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The Art of Verbal Engineering

*Rita L. Marker**
*Wesley J. Smith***

“If thought corrupts language, language can also corrupt thought.”¹

Many years ago, a little girl and her parents immigrated to the United States from what was then Yugoslavia. A short time later, the little girl started first grade even though she spoke little English. She was anxious to learn and listened carefully, picking up words and phrases.

One afternoon, the teacher called on the little girl, and told her to go to the blackboard and draw “light lines.” Eagerly, she went to the front of the classroom, picked up the chalk and began to draw a barrel. When the teacher became angry and the little girl’s classmates laughed, the little girl realized that in English, “light” did not mean “barrel” as it did in her native language. The word that had sounded so familiar to her meant something entirely different.

More than seventy-five years have passed since that day. The once little girl married, raised a family, and is now a widow.

English has been the woman’s main language for decades. But, once again, familiar sounding words are having different meanings. When she hears people speak of compassion, comfort, care, dignity and rights, her understanding of those words differs from theirs.

Sometimes the woman feels like she did while in the first grade. Familiar terms are foreign to her.

The woman’s misunderstanding of a word could now have far greater significance than her confusion in the classroom so many years ago. Then, it meant sadness and embarrassment for her. Now, it could mean the difference between life and death. A

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1. GEORGE ORWELL, *Politics and the English Language*, 4 THE COLLECTED ESSAYS, JOURNALISM AND LETTERS OF GEORGE ORWELL 127, 137 (Sonie Orwell and Ian Angus eds., 1968).

seemingly clear statement such as, "if I am terminally ill, the only medical treatment I want is comfort care," could be interpreted today as a request for death by lethal overdose from a person who may have months or even years of remaining life.

Only a short time ago, any serious suggestion that administration of carbon monoxide poisoning is a "procedure" that constitutes a "heroic effort" to control suffering would have been met with incredulity. Likewise, a reference to this "procedure" as "a kind of new age hospice care" would have been beyond belief. Yet, these very claims were made by Stanley Levy, M.D., an internal medicine physician who specializes in geriatrics.²

In few social movements has the interpretation of words been as important as in the debate over euthanasia and assisted suicide. Additionally, in few social movements have words ever been so effectively used to first blur, then completely obliterate, the line between the acceptable and the repugnant.

Regardless of one's views about assisted suicide and euthanasia, an understanding of the words used when they are discussed is vitally important. This importance is underscored by a changing relationship between patients and health care providers, a relationship increasingly characterized less as a patient-physician relationship and more as a consumer-provider transaction. In practice, the consumer/patient and the doctor/provider are often placed in a position subordinate to that of the managed care bureaucrat. Health care consumers deserve and desperately need to know how definitions have changed, and they have a right to know that these changes affect them profoundly.

I. RESHAPING PERCEPTIONS

On January 27, 1939, in an article titled, "'Mercy Death' Law proposed in State," the *New York Times* reported that the Euthanasia Society of America had drafted a bill to "legalize painless killing."³ Charles E. Nixdorff, the group's treasurer, took issue with both the article's title and its reference to killing and, in a letter to the editor, wrote that the words "killing" and "death" had sinister connotations. He suggested that it would be better to describe euthanasia as "merciful release" so that the public would not fear the Society's proposal.⁴

2. *Kevorkian Takes Stand in Own Defense*, N.Y. TIMES, Apr. 28, 1994, at A8. Dr. Levy called Jack Kevorkian's activities "new age hospice care" while testifying for the defense during Kevorkian's trial in the death of Thomas Hyde, who died of carbon monoxide poisoning on August 4, 1993.

3. *'Mercy Death' Law proposed in State*, N.Y. TIMES, Jan. 27, 1939, at 21.

4. Letter to the Editor from Charles E. Nixdorff, Treasurer, Euthanasia Society of America, *Explaining Euthanasia*, N.Y. TIMES, Jan. 30, 1939, at 12.

Neither the newspaper, nor an official of Nixdorff's own organization, however, heeded his advice. Euthanasia continued to be described in blunt terms. The public was horrified when Dr. Foster Kennedy, president of the Euthanasia Society of America, explained that the primary purpose of his group's legislative proposal was to eventually legalize euthanasia for "born defectives who are doomed to remain defective, rather than for normal persons who have become miserable through incurable illness."⁵

Euthanasia proponents have learned a lot about public relations in the six decades since the Euthanasia Society of America made the first attempt to gain legislative approval for mercy killing. One lesson they have heeded is that all social engineering is preceded by verbal engineering. If words or their meanings can be changed, the quest to change hearts and minds will be achieved.

Today when mercy killing is discussed, it is couched in euphemisms: words of gentleness or the language of rights. Titles of euthanasia advocacy groups contain words like "compassion," "choice" and "dignity." Even the Euthanasia Society of America has undergone name changes to present a more positive image (in 1976 the Euthanasia Society of America changed its name to the Society for the Right to Die and, in 1991, it became known as Choice in Dying).

No longer does anyone but its strongest opponent refer to mercy killing. The word "euthanasia" is generally avoided in proposals to legalize it. Old words are replaced or given different, vague meanings.

Like a constantly changing kaleidoscope, meanings shift ever so slightly, forming new patterns of thinking. Slowly, quietly, but inexorably, the previously appalling is transformed into the presently appealing.

The manner in which words are defined is key to achieving this transformation. This is something that Dutch euthanasia practitioner Dr. M.A.M. Wachter, the ethicist/director for the Institute of Health in the Netherlands, knows well. Speaking at a 1990 international euthanasia gathering, he stated, "[t]he definition builds the road for euthanasia."⁶ He acknowledged that "euthanasia is the intentional ending of the life of another . . . it is always a question of terminating human life" then went on to urge that careful attention be paid to definitions.

5. 'Mercy Death' Law Ready For Albany, N.Y. TIMES, Feb. 14, 1939, at 2.

6. Dr. M.A.M. Wachter, Keynote Address at the eighth biennial conference of the World Federation of Right to Die Societies, Maastricht, The Netherlands, June 7-10, 1990.

"Definitions are not neutral," Dr. Wachter said. "They are not just the innocent tools that allow us to describe reality. Rather, they shape our perceptions of reality. They select. They emphasize. They embody a bias. Therefore definitions constantly need redefinition."⁷

II. A PRECLUSIONARY DEFINITION

So cognizant are the Dutch of this power of definitions that they have managed to define euthanasia in such a way that it literally precludes any finding of nonvoluntary euthanasia. In 1985, the Government Commission on Euthanasia defined "euthanasia" as "the deliberate termination of another's life at his request."⁸ Since the definition requires that there is only euthanasia when the patient requests death, any non-requested mercy killing that would ordinarily be called "nonvoluntary euthanasia" cannot be referred to as a euthanasia death. In effect, nonvoluntary euthanasia has been defined out of existence. This is particularly ironic since the practice of ending patients' lives has given doctors such unprecedented power that it is primarily Dutch doctors, not patients, who determine who will die at their hands.

The first official confirmation of the prevalence of nonvoluntary euthanasia in the Netherlands came on September 10, 1991, when the long-awaited government report, *Medical Decisions About the End of Life*,⁹ was released. Popularly known as the Rummelink Report (named after the chairman of the committee that issued it), the study documents the degree to which doctors have taken over the decision making on questions of euthanasia.

The findings of the Rummelink Report indicated that, in one year, Dutch physicians deliberately ended the lives of thousands

7. *Id.*

8. STATE COMMITTEE ON EUTHANASIA, REPORT ON EUTHANASIA, GOVERNMENT PRINTING OFFICE, THE HAGUE (1985). This definition was also used in the 1991 *Rummelink Report*, and in the summary brochure, *Ministerie van Justitie, MEDICAL PRACTICE WITH REGARD TO EUTHANASIA AND RELATED MEDICAL DECISIONS IN THE NETHERLANDS 3* (1991). The summary brochure was distributed by Dutch consulates and embassies in response to inquiries about the Rummelink Report.

9. The official government report, *Medische Beslissingen Rond Het Levensende*, Sdu Uitgeverij Plantijnstraat (1991), THE HAGUE, was released in two volumes. The 294-page report ("Rummelink Report") was the work of the Committee to Investigate the Medical Practice Concerning Euthanasia appointed in January 17, 1990, by the minister of justice and the state secretary for welfare, public health, and culture. The six member committee was chaired by Professor J. Rummelink, M.J., the attorney general of the High Council of the Netherlands and professor emeritus of criminal law at the Free University. To assure accurate and complete information, physicians who provided data were granted total anonymity and immunity by the Dutch government.

of patients by administering or providing lethal doses or fatal injections:

- * Twenty-three hundred people died as a result of doctors killing them upon request.¹⁰
- * Four hundred people killed themselves with medication provided by their doctors for that purpose.¹¹
- * One thousand people, an average of three each day, died when doctors prescribed, provided or administered a medication with the specific purpose of causing death even though *the patient had made no explicit request* for euthanasia.¹² Of these patients, 14% were fully competent¹³ while 72% had never given any indication regarding termination of life.¹⁴
- * In addition, 8,100 patients died as a result of doctors deliberately giving them overdoses of pain medication with the specific intent of hastening the patient's death.¹⁵ The decision to administer the intentional overdose was *not* discussed with 4,941 (61%) patients, even though 2,187 (27%) of patients who died in this manner were fully competent.¹⁶

As indicated by the above figures, 11,800 deaths were induced by Dutch physicians in one year. Of great significance for this discussion is the fact that *more than one half of those deaths were unrequested* by the patients who died. This is clearly nonvoluntary euthanasia. Because of the way in which the Dutch define euthanasia, however, those unrequested deaths are categorized as "deliberate life-terminating actions without explicit request" and fall within a classification of "terminal care."¹⁷

The Dutch ability to frame unrequested deaths as something other than nonvoluntary euthanasia has been nothing short of a public relations masterpiece; masterful in keeping the true import and consequences of legitimized euthanasia from being clearly acknowledged. It should be noted, however, that euthanasia by any other name is still euthanasia. Or, better stated: Killing is killing is killing.

10. *Remmelink Report*, vol. I, at 13 (1991).

11. *Id.*

12. *Id.* at 15.

13. *Remmelink Report*, vol. II, at 49, tbl. 6.4.

14. *Id.* at 50, tbl. 6.6.

15. According to the *Remmelink Report*, 22,500 deaths (about 17.3% of all deaths) in the Netherlands in one year occurred after dosages of pain medication to patients that may have shortened life. *Remmelink Report*, vol. I, at 16. Of these, 36% took place with the physician's deliberate intent to cause the patient's death. *Remmelink Report*, vol. II, at 58, tbl. 7.2. As a clarification of the intent, it may be useful to recognize that in 64% of such deaths, the stated intent was to kill the pain; in the remaining 36%, a stated intent was to kill the patient.

16. *Remmelink Report*, vol. II, at 61, tbl. 7.7.

17. *Ministerie van Justitie*, *supra* note 8, at 5.

A similar sleight of word has been employed in euthanasia and assisted suicide proposals in the United States.

III. LANGUAGE AS OBFUSCATION

From 1988 through 1992, during campaigns to legalize euthanasia and assisted suicide in California (1988 and 1992)¹⁸ and in Washington (1991)¹⁹, the phrase of choice among euthanasia proponents was "aid-in-dying." The words conjured up images of plumping the pillow, wiping the brow and holding the hand of a patient. But these were not the types of aid that would have been legalized. "Aid-in-dying" was defined in the measures' small print as "aid" that was to be directly and intentionally provided to "end the life"²⁰ or "terminate the life"²¹ of a qualified patient.

Although the exact method for delivering the new death-inducing medical service was not specified, proponents acknowledged that it would probably be accomplished by means of a lethal injection or drug overdose. They went to great lengths, however, to conceal this. "Try not to go into methods of aid-in-dying such as lethal injections" was the advice given in a speakers' packet formulated by the Friends of Initiative 119, an umbrella group for the Washington state measure's supporters. Instead, speakers were advised to say that Initiative 119 was needed to "protect our rights as patients." Audiences were to be told that the measure was needed to correct flaws that had been discovered by members of the medical community in the state's outdated Living Will law.²² The measure was similarly described on national television when a news program described the Initiative as a proposal "to clarify language in Living Wills."²³

Although the proposed laws in California and Washington would have permitted euthanasia by lethal injection and assisted suicide by prescribed drug overdoses, they each categorized such

18. The campaign to place the "Humane and Dignified Death Act" which would have legalized euthanasia and assisted suicide under the name, "aid-in-dying," failed to gain enough signatures to be placed on the 1988 California ballot. California's "Death with Dignity Act," (Proposition 161) which would have permitted "aid-in-dying" did qualify for the ballot, but failed on November 3, 1992 by a vote of 54% to 46%.

19. Washington state voters turned down the "Death with Dignity Act" (Initiative 119) that would have legalized "aid-in-dying" on November 5, 1991 by a vote of 54% to 46%.

20. Initiative 119, Section 2 (9) (Wa. 1991).

21. Proposition 161, Section 2525.2 (k) (Ca. 1992).

22. SUGGESTIONS FOR SPEAKERS, and SUGGESTED FORMAT FOR SPEECH ON INITIATIVE 119, distributed at July 1, 1991 meeting of Spokane (WA) Friends of Initiative 119. The meeting was chaired by Rob Neils, Spokane County coordinator for Hemlock of Washington State.

23. *Newsday* (CNN television broadcast, July 31, 1991).

actions as something other than mercy killing or suicide. California's proposal stated: "Requesting and receiving aid-in-dying by a qualified patient in accordance with this title shall not, for any purpose, constitute a suicide,"²⁴ and "[n]othing in this Act shall be construed to condone, authorize, or approve mercy killing."²⁵

Washington's attempt to carve aid-in-dying out of the definitional suicide and euthanasia niche read: "Nothing in this chapter shall be construed to condone, authorize, or approve mercy killing, or to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying *and to permit death with dignity through the provision of aid-in-dying . . .*"²⁶ As in the Netherlands, these proposals would have permitted euthanasia and assisted suicide while denying that either of those names or the label of mercy killing applied.

Voters in Washington and California did recognize, however, that "aid-in-dying" was merely a deceptively soothing term for the crime of murder under those states' laws and the proposals failed to gain public approval. The public at large, it seems, did not favor turning the specter of a lethal syringe-wielding physician into a reality, whether called "aid-in-dying" or the more apt description, "killing."

IV. EUPHEMISMS R US

Following the abortive attempts in Washington and California, euthanasia advocates went back to the drawing board to reframe their rhetoric. In preparation for a new initiative campaign then being formulated for Oregon, a poll was commissioned in 1993 by the newly formed Euthanasia Research and Guidance Organization (ERGO!). The poll, which was ERGO!'s first activity, was designed to determine "if euphemisms allow people to come to grips with brutal facts which, stated another way, would be repugnant to them."²⁷

Not surprisingly, results indicated that people would be more inclined to vote for laws that were couched in euphemisms. The poll indicated that the greatest number of respondents (65%) would favor a law using the terminology "to die with dignity."²⁸ As the drafting process of what would eventually be known as Measure 16, Oregon's "Death with Dignity Act," went on, infor-

24. Proposition 161, Section 2525.16 (Ca. 1992).

25. *Id.* at Section 2525.23.

26. Initiative 119, Section 10 (Wa. 1991), *emphasis added*.

27. DEREK HUMPHRY, WHAT'S IN A WORD? RESULTS OF ROPER POLL CONDUCTED FOR ERGO! 1 (August 1993).

28. *Id.* at 2-3.

mation from the poll was incorporated to ensure the greatest possible chance of passage.

The first draft was written in September 1993 by attorney Cheryl K. Smith, who served as a special counsel to the political action group, Oregon Right to Die ("ORD"). Smith had previously served as the National Hemlock Society's legal advisor from 1989 to 1993 and as top aide to then Hemlock director, Derek Humphry, until he resigned in 1992. While a student at the University of Iowa College of Law in 1989, Smith helped draft a "Model Aid-in-Dying Act" which allowed for children's lives to be terminated either at their request or, if under six years old, at the request of their parents.²⁹ Now working as Legal Services Director for the Oregon Rehabilitation Association, she has also authored *Departing Drugs*, a how-to-commit suicide manual that is distributed by European euthanasia groups and is the author of several chapters in the *Art and Science of Suicide* project, an on-line "self-deliverance" instruction guide marketed by the Right to Die Society of Canada through its DeathNET site on the Internet.³⁰

Early drafts of Measure 16 (then titled, "A Bill for an Act Relating to the Rights of Patients Who Are Terminally Ill to Receive Aid-in-Dying") allowed doctors to directly end the lives of patients by lethal injection. This was considered a potential stumbling block, however, and was eventually omitted.³¹ Instead, the final draft provided that a doctor could write a prescription for a patient "for medication to end his or her life in a humane and dignified manner."³² As a means of placating those who wanted the wording to allow doctors to actually administer the deadly dose, a compromise was reached by which the physician as well as others were granted immunity if they were "present when a qualified patient takes the prescribed medication to end his or her life in a humane and dignified manner."³³

29. Craig A. Brandt et al., *Model Aid-in-Dying Act*, 75 IOWA L. REV. 125 (1989-90).

30. John Hofsess' announcement of the availability of the *Art & Science of Suicide* project made to the right-to-die mailing list, August 20, 1996. Hofsess described Smith's chapters: "Ms. Smith's chapters provide specialized information on such subjects as tricyclic antidepressants; barbiturates; and carbon monoxide. Each chapter has been updated (August 1996) to include the latest research available. For example, the barbiturates article incorporates new information derived from the experience of Compassion in Dying in Washington State. The carbon monoxide article includes reports of successful suicides in Canada and the United States using various sources of CO."

31. Tom Bates, *Write to Die*, OREGONIAN, Dec. 18, 1994, at A1.

32. OR. DEATH WITH DIGNITY ACT, MEASURE 16, Section 1.01(11). After the passage of Measure 16, Cheryl Smith wrote that the prescription only aspect was adopted "for the practical purpose of getting a law passed." Cheryl K. Smith, *Once more to the ballot box*, LAST RIGHTS, Issue 13, at 42.

33. OR. DEATH WITH DIGNITY ACT, MEASURE 16, Section 4.01(1).

As the measure was evolving, some words and phrases were sacrificed. Others were carefully selected. "Aid-in-dying," which had become identified with the failed California and Washington attempts, was totally eliminated from the title, the definition section, all subheadings, and even the body of the measure. The more soothing phrases, "death with dignity," "to die a dignified death," and "humane and dignified" were added.

Each word and phrase was meticulously examined for its potential impact on voters. For example, the first five drafts had contained the term "informed consent," a medical term meaning that the patient is fully informed prior to consenting to surgery or treatment which his or her doctor has recommended. When ORD members realized that the established term, "informed consent," could pose some nuancing problems, a new term, "informed decision,"³⁴ was used instead.

Since the polling done to prepare for the bill had shown that "suicide" did not play well with the public (only 44% of voters would have favored a law stating that it permitted physician-assisted suicide),³⁵ the Dutch solution to word problems was put into use. Assisted suicide and euthanasia (which were, after all, the goals of Measure 16) would not be called by their real names: "Nothing in this Act shall be construed to authorize a physician or any other person to end a patient's life by lethal injection, mercy killing or active euthanasia. Actions taken in accordance with this Act shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide under the law."³⁶

On November 8, 1994, Oregon voters approved Measure 16 by the slimmest of margins (51%-49%). As ERGO's Derek Humphry had said when he viewed his poll's results, "[t]he euphemisms won."³⁷

While the very terms "euthanasia" and "assisted suicide" have been often replaced by euphemisms such as "gentle landing" and "deliverance," there are a number of words that are so universal to any and all so-called right-to-die proposals and policies that they cannot be replaced. Instead, their interpretations and definitions have blurred as well as multiplied so that, in any one discussion, the same word can have as many meanings as there are speakers and listeners. Among these words are "terminal," "imminent," "treatment" and "care." Such a breadth of interpretation can place caregivers and patients in a position where they

34. *Id.* Section 1.01(7).

35. HUMPHRY, *supra* note 27, at 2.

36. OR. DEATH WITH DIGNITY ACT, MEASURE 16, Section 3.14.

37. Bates, *supra* note 31.

are speaking separate languages, one in which the listener interprets a word in a far different way than the speaker intended.

V. THE MANY DEFINITIONS OF DYING

To the lay person, "terminal" means that death is unavoidable and very close (meaning within days or weeks) no matter what treatments or interventions are used. Proponents of euthanasia and assisted suicide have, until recently, stated or implied that only those whose conditions are considered terminal would be candidates for accelerated death. At least, this is the framework within which most media coverage takes place.

This is certainly how the decisions in *Compassion in Dying v. Washington*³⁸ and *Quill v. Vacco*³⁹ have been reported. Indeed, in Judge Stephen Reinhardt's opinion declaring laws against assisted suicide unconstitutional, he stated that the court was only deciding the issue of assisted suicide for the terminally ill.⁴⁰ At the same time, he hedged by writing, "[o]ur conclusion is strongly influenced by, but not limited to, the plight of mentally competent, terminally ill adults."⁴¹

What does Judge Reinhardt mean by "terminally ill?" He did not say. Nowhere in the lengthy opinion did he provide a definition. He did, however, give some emotionally charged descriptions to portray terminally ill people. He wrote that their fate will be one in which they "can only be maintained in a debilitated and deteriorating state, unable to enjoy the presence of family or friends,"⁴² or one in which they will end up in a "childlike state of helplessness, diapered, sedated, incontinent."⁴³

While such language might be useful in a euthanasia organization's promotional material, it hardly provides guidance about the meaning of "terminal," a word used by courts and in statutes to denote legal categories. For example, if an incapacitated person is "terminal," medical treatment can be withheld or withdrawn based either on the patient's desires as expressed through an advance directive, or in the "best interests" of the patient through surrogate decision making. If euthanasia or assisted suicide is legalized, the presence or absence of a "terminal" condition would determine whether the state retains an interest in

38. *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir. 1996), *en banc*, *cert. granted*, *Washington v. Glucksburg*, 65 U.S.L.W. 3254 (U.S. Oct. 1, 1996) (No. 96-110).

39. *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996), *en banc*, *cert. granted*, *Vacco v. Quill*, 65 U.S.L.W. 3254 (U.S. Oct. 1, 1996) (No. 95-1858).

40. *Compassion in Dying*, 79 F.3d at 790, 832.

41. *Id.* at 816.

42. *Id.* at 821.

43. *Id.* at 814.

protecting a patient's life or whether it stands aside indifferently in the face of induced death. Thus, the applied definition of the word would literally spell the difference between life and death.

Elsewhere, Judge Reinhardt qualified the undefined "terminal" with the word "imminent" when he wrote that the state has an almost negligible interest in safeguarding the interests of third parties "when the patient is terminally ill and his death is imminent"44 Yet nowhere does his opinion give even a clue as to the meaning that should be given to the term "imminent."

Likewise, the Second Circuit Court of Appeals, in its *Quill v. Vacco* opinion, failed to give any specifics about what it meant by "terminal." In finding that the state has no interest in preventing a patient from obtaining drugs to end life "during the final stages of a terminal illness,"45 the court either could not find, or did not look for, any way to explain what it meant by "terminal illness," let alone its "final stages."

Admittedly, it is extremely difficult to clarify what is meant by "terminal." Often the closest a physician can come to defining "terminal" is to use Justice Stewart's words: "I know it when I see it."46 This difficulty has been acknowledged in the Netherlands and may be one of the reasons that the Dutch made no attempt to even pay lip service to requiring that one be "terminal" before being eligible for euthanasia.

The Dutch describe "terminal" as a "concrete expectancy of death."47 No attempt is made to predict when this concrete expectancy will be fulfilled. Even a Dutch physician who has carried out euthanasia is reluctant to say how long the patient might have lived otherwise since "any estimate of the extent of shortening of life can only be very general" and has no "absolute value."48

Even the most cursory look at advance directive laws in the United States, which have attempted to define "terminal," reveals the evolving nature of the word's meaning. The first such law, passed in California in 1976, referred to "terminal" as a condition from which death would occur "regardless of the applica-

44. *Id.* at 827.

45. *Quill*, 80 F.3d at 730.

46. *Jacobellis v. Ohio*, 378 U.S. 184 (1964)(Stewart, J., concurring). Justice Stewart conceded that he might never be able to intelligibly define "hard core pornography," but observed, "I know it when I see it, and the motion picture involved in this case is not that." *Id.* at 197.

47. PAUL J. VAN DER MAAS ET AL., II EUTHANASIA AND OTHER MEDICAL DECISIONS CONCERNING THE END OF LIFE, 23 (English Translation of Volume II, the Rummelink Report) (Elsevier 1992).

48. *Id.* at 23-24.

tion of life-sustaining procedures."⁴⁹ Far broader was the meaning given the word when the state of Idaho passed its Natural Death Act the following year. According to the Idaho statute, a terminal condition was "an incurable physical condition caused by disease or illness which reasonable medical judgment determines *shortens the lifespan* of the patient."⁵⁰ Ironically, the early Idaho definition had great similarity to that which is used by Jack Kevorkian. Kevorkian contends that a terminal condition is "any disease that curtails life even for a day"⁵¹ or "any process that *curtails natural life*."⁵²

While there is little doubt that Idaho legislators of the late 1970's probably had a condition such as end stage cancer in mind, their definition did lend itself to extremely broad interpretation. This is illustrated by Jack Kevorkian's application of the similar definition to his victims, many of whom had decades of life remaining but were considered to fit within his definition of "terminal."

Other states attempted to define the word more precisely. For example, in 1983 the state of Virginia declared that "terminal" was not only a condition from which there could be no recovery, but also that it had to be a condition from which "death is imminent."⁵³ One year later, Wisconsin passed its Natural Death Act, which stated that a condition would be considered "terminal" if death was expected to occur within thirty days regardless of the application of life-sustaining procedures.⁵⁴ Using "imminent" as a qualifier would seem to provide adequate guidance as to the meaning of "terminal." In practice, however, "imminent" also has been found to be open to extremely broad interpretation.

When individuals in Wisconsin thought that the state's thirty day life expectancy requirement was too restrictive, the law was amended, changing "would cause death within 30 days" to "would cause death imminently."⁵⁵ The change was intended to permit greater flexibility in interpretation.⁵⁶ Among examples of this flexibility are the following: A Virginia court determined that death could be considered "imminent" if it was expected to

49. CAL. HEALTH AND SAFETY CODE § 7187.

50. IDAHO CODE Section 39-4503 (2)(1977)(emphasis added).

51. Andrea Stone, *Dr. Death: No Law is Needed on Euthanasia*, USA TODAY, Oct. 28, 1992, at 6A.

52. Jack Kevorkian, *A Modern Inquisition*, THE HUMANIST, Nov-Dec. 1994 at 8 (emphasis added).

53. VA. CODE ANN. Section 54-325.8:2 (1983).

54. WIS. STAT. ANN. Section 154.01(8) (West 1984) (amended 1986).

55. *Id.* as amended by 1985 WISC. ACT 199 (April 10, 1986).

56. Ronni L. Scheier, *Living Wills Gaining Acceptance*, AM. MED. NEWS, Aug. 1, 1986, at 3, 46; CONCERN FOR DYING NEWSLETTER, Spring 1986 at 4.

occur within several months⁵⁷; a Florida hospital began interpreting "imminent" to mean that death would occur within one year;⁵⁸ and such statements as, "for death to be imminent, the patient's life expectancy must be one year or less, according to reasonable medical judgment" began to appear in law journals.⁵⁹ As one physician testified before a legislative committee, "[t]he word 'imminent' in medicine is just not useable"⁶⁰ — nor is it protective.

In many cases, particularly when the concept of right-to-die laws was relatively new, seemingly narrow definitions for the word "terminal" or the addition of words like "imminent" were added to proposals to assure that they would not be too broadly interpreted. Even today, many people still maintain the belief that a diagnosis of a terminal condition has a very specific meaning. Few realize that the same word can simultaneously refer to conditions that may not cause death for weeks, months or even years, even if no treatment is provided. Nor are they aware that one can fall within the category of being in a terminal condition even if the condition could be controlled indefinitely by some type of medical intervention.

Such confusion was even evident on the part of Judge Reinhardt. In his opinion, attempting to draw a distinction between a death resulting from an underlying disease and a death occurring from the removal of food and fluids, Judge Reinhardt referred to the death of Nancy Cruzan: "Ms. Cruzan was not even terminally ill at the time, but had a life expectancy of 30 years."⁶¹

57. *Hazelton v. Powhatan Nursing Home, Inc.*, No CH 98287 (Virginia Circuit Court, Fairfax County), August 29, 1986, appeal denied, record no. 86-814 (Va. 1986). The *Hazelton* case was the first in which the meaning of "imminent" as it pertained to an advance directive was at issue. Harriet Hazelton had four attending physicians, all of whom agreed that she had a probable life expectancy of several months. However, two of the physicians felt that Ms. Hazelton's death could not be considered "imminent" since she had months of predicted life. The other two physicians believed that death could not be considered "imminent" if months of life were expected to remain.

58. James J. McCartney & Jane Mary Trau, *Cessation of the Artificial Delivery of Food and Fluids: Defining Terminal Illness and Care*, 14 DEATH STUD. 435, 437 (1990). In another article, McCartney, the former director of the Bioethics Institute of St. Francis Hospital in Miami Beach, wrote: "St. Francis Hospital in Miami Beach, Florida (a Catholic Hospital sponsored by the Alleghany Franciscan Sisters) has interpreted 'imminent' to mean that death will occur within one year for the purposes of implementing F.S. 765 [Florida's living will law] in accord with hospital policy. Since the legislature has given no guidance as to what it means by 'imminent,' I believe that this interpretation is as valid as any other." James J. McCartney, *Prolonging Life and the Right to Die*, Perspectives from the Catholic and Jewish Traditions (1988) (unpublished, on file with author).

59. Tracy L. Merritt, *Equality for the Elderly Incompetent: A Proposal for Dignified Death*, 39 STAN.L.REV. 689, 731 (1986-1987).

60. *Living Wills: Bill abruptly killed*, NEWS JOURNAL (Wilmington, Del.), May 31, 1996, at A4.

61. *Compassion in Dying*, 79 F.3d at 822.

Judge Reinhardt apparently did not know that in at least one state within the Ninth Circuit, those in conditions like that of Nancy Cruzan are specifically defined, by statute, as "terminally ill." Arizona's "Medical Treatment — Termination of Life-Sustaining Procedures Act" is but one example. It states: "Terminal condition includes a *permanent vegetative state* and irreversible coma."⁶² If it is difficult for a Federal Appeals Court judge to keep up to date on the many and changing legal meanings for "terminal," it is no leap of the imagination to assume that others, not versed in the law, may also lack understanding of the very words which could affect them greatly.

It is not only laws that have stretched the boundaries of definition and interpretation. Some policies, as exemplified in guidelines for Veterans Administration hospitals, have such great elasticity that even individuals whose conditions are solely related to arthritis or mental illness could fall within the category of the "terminally ill." Veterans Administration hospital guidelines have defined "terminal illness" to include "chronic debilitating conditions from which there is no reasonable hope of recovery."⁶³

Well meaning though they may be, individuals who believe that assisted suicide and euthanasia can be limited to those who are in a "terminal" condition are naive. Their illusory safeguards will not protect those in the ever-expanding group of candidates for the "treatment" of death. Just as the word "terminal" has become as hard to pin down as jello to the wall, so, too, has the word "treatment" been pulled and stretched out of shape. Euthanasia advocates have seized upon this in furtherance of their political and social goals.

VI. THE MORPHING OF "TREATMENT"

Televised political advertising in the 1990's has made effective use of what is known as "morphing" (derived from the word "metamorphosis"). With this technique, one image is smoothly transformed into another. Even though it is happening before the viewer's eyes, it creates the illusion that the final image was always there, making it difficult to recall that the final image did not begin as it ended. The purpose is to convey a powerful visual symbolism replacing substantive discussion.

62. ARIZ. REV. STAT. ANN. Section 36-3201(6) (1985) (amended 1991) (emphasis added).

63. VETERANS ADMINISTRATION POLICY GUIDELINES, Nov. 18, 1991, M-2, Part I, Chap. 31, Paragraph 31.02, at 31-2.

So, too, in the legal and public relations campaigns to gain acceptance for assisted suicide and euthanasia, a form of linguistic morphing has transpired. Like its first cousin, visual morphing, the linguistic version is designed to change public perception and pave the way for acceptance of previously unthinkable proposals; all without in depth or substantive analysis.

For example, current attempts to categorize intentionally prescribed fatal overdoses and lethal injections as “treatment” are the culmination of a carefully constructed bridge built from the traditional understanding of the term (i.e. an attempt to cure or ameliorate a medical condition) to a new, deadly, and very final “treatment” (i.e. killing). As with the word “terminal,” the average person maintains a belief that the word “treatment” is simply and easily interpreted, referring to medical interventions intended to cure or ameliorate a condition. But, as with the understanding of terminal illness, the public perception of what is meant by medical treatment is stalled: stranded in a time when a desire to forego life-sustaining treatment meant only that one did not want to be tethered to machines, monitors, buzzers, bells and whistles during the final days of life.

Quite simply, the debate about treatment has traveled so far beyond the original meaning of the word that it almost begs for redefinition in *Webster's*. The tracks have been switched, moving no longer in the direction of natural death but, instead, careening toward killing in the name of compassion.

Pivotal in this shift was what has become known as the “food and fluids issue.” No matter the view that one may maintain regarding the removal of food and fluids from patients, there can be no legitimate denial that nutrition and hydration cases have had significant impact on the current status of the right-to-die debate.

The fundamental moral consensus—that patients should receive care, including nutrition and fluids—came under attack in the 1980's. Debates began to be waged in bioethics circles about the propriety of withdrawing tube feeding from brain damaged or demented patients. No one contended, even then, that a dying patient who could not assimilate food and fluids or for whom the means of their provision was a source of great discomfort should be given them anyway. To do so would be futile and cruel. What did become a matter or debate was whether food and fluids that were effectively sustaining life could be removed for nonmedical reasons, with the intent of causing death.

The authors' discussion about the reclassification of food and fluids from “care” to “treatment” is not intended to reargue the food and fluids issue. Instead, it is intended to provide a back-

ground of the manner in which society and the courts have reached a point where legitimizing the removal of food and fluids by calling this the "removal of 'treatment'" has set the stage for the attempt to legitimize giving intentionally lethal medications under the guise of "provision of 'treatment.'"

In 1983, reflecting on the possible outcome of the debate, Daniel Callahan, then Director of the Hastings Center, wrote that "a denial of nutrition, may, in the long run, become the only effective way to make certain that a large number of biologically tenacious patients actually die."⁶⁴ He further predicted, "[g]iven the increasingly large pool of superannuated, chronically ill, physically marginal elderly, it could well become the *nontreatment* of choice."⁶⁵ He noted, however, that there still was a "deep-seated revulsion"⁶⁶ to withholding or withdrawing food from patients.

While many individuals who, in the upcoming years, lent their support to the concept of removing food and fluids saw little or no connection between that and assisted suicide or euthanasia, leaders of the right-to-die movement were quick to recognize that they could capitalize on its acceptance. This was evident in the remarks of Helga Kuhse, who is a long time leader in the euthanasia movement. Speaking at a 1984 international conference of euthanasia leaders, Kuhse, who is a philosophy professor at Australia's Monash University, said that once people see how painful death by starvation and dehydration is, then, "in the patient's best interest," they will accept the lethal injection.⁶⁷

Considerable verbal engineering was required to transform denial of food and fluids into an appealing "removal of treatment." A series of cases related to the removal of food and fluids provided by means of a tube was the starting point.⁶⁸ Additionally, in media accounts, the very nature of providing nourishment by means of tube became distorted. It was constantly depicted as a rare, exotic procedure of recent origin that required constant monitoring by highly skilled medical professionals.

64. Daniel Callahan, *On Feeding the Dying*, HASTINGS CENTER REP., Oct. 1983, at 22.

65. *Id.* (emphasis added).

66. *Id.*

67. Helga Kuhse, Remarks at the World Federation of Right to Die Societies' Fifth biennial conference, Sept. 20-23, 1984.

68. See generally *Brophy v. New England Sinai Hosp., Inc.*, 497 N.E. 626 (Mass. 1986); *In re Jobs*, 529 A.2d 434 (N.J. 1986); *Gray v. Romeo*, 697 F. Supp. 580 (D.R.I. 1988); *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261 (1990).

In fact, food and water have been provided by means of a gastronomy tube for over one hundred years⁶⁹ and according to a government report, at least 848,100 people per year receive food by means of a tube in hospitals, nursing homes or in their own homes.⁷⁰ A gastronomy tube, inserted through the abdominal wall directly into the stomach, is a simple surgical procedure that can be performed under local anesthesia. Once inserted, the small incision heals and its presence causes essentially no discomfort to the majority of people.⁷¹ Yet, in the debate over fluid and foods, this simple procedure has been described as one which is highly invasive and highly risky.

The 1984 case of Mary Hier⁷² illustrates how the classification of tube feeding as a "medical treatment" can be used when the intent is to withhold food and fluids. Ninety-two-year-old Mary Hier had lived in a state hospital for more than fifty-seven years. Elderly and demented, she thought she was the Queen of England. She was not terminally ill. Because a Zenkers diverticulum in Ms. Hier's pharyngeal esophagus made it almost impossible for adequate food and fluids to pass down her esophagus to her stomach, she had received food by means of a gastronomy tube for many years. When, in an unexplained incident, Ms. Hier's gastronomy tube became dislodged, the care facility sought to replace the tube.

Although her guardian ad litem argued that nutrition should be differentiated from treatment, the court declared, "[w]e do not agree that such a distinction should be drawn as a matter of law."⁷³ The court noted that the 1983 President's Commission for the Study of Ethical Problems in Medicine had taken the position that "artificial feeding" should be thought of as a "treatment" decision.⁷⁴ Additionally, the court found that replacing Ms. Hier's gastronomy tube would entail a "major medical procedure" that was "highly intrusive" and entailed a "relatively high

69. Two articles published in a 1896 publication, describe the ease with which feeding by gastronomy tube was accomplished at that time. McMurtry, *Modern Gastrostomy for Stricture of the Esophagus, with Report of a Case*; and Coomes, *Gastronomy, with Report of a Case*, TRANSACTIONS OF THE KENTUCKY MEDICAL SOCIETY (1896).

70. Office of Technology Assessment, U.S. Congress, *Life-Sustaining Technologies and the Elderly*, (1987) at 924.

71. BY NO EXTRAORDINARY MEANS: THE CHOICE TO FOREGO LIFE-SUSTAINING FOOD AND WATER 26 (Joanne Lynn ed. 1986).

72. *In re Hier*, 464 N.E.2d 959 (Mass. App. Ct. 1984).

73. *Id.* at 964.

74. PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 90 (1983).

risk to the patient due to her age."⁷⁵ Permission to replace the tube was denied.

Mary Hier's story and her life might have ended there had it not been for the fact that just as her case was reported, another story appeared in the same newspaper. It concerned a ninety-four-year-old woman who was doing well following "minor surgery to correct a nutritional problem." The surgery had been performed on an outpatient basis under local anesthesia. The woman's name was Rose Kennedy and the "minor surgery to correct a nutritional problem" was the insertion of a gastronomy tube.⁷⁶ For ninety-four-year-old Rose Kennedy, matriarch of a rich and powerful family, tube feeding was a mere correction of a nutritional problem. For ninety-two-year-old Mary Hier, poor and mentally ill, it was termed "medical treatment" that was too invasive and risky for a woman of her age. Last minute intervention by a local physician and an attorney did eventually lead to Mary Hier's tube feeding being provided again, and both Mary Hier and Rose Kennedy lived for many years.

The choice of words to describe the method of providing food and fluids, as illustrated in the case of Mary Hier, depends upon whether the discussion is intended to lead to their being provided or withheld. Manipulative terminology (i.e., using the language of treatment rather than care) has also been used to describe not only the tube but also the food itself. For example, referring to food received by tube as "artificially implanted nutrition and hydration"⁷⁷ seemed a patent attempt to create the illusion that food and fluids themselves are exotic medical treatment. Yet it seems doubtful that those who contend that food and fluids become "treatment" if taken by tube would tolerate others calling penicillin or milk of magnesia "food" when taken by mouth.

VII. LUNCH TRAYS BEARING TREATMENT

Whether one agrees or disagrees with what has transpired, the reality is that by the time of the *Cruzan*⁷⁸ case, the provision of food and fluids by means of a tube was clearly considered to be a form of medical treatment by society at large and the courts. By the time *Cruzan* was decided, however, some ethicists and right-to-die advocates had begun to expand the boundaries of "treat-

75. *In re Hier*, 464 N.E.2d at 964.

76. *Rose Kennedy doing well after surgery*, BOSTON GLOBE, July 29, 1984 at 35.

77. Brief of Amici Curiae SSM Health System, St. Joseph Health Care System, Mercy Health Services, Catholic Health Corporation, Rev. J. McCartney, Rev. Kevin O'Rourke, and Center for Health Care Ethics, St. Louis University Medical Center, *Cruzan* at 8.

78. *Cruzan*, 497 U.S. at 261.

ment” once again; this time to include oral feeding as a medical intervention that could be withheld or withdrawn ethically. The spotlight had now shifted from the *method* by which food and fluids were provided to the actual food and fluids, *no matter how provided*.

It is no longer unusual to observe a dispassionate discussion among ethicists and medical professionals about the withdrawal of oral feeding from frail, elderly or brain damaged, but non-dying patients. Such discussions take place at many conferences, and can also be observed on the Internet. They certainly take place in the clinical setting.

The willingness to extend denial of even spoon feeding was also apparent in the 1988 testimony of Ronald Cranford, M.D., in the *Cruzan* case. Cranford, an associate physician in neurology at Hennepin County Medical Center in Minneapolis, testified that there really is no definition of “artificial” feeding.⁷⁹ He said that if Ms. Cruzan were able to take food orally, he would still consider provision of food in this manner to be “medical treatment.”⁸⁰

This 1988 statement, that no definition of “artificial” feeding exists, differed from a position Cranford had held only four years earlier when he differentiated between “artificial means” (nasogastric tubes, gastrostomy tubes, hyperalimentation and intravenous lines) and the ability to take food by the “natural route.” At that time, he specifically stated that “it *may* be justifiable to consider withdrawal of fluids and nutrition given by an *artificial* route.”⁸¹ However, by the time he testified in 1988, he included spoon feeding in the category of what might be considered “artificial feeding.” “There is a legitimate difference of opinion concerning spoon feeding,” he said. “It is not fair to say that artificial feeding would only characterize what we call gastrostomy and so forth.”⁸² Cranford stated that spoon feeding is denied in cases like Ms. Cruzan’s (where profound brain damage has occurred) because to spoon feed her “would be totally inconsistent” with what was wanted (i.e. death for the patient).⁸³

79. Tr. at 228, *Cruzan v. Harman*, 760 S.W.2d 408 (Mo. 1988)(en banc)(No. CV384-9P, *aff'd* 497 U.S. 261 (1990).

80. Tr. at 163, *Cruzan*, 760 S.W.2d at 408.

81. Ronald Cranford, *Termination of Treatment in the Persistent Vegetative State*, 4 SEMINARS IN NEUROLOGY, 41. (emphasis added).

82. Tr. at 228, *Cruzan*, 760 S.W.2d at 408.

83. Tr. at 229. The year after this testimony, Cranford and eleven other physician authors published an article in which they concluded that it is morally acceptable for doctors to give patients suicide information and the prescription for a lethal dose. Sidney H. Wanzer et al. *The Physician's Responsibility Toward Hopelessly Ill Patients: A Second Look*, 320 NEW ENG. J. MED. 844, 847 (1989). The article was a “report” of a twelve

In another 1988 case also involving the denial of food and fluids for a patient who was no longer able to make medical decisions, a physician reasoned that if a patient is in a convalescent care facility, even the patient's normal diet must be prescribed; therefore it is always medical treatment.⁸⁴ Thus, in the minds of some, the food on a nursing home patient's tray had now become "treatment" and, as such, could be considered optional.

By 1994, virtually anything that a physician authorized, prescribed, or performed was said by some to fall within the meaning of "treatment." This was evident in testimony given before the Senate Finance Committee by Eric J. Cassell, M.D., of Cornell University Medical College, who stated, "treatments are not merely technologies or drugs, virtually everything done to or for a sick person is part of the treatment."⁸⁵

The notion that all patient care, even the provision of food and fluids taken by mouth, was "treatment" which could be withheld or withdrawn had gained wide acceptance within professional circles. The general public, however, was still far from embracing death by starvation and dehydration as a desirable, noble "option" to be sought. The bridge from tolerance of the concept to widespread support for it was still needed if assisted suicide was to gain a foothold.

As far back as 1972, at a conference of the Euthanasia Educational Council, Cassell acknowledged this when, during a discussion of effective ways to commit suicide and assisted suicide, he stated:⁸⁶

Maybe we ought to accord the right of the suicide [*sic*] to make it an elegant and noble move. What you're describing is a turn around of society in which death becomes the elegant thing: in which you achieve an age when it's proper for you to die and to get help in your dying, and you arrange for a death that's appropriate to your life, with

physician panel funded by the Society for the Right to Die, previously known as the Euthanasia Society of America. In 1992, Cranford joined the board of directors of the organization which by then had changed its name again, this time to Choice in Dying. During a nationally televised interview regarding the article, Cranford acknowledged that assisting suicide is "the same as killing the patient." *MacNeil/Lehrer Newshour* (PBS television broadcast, March 30, 1989). He explained, "we broke new ground, and we were very aware we were doing it. We felt it was an opportunity to make a statement that's very controversial and stand by it." *Id.*

84. Tr. at 56; *McConnell v. Beverly Enter.-Conn., Inc.*, 553 A.2d 596 (Conn. 1989)(Nos. 13477-13479).

85. Eric Cassell, M.D., Testimony before the Committee of Finance, United States Senate, May 5, 1994, at 4.

86. The Euthanasia Educational Council began in 1967 as a branch of the Euthanasia Society of America. It was then called the Euthanasia Educational Fund. Soon after, it changed its name to the Euthanasia Educational Council and then, in 1978, became known as Concern for Dying. Currently, Concern for Dying, along with the group originally called the Euthanasia Society of America, is called Choice in Dying.

all the fittings, without pain and the proper pill⁸⁷ What seems to me I hear [when people request assisted suicide] is a way to dignify it, making it an honorable thing to do, make it respected by other people. That's a profound change in the structure of society which may well come, but it's going to be a while coming. It's not just the finding of the pill — that can be found. It's the finding of the world in which one would have one's death as one would have one's wedding and a few other things. . . .⁸⁸

VII. SELLING THE ATTRACTIVENESS OF PLANNED DEATH

The process of dignifying death by starvation began in a 1994 article by David Eddy, M.D., Ph.D., published in the *Journal of the American Medical Association*.⁸⁹ In the article, dehydrating to death was portrayed as a way for an elderly woman with no life threatening condition to end her life “gracefully.”

Dr. Eddy wrote that his mother was a spunky, self-sufficient widow who had enjoyed an abundant life and who, when ailments made her quality of life no longer acceptable, decided it was time to die. As a physician's wife, she was used to thinking about life and death and prided herself on being able to deal maturely with the idea of death.⁹⁰

With her son, she explored ways to end her life. “Can I stop eating?” she asked. He told her that if she was really intent on dying she should stop drinking, too, since “without water, no one, not even the healthiest, can live more than a few days.”⁹¹

On her eighty-fifth birthday, Virginia Eddy celebrated with her family at a party with all the trimmings. Then, her son wrote, “she relished her last piece of chocolate, and then stopped eating and drinking.”⁹² Her son arranged for her to be placed on a self-administered morphine drip to relieve the pain of dehydration. She died six days later.

“This death was not a sad death; it was a happy death,” Eddy wrote. “She had done just what she wanted to do, just the way she wanted to do it.” According to Eddy, his mother had chosen

87. EUTHANASIA EDUC. COUNCIL, EUTHANASIA: RIGHTS & REALITIES, EXCERPTS FROM PAPERS AND DISCUSSIONS AT THE FIFTH EUTHANASIA CONFERENCE, Dec. 2, 1972, at 24.

88. *Id.* at 26.

89. David M. Eddy, *A Conversation with My Mother*, 272 JAMA 179 (1994). Eddy is a professor of health policy and management at Duke University and a policy adviser to Kaiser Permanente Southern California. He has also advised President Clinton and Blue Cross/Blue Shield on health policy, and he is a strong advocate for health care rationing. See, e.g., David Eddy, *Health System Reform: Will Controlling Costs Require Rationing Services?*, 272 JAMA 324-328 (1994).

90. *Id.* at 179.

91. *Id.* at 181.

92. *Id.*

the time and manner of her death and this had been a positive experience for the entire family. He provided, "[a]lthough we will miss her greatly, her ability to achieve her death at the 'right time' and in her 'right way' transformed for us what could have been a desolate and crushing loss into a time for joy."⁹³

Clearly, this article was intended to significantly influence its readers' attitudes. In fact, the piece was referred to in a report about the impact of medical journal articles on public opinion, clinical-care standards and health care policies. George Lundberg, M.D., who oversees all of the American Medical Association's forty-seven professional journals including *JAMA*, called Eddy's article the "most important article published in the last 50 years." He said, "[t]he openness of the presentation, the competence and compassion, and the method of dying — by withholding food or drink — were all salutary. The argument presented was legal, ethical, moral and loving." Lundberg predicted it would become "a landmark model of dying."⁹⁴

The Hemlock Society's medical director, Richard MacDonald, M.D., who was, at the time, campaigning to legalize assisted suicide in Oregon, jumped on the bandwagon. He wrote, "[s]he [Mrs. Eddy] chose a very rational course, which is the right of every patient — to *refuse treatment* [i.e. post-birthday meals and beverages] which can extend life but is futile as far as improving the quality of life or curing the diseases contributing to that poor quality." Then, making a pitch for Oregon's Measure 16, MacDonald added that "such a peaceful end to suffering is not often available to someone who doesn't have the good fortune to have a physician for a son, as this patient did."⁹⁵

It was not the *method* of induced death that was emphasized but rather the "right" to choose how, when, where and why to die, and the right of someone else to "assist" in bringing about that death, that was being promoted. MacDonald and others campaigning for the Oregon initiative were working to extend the "good fortune" of Mrs. Eddy to all Oregonians by legalizing what would later be termed "comfort care."

IX. SAFE HARBOR FOR DOCTORS, DEATH FOR PATIENTS

The Eddy article was indicative of yet another attitudinal shift, one that now saw intentionally ending life with a doctor's

93. *Id.*

94. Jennifer LaBarbera, *Editors of Medical Journals Wild Pens with the Deftness of Scalpels*, PHYSICIANS FINANCIAL NEWS, Sept. 30, 1994 at 26.

95. Richard MacDonald, M.D., *JAMA Article: Model of American Death?*, HEMLOCK TIMELINES (Hemlock Society), Sept.-Oct. 1994 at 4.

assistance as a graceful exit from life. The right to be free of unwanted treatment had been totally transformed into the right to be free of unwanted life.

It had taken many years, many attempts, many returns to the drawing board, so to speak, and more than anything else, careful manipulation of language. In November of 1994, Oregon, with the passage of Measure 16, became the only state in the history of the nation to approve a proposal permitting physicians to intentionally prescribe lethal overdoses to certain patients. Because of an on-going legal challenge,⁹⁶ Measure 16 has not gone into effect. As in previous attempts in Washington and California to legalize assisted suicide and euthanasia, proponents stated that the purpose of the law was to give a new “right” to patients.

In fact, the major impact of legalizing assisted suicide was not to give rights to those who would be dead, but was to bestow immunity on those who would be instrumental in making them dead. This was acknowledged by Barbara Coombs Lee, Measure 16’s chief petitioner, who described the measure, saying, “[t]he [Death with Dignity] act *creates a safe harbor in Oregon’s assisted suicide laws for an attending physician* to provide a prescription for lethal medication. . . .”⁹⁷ Lee has been vague in describing how the waters in this “safe harbor” would be navigated.

Asked how patient deaths would actually be brought about, she said that the new law is not specific since “it would be pretty outlandish to tell physicians what particular mode of *care* to provide.”⁹⁸ When questioned about the need to educate physicians regarding assisted suicide, she opined that courses dealing with assisted suicide would eventually be taught in medical schools, saying, “[w]riting a lethal prescription is one very small aspect of the total *care* of terminally ill individuals.”⁹⁹

Problematic, of course, is the way a prescription for “care” of this type would be labeled. Lee explained that a physician might write something like, “take as needed to control symptoms.”¹⁰⁰ Without question, a prescription for this type of “care” would “control symptoms”—permanently. That, however, leads to the

96. *Lee v. Oregon*, 891 F. Supp. 1429 (D. Or. 1995).

97. Barbara Coombs Lee: Assisted Suicide in the United States, Testimony Before the House Subcommittee on the Constitution (April 29, 1996) (emphasis added).

98. Tom Bates, *Questions Asked About Assisted Suicide, Chief Petitioner Answers Questions on Measure 16*, OREGONIAN, Nov. 27, 1994, at A20 (emphasis added).

99. *Id.* (emphasis added).

100. *Id.*

difficulty about how the outcome of this "care" would be described.

Almost immediately after Measure 16's passage, rhetorical gymnastics reached Olympian proportions as attempts were made to come up with a label for the new death-producing medical procedure. The problem was, how should deaths in compliance with Measure 16 be categorized, particularly on death certificates? If the law survives legal challenges and goes into effect, such deaths cannot be called "suicides" because Measure 16 prohibits suicide and assisted suicide.¹⁰¹ Lee claimed that the word "suicide" would not apply and asked that deaths resulting from the lethal drug overdose be called "self-administration under Measure 16,"¹⁰² while the Oregon Health Division recommended that the cause of death be designated "drug overdose, legally prescribed."¹⁰³ As far as categorizing the deadly practice for purposes of payment, Oregon's Medicaid director, Jean Thorne, said the procedure would be covered under a part of the Oregon Health Plan called "comfort care."¹⁰⁴

As *Oregonian* reporter Mark O'Keefe observed, "[o]ne thing is certain. Terminology matters. If it did not, politicians would not call tax increase 'revenue enhancements.' Corporations firing thousands of employees would not describe that act as a 'workforce adjustment.'"¹⁰⁵ And a group that provides suicide assistance would not call itself "Compassion in Dying." During the first thirteen months of its operation, before it brought a court challenge to Washington's law prohibiting assisted suicide, it counseled twenty-four patients who committed suicide with prescription drugs. Since then, it has refused to divulge the number of deaths with which it has been involved.¹⁰⁶

Compassion in Dying grew out of the Hemlock Society's failed 1991 attempt to pass an "aid-in-dying" initiative in Washington State. Until recently, the group was headed by Ralph Mero, who had previously served as executive director of Hemlock of Washington State. (In the summer of 1996, Barbara Coombs Lee, Measure 16's chief petitioner, left her position as vice president

101. See *supra* note 36.

102. Mark O'Keefe, *Doctor-Assisted-Suicide Law Boils Down to a War of Words*, OREGONIAN, Dec. 1, 1994, at A1.

103. *Id.*

104. Dan Postrel, *State could cover assisted suicide*, SALEM STATESMAN-JOURNAL, Dec. 1, 1994, at A1.

105. O'Keefe, *supra* note 102.

106. William Cartsen, *When Patients Choose to Die: Seattle Group Gives Assisted Suicide Momentum in Courts*, S.F. CHRON., June 3, 1996, at A1.

for a large Oregon managed care program and took over the helm of Compassion in Dying.)

As the first U.S. group to publicly admit to offering assistance in committing suicide,¹⁰⁷ the Hemlock spin-off received a gigantic boost in achieving one of Hemlock's objectives—the right to decide the manner and means of death¹⁰⁸—when Judge Stephen Reinhardt wrote that there is a constitutionally-protected liberty interest in determining the “time and manner” of death.¹⁰⁹

The *Compassion in Dying* opinion presents a stark picture of the progress that has been made toward accomplishing the euthanasia agenda by distorting legal precedent, misrepresenting philosophical principles, and twisting the meanings of words. For example, contrary to Judge Reinhardt's opinion, *Cruzan*¹¹⁰ did *not* recognize a “liberty interest in hastening one's own death.”¹¹¹ It had, as its underlying rationale, the right to be free of bodily invasion, not the right to be free of life. Similarly, Judge Reinhardt's contention that the principle of double effect permits a doctor to intentionally “assist” a patient “to die through *medical treatment*”¹¹² completely disregards that principle's elements.¹¹³ Judge Reinhardt not only gave judicial approval to the intentional termination of a patient's life, but did so in a style previously reserved by the most outspoken euthanasia activists: placing the labels “medical treatment”¹¹⁴ or “medical function” on actions that have death as their “necessary and inevitable consequence”¹¹⁵

107. Dick Lehr, *Supporting Those Who Want to Die: A Seattle Group Including Doctors and Clergy, Offers Help and Advice for the Suicidal*, BOSTON GLOBE, Jan. 18, 1994 at 8.

108. HEMLOCK QUARTERLY (Hemlock Society), Oct. 1980, at 5. Faye Girsh, Hemlock's executive director, has reaffirmed that group's long held position that there is right to a “certain death” that can “only be accomplished with the help of a doctor.” (Position statement of Hemlock USA, issued by Faye Girsh, Aug. 23, 1996).

109. *Compassion in Dying*, 79 F.3d at 793.

110. *Cruzan*, 497 U.S. 261.

111. *Compassion in Dying*, 79 F.3d at 816.

112. *Id.* at 828, n.102.

113. The “Principle of Double Effect” provides that it is permissible to perform an act that has both a good effect and a bad effect only if *all* of the following conditions are met:

1. The *act* to be done must be good in itself or at least indifferent.
2. The good effect must *not* be obtained *by means of* the bad effect.
3. The bad effect must *not* be intended for itself but *only permitted*.
4. There must be a *proportionately grave reason* for permitting the bad effect.

A. FAGOTHEY, *RIGHT AND REASON: ETHICS IN THEORY AND PRACTICE*, 152-60 (Mosby, St. Louis, 2d ed. 1959).

114. *Compassion in Dying*, 79 F.3d at 828 n.102.

115. *Id.* at 829.

For a number of years, Jack Kevorkian has been carrying out actions that have death as their inevitable consequence. Like Judge Reinhardt, he refers to such acts as medical treatment.¹¹⁶ By mid-August 1996, when the body count from Kevorkian's "treatment" had reached thirty-eight "patients," Linda Emanuel, vice president of ethics for the American Medical Association, remarked, "[t]he bizarre has become normal and the ghastly is no longer seen as ghastly."¹¹⁷

Judge Reinhardt has given the ghastly a judicial seal of approval.

X. CONCLUSION

The success or failure of political or social revolutions often depends on the terms used in the debate. If the movement is in accord with accepted values as expressed by language, success is often the result.

But what if the existing lexicon and traditional understanding of words and phrases hurts the cause and bogs down the movement? The answer is simple: if the people do not want to follow where you want to take them, make the destination appear more attractive.

This is precisely what proponents of the "right to die" have done. By using fuzzy euphemisms, blurring vital distinctions, using imprecise phraseology and redefining well-understood concepts and ethical principles, they created an "Alice Through the Looking Glass World," where previously understood concepts no longer apply. It is as if "up" were now "down" and "hot" were now "cold." Words only mean what the speaker intends them to mean, regardless of the understanding of the listener.

Terms like "killing" and "suicide," which have precise definitions but negative connotations have become outcasts; replaced by subjective, feel-good, meaningless phrases such as "gentle landing," "deliverance," "chosen death," or the ubiquitous "death with dignity." Thus, the ongoing revolution in ethics and values was preceded by a radical shift in the use of language, all

116. During one week in August 1996, Jack Kevorkian "assisted" four deaths. One was the death by lethal injection of Judith Curren, who was taken to Michigan by her physician husband. Curren had no life threatening condition but had a history of depression. She was also the alleged victim of spousal abuse. Following Curren's death, Kevorkian and his attorney said it was Curren's unacceptable quality of life that made it necessary to end her suffering by means of a "medical procedure." See Indira Lakshmanan and Doreen Vigue, *Death ended a troubled relationship*, BOSTON GLOBE, Aug. 24, 1996; *Kevorkian Defends Actions on NBC*, AP, Aug. 26, 1996.

117. *No Legal Action is Anticipated as Kevorkian Suicides Multiply*, WASHINGTON POST, Aug. 24, 1996, at A2.

intended to beckon us to embark on a journey to radical social change.

That direction may or may not be where we, as a society, will want to go. But one thing is certain. We need to use clear definitions and accurate terminology if we are to truly understand what awaits us at the end of that road.

