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THE CONSTITUTIONAL RIGHT TO SUICIDE, THE QUALITY OF LIFE, AND THE "SLIPPERY-SLOPE": AN EXPLICIT REPLY TO LINGERING CONCERNS

by

DR. G. STEVEN NEELEY*

It is a shame when the soul is first to give way in this life, and the body does not give way.[1]

- Marcus Aurelius

For mere living is not a good, but living well. Accordingly, the wise man will live as long as he ought, not as long as he can.[2]

- Seneca

The thought of suicide is a powerful comfort: it helps one through many a dreadful night.[3]

- Nietzsche

INTRODUCTION

Technological innovations in the medical sciences have granted us a higher quality of life than ever before.[4] A mounting concern is the effect this same technology is having upon the quality of dying.[5] It is now possible to sustain human existence far beyond the point where the competent adult might

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1. MARCUS AURELIUS, *Meditations*, *in* MARCUS AURELIUS AND HIS TIMES 61 (G. Long trans., 1973).

2. SENECA, AD LUCILIUM EPISTULAE MORALES 59 (Richard M. Gummere trans., 1934).

3. FRIEDRICH NIETZSCHE, *Beyond Good and Evil, in* BASIC WRITINGS OF NIETZSCHE 281 (Walter Kaufmann trans. & ed., 1968).

4. An earlier version of this paper was presented on the West Virginia Philosophical Society Conference in the Spring of 1991. I would similarly like to express my gratitude to Peter Lang Publishing for permission to use selected excerpts from my forthcoming book: THE CONSTITUTIONAL RIGHT TO SUICIDE: A LEGAL AND PHILOSOPHICAL EXAMINATION (in press, manuscript on file with author).

5. *See It's Over, Debbie*, 259 JAMA 272 (1988); Timothy E. Quill, *Death and Dignity: A Case of Individualized Decision Making*, 324 NEW ENG. J. MED. 691 (1991); Sidney H. Wanzer et al., *The Physician's Responsibility Toward Hopelessly Ill Patients: A Second Look,* 320 NEW ENG. J. MED. 844 (1989).

rationally conclude that life is no longer worth living.[6] Nevertheless, the current state of the law often makes it difficult, if not impossible, for the individual to exercise unfettered control over the circumstances of dying.[7] The common law has long recognized the right of the individual to be free from non-consensual invasions of bodily integrity and this right has been extended to include the freedom to refuse necessary life-saving medical treatment.[8] But the law has equally long been anathematic to suicide[9] and twenty-six states and the Commonwealth of Puerto Rico presently have statutes which prohibit assisting a suicide.[10]

The accepted legal definition of suicide includes: "[s]elf-destruction; the deliberate termination of one's own life;"[11] "the act of self-destruction by a person sound in mind and capable of measuring his moral responsibility."[12] Yet decisions to disemploy life-support are easily swept under the same rubric, and situations have developed in which even seriously ill competent adults have found it nearly impossible to compel the removal of invasive life-support apparatus.[13] Moreover, any decision, however rational and humane,

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6. As Justice Scalia observed in Cruzan v. Director, Missouri Dep't of Health, 497 U.S. 261 (1990), society is faced with "the constantly increasing power of science to keep the human body alive for longer than any reasonable person would want to inhabit it." *Id.* at 292 (Scalia, J., concurring). Note also, that the American Medical Association has recently estimated that "approximately 70% of all Americans will face a decision to refuse life-sustaining treatment for themselves or a family member at some point in their lives." Edward A. Lyon, Note, *The Right to Die: An Exercise of Informed Consent, Not an Extension of the Constitutional Right to Privacy*, 58 U. CIN. L. REV. 1367, 1372 (1990).

7. *See* PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT (1983); Anne Marie Gaudin, Cruzan v. Director, Missouri Department of Health: *To Die or Not to Die: That is the Question - But Who Decides?* 51 LA. L. REV. 1307 (1991).

8. Natanson v. Kline, 350 P.2d 1093, 1104 (Kan. 1960). Schloendorff v. Society of New York Hosp. 105 N.E. 92, 93 (N.Y. 1914)

9. Keith Burgess-Jackson, *The Legal Status of Suicide in Early America: A Comparison with the English Experience,* 29 WAYNE L. REV. 57, 60 (1982).

10. Thomas J. Marzen et al., *Suicide: A Constitutional Right?*, 24 DUQ. L. REV. 1, 97 (1985). Moreover, "[t]hree additional states would apparently hold one who assisted a suicide . . . guilty of murder as a principal," while at least two more states would likely "penalize assisting suicide under the common law of crimes." *Id.* Indiana and Hawaii "make causing suicide an offense but do not prohibit [assisting suicide]." *Id.* at 98. All told, only nine states have "no prohibitions" regarding suicide. *Id.*

11. BLACK'S LAW DICTIONARY 1434 (6th ed. 1990).

12. WEBSTER'S NEW TWENTIETH CENTURY DICTIONARY 1822 (2d ed. 1979).

13. *See generally* Thor v. Superior Court, 855 P.2d 375 (Cal. 1993); Bouvia v. Superior Court, 225 Cal Rptr. 297 (Ct. App. 1986), *review denied* (Cal. 1986); Bartling v. Superior Court, 209 Cal. Rptr. 220 (Ct. App. 1984); *In re* Rodas, No. 86 PR. 139 (Colo. Dist. Ct. Mesa County, Jan. 22, 1987); Satz v. Perlmutter, 362 So.2d 160 (Fla. Ct. App. 1978), *aff'd.*, 379 So.2d 359 (Fla. 1980); *In re* State v. McAfee 385 S.E.2d 651 (Ga. 1989); McKay v. Bergstedt,

to deliberately ease the transition into death is apt to constitute suicide in the patient who consents and assisted suicide, or even murder, in the agent who administers.[14]

As a reaction to this expanding problem, a number of legal scholars have argued for the recognition of a constitutional right to suicide which would protect the right of the individual - at least under certain circumstances - to terminate her own existence.[15] Judicial recognition of a fundamental human right to suicide would subject state legislation infringing this right to "strict scrutiny analysis."[16] Offending legislation would thus have to be necessary to advance some compelling state interest[17] and be narrowly drawn so as to constitute the least restrictive means available to sustain its compelling purpose.[18] The upshot of such a right would be to ensure that no mentally competent adult could be forced to remain alive against her will and best interests.

The courts and commentators have traditionally identified four state interests that may limit a persons' right to refuse life-saving medical treatment: preserving live, preventing suicide, safeguarding the integrity of the medical profession, and protecting innocent third parties.[19] But many courts and

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801 P.2d 617 (Nev. 1990); *In re* Farrell, 529 A.2d 404 (N.J. 1987); *In re* Lydia E. Hall Hosp. 455 N.Y.S.2d 706 (Sup. Ct. 1982).

14. GLANVILLE WILLIAMS, THE SANCTITY OF LIFE AND THE CRIMINAL LAW 318 (1970). In particular, *see* People v. Kevorkian, No. 90-3909637-AZ (Mich. Ct. Cl. Feb. 5, 1991).

15. *See, e.g.,* Alan Sullivan, *A Constitutional Right to Suicide: in* SUICIDE: THE PHILOSOPHICAL ISSUES 229 (M. Pabst Battin & Davide J. Mayo eds., 1980); H. Tristram Engelhardt & Michele Malloy, *Suicide and Assisting Suicide: A Critique of Legal Sanctions,* 36 SW. L.J. 1003 (1982); G. Steven Neeley, *Patient Autonomy and State Intervention: Reexamining the State's Purported Interest,* 19 N. KY. L. REV. 235 (1992); David A.J. Richards, *Constitutional Privacy, the Right to Die and the Meaning of Life: A Moral Analysis,* 22 WM. & MARY L. REV. 327 (1981); James Bopp, *Is Assisted Suicide Constitutionally Protected?,* 3 ISSUES L & MED. 113 (1987). *But see* Marazen, *supra* note 10.

16. The key to invoking "strict scrutiny analysis" is the assertion that the state's practice infringes a "fundamental right." As a general matter, fundamental rights are those explicitly guaranteed by the *Bill of Rights* or otherwise implied but not expressly articulated in the Constitution's text. In seeking to ascertain which rights might legitimately be deemed "fundamental," the Supreme Court has typically employed the nebulous rubric of two landmark decisions. In Palko v. Connecticut, 302 U.S. 319 (1937), it was said that this category includes those fundamental liberties that are "implicit in the concept of ordered liberty," such that "neither liberty nor justice would exist if [they] were sacrificed." *Id.* at 325-26. But in Moore v. City of East Cleveland, 431 U.S. 494 (1977), fundamental rights are characterized as those liberties that are "deeply rooted in this Nation's history and tradition." *Id.* at 503.

17. *See, e.g.,* Roe v. Wade, 410 U.S. 113 (1973); Kramer v. Union Free Sch. Dist., 395 U.S. 621 (1969).

18. Shelton v. Tucker, 364 U.S. 479 (1960).

19. *In re* Satz v. Perlmutter, 362 So.2d 160 (Fla. Ct. App. 1978), *aff'd,* 379 So.2d 359 (Fla. 1980); *In re* Spring, 405 N.E.2d 115 (Mass. 1980); Commissioner of Corrections v. Meyers,

scholars appear to be motivated by yet another and more implicit concern with the so-called "quality of life" argument. This argument suggests that once the legislature or judiciary begins to consider the *quality* of a persons' life, then a dangerous precedent exists for the state-imposed "extermination" of all persons whose "quality of life" does not measure up to sufficient standards.[20] This ofttimes subtle design ultimately proves to be nothing more than a variation of the "slippery-slope" argument. This paper will contend that such arguments are logically fallacious and, *at best*, sway only by emotional appeal. As such, this style of argument should be afforded little forensic weight as it serves only to further confuse the debate over the constitutionality of self-directed death.

THE "SLIPPERY-SLOPE"

In abstract terms, the "slippery-slope" argument typically exemplifies two basic forms, one logical, the other psychological. The logical form of the "slippery-slope" argument is an instance of the *reductio ad absurdum* technique. The proposition at issue is shown to logically entail other propositions which are either 'absurd' or else antecedently unacceptable to the person who advocates the initial proposition."[21] As Rachels provides: "[t]he logical form of the argument goes like this. Once a certain practice is accepted, from a

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399 N.E.2d 452 (Mass. 1979); Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417 (Mass. 1977); *In re* Torres, 357 N.W.2d 332 (Minn. 1984); *In re,* Conroy 486 A.2d 1209 (N.J. 1985); *In re* Colyer, 660 P.2d 738 (Wash. 1983); PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 31-32 (1983); Carol A. Colabrese, Comment, *In re* Storar: *The Right to Die and Incompetent Patients,* 43 U. PITT. L. REV. 1087, 1092 (1982).

20. Consider, for example, the Missouri state supreme court majority opinion in Cruzan v. Harmon, 760 S.W.2d 408 (Mo. 1988) (en banc), *aff'd sub nom* Cruzan v. Director, Missouri Dep't of Health, 497 U.S. 261 (1990):

> It is tempting to equate the state's interest in the preservation of life with some measure of quality of life .... But the state's interest is not in quality of life .... Were quality of life at issue, persons with all manner of handicaps might find the state seeking to terminate their lives.

760 S.W.2d at 420. *See also* De Grella v. Elston, 858 S.W.2d 698, 702, 711, 717 (Ky. 1993); Mack v. Mack, 618 A.2d 744, 761 (Md. 1993); Guardianship of Doe, 583 N.E.2d 1263, 1276 (Mass.), *cert. denied* 112 S.Ct. 1512 (1992); *In re* Guardianship of L.W., 482 N.W.2d 60, 73 (Wis. 1992); Marzen, *supra* note 10 in particular, *see* sources cited *infra* notes 26-30 and accompanying text; Peter J. Riga, *Euthanasia, The Right to Die and Privacy: Observations on Some Recent Cases,* 11 LINCOLN L. REV. 109, 136-140 (1980); Christopher Supernor, Note, *Ignoring an Incompetent Person's Constitutional Right to Forgo Life-Sustaining Treatment* - Cruzan v. Director, Missouri Department of Health, 19 FLA. ST. U. L. REV. 209, 210 (1991).

21. JOEL FEINBERG, HARM TO SELF 346 (1986).

logical point of view we are committed to accepting certain other practices as well, since there are no good reasons for not going on to accept the additional practices once we have taken the all-important first step. But, the argument continues, the additional practices are plainly unacceptable; therefore, the first step had better not be taken."[22] The psychological form of the "slippery slope" argument provides that "once certain practices are accepted, *people shall in fact* go on to accept other more questionable practices."[23] Thus, the psychological form of the argument "is simply a claim about what people will do and not a claim about what they are logically committed to."[24] "[T]his form of the argument says that if we start off by killing people to put them out of extreme agony, we shall *in fact* end up killing them for other reasons, regardless of logic and nice distinctions. Therefore, if we want to avoid the latter, we had better avoid the former."[25]

In practice, the variants of the "slippery-slope" are often fused together, and may be accompanied by appeal to the emotions. The insidiousness of the "slippery-slope" argument is apparent in Bishop Sullivan's condemnation of euthanasia:

> The 'wedge principle' means that an act which, if raised to a general line of conduct would injure humanity, is wrong even in an individual case. . . .
>
> This principle of the wedge may be applied to euthanasia, both voluntary euthanasia and compulsory euthanasia. Here for the sake of argument it will be presumed that the suffering patient wishes euthanasia and that no evil effects will result to his friends or the common good from the single act of administering the euthanasia to him. Nevertheless, euthanasia must not be administered, for to permit in a single instance the direct killing of an innocent person, would be to admit a most dangerous wedge that might eventually put all life in a precarious condition. Once a man is permitted on his own authority to kill an innocent person directly, there is no way of stopping the advancement of that wedge. There exists no longer any rational grounds for saying that the wedge can advance so far and no farther. Once the exception has been admitted it is too late; hence the grave reason why no exception may be allowed. That is why euthanasia under any circumstances must be condemned. . . .
>
> If voluntary euthanasia were legalized, there is good reason to believe that at a later date another bill for compulsory euthanasia would be legalized. Once the respect for human life is so low that an innocent person may be killed directly even at his own request, compulsory euthanasia will

22. James Rachels, *Euthanasia, in* MATTERS OF LIFE AND DEATH 28, 58-59 (Tom Regan ed., 1980).

23. *Id.* at 59.

24. *Id.*

25. *Id.*

> necessarily be very near. This could lead easily to killing all incurable charity patients, the aged who are a public care, wounded soldiers, captured enemy soldiers, all deformed children, the mentally afflicted, etc. Before long the danger would be at the door of every citizen.[26]

Similarly, Grisez has no difficulty in linking voluntary euthanasia with the horrors of Nazi genocide:

> If liberal ideology and the implications of consequentialism are considered together, it becomes clear that no legalization of euthanasia can stop at voluntary euthanasia, or even at the nonvoluntary euthanasia of defective infants. The hesitation of Glanville Williams about the anxiety of those who feel insanity coming on and about the shocking aspects of the idea of disposing of the elderly is hardly likely to block the juggernaut of the pro-death movement.
>
> The final solution in the United States and other western societies will be unlike the final solution in Nazi Germany in its details, but not unlike it in its horror. And I fear that some who now live will experience this final solution. They will live to see the day they will be killed.[27]

Variations of the "slippery-slope" argument as applied to suicide and euthanasia are abundant.[28] Beauchamp has argued, for example, that at least from the perspective of rule utilitarianism, the wedge argument against euthanasia should be taken seriously. Accordingly, although a "restricted-active-euthanasia rule would have *some* utility value" since some intense and uncontrollable suffering would be eliminated, "it may not have the highest utility value in the structure of our present code or in any imaginable code which could be made current, and therefore may not be a component in the ideal code for our society . . . . For the disutility of introducing legitimate killing into

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26. JOSEPH V. SULLIVAN, THE MORALITY OF MERCY KILLING 54-56 (1950).

27. Germain Grisez, *Suicide and Euthanasia, in* DEATH, DYING, AND EUTHANASIA, 742, 810-11. (DENNIS J. HORAN & DAVID MALL EDS., 1977). Grisez continues:

> They will be killed, but not on the authority of a secret, dictatorial decree. They will be killed to vindicate their right to die. This right will be discovered in one or several amendments to the United States Constitution, or perhaps discerned by the sharp insight of some Justice in the penumbra of the right to life. Or, perhaps, they will be killed by the fiat of the Supreme Court, which in disregard of every legal precedent will declare that they are not persons and that people like them never have been persons in the whole sense. Or perhaps, they will be killed both to protect their rights and because they are not persons with rights to protect.
>
> They will be killed, but not with poison gas in a shower room; their bodies will be disposed of, but not in incinerators. Technological process surely will find a better, a more efficient, a less ugly way to do the job – a way which will not cause air pollution. How, then, will they be killed? Nobody can forecast the technical details. But one thing is certain. They will be killed with "dignity."

Id. at 811.

28. *See also* J. Gay-Williams, *The Wrongfulness of Euthanasia, in* INTERVENTION AND

one's moral code (in the form of active euthanasia rules) may, in the long run, outweigh the utility of doing so, as a result of the eroding effect such a relaxation would have on rules in the code which demand respect for human life."[29]

Beauchamp then continues down a now-familiar path:

> If, for example, rules permitting active killing were introduced, it is not implausible to suppose that destroying defective newborns (a form of involuntary euthanasia) would become an accepted and common practice, that as population increases occur the aged will be even more neglectable and neglected than they now are, that capital punishment for a wide variety of crimes would be increasingly tempting, that some doctors would have appreciably reduced fears of actively injecting fatal doses whenever it seemed to them propitious to do so . . . . A hundred such possible consequences might easily be imagined. But these few are sufficient to make the larger point that such rules permitting killing could lead to a general reduction of respect for human life.[30]

At bottom, "slippery-slope" objections to the legalization of voluntary active euthanasia advance the claim that if society were to permit a humane form of voluntary active euthanasia, then inhumane forms of involuntary euthanasia will follow, or, at least, that a general undesirable reduction in society's respect for human life will occur. The logical interpretation of the argument," in all the forms in which it has been leveled against legalized voluntary euthanasia, is a dismal failure. If one explicity restricts one's advocacy to *voluntary* euthanasia, then one can hardly be vulnerable to the charge that one's advocated position logically entails involuntary euthanasia or the Nazi programs of non-euthanasian murders."[31] The *reductio* form of the argument is tantamount to the assertion that "once you allow euthanasia for the patient in terrible agony, *you are logically committed* to approving of euthanasia in other cases as well."[32] Indeed, Sullivan claims that "[o]nce a man is permitted on his own authority to kill an innocent person directly, there is no way of stopping the advancement of that wedge. There exists no longer any rational grounds for saying that the wedge can advance so far and no further."[33] But this is patently false. There are rational and morally relevant

REFLECTION: BASIC ISSUES IN MEDICAL ETHICS 114 (RONALD MANSON ED., 1979); Yale Kamisar, *Some Nonreligious Views Against Proposed "Mercy-Killing" Legislation,* 42 MINN. L. REV. 969 (1958); Riga, *supra* note 20.

29. Tom L. Beauchamp, *A Reply to Rachels on Active and Passive Euthanasia, in* ETHICAL ISSUES IN DEATH AND DYING 246, 253 (TOM L. BEAUCHAMP & SEYMOUR PERLIN EDS., 1978).

30. *Id.*

31. Feinberg, *supra* note 21, at 346.

32. Rachels, *supra* note 22, at 59.

33. Sullivan, *supra* note 26, at 55.

grounds for distinguishing between the patient in agony who voluntarily seeks death and other cases, such as Sullivan's catalogue of "charity patients," "wounded soldiers," and "deformed children," who presumably do not wish to die. The line of demarcation can readily be drawn by the voluntariness of the act. In the first instance, the individual requests death, while in the second, the persons involved do not. The gulf between humanely assisting a competent and willing patient to effect his own death and murdering non-consenting persons under the slogan of "euthanasia" is too wide to glaze over. Society is not logically committed to sanctioning involuntary euthanasia once it permits voluntary active euthanasia. Nor does it follow that society must lose respect for human life once it begins to respect the sanctity of individual choice. The legalization of voluntary active euthanasia simply does not entail the horrors its opponents envision. As such, the logical variant of the "slippery-slope" fails, and cannot be used to justify universal proscriptions of self-willed death.

The psychological interpretation of the "slippery-slope" argument is perhaps more plausible, and exists as part of a "falling dominoes" scenario:

> To be sure, voluntary euthanasia does not *logically entail* involuntary euthanasia, but rather the dominoes are so arranged that once a particular legislature legalizes voluntary euthanasia, then inevitably political pressures will mount for the legalization of nonvoluntary euthanasia, which will in due time be legalized, softening up public opinion for involuntary euthanasia, encouraging politicians to move in that direction, and so on.[34] As Feinberg points out, [w]hether the argument is a good one depends on how the dominoes are in fact placed, and that is a complicated empirical question about which no one can pronounce with dogmatic confidence. But if there is a powerful independent moral case for the legalization of voluntary euthanasia, one would think that the burden would be on its opponents to show that the dominoes are lined up in order, and that the fall of those that are likely to topple would be a bad thing.[35]

The simple recognition that life is not always worth living generates a "powerful independent moral case" for the recognition of the constitutional right to suicide and for the type of voluntary active euthanasia that this right would engender. Yet opponents of the right to suicide have not met the burden of showing that disasterous effects will ensue from the rights' adoption.

There is a good amount of historical and anthropological evidence to support the claim that the approval of killing in one context does not necessarily lead to killing in different contexts of a culture. The infanticide of deformed offspring was widely accepted in ancient Athens and required by

34. Feinberg, *supra* note 21, at 346.

35. *Id.* at 346-47.

law in Sparta. Yet the practice of infanticide "is not a sign that [the Greeks] placed little value on human life. They were not a murderous people, and they took a stern view of some other types of killing."[36] The early Christians accepted homicide in times of war, capital punishment, or out of obedience to God, and yet rejected it under other circumstances.[37] In China, Confucian ethics permitted voluntary death in the case of hopeless disease, and the great Eastern religions, including Shintoism and Buddhism, followed a similar path [38] - in each instance, without apparent disruption to the moral fabric of society. Among Eskimo societies, the killing of infants and the aged was widely practiced as a measure to avoid depletion of the food supply, and yet murder was virtually unheard of. [39] Within contemporary Western society, killing is permitted in numerous circumstances: war, capital punishment, heroic self-sacrifice, and self-defense. Yet there is no evidence that such exceptions to the repulsion for killing have presented dangerous inroads leading to a general devaluation of human life.

Williams has referred to the "slippery-slope" as the "trump card of the traditionalist, because no proposal for reform, however strong the arguments in favour, is immune from the wedge objection. In fact, the stronger the arguments in favour of a reform, the more likely it is that the traditionalist will take the wedge objection—it is then the only one he has."[40] One of the implications of this type of argument is that "you must resist every proposal, however admirable in itself, because otherwise you will never be able to draw the line."[41] Yet there is strong evidence in support of the claim that society can establish a line of distinction along moral grounds and to advance no further with it.

Proponents of the "slippery-slope" objection to suicide and euthanasia frequently make reference to the "final solution" of Germany's Third Reich, suggesting that the horrors of genocide begin with the legitimization of euthanasia. The psychological impact of the accusation is difficult to disregard. Yet as Williams observes, the specter of the Holocaust could be brought to bear with equal psychological force against altering the taboo proscribing sterilization: "When proposals are made for promoting voluntary sterilization on eugenic and other grounds, they are immediately condemned by most

36. Rachels, *supra* note 22, at 52.

37. AUGUSTINE, CITY OF GOD book I, § 26 (George E. McCracken trans., 1957).

38. Rachels, *supra* note 22, at 35.

39. *Id.* at 60.

40. Glanville Williams, *"Mercy-Killing" Legislation — A Rejoinder,* 43 MINN. L. REV. 1, 9 (1959).

41. *Id.* at 10.

people as the thin edge of a wedge leading to involuntary sterilization; and then they point to the practices of the Nazis."[42] But the history of sterilization programs in the United States suggests quite the contrary, and "a more persuasive argument pointing in the other direction can easily be found."[43] At the beginning of the century, a number of sterilization laws were attempted in the United States in response to mounting interest in eugenics.[44] In the 1927 decision of *Buck v. Bell*,[45] the Supreme Court upheld a Virginia law which provided that whenever the superintendent of a state institution considered it in the best interest of a patient and society, patients afflicted with hereditary forms of insanity and imbecility could be considered for sterilization: "We have seen more than once that the public welfare may call upon the best citizens for their lives. It would be strange if it could not call upon those who already sap the strength of the state for these lesser sacrifices . . . ."[46] After a period of widespread employment of eugenic sterilization practices, divided popular opinion and a general decline of interest in eugenics caused the pendulum to swing in the opposite direction.[47] Sterilization found respect in a few states as a branch of social medicine, but most jurisdictions with sterilization laws never put them into serious effect.[48] In 1942, the Supreme Court decided *Skinner v. Oklahoma*,[49] concluding in a different context that the right to procreate was a fundamental right under the Constitution. The momentum for positive eugenics continued to decline as the medical community became increasingly aware of the scientific impracticability of substantially improving the human species through this means.[50] At present, "[s]ome twenty-seven states still have so-called involuntary sterilization laws. Yet medical, legal, and public attitudes toward sterilizing the mentally deficient have undergone a radical change. Today no responsible person advocates the compulsory sterilization of the mentally incompetent."[51] In synopsis:

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42. *Id.*

43. *Id.*

44. GLANVILLE WILLIAMS, THE SANCTITY OF LIFE AND THE CRIMINAL LAW 82 (1970).

45. 274 U.S. 200, 207 (1927).

46. *Id.* at 207.

47. Williams notes that some of the curtailment in sterilization practices may have been due to uncertainty regarding the constitutionality of the laws in question, "but the most important factors are cessation of interest and divided public opinion." WILLIAMS, *supra* note 44, at 83.

48. *Id.*

49. 316 U.S. 535 (1942).

50. WILLIAMS, *supra* note 44, at 84.

51. RONALD MUNSON, INTERVENTION AND REFLECTION: BASIC ISSUES IN MEDICAL ETHICS 449 (Ronald Munson ed., 2d ed. 1983).

> The American experience is of great interest because it shows how remote from reality in a democratic community is the fear — frequently voiced by Americans themselves — that voluntary sterilization may be the "thin edge of the wedge," leading to a large-scale violation of human rights as happened in Nazi Germany. In fact, the American experience is the precise opposite — starting with compulsory sterilization, administrative practice has come to put the operation on a voluntary footing.[52]

SUBSTITUTED JUDGMENT

If suicide were to become a constitutional right, then — under certain circumstances — the doctrine of substituted judgment could conceivably apply to allow a guardian ad litem to assert this right on behalf of comatose or otherwise incompetent patients. The question arises whether this type of nonvoluntary euthanasia[53] could present a wedge which would ultimately lead to involuntary euthanasia. It is sufficient to respond that there remains a tremendous difference between this variety of nonvoluntary euthanasia and involuntary euthanasia. The doctrine of substituted judgment exists so that an individual will not lose his right of autonomy simply because he has lost the ability to directly exercise that right.[54] In cases allowing a guardian to

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52. WILLIAMS, *supra* note 44, at 90-91. It is, of course, conceivable that a proponent of the wedge objection might seek to dismiss anthropological and historical evidence contrary to his position as "irrelevant." Accordingly, the argument would suggest that the behavior exhibited by different cultures while permitting killing under certain contexts does not serve as an adequate predictor of how our society would react to the legalization of suicide and euthanasia. A host of growing public concerns such as the cost and accessibility of health care and the increasing number of elderly persons within the society may serve to separate our culture from others regarding the foreseeable misuse of the right to suicide.

It is sufficient to respond to such charges that if anthropological and historical evidence is not considered relevant to the discussion of suicide and euthanasia, then proponents of the wedge objection will lose the major weapon of their arsenal: the fear that the legalization of euthanasia will lead to atrocities rivaling Nazi genocide. Either historical and anthropological evidence is allowable within the debate or it is not. If it is allowable, then relevant evidence can be produced on both sides of the debate. If such evidence is not allowable because it is culturally disparate and thereby "irrelevant," then the wedge objection loses much of its vitality. Indeed, one might suggest under the latter case that simply because something happened once does not mean that it would ever happen again. In short, there are few rights or liberties which cannot become engines of abuse. Any potential for abuse of the right to suicide calls for caution in its implementation and exercise, not for rejection of the right.

53. Rachels provides that "[n]onvoluntary euthanasia occurs when the patient is unable to form a judgment or voice a wish in the matter and, therefore expresses no desire whatever." Rachels, *supra* note 22, at 31. He thereupon recites two hypothetical patients as examples of recipients of nonvoluntary euthanasia, one who is "senile and only semiconscious," the other who is "permanently comatose." *Id.*

54. *See, e.g.*, Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417 (Mass. 1977).

decline medical intervention on behalf of incompetent patients, the courts have permitted substituted judgment as a humane measure to effect the probable wishes of the patient under the circumstances as calculated by existing evidence.[55] In this respect, passive nonvoluntary euthanasia is already firmly established within the law. Moreover, because the court endeavors to follow whatever course of action the incompetent patient would have chosen had he not been incapacitatied, instances of nonvoluntary euthanasia performed under the doctrine of substituted judgment are actually a species of voluntary euthanasia. If a situation calling for active nonvoluntary euthanasia should present itself, the presiding court would similarly be guided by the humanitarian credo of seeking to effect the will and best interests of the patient. The laudable aims of respecting individual choice (even within a scenario involving substituted judgment)[56] and seeking the best interests of the individual are diametrically opposed to schemes advocating involuntary euthanasia.

Moreover, the courts have undertaken every possible precaution to ensure that the doctrine of substituted judgment will not be abused. Ever since the seminal decision of *In re Quinlan*[57] in 1976, courts utilizing the doctrine of substituted judgment within right-to-die scenarios have applied one of five tests or procedures specifically designed to safeguard the rights of incompetents:[58] (1) substituted judgment based upon clear and convincing evidence of the patient's wishes, (2) substituted judgment where the family's best assessment of the patient's desires is respected, (3) a combination of (1) and (2) above, (4) a best interests/pure objective standard based upon such considerations as "a patient's relief from suffering, his prognosis and possibility of recovery, and the quality and extent of his life on the life-sustaining treatment"[59] as well as "the satisfaction of present desires, the opportunities for future satisfactions, and the possibility of developing or regaining the capacity for self-determination"[60] and (5) a limited objective standard based upon "trustworthy"[61] evidence of the patient's wishes" where it is clear that the

55. *E.g.*, John F. Kennedy Memorial Hosp. v. Bludworth, 452 So.2d 921 (Fla. 1984); Brophy v. New England Sinai Hosp. 497 N.E.2d 626 (Mass. 1986); *In re* Torres, 357 N.W.3d 332 (Minn. 1984); *In re* Conroy, 486 A.2d 1209 (N.J. 1985).

56. The very purpose of the doctrine of substituted judgment is to protect the individual's right of choice even under circumstances in which she cannot exercise that right.

57. 355 A.2d 647 (N.J. 1976), *cert. denied*, 429 U.S. 922 (1976).

58. Anne Marie Gaudin, Cruzan v. Director, Missouri Department of Health: *To Die or Not to Die: That is the Question – But Who Decides?* 51 LA. L. REV. 1307, 1328 (1991).

59. *Id.* at 1335 (citing Rasmussen v. Fleming, 741 P.2d 674, 689 (Ariz. 1987) and *In re* Conroy, 486 A.2d 1209, 1232 (N.J. 1985)).

60. *Rasmussen*, 741 P.2d at 689.

61. Gaudin, *supra* note 58, at 1337 (citing *In re* Conroy, 486 A.2d at 1232).

burdens of life continued by treatment outweigh the benefits of life."[62] In *all* cases, the goal of substituted judgment "is not to do what most people would do, or what the court believes is the wise thing to do, but rather what this particular individual would do if she were competent and understood all the circumstances."[63]

THE DISENFRANCHISED

Proponents of the "slippery slope" objection have also charged that those who are already disvalued by society — the aged, infirm and other groups traditionally victimized by discrimination will be particularly susceptible to that ever-advancing and tenuous edge of involuntary euthanasia. It has similarly been touted that the legalization of any form of active euthanasia will impart a societal message inherently disrespectful of life which will weigh especially hard upon the disadvantaged. But it must be remembered that the sick and dying are also a discrete and insular[64] group that is typically disvalued by society, and that it would be particularly unfair to deny such persons the right to control the course of their own destiny, and force them to suffer needlessly in order to placate society's abstract concern for the sanctity of life. Furthermore, interpreting the "messages" implicitly communicated by the legalization of voluntary active euthanasia is a speculative undertaking with which no one can speak *ex cathedra*. It might just as well be argued that respect for the wishes of the seriously ill is a necessary step towards respect for all persons. Finally, this twist of the "slippery slope" argument neglects to consider the importance of all of the other forces at work in our culture. It is not the occasional euthanatic killing motivated by compassion that negatively affects social relations and the quality of life in America, but the thousands of discompassionate killings that occur every day perpetrated by individuals with little or no ties to the social and moral community.

The manifold arguments against suicide and euthanasia contrast with the simple humanitarian arguments for their acceptance.[65] When death becomes

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62. *Id.*

63. *In re* Guardianship of Ingram, 689 P.2d 1363, 1369 (Wash. 1984).

64. United States v. Carolene Products Co., 34 U.S. 144, 152 n.4 (1938) (J. Stone).

65. WILLIAMS, *supra* note 44, at 316. Similarly, Rachel states:

> The single most powerful argument in support of euthanasia is the argument from mercy. It is also an exceptionally simple argument, at least in its main idea, which makes one uncomplicated point. Terminal patients sometimes suffer pain so horrible that it is beyond the comprehension of those who have not actually experienced it. . . . The argument from mercy says: Euthanasia is justified because it provides an end to that.

Rachels, *supra* note 22, at 40.

the only respite from torment, it is both humane and rational to allow the individual to terminate his own existence. When the patient is unable to carry out his wishes, it is morally acceptable to assist the individual to achieve a swift and easy passage. Conversely, it is inhumane to keep a person alive against his will and best interests in order to satisfy abstract claims made by the state, or in order to force grudging allegiance to an eschatology which the individual may not accept. Yet as Williams observes with customary eloquence, behind the simple humanitarianism of the affirmative argument there lies a profound question of philosophy:

> It is good that men should feel a horror of taking human life, but in a rational judgment the quality of the life must be considered. The absolute interdiction of suicide and euthanasia involves the impossible assertion that every life, no matter what its quality or circumstances, is worth living and obligatory to be lived. This assertion of the value of mere existence, in the absence of all the activities that give meaning to life, and in the face of the disintegration of personality that so often follows from prolonged agony, will not stand scrutiny. On any rationally acceptable philosophy there is no ethical value in living any sort of life: the only life that is worth living is the good life.[66]

The recognition that life is not always worth living gives rise to an independent moral argument for the legalization of suicide and euthanasia. The proposed right to suicide advances this claim and stems from the Constitution's commitment to personal autonomy — the view that the individual should have unfettered liberty over his own life and person insofar as the exercise of such liberty does not harm others. As such, the right to suicide is born of respect for individual choice and could never be used to sanction involuntary euthanasia.[67] Proponents of the "wedge" objection cannot successfully demonstrate that undesirable effects will follow the right's adoption. It is particularly unobvious that the legalization of suicide and euthanasia will

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66. WILLIAMS, *supra* note 44, at 316-17. Williams continues this line of reasoning with a quotation from Sidney Hook:

> We may define the good life differently, but no matter what our conception of the good life is, it presupposes a physical basis – a certain indispensable minimum of physical and social well-being – necessary for even a limited realization of that good life. Where that minimum is failing together with all rational probability of attaining it, to avoid a life at its best can be only vegetative and at its worst run the entire gamut of degradation and obloquy, what high-minded person would refuse the call of the poet *"mourir entre les bras du sommeil"*? We must recognize no categorical imperative "to live," but "to live well."

Id. at 317 (quoting *The Ethics of Suicide*, 37 INT'L J. ETHICS 173, 186 (1927)).

67. It would be preposterous to claim that the Constitution's protection of the abortion right could one day be used to sanction mandatory involuntary abortion. It should be considered equally absurd to argue that the constitutional right to suicide could ultimately

lead to a disvaluation of human life. Indeed, it is equally tenable to postulate that a refusal to recognize the right to suicide will actually pose a greater threat to the sanctity of human life because such a stance would promote disregard for the quality and meaning of life. Universal proscriptions of self-willed death run afoul of respect for individual choice and accommodate callous indifference towards the suffering of others. Forcing an individual to remain alive against his own considered rational decree out of blind allegiance to archaic legal and social taboos is antithetical to human dignity, as it effectively treats the person as a means to advance society's ends. In this respect, it is simple enough to subvert the "wedge" objection by constructing an "anti-wedge" argument along similar lines — for once society fails to recognize the importance of self-sovereignty, and begins to ignore those critical aspects of existence which give life its meaning, then there is little to prevent an erosion of personal rights which would ultimately culminate in the loss of all freedom.

EUTHANASIA IN THE NETHERLANDS: TESTING THE "SLIPPERY-SLOPE"

Article 293 of the Dutch Penal Code states that "he who robs another of life at his express and serious wish, is punished with a prison sentence of at most twelve years . . . ."[68] The punishment for mercy killing imposed by Article 293 is less severe than the punishment for murder due to the request of the patient.[69]

The first court decision in which a physician was convicted but not sentenced under Article 293 occurred in 1950.[70] But it was not until 1971 that the Dutch actually began to move toward the legalization of voluntary active euthanasia.[71] The movement was ignited when a physician, Dr. Geertruida Postma, injected her terminally ill mother with a lethal dose of morphine.[72] When the physician was brought to trial, the court acknowledged that it was not unusual for the "average physician in the Netherlands" to allocate suffi-

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lead to involuntary euthanasia.

68. Marian H. N. Driesse et al., *Euthanasia and the Law of the Netherlands,* 3 ISSUES IN L. & MED. 385, 386 (Walter Lagerway trans. 1988).

69. Deborah A. Wainey, *Active Voluntary Euthanasia: The Ultimate Act of Care for the Dying,* 37 CLEV. ST. L. REV. 645, 663 (1989) (citing Driesse, *supra* note 68, at 386).

70. *Id.* at 654.

71. The definition of euthanasia widely accepted in the Netherlands is: "the active termination of a patient's life at his or her request, by a physician." Maurice A. M. de Wachter, *Euthanasia in the Netherlands,* HASTINGS CENTER REP., Mar. - Apr. 1992, at 23.

72. *See* Judgment of Feb. 21, 1973, Rb. [district court] Leeuwarden, 1973 Nederlandse Jurisprudentie [NJ], No. 183 (Neth.), *translated in* 3 ISSUES IN L. & MED. 439 (Walter Lagerway trans., 1988).

cient medication to alleviate the unbearable suffering of an incurably ill patient, even if the prescribed course of pain alleviation would shorten the patient's life.[73] The court adopted the prevailing medical standard as a guide. It further held that although the required conditions for a course of alleviation[74] were present, Postma had erred by circumventing this course and administering "a lethal dose all at once."[75] The doctor was given a conditional sentence of one week along with a probationary period of one year.

The Postma decision brought the principle of double effect to the critical foreground in Holland. The Dutch medical community condoned the administration of drugs to relieve suffering even if the result would be to shorten the patient's life. Yet it was forbidden to manipulate dosages with the intent to hasten or cause death. The pivotal issue, therefore, seems to be the specific intent of the actor and not the consequences.[76] If Postma had dispensed her mother's medication over a period of time in ostensible effort to relieve her suffering, instead of utilizing an immediately fatal injection, her actions would not have been punished. This seems to imply that an action which is impermissible when performed outright, can be permissibly carried out in increments.[77] This dichotomy renders the case particularly difficult to decipher. Was the court merely sanctioning the principle of double effect or rather promulgating specifications under which a physician could avoid the penalties of Article 293? The court's emphasis on the fact that Postma had circumvented the course of alleviation suggests that it is legally permissible for a physician to terminate a patient's suffering as long as she does not resort to lethal means without first pursuing the course of alleviation.[78]

The Postma decision essentially afforded a terminally ill patient with unbearable suffering the right to request and receive assistance-in-dying from

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73. *Id.* at 439.

74. The course of alleviation is considered appropriate when the following five conditions are present:

> A. [When] it concerns a patient who is incurable because of illness or accident . . . or who must be regarded as incurably ill from a medical standpoint;
> B. subjectively, his physical or spiritual suffering is unbearable or serious to the patient;
> C. the patient has indicated in writing, it could even be beforehand, that he desires to terminate his life, in any case that he wants to be delivered from his suffering;
> D. according to medical opinion the dying phase has begun for the patient or is indicated; and
> E. action is taken by the doctor, that is, the attending physician or medical specialist, or in consultation with that physician.

Id.

75. *Id.* at 442.

76. Wainey, *supra* note 69, at 656.

77. *Id.*

78. *Id.*

his attending physician.[79] A 1981 ruling expanded this right to cover non-terminal patients afflicted with continuous, unbearable physical and spiritual suffering.[80] In 1983, this standard was relaxed to require only continuous suffering without "reference to suffering being unbearable as an independent condition."[81]

The Dutch courts continue to pave the way toward making voluntary active euthanasia a reality in the Netherlands.[82] Yet it is clearly the medical profession which is charged with the primary responsibility of deciding whether to proceed with the practice of euthanasia, since the courts have placed such strong emphasis upon the standards of prevailing medical practice. The obvious divergence between case law and statutory law has left the Dutch government, medical profession, and Public Prosecutor with little certain ground, and has caused concern among opponents of euthanasia that this practice has begun to stretch into the realm of involuntary euthanasia.[83]

In 1982, the Queen of Holland created a State Commission on Euthanasia in an effort to determine "the future policy of the government in the matter of euthanasia . . . in particular with respect to legislation and the application of law."[84] In 1985, that Commission issued a report advising the Queen that Article 293 should be revised to legalize voluntary euthanasia, and proposed statutory reform that would allow a physician to avoid punishment under Article 293 provided that the euthanasia be performed at the request of the patient, and in accordance with the guidelines outlined by the Commission.[85] A bill was accordingly presented to Parliament in response to the Commission's report.[86] The government responded to this bill by issuing its own, more conservative Trial Proposal in 1986.[87] Both bills were in turn introduced to the Council of State — the highest advisory organ of the Dutch government — for review. The Council of State responded by advising the government to refrain from modifying Article 293 until the corpus of case law

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79. *Id.*

80. *Id.* at 656-58 (citing Driesse, *supra* note 68, at 394).

81. Driesse, *supra* note 68, at 394.

82. Wainey, *supra* note 69, at 661.

83. *Id.*

84. Driesse, *supra* note 68, at 394-95.

85. *Id.*

86. *Id.*

87. H.R.G. Ferber, *De wederwaardigheden van artikel 293 vanhet Wetboek van Strafrecht vanaf 1981 tot heden [The Vicissitudes of article 293 of the Penal Code from 1981 to the Present], in* EUTHANASIE KNELPUNTEN IN EEN DISCUSSIE [EUTHANASIA: BOTTLENECKS IN A DISCUSSION] 54 (G. A. Van Der Wal ed., 1987), *translated in* 3 ISSUES IN L. & MED. 455 (Walter Lagerway trans., 1988).

could develop further. This recommendation was in direct conflict with the Commission's report which had concluded that statutory reform was needed because it would take years to achieve clarity in the law if the issue remained solely within the purview of the courts.[88]

Opponents of legalized voluntary euthanasia in the Netherlands criticized the courts for having vested such responsibility in the medical community when there was no real consensus on the permissibility of euthanasia. Thus, in 1987, the Royal Netherlands Society for the Promotion of Medicine, and the Recovery Interest Society for Nurses and Nursing Aides issued a joint declaration establishing practical guidelines for health care professionals involved in euthanasia decisions.[89] While the organizations did not necessarily condone euthanasia, they were able to provide some semblance of "official" guidance to those physicians who elect to perform euthanasia, and to the nursing staff who might assist.[90]

Physicians in Holland are not required to report crimes against life.[91] As such, euthanasia killings involving physicians are likely to go unnoticed unless the doctor reports the incident or is turned in to the prosecutor by others. Only a handful of such cases are reported.[92] Commentary addressing the issues of physician aid-in-dying often points to the Netherlands as a case study. The literature has "drawn somewhat indiscriminately on the Dutch experience to support arguments both for and against physician assisted suicide and, especially, euthanasia."[93] Quite often, reports of alleged abuse are cited as definitive illustrations of the "slippery slope" effect.[94] Thus, the January, 1989 Hastings Center Report Special Supplement on euthanasia brandished an article by Richard Fenigsen, a Dutch cardiologist that was scathingly critical of both the law and practice of euthanasia in the Netherlands.[95] Fenigsen claimed that involuntary euthanasia was widely accepted and openly supported in his country, and that "[t]hose who contend that it is possible to accept and practice 'voluntary' euthanasia and not allow involun-

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88. Wainey, *supra* note 69, at 662.

89. P. Schepens, *Euthanasia: Our Own Future?*, 3 ISSUES IN L. & MED. 371, 377-78 (1988).

90. Wainey, *supra* note 69, at 663.

91. *Id.* at 664.

92. *Id.*

93. de Wachter, *supra* note 71, at 23.

94. *See* Daniel Callahan *When Self-Determination Runs Amok*, HASTINGS CENTER REP., Mar. - Apr. 1992, at 52, 54; Alexander Morgan Capron, *Euthanasia in the Netherlands: American Observations,* HASTINGS CENTER REP., Mar. - Apr. 1992, at 30, 32; Richard Fenigsen, *Euthanasia in the Netherlands,* 6 ISSUES IN L. & MED. 229, 243 (1990).

95. Richard Fenigsen, *A Case Against Dutch Euthanasia,* HASTING CENTER REP., Jan. - Feb. 1989, at 22.

tary [euthanasia] totally disregard the Dutch reality."[96] In stark contrast, a following article by Henk Ritger, director of the Dutch Health Council, answered that there was simply no evidence of the practice of involuntary euthanasia.[97] Furthermore, in a letter to the Report's editors the following November, a large and prestigious assembly of Holland's leading experts in law, medicine and ethics verified that Ritger's assessment of the situation was quite correct and that Fenigsen's commentary was "completely misplaced."[98] Most recently, Carlos F. Gomez[99] and John Keown[100] have drawn upon Fenigsen's claim to assert evidence of abuse in the Netherlands. In response to Gomez and Keown, Margaret Pabst Battin has critically warned that the various allegations of abuse may well be fatally defective. Accordingly, "[s]uch works tend to conflate two issues: whether abuse is actually occurring, and whether there are adequate protections against abuse; within the former category they also fail to distinguish between procedural abuse (e.g., not following the guidelines) and substantive abuse (killing patients against their will)."[101]

In the autumn of 1991, the results of two empirical studies on euthanasia in the Netherlands were released. Van der Wal, van Eijk, Leenen, and Spreeuwenberg reported the results of an "exploratory, descriptive, retrospective study of morbidity, age and sex of patients whose family doctors helped them to die,"[102] while the more influential Committee on the Study of Medical Practice concerning Euthanasia (the Remmelink Committee) sought to investigate "all situations in which physicians make decisions that aim (also) at ending suffering by hastening the end of the patient's life or in which the probability of a hastening of the end of life must be taken into account."[103]

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96. *Id.* at 26.

97. Henk Ritger, *Euthanasia in the Netherlands: Distinguishing Fact from Fiction,* HASTINGS CENTER REP., Jan. - Feb. 1989, at 31.

98. G.M. Aartsen, et al., *Letter to the Editor* HASTINGS CENTER REP., Nov. - Dec. 1989, at 47, 48.

99. Carlos F. Gomez, REGULATING DEATH: EUTHANASIA AND THE CASE OF THE NETHERLANDS (1991).

100. John Keown, *On Regulating Death,* HASTINGS CENTER REP., Mar. - Apr. 1992, at 39.

101. Margaret Pabst Battin, *Assisted Suicide: Can We Learn from Germany?*, HASTINGS CENTER REP., Mar. - Apr. 1992, at 44, 51 n.2.

102. G. van der Wal et al., *Euthanaise en hulp bij zelfdoding door artsen in de thuissituatie* [*Euthanasia and Medically Assisted Suicide in the Home Situation*], NEDERLANDS TIJDSCHRIFT VOOR GENEESKUNDE, 1593 (1991), *cited in* Henk A.M.J. ten Have & Jos V.M. Welie, *Euthanasia: Normal Medical Practice?*, HASTINGS CENTER REP., Mar. - Apr. 1992, at 34.

103. COMMISSIE ONDERZOCK MEDISCHE PRACTIJK INZAKE EUTHANASIE, MEDISCHE BESLISSINGEN ROND HET LEVENSEINDE MEDICAL [DECISIONS CONCERNING THE END OF LIFE], (1991), *cited in* ten Have, *supra* note 102.

It is accordingly estimated that 130,000 people die each year in the Netherlands. In 49,000 of these deaths "physicians have to decide whether to continue life support, withhold treatment, increase the dose of morphine to provide adequate pain relief, even at a potentially lethal level, assist in suicide, or actually kill the patient."[104]

It is further estimated that assisted suicide is "relatively uncommon" and occurs only 400 times a year.[105] Euthanasia, denoting "any action that intentionally ends the life of someone else, on the request of that person," occurs 2,300 times a year (five percent of the 49,000 deaths involving physician discretion).[106] Since 9,000 patients request euthanasia each year, it would appear that physicians grant such wishes less than half of the time.[107] Moreover, euthanasia has the highest incidence among family physicians and general practioners, whereas physicians in nursing homes seldom perform euthanasia.[108]

Critics have alleged, however, that many physicians do not classify their actions as euthanasia, even when those actions fall strictly under the definition employed by the studies.[109] Consequently, the figure of 2,300 may not accurately portray the number of euthanatic killings as "other forms of intentional hastening of death are common practice in the Netherlands, yet fully escape professional, judicial, and social scrutiny."[110]

There may also be as many as 1,000 patients annually whose demise is caused or hastened by physicians despite the absence of any specific request on the part of the patient.[111] This figure encompasses patients who suffer severely and are no longer competent to make treatment decisions. The Remmelink Committee found that in forty-five percent of these nonvoluntary euthanasia cases, the treatment of pain was no longer adequate to relieve suffering.[112] However, the impossibility of effective pain management was cited as the reason for euthanasia in only thirty percent of the cases. The remaining seventy percent of nonvoluntary euthanasia decisions were rendered by physicians for reasons including "(1) low quality of life; (2) no prospect for improvement; (3) all forms of medical treatment had become futile;

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104. ten Have, *supra* note 102.

105. *Id.* The authors do not define the term "assisted suicide".

106. *Id.*

107. *Id.* at 34-35.

108. *Id.* at 35.

109. *Id.*

110. *Id.*

111. *Id.*

112. *Id.* at 36.

(4) all treatment was withdrawn but the patient did not die; or (5) one should not postpone death."[113] In one-third of the cases, the fact that the patient's loved ones could no longer bear the situation played a role in the decision, and at least one respondent indicated that economic considerations, such as a shortage of beds, played a role.[114]

It is difficult to gauge what these figures actually mean. At least one report has charged that the Remmelink Committee swayed its findings in an effort to accommodate a predetermined political bias.[115] The Committee allegedly sought to remove social anxiety regarding the practice of euthanasia, and utilized "fallacious rhetoric" to emphasize that there is little cause for concern. But it is just as likely that opponents of euthanasia skew their findings and employ emotionally charged language in earnest endeavor to show that abuse is widespread. Statistics and emotional overtones are easily manipulated - by either side of the debate. Nevertheless, opponents of legalized voluntary euthanasia in the Netherlands have largely failed to address certain salient questions: What is meant by physician abuse? Are doctors bending the black letter of the law in order to comply with their patient's voluntary request and best interests or are they actually putting people to death without due concern for the patient's intent? Does the alleged abuse take the form of nonvoluntary euthanasia or involuntary euthanasia? Would adequate procedural safeguards or even a clear understanding of the present state of the law curtail the abuse alleged?

One certain fact regarding euthanasia in the Netherlands is that is takes place within the context of an ambiguous legal framework.[116] Despite various attempts by sundry organizations, no specific, comprehensive ethical or legal framework has been constructed.[117] Hospitals have developed their own standards,[118] and physicians effectively operate from a pending "rule of thumb." Thus, while euthanasia is still technically illegal,[119] physicians who adhere to certain conditions recognized by the courts and the 1985 State Commission on Euthanasia generally escape criminal sanction. The necessary conditions involve:

(1) voluntariness: a persistent, conscious and free request by the patient;

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113. *Id.*

114. *Id.*

115. *Id.*

116. Stephen A. Newman, *Euthanasia: Orchestrating "The Last Syllable Of . . . Time"*, 53 U. PITT. L. REV. 153, 187 (1991).

117. Maurice A. M. de Wachter, *Active Euthanasia in the Netherlands,* 262 JAMA 3316, 3319 (1989).

118. Newman, *supra* note 116, at 188.

119. de Wachter, *supra* note 71, at 23.

(2) a hopeless situation: a state of the disease or illness that both physician and patient consider to be beyond recovery; and (3) consultation of a colleague: confirmation of the decision-making process whereby physician and patient agree on the appropriateness of the euthanasia request.[120]

Physicians, however, have no guidelines regarding nonvoluntary euthanasia. Although the issue has been summarily debated, "no case law has yet developed nor has the medical profession laid down guidelines for practice."[121]

In sum, it is presently impossible to extrapolate any standard from the Dutch experience that could realistically serve to bar the recognition of the constitutional right to suicide within the United States. Many factors differentiate the two political climes. While there are scant allegations of abuse within the Dutch system, there is certainly no incontrovertible evidence of substantive abuse. Whatever abuse, if any, that exists in the Netherlands might well be halted altogether if there were clearer guidelines for health care workers to follow. As it is, euthanasia remains illegal in Holland, yet it is not always punished, while specific guidelines for the practice are effectively contingent upon further case law development. It would stand to reason that even the most earnest practitioner under such a system would be hesitant to invite public and legal scrutiny. One cannot unerringly follow guidelines when the guidelines are nonexistent or unclear.

Furthermore, a certain equitable and logical burden of proof ought to be involved in any fair hearing on the merits of a proposal. As previously addressed, there exists a very powerful and convincing moral argument for the legalization of voluntary active euthanasia. If opponents of euthanasia are not, in turn, required to at least match this argument with an equal measure of forensic weight, then the proposal will be effectively dismissed on *a priori* grounds. No proposal for reform, however beneficent, can ever escape the allegations of potential abuse. If the constitutional right to suicide is given a fair and impartial hearing on the merits, then "slippery-slope" arguments stemming from supposed abuse in the Netherlands will not prevail, if, however, the right to suicide is not given a fair hearing, then no discussion of individual liberty will be left uncompromised.

THE BOTTOM LINE: SOME PRACTICAL CONSIDERATIONS

The scope of the constitutional right to suicide is to protect the right of the competent adult to terminate his own existence. The impact of the right

120. de Wachter, *supra* note 117, at 3316. *See also* de Wachter, *supra* note 71, at 23.

121. de Wachter, *supra* note 71, at 24.

will fall upon seriously ill patients who seek death but lack the wherewithal to effect their own destruction. Judicial recognition of this right will not open social floodgates to a wave of unwarranted suicides.[122] Individuals who want to die and are capable of carrying out their wishes are not likely to be deterred by the threat of criminal sanctions. Thus, incompetent or distraught persons who would destroy themselves without sufficient cause or consideration will not be affected by a change in the legal status of suicide. As a practical matter, therefore, broad proscriptions of suicide and (in particular) assisted suicide seem to deny access to self-imposed death to that specific class of persons who might actually benefit from existing life — terminal and seriously ill patients.

If suicide were recognized as a fundamental human right under the Constitution, it would mean two things: (1) the state could not infringe this right unless the proposed abridgment were necessary to advance some compelling state interest,[123] and (2) the legislation in question would need to be narrowly tailored so as to constitute the least restrictive means available to sustain the state's compelling purpose.[124] The four state interests typically asserted as restrictions upon an individual's right to self-determination are: the preservation of life, the prevention of suicide, safeguarding the integrity of the medical profession, and protecting innocent third parties.[125] Yet a thorough analysis[126] of the purported interests reveals that the states' real concern should be with preserving the lives of those persons for whom the loss of life would be infelicitous and with preventing unnecessary harm to all relevant parties concerned. This statement of government interest takes into consideration the

122. Opponents of the constitutional right to suicide have suggested that judicial recognition of the right will have disasterous consequences for society because "the Constitution would not permit an absolute prohibition on any attempt to exercise an acknowledged constitutional right. Marzen, *supra* note 10, at 101. The implication proposed is that once suicide becomes a constitutional right, society will be impotent to prevent irrational acts of self-destruction by minors, incompetents or the temporarily distraught. But it betrays a rather naive grasp of constitutional law to suggest that the right to suicide would not permit regulatory safeguards. The state may regulate within the sphere of fundamental liberties provided that such restrictions satisfy the requirements of "strict scrutiny" analysis. If freedom of expression, for example, may be circumscribed by reasonable limits designed to curtail its misuse, Chaplinsky v. New Hampshire, 315 U.S. 568 (1942); Feiner v. New York, 340 U.S. 315 (1951); Colten v. Kentucky, 407 U.S. 104 (1972), there is no reason to believe that the same would not hold true of the right to suicide.

123. *See* Roe v. Wade, 410 U.S. 113 (1973); Kramer v. Union Free Sch. Dist., 395 U.S. 621 (1969).

124. *See* Shelton v. Tucker, 364 U.S. 479 (1960).

125. *See* cases and commentary *supra* note 16.

126. For a thorough analysis of the state interests involved in right-to-die scenarios see G. Steven Neeley, *Patient Autonomy and State Intervention: Reexamining the State's Purported Interest,* 19 N. KY. L. REV. 235 (1992).

observation that life is not always worth living and that the state must not ignore or disvalue the overriding concern of the patient in effecting a balancing of interests. It reflects the understanding that the "prevention of suicide" is not an independent interest worthy of consideration but rather is subsumed within the more general interest in the "preservation of life,"[127] and further recognizes that the integrity of the medical profession is not threatened by allowing the autonomy rights of individuals to supersede institutional considerations.[128]

Legislation which broadly proscribes all deliberate acts of self-destruction — or aiding and abetting such acts — does not constitute the least restrictive means of advancing the state's compelling purpose. Recognition of the constitutional right to suicide would accordingly herald the demise of criminal sanctions which flatly condemn suicide or assisted suicide. It would not mean, however, that the state could never impose justifiable constraints upon the exercise of the right. It would mean only that the legislature would be forced to draft narrowly tailored laws which advance the state's compelling purpose without unnecessarily stifling the fundamental liberty of thoroughgoing self-determination. The breadth of legislative abridgment of the right would be held in check by the "less drastic means" test[129] afforded to fundamental liberties under "strict scrutiny" analysis. The upshot of judicial recognition of the right to suicide would be the creation of a legal atmosphere in which the state could still promote legislation geared toward the protection of life — such as enactments seeking to protect minors or incompetents from unwarranted acts of self-destruction — but in which no competent adult could be forced to remain alive against his will and best interests. As a positive right, rather than simply a negative claim, the right to suicide could be used to solicit the assistance of others in order to make death as painless and dignified as possible. But precisely because the right to suicide stems from the Constitutions's core commitment to personal autonomy, it would be conceptually antithetical to the usurpation of self-sovereignty and could never be used to sanction involuntary euthanasia.

127. *Id.* at 246-48, 251; *In re* Conroy, 486 A.2d 1209, 1224 (N.J. 1985).

128. Neeley, *supra* note 126, at 246-248, 251; Bouvia v. Superior Court, 225 CAL. RPTR. 297, 307-08 (Ct. App. 1986) (Compton, J. concurring).

129. Even if the legislative purpose is legitimate and substantial, "that purpose cannot be pursued by means that broadly stifle fundamental personal liberties when the end can be more narrowly achieved. The breadth of legislative abridgment must be viewed in the light of less drastic means for achieving the same basic purpose." Shelton v. Tucker, 364 U.S. 479, 488 (1960). *See also* Roe v. Wade, 410 U.S. 113 (1973); Dean Milk Co. v. Madison, 340 U.S. 349 (1951).