

The Legality and Morality of Physician-Assisted Suicide

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Introduction

Founded predominantly on the principle of free choice, the United States prides itself as a country offering and protecting an array of choices to its citizenry. Yet despite the plethora of free choice, one option denied to most Americans is the choice of how to die. On June 4, 1990, physician-assisted suicide, hereinafter PAS, and euthanasia captured the nation's attention when Jane Adkins, an Oregon woman in the early stages of Alzheimer's disease, killed herself with the help of a suicide machine called the "mercitron" devised by Dr. Jack Kevorkian.¹ While the murder charges against Kevorkian for his involvement in that particular suicide were subsequently dropped, the incident generated an explosion of debate that continues to rage on today.

Though many of our daily decisions are guided by free will, in the arenas of PAS and euthanasia one's decision whether to engage another in assisting suicide is checked by a system which essentially denies an individual that choice. The following article will analyze whether any governmental obstacles to obtaining PAS or euthanasia are valid and defensible exercise of the police power, or whether PAS and euthanasia should be granted constitutional protection. This article is divided into three main sections. The first section is an introduction which is further subdivided into four parts: (a) distinguishing physician-assisted suicide from euthanasia, (b) how euthanasia fits under the crime of assisted suicide, (c) historical attitude toward assisted suicide, and (d) the current legal status of PAS and euthanasia. The second section of the article presents an argument which has been subdivided into three parts: (a) the argument against allowing PAS and euthanasia, (b) the argument in support of granting protection to PAS and euthanasia, and (c) proposals. The third and final section is the conclusion.

¹ JAMES HOEFLER & BRIAN KAMOIE, DEATHRIGHT: CULTURE, MEDICINE, POLITICS, AND THE RIGHT TO DIE, 151 (1994).

I. Background

A. Distinguishing Physician-Assisted Suicide From Euthanasia

Though PAS and euthanasia are closely related, they are distinguishable on the ground that one deals with direct assistance while the other hinges on indirect assistance. PAS is the voluntary termination of one's own life by administration of a lethal dosage of medication prescribed by a physician.² In a physician-assisted suicide, the doctor shares with a competent patient a prescription for a medication that the patient himself uses to end his or her own life.³

Juxtaposed with PAS, where the means of death is administered by the patient himself, euthanasia occurs when the physician takes direct action to end another's life.⁴ The term euthanasia originated with British philosopher Sir Francis Bacon in the 17th century. Its etymology stems from two Greek words meaning "good death" to describe the "fair and easy passage from life" that people hope to have.⁵ Ironically, Bacon used the words to refer to a natural death, not a death caused by another to end suffering, the meaning it currently assumes.⁶

There exist two forms of euthanasia: active euthanasia in which specific steps are taken to end someone's life for the purpose of relieving that person's suffering, and passive euthanasia whereby a person's death is caused by withdrawing or not initiating life-sustaining medical treatment so that the patient essentially is allowed to die.⁷ The American Medical Association's

² JANET DOLGIN & LOIS SHEPHERD, *BIOETHICS AND THE LAW*, 794 (2005).

³ Council on Ethical and Judicial Affairs, American Medical Association, *Decisions Near the End of Life*, 267 JAMA 2229, 2229-2230 (1992).

⁴ DOLGIN & SHEPHERD, *supra* note 2, at 794.

⁵ LISA YOUNT, *PHYSICIAN-ASSISTED SUICIDE AND EUTHANASIA*, 98 (2000).

⁶ *Id.* at 98.

⁷ *Id.* at 130.

Council on Ethical and Judicial Affairs defines euthanasia to mean the “administration of a lethal agent in order to relieve a patient’s intolerable and untreatable suffering.”⁸

B. How Euthanasia Fits Under the Crime of Assisted Suicide

Suicide and assisted suicide are perceived and treated by American law quite differently. While suicide itself is not illegal in many states, most states in the United States have passed laws specifically banning the act of assisting in a suicide.⁹ The earliest American statute that explicitly outlaws assisted suicide was enacted in 1828 in the state of New York.¹⁰ Unlike assisted suicide, there are no statutes specifically criminalizing euthanasia.¹¹ However, the practice of euthanasia involves the “medical administration of a lethal agent” to bring about a person’s death¹² and is generally considered to constitute killing. Thus, the practice of euthanasia is treated as an offense under homicide and is criminalized accordingly.¹³

Neither suicide nor attempted suicide is criminalized because there is no viable criminal punishment for a completed suicide.¹⁴ Moreover, punishment would not effectively deter attempted suicide; it would probably only exacerbate the troubled individual’s mental state. At common law, persons who aided or abetted suicide were guilty of murder.¹⁵ Currently, thirty-nine states have a statute prohibiting assisted suicide. Six states – Alabama, Idaho, Massachusetts, Nevada, Vermont, and West Virginia – prohibit assisted suicide through

⁸ Council on Ethical and Judicial Affairs, *supra* note 3, at 2231. (From both a practical point and from a psychological perspective, PAS and euthanasia are distinguishable.)

⁹ MODEL PENAL CODE § 210.5.

¹⁰ Act of Dec. 10, 1828, ch. 20, § 4, 1828 N.Y. Laws 19 (codified at 2 N.Y. Rev. Stat. pt. 4, ch. 1, tit. 2, art. 1, § 7, p. 661 (1829)).

¹¹ Maria T. Celoz Cruz, *Aid-In-Dying: Should We Decriminalize Physician-Assisted Suicide and Physician-Committed Euthanasia?*, 18 Am. J.L. & Med. 369, 380-81 (1992).

¹² AMA Council, *supra* note 3, at 2231.

¹³ MODEL PENAL CODE § 210.5(1).

¹⁴ YOUNT, *supra* note 5, at 7.

¹⁵ MODEL PENAL CODE § 210.5 comment 1 & n. 7.

application of common law.¹⁶ The Model Penal Code also criminalizes assisted suicide, but differentiates between that which is purposely caused by “force, duress or deception”¹⁷ and that which results from the purposeful aid or solicitation of another. The former may result in a homicide conviction; the latter may result in a conviction for a felony in the second degree.¹⁸

C. Historical Attitudes Toward Assisted Suicide and Euthanasia

A historical survey of the Anglo-American common law of suicide shows that the state’s interest in suicide prevention is founded on three theories: (1) religious belief; (2) the common law’s traditional treatment of suicide as a felony; and (3) protection of a vulnerable minority – those who are perceived as mentally ill.¹⁹ Of these three grounds, only the last can serve as a modern-day basis for an argument opposing a right to suicide or suicide assistance.

Though religious belief may be eliminated as a valid ground on the basis of the constitutional principle of neutrality toward religion,²⁰ at a minimum it would be remiss to overlook that our society’s norms are guided by religious influences. While most religions practiced do not currently support PAS and euthanasia, such has not always been the case. The ancient Greeks believed it was morally acceptable to end one’s life if the person no longer considered his life to be worthwhile.²¹ And while the concept of mercy-killing is now almost universally rejected in Western religious teaching, some exceptions have been allowed. For example, in 1957 Pope Pius XII declared that if a patient is hopelessly ill, a physician may discontinue heroic measures, and, if the patient is unconscious, relatives may request the

¹⁶ Longwood University, *Doctor-Assisted Suicide: A Guide to Websites and the Literature*, <http://www.longwood.edu/library/suic.htm> (January 13, 2004).

¹⁷ MODEL PENAL CODE § 210.5(1).

¹⁸ MODEL PENAL CODE § 210.5(2).

¹⁹ CeloCruz, *supra* note 11, at 375-376.

²⁰ *Id.* at 376.

²¹ CARRIE SNYDER. DEATH AND DYING: WHO DECIDES, (2001).

withdrawal of life support.²² Another exception to the almost universal Anglo-American condemnation of voluntary active euthanasia occurred during the Renaissance. Sir Thomas More's *Utopia* described a society that officially permitted and even encouraged voluntary active euthanasia under certain narrowly delimited circumstances when, besides being incurable, the disease caused constant excruciating pain.²³ The origin of suicide as an English common law offense was clearly ecclesiastical.²⁴ Judaism,²⁵ Islam, and Christianity consider the active euthanasia of a dying person, even when done to relieve considerable pain and suffering, to constitute intentional killing and flatly prohibit it.²⁶ Yet many persons of devout faith maintain that assisted suicide is acceptable and does not violate their religion. But perhaps what most weakens the strength of the religious taboo argument is that religion has not consistently maintained a consistent attitude toward assisted suicide.

D. Current Legal Status of PAS and Euthanasia

Despite the highly controversial debate over PAS and euthanasia, criminal law rarely penalizes acts of PAS and euthanasia.²⁷ The distinction between PAS and euthanasia has significant legal implications. A physician who commits euthanasia may be criminally charged with the patient's homicide in virtually every state, as the physician has purposely and directly caused the patient's death.²⁸ In contrast, a physician who does not perform the actual life-ending act itself, but who supports the patient in his endeavor to commit suicide by facilitating

²² SNYDER, *supra* note 21.

²³ TOYOMASA FUSE, *SUICIDE, INDIVIDUAL AND SOCIETY*, 19 (1997).

²⁴ *Id.* at 373.

²⁵ GEMARAH: SANHEDRIN 37a.

²⁶ YOUNT, *supra* note 5, at 6.

²⁷ T. Howard Stone & William J. Winslade, *Physician-Assisted Suicide and Euthanasia in the United States*, 16 *J. Legal Med.* 481, 482 (1995).

²⁸ CeloCruz, *supra* note 11, at 382.

the means or information, can be criminally charged under laws specifically proscribing assisted suicide.²⁹ Such laws typically provide that persons who deliberately or intentionally advise, promote, aid, or encourage others to commit suicide are guilty of a felony less serious than homicide. Then Chief Justice William H. Rehnquist cited this proposition when he handed down the 1997 *Washington v. Glucksberg* decision, noting that “in almost every State, indeed, in almost every western democracy, it is a crime to assist a suicide. The States’ assisted-suicide bans...are longstanding expressions of the States’ commitment to the protection and preservation of all human life.”³⁰

Though most states today have banned PAS and euthanasia, individual states currently possess the legal authority to legalize PAS and euthanasia. In November 1994, voters in Oregon acted on this right and through a ballot initiative passed the Death with Dignity Act – the nation’s first law designed to permit terminally ill patients to ask their physicians for a lethal prescription of medication which could bring about death.³¹ The Oregon Death with Dignity Act says in part, “an adult who has been determined by the attending physician and consulting physician to be suffering from a terminal disease may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner.”³² In 2006, PAS proponents celebrated when the Court decided *Gonzales v. Oregon*.³³ In that case the United States Attorney General challenged the validity of the Oregon Death with Dignity Act when he tried to have doctors’ licenses to prescribe federally controlled substances revoked if doctors

²⁹ Catherine L. Bjorck, *Physician-Assisted Suicide: Whose Life Is It Anyway?*, 47 S.M.U. L. Rev. 371, 379 (1994) (25 states have statutes expressly criminalizing assisted suicide, and the other states do not legislatively provide for such conduct); Celoz Cruz, *supra* note 11, at 377 (noting other jurisdictions criminalize assisted suicide under case law).

³⁰ *Washington v. Glucksberg*, 521 U.S. 702 (1997).

³¹ Oregon Death with Dignity Act, Ballot Measure 16 (Nov. 8, 1994, general election).

³² Oregon Death with Dignity Act § 2.01 ORS 127.800.

³³ *Gonzales v. Oregon*, 546 U.S. 243 (2006).

prescribed them for use in assisted suicide. PAS proponents rejoiced when the Court ruled against the Attorney General stating that the Attorney General was overstepping his power in trying to use the Controlled Substances Act to override the state's legislation.³⁴

One might surmise that if presented with the choice of whether to legalize PAS, a state's citizens would seize the opportunity. Yet evidence reveals otherwise. Unlike Oregon, other states, when faced with the opportunity to legalize some form of assisted, suicide have elected not to do so. In the November 1998 elections, voters in Michigan defeated a ballot measure to legalize PAS. Likewise, voters in California and Washington defeated similar ballot initiatives that would have permitted PAS in those states.³⁵

As briefly discussed, the Supreme Court has decided several significant cases concerning an individual's right to die.³⁶ In *Cruzan v. Director, Missouri Department of Health*, the Supreme Court recognized the right of a patient to refuse or stop life-sustaining treatment.³⁷ The Court reached its decision by applying the common law right against unwanted touching to refuse unwanted treatment. Citing the much earlier case of *Union Pacific R. Co. v. Botsford*,³⁸ the Court reasoned:

[b]efore the turn of the century, this Court observed that '[n]o right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.'³⁸

In 1997, the Supreme Court reversed the decisions of two federal courts of appeal that had declared state laws prohibiting assisted suicide unconstitutional as applied to terminally ill

³⁴ *Id.*

³⁵ Bjork, *supra* note 29, at 386.

³⁶ *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990), *Vacco v. Quill*, 521 U.S. 793 (1997); *Washington v. Glucksberg*, 521 U.S. 702 (1997); *Gonzales v. Oregon*, 546 U.S. 243 (2006).

³⁷ *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261, 269 (1990).

³⁸ *Union Pacific R. Co. v. Botsford*, 141 U.S. 250, 251 (1891).

patients who asked to hasten their deaths with medication prescribed by their physicians. Speaking on behalf of the Court, Justice Rehnquist explained that no clause in the Fourteenth Amendment protected a general “right to die.”

In the *Glucksberg* decision, the Court addressed a constitutional challenge to Washington’s assisted suicide ban under the Due Process Clause of the Fourteenth Amendment. In the related case of *Vacco v. Quill*, a case arising out of New York, the Supreme Court overruled the Second Circuit by holding that a right to assistance in committing suicide was not protected by the Equal Protection Clause of the Fourteenth Amendment.³⁹ The *Vacco* decision distinguished between deaths caused by an assisted suicide and deaths caused by the withdrawal of life-sustaining treatment. In the former, the patient who refuses the life-sustaining treatment dies from an underlying fatal disease or pathology, whereas in the latter, the patient dies after ingesting a lethal medication prescribed by a physician. This distinction, the Court felt, was one recognized by the medical profession.⁴⁰

Most commentators were not surprised by the justices’ decision. The Court had been widely criticized for preempting a social debate on abortion in its *Roe v. Wade*⁴¹ ruling, and therefore legal scholars believed the 1997 Court would be careful not to repeat such action. Though the justices agreed that there was no constitutionally protected right to hasten death, they agreed that state legislatures and voters rather than the judicial system should make the next attempts at legalizing PAS and euthanasia. Several of the justices’ concurring opinions indicated that they may support the right of terminally ill individuals to ask for help in hastening their deaths in the future.⁴² Instead of simply ending the debate by issuing a bright-line rule stating

³⁹ DOLGIN & SHEPHERD, *supra* note 2, at 807.

⁴⁰ *Vacco v. Quill*, 521 U.S. 793 (1997).

⁴¹ *Roe v. Wade*, 410 U.S. 113 (1973).

⁴² YOUNT, *supra* note 5, at 91.

what rights people have when they wish to die, the Court allowed the debate to continue suggesting that state legislatures and the voters of each state should decide their respective course of action.

I. Argument

A. Arguments against allowing PAS and Euthanasia

Opponents of PAS and euthanasia list a number of ways in which it could potentially harm society if PAS or euthanasia were ever to be made uniformly legal. While an arsenal of reasons are put forth against PAS and euthanasia, the foundation of most of these arguments rests on the basis of (1) the value of life from a religious and moral perspective, (2) pressures on the individual seeking suicide assistance, and (3) a slippery slope argument based on the Dutch model of euthanasia.

The lone ethical argument opposing PAS and euthanasia is the value of human life argument. The value of a human life, it is argued, has a unique intrinsic value which should not be ignored.⁴³ Though church and state cannot legally be mixed, it is important to discuss and recognize the role religion plays in shaping the debate. The religious and philosophical underpinning of this argument suggests that life should not be shortened since life is sacred; life is a gift from God, and therefore humans should not have the impudence to end it.⁴⁴ Yet many of the same people who decry the moral implications of euthanasia appear perfectly comfortable with the casualties of war or capital punishment.⁴⁵ If life is as sacred as this argument supposes, then the rule must be no intentional killing whatsoever. If that is the case then our society is

⁴³ JOHN B. MITCHELL, UNDERSTANDING ASSISTED SUICIDE, 14 (2007).

⁴⁴ *Id.* at 35.

⁴⁵ *Id.* at 13.

doing a poor job – many states have capital punishment, and our government regularly sends our troops to war.

While the Christian Church has recently been consistent in its position that suicide is wrong, historically that has not always been the case. For example, the Christian church acknowledges that suicide by Christian virgins and married women who killed themselves rather than face rape by pagan males was accepted by the Church, as was suicide to avoid arrest and torture after arrest.⁴⁶ Furthermore, the argument that it is for God alone to decide when someone should die seems to implicate that it is equally sinful for the medical profession to intervene when it has life-saving procedures at its disposal?⁴⁷ The argument that God alone will decide when people die results in the conclusion that any time a human life is saved by the medical profession, God's will has been rebuffed. As previously discussed, the religious norms governing our society often adapt to the times. As the times change so too do the norms.

Opponents of PAS and euthanasia worry that if assisted suicide were legalized its usage would increase at an unacceptable rate. Opponents argue that some people could be coerced into committing suicide either because they are depressed and see death as the best available solution, or because they feel like they have some sort of a duty to die because they feel they are a financial burden or strain upon their families and friends.⁴⁸ Concerns are raised that persons whose autonomy and well-being are compromised by poverty or by membership in a stigmatized social group (such as persons with disabilities and ill older persons in general), could be coerced into assisted suicide. The argument is that while assisted suicide would purport to be about free choice, it would in practice be more about a lack of choices for many people. Financial pressures, for example, might be a real problem that would coerce patients into choosing to end

⁴⁶ *Id.* at 31.

⁴⁷ *Id.* at 40.

⁴⁸ *Id.* at 48.

their lives when that is not their true desire. These pressures could conceivably come from either the relatives financially supporting them or from doctors who are being pressured by insurance companies.

These arguments of financial pressures are very practical. In 35% of cases reported by the Oregon Department of Human Services, “burden on family, friends/caregivers” was given as an influential reason in requesting to die.⁴⁹ For those with factors that might inhibit a free choice - such as elderly individuals who would not want to be a burden on their families or individuals who lacked good health care – the choice of assisted suicide could prove to be not an act of personal autonomy, but instead an act of desperation.

In evaluating this concern, a balance must be drawn to weight the opposing arguments. The consequences for those who may feel coerced into suicide must be measured against those who must continue to suffer, because although they desire to die they cannot, as they are not allowed to seek the assistance they need. When considering all the competing concerns involved, the balance seems to weigh in favor of permitting PAS and euthanasia.

The most persuasive argument against legalizing PAS and euthanasia is based on a slippery slope argument. Opponents worry that if doctors are allowed to actively take a patient’s life at the patient’s request, then at some point doctors could start to decide on their own when one of their patients should be killed without first obtaining consent.⁵⁰

The Netherlands is one of few countries in the world with a regularly operates an assisted suicide and euthanasia regime. Therefore, it would be of obvious benefit to study the Dutch model and the effect legalized suicide has had. To date, two large-scale studies have been published regarding Dutch assisted suicide and euthanasia practices, one in 1990 (hereinafter the

⁴⁹ DOLGIN & SHEPHERD, *supra* note 2, at 828.

⁵⁰ YOUNT, *supra* note 5, at 4.

“1990 Survey”) and the other in 1995 (hereinafter the “1995 Survey”). The 1990 Survey found that 1.9% of all Dutch deaths (2447) were attributable to the practice of euthanasia. Substantially more people died in the Netherlands as a result of euthanasia than HIV, leukemia or homicide.⁵¹ The 1990 Survey found that an additional 0.3% of all deaths – nearly 400 cases – were the product of PAS. By 1995, these figures had grown: 2.3% of all deaths nationwide were the result of euthanasia and 0.4% were due to assisted suicide. The Surveys also reveal that requests for euthanasia increased dramatically between 1990 and 1995, as did the actual rate of euthanasia and assisted suicide.⁵²

What is most discomfoting about these studies is that in 1995 the authors of the surveys found that 0.7% of all deaths nationwide were the result of nonconsensual killings (approximately 950). In the 1990 Survey, Dutch physicians involved in nonconsensual affirmative killings conceded that ending pain and suffering motivated them in only 18.8% of the cases; that the “absence of any prospect of improvement (60%), . . . avoidance of ‘needless prolongation’ (33%), the relatives’ inability to cope (32%), and the patient’s ‘low quality of life’ (31%)” motivated them to honor assisted suicide and euthanasia requests in other instances.⁵³ In 1995, the New York State Task Force on Life and the Law issued a recommendation against legalizing assisted suicide in part based of the concerns raised by the 1990 Survey data. Referring to the 2700 reported deaths resulting from assisted suicide and euthanasia in the Netherlands and the 1000 cases of nonconsensual terminations, the task force reasoned: “If euthanasia were practiced in a comparable percentage of cases in the United States, voluntary

⁵¹ Neil M. Gorsuch, *The Legalization of Assisted Suicide and the Law of Unintended Consequences: A Review of the Dutch and Oregon Experiments and Leading Utilitarian Arguments for Legal Change*, 2004 Wis. L. Rev. 1347, 1362-1364 (2004).

⁵² *Id.*

⁵³ Gorsuch, *supra* note 51, at 1367.

euthanasia would account for about 36,000 deaths each year, and euthanasia without the patient's consent would occur in an additional 16,000 deaths.”⁵⁴

What exacerbates matters for PAS and euthanasia proponents is that according to the Dutch government, it is not patient autonomy or even the alleviation of pain that stands as the ultimate justification for assisted suicide and euthanasia. Instead, it is the physician's assessment of the patient's quality of life as “degrading,” “deteriorating” or “hopeless” that is the ultimate justification for killing.⁵⁵ This observation strongly weighs against the assisted suicide movement here in the United States as a major concern. The inherent subjectivity involved should give advocates of PAS and euthanasia legalization a reason to pause and consider the ramifications.

Opponents rightfully worry that the legalization of PAS and euthanasia may lead to the non-voluntary euthanasia for ever-larger groups of persons, including the non-terminally ill, those whose quality of life is perceived to be diminished by a physical disability, and persons whose pain is emotional instead of physical. Some say there is too great a risk that vulnerable patients will end their lives involuntarily or will succumb to pressures from others to end their lives. However, an unrelated study recently released, which gathered data from Oregon and the Netherlands, reveals that rates of assisted dying in Oregon and in the Netherlands showed no evidence of heightened risk for the elderly, women, the uninsured (inapplicable in the Netherlands, where all are insured), people with low educational status, the poor, the physically disabled or chronically ill, minors, people with psychiatric illnesses including depression, or

⁵⁴ New York State Task Force on Life & the Law: *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context*, 133-34 (1997 supplement).

⁵⁵ Gorsuch, *supra* note 51, at 1365.

racial or ethnic minorities, compared with background populations.⁵⁶ Thus, the forecasts that PAS and euthanasia would be practiced disproportionately on vulnerable groups have proven inaccurate.

An additional concern raised is that physicians may spend less time treating their dying patients if in the back of their minds they know assisted suicide is an option. It is emotionally draining and time consuming to provide appropriate comfort and other care to patients who are seriously ill, and physicians may well find it psychologically difficult to respond to the needs of these patients. If people can choose suicide, the fear is that physicians may see less of a need to respond to their dying patients' needs. This concern is valid, but it also counsels against permitting the withdrawal of life-sustaining treatment which is permitted by law. With the withdrawal of life-sustaining treatment as an option, physicians may also be discouraged from responding to the needs of their dying patients. So while the concern that doctors may not spend the time with seriously ill patients when they know assisted suicide is an option remains a legitimate concern about PAS, it does not explain the distinction between assisted suicide and the withdrawal of life-sustaining treatment.⁵⁷

However, one must remember that under the Dutch model, the decision whether to begin the patient's death rests with the physician. The 1990 and 1995 surveys done in the Netherlands consistently found that a significant proportion of assisted suicides and acts of euthanasia went unreported, even though Dutch professional and legal guidelines allow the practice and expressly require them to be reported to public authorities. The

⁵⁶ Margaret P. Battin; Agnes van der Heide; Linda Ganzini; Gerrit van der Wal; Bregje D. Onwuteaka-Philipsen, *Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in "vulnerable" groups*, 10/1/07 J. Med. Ethics 591, Vol. 33; Issue 10 (2007).

⁵⁷ David Orentlicher, *The Legalization of Physician Assisted Suicide: A Very Modest Revolution*, 38 B.C. L. Rev. 443, 460 (1997).

1990 study shows that of the 2,700 cases of assisted suicide and euthanasia recorded in 1990, only 486 were reported pursuant to Dutch medical guidelines, meaning, in effect, that doctors illegally certified 82% of these cases as death by “natural causes.”⁵⁸ Applying the same formula to the United States could translate to a death toll well beyond an acceptable number. Even if the doctors in the United States were expected to do everything in their power to treat the patient, they would still have the secondary option to engage in a PAS.

There really is no rebuttal against this slippery slope argument. The fact that the Netherlands has seen an increase in the number of deaths from assisted suicide is disconcerting. So too is the fact that physicians wield the ultimate authority to make life and death decisions, and their admissions of engaging in non-voluntary euthanasia acts. The only honest response to this concern is that the Netherlands is not the United States. What may be true there may not necessarily prove true here.

Another concern somewhat connected to the slippery slope argument focuses on the projected effect on the psyche of patients. As doctors become willing to assist in suicide, and perhaps euthanasia, more patients could become less trustful of doctors, and some may even develop a paranoia that the doctor will kill them.⁵⁹ However, it is difficult to see the connection between the knowledge that one’s doctor sometimes helps his patients commit suicide and the concern that the doctor would want to kill every patient. In fact, one’s trust in his doctor may actually increase as he knows his doctor will do everything possible to relieve his suffering, including PAS.⁶⁰

⁵⁸ Gorsuch, *supra* note 51, at 1366-67.

⁵⁹ David C. Thomasama, *When Physicians Choose to Participate in the Death of their Patients: Ethics and Physician Assisted Suicide*, 24 *Law, Med. & Ethics* 183, 193 (1996).

⁶⁰ MITCHELL, *supra* note 43, at 69.

Oftentimes, opponents of PAS and euthanasia contend that suicide assistance violates the physician's professional role. There are two responses to this important argument against assisted suicide. First, physicians are providers of comfort just as they are healers of illness. When these two roles conflict, it is not clear why the healing role should take priority over the comforting role. If physicians' fundamental role is to relieve discomfort or disease, with health promotion being a part of that role, then assisting suicide is not only compatible with the physician's role, it is essential.⁶¹

Second, even if one accepts the premise that healing is a physician's fundamental role, permitting assisted suicide can facilitate that role. What patients often want from the right to assisted suicide is not so much the ability to die, but the knowledge that they themselves will retain the control over the timing of their death. Accordingly, they may be more willing to undergo aggressive medical treatments that are painful and risky. If the treatments do not succeed, the patients would be assured that they could end their suffering with their doctor's help. Without such assurance, they might well forgo the treatments entirely.⁶² If the fear of doctors not giving their patients proper medical care, or worse doctors who provide negligent medical treatment, were really to come to fruition, the patient could always file a medical malpractice lawsuit. Doctors would still have to answer any time their care was below the proper medical standard.

PAS and euthanasia opponents ignore the reality that the assistance factor in fact helps a patient and his family. Facilitating the act makes life for the person seeking assisted suicide easier and less stressful, as well as life for that person's family. Ultimately, the patient and his family are in control. The patient retains the decision of when and where he will die, while the

⁶¹ Orentlicher, *supra* note 57, at 452.

⁶² *Id.* at 453.

family knows the means of their loved one's death, as well as the time and place. Without some assistance, some very sick people would not be able to end their lives unless without using a brutal tool like a gun, which would obviously not leave behind a loving memory or a pretty scene.⁶³ The assistance of a physician in terminating one's life provides an emotional support (you are not dying alone) and social acceptance (at least one person approves of what you are doing.)⁶⁴ Opponents of PAS and euthanasia would have the system deny a person who reasonably seeks assistance in procuring a comfortable exit.

In conclusion, the chief opponents of PAS and euthanasia were, and continue to be, the Catholic Church, Protestant fundamentalist groups, and the Right to Life movement which formed in response to the legalization of abortion. These groups have vowed to protect the "sanctity of life" at life's end as well as at its beginning. The American Medical Association (AMA), the American Nurses Association and other such medical organizations also have usually opposed the legalization of PAS and euthanasia.⁶⁵ While the religious arguments against legalizing PAS and euthanasia cannot be discarded, one must bear in mind that suicide was once tolerated by the same religion that now condemns it. And as for the AMA, not all doctors oppose assisted suicide, and many medical professionals openly support PAS and euthanasia. In truth, the only real predicament stopping PAS and euthanasia legalization is the slippery slope concern raised by the evidence generated from the Netherlands. Understandably, non-voluntary euthanasia is a legitimate concern that must not be taken lightly.

⁶³ MITCHELL, *supra* note 43, at 53.

⁶⁴ *Id.*

⁶⁵ YOUNT, *supra* note 5, at 28-29.

B. Arguments in Support of Legalizing PAS and Euthanasia

Proponents advocating a right to assisted suicide cite a number of reasons supporting their position. The primary justifications for PAS and euthanasia from which several other arguments derive include: (1) bodily autonomy and the duty to respect free choice, (2) responsibility to respond to pain, (3) and health care economics.

Science, medicine, and the law have advanced to a point where it is possible to make anatomical gifts. State legislatures, in response to these scientific and technological advances, have enacted legislation allowing such transfers of body parts. The current legal acceptance of organ donation in the United States allows individuals to make anatomical gifts upon death. The right to make such gifts, and the right to transfer such property, recognizes at least some form of property rights in the human body.⁶⁶ This choice to share one's body demonstrates the individual's right to control his or her own body. This leads to the logical conclusion that people own their bodies as a whole unit and may dispose of them as they please, including by means of suicide, assisted suicide, or voluntary active euthanasia.⁶⁷ If there is a moral and legal right to donate a body part, it involves a choice to transfer, and hence a property right in the body. People have a moral right to do with their bodies as they please.

Before the turn of the century, the Supreme Court observed that “[n]o right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.”⁶⁸

⁶⁶ Roger Friedman, *It's My Body and I'll Die If I Want To: A Property-Based Argument In Support of Assisted Suicide*, 12 J. Contemp. Health L. & Pol'y 183, 201(1995).

⁶⁷ *Id.*

⁶⁸ *Union Pac. R. Co. v. Botsford*, 141 U.S. 250, 251 (1891).

Freedom of choice is rooted in America's belief in and commitment to individual freedom. One of the central tenants of the Constitution is the ability to control one's life. The autonomy argument suggests that an individual should be in control and responsible for his own life.⁶⁹ Citing this argument of self-autonomy, PAS and euthanasia advocates claim that the right to choose assisted suicide is a right which should be allowed, as their existence would not harm the people who choose to not engage in those practices. Some argue that the constitutional rights to privacy and autonomy lead to a proper understanding of case law that requires a positive right to suicide (i.e., to attain assistance in killing oneself).⁷⁰

In the absence of causing harm to others (which would outweigh the commitment to freedom), individuals should be free from restraint to do as they want; if that means engaging in assisted suicide then so be it – it is not causing any actual harm to someone else. Moreover, any prohibition on assisted suicide would not only serve as restrictions on the individual liberty of the person seeking assistance, but would also indirectly challenge the freedom of the potential suicide assister.⁷¹

The counterargument to this claim for freedom from restraint in the absence of harm to others is that it ignores the reality that the autonomy right is not absolute. People are allowed to do many things that would, on a primary level, seem like an autonomous action. Yet some actions, despite the fact that they are actions of autonomy, such as using drugs, are actions society prohibits because of the secondary effects they produce. So too, the argument goes, PAS

⁶⁹ Thomas F. Schindler, *Assisted Suicide and Euthanasia: Ethical Dimensions of the Public Debate*, 72 U. Det. Mercy L. Rev. 719, 722 (1995).

⁷⁰ STEVEN NEELY, *THE CONSTITUTIONAL RIGHT TO SUICIDE*, 80 (1994).

⁷¹ Robert L. Risley, *Ethical and Legal Issues In the Individual's Right to Die*, 20 Ohio N.U. L. Rev. 597, 609-610 (1994).

and euthanasia, while autonomous actions in theory, in reality produce negative effects on loved ones and society as a whole.

Autonomy arguments for PAS and euthanasia are further attacked on the grounds that PAS and euthanasia are not competent autonomous decisions. This attack questions the rationality component of a decision to engage another in assisting suicide. Opponents of PAS and euthanasia fear that persons seeking assistance in suicide cannot fully comprehend the consequences of their action, as they lack the same rational capacity as someone who is not facing a terminal illness or some other impending cause of death.

Consequently, opponents of the legalization of assisted suicide argue that legalization poses a threat to the individual's right to autonomy, rather than enhancing it. The fear is that the legalization of assisted suicide would send a message to already marginalized members of society that suicide is an acceptable, responsible or even expected option, especially if the doctor openly discusses the possibility.⁷² That message from a medical professional in a position of authority and trust, which says that assisted suicide is a viable option worth considering, might potentially override the preexisting autonomous choice to continue living. However, even if the choice to commit assisted suicide is a socially shaped choice, it is nonetheless a decision that should be respected as autonomous. People often choose a course of action solely because of its acceptance by society. When a fully independent, healthy and intelligent person chooses to engage in an activity that others may question as irrational, he is entitled to continue in his action. For example, bungee jumping is an activity which inherently is fraught with risk; yet when someone bungee jumps off the side of a bridge and risks his life in the process, he is allowed to jump. Similarly, when a person seeking assisted suicide meets a threshold level for

⁷² WILLIAM H. COLBY, UNPLUGGED: RECLAIMING OUR RIGHT TO DIE IN AMERICA, 113 (2006).

rational mental capacity, his autonomous decision to commit suicide with the help of another should be accepted and complied with.

Returning to the religious argument, many opponents argue that even if the autonomous argument is conceded, because life is a gift from God it must not be destroyed. Yet if life is truly a gift from God, then accepting that premise, the recipient of that gift can do with it as he pleases. If the recipient of a gift chooses to discard his gift, then his choice should be respected. After all, it is a gift.⁷³ No matter how fortunate and lucky one may feel to have a particular gift, it defies the notion of giving a gift if one is obligated to keep and use it.

Moving to the second primary argument in support of PAS and euthanasia, one must consider the pain that the patient experiences. There is arguably a moral mandate that one must help to ease another's pain when something can be done, that it is unethical to leave such an individual in pain.⁷⁴ To recognize that assisted suicide and euthanasia can be morally mandated to help those in pain, and then to impose substantial burdens on the right to satisfy that moral mandate seems illogical.⁷⁵ If protecting the psychologically unsound from causing harm to themselves remains a valid ground for the state interest in suicide prevention, then of course the state may justifiably take measures to stop people's suicides and may prohibit others from helping them. However, that does not mean that the state may legitimately prevent rational persons from committing suicide. Logically, the state's paternalistic concern disappears if the suicidal individual is demonstrably rational.⁷⁶ Thus, if states can legislate adequate safeguards to ensure the rationality of those who wish to commit suicide, a right to suicide and suicide assistance should be granted consistent with the state's historical interest in suicide prevention.

⁷³ MITCHELL, *supra* note 43, at 35-37.

⁷⁴ Schindler, *supra* note 69, at 720.

⁷⁵ *Id.* at 721.

⁷⁶ CeloCruz, *supra* note 11, at 376.

As mentioned, the compassion argument is based on the belief that no human should have to bear any pain, emotional or physical, that can be relieved. The obvious result of this assumption is that if a patient is suffering unnecessarily, he should be allowed the choice to die. The logic of allowing someone who is not in a position of suffering to deny a choice to someone who is suffering is rather perverse. It is hardly reasonable for people who are not experiencing the same physical and emotional pain to dictate to the suffering individual what is best for him and what he can or cannot do to alleviate his anguish.

Countless ailments and diseases exist where patients are terminally ill and in pain. While in the vast majority of these cases doctors have sufficient pain medication that they can relieve a patient's pain or at least make it tolerable, in many other cases medicine cannot relieve the physical pain that the patient is experiencing. For this reason, there is a quietly accepted practice in the medical profession to overly medicate a patient that doctors know wants to die because he simply cannot survive in his current condition. Even though physicians do not have the legal right to do so, survey after survey reveals that under certain circumstances, physicians regularly assist in death.⁷⁷ Of 355 American oncologists interviewed in 1998, 56 (15.8%) admitted to having carried out PAS or euthanasia. Marcia Angell, former executive editor of the *New England Journal of Medicine*, claimed in March 1999 that at least 15,000 PAS deaths occur annually in the United States.⁷⁸ An even more staggering estimate of the number of PAS deaths is shared by the Death with Dignity Education Center, which puts the number at 7,000 a month.⁷⁹ Legal arguments suggest that it would be in the best interest of dying patients to be able to regulate practices that are currently being used covertly for assisted suicide. Such regulations

⁷⁷ YOUNT, *supra* note 5, at 5.

⁷⁸ *Id.*

⁷⁹ *Id.*

would also provide safeguards for practitioners who are currently complying illegally with patient requests out of compassion.

Society and the legal system obviously recognize there are legitimate concerns justifying PAS, because “double effect” prescriptions have been allowed to become commonplace. The “double effect” practice occurs when a patient dies after the physician gives high doses of narcotics, primarily for the purpose of controlling the pain, but also knowing that such doses will shorten or perhaps end the patient’s life.⁸⁰ The double effect rationale is based solely on compassion. The doctor or nurse who administers the extra pain reliever only does so to try to alleviate the terrible suffering of a terminal patient. Under these situations, where overdoses are administered by a medical professional, death is seen as an acceptable outcome. The same can be said for the withdrawal of life sustaining treatment. Were it not for the belief that sometimes death is preferable to life, life sustaining treatment would not be allowed to be withdrawn. It is somewhat strange that the judicial system has so readily embraced the validity of withdrawal of life support, but has been so reluctant to grant its approval to the practices of PAS and euthanasia. After all, both treatments stem from the same goal and share the same characteristics – sparing a human any unnecessary suffering and honoring the patient’s right to die.

The main counterargument to the compassion argument is that nothing is limiting \ palliative care, even to the point of death. Opponents argue that “double effect” reasoning is sufficient and therefore neither PAS nor euthanasia needs public approval. Rather than advertise a legal system of PAS and euthanasia, many claim that doctors can continue offering “double effect” doses without outwardly flaunting the practice. They argue further that rather than allowing PAS and euthanasia, more could be done to expand palliative care and counseling. Admittedly, expanding palliative care does seem like a good idea. Opponents are correct that

⁸⁰ *Id.*

while oftentimes a patient will opt for assisted suicide as the means to escape pain, sometimes it is in the best interest of the patient to prevent him from deciding to end his life, particularly when he may be suffering from some mental deficiency.⁸¹ The concern that there may be some depression or other impediments to free will operating within a patient is the same reason a patient should be counseled before being allowed to submit to PAS. Once the patient has undergone some form of counseling and met a standard for mental competency, his right to die should be respected.⁸²

Perhaps the most significant problem that advocates of PAS and euthanasia meet is explaining the relationship between the health maintenance organizations (HMO's) and the assisted suicide movement. Opponents argue that it is too dangerous to allow assisted suicide in a health care system that is increasingly becoming dominated by managed care. The cost of the lethal medication usually administered in an assisted suicide is about \$35 to \$50, a bill far less expensive than the cost of treatment for most long-term medical conditions. The California Disability Alliance claims that the incentive to save money by denying treatment is already a significant danger; it would be far greater if assisted suicide was legalized.⁸³ Patients, it is argued, will be driven to choose suicide when better care would have caused them to change their minds. A 1998 study from Georgetown University's Center for Clinical Bioethics highlighted the connection between profit-driven managed health care and assisted suicide. The University's research found a strong link between cost-cutting pressure on doctors and their

⁸¹ Courtney S. Campbell, *Suffering, Compassion, and Dignity in Dying*, 35 Duq. L. Rev. 109, 124 (1996).

⁸² See *proposals* section infra.

⁸³ Marilyn Golden, *Why Assisted Suicide Must Not Be Legalized*, California Disability Alliance, <http://disweb.org/cda/issues/pas/golden1.html>.

willingness to prescribe lethal drugs to patients, were it legal to do so.⁸⁴ However, resource constraints are even more likely to cause the premature withdrawal of a life-sustaining machine, and yet the withdrawal of life-sustaining treatment remains legal. Patients dependent on ventilators or dialysis consume more resources than patients who are not so dependent.⁸⁵ Patients can live many more years, even decades, while being sustained on artificial life support, yet it is legal for a doctor to pull the plug on these support systems.

Despite the seemingly cozy relationship between HMO's and the assisted suicide movement, the fact remains that if PAS and euthanasia were legalized, society as a whole would financially benefit. Though this economics argument is not a particularly sensitive one and holds little emotional appeal, it does make sense on a rational utility-maximizing level. The money, time, and resources could be better used on non-terminal patients. An estimated 27% of Medicare's annual budget goes to patients in their last year of life.⁸⁶ Another study claims that 40% of total Medicare expenses come in just the last few months of life.⁸⁷ That money could be put to more effective use elsewhere in providing care. Moreover, since this is money generated from tax dollars, the greatest number of people possible should be helped with these funds. By allowing over a quarter of public healthcare funds to go to people who are not going to recover, a cost/benefit analysis from a monetary perspective demonstrates the patent inefficiency of the current healthcare system.

⁸⁴ Daniel P. Sulmasy, Benjamin P. Linas, Karen F. Gold, & Kevin A. Schulman. *Physician resource use and willingness to participate in assisted suicide*. Archives of Internal Medicine, 158, 974-978 (1998).

⁸⁵ Orentlicher, *supra* note 57, at 460.

⁸⁶ Julie Appleby, *Debate Surrounds End-of-Life Health Care Costs*, USA Today, http://www.usatoday.com/money/industries/health/2006-10-18-end-of-life-costs_x.htm (October 19, 2006).

⁸⁷ MITCHELL, *supra* note 43, at 74.

C. Proposals

Opponents to PAS and euthanasia assert reasonable concerns, questioning the soundness of a state-sanctioned assisted suicide system. In response to these concerns, three viable solutions are proposed and explored in this section which would effectively allow for the creation of an assisted suicide program while addressing the potential concerns and arguments opponents make.

The first solution would be for each state to establish a governing board comprised of a select few physicians who would need to authorize any PAS or euthanasia procedure. To qualify as a member of this unit of governing physicians, a doctor would have to have published extensively and be recognized as a leading specialist in his field of medicine. This governing board would draw its membership from physicians from different fields in medicine. Such a committee, once established, would review petitions for PAS or euthanasia procedures. By establishing one governing board, the state would create a safeguard which would both greatly reduce the chances of a patient manipulation as well as the risk of misdiagnosis. These measures, if correctly implemented, would ensure that physician assisted suicide would not expand beyond its appropriate context.

The second function of a board such as this would be to assign a psychiatrist to each patient who requests a procedure for PAS or euthanasia. This trained psychiatrist would meet with the patient and determine whether the patient is experiencing any depression, or alternately whether the patient has a rational basis for his choice of assisted suicide.

The concern that physicians can be wrong about estimating how much time a patient has left to live, thus causing unnecessary deaths,⁸⁸ would also be reduced if such a board were in place. While it is common for medical predictions of a short life expectancy to be wrong, the

⁸⁸ MITCHELL, *supra* note 43, at 49-50.

media exacerbates the belief in technological advances to the point where people have come to unrealistically expect that science will conquer illness and even death itself.⁸⁹ The media magnifies and distorts the significance of unexpected recoveries. Unexpected remissions are attributed to miracle cures instead of random chance, and that tends to stimulate hopes that doctors can pull off yet another miracle.⁹⁰ There is a monumental difference between an experimental drug that might potentially cure a disease and a drug which does exist. Until a drug is developed and placed in the market that could heal a given patient, that patient should be free to at least petition for PAS or euthanasia. A board of independent and educated physicians can evaluate that petition and determine whether to authorize PAS or euthanasia. Such a process would both diminish the risk of premature killing when a better treatment is available, and ensure that the number of assisted suicide deaths remains under control.

A second solution focuses on the need to establish an entirely new type of doctor. Kevorkian can be credited with this concept. He proposed a new profession of physicians, called obituarists, whose sole role would be dealing with ending life.⁹¹ Developing a new profession whose responsibility is strictly focused on helping people find a way to die could eliminate an unfounded mistrust of doctors in general. As part of their training, these certified obituarists would have to pass state admissions tests and meet certain state requirements. The state or even the federal government could easily regulate the profession. Strict admission requirements and continuous monitoring would be starting points before a license would be issued.

Neither of these solutions are without flaws. They are intended simply to steer potential claimants requesting aid in committing suicide away from that path when a viable path to recovery is available. Involving mental health professionals such as psychiatrists and

⁸⁹ HOEFLER & KAMOIE, *supra* note 1, at 35.

⁹⁰ *Id.*

⁹¹ NEELY, *supra* note 70, at 84; HOEFLER & KAMOIE, *supra* note 1, at 244.

psychologists would provide appropriate and necessary intervention for patients who may be experiencing depression. It is therefore imperative that in both of the plans suggested thus far that psychologists or psychiatrists are involved and consulted for each patient requesting suicide assistance. Of course, treatment of depression does not always change the desire for assisted suicide, but if psychiatrists are involved in the process it would reduce the percentage of wrongful assisted suicide deaths and bring credibility to the process.

A third possible solution to the concerns raised with PAS is a mandatory waiting period. The state could require a patient to undergo a series of assessments in order to become eligible for PAS or euthanasia. The state could mandate that every person who wants assistance in dying must first consult a variety of specialists and then wait for some prescribed period of time before a final decision would be rendered. Independent evaluations from various doctors practicing in different specialties, or evaluations from the state itself, would determine whether such an invasive procedure would be authorized. Requiring the patient to wait a certain period of time would have two beneficial consequences. First, it would give the patient the opportunity to carefully ponder his decision and an opportunity to change his mind. Second, if any new drug were introduced to the market, the patient would be able to avail himself of that opportunity.

In addition to these two positive benefits, research overwhelmingly shows that people with new disabilities frequently go through initial despondency and suicidal feelings, but later adapt well and find satisfaction in their lives. However, the adaptation usually takes considerably longer than the fifteen-day waiting period required by Oregon's law.⁹² Requiring a person to wait a fixed number of days before his right to die would be realized would help alleviate the concern that the person's decision was not guided by that initial sense of

⁹² Golden, *supra* note 83.

despondency. However, if a waiting period were implemented, flexibility would have to be built into the system to allow for a patient in extreme pain to speed through the waiting period.

D. Constitutional Argument in Support of PAS

Perhaps the strongest argument supporting one's right to PAS is a constitutional one. Ordinarily, when the government restricts liberty, it does so out of a concern for the general welfare that is believed to outweigh the autonomy and liberty interests of the individual. In this instance, however, the right to PAS is an issue significantly affecting personal autonomy, and one for which the government's interest is comparatively limited. Thus, there is a strong argument for the recognition of a constitutional right to death with dignity under the Due Process Clause of the 14th Amendment.

As discussed supra, the case which is most central to any discussion of PAS is *Washington v. Glucksberg*.⁹³ Though the *Glucksberg* Court ruled against recognizing a right to PAS, that conclusion was discordant with both older and more recent Supreme Court opinions on substantive due process, particularly *Lawrence v. Texas*.⁹⁴ Additionally, the facts in *Glucksberg* were morally (though not factually) indistinguishable from the fact pattern in *Cruzan*,⁹⁵ which the Ninth Circuit acknowledged in its analysis of the case⁹⁶ before being reversed by the Supreme Court. *Lawrence v. Texas* – decided just 6 years later – brings the analysis and conclusion from the *Glucksberg* case into serious question. *Lawrence v. Texas* seems irreconcilable with *Glucksberg*, given its strong language in support of the individual's right to

⁹³ *Washington v. Glucksberg*, 521 U.S. 702 (1997).

⁹⁴ *Lawrence v. Texas*, 539 U.S. 558 (2003).

⁹⁵ *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990).

⁹⁶ *Compassion in Dying v. Washington*, 79 F.3d 790

make intimate personal decisions where the interests of the state are comparatively limited.⁹⁷ The Court's approach to substantive due process analysis in *Glucksberg* and *Bowers*, which *Lawrence* overturned, relied almost exclusively on whether a right was strongly bound up in our nation's "history and traditions." The Court moved away from this approach in *Lawrence*, recognizing a right which was not historically protected – the right of homosexual couples to engage in private consensual sex in their homes. This interest in protecting intimate personal conduct and decisions from unwarranted government intrusion seems to apply equally to PAS, particularly in light of other precedents such as *Cruzan*.

The Supreme Court has not yet clarified the continuing validity of *Glucksberg* in light of *Lawrence*, but lower courts have mostly continued to apply the *Glucksberg* approach and have largely ignored the implications of *Lawrence*.⁹⁸ The lower courts seem to prefer to apply *Glucksberg* and shy away from creating new constitutional rights,⁹⁹ perhaps out of a sense that such decisions should be left to the Supreme Court. However, the fact that courts appear reluctant to extend new constitutional rights should not negate the important moral and constitutional considerations supporting a right to die. At least from a constitutional perspective, *Lawrence* implicitly grants the Court the opportunity to reconsider *Glucksberg* and establish a right to die as one chooses.

III. Conclusion

The right of competent adults to refuse medical treatment, including medical treatment that sustains life, is legally recognized in every state and in most Western countries. While

⁹⁷ See *Glucksberg* at 702, "Liberty presumes an autonomy of self that includes freedom of thought, belief, expression, and certain intimate conduct.

⁹⁸ Brian Hawkins, *The Glucksberg Renaissance: Substantive Due Process Since Lawrence v. Texas*, 105 Mich. L. Rev 409, 425.

⁹⁹ *Id.* at 428.

active euthanasia is not supposed to be practiced anywhere in the United States, the evidence tells a very different story. Even though they seldom have an explicit right to do so, countless surveys indicate that under certain circumstances, physicians regularly do assist in death.¹⁰⁰ As discussed¹⁰¹ many of these assisted deaths occur after the physician gives the patient a high dose of narcotics primarily for the purpose of controlling the pain, but knowing that such doses will also shorten or perhaps even end a terminally ill patient's life. In 1996 the United States Court of Appeals for the Ninth Circuit recognized this practice:

Our attitudes toward suicide of the type at issue in this case [PAS] are better understood in light of our unwritten history and technological developments. Running beneath the official history of legal condemnation of physician-assisted suicide is a strong undercurrent of a time-honored but hidden practice of physicians helping terminally ill patients to hasten their deaths. According to a survey by the American Society of Internal Medicine, one doctor in five said he had assisted in a patient's suicide.¹⁰²

Physicians are uniquely placed in a position to assist suicide or perform euthanasia because of their medical skills and access to painless lethal drugs. Whether doing so is an extension of the physician's role as healer and comforter or the ultimate violation of the Hippocratic Oath is the difficult question. The Hippocratic Oath reads in part, "I will not give a deadly drug to anybody if asked for it, nor will I make a suggestion to that effect."¹⁰³

The criticism that doctors agreeing to assist in suicide would violate the Hippocratic Oath is refuted on two grounds. First, the original Oath prohibiting killing also prohibited abortions, surgery, and charging teaching fees, all of which have been modified to meet contemporary realities. Second, those who take the Oath are expected to take all measures necessary to relieve

¹⁰⁰ YOUNT, *supra* note 5, at 5.

¹⁰¹ *Supra* note 72, *see* pp. 20-21.

¹⁰² *Compassion in Dying v. State of Washington*, 79 F.3d 790 (9th Cir. 1996).

¹⁰³ Hippocratic Oath

suffering. Many interpret this obligation to include assisting a patient in his endeavor to commit suicide when that is the only way suffering can be relieved.

Physicians who have chosen to help with suicides or perform euthanasia are motivated by compassion for their patients' suffering or out of respect for their patients' preferences, and they engage in such activities despite their illegality. Personal privacy and individual liberty, core values in our culture, are undermined by legal inflexibility and intolerance. The law should respect those patients for whom control over the time, place, and manner of their own death is a source of hope and meaning near the end of life. That a physician can legally withdraw life-sustaining treatments but not give comforting aid to terminally sick patients is remarkable.

If all else is ignored – the medical arguments, the legal arguments, and the moral and ethical arguments in support of PAS and euthanasia – one component of the debate that cannot be ignored is the changing attitude of the American public. Public opinion has overwhelmingly turned to support PAS and euthanasia in certain circumstances. In 1996 the Ninth Circuit recognized this shift in support for PAS and euthanasia when they cited various polls which indicated that a majority of Americans, approaching 90% in certain circumstances, endorsed physician-assisted suicide for the terminally ill. The Ninth Circuit cited both the April, 1990 Roper Report, which found that 64% of Americans believed that the terminally ill should have the right to request and receive physician aid-in-dying, and the 1994 Harris poll which found that 73% of Americans favored legalizing PAS.¹⁰⁴

As noted in the introduction, one physician who publicly flaunted the judicial system by openly engaging in the practice of euthanasia was Dr. Jack Kevorkian. Kevorkian, licensed in clinical pathology, came to be known as “the suicide doctor” or “Dr. Death.”¹⁰⁵ Though

¹⁰⁴ *Compassion in Dying*, 79 F.3d at 810.

¹⁰⁵ HOEFLER & KAMOIE, *supra* note 1, at 151.

Kevorkian was eventually convicted for one of his numerous euthanasia deaths, he did manage to garner support and sympathy from both juries and judges. In May 1993, Judge Cynthia Williams, the judge scheduled to handle Kevorkian's sixteenth assisted suicide case in Wayne County, Michigan, called Kevorkian, "very courageous." Williams then said "it would be difficult for many of us to say there isn't some right to say how we can leave here."¹⁰⁶ A few months later on December 13, 1993, Kevorkian was charged in a different homicide in Oakland County, Michigan. The judge assigned to that case, Judge Richard C. Kaufman, commented "when a person's quality of life is significantly impaired by a medical condition and the medical condition is extremely unlikely to improve" that person has a "constitutionally protected right to commit suicide."¹⁰⁷

Considering that one third to nearly two thirds of Americans support some form of a right to assisted suicide, it begs repeating the question – should one have the right to get help in dying? The time has come for states to listen to the American public and legally sanction the right to die with a physician's assistance.

¹⁰⁶ *Id.* at 155.

¹⁰⁷ *Id.* at 156.