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David R. Schanker

Indiana University School of Law

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Of Suicide Machines, Euthanasia Legislation, and the Health Care Crisis

DAVID R. SCHANKER*

Helping another person to die is presently against the law. You may think this is a stupid, unreasonable ban but we live in a society under the rule of law so we have to be careful about what we do.¹

The moment had come. With a nod from Janet I turned on the ECG and said, "Now." Janet hit the Mercitron's switch with the outer edge of her palm. In about ten seconds her eyelids began to flicker and droop. She looked up at me and said, "Thank you, thank you." I replied at once as her eyelids closed, "Have a nice trip."²

INTRODUCTION

On June 4, 1990, a bizarre event in a trailer park in a suburb of Detroit, Michigan, brought national attention to the issue of euthanasia. In the back of a rusted Volkswagen van, retired pathologist Dr. Jack Kevorkian assisted Janet Adkins to take her own life using a "suicide machine" he had invented.³ Adkins, a victim of Alzheimer's disease, had only to touch a hair-trigger switch to begin the intravenous self-administration of a coma-inducing drug, followed by a lethal dose of potassium chloride.⁴ While much of the medical community condemned Kevorkian, public opinion supported Adkins's right to control her own fate,⁵ and the incident helped move euthanasia from a fringe belief to a mainstream concern.⁶ Since Adkins's death, a series of events has kept the issue before the public,⁷ and if euthanasia advocates have their way,

* J.D. Candidate, 1993, Indiana University School of Law-Bloomington; M.F.A., Columbia University, 1987; B.F.A., New York University, 1979. I wish to thank Professor Roger Dworkin for his guidance and comments on drafts of this Note.

1. DEREK HUMPHRY, *FINAL EXIT 29* (1991).

2. JACK KEVORKIAN, *PRESCRIPTION: MEDICIDE 230* (1991).

3. Lisa Belkin, *Doctor Tells of First Death Using His Suicide Device*, N.Y. TIMES, June 6, 1990, at A1.

4. *Id.* at B6.

5. Tamar Lewin, *Doctor Cleared of Murdering Woman with Suicide Machine*, N.Y. TIMES, Dec. 14, 1990, at B8.

6. Timothy Egan, *Washington Voters Weigh If There Is a Right to Die*, N.Y. TIMES, Oct. 14, 1991, at A1.

7. In July, 1991, a grand jury in Rochester, New York, refused to indict a physician who admitted helping a leukemia patient commit suicide. Lawrence K. Altman, *Jury Declines to Indict a Doctor Who Said He Aided in a Suicide*, N.Y. TIMES, July 27, 1991, at A1; see *infra* notes 77-83 and accompanying text. In August, 1991, *Final Exit*, a do-it-yourself suicide manual by Hemlock Society founder Derek Humphry reached *The New York Times* bestseller list, where it stayed for 18 weeks. *Best Sellers*, N.Y.

voluntary euthanasia will be legalized, irrevocably altering the way death occurs in our society and the fundamental relationship of human beings to death and dying.

Euthanasia proponents contend that allowing a patient to request medical assistance in dying is "the ultimate extension of patients' rights."⁸ Opponents maintain that medicine should remain a profession dedicated to healing—"[i]ts tools should not be used to kill people."⁹ Legal euthanasia represents a momentous departure from medical tradition, and it presents a host of problematic legal, moral, ethical, and medical issues.

The rapid advance of biotechnology over the past three decades has revolutionized the process of dying, and many terminally ill patients and their families have found themselves helplessly confronted with a death agonizingly

TIMES, Jan. 26, 1992, § 7 (Book Review) at 22. In September, 1991, the Dutch government released the first comprehensive study of the practice of euthanasia in the Netherlands. Marlise Simons, *Dutch Survey Casts New Light on Patients Who Choose to Die*, N.Y. TIMES, Sept. 11, 1991, at C12. In October, 1991, Kevorkian assisted the suicides of Sherry Miller, 43, a victim of multiple sclerosis, and Marjorie Wantz, 58, who had papilloma virus; neither woman was terminally ill. *Suicide Victims Were Adamant, Lawyers Clam*, L.A. TIMES, Oct. 28, 1991, at A17. In November, 1991, an "Initiative for Death With Dignity" went before the voters in Washington State, who rejected the opportunity to make Washington the first state in the union to allow doctors actively to end the life of a terminally ill patient upon request. Egan, *supra* note 6. Designated "Initiative 119," the measure was put on the ballot after 233,000 signatures were gathered by a coalition of pro-euthanasia groups. *Id.* On May 15, 1992, Kevorkian assisted the suicide of Susan Williams, 52, a multiple sclerosis victim. Al Koski, *Dr. Death Strikes Again*, UPI, May 15, 1992, available in LEXIS, Nexis Library, Wire Service File. On July 21, 1992, Kevorkian was acquitted of the October 1991 suicides. Al Koski, *Judge Frees 'Dr. Death' of Murder Charges*, UPI, July 21, 1992, available in LEXIS, Nexis Library, Wire Service File [hereinafter Koski, *Acquittal*]. On September 26, 1992, Kevorkian assisted the suicide of Lois Hawes, 52, a cancer victim. Robert Ourlian & Elizabeth Atkins, *Supporters of 'Dr. Death' See New Era in Assisted Suicides*, Gannett News Service, Sept. 28, 1992, available in LEXIS, Nexis Library, News Service File. On October 6, 1992, the Michigan House of Representatives Subcommittee on Death and Dying approved a bill to allow physician-assisted suicide. Joyce Price, *Michigan Committee Approves Assisted-Suicide Bill*, WASH. TIMES, Oct. 8, 1992, at A5. On November 3, 1992, California voters rejected Proposition 161, a measure to legalize voluntary active euthanasia in that state. George de Lama, *States Take Pulse on Morality*, CHI. TRIB., Nov. 5, 1992, § 1, at 7. On November 23, 1992, Kevorkian assisted the suicide of Catherine Andreyev, 46, a breast cancer victim. Al Koski, *Kevorkian Helps Sixth Woman Commit Suicide*, UPI, Nov. 23, 1992, available in LEXIS, Nexis Library, Wire Service File. On December 15, 1992, Kevorkian assisted the suicides of Marguerite Tate, a 70-year-old victim of heart disease, emphysema, and arthritis, and Marcella Lawrence, a 67-year-old victim of amyotrophic lateral sclerosis, just hours before Michigan Governor John Engler signed legislation banning assisted suicide for two years beginning March 30, 1993, while a commission studies the issue. *Two More Suicides Before Governor OKs Ban*, CHI. TRIB., Dec. 16, 1992, § 1, at 6; see *infra* notes 72-73 and accompanying text. In the weeks before the ban was to take effect, Kevorkian stepped up his pace, assisting the suicides of four men and three women, ages ranging from 41 to 82. Tom Morganthau, *Dr. Kevorkian's Death Wish*, NEWSWEEK, Mar. 8, 1993, at 46. In response, the Michigan legislature moved the ban's effective date up to February 25, 1993. *Id.*

8. Egan, *supra* note 6 (quoting Dr. Linda Gromko, a Seattle family physician and euthanasia advocate).

9. *Id.* (quoting the American Medical Society's ethics committee).

protracted through the intervention of life-sustaining medical devices. From the New Jersey Supreme Court's *Quinlan*¹⁰ decision in 1976 through the United States Supreme Court decision in *Cruzan*¹¹ in 1990, the judicial system has struggled to define the limits of patient autonomy.¹² Most states now recognize that patients have the right to refuse medical treatment, including artificially supplied nutrition and hydration, either themselves, if competent, or through the use of advance directives.¹³ Opinion polls indicate

10. *In re Quinlan*, 355 A.2d 647 (N.J.), cert. denied, 429 U.S. 922 (1976).

11. *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261 (1990).

12. Courts have defined the limits of patient autonomy by balancing self-determination interests against state interests in the preservation of life. In *In re Quinlan*, the New Jersey Supreme Court held that the federal constitutional right to privacy encompassed "a patient's decision to decline medical treatment under certain circumstances." *In re Quinlan*, 355 A.2d at 663. In *Superintendent of Belchertown State School v. Saikewicz*, 370 N.E.2d 417 (Mass. 1977), the Supreme Judicial Court of Massachusetts held that incompetent persons retain the same rights as competent persons "because the value of human dignity extends to both," and balanced those rights against countervailing state interests. *Id.* at 427. In the first federal case to confront these issues, *Gray v. Romeo*, 697 F. Supp. 580 (D.R.I. 1988), the court distinguished suicide from self-determination, finding that suicide is "deliberately ending a life by artificial means," while self-determination is "allowing nature to take its course." *Id.* at 589 (citations omitted). In its 1990 *Cruzan* decision, the United States Supreme Court assumed, for purposes of its decision, that "the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition." *Cruzan*, 497 U.S. at 279.

Of the several cases dealing with the right of competent patients to refuse life-saving treatment, most early cases involved Jehovah's Witnesses' refusal of blood transfusions. See Martha A. Matthews, Comment, *Suicidal Competence and the Patient's Right to Refuse Lifesaving Treatment*, 75 CAL. L. REV. 707, 716-18 (1987). Since 1973, however, competent patients have been permitted to refuse a breast biopsy, *In re Yetter*, 41 Northampton County Rptr. 67, 62 Pa. D. & C.2d 619 (1973), refuse amputation of a gangrenous limb, *In re Quackenbush*, 383 A.2d 785 (Morris County Ct., N.J. 1978); *Lane v. Candura*, 376 N.E.2d 1232 (Mass. Ct. App. 1978), refuse dialysis, *In re Lydia E. Hall Hospital*, 455 N.Y.S.2d 706 (Sup. Ct. 1982), and demand the removal of a respirator, *Satz v. Perlmutter*, 362 So.2d 160 (Fla. Dist. Ct. App. 1978). Two California cases, *Bartling v. Superior Court (Glendale Adventist Medical Center)*, 209 Cal. Rptr. 220 (Cal. Ct. App. 1984), and *Bouvia v. Superior Court (Glenchar)*, 225 Cal. Rptr. 297 (Cal. Ct. App. 1986), allowed the refusal of treatment by individuals who were not considered terminally ill. In *Bartling*, the court held that competent patients have the right to decide whether to submit to medical treatment, balancing that right against the state interests enunciated in *Saikewicz*. *Bartling*, 209 Cal. Rptr. at 224. The *Bouvia* court, in deciding to allow a 28-year-old quadriplegic woman with cerebral palsy and degenerative arthritis to compel the removal of a nasogastric feeding tube, denied a state interest in preserving the life of an individual in *Bouvia's* condition:

We do not believe it is the policy of this State that all and every life must be preserved against the will of the sufferer. It is incongruous, if not monstrous, for medical practitioners to assert their right to preserve a life that someone else must live, or, more accurately, endure for "15 to 20 years."

Bouvia, 225 Cal. Rptr. at 305.

13. An advance directive is a document that allows an individual to specify the kind of care he or she wishes to receive (or not to receive) in the event of incompetency. Advance directives generally take two forms: living wills and durable powers of attorney. Living wills permit patients to request that medical interventions that would prolong the dying process not be administered. PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIOR RESEARCH, *DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT* 139 (1983). Durable power of attorney

widespread support for extending patient autonomy to permit voluntary euthanasia,¹⁴ and while physicians' associations, including the American Medical Association, oppose euthanasia, many doctors support the administration of euthanasia in exceptional circumstances.¹⁵ In the Netherlands, despite its statutory illegality, euthanasia was practiced routinely under judicial guidelines for nearly twenty years, until the Dutch Parliament codified a set of guidelines in February 1993, virtually immunizing physicians from prosecution.¹⁶ Many American physicians believe that active euthanasia is already performed on a regular basis in hospitals throughout the United States.¹⁷

The spread of AIDS, the suffering of patients with advanced cancer, and the desire of many Americans to wrest control of their medical destinies from the health care establishment may be important factors in public support for legal euthanasia. Moreover, euthanasia is emerging as a significant public policy issue at a time when health care policy making is in turmoil. Issues of resource allocation, the care of the medically indigent, and the care of the terminally ill are facets of a health care crisis of dire proportions. The recent surge of interest in euthanasia may also be symptomatic of many Americans' lack of faith in our ability to solve the seemingly intractable dilemmas in our health care system.

This Note examines the question of whether the law should accommodate a mechanism by which physicians may actively end the life of a terminally ill

statutes permit individuals to appoint a surrogate to make health care decisions should the individual become incompetent. *Id.* at 145. The Patient Self-Determination Act, which went into effect on December 1, 1991, was intended to bring about greater awareness of advance directives. Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508 (1990), §§ 4206(a), 4751(a) (Patient Self-Determination Act). Hospitals and nursing homes participating in Medicare or Medicaid are now required to inform all adult patients of their rights under state law to make decisions concerning their care, including the right to accept or refuse treatment. *Id.*

14. An April, 1990, Roper poll asked: "When a person has a painful and distressing terminal disease, do you think doctors should or should not be allowed by law to end the patient's life if there is no hope of recovery and the patient requests it?" The results: Yes, 64%; No, 24%; Don't know, 13%. Don C. Shaw, *Reflection, in ACTIVE EUTHANASIA, RELIGION, AND THE PUBLIC DEBATE 98* (Ron Hamel ed., 1991) [hereinafter ACTIVE EUTHANASIA]. Polls taken in Washington State during the campaign for Initiative 119 and in California during the campaign for Proposition 161 showed wide margins of support for the measures until the last days before voting took place. Peter Steinfeld, *Beliefs*, N.Y. TIMES, Nov. 9, 1991, at 11; *California: Proposition 166 on the Defensive*, HEALTH LINE, Oct. 13, 1992. The last-minute change of heart in both states may be attributed to the effective and ubiquitous anti-euthanasia advertising campaigns by a coalition of Catholic and pro-life groups and medical associations. de Lama, *supra* note 7; Egan, *supra* note 6.

15. Robert Moss, *Reflection, in ACTIVE EUTHANASIA, supra* note 14, at 95-97.

16. William Drozdiak, *Dutch Remove Barrier to Doctors Carrying Out Euthanasia*, WASH. POST, Feb. 10, 1993, at A23. See *infra* notes 84-124 and accompanying text.

17. Richard A. Knox, *Dutch Study Reports Euthanasia Practiced Widely but Cautiously*, BOSTON GLOBE, Sept. 13, 1991, at 1; see also *infra* note 39 and accompanying text.

patient through voluntary euthanasia. Much of the recent dialogue concerning euthanasia has centered on whether euthanasia is ever morally justifiable.¹⁸ In this Note, I set aside the moral and ethical dimensions of the debate and deal primarily with the likely consequences attending the various schemes for legal voluntary euthanasia in our society and present health care system.

Part I of this Note surveys current arguments for and against the legalization of euthanasia. Part II examines the way courts in the United States and the Netherlands have dealt with voluntary euthanasia and analyzes proposals for statutory reform. Part III presents an argument that the law should not accommodate voluntary euthanasia until systemic problems in our health care institutions are resolved and our management of death and dying is reformed.

I. BACKGROUND: THE EUTHANASIA DEBATE

To the ancient Greeks, the term *eu thanatos* meant "good or easy death," in the sense of dying peacefully and with a psychologically balanced state of mind.¹⁹ Today, euthanasia is commonly understood to refer to the intentional medical inducement of death.

Arguments in favor of legal euthanasia stress autonomy and mercy as values served by voluntary euthanasia. The autonomy argument holds that a patient's power to request that a physician end his life is the ultimate extension of self-determination, based on the established right of privacy and right to refuse treatment.²⁰ The mercy argument holds that if a terminal patient prefers

18. For a detailed analysis of the moral aspects of euthanasia from a pro-euthanasia point of view, see JAMES RACHELS, *THE END OF LIFE* (1986). The opposing moral arguments are well expressed in Arthur J. Dyck, *An Alternative to the Ethic of Euthanasia*, in *ETHICAL ISSUES IN DEATH AND DYING* 281 (Robert F. Weir ed., 1977).

19. Edwin R. DuBose, *A Brief Historical Perspective*, in *ACTIVE EUTHANASIA*, *supra* note 14, at 18.

20. See *supra* note 12. See generally Steven J. Wolhandler, Note, *Voluntary Active Euthanasia for the Terminally Ill and the Constitutional Right to Privacy*, 69 *CORNELL L. REV.* 363 (1984); Note, *Physician-Assisted Suicide and the Right to Die with Assistance*, 105 *HARV. L. REV.* 2021 (1992). The concept of patient autonomy, when framed in terms of rights, is ultimately unhelpful in formulating euthanasia policy. Even fundamental libertarianism derived from John Stuart Mill and the contractual libertarian theory of Hobbes and Locke recognize that government may interfere in the sphere of private action when societal interests are implicated. See generally John S. Mill, *On Liberty*, in *PREFACES TO LIBERTY: SELECTED WRITINGS OF JOHN STUART MILL* 239 (Bernard Wishy ed., 1959) (1859); THOMAS HOBBES, *LEVIATHAN* (Cambridge Univ. Press 1991) (1651); JOHN LOCKE, *TWO TREATISES OF CIVIL GOVERNMENT* (Peter Laslett ed., student ed. 1988) (1698). Suicide, assisted suicide, and voluntary euthanasia are activities which may be described on a continuum of autonomy: suicide is a solitary, self-referential act; assisted suicide requires advice or assistance with the act; voluntary euthanasia needs the completion of the act by another. Suicide is more likely than are assisted suicide and voluntary euthanasia to satisfy libertarian criteria for a liberty which deserves no interference, but, as Mill asserts, "No person is an entirely isolated being; it is impossible for a person to do anything seriously or

death to lingering on in torment, it is not immoral to help the patient die sooner.²¹ At the same time, the values of autonomy and mercy can each be extrapolated to situations which do not involve the other. Autonomy may be extended to allow euthanasia where the patient is not in pain but wishes to die for other reasons: a deterioration in quality of life, the loss of dignity, or the wish not to burden his family financially with a prolonged hospital or nursing home stay. The value of mercy may be extended to allow euthanasia for patients who are incompetent to make informed decisions regarding their care—such as Alzheimer's patients, the senile, children, or the retarded—yet who suffer intense and intractable pain. Proposed euthanasia legislation is generally intended to permit the narrow range of cases embodying both the expression of autonomy and the merciful alleviation of suffering.²²

Arguments against legalization of euthanasia comprise three major themes: the sanctity of human life, the slippery slope, and the danger of abuse.²³ The sanctity of life argument emphasizes the inviolability of our cultural prohibition against killing.²⁴ Slippery slope arguments envision the legalization of voluntary euthanasia as inexorably leading to forms of involuntary euthanasia and an attendant devaluation of human life.²⁵ Danger of abuse arguments envision the coercion of patients by their families, doctors, or health care workers to request euthanasia, and the disregard of euthanasia guidelines by physicians and institutions.²⁶ The arguments presented in Part III of this Note fall roughly into this last category, examining the potential effects of allowing the practice of euthanasia in our health care system.

permanently hurtful to himself without mischief reaching at least to his near connections, and often far beyond them." Mill, *supra*, at 326.

21. RACHELS, *supra* note 18, at 154. Rachels develops the mercy argument using utilitarian principles: "Any action is morally right if it serves to increase the amount of happiness in the world or to decrease the amount of misery." *Id.*

22. See *infra* notes 125-73 and accompanying text.

23. See Tom L. Beauchamp & Seymour Perlin, *Euthanasia and Natural Death*, in ETHICAL ISSUES IN DEATH AND DYING 217-18 (Tom L. Beauchamp & Seymour Perlin eds., 1978) [hereinafter ETHICAL ISSUES].

24. See C. Everett Koop, *The Challenge of Definition*, 19 HASTINGS CENTER REP. (Special Supp.), Jan.-Feb. 1989, at 2.

25. Yale Kamisar and Glanville Williams debated "slippery slope" and "wedge" (Williams's term) arguments on euthanasia in an exchange of articles in the late 1950s. Kamisar wrote an article, Yale Kamisar, *Some Non-Religious Views Against "Mercy Killing" Legislation*, 42 MINN. L. REV. 969 (1958) [hereinafter Kamisar, *Non-Religious Views*], in response to Williams's book *The Sanctity of Life and the Criminal Law*. GLANVILLE WILLIAMS, *THE SANCTITY OF LIFE AND THE CRIMINAL LAW* (1957). Williams replied with an article of his own. Glanville Williams, *"Mercy Killing" Legislation—A Rejoinder to the Non-Religious Objections*, 43 MINN. L. REV. 134 (1959). In 1991, Kamisar revisited the debate. Yale Kamisar, *When Is There a Constitutional "Right to Die"? When Is There No Constitutional "Right to Live"?*, 25 GA. L. REV. 1203 (1991) [hereinafter Kamisar, *Right to Die?*].

26. Beauchamp & Perlin, *supra* note 23, at 218.

At the core of the euthanasia debate, however, is the distinction between active and passive euthanasia, that is, between "killing" and "letting die."²⁷ Active euthanasia is the administration of any means intended to produce death, such as the deliberate injection of a lethal dose of morphine. Passive euthanasia is the withdrawal of life-sustaining care, such as artificially supplied nutrition and hydration or a respirator.

Passive euthanasia has been legally sanctioned since *In re Quinlan*,²⁸ in which the New Jersey Supreme Court permitted a respirator to be removed in order to allow an incompetent patient to die. No statutory change was necessary to immunize physicians from legal responsibility for withdrawal of treatment.²⁹ Legalizing active euthanasia, on the other hand, is likely to necessitate a statutory change because the act of killing a patient, regardless of the circumstances, is currently considered murder.³⁰ Even if a physician were merely to supply a patient with lethal drugs for the patient's self-administration, as Dr. Kevorkian did, the physician would, in most states, be violating laws against assisted suicide.³¹

27. Six identifiable major forms of euthanasia were delineated from a medical perspective by Dr. George Lundberg, editor of the *Journal of the American Medical Association*: (1) *passive*, where a physician may choose not to treat a life-threatening condition in a noncomatose patient; (2) *semipassive*, where a physician may withhold medical treatment, such as nutrition or fluids, from a person in a coma; (3) *semiactive*, where a physician may disconnect a ventilator from a patient who is in a stable, vegetative state and has no hope of regaining consciousness; (4) *accidental* ("double effect"), where a physician may administer a narcotic to relieve pain and the narcotic may incidentally depress respiration sufficiently to cause death; (5) *suicidal*, where a physician may provide a patient with lethal drugs which the patient may choose to take; and (6) *active*, where a physician may administer a lethal overdose of morphine or potassium in a patient with, for example, advanced AIDS. George D. Lundberg, *'It's Over, Debbie' and the Euthanasia Debate*, 259 JAMA 2142, 2143 (1988).

28. 355 A.2d 647 (N.J.), *cert. denied*, 429 U.S. 922 (1976).

29. In 1983, two California doctors were convicted of murder and conspiracy to commit murder for removing a respirator and withdrawing artificially supplied nutrition and hydration from a comatose patient at the family's request. *Barber v. Superior Court*, 195 Cal. Rptr. 484, 486-87 (Cal. Ct. App. 1983). On appeal, the court ruled for the first time that nutrition and hydration constituted a medical procedure, and stated that physicians are under no duty to continue treatment when there is no hope of recovery. *Id.* at 493.

30. See *infra* notes 41-43 and accompanying text. It is possible, however, that if a constitutional "right to die" is established for patients, homicide statutes could not be constitutionally applied to physicians who kill patients in furtherance of that right. A case has yet to be reported in which a physician uses a constitutional argument as a defense to homicide (or assisting a suicide) in voluntary euthanasia.

31. Currently, 31 states and Puerto Rico have statutes criminalizing assisted suicide: Alaska, ALASKA STAT. § 11.41.120(a)(2) (1989); Arizona, ARIZ. REV. STAT. ANN. § 13-1103(A)(3) (1989); Arkansas, ARK. CODE ANN. § 5-10-104(a)(2) (Michie 1987); California, CAL. PENAL CODE § 401 (West 1988); Colorado, COLO. REV. STAT. § 18-3-104(1)(b) (1978); Connecticut, CONN. GEN. STAT. ANN. § 53a-56(a)(2) (West 1985); Delaware, DEL. CODE ANN. tit. 11, § 645 (1987); Florida, FLA. STAT. ANN. § 782.08 (West 1992); Hawaii, HAWAII REV. STAT. § 707-702(1)(b) (1985); Illinois, ILL. ANN. STAT. ch. 38, para. 12-31 (Smith-Hurd 1992); Indiana, IND. CODE ANN. § 35-42-1-2 (Burns 1985); Kansas, KAN. STAT. ANN. § 21-3406 (1988); Maine, ME. REV. STAT. ANN. tit. 17-A, §§ 201, 204 (1983);

Euthanasia proponents assert that the distinction between active and passive euthanasia is arbitrary and morally irrelevant.³² Opponents uphold the active/passive distinction as the most appropriate place to draw the line on how far society can safely go in allowing any form of euthanasia.³³ Efforts to legalize active voluntary euthanasia have relied on the premise that the active/passive distinction is irrelevant—in other words, since the lethal injection or the withdrawal of treatment both result in the patient's death, the lethal injection should also be allowed.³⁴ The active/passive distinction is closely related to the categorical differences of acts of commission and omission, of withholding and withdrawing treatment, and of the direct and indirect causation of death.³⁵ Perhaps the strongest argument for its maintenance is that it preserves the historical role of physicians as healers and comforters, not as agents of death.³⁶ The fact remains that the active/passive distinction is the prevailing legal boundary which physicians must observe with respect to their patients' right to die.

II. EUTHANASIA AND THE LAW

Euthanasia has been addressed in courts and legislatures in the United States sporadically during the twentieth century. Its treatment suggests public

Michigan, Act of Dec. 15, 1992, 1992 Mich. Pub. Acts 270 (creating Michigan commission on death and dying and prohibiting certain acts pertaining to suicide assistance); Minnesota, MINN. STAT. ANN. § 609.215 (West 1987); Mississippi, MISS. CODE ANN. § 97-3-49 (1973); Missouri, MO. REV. STAT. § 565.023 (1992); Montana, MONT. CODE ANN. § 45-5-105 (1991); Nebraska, NEB. REV. STAT. § 28-307 (1989); New Hampshire, N.H. REV. STAT. ANN. § 630:4 (1986); New Jersey, N.J. STAT. ANN. § 2C:11-6 (West 1982); New Mexico, N.M. STAT. ANN. § 30-2-4 (Michie 1984); New York, N.Y. PENAL LAW § 120.30 (McKinney 1987); North Dakota, N.D. CENT. CODE § 12.1-16-04 (1991); Oklahoma, OKLA. STAT. ANN. tit. 21, §§ 813-818 (West 1983); Oregon, OR. REV. STAT. § 163.125(1)(b) (1990); Pennsylvania, 18 PA. CONS. STAT. ANN. § 2505 (1983); Puerto Rico, P.R. LAWS ANN. tit. 33, § 4009 (1984); South Dakota, S.D. CODIFIED LAWS ANN. § 22-16-37 (1988); Texas, TEX. PENAL CODE ANN. § 22.08 (West 1989); Washington, WASH. REV. CODE ANN. § 9A.36.060 (West 1988); and Wisconsin, WIS. STAT. ANN. § 940.12 (West 1982).

32. RACHELS, *supra* note 18, at 108. James Rachels, Glanville Williams, and Joseph Fletcher, among others, have argued against the active/passive distinction. *See id.*, WILLIAMS, *supra* note 25; JOSEPH FLETCHER, *MORALS AND MEDICINE* (1954).

33. TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 146-47 (3d ed. 1989). Yale Kamisar, Tom Beauchamp, and Daniel Maguire have argued in favor of maintaining the distinction. *See generally* DANIEL MAGUIRE, *DEATH BY CHOICE* 97-103 (1987); Tom L. Beauchamp, *A Reply to Rachels on Active and Passive Euthanasia*, in *ETHICAL ISSUES*, *supra* note 23, at 246; Kamisar, *Non-Religious Views*, *supra* note 25; Kamisar, *Right to Die?*, *supra* note 25.

34. James Rachels, *Active and Passive Euthanasia*, in *ETHICAL ISSUES*, *supra* note 23, at 245.

35. BEAUCHAMP & CHILDRESS, *supra* note 33, at 134-47.

36. Daniel Callahan, *Can We Return Death to Disease?*, 19 HASTINGS CENTER REP. (Special Supp.), Jan.-Feb. 1989, at 4, 6.

sympathy for the principle of euthanasia and judicial and legislative reluctance to grant euthanasia the protection of the law. In court cases of mercy killings or assisted suicides by physicians, courts have generally either acquitted or failed to indict the physician,³⁷ but no precedent has been set explicitly granting judicial approbation to either euthanasia or assisted suicide.

In the Netherlands, euthanasia has held a unique quasi-legal status for nearly two decades. Despite its statutory illegality, courts have, in a series of mercy killing acquittals, promulgated guidelines for physicians in the practice of euthanasia. The result has been its *de facto* legalization.

Section A of this Part surveys euthanasia in the courts, beginning with instances of physicians charged with mercy killing in the United States. This section then examines the development of guidelines governing the practice of euthanasia in the Netherlands and discusses arguments against adoption of an analogous system in the United States. Section B of Part II analyzes several statutory proposals for the legalization of euthanasia that have been made in the United States and Great Britain since 1906.

A. Judicial Responses to Euthanasia

1. The United States

Active euthanasia is illegal in the United States. Physicians who cause the death of a patient or assist in a patient's suicide may be prosecuted under homicide statutes, which exist in every state, or laws prohibiting assistance to suicide, which currently exist in thirty-one states.³⁸ Despite the reputed practice of active euthanasia by physicians,³⁹ few indictments have been returned, and very few cases have been brought to trial. The greatest number of mercy killing cases have involved the killing of a spouse, parent, or child

37. Two exceptions are Dr. Joseph Hassman of New Jersey and Dr. Donald Caraccio of Michigan. See *infra* note 41.

38. See *supra* note 31.

39. Some commentators believe the frequency of euthanasia in the U.S. to be fairly close to that of the Netherlands (about three percent of all deaths), though the practice is much more covert here. Knox, *supra* note 17. Dr. Jan van Eys of the University of Texas Medical Center, a Dutch native who has served on U.S. panels debating euthanasia, said, "I wouldn't be surprised if the U.S. had that incidence already." *Id.*

by a nonphysician,⁴⁰ and, until recently, most have occurred without the consent of the victim.⁴¹

The first widely publicized mercy killing case involving a physician took place in New Hampshire in 1949. Dr. Herman Sander, a general practitioner, injected air into the vein of a comatose cancer patient who was on the verge of death. Dr. Sander dictated a description of his actions into the hospital record, and was arrested two weeks later when the hospital's records librarian reported the incident to her superiors. After an outpouring of support from the general public (and condemnation from religious groups),⁴² a jury trial was held and Dr. Sander was acquitted.⁴³

In 1973, Dr. Vincent Montemarano, chief surgical resident at the Nassau County Medical Center in New York, was indicted for murder after giving a fifty-seven-year-old throat cancer victim a fatal injection of potassium chloride.⁴⁴ The victim, who had only days to live, died within five minutes of the injection. After deliberating for fifty-five minutes, the jury returned a not guilty verdict.⁴⁵

40. In 1938, a Nassau County, New York, grand jury refused to indict Harry C. Johnson, who had asphyxiated his cancer-stricken wife. Kamisar, *Non-Religious Views*, *supra* note 25, at 971 n.11. In 1950, Carol Ann Paight was acquitted on grounds of temporary insanity in the shooting death of her father, who had just been diagnosed with cancer. *Id.* at 1020 & n.173. In 1939, Louis Greenfield was acquitted in New York of chloroforming his son, an "incurable imbecile," to death. *Id.* at 1021 n.180. The Greenfield case inspired Louis Repouille, a resident alien, to administer chloroform to his own imbecilic son, who was blind and bedridden since infancy. Repouille was found guilty of manslaughter and freed on a suspended sentence, but years later was denied naturalization because he had not exhibited "good moral character." The Second Circuit Court of Appeals, in a now famous opinion by Judge Learned Hand, held that "only a minority of virtuous persons would deem the practice morally justifiable, while it remains in private hands, even when the provocation is as overwhelming as it was in this instance." *Repouille v. United States*, 165 F.2d 152, 153 (2d Cir. 1947).

41. Of the eleven physicians who have been charged in connection with the killing of a patient or an ill or incapacitated member of the physician's family, none has been imprisoned. In Colorado in 1935, Dr. Harold Blazer killed his daughter, a victim of cerebral spinal meningitis, using chloroform, and was acquitted at trial. In New York in 1985, Dr. John Kraai killed a friend and patient who suffered from Alzheimer's disease and gangrene of the foot; Dr. Kraai subsequently killed himself three weeks after his arrest. In 1986 in New Jersey, Dr. Joseph Hassman injected his mother-in-law, an Alzheimer's victim, with a lethal dose of Demerol; he was found guilty and sentenced to two years' probation, fined \$10,000, and ordered to perform 400 hours of community service. In 1987 in Ft. Myers, Florida, Dr. Peter Rosier was acquitted after a botched attempt at ending the life of his cancer-stricken wife (the mercy killing was successfully completed by the wife's stepfather). In Michigan in 1989, Dr. Donald Caraccio pleaded guilty to the murder, by lethal injection, of a comatose 74-year-old woman; he received five years probation with community service. DEREK HUMPHRY, *EUTHANASIA* 129-35 (1991).

42. O. RUTH RUSSELL, *FREEDOM TO DIE* 104-06 (rev. ed. 1977).

43. At trial, the defendant asserted that the patient was already dead when he injected the air. It was also revealed that the patient's family was split over the doctor's actions. The husband and one brother sided with the doctor; another brother felt the patient's fate belonged to "the will of God." Kamisar, *Non-Religious Views*, *supra* note 25, at n.172 (quoting 40 *cc of Air*, TIME, Jan. 9, 1950, at 13).

44. RUSSELL, *supra* note 42, at 197.

45. HUMPHRY, *supra* note 41, at 130.

The June, 1990, suicide of Janet Adkins generated worldwide interest as the first use of the notorious "suicide machine" invented by longtime euthanasia advocate Dr. Jack Kevorkian.⁴⁶ Kevorkian, who had publicized his device (dubbed the "Mercitron") in the national media since 1989, was contacted by Adkins, who asked his help in ending her life. Adkins, who was fifty-four, said that she had made her decision to die nearly a year earlier, when she was first diagnosed with Alzheimer's disease.⁴⁷ At the time of her death, the disease had progressed to the point where Adkins had begun to lose her memory and could no longer play the piano and flute, but she was well enough to play tennis with her son and to enjoy a last romantic weekend with her husband.⁴⁸

Dr. Kevorkian's suicide machine was a sophisticated extrapolation on the concept of a physician leaving a lethal dose of medication by a patient's bedside. It consisted of an intravenous tube connected to three bottles, one containing harmless saline solution, one containing thiopental, and one containing potassium chloride. After Kevorkian inserted the intravenous tube into Adkins's arm and began the saline solution, she pressed a button which switched the line to the thiopental, which caused her to lose consciousness. A minute later, a timing device switched the line to the potassium chloride, which stopped her heart and caused death within minutes.⁴⁹ By activating the fatal device, Adkins had, in effect, taken her own life.

Kevorkian's device was designed to take advantage of the then-existing gap in Michigan law regarding assisted suicide, which had been uncertain since the 1984 Michigan Supreme Court refused to consider an appeal from the Michigan court of appeals in *People v. Campbell*.⁵⁰ In that case, the defendant, who was charged with murder in a suicide death, appealed from the denial of a motion to dismiss on the ground that providing a weapon to an individual who subsequently uses it to commit suicide does not constitute

46. Belkin, *supra* note 3. Kevorkian, 67, has been considered "something of an eccentric" since his days as a resident at the hospital at the University of Michigan, where he was forced to leave when officials heard of his proposal to make death row prisoners permanently unconscious for medical experimentation. Isabel Wilkerson, *Physician Fulfills a Goal: Aiding a Person in Suicide*, N.Y. TIMES, June 7, 1990, at D22. A self-described "outcast," Kevorkian claims not to have held a job since 1982 because his "renegade ideas" have frightened hospitals from hiring him—"I don't apply anymore," he said. *Id.* Derek Humphry has called Kevorkian "the loose cannon of the euthanasia movement." Jane Gross, *Voters Turn Down Mercy Killing Idea*, N.Y. TIMES, Nov. 7, 1991, at B16.

47. Belkin, *supra* note 3.

48. Albert W. Alschuler, *Reflection*, in ACTIVE EUTHANASIA, *supra* note 14, at 107.

49. Belkin, *supra* note 3.

50. 342 N.W.2d 519 (Mich. 1984), *appeal denied from* 335 N.W.2d 27 (Mich. Ct. App. 1983).

murder.⁵¹ The court of appeals agreed, reversing the trial court, and stated that “[w]hile we find the conduct of the defendant morally reprehensible, we do not find it to be criminal under the present state of the law”⁵² In doing so, the court rejected the prosecution’s reliance on a 1920 case, *People v. Roberts*,⁵³ in which the defendant had placed a portion of paris green, a highly poisonous pigment containing arsenic trioxide, within the reach of his wife, who had terminal multiple sclerosis and who had requested her husband to help her die. Roberts was charged and convicted of first degree murder. The *Roberts* court treated issues of homicide only, and did not discuss the incident as a suicide.⁵⁴ In contrast, the *Campbell* court held, “the term suicide excludes by definition a homicide. Simply put, the defendant here did not kill another person.”⁵⁵ The court further explicitly invited the legislature to adopt legislation regarding assisted suicide.⁵⁶

Nearly six months after Janet Adkins’s death, Kevorkian was arrested and charged with first degree murder.⁵⁷ The prosecutor cited *Roberts*, which was never explicitly overturned, and called Kevorkian “the legal and primary cause” of Adkins’s death, asserting that Kevorkian could not “avoid culpability by the clever use of a switch.”⁵⁸ Kevorkian’s attorneys invoked *Campbell*.⁵⁹ Ten days later, after a two day preliminary hearing, Judge Gerald McNulty of the Oakland County District Court dismissed the murder

51. Steven Paul Campbell was charged in the October 4, 1980, suicide of Kevin Patrick Basnaw. According to testimony, two weeks earlier Campbell had caught Basnaw in bed with Campbell’s wife. On the night of the suicide, Campbell and Basnaw were drinking heavily at Basnaw’s home. Late in the evening Basnaw began talking about committing suicide, and said he did not have a gun. At first, Campbell refused to allow Basnaw to borrow or buy one of his guns, but later changed his mind and drove with Basnaw to Campbell’s parents’ home to get a gun. They returned to Basnaw’s home with a gun and five shells, and Basnaw told his girlfriend to leave with Campbell because he was going to kill himself. Basnaw put the shells and the gun on the kitchen table and began to write a suicide note. Campbell and Basnaw’s girlfriend left at approximately 3:00 a.m. The next morning, Basnaw was found dead at the kitchen table with the gun in his hand. *People v. Campbell*, 335 N.W.2d 27, 28-29 (Mich. Ct. App. 1983).

52. *Id.* at 31.

53. 178 N.W. 690 (Mich. 1920).

54. *Campbell*, 335 N.W.2d at 29.

55. *Id.* at 30.

56. *Id.* at 31. The Michigan legislature has since taken action on both sides of the issue. In October, 1992, the Michigan House of Representatives Subcommittee on Death and Dying approved a bill to permit physician-assisted suicide and sent it to the House Judiciary Committee for debate. Price, *supra* note 7; see *infra* notes 161-70 and accompanying text. On December 15, 1992, an anti-euthanasia bill was signed into law by Michigan Governor John Engler. *Two More Assisted Suicides Before Governor OKs Ban*, *supra* note 7; see *infra* notes 72-73 and accompanying text.

57. Isabel Wilkerson, *Inventor of Suicide Machine Arrested on Murder Charge*, N.Y. TIMES, Dec. 4, 1990, at A1.

58. *Id.*

59. *Id.*

charges, finding no probable cause that Kevorkian had committed murder.⁶⁰ Stating that it was Mrs. Adkins, not Kevorkian, who had caused her death, he called upon the state legislature to address the issue of assisted suicide.⁶¹

On October 23, 1991, nearly seventeen months after Adkins's death, Kevorkian assisted two other women to commit suicide in Michigan.⁶² One was a forty-three-year-old victim of multiple sclerosis; the other woman, fifty-eight, suffered from papilloma virus, a painful pelvic condition.⁶³ Neither woman was in danger of imminent death.⁶⁴ Kevorkian used a newly designed version of his suicide machine in one death; the other was accomplished using a carbon monoxide tank and mask.⁶⁵ On November 20, 1991, the Michigan Medical Association suspended Kevorkian's license to practice medicine in that state.⁶⁶ On January 6, 1992, an Oakland County grand jury opened an investigation into Kevorkian's role in the suicides; an indictment was returned and on February 21, 1992, Kevorkian was ordered to stand trial for murder. While awaiting trial, on May 15, 1992, Kevorkian assisted the suicide of Susan Williams, a fifty-two-year-old victim of multiple sclerosis.⁶⁷ Prosecutors had not yet filed charges in that case when, on July 21, 1992, Oakland County Circuit Judge David Breck dismissed the charges in the October, 1991,

60. Tamar Lewin, *Doctor Cleared of Murdering Woman with Suicide Machine*, N.Y. TIMES, Dec. 14, 1990, at B6.

61. *Id.* Although charges were dropped against Kevorkian, he remained barred by judicial order issued four days after Adkins's death from using his suicide device again. *Id.* Two months after Adkins's suicide, Bertram and Virginia Harper and their daughter flew to Michigan from California, where assisted suicide is a felony, to exploit the legal vacuum Kevorkian had publicized. In a suburban Detroit motel room, Virginia Harper, who suffered from liver cancer, took an overdose of sleeping pills and fastened a plastic bag over her head. After Virginia became unconscious, Bertram fastened the bag more securely around her neck; this fact was seized upon by prosecutors who hoped to show that Bertram caused her death. Bertram Harper was charged with first degree murder, but a jury acquitted him nine months later, finding that the sedatives taken by Virginia's own hand were the primary cause of death. *Man Who Helped Wife Commit Suicide is Acquitted of Murder*, CHI. TRIB., May 11, 1991, at C2.

62. *Doctor Assists in Two More Suicides in Michigan*, N.Y. TIMES, Oct. 24, 1991, at A1.

63. *Id.*

64. *Suicide Victims Were Adamant, Lawyers Claim*, *supra* note 7.

65. *Doctor Assists in Two More Suicides in Michigan*, *supra* note 62. Carbon monoxide gas became Kevorkian's exclusive method after his medical license was suspended and it was no longer possible for him to obtain potassium chloride. David Margolick, *Doctor Who Helps Suicides Has Made the Bizarre Banal*, N.Y. TIMES, Feb. 22, 1993, at A1. To begin the flow of gas, the individual tugs a string attached to a clip on the plastic tube running from the carbon monoxide canister to the mask. Death occurs within minutes. *Id.*

66. *In Wake of 3 Suicides, Dr. Kevorkian Loses Michigan License*, CHI. TRIB., Nov. 21, 1991, at C16.

67. *Kevorkian Provided the Gas for Woman's Suicide*, N.Y. TIMES, May 17, 1992, at A21.

suicides, explicitly rejecting *Roberts*⁶⁸ and holding that "because physician-assisted suicide is not a crime, defendant was wrongly bound over."⁶⁹

On September 26, 1992, Kevorkian assisted the suicide of Lois Hawes, a fifty-two-year-old cancer victim, again employing carbon monoxide.⁷⁰ Chastened by the two previous dismissals, Oakland County prosecutor Richard Thompson said that he would not prosecute again without action by the legislature or appellate courts.⁷¹

On November 24, 1992, the Michigan House of Representatives acted, passing a provisional anti-euthanasia measure that outlawed assisted suicide for two years beginning March 30, 1993, while a newly created commission on death and dying studies the problem and develops recommendations for legislation.⁷² The measure, which makes assisted suicide a felony punishable by up to four years imprisonment and a \$2,000 fine, was quickly passed by the Senate, then signed by Michigan's governor on December 15, 1992, a day on which Kevorkian aided two additional suicides.⁷³

During the next two months, Kevorkian aided the suicides of seven other individuals, prompting the Michigan legislature to move the effective date of the ban to February 25, 1993.⁷⁴ On March 1, 1993, the American Civil Liberties Union of Michigan filed suit on behalf of two terminally ill cancer patients and seven local doctors, challenging the law as an unconstitutional violation of the right to privacy and asking for a preliminary injunction to stop enforcement of the law.⁷⁵ Kevorkian, who is not a party to the suit, said

68. *People v. Roberts*, 178 N.W. 690 (1920); see *supra* notes 53-54 and accompanying text.

69. Koski, *Acquittal*, *supra* note 7.

70. Ourlan & Atkins, *supra* note 7.

71. *Id.*

72. Act of Dec. 15, 1992, 1992 Mich. Pub. Acts 270 (creating Michigan commission on death and dying and prohibiting certain acts pertaining to suicide assistance).

73. Michael Abramowitz, *Kevorkian Aids in 2 More Suicides; Michigan Governor Signs Bill Making Practice a Felony*, WASH. POST, Dec. 16, 1992, at A2; see *supra* note 7.

74. Act of Feb. 25, 1993, 1993 Mich. Pub. Acts 3 (amending 1992 Mich. Pub. Acts 270 to take effect Feb. 25, 1993).

75. Carol J. Castaneda, *Aided-Suicide Ban Faces Challenge*, USA TODAY, Mar. 1, 1993, at 6A. According to attorney and law professor Robert Sedler, who is litigating the case for the American Civil Liberties Union of Michigan, the ACLU's challenge relies on due process liberty interests of the kind protected in *Planned Parenthood v. Casey*, 112 S. Ct. 2791 (1992), and the line of reproductive rights cases articulating the constitutional right to privacy. Telephone interview with the author, Mar. 9, 1993. Sedler emphasized that the suit "has nothing to do with euthanasia" and is not intended to free Kevorkian's hand; rather, the challenge has been brought to preserve the privacy of the doctor-patient relationship, including the freedom of doctors to prescribe barbiturates and other pain-killing drugs which may have the effect of hastening death and to instruct patients on the proper dosage if a lethal effect is desired. *Id.*

that he would not assist any additional suicides until a decision is rendered in the preliminary injunction hearing.⁷⁶

Another physician, Dr. Timothy Quill, attracted the attention of prosecutors when he published an article in the *New England Journal of Medicine* in March, 1991, describing his role in enabling a forty-five-year-old leukemia victim to end her life.⁷⁷ Dr. Quill, a professor at the University of Rochester Medical School, had been the patient's physician for many years.⁷⁸ He supported her adamant decision to forego chemotherapy and prescribed, at her request, enough barbiturates to kill her. The patient did not use the barbiturates until several months later, when her condition had deteriorated considerably. Dr. Quill was not present at her suicide.⁷⁹ Nonetheless, prosecutors in Rochester, New York, where the incident took place, searched death records to find a case which matched the one described in Quill's article.⁸⁰ The victim was identified and her body found at a local college, where it was being used as an instructional cadaver.⁸¹ The prosecutors requested an indictment under the New York statute criminalizing assisting suicide,⁸² but after three days of hearings a grand jury failed to indict him. Following that decision, both the New York State Medical Society and the New York State Health Department declined to initiate disciplinary proceedings.⁸³

Physician involvement in patient suicide remains an offense in most states, though the degree to which prosecutors, juries, and courts will tolerate the practice depends on the circumstances of the suicide. The willingness of prosecutors to enforce assisted suicide statutes may face further tests if more physicians come forward with tales of euthanasia and assisted suicide. Public sympathy for physicians who aid their terminally ill patients in dying would also be tested. While it is likely that Dr. Kevorkian could have been

76. Castaneda, *supra* note 75.

77. Timothy E. Quill, *Death and Dignity*, 324 NEW ENG. J. MED. 691 (1991). Dr. Quill decided to write his article after reading an anonymous account of a mercy killing by a physician published in 1988 in the *Journal of the American Medical Association (JAMA)*. Robert Steinbrook, *Support Grows for Euthanasia*, L.A. TIMES, Apr. 19, 1991, at A1. The article, *It's Over, Debbie*, described the administration of a lethal injection of morphine to a dying, pain-racked cancer patient whom the doctor had never before met. Name Withheld By Request, *It's Over, Debbie*, 259 JAMA 272 (1988). The article sparked heated debate, and letters to *JAMA* from physicians ran four to one against the mercy killing. Lundberg, *supra* note 27, at 2142.

78. Altman, *supra* note 7.

79. Quill, *supra* note 77, at 693.

80. Altman, *supra* note 7.

81. *Id.*

82. N.Y. PENAL LAW § 120.30 (McKinney 1987) ("A person is guilty of promoting a suicide attempt when he intentionally causes or aids another person to attempt suicide.").

83. Altman, *supra* note 7.

successfully prosecuted under New York's statute, the circumstances under which Dr. Quill enabled his patient to die are likely to be tolerated in most parts of the country

2. The Netherlands

Active voluntary euthanasia has been practiced openly in the Netherlands since 1973,⁸⁴ when, for the first time, a Dutch physician was charged with participating in a mercy killing under Article 293 of the *Netherlands Penal Code*.⁸⁵ In that case, which was heard by the lower court in Leeuwarden, the physician acceded to repeated requests for death by her seventy-eight-year-old mother, who was wheelchair-bound, incontinent, and partially deaf.⁸⁶ The physician was found guilty and given a suspended sentence, but the court set forth four conditions under which euthanasia would be acceptable: (1) the patient's condition is incurable; (2) the patient's suffering is unbearable; (3) the patient requests euthanasia in writing; and (4) a physician performs the euthanasia.⁸⁷ Also in 1973, the Royal Dutch Medical Association (KNMG) issued a statement asserting that circumstances exist under which euthanasia is justifiable, but that it should remain illegal.⁸⁸

The Leeuwarden decision and the KNMG statement set the stage for a series of court decisions during the 1970s and early 1980s which developed the existing guidelines into three necessary conditions for the acceptable practice

84. The judicial decisions which led to the decriminalization of euthanasia in the Netherlands must be viewed in the context of the Dutch civil law system, which differs from the United States' common law system in several crucial respects. Judges in the Netherlands are appointed for life by the Queen, and their independence is constitutionally guaranteed. There is no form of trial by jury. The judge's task is to interpret the law and apply it to the case before him. There is no precedent law, except for the rulings of the Supreme Court, which does not have the power of judicial review of the other branches of government—Crown and Parliament. The rigidity of the system, as regards criminal law, is compensated for by placing discretion in the Public Prosecutor's Office, which may drop criminal cases if doing so serves the public interest. Euthanasia cases, because of their controversial nature, are given special treatment and may be referred to the Minister of Justice. The Public Prosecutor's Office also has the discretion to involve the Office of Medical Inspectors, which controls the quality of health care, so as to insulate euthanasia cases whenever possible from the criminal law. Eugene Sutorius, *How Euthanasia Was Legalized in Holland*, Address at Hemlock Society Convention 9-11 (Feb. 9, 1985) (transcript on file with the *Indiana Law Journal*).

85. Article 293, enacted in 1886, states: "He who robs another of life at his express and serious wish is punished with a prison sentence of at most twelve years or a fine of the fifth category." CARLOS F. GOMEZ, *REGULATING DEATH* 19 (1991). A fine of the fifth category may reach 100,000 guilders (approximately \$50,000 at 1991 exchange rates). *Id.* at 147 n.1. Article 294 provides criminal sanctions for incitement or assistance to suicide, including a prison term of up to three years and a fine. *Id.* at 19.

86. *Nederlandse Jurisprudentie* 1973:183; see GOMEZ, *supra* note 85, at 28.

87. *Id.* at 30.

88. M.A.M. de Wachter, *Active Euthanasia in the Netherlands*, 262 *JAMA* 3316, 3317 (1989).

of active euthanasia: (1) the patient must request euthanasia freely, without solicitation or family pressure; (2) the patient must experience his condition as unbearable; and (3) the physician must consult a colleague to confirm the prognosis and diagnosis, to verify the medical performance of euthanasia, and to ensure all legal requirements are met.⁸⁹ Courts generally applied these standards, though judges were free to apply, and did apply, other standards, including "the presence of an incurable disease" or that "unnecessary suffering" not be inflicted on others.⁹⁰ In 1981, however, the boundaries of toleration of euthanasia were unsettled when the Rotterdam district court convicted a nonphysician of assisting in a suicide, and in the process promulgated a new set of euthanasia guidelines.⁹¹ The variation in criteria signalled physicians that although Article 293 would not be strictly interpreted, there was no assurance that they would not be prosecuted.⁹² If unfortunate enough to encounter a zealous prosecutor or unsympathetic judge, a physician could be charged and convicted of a felony under Article 293.⁹³

The Supreme Court of the Netherlands clarified much of the ambiguity in its 1984 ruling on the euthanasia conviction of a physician from Purmerend, Dr. Schoonheim.⁹⁴ In 1976, at age eighty-nine, Maria Barendregt, a "vital, mentally strong person,"⁹⁵ was forced by infirmities to move into a "living-center," where she came under the care of Dr. Schoonheim. In 1980, she signed a euthanasia declaration, and in 1981, after fracturing her hip in a fall, declared that she would not submit to an operation unless assured that she would not live through it. Dr. Schoonheim declined to operate, and over the following months, Maria became bedridden, catheterized, and totally dependent on the nursing staff. Her requests to be helped to die increased in urgency until, in the last week of her life, she could no longer speak or drink. After a few days, there was a slight remission, and she was able to speak, at which time Maria begged her son to ensure that she receive euthanasia. She repeated her request to Dr. Schoonheim, who ultimately agreed. Later that week, after saying goodbye to her son and daughter-in-law, Maria again confirmed her wish to die: "If it can be done please do it at once doctor;

89. *Id.*

90. *Id.*

91. GOMEZ, *supra* note 85, at 32-33.

92. *Id.* at 34.

93. *Id.*

94. Nederlandse Jurisprudentie 1984:106.

95. Sutorius, *supra* note 84, at 3.

quickly, not one night more."⁹⁶ Dr. Schoonheim then gave Maria three injections to end her life.⁹⁷

After Dr. Schoonheim obeyed the law by reporting his actions to the municipal medical examiner and the police, he was charged under Article 293 and brought to trial. His defense was that a conflict of loyalties—to the law and to his patient—had caused him to act under *force majeure*.⁹⁸ He said he had weighed the “conflicting duties and interests” of the case and acted in accordance with professional standards of medical ethics.⁹⁹

The court acquitted Schoonheim, finding that no crime had been committed. The prosecutor appealed to the Amsterdam Court of Appeals, which reversed the district court on the grounds that Article 293 had clearly been violated. The court of appeals further asserted that the physician had not proved “unbearable suffering” on the patient’s part and therefore could not demonstrate that the patient’s suffering had left him no reasonable alternative.¹⁰⁰

The Netherlands Supreme Court, in what became a landmark decision, reversed the Amsterdam Court of Appeals. The Court agreed that Article 293 had been violated, but criticized the appellate court for not investigating further into the specific circumstances under which the physician had acted. Was the patient’s suffering (mental or physical) expected to worsen? Was it foreseeable that the patient would no longer be able to live in a dignified way? Were there still alternative ways to alleviate the patient’s suffering?¹⁰¹ Because the Supreme Court could only consider questions of law, it referred the case to the Court of Appeals of the Hague, and instructed that court to consider whether euthanasia, as practiced in this case, would be justified by *force majeure* from a medical perspective.¹⁰²

The Court of Appeals of the Hague fulfilled its mandate by requesting that the KNMG present an opinion. The KNMG’s response was to affirm that there were situations of necessity in medicine in which physicians and patients might be under such duress that euthanasia would be justifiable. Therefore, the legality of euthanasia need not be questioned; the defense of necessity, for

96. *Id.* at 5.

97. *Id.*

98. The defense of *force majeure* has become standard in Dutch euthanasia cases, and stands for the idea that the patient’s extreme and enduring pain forces the physician to do something outside normal practice. The concept of *force majeure* has historically been used to excuse defendants who broke the law under coercion. GOMEZ, *supra* note 85, at 150 n.26 (quoting personal interview with Sutorius).

99. Sutorius, *supra* note 84, at 6.

100. GOMEZ, *supra* note 85, at 35-36.

101. Sutorius, *supra* note 84, at 13.

102. GOMEZ, *supra* note 85, at 36.

which the physician would bear the burden of proof, would justify acquittal.¹⁰³

After the Supreme Court decision, policies and guidelines to govern the administration of euthanasia were developed by several institutions, including the KNMG, the University of Utrecht, and the health care services directors of Amsterdam and Rotterdam. Generally, such guidelines dictate procedures for consultation with the family and hospital authorities after a patient has requested euthanasia—setting timetables, documentation, and the actual performance of the euthanasia.¹⁰⁴ The Amsterdam policy also specifically sets forth procedures for post-mortem review, addressing the issue of the physician's liability¹⁰⁵

In September, 1991, the first long-term study of the practice of euthanasia in the Netherlands, commissioned by the Dutch government, was released.¹⁰⁶ Researchers from four Dutch universities studied individuals who requested euthanasia or suicide assistance from 1986 to 1989,¹⁰⁷ with results that surprised both sides of the debate.¹⁰⁸ The study found that about three percent of all Dutch deaths—about 3,900 out of 129,000 deaths annually—are caused by euthanasia, though thirty-five percent of all deaths involve the withdrawal of care or the administration of potentially life-shortening painkillers.¹⁰⁹ These figures were far lower than predicted, lending credence to the view that euthanasia can be controlled. At the same time, the official study's figures contrasted with those of the Ministry of Justice, which showed

103. *Id.* at 37-38.

104. de Wachter, *supra* note 88, at 3318-19.

105. According to the Amsterdam policy, the following steps must be taken: (1) the coroner, who must be contacted before a death certificate can be written, examines the reasons for the euthanasia and whether it was performed with professional care; (2) the coroner reports to the district attorney; (3) the police question the physician and investigate the circumstances of the euthanasia (the family is not questioned unless something unusual is uncovered); (4) the district attorney decides whether an autopsy is necessary; (5) the district attorney consults with the public health inspector; (6) the district attorney submits a final report to the appropriate attorney general; (7) all five attorneys general and the secretary general of the Ministry of Justice discuss the case and decide whether to prosecute or to dismiss the case. *Id.* at 3319.

106. Simons, *supra* note 7.

107. *Id.* The researchers reviewed 7,000 deaths, interviewed 405 physicians, and arranged for 322 doctors to keep track of all deaths in their practices over a six-month period. Knox, *supra* note 17.

108. Knox, *supra* note 17.

109. *Id.* The study also revealed: In nearly two-thirds of the cases, the patients were estimated to have two weeks or less to live when they asked to die. In eighty-three percent of the cases, the patients first broached the subject of euthanasia, while in ten percent the physician first raised it. Doctors more readily applied euthanasia when patients had just days to live; if life expectancy was three months or more, doctors preferred to assist the patient in taking his own life. Simons, *supra* note 7.

only 454 cases officially reported in 1990,¹¹⁰ indicating that physicians are largely ignoring the existing guidelines.¹¹¹

On February 9, 1993, after lengthy and contentious debate, the Dutch Parliament approved (by a vote of 91 to 48 in the lower house) legislation that codifies and strengthens the existing guidelines.¹¹² Scheduled to take effect in 1994, the new law stops short of legalizing euthanasia, which is still punishable under Article 293, but effectively immunizes from prosecution physicians who follow a detailed set of rules.¹¹³ Among other requirements, these rules specify that the patient must voluntarily request euthanasia repeatedly over a period of time, be mentally competent, and have a terminal disease accompanied by unbearable physical or mental suffering.¹¹⁴ The physician must consult a colleague experienced in euthanasia and submit a documented report stating the patient's medical history and the circumstances of the euthanasia.¹¹⁵

Two critics of Dutch euthanasia, the American physician Carlos Gomez, author of the first detailed American study of the Dutch system of euthanasia,¹¹⁶ and Richard Fenigsen, a Dutch cardiologist,¹¹⁷ argue that not only are abuses inevitable and ongoing, but endemic to the practice of euthanasia.

Based on his analysis of twenty-six cases of euthanasia that took place between 1985 and 1988, Dr. Gomez charges that the regulatory framework governing euthanasia is a sham. In the vast majority of cases, self-reporting by physicians does not occur, and even in instances where the district attorney is notified, physicians are rarely brought to court.¹¹⁸ The requirement that physicians consult with another doctor is vague, and does not specify the

110. *Dutch Study Brings Euthanasia Taboo Out into the Open*, Reuters Library Report, Sept. 13, 1991, available in LEXIS, Nexis Library, Wires File.

111. *Id.* Dutch proponents of euthanasia have been split over whether statutory legalization of euthanasia would improve adherence to guidelines and accountability. Pieter V Admiraal, a Delft oncologist and practitioner of euthanasia, says, "It wouldn't change much." Eugene Sutorius, the leading defense attorney for physicians in euthanasia cases, worries that legalization will make euthanasia "mechanical" and remove responsibility from doctors. Klazien Sybrandy, founder of the Information Center for Voluntary Euthanasia, contends that the ambiguous legal status of euthanasia gives prosecutors such discretion that physicians are discouraged from reporting. She argues that formal legalization would encourage openness and reduce the potential for abuse. John Horgan, *Death with Dignity: The Dutch Explore the Limits of a Patient's Right to Die*, SCI. AM., March 1991, at 17, 20.

112. Drozdziak, *supra* note 16.

113. Marlise Simons, *Dutch Parliament Approves Law Permitting Euthanasia*, N.Y. TIMES, Feb. 10, 1993, at A5.

114. *Id.*

115. *Id.*

116. See GOMEZ, *supra* note 85.

117. See Richard Fenigsen, *A Case Against Dutch Euthanasia*, HASTINGS CENTER REP. (Special Supp.), Jan.-Feb. 1989, at 22.

118. GOMEZ, *supra* note 85, at 130.

other physician's public function and accountability. As a result, doctors who do seek outside review before performing euthanasia do so to fulfill the legal formality, not as a test of their clinical assessment.¹¹⁹

Dr. Fenigsen paints an even more frightening picture of the practice of euthanasia, presenting a litany of abuses that he claims occur routinely: sloppy diagnosis, misrepresentation of the family's wishes, hasty evaluation of the patient's wishes, coercion of one spouse by the other, and coercion and intimidation of patients by doctors and nurses.¹²⁰ He claims that involuntary active euthanasia has been widely performed on adults and children,¹²¹ and that Holland has created a culture of propaganda in favor of death, applying praise to the request to die, terming it "brave," "wise," and "progressive."¹²² Fenigsen reports that severely handicapped adults live in fear and uncertainty, and that the practice of euthanasia has brought about an "ominous" change in society, sending a message to the weak and dependent that "we wouldn't mind getting rid of you."¹²³

According to Dr. Gomez, the chaotic, extralegal state of affairs that existed in the Netherlands derived from an unresolvable tension in public policy between favoring greater autonomy and the unwillingness to dispense with legal prohibitions against killing, no matter how well-intentioned.¹²⁴ The new Dutch law, despite retaining criminal penalties for assisting suicide, may be an attempt to ameliorate that tension. While the Netherlands model of legal euthanasia may be too idiosyncratic in its development to transplant to the United States, the same unresolvable tension exists in our society, as evidenced by the ongoing euthanasia debate and the near misses of Washington State's Initiative 119 and California's Proposition 161.

119. *Id.*

120. Fenigsen, *supra* note 117, at 22.

121. Two cases illustrate what Fenigsen considers to be the dangerously tolerant attitude of the Dutch medical profession. In 1985, a physician was arrested under suspicion of having performed involuntary euthanasia on twenty patients at the *De Terp* nursing home in the Hague. *Id.* at 25. He was convicted of three killings, but the charges were dismissed by a higher court after an intensive lobbying effort on the physician's behalf by the Royal Dutch Medical Association (KNMG) and other groups. *Id.* Likewise, four nurses who admitted having secretly killed several unconscious patients won a dismissal of all charges and an emotional televised thank you from the victims' parents. *Id.*

122. *Id.* at 24.

123. *Id.* at 26.

124. GOMEZ, *supra* note 85, at 131-32.

B. Legislative Responses to Euthanasia

The first modern proposal for euthanasia legislation, made in the Ohio legislature in 1906, provided that when an adult of sound mind had been fatally hurt or was terminally ill, his physician would be permitted to ask him in the presence of three witnesses if he wished to die.¹²⁵ If the answer was yes, three other physicians were required to confirm the original prognosis before the individual could be put to death.¹²⁶ The bill was defeated by a vote of twenty-three to seventy-nine.¹²⁷

In the 1930s, Great Britain and the United States witnessed a burst of pro-euthanasia activity, including the founding of euthanasia societies on both sides of the Atlantic. In 1936, a "Voluntary Euthanasia Bill" was introduced into the House of Lords.¹²⁸ The bill permitted adult patients suffering from an incurable and fatal illness to request euthanasia by signing a form in the presence of two witnesses. This form, accompanied by medical certificates, was then to be submitted to a "euthanasia referee" appointed by the Minister of Health. The euthanasia referee was required to interview the patient, and if satisfied that the patient sincerely desired death, he would issue a certificate. The patient's application, the medical certificates, and the referee's certificate would then go to a special court, which had the right to question the referee, the physicians, and family members. If the court was satisfied, it would issue two certificates, one to the patient and one to the physician, allowing death to be administered in the presence of an official witness.¹²⁹ These cumbersome safeguards were intended by promoters of the bill to mollify the opposition,¹³⁰ but the effect was just the opposite—it was complained that the safeguards created too much formality, destroying the doctor-patient relationship.¹³¹ Yale Kamisar has theorized that the stringency of these safeguards was calculated with the expectation of pushing through a second and less restrictive bill as soon as the first had sufficiently "educated" public opinion.¹³²

125. RUSSELL, *supra* note 42, at 61.

126. *Id.*

127. *Id.*

128. JONATHAN GOULD & LORD CRAIGMYLE, *YOUR DEATH WARRANT?* 29 (1971).

129. *Id.* at 29-30.

130. WILLIAMS, *supra* note 25, at 334.

131. *Id.*

132. Kamisar, *Non-Religious Views*, *supra* note 25, at 1015. Kamisar supports this contention with a quote from Lord Chorley during a 1950 House of Lords debate on another euthanasia measure:

Another objection is that the bill does not go far enough, because it applies only to adults and does not apply to children who come into the world deaf, dumb and crippled, and who have a much better cause than those for whom the Bill provides. That may be so,

In the United States, a bill similar to the British bill was introduced and rejected in the Nebraska legislature in 1937.¹³³ A year later, the Euthanasia Society of America was formed in New York, where a bill based on the British model was introduced and defeated in 1939.¹³⁴ In 1947, a similar bill was again introduced in the New York legislature and rejected.¹³⁵ By that time, reports of the Nazi practice of euthanasia and medical experimentation on human subjects were widespread, and offered support for the notion that euthanasia, once legalized, could not be effectively controlled.¹³⁶

The next significant effort to pass a euthanasia bill did not take place until 1969, when the House of Lords debated a revised version of the 1936 bill. The 1969 bill attempted to relax some of the formal procedures of the earlier bill by permitting a patient to make a "declaration in advance" requesting the administration of euthanasia in the event of an "irremediable condition," defined as a serious physical illness or impairment reasonably thought to be incurable and "expected to cause him severe distress or render him incapable of rational existence."¹³⁷ The bill required two physicians to verify the patient's condition and two witnesses to the declaration, and it contained a series of provisions that have become standard in subsequent legislative proposals: the declaration may be revoked at any time by destruction or cancellation; no physician or nurse is under any legal duty to participate in euthanasia; no physician or nurse shall be found guilty of an offense in connection with authorized euthanasia; and no insurance policy in force for twelve months shall be vitiated by the administration of euthanasia to the

but we must go step by step.

Id. at 1016 (quoting 169 H.L. Deb. 551, 559 (1950)).

133. GOULD & CRAIGMYLE, *supra* note 128, at 30.

134. RUSSELL, *supra* note 42, at 74.

135. *Id.* at 95-96.

136. German Jews were at first excluded from euthanasia under the Nazis; it was originally considered that "the blessing of euthanasia should be granted only to [true] Germans." Kamisar, *Non-Religious Views*, *supra* note 25, at 1033 (quoting defendant Viktor Brack, Chief Administrative Officer in Hitler's private chancellory, testifying at the Nuremberg Medical Trial, 1 Trials of War Criminals Before the Nuremberg Military Tribunal Under Control Council Law No. 10, 877-80 (1950)).

An examination of euthanasia in Nazi Germany by Dr. Leo Alexander describes propaganda efforts to facilitate acceptance of euthanasia. In a high school textbook, for example, a mathematics problem compared the cost of caring for the disabled with the cost of building new housing units or marriage-allowance loans for newly married couples. Leo Alexander, *Medical Science Under Dictatorship*, in *DEATH, DYING AND EUTHANASIA* 571, 572 (Dennis J. Horan & David Mall eds., 1977). Alexander also describes the resistance of Dutch physicians to the imposition of euthanasia by the Nazis. One hundred Dutch physicians were sent to concentration camps to force the profession's compliance, but "not a single euthanasia or nontherapeutic sterilization was recommended or participated in by any Dutch physician." *Id.* at 586.

137. GOULD & CRAIGMYLE, *supra* note 128, at 139.

insured.¹³⁸ The bill was ultimately defeated, forty to sixty-one, after a lengthy debate.¹³⁹ Among the objections to the bill was that the declaration, once renewed, was valid for life unless canceled or destroyed—no provision had been made for revocation by a new declaration. Also, unlike the 1936 bill and most subsequent proposals, the bill allowed euthanasia to be performed on incompetent patients who had previously signed a declaration. Further, the “irremediable” condition required by the bill was so vaguely defined that it could apply to the loss of a limb, and it was never specified that the illness be fatal.¹⁴⁰

The 1969 English bill was the first directive-type statute to be proposed, and it provided the model for bills introduced in legislatures in Idaho, Oregon, and Montana between 1969 and 1974.¹⁴¹ After the 1976 *Quinlan*¹⁴² decision, the development and proliferation of living wills statutes largely preempted the euthanasia debate until the 1980s, when the Hemlock Society and its founder, Derek Humphry, began their national campaign of euthanasia advocacy.¹⁴³ In 1988, a group called Americans Against Human Suffering attempted to place a euthanasia initiative on the California ballot, but failed to gather enough signatures.¹⁴⁴ Then, in 1991, Washington Citizens for Death with Dignity, in coalition with other advocacy groups, placed an “Initiative for Death with Dignity” on the Washington ballot.¹⁴⁵ Designated “Initiative 119,” the Washington measure came closer to enactment than any previous euthanasia proposal, winning forty-six percent of the popular vote.¹⁴⁶

Initiative 119 was a proposal to amend Washington’s Natural Death Act,¹⁴⁷ a living wills statute, to accommodate voluntary euthanasia, or

138. *Id.* at 139-41.

139. *Id.* at 63.

140. *Id.* at 33-35.

141. RUSSELL, *supra* note 42, at 192-94.

142. *In re Quinlan*, 335 A.2d 647 (N.J.), *cert. denied*, 429 U.S. 922 (1976).

143. HUMPHRY, *supra* note 41, at 107-08.

144. Allan Parachini, *The California Humane and Dignified Death Initiative*, 19 HASTINGS CENTER REP. (Special Supp.), Jan.-Feb. 1989, at 10.

145. Michael McCarthy, *Euthanasia on the Ballot; Voters in Washington State May Endorse Right to Die*, WASH. POST, Aug. 20, 1991, at Z12. Washington is one of 26 states allowing the adoption of statutory reform by direct election through initiatives. Two states allow initiatives only for constitutional amendment. Julian N. Eule, *Judicial Review of Direct Democracy*, 99 YALE L.J. 1503, 1510 (1990).

146. Jane Gross, *Voters Turn Down Legal Euthanasia*, N.Y. TIMES, Nov. 7, 1991, at A10. With 99% of the vote tabulated, there were 701,440 votes against the initiative (54%), 606,039 in favor (46%). *Id.*

147. WASH. REV. CODE §§ 70.122.010-.905 (1990). Initiative 119 also included two proposals relating to passive euthanasia. The first categorized “artificially administered nutrition and hydration” as a “life-sustaining procedure,” allowing its withdrawal if requested in a living will. The second included “irreversible coma” and “persistent vegetative state” in the definition of “terminal conditions,” allowing life-sustaining procedures to be withdrawn or withheld from patients in those conditions.

"physician aid-in-dying" as it was called in the initiative. Only competent patients with six months or less to live (in the written opinion of two examining physicians) would be eligible for aid-in-dying, which must be requested solely by the patient in the presence of two disinterested witnesses.¹⁴⁸ An aid-in-dying directive could only be executed at the time euthanasia was requested, not in advance.¹⁴⁹ In addition, no physician would be compelled to provide aid-in-dying; physicians who object to the practice would be obliged only to make a good faith effort to transfer the patient to a physician who would perform the service.¹⁵⁰ Other provisions were designed to allow the patient to revoke the directive at any time, to ensure that life insurance is not impaired, and to provide criminal penalties for interference with a directive or the revocation of a directive.¹⁵¹

Initiative 119 was carefully drafted to permit voluntary euthanasia for a narrow range of cases with a moderate degree of bureaucratic oversight. The restriction of euthanasia to competent patients would prevent its use by (or on) victims of Alzheimer's disease, the senile, the mentally ill, or children. Comatose patients and patients in a persistent vegetative state would also be ineligible; advance directives by such patients would only allow the withdrawal of life-sustaining treatment.

California's Proposition 161, the "California Death with Dignity Act,"¹⁵² on the ballot in 1992, was a revision of the 1988 bill proposed in that state.¹⁵³ Although it was designed to improve upon the procedural safeguards in the Washington initiative, its provisions created new possibilities for abuse. For example, the Washington measure failed to provide for any waiting time or cooling-off period between execution of the aid-in-dying directive and the administration of euthanasia. The California bill attempted to remedy this problem by requiring the directive to be executed and witnessed in advance.¹⁵⁴ However, under the California bill, the directive could have been executed years before death, and no witness was required for the final request for death or at the time of death.¹⁵⁵ Also, while the Washington measure made no special provision for nursing home patients, the California bill

Initiative for Death with Dignity § 2 (Washington Committee for Death with Dignity 1991) [hereinafter Initiative 119], amending WASH. REV. CODE § 70.122.020(4), (7) (1990).

148. Initiative 119, *supra* note 147, §§ 2, 3.

149. *Id.* § 10, amending WASH. REV. CODE § 70.122.100 (1990).

150. *Id.* § 6(2), amending WASH. REV. CODE § 70.122.060(2) (1990).

151. *Id.* §§ 4(1), 7(2), 9, amending WASH. REV. CODE §§ 70.122.040(1), .070(2), and .090 (1990).

152. The California Death with Dignity Act (Californians Against Human Suffering 1992) [hereinafter Proposition 161].

153. *See supra* note 144 and accompanying text.

154. Proposition 161 § 2525.3.

155. *Id.* §§ 2525.2(i), 2525.7.

required that in such cases a patient advocate or ombudsman designated by the state Department of Aging be a witness to the directive.¹⁵⁶ However, the state official need only be present when the directive is signed, not when it is carried out.¹⁵⁷ The California measure was also flawed by its failure to contain a requirement that the patient be experiencing a certain level of pain and suffering before the directive could be made. Finally, its definition of "terminal condition" was so vague as to include serious, but not immediately life-threatening illnesses, like diabetes.¹⁵⁸

In 1992, euthanasia bills were also introduced in the state legislatures of Iowa, Maine, Michigan, and New Hampshire. The Iowa¹⁵⁹ and Maine¹⁶⁰ bills closely track Proposition 161. The Michigan bill¹⁶¹ contains a number of innovative safeguards. First, the directive must be certified within seven days of execution by a psychologist or psychiatrist, attesting that the patient is of sound mind and not suffering from depression.¹⁶² Second, the attending physician must have attended the patient for at least six months.¹⁶³ Third, the patient must be determined to be suffering from both a terminal illness and physical pain so great that its elimination would render the patient unconscious.¹⁶⁴ Fourth, sixty days must pass between the execution of the directive and the euthanasia,¹⁶⁵ and the patient must request euthanasia at least twice, with seven days between each request.¹⁶⁶ Fifth, each request must be videotaped and witnessed by two individuals, and the performance of euthanasia must also be videotaped.¹⁶⁷ Finally, the decision of the attending physician to administer euthanasia must be reviewed and approved by at least two members of a three-member committee appointed by the county medical examiner or the administrator of the health facility where the patient is dying.¹⁶⁸ This complex and unwieldy procedure was criticized by both pro- and anti-euthanasia forces.¹⁶⁹ Kevorkian commented, "You don't have a law

156. *Id.* § 2525.4.

157. *Id.*

158. *Id.* § 2525.2(j).

159. Assistance-in-Dying Act, Iowa Senate, Sen. File 2066 (1992).

160. An Act Regarding the Terminally Ill, Maine Senate, 2nd Sess., S.P. 885, Legislative Doc. No. 2257 (1992).

161. Death with Dignity Act of 1992, H.R. 5415, 86th Leg., Reg. Sess., Mich. (1992).

162. *Id.* § 3(4).

163. *Id.* § 4(b).

164. *Id.* § 4(c).

165. *Id.* § 4(d).

166. *Id.* § 4(e), (e)(ii).

167. *Id.* § 4(e)(iii), (k).

168. *Id.* § 4(h).

169. Price, *supra* note 7.

telling doctors how to perform gallbladder operations or any other surgeries.¹⁷⁰

The New Hampshire measure¹⁷¹ takes a unique approach. Upon request by a patient determined to be terminally ill by two physicians, the attending physician may prescribe a lethal dose of medication that the patient may self-administer at the time and place and in the manner of his choosing.¹⁷² Before acceding to the patient's request, the physician must consult with an institutional or state ethics committee, which will review the case.¹⁷³

Despite their attempts to strike an adequate balance between respect for patient autonomy and societal safeguards, each of these four legislative efforts, like Initiative 119 and Proposition 161, is still susceptible of abuse, and raises the question, again, of whether euthanasia legislation is a fundamentally unsound idea. On the one hand, it is possible to imagine a safe and compassionate administration of euthanasia, with physicians and families working together to create a supportive and loving environment in which to make the crucial decision about the appropriateness of euthanasia. This ideal may have been accomplished in some cases in the Netherlands, as well as in the case of Dr. Quill, where the physician's longstanding relationship with the patient provided a foundation for his decision to accede to her request for assistance with suicide. On the other hand, it is equally possible, and perhaps closer to reality, to imagine deathbed scenes fraught with anxiety, conflict, and mistrust. As ethicist Leon Kass hypothesized:

Imagine the scene: you are old, poor, in failing health, and alone in the world; you are brought to the city hospital with fractured ribs and pneumonia. The nurse or intern enters late at night with a syringe full of yellow stuff for your intravenous drip. How soundly will you sleep? It will not matter that your doctor has never yet put anyone to death; that he is legally entitled to do so will make a world of difference.¹⁷⁴

The realities of terminal care and dying in our present health care system constitute the strongest argument against legalizing euthanasia. A system which fails to care adequately for the living must not be empowered with a license to kill.

170. *Id.* (quoting Dr. Jack Kevoorkian).

171. Death with Dignity Act, H.R. 1275, 152d Leg., Reg. Sess., N.H. (1992). [House Bill 92-2332 (1992)].

172. *Id.* § 137-K:3(I).

173. *Id.* § 137-K:4.

174. *Euthanasia: Final Exit, Final Excuse*, FIRST THINGS, Dec. 1991, at 4, 8 (quoting Leon Kass in an editorial).

III. EUTHANASIA AND THE HEALTH CARE CRISIS

In formulating public policy on euthanasia, the benefits of legalization must be balanced against the harms legalization may entail. Public policy is not created in a vacuum; arguments for euthanasia that rely on autonomy or mercy are persuasive when applied to specific cases, but a public policy to lift the general prohibition on euthanasia must take societal consequences into account. If legalized, euthanasia would be practiced within a health care system that is reaching a critical state: rising costs in all areas of the industry and the care of the uninsured and underinsured have placed onerous burdens on hospitals, employers, and federal and state governments. An examination of euthanasia through the lens of the health care dilemma moves the debate from the context of issues of autonomy and mercy into the sphere of externalities—systemic pressures and the quotidian realities of the health care industry. If euthanasia is to be seriously considered as an addition to the canon of medical procedures to be performed within that system, it must be assessed in the context of our health care institutions.

This Part examines what the legalization of voluntary euthanasia might mean in the context of our health care system. The first section argues that our present health care system is incapable of safely accommodating euthanasia. The second section argues that reform of the management of death in health care institutions would preempt the need for legal euthanasia.

A. The Cost Factor

A presumption in favor of treatment remains strong in the practice of medicine. Traditionally, health care professionals have tended to regard the cost of treatment as irrelevant to their obligation to act for the good of their patients.¹⁷⁵ Today, however, the rising cost of health care has forced the federal and state governments, private insurers, and employers to set limits on health care coverage.¹⁷⁶ Thirty-four to thirty-seven million Americans are without medical insurance, including entire families with full-time job holders.¹⁷⁷ Medical indigence is a “silent, largely invisible epidemic,”¹⁷⁸ spreading quickly—the number of Americans with private coverage of hospital

175. THE HASTINGS CENTER, GUIDELINES ON THE TERMINATION OF LIFE-SUSTAINING TREATMENT AND THE CARE OF THE DYING 123 (1987).

176. *Id.*

177. Edwin Chen, *Medical Care Reform May Be Reaching Turning Point*, L.A. TIMES, July 21, 1991 (Sunday final ed.), at A1.

178. Emily Friedman, *The Torturer's Horse*, 261 JAMA 1481, 1481-82 (1991).

costs continues to decrease at the rate of one million per year.¹⁷⁹ In 1989, hospitals provided \$11.1 billion in uncompensated care. Among the costliest afflictions were those that often stem from poverty: AIDS, drug abuse, and problem pregnancies.¹⁸⁰

The financial survival of health care institutions now depends directly on controlling costs generated by individual patient care decisions.¹⁸¹ Cost containment already affects patient decision making, particularly when health insurance benefits fail to keep pace with the cost of treatment. Patients are sometimes forced to forego beneficial treatments they wish to receive.¹⁸² For the twenty-six million poor, disabled, and elderly Americans who receive health care through Medicaid,¹⁸³ the "unrealistically low" provider reimbursement levels mean limited access to treatment.¹⁸⁴ For the uninsured, receiving access to any form of health care is problematic. More and more hospitals are faced with the choice of caring for all the uninsured and going under financially, or turning at least some of them away.¹⁸⁵ The cost of care of the uninsured has become a significant factor in the increase in the cost of care for everyone,¹⁸⁶ and as cost containment measures are implemented in Medicaid and private health insurance programs, the quality of care declines.¹⁸⁷

The medically indigent are most at risk of abuse in a scheme of legal euthanasia. The uninsured poor, who include the very elderly, AIDS patients, the homeless, and the mentally ill,¹⁸⁸ receive not only diminished access to health care providers, but fewer services once entry to the health care system is achieved.¹⁸⁹ The uninsured usually receive no more than last-minute interventions in emergency departments, and the availability of non-emergency care for indigents continues to erode.¹⁹⁰

179. *Id.*

180. Emily Friedman, *The Uninsured: From Dilemma to Crisis*, 265 JAMA 2491, 2491 (1991).

181. OFFICE OF TECHNOLOGY ASSESSMENT, U.S. CONGRESS, INSTITUTIONAL PROTOCOLS FOR DECISIONS ABOUT LIFE-SUSTAINING TREATMENTS 4 (1988).

182. *Id.*

183. Gail R. Wilensky, *From the Health Care Financing Administration*, 265 JAMA 2461, 2461 (1991).

184. James S. Todd et al., *Health Access America—Strengthening the U.S. Health Care System*, 265 JAMA 2503, 2504 (1991).

185. Friedman, *supra* note 180, at 2494.

186. *Id.*

187. OFFICE OF TECHNOLOGY ASSESSMENT, U.S. CONGRESS, LIFE-SUSTAINING TECHNOLOGIES AND THE ELDERLY 18 (1987) [hereinafter OTA].

188. Friedman, *supra* note 178, at 1481.

189. Mark B. Wenneker et al., *The Association of Payer with Utilization of Cardiac Procedures in Massachusetts*, 264 JAMA 1255, 1255 (1990).

190. Friedman, *supra* note 178, at 1481.

For indigent patients, particularly those without family members willing to challenge health care providers to maintain a reasonable standard of care, the option of euthanasia is fraught with danger. An institution providing an indigent patient with care would be called upon to resist substantial incentives to encourage the patient to avail himself of euthanasia, including financial savings and the release of resources to insured patients. The same incentives already exist for institutions to influence the decision to withhold or withdraw treatment from a terminally ill indigent patient. The possible statistical correlation between insurance status and withholding or withdrawal of treatment should be studied. The changing policies of health care institutions in response to the Patient Self-Determination Act and the likely increase in execution of advance directives by inpatients may shed light on this question, and consequently illuminate the potential for abuse under legal euthanasia.

Even under circumstances of non-indigence, when a patient is dying or terminally ill, family members, physicians, and nurses are under great physical and psychological stresses.¹⁹¹ Family members are dealing with anticipatory grief, financial burdens, and excessive demands on their time, and involvement in treatment decisions is likely to be filled with anxiety and guilt.¹⁹² Health care professionals must deal with the emotional burdens of the ill patient and the grieving family, and with constant reminders of their own mortality.¹⁹³ As cost containment becomes a factor in the decision whether or not to offer specific life-saving treatment, this already tense environment is likely to become charged with a sense of futility and hopelessness.

If voluntary euthanasia is legalized before the financial stresses in our health care system are reasonably ameliorated, the potential for abuse is great. As ethicist Tom Beauchamp warns, "[T]he aged will be even more neglectable and neglected than they now are, [and] doctors would have appreciably reduced fears of actively injecting fatal doses whenever it seemed to them propitious to do so."¹⁹⁴ Pressures on terminally ill patients to "get it over with" and spare their loved ones expense and misery will be exerted by families and caregivers, and such subtle (or unsubtle) coercion would hardly be discouraged by hospitals stretching tight budgets. If one takes into account the fact that more than 10,000 American adults remain in nursing homes and hospitals in vegetative comas at the public expense of \$350 million per

191. OTA, *supra* note 187, at 25.

192. *Id.*

193. *Id.*

194. Tom L. Beauchamp, *A Reply to Rachels on Active and Passive Euthanasia*, in *ETHICAL ISSUES*, *supra* note 23, at 253.

year,¹⁹⁵ the potential utility of euthanasia as a cost containment device becomes clear.

Comparison with health care in the Netherlands reveals the inadvisability of transplanting euthanasia to the United States. According to Teresa Takken, a Catholic nun and ethicist from the University of Utrecht, Holland's comprehensive health care and welfare system probably keeps requests for euthanasia at a minimum and makes abuses unlikely.¹⁹⁶ But, she insists, "We have no business even talking about euthanasia here [in the United States] until we have health care for all, and even housing for all."¹⁹⁷ Ethicist Corrine Bayley agrees that economic considerations could corrupt decisions involving euthanasia in the United States, and adds that American physicians generally have much shorter term and less trusting relationships with their patients than Dutch physicians, and so are less equipped to cope with requests for euthanasia.¹⁹⁸ Dr. Carlos Gomez, who argues that significant abuses have taken place in the Netherlands, fears that "euthanasia will be used, as it sometimes is in Holland, as a tool of social and economic control. Poor people, especially in this country where we deny medical services to many of them, are the most vulnerable to be euthanized."¹⁹⁹

Moreover, sanctioning physicians to kill patients may rob the health care establishment of the impetus to make serious movement toward reform of the care of the terminally ill, and may serve as a pressure valve, enabling the system to avoid the financial and ethical dilemmas now crying out to be addressed.

B. *The Care of the Dying*

The power of medicine to extend life under circumstances of technological dependency, pain, incompetency, and coma is widely feared.²⁰⁰ Treatment in hospitals has become increasingly fragmented, and people who two decades ago might have died quietly at home or in the company of a trusted family doctor today die surrounded by machines and teams of specialists they hardly know.²⁰¹ Yet, concurrent with the development of life-sustaining technology

195. Shaw, *supra* note 14, at 97-98.

196. Horgan, *supra* note 111, at 20.

197. *Id.*

198. *Id.*

199. Egan, *supra* note 6.

200. Callahan, *supra* note 36, at 4.

201. Elisabeth Rosenthal, *In Matters of Life and Death, the Dying Take Control*, N.Y. TIMES, Aug. 18, 1991, § 4, at 1. In an intensive care unit, a cancer patient's general practitioner is a bystander to the oncologist, infectious disease specialist, kidney consultant, and a rotating team of intensive care doctors. *Id.*

has been the growth of awareness that the management of death in health care institutions must be reformed. The general acceptance by the medical profession of the concept of patient autonomy and of the participation of patients and their families in health care decision making is one positive development.

Another significant development has been the growth of the hospice movement and the proliferation of hospice programs throughout the country.²⁰² The hospice concept, which can be realized in a patient's home or in institutions, was created to remedy the sense of isolation, depersonalization, and loss of control that dying patients suffer in hospitals, surrounded by medical technology.²⁰³ When a patient begins hospice care, all extraordinary or life-sustaining measures are discontinued, and the focus of treatment is on palliative care only—comfort and symptom control.²⁰⁴ Hospice is intended to meet the physical, social, psychological, and spiritual needs of both the dying patient and family,²⁰⁵ and provides a caring response to many patients' fears of pain, of dying alone, and of the tyranny of medical technology.²⁰⁶

Voluntary euthanasia, on the other hand, may provide not release from medical technology, but a "deceptively easy technological 'quick fix' the ultimate triumph of technical virtuosity over humane medicine,"²⁰⁷ as it may be a symptom of our cultural avoidance of the responsibility to come to terms with death and dying.²⁰⁸ As Dr. Elisabeth Kubler-Ross wrote more than twenty years ago, the further that science advances, "the more we seem to fear and deny the reality of death."²⁰⁹ Physicians and nurses often become neglectful of patients once they have been diagnosed as terminal and may separate themselves mentally and physically from the dying patient.²¹⁰ Hospitals, which are primarily focused on preserving life, curing, diagnosis, and treating illness, tend to conceal death.²¹¹ If the option of ending a

202. See Vande Cox, *The Hospice Concept: Dying as a Part of Living*, NURSING HOMES AND SENIOR CITIZEN CARE, July-Aug. 1988, at 29, 29.

203. *Id.* at 29-30.

204. See *id.* at 30. The hospice patient, however, "retains the option to reinstate treatment at any phase of his illness." *Id.* at 32.

205. *Id.* at 31.

206. See ELISABETH KUBLER-ROSS, *TO LIVE UNTIL WE SAY GOOD-BYE* 138-40 (1978).

207. James F. Bresnahan, *Reflection, in ACTIVE EUTHANASIA*, *supra* note 14, at 83, 85.

208. *Id.*

209. ELISABETH KUBLER-ROSS, *ON DEATH AND DYING* 6-7 (1969).

210. Cox, *supra* note 202, at 29-30.

211. *Id.*

terminally ill person's life early is available to physicians and hospitals, the quality of care given to such patients is unlikely to improve.²¹²

If care of the dying were more humanely managed, there would be little need for euthanasia.²¹³ In a 1989 article in the *New England Journal of Medicine*, twelve physicians set forth views concerning treatment of hopelessly ill patients.²¹⁴ The article gained notoriety through the endorsement of physician-assisted suicide by ten of the twelve physicians,²¹⁵ but the article also addressed the inadequacies of current modes of care for the dying and proposed a number of feasible and cost-effective reforms. Among these proposals were the initiation of timely discussions with patients about dying, the solicitation and execution of advance directives, the facilitation of dying at home, the development of hospice care, the discouragement of intensive care units for dying patients, the formulation by physicians of flexible and adjustable programs of care, the training of physicians in care of the dying, and the aggressive use of painkillers, even if death is thereby hastened.²¹⁶

Many of these reforms are already, to varying degrees, in practice in many parts of the country. Doctors are far more likely now than ever before to honor patients' wishes to forego aggressive treatment; the hospice movement uses sophisticated technology to keep terminal patients pain free and comfortable; and physicians are becoming more comfortable with administering increased morphine doses to control pain.²¹⁷ There is still much to be accomplished. Radical changes in the care of the terminally ill are needed, and should be an integral part of any health care reform package to come out of the United States Congress.

CONCLUSION

Voluntary euthanasia may ultimately be viewed as a backlash against a medical profession that failed to address the needs of the terminally ill, or it may be an idea whose time has come. Over the coming decades, the elderly population will increase dramatically, and if the spread of AIDS and social

212. Stephen Sapp, *Reflection*, in ACTIVE EUTHANASIA, *supra* note 14, at 88, 90.

213. Ronald E. Cranford, *Reflection*, in ACTIVE EUTHANASIA, *supra* note 14, at 80, 81.

214. Sidney H. Wanzer et al., *The Physician's Responsibility Toward Hopelessly Ill Patients*, 320 NEW ENG. J. MED. 844 (1989).

215. *Id.* at 848. The acceptance of assisted suicide under certain conditions by the ten physicians is couched in terms that would limit the procedure to exceptional cases: "If care is administered properly at the end of life, only the rare patient should be so distressed that he or she desires to commit suicide." *Id.* at 847.

216. *Id.* at 844-49.

217. Rosenthal, *supra* note 201, at 1-2.

ills associated with poverty continues unabated, our health care system will be burdened far beyond its present capacity. If reforms are not undertaken to ensure access to adequate health care for all Americans and to provide for more compassionate policies and strategies in the care of the dying, voluntary euthanasia may one day be seen, for the terminally ill and their families, as presumptively correct—the only way out of a hellish situation.

Even in the absence of legal voluntary euthanasia, some physicians will continue to assist patients to end their lives. In certain cases, such assistance may be justified, just as mercy killing may, under extreme circumstances, be so morally justified as to warrant acquittal in court. Yet to authorize euthanasia legislatively would be to create social policy based on the exceptional situation. Hard cases do indeed make bad law. Passing legislation to permit the few justifiable cases of euthanasia, at the expense of potentially opening the door to widespread abuses, is bad law and irresponsible social policy.