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Melvin I. Urofsky

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## JUSTIFYING ASSISTED SUICIDE: COMMENTS ON THE ONGOING DEBATE

MELVIN I. UROFSKY\*

If the right to control the time and manner of one's death—the right to shape one's death in the most humane and dignified manner one chooses—is well founded, how can it be denied to someone simply because she is unable to perform the final act herself?

—Yale Kamisar<sup>1</sup>

On the last day of the term in June 1997, the Supreme Court handed down its decisions in two cases involving physician-assisted suicide. The Court's opinion, written by Chief Justice Rehnquist and endorsed by all the other justices, held that neither history nor jurisprudence supported the claim of a constitutional right to assisted suicide.<sup>2</sup> The results did not surprise anyone, since the conservative majority that has held sway since the early 90s has been loathe to create new constitutionally protected rights. What did astonish legal scholars and advocacy groups was the fact that five members of the Court wrote separate concurrences that practically amounted to dissents.<sup>3</sup> In effect, they said that they would go along with this cautious approach for now, but should states make end-of-life choices too narrow, they would be willing to revisit the issue. Justice Souter, in an extremely sensitive and well-reasoned opinion, indicated how the Due Process Clause of the Fourteenth Amendment allows for the development of new rights, and intimated that assisted suicide might well come under that rubric in the future.<sup>4</sup>

If one believes, as I do, that there is a constitutionally protected right of privacy—"the most comprehensive of rights and

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\* Professor of Constitutional History and Public Policy, Virginia Commonwealth University; Ph.D., 1968, Columbia University; J.D., 1983, University of Virginia. The author wishes to thank Leslie Rezac Urofsky for research assistance on this article.

1. Yale Kamisar, *Are Laws Against Assisted Suicide Unconstitutional?*, HASTINGS CENTER REP., May-June 1993, at 32, 35.

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

3. The five were Justices Stevens, O'Connor, Souter, Ginsburg, and Breyer.

4. See *Glucksberg*, 521 U.S. at 752.

the right most valued by civilized men"<sup>5</sup>—then one must question the majority's reasoning and conclusion. The Court, in its last major abortion case, noted that matters "involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment."<sup>6</sup> Certainly there are few things in one's life that can be considered more intimate and personal than how one chooses to die, either by letting nature take its course or by hastening the end through direct or indirect means.

This article looks first of all at the law as it now stands regarding the right to die in general, and assisted suicide in particular. Part II looks at the ethical issues that are part of the debate, and Part III discusses the public policy questions that our society will have to grapple with as it comes to terms with an aging population, rising health costs, a medical technology that can keep very sick, indeed comatose patients, "alive," and a culture in which the quality of life is important to many people.

To meet "truth in advertising" criteria, let me state at the outset that I favor not only the right of people to end medical treatment even if that will lead to death (the right to die), but I also support, under appropriate safeguards, the right of persons who are terminally ill to end their lives and to have assistance to that end. As to the larger question of suicide for non-terminally persons, like most people I find that a most difficult and disturbing issue, but one that is, to a large extent, not apposite to the matter at hand.

In any good discussion of law or ethics, one starts with hypotheticals—"what ifs"—and tries to draw out principled answers. Let me provide the following examples of people who were sick, suffered greatly, and had they not acted would in any case have died sooner rather than later, and let us see if there are any principled ways of differentiating among them.

1. Adam, sixty-three years old, suffered from amyotrophic lateral sclerosis (ALS), commonly called Lou Gehrig's disease, a progressive deterioration and hardening of the spinal cord leading to loss of muscle control and, ultimately, paralysis. Adam relied on a respirator to sustain his breathing, but while his body was ravaged his mind remained clear. He knew that if taken off the respirator he would die within a few hours; with the respira-

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5. *Olmstead v. United States*, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting).

6. *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833, 851 (1992).

tor he might continue to live for another two years. An active man all his life, Adam hated this existence, which he saw as no life at all. After talking to his family, Adam, with their support, informed his doctor that he wished to be taken off the respirator. The doctor acceded to his wishes, and with his family at his side, Adam died.<sup>7</sup>

2. Barbara, in her late fifties, had an inoperable brain tumor, with a prognosis of increasing pain, loss of emotional control, and dementia before death. Barbara had always been an outgoing person, cherished by her friends for her wit and humor. Rather than face this grim scenario of deterioration, she asked her husband to get her a gun, and one morning after her family had left the house, she shot herself.

3. Carole had contracted uterine cancer, which had rapidly metastasized, and she was in great and constant pain. When admitted to the hospital she was placed, with her full consent and knowledge of the consequences, on a morphine drip to alleviate the pain. As the cancer spread and the pain increased, her doctor increased the morphine level, and five days after entering the hospital she died. The death certificate listed cancer as the cause of death, but in fact she died from an overdose of morphine.

4. Diane with the help of her family doctor had overcome alcoholism and depression, and just when she thought she could begin to enjoy life again, she was diagnosed with acute leukemia. Although her doctor recommended chemotherapy and a bone-marrow transplant, Diane's own research led her to believe—correctly—that these painful treatments had little chance of success. Rather than go through with them, she wanted to die when the pain became too much. Her doctor prescribed barbituates for her insomnia, and told her very explicitly how many pills constituted a lethal dose. After she had taken the pills, her husband called the doctor to the house; he listed leukemia as the cause of death.<sup>8</sup>

5. Edward also suffered from ALS, and his condition had deteriorated to the point that he was confined to a wheelchair and had practically no control over his body; his hands lay immobile on the wheelchair tray. Edward's greatest fear was that he would choke to death on his own saliva. He could not take pills

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7. This hypothetical is based on the story of Abe Perlmutter. See *Staz v. Perlmutter*, 362 So. 2d 160 (Fla. Dist. Ct. App. 1978).

8. This example is, of course, the "Diane" described in Timothy E. Quill, *Death and Dignity: A Case of Individualized Decision Making*, 324 NEW ENG. J. MED. 691 (1991).

nor shoot a gun, and since he was not in great pain nor near death, he did not qualify for a morphine drip. At his request, and with the support of his family, a doctor gave him a lethal injection.<sup>9</sup>

All of these people died, arguably before their allotted time, and to some extent at their own hands. They made the decision to unplug the ventilator, pull the trigger, go on a morphine drip, take the pills or have a physician administer a lethal dose. One might think that all of these people committed suicide, and in a profound way that is true; they caused their own deaths. But both law and ethics treat these cases differently. Adam died, at least according to the law, not from unplugging his ventilator but from the underlying illness. Barbara is the only true suicide, at least by the legal definition. Common sense would tell us that Carole benefited from physician-assisted suicide, but the courts have held that so-called "palliative medication," even if it leads to death, is neither murder nor assisted suicide; rather death is an unintended consequence of the doctor's primary purpose, alleviating pain. Diane is a true case of physician-assisted suicide, in that although the doctor nominally prescribed the barbiturates for insomnia, he knew why Diane wanted the pills, and he made sure she knew what constituted a lethal dose. And Edward, according to the law, had been murdered, for which act the doctor stood trial and was found guilty.

The results in all the hypotheticals are the same: a person in great pain and suffering ended that pain and suffering. In each instance that person had to have the help of someone else—to turn off the machinery, buy a gun, provide the medication, administer it. Yet law and ethics as well as social policy draw significant distinctions among them. Should this be so and if so, why?

## I.

### A.

The modern law on right to die derives from both common law and constitutional sources. It has long been an axiom of the common law that people need not take medication or treatment against their will, even if that decision may lead to dire consequences. In a nearly century-old tort case still studied by first-year law students, a Minnesota court ruled that, in the absence of

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9. On November 22, 1998, *60 Minutes* aired a videotape of Dr. Jack Kevorkian administering a lethal injection to Thomas Youk, aged 52, who suffered from ALS. Youk requested Kevorkian to do this and Youk's family supported his decision.

an emergency, a doctor could not perform a procedure unauthorized by the patient. "If the operation was performed without the plaintiff's consent, and the circumstances were not such as to justify its performance without, it was wrongful; and if it was wrongful, it was unlawful."<sup>10</sup> A decade later Benjamin Cardozo ruled that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body."<sup>11</sup> The common law did not so much speak to a right to die as to individual autonomy, the control a person has over his or her own body against unwanted action. A person must consent to treatment, but may also refuse, even if that refusal leads to death. A personal right, it need not conform to what a majority of society thinks the person ought to do.<sup>12</sup>

On the constitutional side, one can begin with the right to privacy, first enunciated by Justice Brandeis in his dissent in *Olmstead*,<sup>13</sup> endorsed by the Supreme Court in the landmark case of *Griswold v. Connecticut*,<sup>14</sup> and later expanded in the first abortion case, *Roe v. Wade*.<sup>15</sup> In these cases, the Court held that a person's privacy right included control over one's bodily autonomy, and while never mentioning right to die, one can infer that a decision to refuse or terminate treatment would surely be included within this rubric. Certainly the New Jersey Supreme Court thought so when it heard the first major right to die case in modern times, *In re Quinlan*.<sup>16</sup>

When studying the legal aspects of the right to die, one often starts with Karen Ann Quinlan, in which a New Jersey court granted to her parents the right to remove their comatose daughter from life-support equipment. But as Peter Filene has shown, the question of right to die had become popularized well before *Quinlan*. Starting in the mid-fifties, with the publication of Lael Wertenbaker's *Death of a Man*, in which she told how she helped her sick husband kill himself, a veritable explosion of books and articles about death, euthanasia and bereavement appeared. Between 1968 and 1973 the number of articles about death in popular magazines doubled each year, and then between 1973 and 1975 doubled again. A bibliographer listed

10. *Mohr v. Williams*, 104 N.W. 12, 16 (Minn. 1905).

11. *Schloendorff v. Society of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914).

12. See *In re President of Georgetown College*, 331 F.2d 1000, 1015 (D.C. Cir. 1964) (Burger, J., dissenting).

13. See *Olmstead v. United States*, 277 U.S. 438, 471 (Brandeis, J., dissenting).

14. 381 U.S. 479 (1965).

15. 410 U.S. 113 (1973).

16. 355 A.2d 647 (N.J. 1976).

1,200 books on death and bereavement that appeared between 1935 and 1968; in the next five years another 1,200 were published.<sup>17</sup> All this, it should be noted, happened *before* Karen Quinlan's case caught public attention. Perhaps the case caused as much of a furor as it did because the public already knew a great deal about death and dying, subjects once considered taboo for polite conversation.

In the 1970s and early 1980s, state courts reaffirmed the notion that a competent person, voluntarily making a knowledgeable decision, had the legal right to refuse or terminate treatment.<sup>18</sup> In addition, state courts also recognized the use of advanced directives, or living wills, by which a competent person could direct what medical treatment he or she wanted or did not want in the future.<sup>19</sup> Following *Quinlan*, the idea of a living will caught on rapidly, and at present all fifty states and the District of Columbia have adopted some form of advance directive statute.<sup>20</sup> Although state courts have consistently upheld the validity of these state statutes,<sup>21</sup> not all patients have living wills, and even when they do, not all doctors and hospitals are willing to abide by the instructions.<sup>22</sup> In response to demands for greater patient autonomy, in October 1990, Congress passed the Patient Self-Determination Act.<sup>23</sup> The law went into effect in December 1991, and requires all hospitals receiving Medicare or Medicaid funds to provide entering patients written information about their rights under applicable state law to accept or refuse medical treatment, as well as their right to formulate advance directives and durable powers of attorney. In addition, hospitals must note

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17. See PETER G. FILENE, *IN THE ARMS OF OTHERS: A HISTORY OF THE RIGHT-TO-DIE IN AMERICA* 49 (1998).

18. See, e.g., *Satz v. Perlmuter*, 379 So. 2d 359 (Fla. 1980); *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417 (Mass. 1977); *In re Dinnerstein*, 380 N.E.2d 134 (Mass. App. Ct. 1978); *Eichner v. Dillon*, 426 N.Y.S.2d 517 (N.Y. App. Div. 1980).

19. An Illinois attorney is normally given credit for proposing a formal advance directive. See Luis Kutner, *Due Process of Euthanasia: The Living Will, A Proposal*, 44 IND. L.J. 539 (1969).

20. For an evaluation of the different state laws, see Christopher J. Condie, *Comparison of the Living Will Statutes of the Fifty States*, 14 J. CONTEMP. L. 105 (1988); Shari Lobe, *The Will to Die: Survey of State Living Will Legislation and Case Law*, 9 PROB. L.J. 47 (1989).

21. See, e.g., *John F. Kennedy Mem'l Hosp. v. Blutworth*, 452 So. 2d 921 (Fla. 1984); *In re Peter*, 529 A.2d 419 (N.J. 1987); *Saunders v. State*, 492 N.Y.S.2d 510 (N.Y. App. Div. 1985).

22. For a particularly egregious example, see Englebert L. Schucking, *Death at a New York Hospital*, LAW, MED. & HEALTH CARE, Dec. 1985, at 261.

23. See 42 U.S.C. §§ 1395cc(f)(1), 1396a(a) (2000).

in each patient's records whether or not an advanced directive has been provided, and to train their staffs on the subject.<sup>24</sup>

The federal law did not affect the rights of states to establish evidentiary and procedural standards in their own laws, and not all states follow the Uniform Rights of the Terminally Ill Act, which is generally liberal in its provisions for proving individual wishes. Missouri, for example, has a higher evidentiary standard, and that led to the first and so far only right-to-die case to come before the U.S. Supreme Court, *Cruzan v. Director, Missouri Department of Health*.<sup>25</sup>

## B.

The facts of the *Cruzan* case are well-known by now, and need be rehearsed only briefly. Coming home from work one night in January 1983, twenty-five-year-old Nancy Beth Cruzan lost control of her car on an icy road near Carthage, Missouri. The car turned over, and she was thrown out some thirty-five feet face down into an icy ditch. Emergency help came promptly, but not soon enough. The rescue squad resuscitated the young woman, but her brain had been deprived of oxygen too long. Like Karen Ann Quinlan, Cruzan never regained consciousness and sank into a persistent, vegetative state. Unlike Quinlan, she could breathe on her own, but for seven years lay curled in a fetal position in the Missouri Rehabilitation Center in Mount Vernon, kept alive by a tube inserted into her stomach to provide nutrients and water. She had been a healthy person before the accident, and doctors said she might live like this for another thirty years. Her parents finally gave up hope that she would regain consciousness, and went into court to have the feeding tube removed.<sup>26</sup>

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24. There are no studies as to how effective this has been. However, in Michigan, a jury awarded Brenda Young and her family \$16.5 million in a suit against Genesys St. Joseph Hospital for ignoring Ms. Young's directions that she not be put on a ventilator. After Ms. Young suffered a series of seizures while in the hospital, doctors put her on life support, saving her life, but leaving her in the kind of existence she had feared and wanted to avoid. She now needs around-the-clock attendance, is mentally incompetent, has little control over her bodily functions, and must be tied to the bed to prevent her from hurting herself. See Tamar Lewin, *Ignoring 'Right to Die' Directives, Medical Community is Being Sued*, N.Y. TIMES, June 2, 1996, at A1.

25. 497 U.S. 261 (1990).

26. Although the American Medical Association and many medical ethicists consider artificial feeding and hydration a medical treatment that, like a ventilator, can be withdrawn from a terminally ill person, the idea horrifies many people. Food and water, even through a tube, are seen as the basic necessities of life, and evoke a far more emotional response than do respirators.



The Cruzans went into local probate court, and if Nancy had been a minor, her parents would have had the authority to act on their own. Judge Robert E. Teel appointed a guardian, Thad C. McCanse, to represent Nancy's interests, and McCanse agreed with the parents that the feeding tube should be withdrawn. Judge Teel granted the Cruzans' request, but Missouri Attorney General, William L. Webster, decided to appeal the decision. He claimed that under Missouri law, there had to be clear and convincing evidence that Nancy Cruzan had earlier indicated that she wanted all medical assistance terminated. The Missouri Supreme Court, by a four to three vote, agreed with Webster that the Cruzans had not met the evidentiary level;<sup>27</sup> the Cruzans appealed to the Supreme Court, which accepted the case.

Chief Justice Rehnquist's decision for the Court was extremely cautious, but the majority ruled that as part of personal autonomy, there exists a constitutionally protected right to die. The opinion emphasized that this right did not derive from any right to privacy, but from the Fourteenth Amendment's Due Process Clause. "The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions."<sup>28</sup> The key word is competent, however, and the Court noted that this is an area normally assigned to state jurisdiction, not federal law. Although only two other states, New York and Maine, required the same higher standard as Missouri, under a federal system a state's powerful interest in protecting life gives it the authority to establish such a test, provided it does not unduly burden the individual's constitutionally protected liberty interest. The Chief Justice found that Missouri's standards met that test.<sup>29</sup>

The element of the opinion that most disturbed right-to-die advocates and civil libertarians was Rehnquist's discussion of balancing an individual's liberty interest against opposing state concerns. Declaring that a liberty interest exists, according to the Chief Justice, merely begins the judicial inquiry; courts must then determine whether the liberty interest outweighs the claims of the state. Rehnquist seemed to indicate that courts need do no

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27. See *Cruzan v. Harmon*, 760 S.W.2d 408 (Mo. 1988).

28. *Cruzan*, 497 U.S. at 278 (citing *Washington v. Harper*, 494 U.S. 210 (1990) (administering antipsychotic medication to a prisoner); *Parham v. J.R.*, 442 U.S. 584 (1979) (involuntary confinement of a child for medical treatment); *Jacobson v. Massachusetts*, 197 U.S. 11 (1905) (a state's interest in preventing disease trumps an individual's interest in refusing a smallpox vaccination)).

29. See *Cruzan*, 497 U.S. at 281-82.

more than apply a simple rational basis test, the lowest standard of constitutional review, in weighing individual interests against state concerns. Moreover, the burden of proof rests upon the family of an incompetent to "prove" that the patient, if competent and able to make his or her wishes known, would want to have treatment stopped.

Despite the several opinions,<sup>30</sup> two things stand out in the case. The Supreme Court for the first time acknowledged a constitutionally protected right to die and grounded it in the liberty interests of the Fourteenth Amendment's Due Process Clause. Second, the Court did not see it as an absolute right, but allowed states great leeway in establishing appropriate procedures to govern that particular end-of-life choice. Even Justice Scalia, the least sympathetic of the justices to a federally protected right, concurred with the majority's ruling; he would have allowed the right, but set it within the context of state rather than federal law.

### C.

At about the same time as the Court handed down its decree in *Cruzan*, and before the meaning of the decision and its impact could be analyzed, the legal, ethical and public policy debate was pushed to a new level by an unlikely protagonist, a retired pathologist who not only believed in the right-to-die, but in the right of people to commit suicide and to have help doing so. On June 4, 1990, Dr. Jack Kevorkian hooked up fifty-four-year-old Janet Adkins, a Portland, Oregon, school teacher suffering from early stages of Alzheimer's disease, to his so-called "mercy machine." Over the next several years Kevorkian reportedly helped more than one-hundred people die,<sup>31</sup> and focused national attention on the whole issue of physician-assisted suicide. The following year, Dr. Timothy Quill, a doctor in Rochester, New York, discussed a practice he said many doctors engaged in secretly: helping their terminally ill patients die. Unlike Kevorkian, who barely knew the people he helped die, Quill had had a long professional relationship with "Diane," and understood and grieved with her over her condition.<sup>32</sup> Both Quill and Kevorkian raised the interesting legal points of what constituted assisted suicide and whether it could be punished.

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30. For a discussion of the concurring and dissenting opinions, see Melvin I. Urofsky, *Leaving the Door Ajar: The Supreme Court and Assisted Suicide*, 32 U. RICH. L. REV. 313, 323-25 (1998). None of the justices opposed a right-to-die, but differed on how far they would go in protecting it.

31. See *Lawyer Puts Kevorkian Cases at "Nearly 100"*, N.Y. TIMES, Aug. 14, 1997, at A21.

32. See Quill, *supra* note 8, at 691.

Many American states initially adopted the English rule of considering suicide a criminal act, a practice that dated back to the tenth century when King Alfred ruled a suicide's property would be forfeit to his feudal lord. Somewhat later the rule changed so that the suicide's estate would be forfeit to the crown. In order to justify this change, the royal courts noted that every felon forfeited goods to the king, and so by making suicide a felony, this general rule would apply. In *Hales v. Petit*,<sup>33</sup> the court classified suicide as a felony and condemned self-murder as a criminal act. That being the case, then assistance in a criminal act would be a crime as well as even attempting the act. The first known case of legal punishment of assisted suicide occurred in 1854, in which the judge held the criminality of attempted suicide a self-evident truth.<sup>34</sup> In modern times the public and legal attitude toward suicide has changed, and today no jurisdiction in the United States makes suicide a crime. At worst, a failed attempt may lead to mandated therapy or perhaps incarceration in a mental hospital. But nowhere is it legal for doctors or anyone else to assist in suicide. Forty-four states, the District of Columbia, and two territories prohibit or condemn assisting suicide.<sup>35</sup> In April 1997, President Clinton signed into law the Federal Assisted Suicide Funding Restriction Act,<sup>36</sup> prohibiting the use of federal funds in support of physician-assisted suicide. Given this legal bias against assisted suicide, as well as the growing notion of a right-to-die, inevitably advocates of the latter would take the logical step of attacking the former.

#### D.

The attack took place on both coasts. In the State of Washington, an organization called Compassion in Dying, five physicians, as well as three dying patients who wanted doctors to help them die challenged the state statute that held a "person is guilty of promoting a suicide attempt when he knowingly causes or aids another person to attempt suicide."<sup>37</sup> Promoting suicide in Washington is a class C felony punishable by imprisonment for up to five years and by a fine of up to \$10,000.<sup>38</sup> The Washington

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33. 75 E.R. 398 (1562). Not until the Suicide Act of 1961 did Her Majesty's Government finally stop making suicide or its attempt a crime.

34. See *Regina v. Doody*, 6 Cox 453 (1854).

35. See *Compassion in Dying v. Washington*, 79 F.3d 790, 847 (9th Cir. 1996) (Beezer, J., dissenting). A list of the statutes can be found in *Washington v. Glucksberg*, 521 U.S. 702, 775 n.14 (1997).

36. See 42 U.S.C. §§ 14401-08 (2000).

37. WASH. REV. CODE § 9A.36.060(1) (1988).

38. See *id.* §§ 9A.36.060(2), 9A.20.020(1)(c).

law had been on the books in one form or another since 1854 but had rarely been enforced. Even Compassion in Dying, while apparently operating in violation of the statute, had never been threatened with prosecution.<sup>39</sup> Washington, it should be noted, had no law prohibiting or criminalizing suicide or attempted suicide.

On the east coast, Timothy Quill and two other doctors launched an attack in July 1994 to have New York's ban on assisted suicide declared unconstitutional. Three terminally ill patients also were plaintiffs, but all of them died before the case went to trial, leaving only the physician plaintiffs. The New York Penal Code provides that "[a] person is guilty of manslaughter in the second degree when . . . [h]e intentionally . . . aids another person to commit suicide."<sup>40</sup> A person "is guilty of promoting a suicide attempt when he intentionally . . . aids another person to attempt suicide."<sup>41</sup>

The west coast plaintiffs won in the district court,<sup>42</sup> initially lost in the court of appeals,<sup>43</sup> and then in a rare grant of rehearing, won before the Court of Appeals for the Ninth Circuit sitting *en banc*.<sup>44</sup> By an eight to three vote, the appeals court found that the Washington statute violated the Fourteenth Amendment's Due Process Clause. On the east coast, the challengers to the New York law lost before the district court,<sup>45</sup> then won on appeal in the court of appeals.<sup>46</sup> The Second Circuit ruled that the New York statute violated the Equal Protection Clause, in that the judges could see little difference between assisted suicide and the termination of treatment.

With both the Second and Ninth Circuits in agreement on the results, if not the reasoning, there seemed little reason for the Supreme Court to grant certiorari except to overturn the rulings. Moreover, in recent years the justices seem intent on cutting down the docket, and have been fairly stingy in accepting cases. Nonetheless, the Court granted certiorari to both cases at the beginning of October 1996 Term, heard oral argument on January 8, 1997, and handed down their decisions on June 26th,

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39. See Timothy Egan, *Federal Judge Says Ban on Assisted Suicide is Unconstitutional*, N.Y. TIMES, May 5, 1994, at A1, A24.

40. N.Y. PENAL LAW § 125.15(3) (McKinney 1965).

41. *Id.* § 120.30.

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

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

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

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

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

the last day of the term. Their finding, that the Constitution did not provide a right to physician-assisted suicide, did not surprise anyone, although the fact that all of the justices agreed with this result did raise a few eyebrows.

The results in the two cases are far from straightforward, despite the Chief Justice's opinions for the Court. Five justices, even while agreeing with the result, filed concurring opinions that raised many questions, and left the door open for future challenges to laws prohibiting assisted suicide.<sup>47</sup> The three justices in *Cruzan* who would have found a stronger liberty interest—Brennan, Marshall and Blackmun—had left the bench, and the centrists who had taken their place shared the view that the Court had to be careful in finding new rights. As in *Cruzan*, Chief Justice Rehnquist delivered the Court's opinions.

### E.

In *Glucksberg*, the Court rejected the Ninth Circuit's claim that physician assisted suicide constituted a fundamental liberty interest protected by the Due Process Clause. Rehnquist found that neither history nor tradition yielded support for the proposition that assistance in suicide had ever been considered a personal right, and "for over 700 years, the Anglo-American common-law tradition has punished or otherwise disapproved of both suicide and assisting suicide."<sup>48</sup> The recent trend away from the common law's harsh sanctions reflected not an acceptance of suicide but rather a belief that the suicide's family should not be punished for his wrongdoing. As for assisting suicide, the various states had in recent years re-examined and generally reaffirmed the ban. "Despite changes in medical technology and not withstanding an increased emphasis on the importance of end-of-life decisionmaking, we have not retreated from this prohibition."<sup>49</sup>

As for the constitutional claims, Rehnquist agreed that the Due Process Clause protects more than fair process, and the liberty "it protects includes more than the absence of physical restraint."<sup>50</sup> He ticked off a long list of cases in which the Court had found fundamental rights and interests, but "we 'ha[ve] always been reluctant to expand the concept of substantive due process because guideposts for responsible decisionmaking in

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

48. *Glucksberg*, 521 U.S. at 711.

49. *Id.* at 719.

50. *Id.* (citing *Collins v. Harker Heights*, 503 U.S. 115, 125 (1992)).

this uncharted area are scarce and open-ended.”<sup>51</sup> The Court’s established due process analysis involves determining whether the claimed liberty interest is “deeply rooted in this Nation’s history and tradition,”<sup>52</sup> and whether there is a “careful description” of the asserted liberty interest.<sup>53</sup>

Having disposed of any historical claim, the Court also rejected the respondents’ claim that the liberty interest in assisted suicide was consistent with the Court’s long line of due process decisions enumerating rights protected under the Fourteenth Amendment. Rehnquist went into an extended analysis of the state’s interest in preventing suicide, and found all of them convincing—preservation of human life,<sup>54</sup> protecting the integrity of the medical profession,<sup>55</sup> protecting vulnerable groups such as the poor and the elderly,<sup>56</sup> and fear of a slippery slope, that permitting assisted suicide will lead to voluntary and perhaps even involuntary euthanasia.<sup>57</sup> In the Court’s opinion, all of these interests were legitimate, and “Washington’s ban on assisted suicide is at least reasonably related to their promotion and protection.”<sup>58</sup>

In conclusion, the Chief Justice noted that “[t]hroughout the Nation, Americans are engaged in an earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a democratic society.”<sup>59</sup> Despite the fact that states had traditionally opposed assisted suicide, nothing in the Court’s opinion was intended to foreclose them from changing their minds. The decision followed almost precisely the prescription laid out by Professor Cass Sunstein: an opinion that did not constitutionalize a right to assisted suicide, did not foreclose that as an option for the states, and continued the democratic dialogue.<sup>60</sup>

In the companion case of *Vacco v. Quill*, Rehnquist took less than seven pages to overturn the Second Circuit, in part because he did not find it necessary to reiterate his lengthy historical

51. *Id.* at 720 (citing *Collins*, 503 U.S. at 125).

52. *Id.* at 721 (quoting *Moore v. City of East Cleveland*, 431 U.S. 494, 503 (1977)).

53. *Id.* (citing *Reno v. Flores*, 507 U.S. 292, 302 (1993)).

54. *See id.* at 728-29.

55. *See id.* at 731.

56. *See id.* at 731-32.

57. *See id.* at 732-33.

58. *Id.* at 735.

59. *Id.*

60. *See* Cass R. Sunstein, *The Right to Die*, 106 YALE L.J. 1123 (1997).

analysis from the Ninth Circuit opinion. He began his analysis by noting that facially, New York's ban on assisted suicide and its statutes permitting patients to refuse life-sustaining treatment do not "treat [ ] anyone differently from anyone else or draw [ ] any distinctions between persons. *Everyone*, regardless of physical condition, is entitled, if competent, to refuse unwanted lifesaving medical treatment; *no one* is permitted to assist a suicide."<sup>61</sup> In general, according to the Chief Justice, "laws that apply evenhandedly to all 'unquestionably comply' with the Equal Protection Clause."<sup>62</sup>

Since logic and practice supported New York's judgment that a clear and important distinction existed between allowing a patient to die and making that patient die, the state could therefore treat these two groups of patients differently without violating the Constitution. In conclusion, the Chief Justice reiterated what he saw as important state interests—prohibiting intentional killing; preserving life; protecting the role of physician as healer; sheltering vulnerable people from abuse, prejudice, and financial pressure to end their lives; and "avoiding a possible slide toward euthanasia"—all discussed in *Glucksberg*.<sup>63</sup> "These valid and important public interests easily satisfy the constitutional requirement that a legislative classification bear a rational relation to some legitimate end."<sup>64</sup>

## F.

The concurring opinions are, in many ways, more interesting and nuanced than the majority decisions in which the Chief Justice took such a narrow approach. The most important is the eighteen-page opinion by Justice David Souter, which, I believe, may prove far more influential in future constitutional litigation than the simplistic majority view. Souter explored the history of substantive due process from the early days of the Republic to its repudiation after its abuse by conservatives attacking economic regulation.<sup>65</sup> But substantive due process had been used to defend individual liberties as well as property rights, and here Souter clearly considered Justice John Marshall Harlan's dissent in *Poe v. Ullman*<sup>66</sup> the most important statement of the type of rights subsumed within due process. Souter listed three ele-

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61. *Vacco*, 521 U.S. at 793 (emphasis added).

62. *Id.* at 800 (citing *New York City Transit Auth. v. Beazer*, 440 U.S. 568, 587 (1979)).

63. *Id.* at 809.

64. *Id.*

65. See *Glucksberg*, 521 U.S. at 752, 756-62 (Souter, J., concurring).

66. 367 U.S. 497, 543 (Harlan, J., dissenting).

ments of that opinion necessary to any analysis of Fourteenth Amendment liberty interests. First, he noted Harlan's "respect for the tradition of substantive due process review," and the necessity for the courts to undertake that review.<sup>67</sup> The very text of the Due Process Clause, Souter concluded, imposes on the courts "nothing less than an obligation to give substantive content to the words 'liberty' and 'due process of law.'"<sup>68</sup>

Harlan's second point was that the purpose of such review "is not the identification of extratextual absolutes but scrutiny of a legislative resolution (perhaps unconscious) of clashing principles, each quite possibly worthy in and of itself, but each to be weighed within the history of our values as a people."<sup>69</sup> The Court must weigh the strengths of opposing claims and not substitute its judgment based on what the justices see as first premises; they cannot substitute their judgment for that of the legislature, unless that body has exceeded clear constitutional parameters. This led to Harlan's third point, the necessity to pay attention to detail as an element no less essential than understanding the positions of the competing sides or recognizing the extent of legislative judgment.

Souter undertook this analysis, I believe, because he found the majority opinion devoid of compassion or awareness of the claims of terminally ill patients. The majority had said there was no historic basis for recognizing assisted suicide as a liberty interest, and therefore no liberty interest existed. Souter understood that due process had been used in the past to create or at least to recognize hitherto latent rights.<sup>70</sup> While not ready to create a right to assisted suicide, he wanted to acknowledge that even if the legislature was well within its powers to make the choice it did, and even if judicial deference required the courts to respect that decision, those seeking the right also had a claim. Courts needed to hear this claim even if they did not agree with it.

Courts had "to assess the relative 'weights' or dignities of the contending interests, and to this extent the judicial method is familiar to the common law."<sup>71</sup> But in doing so, courts had to be careful to confine any liberty interests they recognized to those that truly deserved constitutional stature, those "so rooted in the traditions and conscience of our people as to be ranked as fundamental."<sup>72</sup> Courts also had to remember that their business

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67. *Glucksberg*, 521 U.S. at 763.

68. *Id.* at 764.

69. *Id.*

70. *See id.* at 763.

71. *Id.* at 767.

72. *Id.* at 768 (citing *Palko v. Connecticut*, 302 U.S. 319, 325 (1937)).



involved constitutional review, not judicial lawmaking. Thus judges had to review the competing claims carefully with great attention to detail, but they had no right to substitute their preferences for those of the legislative branch. Justice Harlan had set clear standards for courts to follow in due process review, a path that on the one hand avoided the arbitrariness of absolutes and on the other stood firm against making simple reasonableness a standard for declaring rights.

With these standards in mind, Souter now turned to the issue before the Court, and framed the question in very limited terms. “[H]ere we are faced with an individual claim not to a right on the part of just anyone to help anyone else commit suicide under any circumstances, but to the right of a narrow class to help others also in a narrow class under a set of limited circumstances.”<sup>73</sup> To this claim the state responds “that rights of such narrow scope cannot be recognized without jeopardy to individuals whom the State may concededly protect through its regulations.”<sup>74</sup>

Souter’s analysis of the patient and doctor claim showed far greater sensitivity to nuance than did the majority opinion. The respondents did not base their claim on history, but in fact acknowledged that historically there had been prohibitions. The lesson of history was not that suicide had at one time been considered a criminal act, but rather that it had long since been decriminalized. But Souter refused to follow the respondents’ argument that this opened the door to requiring the decriminalization of assisting in suicide. The reasons for decriminalization of suicide may have had far more to do with the practical ability of the state to prevent such acts than any change in popular moral views. “Thus it may indeed make sense for the State to take its hands off suicide as such, while continuing to prohibit the sort of assistance that would make its commission easier.”<sup>75</sup> Decriminalization by itself did not imply the existence of any constitutional right or liberty interest.

Both the Ninth Circuit and the respondents had made much of the Court’s analysis of bodily autonomy in *Casey*, and Souter acknowledged that analogies existed between the abortion cases and those dealing with assisted suicide, most importantly, the need for a doctor in both instances. Without a doctor’s assistance in abortion, “the woman’s right would have too often amounted to nothing more than a right to self-mutila-

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73. *Id.* at 773.

74. *Id.*

75. *Id.* at 777.

tion, and without a physician to assist in the suicide of the dying, the patient's right will often be confined to crude methods of causing death, most shocking and painful to the decedent's survivors."<sup>76</sup>

Souter also agreed that one could make a strong case that physician-assisted suicide fell within "the accepted tradition of medical care in our society."<sup>77</sup> In the abortion cases the Court recognized the need for a doctor, and not just to perform the medical procedure. The Court "recognized that the good physician is not just a mechanic of the human body whose services have no bearing on a person's moral choices, but one who does more than treat symptoms, one who ministers to the patient."<sup>78</sup> The idea of the physician treating the whole person is just as important in end of life decisions as in abortion. The patients in this case wanted not only to end their pain (which Souter noted they might have done although only at the price of stupor), "but an end to their short remaining lives with a dignity that they believed would be denied them by powerful pain medication, as well as by their consciousness of dependency and helplessness as they approached death."<sup>79</sup> One could hardly imagine any other circumstances in which the call for bodily autonomy carried greater weight, and in which the role of the physician, including assistance, fell within the "traditional norm" of health care. In fact, the state had already recognized this right in its willingness to allow terminally ill patients to stop treatment and to withdraw life-sustaining medication, thus hastening death. It also allows physicians to administer powerful pain-killing medication to terminally ill patients, even if such dosages bring on death.

Up until this point one might have thought Souter had prepared a dissent rather than a concurrence. He summed up the respondents' arguments as going through "three steps of increasing forcefulness." First, the decriminalization of suicide; second, this decriminalization provides freedom of choices analogous to individual options in recognized areas of bodily autonomy, such as abortion; and third, the claim for assistance is not based on some broad principle but rather on the traditional role of doctors in ministering to all the medical needs of their patients. This was a powerful argument, Souter noted, one demanding

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76. *Id.* at 778.

77. *Id.*

78. *Id.* at 779 (referring to *Roe v. Wade*, 410 U.S. 113, at 153 (1973); *Griswold v. Connecticut*, 381 U.S. 479, 482 (1965)).

79. *Id.*

under the *Poe* criteria “careful scrutiny of the State’s contrary claim.”<sup>80</sup>

Souter then proceeded to do just that. The State had essentially put forward three interests to justify its law—protecting life generally, discouraging suicide (even if knowing and voluntary), and protecting terminally ill patients from involuntary suicide or from euthanasia. Souter found it unnecessary to discuss the first two, since the third argument proved dispositive for him. The State had argued that a very slippery slope existed, and that it would be all too easy, perhaps inevitable, to progress down that slope:

[M]istaken decisions may result from inadequate palliative care or a terminal prognosis that turns out to be error; coercion and abuse may stem from the large medical bills that family members cannot bear or unreimbursed hospitals decline to shoulder. Voluntary and involuntary euthanasia may result once doctors are authorized to prescribe lethal medication in the first instance, for they might find it pointless to distinguish between patients who administer their own fatal drugs and those who wish not to, and their compassion for those who suffer may obscure the distinction between those who ask for death and those who may be unable to request it.<sup>81</sup>

Here, unlike the majority opinion, is found not only the suffering of the individual patient, but also the concerns of a compassionate state. The Chief Justice had found the state interests rational and the history opposed to assisted suicide, and there is barely a hint of the individual—patient or doctor—who must live within this system with no recourse. Souter seemed to imply that should conditions change, the Court might also reconsider. The example of the Netherlands, where fairly strict regulation exists, had been invoked by both sides, the respondents to support their claim that strong rules would prevent abuse, the state to prove that euthanasia had gotten out of control. Souter took the middle route, and the one supported by the bulk of the evidence, namely, that “a substantial dispute” existed about what the Dutch experience meant.<sup>82</sup> While that dispute might someday be resolved, until it was there existed enough evidence to support the state’s concern about legitimizing assisted suicide. “The day may come when we can say with some assurance which side is right [in what the Dutch practice means], but for now it is the

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80. *Id.* at 782.

81. *Id.* at 782-83.

82. *Id.* at 786.

substantiality of the factual disagreement, and the alternatives for resolving it, that matter. They are, for me, dispositive of the due process claim *at this time*.<sup>83</sup>

Given this dispute, Souter would defer to the legislative judgment, but added that there was still much learning to be done on the subject. For the moment the legislature was as well suited as the judiciary to undertake that examination. Moreover, in declaring constitutional rights, courts ought to act with finality and cannot experiment with what might or might not be done under differing circumstances:

Legislature, however, are not so constrained. The experimentation that should be out of the question in constitutional adjudication displacing legislative judgment is entirely proper, as well as highly desirable, when the legislative power addresses an emerging issue like assisted suicide. . . . *While I do not decide for all time that respondents' claim should not be recognized*, I acknowledge the legislative institutional competence as the better one to deal with that claim at this time.<sup>84</sup>

Souter's is, I suggest, a far better opinion than that of the majority. The latter is rigid and formulaic, with barely a hint of the great emotional issues involved: the pain and suffering of individuals and their families, the moral dilemmas of doctors, the effect on society. Souter is cognizant of these matters, and if he cannot give those in pain the answer they want, he at least acknowledges that they have a legitimate claim and that mere recourse to history is an evasion rather than an answer. And he clearly leaves the door open for the Court to revisit this matter, even as he urges the states to grapple further with it.

### G.

The other concurrences, although much shorter, also reflected the justices' discomfort with the simplistic majority view. Justice Sandra Day O'Connor, the only justice to file a concurrence who also signed onto the Court's opinion, wrote an opinion that also implied that given another set of factual circumstances and claims, she too would be willing to reconsider the decision. The majority had framed the issue fairly narrowly, and she agreed "that there is no generalized right to 'commit suicide.'<sup>85</sup> Respondents, however, had asked the Court to address a narrower question: whether a mentally competent per-

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83. *Id.* (emphasis added).

84. *Id.* at 789 (emphasis added).

85. *Id.* at 736 (O'Connor, J., concurring).

son experiencing great pain and suffering has a constitutionally protected right to control the circumstances of his or her imminent death?

This claim need not be reached in either case, O'Connor noted, because such people could already get the relief they sought. "The parties and amici agree that in these States a patient who is suffering from terminal illness and who is experiencing great pain has no legal barriers to obtaining medication, from qualified physicians, to alleviate that suffering, even to the point of causing unconsciousness and hastening death."<sup>86</sup> Given this fact, she saw no reason why the state should not be allowed to pursue its legitimate interests in protecting those not truly competent or whose decisions might not be truly voluntary. What O'Connor left unsaid was what she would do were the states to change that situation and, in their efforts to protect those needing protection, impinged upon the ability of the competent to gain this relief. She urged the states to continue in their "extensive and serious evaluation of physician-assisted suicide and other related issues," because "[e]very one of us at some point may be affected by our own or a family member's terminal illness."<sup>87</sup>

Justice Ruth Bader Ginsberg noted briefly that she concurred in the judgments in the two cases, "substantially for the reasons stated by Justice O'Connor in her concurring opinion."<sup>88</sup> Justice Stephen Breyer also joined in O'Connor's concurrence, but not insofar as it joined in the majority reasoning. Breyer agreed with the majority that the critical question is whether a liberty interest exists under the Fourteenth Amendment to support the respondents' claim. But he differed with the Court on how it formulated that right, namely, a right to commit suicide with another's assistance. Breyer said he would not reject the claim without considering a different wording which might have greater support within the American legal tradition. "That formulation would use words roughly like a 'right to die with dignity.' But irrespective of the exact words used, at its core would lie personal control over the manner of death, professional medical assistance, and the avoidance of unnecessary and severe physical suffering—combined."<sup>89</sup>

The lone member of the *Cruzan* minority still sitting on the Court, John Paul Stevens, also concurred in the judgment. The

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86. *Id.* at 736-37.

87. *Id.* at 737.

88. *Id.* at 736 (Ginsburg, J., concurring).

89. *Id.* at 790 (Breyer, J., concurring).

majority had noted that its holding remained consistent with the ongoing debate over the morality, legality and practicality of physician-assisted suicide; Stevens wrote separately "to make it clear that there is also room for further debate about the limits that the Constitution places on the power of the States to punish the practice."<sup>90</sup> While Stevens agreed that there is no absolute right to physician-assisted suicide, he believed that *Cruzan* meant that people who were at death's door had "a constitutionally protected interest that may outweigh the State's interest in preserving life at all costs."<sup>91</sup> Stevens believed that in such situations, the liberty interest was different from and far stronger than the common law rule and also trumped any state interest. "It is an interest in deciding how, rather than whether, a critical threshold shall be crossed."<sup>92</sup>

Stevens concurred in the New York case because he did believe a difference existed between letting someone die and hastening that person's death, and in the Washington case because he did not think a broad liberty interest existed. But he, like Souter, O'Connor, Ginsberg and Breyer, did not believe the issue definitively resolved. Like them, he also encouraged the states to experiment and explore the issue further, but there is no question that he too wanted to keep the door to the Court ajar.

## II.

If one read only the Chief Justice's majority opinion, one might be forgiven for thinking that the moral repulsion of suicide is widespread, and that there is only one side in the ethical debate, namely a universal condemnation of self-murder. In fact, library shelves are full of religious tracts, scholarly monographs and popular journals and books that take an astonishing variety of moral and ethical positions on suicide.<sup>93</sup> It is not my intent to get involved in this debate, other than to state the obvious: if one believes, from the standpoint of a particular religious system or from a structured ethical base, that suicide is wrong, then clearly assisted suicide is also wrong. I have no argument with these peo-

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90. *Id.* at 738 (Stevens, J., concurring).

91. *Id.* at 745.

92. *Id.*

93. For a survey of moral arguments concerning suicide, see, for example, MARGARET PABST BATTIN, *ETHICAL ISSUES IN SUICIDE* (1995); TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* (4th ed. 1994). English and American practices, as well as changing popular attitudes, are described in HOWARD J. KUSHNER, *SELF-DESTRUCTION IN THE PROMISED LAND: A PSYCHOCULTURAL BIOLOGY OF AMERICAN SUICIDE* (1989).

ple, other than to ask that they not impose their religious/ethical beliefs on others who do not share them.

However, the obverse is not as clear-cut. Even if one believes in complete individual autonomy, that does not necessarily mean that all suicides are justifiable, or that assisting suicide is logically or ethically permissible. One has to have some guidelines, and because the law is involved, these guidelines have to be sufficiently clear and constant so that fact-finders and law-finders can make consistent rulings.

#### A.

Let us begin by distinguishing between assisted suicide and euthanasia, a term that for many people conjures up images of Nazis putting the elderly, the sick, the retarded and the disabled to death. Until relatively recently, euthanasia had little to do with doctors, but referred to the experience of the dying person. Doctors, according to the original code of ethics of the American Medical Association, had the obligation to comfort their patients and when possible to revive them.<sup>94</sup> The state of medical knowledge in the mid-nineteenth century, however, led most doctors to believe they should let nature take its course. They might prescribe a cordial, probably an opium derivative, to ease the pain, and because they had ministered not only to the patient but to the family, they joined in the death watch and did what they could to comfort the living. Because nearly everyone died at home in those days, we have no data on just what doctors actually did, but the anecdotal evidence is that many doctors saw it as their duty to relieve the pain, even to the point of causing their patient's death. As one doctor told a public symposium in 1913, "Others have assumed the responsibility which I myself have taken in more than one case, of producing euthanasia."<sup>95</sup>

Whether doctors acted on their own, or acceded to the wishes of the patient and family, is impossible to tell, but we can surmise that what we now call physician-assisted suicide took place in at least some instances. Doctors who could do little except relieve pain might well acquiesce to a patient's desire to end all suffering. In some ways, modern advocates of physician-assisted suicide want to return, not to the state of medical knowledge in the nineteenth century, but to a condition in which patients can look for a good death and expect help from the doctors whom they have known and trusted for years.

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94. See Harold Y. Vanderpool, *Doctors and the Dying of Patients in American History*, in *PHYSICIAN-ASSISTED SUICIDE* 35 (Robert F. Weir ed., 1997).

95. FILENE, *supra* note 17, at 4.

If we adopt the modern terminology, however, euthanasia often refers to the act of one party upon another, a doctor, for example, causing the death of a patient, albeit for a benevolent purpose, to end the patient's suffering. We differentiate between "passive" euthanasia, in which actions that might prevent death are not taken, and "active" euthanasia, in which an action is deliberately taken for the purpose of causing death. When the action or the failure to act is undertaken at the wishes of the patient, it is called "voluntary." The euthanasia of an incompetent person is referred to as "involuntary" or "nonvoluntary."

For some people, there is major factual and ethical, as well as legal, difference between assisted suicide and euthanasia. The doctor who writes a prescription for a lethal dose of barbiturates is considered less involved—and responsible—for the patient's death than if she administers the medicine herself. With assisted suicide, the patient takes his or her own life—the "Diane" of our hypotheticals—and advocates of individual autonomy believe this is a preferable option, one that allows the individual to retain the fullest control. The role of the doctor is to give the patient the widest range of choices, but not to make the decision. The doctor may hope, for example, that the patient will change his mind, but in any case, there is clearly less legal liability in prescribing medication that may lead to death and actually administering a lethal dose. As Howard Brody put it:

There are psychological reasons to prefer patient control over physician-assisted lethal injection whenever possible. The normal human response to facing the last moment before death, when one has control over the choice, ought to be ambivalence. The bottle of pills allows full recognition and expression of ambivalence: I, the patient, can sleep on it, and the pills will still be there in the morning. I do not lose my means of escape through the delay. But if I am terminally ill of cancer in the Netherlands and summon my family physician to my house to administer the fatal dose, I am powerfully motivated to deny any ambivalence I may feel.<sup>96</sup>

Admittedly, some people do not draw any distinction between assisted suicide and euthanasia, and believe there is no justification for trying to differentiate as a basis for formulating policy.<sup>97</sup> True, the end result is the same, but leaving the final

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96. Howard Brody, *Assisted Death—A Compassionate Response to Medical Failure*, 327 NEW ENG. J. MED. 1384, 1386 (1992).

97. See, e.g., G.C. Graber & J. Chassman, *Assisted Suicide Is Not Voluntary Active Euthanasia, But It's Awfully Close*, 41 J. AM. GERIATRICS SOC'Y. 88 (1993).



decision in the hands of the patient increases personal autonomy and may provide legal as well as psychological defense for the physician.

## B.

Personal autonomy is one of the most highly valued aspects of a democratic society, and nowhere more so than in the United States. Here both the culture as well as the law support the notion that liberty exists and is justified by giving individuals the right to make personal choices regarding fundamental values. But we are not a society of libertarians, oblivious of responsibilities to others, and a continuing thread through the debate over the right to die is what do people who want to die owe to others and to society as a whole. More specifically, how does a desire to end one's life fit into a social context that reverences human life?

Proponents of assisted suicide argue that respect for the individual requires that we not only allow them to choose death, but to have assistance if necessary in carrying out that wish. (Here again, let me emphasize that we are not talking about emotionally deranged or disturbed persons, the teenager who did not get asked to the prom or the guy who has been diagnosed as clinically depressed. Obviously, seriously ill people will be depressed, and that is normal, but they can function, they can make rational and knowing decisions. There are few people who would deny that for a person suffering from advanced stages of AIDS or cancer, who is in great pain, and who knows that death is not a question of "if" or even of "when" but of "how soon," ending one's life may be a very rational decision.) One need not argue for an unlimited right of suicide to recognize that in appropriate cases, suicide can be not only a logical but perhaps even the only way to end great suffering and maintain one's human dignity.

It is true that in some instances pain can be alleviated, and in extreme instances there is the morphine drip, but for many people the price of reduced pain is the loss of control, the ending of the way they want to live their lives. The writer Anna Quindlan perhaps put it best when she wrote that "[p]ain management and hospice care are better than ever before. But for some people they are simply the trees. The forest is that they no longer want to live, and they believe the decision to die belongs to them alone."<sup>98</sup>

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98. Anna Quindlan, *Death: The Best Seller*, N.Y. TIMES, Aug. 14, 1991, at A19.

But what about the obligation of the individual to society? How can one square a right to assisted suicide with a social preference for life? Putting religion aside, there are many people for whom taking life is a violation of deeply held ethical principles, and suicide is not a liberty but the worst form of license. "Like the 'freedom' to sell oneself into slavery, the freedom to end one's life should be limited for the sake of freedom."<sup>99</sup> Euthanasia seems to make a mockery of all the customs and laws we have erected to protect life, including the ban on murder.

Daniel Callahan, a founder of the Hastings Institute, is one of the most articulate opponents of assisted suicide and champion of the community needs over individual desires in this area.<sup>100</sup> Callahan has little use for the autonomy argument, and considers it over-valued. In an interesting attack, he argues that in assisted suicide, the individual is in fact giving up autonomy, since he is handing over his life into the absolute control of another, and he compares it to slavery. This absolute power, he claims, "is not compatible with respect for our human dignity," since even in the name of mercy it gives one person an absolute power over another.<sup>101</sup> He quotes approvingly Joel Feinberg's comment

there is no such thing as "trivial interference" with personal sovereignty; nor is it simply another value to be weighed in cost-benefit comparison. In this respect, if not others, a trivial interference with sovereignty is like a minor invasion of virginity: the logic of each concept is such that a value is respected in its entirety or not at all.<sup>102</sup>

With all due respect, this is little more than casuistry. While it is certainly true that we cannot sell ourselves into slavery (although at one time that was not only possible but permissible), I do not give up my autonomy if I seek help to accomplish something I desperately want but am unable to do by myself. By this argument, it would appear that it is all right for me to commit suicide providing I do not involve anyone else, for example, I go out to the gun store, purchase a shotgun, load it, put the barrel in my mouth, and pull the trigger. I have thus kept my "sovereignty." That this might be a horrible death, that it might cause great pain to people I love, seems to be irrelevant. People who

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99. NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, *WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT* 88 (1994).

100. See, e.g., DANIEL CALLAHAN, *THE TROUBLED DREAM OF LIFE* (1993).

101. Daniel Callahan, "Aid-in-Dying": *The Social Dimensions*, in *COMMONWEAL* 476 (1991).

102. Joel Feinberg, *Autonomy, Sovereignty and Privacy: Moral Ideals in the Constitution?*, 58 *NOTRE DAME L. REV.* 448, 492 (1983).

are seriously ill have already had their "sovereignty" compromised. They can no longer do all they want; they may not even have complete or perhaps even partial control over their bodies. Their autonomy is not reduced if someone helps them to die and to end their suffering.

### C.

Aside from their objections to an individual taking his life, opponents of assisted suicide also fear the effects it will have upon the medical profession. For two millennia doctors have taken the oath of Hippocrates, and even if they no longer swear to the god Apollo, they still adhere to an ethos that they will do no harm to patients nor "give a deadly drug to anybody if asked for it, nor . . . make a suggestion to this effect." The official position of the American Medical Association is that "physician-assisted suicide is fundamentally incompatible with the physician's role as healer."<sup>103</sup> Medical ethicists and others worry that if the doctor becomes a dispenser of death, this will adversely affect the doctor-patient relationship, destroying the trust that is essential to good care. As one group of doctors put it: "If physicians become killers or are even merely licensed to kill, the profession—and, therefore, each individual physician—will never again be worthy of trust and respect as healer and comforter and protector of life in all its frailty."<sup>104</sup>

(There is, one should note, an on-going debate over the role of doctors in the execution of prisoners condemned to death. Several states have adopted lethal injection as a more humane form of execution than the electric chair, and have typically turned to physicians to set up the intravenous tube and inject the combination of substances. While some doctors and ethicists see this as completely opposed to the very essence of medicine, the saving of life, others justify it as a humane response to an extraordinary circumstance. If doctors do not perform this act it will be done by those who are not trained, errors will occur, and instead of a humane death one will have a butchery.<sup>105</sup>)

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103. AMA, CODE OF ETHICS Rule 2.211 (1994). However, polls of doctors show them to be greatly divided on this issue, with only a minority favoring the AMA official position. See *Washington v. Glucksberg*, 521 U.S. 702, 749 n.12 (Stevens, J., concurring) (citing studies on this issue).

104. W. Gaylin et al., *Doctors Must Not Kill*, 259 JAMA 21, 39-40 (1988).

105. See AMA Council on Ethical and Judicial Affairs, *Physician Participation in Capital Punishment*, 270 JAMA 365 (1993); Erich H. Loewy, *Healing and Killing, Harming and Not Harming: Physician Participation in Euthanasia and Capital Punishment*, 3 J. CLINICAL ETHICS 29 (1992).

Critics worry not only about physicians as healers, but also as individual moral agents. If sanctioned to carry out euthanasia, then they must have independent moral grounds to kill others. If a patient asks a doctor to help her die because her life has become one unending round of pain and she is no longer able to do any of the things that mattered to her, is the doctor to make an independent judgment at this point or merely to accept what the patient tells him? The degree to which people suffer from pain varies enormously; three patients with identical conditions may react in three different ways. What is the obligation of the doctor to seek other forms of therapy, perhaps aggressive pain treatment? Doctors in the Netherlands agree that the most difficult aspect in euthanasia is that there is no objective way of judging patient claims regarding pain. Given the recent emphasis on patient rights and self-determination, will doctors simply abandon independent moral or even medical judgments and simply agree to patient demands for death? Will they, in effect, become moral cripples?<sup>106</sup>

But what is a doctor's obligation to her patient? In general, one expects that a physician will do all that can be done to cure an illness, repair an injury, and mitigate pain. But what happens when the illness is incurable, when the injury is beyond repair, and when the level of pain thwarts the most potent medicines in our modern pharmacopoeia? In this case, if the patient wants to end the suffering by ending life, does the doctor have an obligation to help if that would be in the patient's best interests?

There are doctors and medical ethicists who take this position, and believe that like the old-fashioned family doctors, modern physicians have to treat the whole patient, and do what is in the best interests of the patient. For a doctor to seriously discuss suicide as an alternative, and be willing to assist if necessary, would demonstrate a commitment to the patient's well-being right up until the moment of death. Certainly there is no indication that doctors in the Netherlands have lost the respect of their patients; rather, they are seen as trusted friends of the family, who stay with a patient in the final moments. Nor do they appear as moral cripples to themselves, their patients or society.

Doctors who, for whatever reason, choose not participate in assisted suicide need not do so, providing they are open and upfront about their position. Some doctors will not perform abortions, even though the Supreme Court has held that a woman's

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106. See Daniel Callahan, *When Self-Determination Runs Amok*, HASTINGS CENTER REP., May-June 1992, at 52-53.

right to abort is constitutionally protected.<sup>107</sup> They have chosen, whether for medical, moral, political or financial reasons, not to perform abortions, and they cannot be forced to do so. When a new patient registers, she is told that the particular doctor or the office does not perform abortions, and if that is her need, she is free to go elsewhere. There is no reason why doctors who will not assist in suicide cannot inform their patients in a similar manner.

Many doctors in fact do help their patients die, but because of the law and social restrictions they have to do so quietly, secretly, and in many ways fraudulently.

#### D.

In order to justify a right to terminate treatment, judges and medical ethicists have latched onto the alleged difference between killing and letting die.<sup>108</sup> In our first hypothetical, Adam decided to stop treatment; he did not committ suicide, but died from the underlying disease, while the doctor who turned off the machine did not assist suicide. This may be a nice legal distinction, but I suggest it is a distinction without a difference. Adam chooses to turn off the machine for a very deliberate purpose—he wants to die, and in stopping the treatment he achieves his goal, just as effectively as if he had put a gun to his head. Moreover, the doctor who accedes to Adam's wishes and turns off the ventilator has assisted Adam in his purpose, just as if he had provided an overdose of barbiturates or injected a lethal substance. The result is the same—a person has willed his death and with the aid of a doctor has achieved that result.

Is the distinction between killing and letting die, between active euthanasia and forgoing treatment, sufficiently clear that one can build an ethical or legal rationale for sustaining it, or is it merely a rationalization to avoid the hard issues?<sup>109</sup> Two of the country's leading biomedical ethicists, Tom L. Beauchamp and James Childress suggest it is not, and use the 1982 case of "Baby Doe" as an example. A newborn with Down syndrome needed an operation to correct a tracheoesophageal fistula. The parents

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107. See *Roe v. Wade*, 410 U.S. 113 (1973).

108. According to the American Medical Association, "[w]hen a life-sustaining treatment is declined, the patient dies primarily because of an underlying disease." *Report of the Council on Ethical and Judicial Affairs of the American Medical Association*, 10 ISSUES L. & MED. 91, 93 (1994).

109. For what appear to me to be rationalizations, see Raymond J. Devetere, *The Imprecise Language of Euthanasia and Causing Death*, 1 J. CLINICAL ETHICS 268 (1990); Edmund D. Pellegrino, *Doctors Must Not Kill*, 3 J. CLINICAL ETHICS 95 (1992).

and attending physicians concluded that even if the operation was successful, the child's future quality of life would be so poor that survival was not in the infant's best interest. They decided not to perform the operation and also chose to stop intravenous feeding, so that the child would soon die from starvation. In their minds the act of omission did not constitute killing; rather the child died of the underlying condition. The case triggered a public outcry, and critics charged that the parents and doctors had killed the infant by negligently refusing to perform a duty they owed to the child.<sup>110</sup>

To take another example, fifteen-month old Samuel Linares had swallowed a balloon and had stopped breathing. His father Rudy rushed the child to the nearest emergency room where the doctors quickly removed the blockage, but the boy remained unconscious, able to breathe only with the aid of a respirator. Doctors determined that during the time Samuel had been unable to breathe he had suffered brain damage; they told the family that the child would never recover. For the next several weeks the infant lay in a hospital room on a respirator, until his father asked the hospital authorities to turn off the machine and let his son die a natural death. Hospital officials refused, and told him in effect that they were in charge, and if he did not like it, he should get a lawyer and a court order. Linares pleaded with the hospital and was shunted from one office to another; no one paid him any attention.<sup>111</sup>

Finally, after nine months, Rudy Linares decided to release his son from the machine. He came to the hospital armed with a pistol, and holding off the staff, disconnected Samuel and then held the child in his arms until he died, telling the doctors and nurses he held at bay that he was doing this because he loved his son. After Samuel died, Rudy laid down his gun. Police arrested him, and the district attorney charged him with murder. The charge outraged the public, and a few weeks later, a Cook County grand jury refused to indict him.

What would one think if Linares had said: "I did not kill my son. The balloon he swallowed killed him. All I did was let him die from the underlying problem." While it is true that swallowing the balloon led to the child's predicament, and that if left alone (i.e., not put on a ventilator) he would have died, there is also no question that his father, in a very real sense, "killed" him.

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110. See BEAUCHAMP & CHILDRESS, *supra* note 93, at 219-20.

111. In fact, under Illinois law the family had the right to order discontinuation of treatment, but Linares, a laborer, did not know the law or his rights in the matter.

What if the hospital authorities had behaved as they were required to do under Illinois law, and upon the family's request had removed Samuel from the machine? Would this have changed the ethical dimensions in any meaningful way? It would have amounted to "allowing to die," a situation condoned by law, yet the end result is the same. What a physician did in Adam's case and what Rudy Lenares did in that of his son is causally the same—they removed a machine and as a result the patient died.

To take another one of our earlier hypotheticals, Carole entered the hospital to be put on a morphine drip, knowing full well that before long that treatment would end her life. The doctor who administered the morphine also knew that increasing the dosage would not only alleviate the pain, but lead to death. In the eyes of the law and of the medical profession, Carole did not commit suicide nor did her doctor kill her; she suffered from cancer, and the doctor let her die. This may soothe the qualms of the medical profession, but logic tells us that Carole willed her death, and the doctor joined in her enterprise; in fact, his actions made it possible.

Should we therefore abandon the distinction between killing and letting die, and is there any reason to maintain the fiction that refusal of treatment is somehow different than suicide? Dan Brock has written:

The judgment of a person who competently decides to commit suicide is essentially that "my expected future life, under the best conditions possible for me, is so bad that I judge it to be worse than no further continued life at all." This seems to be in essence exactly the same judgment that some persons who decide to forego life-sustaining treatment make. The refusal of life-sustaining treatment is their means of ending life; they intend to end their life because of its grim prospects. Their death now when they otherwise would not have died *is* self-inflicted, whether they take a lethal potion or discontinue a respirator.<sup>112</sup>

The person who discontinues dialysis or who takes an overdose of barbiturates has chosen death, and has effectively committed suicide no matter what the underlying illness may be. Similarly, the person who provides a lethal overdose or who turns off the ventilator has helped to kill the person.

Does this mean that we should draw no distinctions among doctors who deliberately, whether directly or indirectly, cause death? Does it also mean that we should make no distinctions

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112. BEAUCHAMP & CHILDRESS, *supra* note 93, at 224.

between people who choose to die by their own hand, whether by using a gun, taking an overdose or refusing life-sustaining treatment? The answer is not as simple as the question might make it appear. In law as in ethics, there are important distinctions to be made. These distinctions may make it possible for us to reach a principled basis for evaluating physician-assisted suicide.

### E.

First of all, even if we say that killing is the same as allowing to die, there are moral distinctions to be made in killing. A person who kills for hire is to be distinguished from a soldier who kills in war, a racial lynching is different from someone who kills in self-defense. A doctor who disconnects life-support from a terminally ill patient is different from a doctor who fails or refuses to act when a life could be saved. Neither killing or letting die is by itself moral or immoral, but depends on the circumstances.

The law has for the past several centuries drawn distinctions in homicide, and it has adopted a totality of the circumstances approach in determining whether a killing is premeditated murder or manslaughter or negligent homicide. Since about 1600, judges have defined common-law crimes as requiring some sort of bad intent, a guilty mind—*mens rea*—as well as an illegal act to constitute a crime. *Actus not facit reum nisi mens sit rea*—“An act does not make one guilty unless one’s mind is guilty.” There are, of course, differing degrees of knowledge about one’s acts and their consequences. We need to know something about whether a person has acted maliciously or out of good intentions, whether in acting a doctor has strayed beyond the limits of reasonable behavior, whether what society considers normative has been egregiously violated, and other factors.

Bright line tests do not work well here. The official position of the American Medical Association that “physician-assisted suicide is fundamentally incompatible with the physician’s role as healer”<sup>113</sup> runs afoul the common-sense perception that many doctors as well as laymen have that in some cases “healing,” i.e., keeping alive, may not be in the patient’s best interests. The extreme case of the anonymous intern who decided to inject a lethal solution into a suffering patient whom he did not know certainly affronts us; what we do not know is whether that woman was happy to see someone who could put an end to her pain.

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113. AMA, CODE OF ETHICS Rule 2.211 (1994).



The important thing is that we cannot generalize from one case. Justifying a specific act of withdrawal of treatment or lethal injection is not the same as justifying a policy of approving all such acts. What is the mental state of the ill person? What are the chances of recovery? Is the act one of humaneness or an effort to save money? Did the person choosing to terminate treatment act in a competent, knowing and voluntarily manner? How much discretion, if any, do we wish to place in the hands of physicians in such matters? How willing are we to honor the principle of individual autonomy in practice as well as in theory?

If this sounds like situational ethics, it is, because I would suggest that if one truly believes not only in individual autonomy but also individual uniqueness, then a rigid rule, no matter how appealing in its simplicity, cannot work. But can a code that tries to take into account so many variables work? I believe it can, if we allow common sense as well as common humanity to prevail. Judges have for centuries weighed cases under a "totality of the circumstances" ethic, determining that an act in one set of circumstances triggers a different legal response from that same identical act in another setting. The rigidity of the law brought equity into existence, to temper the law with mercy and thus achieve justice. What is needed, I would suggest, is an ethics of "equity" as well as a jurisprudence of compassion in this area.

### III.

The debate over physician-assisted suicide in the United States has operated on several levels, in courtrooms, newspapers, scholarly journals and popular magazines; it certainly has not been hidden, and there is evidence that popular attitudes are changing. In a New York Times/CBS News poll taken in the spring of 1990 on the question of whether a doctor should help a terminally ill person die, fifty-three percent said yes, forty-two percent said no, with the rest undecided.<sup>114</sup>

Many years ago, Justice Louis Brandeis wrote that it is one of the happy incidents of the federal system that a single courageous state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.<sup>115</sup> The Supreme Court, while denying that a constitutional right to assisted suicide exists, did not find a constitutional barrier to it either, and made clear that if individual

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114. See Andrew H. Malcolm, *Giving Death a Hand: Pending Issues*, N.Y. TIMES, June 9, 1990, at A6.

115. *New State Ice Co. v. Liebman*, 285 U.S. 262, 311 (Brandeis, J., dissenting).

states wanted to experiment in this area, they stood free to do so. One country, the Netherlands, now allows physicians to help their patients die. Is there anything we can learn from the Dutch experience to allow us to formulate a workable public policy in the United States? One state, Oregon, has chosen to legalize assisted suicide under specific conditions. If other states follow, what factors should they take into account in formulating their policies? Is it possible to craft procedures that allow for maximum individual choice yet also establish legitimate safeguards against abuse?

A.

In 1973, Dr. Geertruida Postma, a general practitioner in the Netherlands, stood trial for the murder of her mother by injection of morphine. The old lady lived in a nursing home, had suffered a cerebral hemorrhage which left her partially paralyzed, was deaf and spoke with great difficulty, and at the time was being treated for pneumonia. She had failed in a suicide attempt, and told her daughter, "I want to leave this life. Please help." At her trial, Dr. Postma declared that she regretted not having done it earlier. The court found her guilty and sentenced her to one week in jail and one year of probation.

Perhaps even more important, the court laid down guidelines under which assisted suicide would not be liable to criminal sanction. These conditions required that the patient be suffering from a terminal illness, be in unbearable pain, make a written request to the doctor, have entered into "the dying phase," and the assistance must be by a doctor, not a lay-person.<sup>116</sup> The case brought forth an out-pouring of statements from other physicians that they would have done the same thing, and started the Netherlands down a path where it became the only nation in the world where euthanasia, while technically illegal, could be practiced openly.

The Dutch experience has been used by both sides in the assisted suicide debate to reinforce their points. Supporters point to the small number of deaths resulting from physician action, while opponents declare that the practice has grown out of control, with many people involuntarily dying at the hands of doctors. One needs to understand how euthanasia works in the Netherlands, but one needs to keep in mind that the United States is a far different country, and it is questionable whether

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116. See CHARLES F. GOMEZ, *REGULATING DEATH: EUTHANASIA AND THE CASE OF THE NETHERLANDS* 28-36 (1991); DEREK HUMPHREY, *LAWFUL EXIT: THE LIMITS OF FREEDOM FOR HELP IN DYING* ch. 2 (1993).

one can actually apply the Dutch experience to the American environment.<sup>117</sup>

Nearly all analyses of the Dutch experience start with World War II, when the Germans occupied Holland for nearly five years. The Nazi satraps ordered the local doctors to help carry out their policies of sterilizing Jews, euthanizing the handicapped, and deporting Jews and other "undesirables" to labor camps. Alone of all the occupied countries, the Dutch medical profession as a group refused to participate in the Nazi atrocities. As a result, the Germans voided all of the Dutch medical licenses, but the doctors continued to treat patients while no longer signing birth and death certificates. To force compliance, the Nazis arrested one-hundred doctors and deported them to labor camps in Germany; but the Dutch held firm and refused to collaborate; eventually the occupiers gave up. As a result of this experience, no one in Holland considers the doctors butchers or murderers, and charges of physicians "playing God" with patients' lives are pretty much absent from the Dutch debate (although not from the charges of those outside the Netherlands who condemn euthanasia).<sup>118</sup>

Following the Postma decision, over the next twenty years a series of court rulings helped to refine what might be called the "unofficial" policy regarding physician-assisted suicide in the Netherlands, since technically the Dutch penal code still considers euthanasia a crime.<sup>119</sup> Most of these cases came to the court more in an effort to develop a policy rather than to punish individual doctors. In this sense they resemble the collusive cases brought by hospitals and doctors in the United States to develop a legally sanctioned policy of allowing patients to terminate life support.

The crucial case involved a physician who had, at her request, helped a very sick and elderly woman to die. The case went all the way to the Supreme Court, which in 1984 sent it back to the Rotterdam local court for a rehearing. There, the judges

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117. The most comprehensive and recent survey of euthanasia in the Netherlands is *ASKING TO DIE: INSIDE THE DUTCH DEBATE ABOUT EUTHANASIA* (David C. Thomas et al. eds., 1998) [hereinafter *ASKING TO DIE*].

118. See HUMPHREY, *supra* note 116.

119. There is a move to legalize the current practice, but as of this writing the Dutch legislature had not acted. Sections 293 and 294 of the Dutch penal code make physician-assisted death a crime. Dutch courts have rationalized their not punishing doctors on the grounds that the physician's duty to act in a patient's best interests conflicts with the duty to obey the law. See Helga Kuhse, *The Case for Active Voluntary Euthanasia*, 14 *LAW, MED. & HEALTH CARE* 145, 146-47 (1989).

enunciated the so-called "Rotterdam criteria" which narrowed the circumstances under which physician-assisted suicide would be permissible. The patient's death may not cause unnecessary suffering for others; following a patient's request the physician must consult the patient's family, unless the patient objects; and a second doctor had to agree with the prognosis.<sup>120</sup>

That same year the Royal Dutch Medical Society announced its approval of physician-assisted dying, and set out "Rules of Careful Conduct" to guide doctors.<sup>121</sup> The Rotterdam criteria and the blessing of the organized professional body created a climate in which doctors could help end the lives of their patients without fear of prosecution. But a critical ingredient went missing. Under the guidelines doctors had to turn in extensive reports about the circumstances of deaths they aided, and stand ready to be interviewed by an investigator from the Ministry of Justice if any thing seemed out of the ordinary. As busy men and women, doctors often avoided the lengthy paperwork by signing death certificates listing the underlying cause of death, such as cancer, and neglecting to add that the death had been hastened by drugs.

As a result, the Ministry of Justice initially received only about a dozen reports a year of euthanasia, although the number increased as physicians grew more familiar with the practice. Because of conflicting information, the Dutch government, in 1990, named a special commission headed by Professor Jan Remmelink, the attorney general of the Dutch Supreme Court. The R Emmelink Commission undertook a careful nationwide study of euthanasia in the Netherlands, and the following year reported its findings. In a country of 15,000,000 people, there had been roughly 130,000 deaths in 1990. Extrapolating from official reports as well as interviews with doctors, the Commission estimated that 2,300 deaths, 1.8 percent of the total, had resulted from euthanasia, while another 400 could be classified as physician-assisted suicide. However, only 486 of these deaths had been reported on the death certificate as euthanasia or assisted suicide. In nearly all of the 2,700 cases, however, the guidelines established by the Rotterdam court as well as by the Medical Society had been met, with the obvious exception of reporting.<sup>122</sup>

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120. See Nurit Lev, *The Legalization of Euthanasia: The Right to Die or the Duty to Die*, 19 SUFFOLK TRANSNAT'L L. REV. 297, 300 (1995).

121. See Johan Legemaate, *Twenty-Five Years of Dutch Experience and Policy on Euthanasia and Assisted Suicide: An Overview*, in ASKING TO DIE, *supra* note 117, at 21.

122. See MEDICAL DECISIONS ABOUT THE END OF LIFE: REPORT OF THE COMMISSION TO STUDY THE MEDICAL PRACTICE CONCERNING EUTHANASIA (1991).

The Rummelink group did, however, uncover one disturbing feature of the Dutch practice. In an additional 1,000 cases, the patient had not been competent when the doctor had injected the drugs, raising questions about whether the family had been involved or if the doctor had arbitrarily and solely decided on the procedure. (The Dutch do not use the term "euthanasia" for such cases, reserving it solely for instances in which the patient voluntarily requested the doctor to act.) For opponents of assisted suicide, these deaths clearly pointed to physician abuse, and they direly warned of the slippery slope in which doctors would choose who would live and who would die, a Nazi-like extermination of the very old, the very young, the sick and the disabled, or those whose illnesses placed heavy financial or emotional burdens on their families.

The Dutch investigators did look closely at these 1,000 cases, and did not come to such a frightful conclusion. Over half of the patients had previously while competent expressed an interest in euthanasia, and most were moribund at the time of the lethal injections. This information, however, came from doctor interviews, and while one might surmise that in a majority of the instances the actions probably would have been approved by the patients if they had been able to voice their sentiments, one can also conclude that there were some cases of involuntary euthanasia. Whether the incidence of such abuse is greater in the Netherlands than elsewhere is impossible to say. The vast majority of deaths in the United States are not investigated, nor are there autopsies except under suspicious circumstances. A very sick person dies, the attending physician signs a certificate attributing death to the disease, and that is the end of the matter. Anecdotal information as well as some surveys indicate that in at least some instances doctors hastened death, and without the open consent of the patient.

To supporters of physician-assisted suicide, the Rummelink findings proved reassuring. The number of euthanasia and assisted suicide deaths accounted for only a small fraction (2.1 percent) of the total deaths in the country; even if one added in the estimated 1,000 non-voluntary deaths, the total still amounted to less than three percent. Moreover, doctors did not practice euthanasia on all who requested it; physicians acceded to only one request in three. As far as could be determined, doctors euthanized only persons in the terminal stage of illness; eighty-seven percent of the patients had been expected to die within a week, and another twelve percent within a month.

One of the main concerns of opponents of euthanasia, as well as the stated policy of American medical associations, is the

effect that such practice will have on physicians. Giving doctors legal power to end life, they claim, subverts the entire basis of the healing arts, and will demean not only the profession but dehumanize doctors as well. For evidence, they point to the Dutch Pediatric Association, which in 1992, issued guidelines on how physicians should handle the euthanasia of children and newborns. In deciding whether to end the life of a severely handicapped newborn, doctors would judge the expected quality of life for the infant, and if prospects seemed dim that the child could lead even a semblance of a normal life, then euthanasia would be justified.<sup>123</sup> In February 1993, the Ministry of Justice proposed expanding guidelines to allow doctors to perform "active medical intervention to cut short life without an express request."<sup>124</sup> In April of the same year, a court formally approved the euthanasia of psychiatric patients, after a doctor helped end the life of a woman who stated that she wanted to die after losing two of her children and going through a divorce.

In 1995, a second nationwide investigation, consisting of two major studies, followed up on the original Rummelink report and seemed to cut the ground from under the slippery slope argument. One study compared practices in 1995 to those in 1990, while the second sought to assess the notification procedure which had been formulated by the Ministry of Justice and the Royal Dutch Medical Association in the early 1990s and which had been enacted into law in 1994.

The first study team, led by Paul J. van der Maas, found that practices in 1995 differed little from those in 1990. Euthanasia had become somewhat more frequent, but they attributed this to the aging of the population as well as an increase in mortality from cancer, the usual underlying disease in cases of euthanasia. Physician-assisted suicide remained rare according to van der Maas because it is slower than euthanasia and because the Dutch draw no moral distinction between the two. As in 1990, nearly all of the euthanasia cases involved patients suffering from terminal sickness with only a short time left to live. The number of cases in which the patient did not explicitly request the doctor to act declined somewhat from 1990. The report concluded that the Netherlands had not started down a slippery slope, and that

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123. See Abner Katzman, *Dutch Debate Means Killing of Babies*, *CONTRA COSTA TIMES*, July 30, 1992, at 3B.

124. *Critics Fear Euthanasia Soon Needn't Be Requested*, *VANCOUVER SUN*, Feb. 17, 1993, at A10.

Dutch doctors continued to practice euthanasia carefully and only under compelling circumstances.<sup>125</sup>

The second study showed that the incidence of doctors reporting euthanasia or assisted suicide had risen from eighteen percent in 1990 to forty-one percent in 1995, indicating that a majority of the cases still went unreported. While agreeing with the need for some form of oversight, the medical profession found burdensome the multiple levels of legal review, and also resented the fact that euthanasia technically remained a crime, despite the official guidelines. For many doctors, even the slightest chance of criminal prosecution, or even investigation by the Ministry of Justice, justified attributing death to an underlying illness rather than to euthanasia.<sup>126</sup>

What effect does practicing euthanasia have on Dutch doctors? Have they become Nazi-like arbiters of death for the aged and infirm, or have they expanded the role of physician to include compassionate end-of-life treatment? The relatively low incidence of euthanasia would seem to negate the first view, although the number of involuntary cases would indicate that some doctors have chosen to act on their own. However, this arrogation of power is not limited to doctors in the Netherlands. In the United States, about seventy percent of hospital deaths occur after a decision has been made, sometimes by the family, sometimes by the family and the doctor, and in some cases by the doctor alone, to forego further treatment; in the Netherlands that figure is only twenty percent. In addition, both countries allow the use of morphine and other opioids to treat pain in doses that could lead to death, the so-called "double effect." The Dutch are just much more open about what they are doing.

Probably the one aspect about the practice that vexes most doctors is the reporting requirement and the fact that their decisions to help patients end their lives, decisions based on knowledge of the patient and of the disease, are reviewed by non-medical bureaucrats. About three-fifths of all physician-assisted deaths go unreported, with doctors claiming that they want to spare the patient families and themselves the scrutiny of an inquiry. Since 1981, only twenty doctors have been prosecuted for violating the guidelines, and only six have received prison

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125. See Paul J. van der Maas et al., *Euthanasia, Physician-Assisted Suicide, and Other Medical Practices Involving the End of Life in the Netherlands, 1990-1995*, 335 NEW ENG. J. MED. 1699 (1996).

126. See Gerrit van der Wal et al., *Evaluation of Notification Procedures for Physician-Assisted Death in the Netherlands*, 335 NEW ENG. J. MED. 1706 (1996).

sentences—all suspended.<sup>127</sup> By any standards, doctors have not abused the system in any significant way.

## B.

While many people see the Dutch way as the future for the United States, a closer analysis of the medical culture in Holland suggests that the model may not transfer easily across the ocean. The Netherlands is a small country, prosperous, technologically advanced, democratic, and with a well-educated citizenry. But it is not a miniature version of the United States. It has some fifteen million people living in an area smaller than West Virginia, and ninety-six percent of them are white and native-born. While there is a rich religious diversity, the different groups coexist peacefully and enjoy a long tradition of tolerance. The Catholic and Protestant political parties are both centrist, and the Dutch Catholic Church has long been known for its independence from the more conservative pronouncements of the Vatican.

In a country in which most people are comfortable middle class, there is also an extensive state welfare system in place. Nearly everyone in the small country is covered by either government or private health insurance that pays practically all medical expenses, thus alleviating the patient's fear of becoming a financial burden upon one's family. Even nursing homes are funded by the government and are available to everyone. Dr. Herbert Cohen, who is regarded by many as the archetype of the compassionate doctor practicing euthanasia, says that physician-assisted death "is not a way out of social misery. You don't have to request euthanasia because you can't get any medical attention."<sup>128</sup> In the United States, where one out of six persons has no health insurance of any sort and millions more lack full coverage, hospitalization and nursing home care can impoverish a family. The people of Holland face practically no out-of-pocket expenses at the end of life.<sup>129</sup>

In the United States, there is one general practitioner for every 6.5 specialists; in the Netherlands the ratio is one to one and a half. Dutch GPs live in the neighborhood of their patients, their offices are in their homes, and they make house calls when their patients are too sick to come to the office. There is a close relationship between the doctors and their patients, many of whom they have treated for decades, a relationship strikingly sim-

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127. See Joseph R. Shapiro, *Euthanasia's Home*, U.S. NEWS & WORLD REP., Jan. 13, 1997, at 24, 26-27.

128. *Id.* at 26.

129. See *id.*



ilar to what health care used to be in the United States before it became so technological and hospital-centered.<sup>130</sup>

If anything the trusting relationship between doctor and patient is one reason that the Dutch policy works. The doctor does not come in when a patient asks for euthanasia, give an injection, and leave. In 1994, Netherlands television broadcast an actual euthanasia, and it showed Dr. Wilfred van Oijen visiting his patient, Cornelis van Wednel de Joode, who suffered from ALS, a number of times, and Dr. van Oijeb stayed with de Joode and his wife throughout the final act.<sup>131</sup> To give another example, when Andrea de Lang chose to end her life because of the pain and debilitating effects of pancreatic cancer, her doctor stayed the entire night in her apartment with her husband, three grown children, a sister and other friends. In Holland, forty percent of all deaths take place in the home, compared to only fifteen percent in the United States.<sup>132</sup>

Holland has been described as a "consensus" society. Because there is some significant opposition to euthanasia, the practice remains illegal on the books. At the same time there are official guidelines for doctors and public officials to follow. Dutch ethicist Evert Van Leeuwen thinks that the consensus among the citizenry is what makes the practice work, and that the type of physician-assisted suicide that would ultimately be considered in the U.S. Supreme Court would never work in Holland. Patients cannot "demand" euthanasia, but rather must work it out with their doctors as partners in the decision process. "We do not talk in terms of rights," he says. Only about a third of those who request euthanasia get it, and unlike the United States, the other sixty-three percent do not go to courts.<sup>133</sup>

The practice of euthanasia appears to be growing in the Netherlands. Although the percentage of deaths caused by euthanasia remained relatively constant, requests for ending life jumped nearly forty percent between 1990 and 1995, and has been common among those infected by the AIDS virus. The majority of requests come from people between the ages of thirty-five and seventy who have cancer.<sup>134</sup>

Some Dutch believe that their acceptance of euthanasia as a socially useful and humane practice stems from their strong belief in individual autonomy, and interviews of those choosing

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130. See FILENE, *supra* note 17, at 208-09; Shapiro, *supra* note 127, at 26.

131. See *Helping a Man Kill Himself, As Shown on Dutch TV*, N.Y. TIMES, NOV. 13, 1994, at A1.

132. See FILENE, *supra* note 17, at 209.

133. See Shapiro, *supra* note 127, at 25.

134. See *id.* at 26.

to end their lives indicate that it is not the pain that is the driving force behind their decision, but their desire to control their lives, to go out when they choose and in a manner they deem respectful of human dignity. The people of Holland see euthanasia as an aspect of medical care, and like other medical procedures, needs to be entered into carefully and with the guidance of a physician.

The United States has a much different culture. It is geographically large and its nearly 300 million people are diverse in race, creed and ethnic origin. It is a contentious rather than a consensus society, and in recent years there has been a growth of divisive forces fighting over a large number of issues. Regrettably, the debate has often been vitriolic with neither side willing to accept a compromise position. Perhaps the best example of this is abortion, into which have been woven all the volatile elements of the women's movement, religious and political fundamentalism, and a host of other concerns. As some commentators have argued, America is in the grips of a culture war, and physician-assisted suicide is one of the flashpoints.

The debate has been framed in terms of rights, and the phrase "right to die," which may mean different things to different groups, has nonetheless passed into the common lexicon. Where the Dutch approach the issue as a matter of medical practice, in the United States it comes in the raiment of politics and law.

### C.

Even before *Glucksberg* and *Quill* began their trek to the high court, several advocacy groups, sensing growing public support, tried to by-pass hostile state legislatures and make physician-assisted suicide law through the state-wide referenda. A series of votes in western states in particular demonstrates vividly not only how opinions are changing but how open a debate this has been. In November 1991, voters went to the polls in the State of Washington to cast their ballots on Initiative 119. Entitled a "death with dignity" measure, the proposal would have authorized doctors to administer lethal injections to incurably ill patients. The patient had to make the request in writing, and had to have been diagnosed by two doctors as having less than six months to live. Two impartial persons, not members of the patients' family, had to witness the written request. If 119 had passed, the state would have become the first jurisdiction in the world to legalize a form of euthanasia.

The Hemlock Society provided the major backing for 119, arguing that the proposal would provide terminally ill people with freedom of choice. Both proponents and opponents of the initiative flooded the state with media spots. In one ad, a hospice worker charged that "Initiative 119 would let doctors kill my patients," while in another a woman who been diagnosed as having cancer seven years earlier told how glad she was to still be alive. Yes, there had been some rough moments, and if 119 had been in effect, she might have chosen death; but she was so happy to still be alive.

Supporters of the measure ran equally emotional ads, with stories of people who died agonizing deaths. One woman, Vera Belt, told how her mother had died in great pain from throat cancer after doctors had refused her pleas for help in ending her life. When Ms. Belt's sister became similarly ill, she knew what awaited her, so she killed herself by putting a gun in her mouth and pulling the trigger.

The proposal split religious and medical groups. The Catholic Church strongly opposed the measure, but more than 200 Protestant ministers from mainstream and liberal groups endorsed it. United Church of Christ minister Dale Turner, a supporter of 119, declared that "We're on the frontier of the world," and he dismissed concerns that people would too readily choose suicide if it became so easily available. Turner, seventy-four, said that "Nobody loves life like an old man. A person has to be pretty ill and desperate to want to leave."<sup>135</sup>

Many doctors bitterly fought the proposal. They had been trained to save lives, not to take them, and they saw 119 as opening the doors to a flood of abuse. When the Washington State Medical Society debated the issue, delegates voted five to one against it, but a poll of the general membership showed doctors split roughly evenly.<sup>136</sup> Although early signs indicated that Initiative 119 would pass, opponents gained ground as election day approached. Critics claim that American voters are apathetic, but 119 galvanized the populace, and voters came out in large numbers. The initiative failed by a eight percent margin. Both sides agreed that the debate had been useful, and that an important public policy issue had been raised, one that would not quietly go away. "If we don't deal with the problems raised by 119, we'll be facing this issue again and again and again" said Dr. Peter McGough, an opponent of the measure. "Saying 'No' to

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135. WASHINGTON POST, Nov. 3, 1991, at A6, 7.

136. See Jonathan S. Cohen et al., *Attitudes toward Assisted Suicide and Euthanasia among Physicians in Washington State*, 331 NEW ENG. J. MED. 89 (1994).

assisted death is not enough. Now we have a responsibility to deal with the problems that brought out this concern."<sup>137</sup>

In November 1992 a measure similar to Washington's Initiative 119 went down to defeat in California, by an identical margin, eight percent.<sup>138</sup> The Hemlock Society, encouraged by the large number of voters supporting its position in Washington and California, decided to try again, this time in Oregon. In November 1994, Oregon voters, by a margin of 627,980 to 596,018, passed Measure 16, the Oregon Death with Dignity Act, becoming the first jurisdiction in the world to make assisted suicide legal.<sup>139</sup> The Oregon initiative was more carefully constructed than the measures that went down to defeat in its neighboring states. To safeguard against abuses, the act applies only in the last six months of life, mandates a second opinion about the patient's condition from another doctor, requires multiples requests, has two waiting periods, and limits the type of aid that a physician can offer to prescribing but not administering medication.

Despite an intense debate and spirited opposition similar to that in Washington, Measure 16 passed because of four things. First, the Washington initiative had been the first to reach the ballot, and it met a stronger and more combative opposition than its sponsors had been prepared to face. Second, the Oregon measure contained additional safeguards that blunted many of the charges that had been raised in Washington. Most important, Oregon had long been a progressive state, and its western tradition prized individualism. The notion of a person controlling his or her own fate appealed to many Oregonians. Finally, the Oregon medical profession, unlike that in Washington, decided to stay neutral in the campaign. Oregon doctors broke with the national office of the American Medical Association (which opposed Measure 16), because, after a heated debate, the state's medical association could find no consensus among its members.

Almost immediately after passage of Measure 16, a group of physicians, patients and hospitals challenged the law on the grounds that it violated the Equal Protection and the Due Process Clauses of the Fourteenth Amendment, as well as the First Amendment and the Americans with Disabilities Act. The gist of their complaint was that Measure 16 denied terminally ill

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137. N.Y. TIMES, Nov. 7, 1991, at B16.

138. *See id.* at B8.

139. OR. REV. STAT. §§ 127.800 - .897 (2000); *see also* Lee v. Oregon, 107 F.3d 1382, 1392 (9th Cir. 1997).

patients the same type of safeguards against committing suicide under undue influence or while suffering from depression as that provided for non-terminally ill people.<sup>140</sup> Chief Judge Michael R. Hogan found numerous inadequacies in the act's protections for the terminally ill,<sup>141</sup> no rational basis for the distinction between terminally ill and non-terminally ill,<sup>142</sup> and concluded that the act did violate the Equal Protection Clause.<sup>143</sup> The state appealed, and in a relatively brief opinion, Circuit Judge Melvin Brunetti vacated the lower court ruling, on grounds that the claims were not yet ripe and the plaintiffs had no standing.<sup>144</sup>

On March 24, 1998, a woman in her mid-eighties became the first person in Oregon to commit suicide with the legal assistance of a doctor. The woman, whose identity was kept secret under terms of the state law, suffered from breast cancer and, according to her doctor, had less than two months to live. She had been having increasing difficulty in breathing, and could no longer enjoy the simple pleasures that had meant so much to her, such as gardening. Hannah Davidson, with the Oregon Death With Dignity Legal Defense and Education Fund, noted that a death is not a reason to celebrate, "but it is good for us. It was a personal decision, and it showed that the law worked." Opponents predictably denounced the event. Gayle Atteberry, executive director of Oregon Right to Life, issued a statement saying, "This marks the first day in history when a society sits idly by and lets someone kill themselves with the help of a doctor."<sup>145</sup> Oregon medical groups did not comment.

Predictions that Oregon would become a beacon for the suicidal, or start the nation down the slippery slope to mass death, have not materialized. In fact, relatively few people have exercised their rights under this law. At the end of August 1998, ten months after the law went into effect, only eight people had died from lethal drugs prescribed by a physician. Two others had secured prescriptions, but succumbed to their illness before using the medication. Nine of the ten suffered from cancer, and

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140. See *Lee*, 891 F. Supp. at 1431.

141. See *id.* at 1434-37.

142. See *id.* at 1434.

143. See *id.* at 1437.

144. See *Lee v. Oregon*, 107 F.3d 1382 (9th Cir. 1997). The case had been argued before the Ninth Circuit panel on July 9, 1996, but the court had withheld judgment once it learned that the Supreme Court had accepted two cases dealing with assisted suicide.

145. William Booth, *Woman Commits Doctor-Aided Suicide*, WASHINGTON POST, Mar. 26, 1998, at A7.

the other had heart problems. There were five men and five women, with an average age of seventy-one.<sup>146</sup> In the last year for which figures are available, only fifteen people committed suicide with a doctor's help.<sup>147</sup>

It is too early to tell how the Oregon program will work. Although Measure 16 is fairly specific, there are a number of technical problems to be resolved. Doctors are still discussing how a patient's request for lethal medication should be honored. Pharmacists, who are often called upon by customers for information about medications, wonder what advice they should give to persons who hand them prescriptions for lethal drug dosages and whether any liability will attach in filling these prescriptions. The law provides for adult Oregon residents, but how is that to be defined and will that definition conflict with federal and constitutional provisions about residency? Will other options, such as hospice care, be ignored by people for whom that may be the best choice?<sup>148</sup>

Even those who favor physician-assisted suicide recognize that there are many potential problems. Doctors educated to save lives as their primary concern will have to learn new skills and attitudes. Dr. Martin Skinner, an internist in suburban Portland, had mixed feelings about Measure 16. "I don't know how to deal with it," he told a reporter. "I can conceive of myself being in a position to make such a decision, but I honestly do not know what I would do."<sup>149</sup> The law's definition of a terminally ill patient, one with six months or less to live, is also problematic. According to Skinner, doctors are fairly accurate in determining how long someone has to live when the illness is cancer, but there is far less certainty with other diseases.<sup>150</sup> There is also concern about how the law will affect the vulnerable, one of the main concerns that led Judge Hogan initially to block Measure 16's implementation. Will there be undue pressure on elderly patients, whose illness is a financial and emotional drain on their families, to do the "right" thing and opt for suicide? Arthur Caplan, director of the Center for Bioethics at the University of Pennsylvania School of Medicine, could not predict what the exact consequences of the Oregon initiative would be, but he declared that the "legalization of any form of assisted suicide will

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146. See *Eight in Oregon Used Suicide Law to Die*, RICH. TIMES-DISPATCH, Aug. 19, 1998, at A2.

147. See *Painful Debate*, TIME, Sept. 27, 1999, at 44.

148. See *The Uncharted Waters of Oregon's Assisted Suicide Law*, 4 CHOICES 1, 6 (1995).

149. N.Y. TIMES, Nov. 25, 1994, at B14.

150. See *id.*

have just tremendous consequences that will reverberate through American society."<sup>151</sup>

#### D.

Although the social, political and economic contexts in which physician-assisted death takes place in the Netherlands are much different than those in the United States, I believe there is at least one lesson that can be learned. The predictions that doctors will be dehumanized, that the medical profession will fall into disrepute, and that death will become a casual matter have certainly not been born out in Holland. If anything, the fact that one can turn to a doctor to ease the final pain and suffering has enlarged the respect in which the Dutch hold doctors. That there are some abuses in the system is undeniable, but certainly these are no greater than abuses reported in the American system of health care delivery.

Oregon is now embarked on an experiment, and initial reports do not indicate any great rush of people to hasten their death. To critics of physician-assisted suicide, even a single doctor helping a single patient hasten the moment of death is an abuse. Supporters of the plan will not cheer death, but they will point out that personal autonomy is honored within a system designed to prevent mistreatment.

If one were asked to design a system that would allow greater end-of-life choices, including physician-assisted suicide, what would be the policy imperatives one would want to take into account? This is certainly not a new question, and has been grappled with before by doctors and medical ethicists, Margaret Battin, for example, has posed seventeen questions physicians and mental health professionals should ask when dealing with requests for assistance in suicide, such as, "Is the request consistent with the person's basic values?" "Are the medical facts cited in the request accurate?" "Has the person considered the effects of his or her suicide on other persons?"<sup>152</sup> But these are the questions that doctors should ask. What are the larger safeguards that a legislature should take into account if it wanted to establish a system of legalized physician-assisted suicide?

Only persons *within six months of expected death* will be eligible to request physician-assisted death. While no one can predict the exact moment of death, the medical profession has sufficient

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151. *Id.* at A28.

152. BATTIN, *supra* note 93, ch. 13; see also Howard Brody, *Care of the Hopelessly Ill: Proposed Clinical Criteria for Physician Assisted Suicide*, 327 NEW ENG. J. MED. 1380 (1992).

experience with AIDS, cancer, ALS and other such diseases that its practitioners can make well-educated estimates as to how much time a person has left to live.

The decision must be completely *voluntary*. There are a variety of safeguards that can be erected to ensure this, such as requiring a request for physician-assisted suicide to be made at least twice, both orally and in writing with a certain time period elapsing between each request; that the request be witnessed by at least one physician or qualified health-care professional other than the attending physician,

The patient making the request be *competent*. This requirement means not only that the patient understand the consequences of the act, but be mentally able to make a decision. If the person is suffering from acute depression, is mentally incapacitated in some way, then he or she will not qualify. One might note that there is a long legal experience in judging competency that can be brought to bear here, including, if necessary, the appointment of a guardian *ad litem* to determine competency.

If a person fears that some future event may result in inability to act, then a living will may provide for a *health care proxy* to make a request for assisted death. At present we allow a living will to govern decisions not to resuscitate and to take patients off life-support equipment. However, a person may not be on life support and yet may be reduced to a vegetable-like existence which she would not want. This provision will allow a proxy to act, with a properly executed legal instrument serving as proof of both voluntariness and competency. It will also negate the six-month requirement of item one.

Once a person has been adjudged to have met the above requirements, he or she may obtain a lethal dose of drugs after a *fourteen-day waiting period*.

*No physician will be required to administer the drugs or be present at the time of the suicide.* However, if a relationship exists between the physician and the patient, such as personal friendship or a lengthy professional tie, if the doctor is willing to assist personally in administering drugs or a lethal injection, and be present at the time of the suicide, no legal liability shall attach to these actions.

*Record keeping must be accurate.* Both the patient and the physician must fill out appropriate forms and register them with the appropriate state or local office. If the procedures have been duly followed and the forms submitted, then no legal liability, either civil or criminal, shall attach to the physician or to any family members or friends who assist the patient.



A person who meets these criteria and commits suicide will have *two entries on her death certificate*—physician-assisted suicide as well as the underlying disease. In such cases, insurance companies will not be permitted to invoke the standard suicide clause in their policies.

These criteria are not meant to be exhaustive. Providing the state does not impose limitations burdensome to the individual, it may require additional safeguards, such as a sworn affidavit to a proper magistrate. The idea is not to make assisted suicide easy, but rather in appropriate situations to make it possible with sufficient safeguards yet a respect for individual autonomy.

The one group for whom these criteria may prove both burdensome and unhelpful consists of people who are suffering from a severely painful condition, but one that is not life-threatening. One might well ask why these people should not be included, and the answer may very well be that they should be. But there are practical difficulties associated with pain; it is difficult for doctors to gauge the extent of the pain, or how it affects the ability of the person to function in a normal manner. At least for the moment, I should prefer to limit physician-assisted suicide to those whom medical experience pronounce to be near the end of their lives, and to see how the system operates. I would not object in theory to extending the system to these people, but see many practical difficulties.

The sixth standard is there, not for the patient's safety, but for the doctor's peace of mind. Given the way medicine is practiced in the United States today, far fewer people have personal or long-term relationships with their doctor as existed a generation or two ago. We have become an urbanized nation, and the social ties that existed in small towns, where the family doctor did in fact treat everything from birth to death, have in most places disappeared. This is a shame, for as Charles Baron wrote:

Ending one's life in solitude can be a lonely and frightening undertaking, fraught with uncertainty, ambivalence, and opportunities for failure. We hope the responsible physician will be present at the patient's death in order to reassure the patient and to make certain that the process is carried out effectively.<sup>153</sup>

One hears the words of Justice Souter here, that without a doctor's assistance "the patient's right will often be confined to crude methods of causing death."<sup>154</sup>

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153. Charles Baron et al., *A Model State Act to Authorize and Regulate Physician-Assisted Suicide*, 33 HARV. J. ON LEGIS. 1, 21 (1996).

154. *Washington v. Glucksberg*, 521 U.S. 702, 778 (1997).

One consideration that will be offensive to many people is cost, and there are few ethicists writing today who seem willing to discuss this matter. Permitting physician-assisted suicide could mean huge savings in medical expenses at the end of life. The person suffering from cancer who has to spend weeks or months in a hospital or even on a morphine drip runs up a large bill, and whether it is paid for by insurance, the family or a state assistance program, it is a cost that must be borne. Obviously, no one is suggesting that such persons simply be put to death to save money, but considerations of public policy do require that costs be looked at.

Various studies indicate that eighty or more percent of a person's lifetime medical expenses occur in the last year of life. Clearly, if one knew that a disease was terminal, and that death would come sooner or later, he or she might well choose to end life and save the family the financial as well as the emotional costs associated with a long illness. But while allowing people to terminate their lives earlier would mean significant savings to some families and to the insurers, would it mean a great deal in terms of society's overall medical costs? Margaret Battin has argued that if the person voluntarily chooses to end life rather than suffer from a deteriorative illness, and that if in making this choice the person factors in monetary costs, it is a legitimate concern.<sup>155</sup> But, as noted above, one of the safeguards one would want in such a system is a means to ensure that such decisions are truly voluntary. If a patient decides that he would rather not live for another two or three months suffering from ceaseless pain, tied to machinery in a hospital, and if he wants to take into account what the costs of this health care would be to his family, that is a legitimate consideration, and no different from other decisions during a lifetime in which costs play a significant role.

But, according to figures Battin and Ezekial Emanuel have compiled, the actual savings in total health care costs to the nation would be at most 1/100th of the U.S. health care budget, and perhaps as little as 1/900th. "The smallness of this figure," she claims, "ought to silence talk of costs in discussions of the morality of physician-assisted suicide."<sup>156</sup> Perhaps, but the one area where one should fear a slippery slope is in the area of costs, where insurers and health-care providers will be looking for ways to cut costs and maximize limited resources to serve as many people as possible. So far, no court has been willing to grant a hospital permission to take a patient in a persistent vegetative state off

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155. See MARGARET PABST BATTIN, *ETHICAL ISSUES IN SUICIDE* 210 (1995).

156. *Id.* at 211.

life support when the patient or the patient's family is opposed.<sup>157</sup> One must ensure that all end of life decisions are carefully circumscribed to make sure that autonomy is respected.

### CONCLUSION

In conclusion, if one believes that individual autonomy must be respected, then unless a person is legally incompetent or misinformed, then that person's wishes ought to be, if at all possible, honored.

If a person finds that life is no longer worth living because of pain and suffering caused by illness, that judgment should be determinative. Here, of course, all forms of appropriate treatment must be offered, but if the patient decides that a particular therapy would have little chance of success and do little more than cause additional pain, or that heavy medication will relieve pain but lead to a vegetable-like existence, that decision—if made with full knowledge of the facts and of the consequences—should be honored.

If a person wants to end his life under these conditions, if appropriate safeguards are built into the process, and if the attending physician is willing to cooperate, I see no ethical or public policy reasons why this person should not be allowed to end his suffering and control the details of his death. That there are dangers in such a policy is undeniable, but so far, the experience of the Netherlands and of Oregon would seem to indicate that abuses can be minimized. That some people may be offended is also undeniable, but there is no justifiable reason why one religion or one group or one individual should be able to impose their views on others.

A system with appropriate safeguards will not be perfect, but perfection is not required. What is needed is a means by which competent individuals, fully informed of the facts and of the consequences of their decisions, may, if they choose end their pain and suffering in a manner consistent with human dignity.

What we do not need is an effort to cut short the experiment that has now begun. It took several years for Oregon to decide to permit physician-assisted suicide, and the voters of that state twice approved the necessary implementing legislation. Other states are now waiting to see how the Oregon experiment works, and whether they should adopt it as well. This is how the federal system in the United States should work. But once again, foes of

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157. See *In re* the Conservatorship of Wranglie, No. PX-91-283, (Minn. Dist. Ct., Probate Div., July 1991).

assisted suicide, led by religious conservative groups as well as the Catholic Church, are attempting to impose their views in lieu of those of the people.

In September, the House Judiciary Committee passed a bill that would outlaw assisted suicide. The so-called Pain Relief Promotion Act would send doctors to jail for life for prescribing controlled substances with the intent of hastening death. The bill has not appeared on the House floor as of this writing, but Oregon Senator Ron Wyden has promised a filibuster in the upper house should it ever get that far. The bill is, from all aspects, a terrible proposal. Supposedly, it will encourage doctors to aggressively treat pain, and physicians would not be prosecuted if they "accidentally" killed patients through massive doses of painkillers, such as opioids. But patient advocates say it will be impossible to determine if a death caused by painkillers was intentional or not, and the experience of intermeddling busybodies in the case of infant treatment would promise that each case would lead to demands for police investigation.<sup>158</sup>

In the matter of assisted suicide, one should keep in mind Louis Brandeis's great statement that it "is one of the happy incidents of the federal system that a single courageous state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country."<sup>159</sup> Brandeis had great faith in the wisdom of the people, and were he alive today, whatever his personal feelings, would have defended the people of Oregon in their social experiment. Clearly those who claim to hold life more dear than anything else lack this same faith in democracy, and believe that their views are correct and should be imposed on everyone. That, I would suggest, is in no case a proper way to frame public policy.

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158. See *Painful Debate*, TIME, Sept. 27, 1999, at 44.

159. *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (Brandeis, J., dissenting).

