutes unconstitutional? Surely they are not, and their longstanding character may well testify to their wisdom and good sense, not to their doubtful legitimacy. A constitutional doctrine would be absurd if it declared all old enactments void. The answer would have to be that the prohibition against desuetude applies not only when a law is very old, but also when (a) a liberty interest is at stake; (b) the rationale brought forward in the law's defense did not play any kind of role in the enacting legislature; (c) there is a demonstrated problem of sporadic and perhaps discriminatory enforcement; and (d) the relevant rationale, if supported by adequate facts and an actual legislative judgment, may well be sufficient to justify the intrusion on the liberty interest.

But there is another objection. An approach based on desuetude puts courts in the business of setting the legislative agenda. Any legislature has a great deal to do, and its failure to alter a law involving assisted suicide may well not signify indifference or neglect, but something like a considered judgment that the status quo is acceptable. In fact, this is a reasonable view about New York itself in *Quill v. Vacco*.¹⁶¹ And if the legislature has recently considered the problem and failed to do anything new, the doctrine of desuetude probably should not apply. But for cases that involve an unusually strong liberty interest and a justification that is post hoc and of questionable relevance to any actual legislative decision, a ruling founded on desuetude makes a great deal of sense as a less restrictive alternative to an equal protection or due process ruling. It should be seen as an effort to create a more deliberative democracy, one in which certain interests can be compromised only on the basis of a recent deliberative judgment, not as a kind of accident.

160. *See id.*

161. *See infra* text accompanying notes 163–64.

3. *Desuetude Misapplied?*

An idea of this kind provides the strongest support for *Griswold* itself, and, as we have seen, it is far from entirely foreign to constitutional law. But this rationale could not be used if the statute forbidding physician-assisted suicide were the product of recent and sustained legislative deliberation. Here we find the simplest response to the argument from desuetude: These are not at all cases in which states have been inattentive to the underlying issues of fact and policy. On the contrary, the issue of physician-assisted suicide has received a great deal of attention. In the state of Washington, the relevant law was enacted in 1992.¹⁶² In New York, there has been no recent legislative enactment forbidding physician-assisted suicide, but the issue has been receiving intense consideration at the highest levels of state government. Thus a new enactment specified the conditions for withdrawal of life-saving equipment as recently as 1990,¹⁶³ and in 1994, a highly visible Task Force issued a report recommending that things be left as they were.¹⁶⁴

Judge Calabresi may be suggesting that intense consideration is not enough and that a state must not only consider a statute that raises problems of desuetude but also reenact it.¹⁶⁵ The apparent thought is that inertia may reflect something other than approval, and that in any case, an intense minority may be able to block consideration, in the sense of an actual vote, without being able to block enactment once a vote occurs. In some ways this is an attractive view; it suggests a possible distinction between New York and Washington. But if there is good evidence that a state government has actively and intensely considered an issue, as New York has, it seems strained to say that the Due Process Clause requires actual reenactment. The question is whether it would really make sense to invalidate the New York ban while upholding the ban in Washington, when the distinction seems relatively thin in light of the large volume of public attention given to the issue in both states. Nor is this a case like *Griswold*, in which a politically intense minority was able to block legislative change that was generally desired.¹⁶⁶ With respect to physician-assisted suicide, politically intense minorities are on all sides of the question, and no particular group faces or creates a systematic barrier to well-functioning democratic deliberation.

I conclude, then, that the general idea of desuetude serves important constitutional values and has significant advantages over the substantive due

162. See *Compassion in Dying v. State of Washington*, 49 F.3d 586, 590 (9th Cir. 1995), *rev'd*, 79 F.3d 790 (9th Cir.), *cert. granted*, 117 S. Ct. 37 (1996).

163. See *Quill v. Vacco*, 80 F.3d 716, 728 (2d Cir.), *cert. granted*, 117 S. Ct. 36 (1996).

164. See *id.* at 734–35.

165. See *id.* at 735 (“inertia will not do”); accord BICKEL, *supra* note 117, at 148 (claiming that failure to repeal statute is not necessarily sufficient to rebut challenge on grounds of desuetude).

166. See POSNER, *supra* note 118, at 326–28 (defending *Griswold* and arguing that statute persisted only because of political power of Catholic Church).

process route; that we could imagine cases involving physician-assisted suicide that would provide a good arena for invoking that idea; but that the issue has been under intense discussion in many states and that Washington and New York have had intense recent deliberations. If the Court is to accept a version of Judge Calabresi's proposal—and I believe that it ultimately should—it should do so in a simpler and more compelling setting.

D. *Death and Abortion: A Note*

At several points I have compared the right to physician-assisted suicide with the right to have an abortion, and it will now be useful to bring together some strands of the comparison, since *Roe* looms so clearly in the background of the discussion of a constitutional right to die. A central distinction is that *Roe* is best understood as largely a case about sex equality. It was not simply a due process case, as the Court has come to recognize; it depended centrally on the fact that restrictions on the right to abort are a form of discrimination against women and closely associated with traditional and no longer legitimate ideas about women's appropriate role.¹⁶⁷ The right to die does not have this equal protection element.¹⁶⁸

Along the dimension of justification, there is also a difference between *Roe* and the right to physician-assisted suicide. The principal justification in *Roe* rested on the perceived importance of protecting the fetus. It is possible to think that fetuses are not people and that a commitment to the overriding importance of their survival depends on sectarian claims. Without defending this controversial view, we can see that a claim of this general sort underlies *Roe* itself. By contrast, the state's justifications for interfering with the right to physician-assisted suicide are unquestionably legitimate and largely empirical in nature. To the extent that the state is saying that it fears risks of abuse, it is able to offer a quasi-predictive defense of the sort that was unavailable in *Roe*.

It also follows from what I have said thus far that the Court should be very cautious about duplicating the experience of *Roe* and that it is by no means clear that the broad holding of *Roe* was right at the time. At the very least, it is by no means clear that the Court was correct to have created so broad a right in its first confrontation with the abortion issue. The Court would have done much better to have proceeded narrowly and incrementally, and to

167. For a recent discussion, see *United States v. Virginia*, 116 S. Ct. 2264, 2274–76 (1996), in which the Court invalidated same-sex education at Virginia Military Institute. AVISHAI MARGALIT, *THE DECENT SOCIETY* (1996), is, in my view, a relevant discussion of the phenomenon of “humiliation” via state channels.

168. See *supra* Section IV.B.

have engaged in a form of dialogue with the political process.¹⁶⁹ It would have done much better because it would not have caused so much destructive and unnecessary social upheaval, because it probably would have produced a range of creative compromises well-adapted to a federal system, and because a more cautious approach would not deeply have compromised the underlying right, as that right is best conceived. The *Roe* experience is not one that the Court should duplicate, at least when the Court's underlying judgment is subject to reasonable dispute and when there is no particular reason to distrust political processes.

V. CONCLUSION

In this Essay I have made three claims. First, I have suggested that courts should be reluctant to invalidate legislation under the Due Process Clause in its "substantive" dimension when there is no defect in the system of democratic deliberation and when reasonable people might decide the underlying questions of value and fact either way. I have also suggested that this idea plays a large and underappreciated role in existing law. The key privacy cases, though decided as a matter of substantive due process, had important dimensions of desuetude and equal protection. The equal protection "fundamental rights" cases had large dimensions of democracy-reinforcement, involving as they did political rights or groups at particular risk in democratic processes.

Second, I have argued that when conditions are, or appear to be, medically hopeless, the individual's interest in physician-assisted suicide should probably qualify as one on which the state may intrude only with special justification. But—and this is the third claim—I have also suggested that this principle should not be understood to invalidate state efforts to prevent people from taking their own lives on their own or with the assistance of others. It is not easy to decide how states should handle the forms of distress that produce requests for physician-assisted suicide; much of that distress might be alleviated by helping patients and families come to terms with the fact of death. Physician-assisted suicide creates palpable risks of abuse, and the weight to be given to these risks depends on hard predictive judgments and complex assessments of how to handle factual uncertainty. A reasonable legislature, even giving great weight to the interests of patients, might decide that those risks are sufficient to justify a prohibition. A state could decide, with reason, that a ban on physician-assisted suicide actually promotes the autonomy of many or most people and in the process has salutary effects on the norms and practices of the medical profession. Probably the simplest

169. See Ginsburg, *supra* note 113, at 381–86 (urging narrower holding in *Roe*); see also Sunstein, *supra* note 72, at 49–50 (criticizing *Roe* for its "maximalism").

opinion would assume for purposes of argument that the right to physician-assisted suicide qualifies as a “fundamental right” while finding that the state has sufficient reason to override that right.

It is hard to be comfortable with this conclusion. In actual cases, fully competent people, joined by their loved ones, are seeking to terminate their lives amidst hopeless conditions and an inevitable period of helplessness, despair, and perhaps intense emotional or physical pain. Those of us who are healthy are likely to have known people in such situations; those of use who are healthy may eventually find ourselves in such situations. In cases of this kind, an insistence on the abstract “right to life” can seem an egregious and unnecessary cruelty, and the notion of “death with dignity” acquires immense force. Lawyers and citizens should be aware that a judgment that people have no constitutional right to commit some act does not mean that they do not deserve, in the deepest moral sense, that very right. Undoubtedly doctors should consult closely with patients, friends, and family members, and on occasion, all will conclude that physician-assisted suicide is a merciful and fully legitimate act. Sometimes they will reach this conclusion whatever the technical content of state law, and in such cases prosecutors should tread very cautiously indeed. And here we arrive at the heart of the matter. The argument I have offered is institutional rather than substantive: It is not the Supreme Court but these other arenas—state legislatures, prosecutors’ offices, hospitals, and private homes—that should decide whether, when, and how to legitimate a “right to die.”

