

TO DIE WITH DIGNITY: COMPARING PHYSICIAN ASSISTED SUICIDE IN THE UNITED STATES, JAPAN AND THE NETHERLANDS

I see there is an instinctive horror of killing living things under any circumstances whatever. For instance, an alternative has been suggested in the shape of confining even rabid dogs in a certain place and allowing them to die a slow death. Now my idea of compassion makes this thing impossible for me. I cannot for a moment bear to see a dog, or for that matter any other living being, helplessly suffering the torture of a slow death. I do not kill a human being thus circumstanced because I have more hopeful remedies. I should kill a dog similarly situated because in its case I am without a remedy. Should my child be attacked with rabies and there was no helpful remedy to relieve his agony, I should consider it my duty to take his life.¹

I. INTRODUCTION

There is a growing terminally ill² population in the world.³ Physicians increasingly face a difficult request from their patients: physician assistance⁴

1. Mahatma Gandhi, *Young India* (Nov. 18, 1926), in MARVIN KOHL, *THE MORALITY OF KILLING* 70 (1974).

2. There is no generally accepted medical definition of "terminal." See *Developments in the Law—Medical Technology and the Law*, 103 HARV. L. REV. 1519, 1644 n.11 (1990). This Note deems an illness "terminal" if death is reasonably expected within one year. *Id.*

3. Since World War II, the advances in modern medicine have changed what diseases kill people. Today, chronic, degenerative diseases, such as cancer and heart disease, account for 70% of all deaths in the United States. Sanford H. Kadish, *Letting Patients Die: Legal and Moral Reflections*, 80 CAL. L. REV. 857, 858 (1992). Desire for death as an escape from suffering is very common among patients with incurable terminal illnesses. Timothy E. Quill, *Doctor I Want to Die. Will You Help Me?*, 270 JAMA 870, 871 (1993).

4. Many confuse the terms euthanasia and assisted suicide. Therefore, these terms must be defined. Euthanasia is the intentional act of causing another person's death for compassionate reasons. It is an action performed, usually by a doctor, to bring about the painless death of a person suffering from an incurable illness. There are many subclassifications under euthanasia. Active euthanasia is the commission of an act to end life. Passive euthanasia is the omission of an act that would prolong life. Passive euthanasia, that is, letting a seriously ill person die by withholding or withdrawing treatment, is now widely accepted and practiced in the United States. See *infra* notes 59-60 and accompanying text. In voluntary euthanasia, a terminally ill person, who is of sound mind, requests an administered death. In involuntary euthanasia, a doctor deliberately ends the life of a suffering, dying patient without an explicit request from the patient.

Physician assisted suicide is characterized by providing a patient with medication or other means to end the patient's life. The "right to die with assistance" is language that encompasses a patient's right to authorize

to die with dignity. Both physicians and patients are affected by the social, legal, ethical, medical, and religious ramifications connected to assisted suicide. These concerns result in vastly different treatment of patients' requests to die, depending on the country in which they reside.⁵

Consider the case of ANJ. She was once a healthy, vibrant woman, but at age 55 was diagnosed with myeloma, a form of blood cancer that attacks the bone marrow and causes the bones to crumble and break.⁶ For three years after the diagnosis, she actively pursued aggressive treatment. Unfortunately, treatment was unsuccessful and the cancer spread throughout her body. Seven months ago, her physician informed her there were no further treatments available and that she would die within a year. ANJ now faces constant pain that painkillers cannot eliminate. Soon after her diagnosis, she and her husband talked about her request to die. After discussing the issue with her entire family, she repeatedly has asked her physician to assist her in ending her life. Her family supports her decision.⁷ Yesterday she told her physician,

a physician to perform an act that intentionally results in the patient's death, without the physician being held civilly or criminally liable for causing the death. For the purposes of this Note, physician assisted suicide refers only to cases where, at a patient's request, a physician legally prescribes a drug that ends the life of a terminally ill, mentally competent adult patient. Physician assisted suicide shifts the emphasis from the doctor to the patient because the patient makes the ultimate choice. Anne Mullens, *Death-The Last Resort*, VANCOUVER SUN, May 23, 1995, at B6.

5. In the United States, the American Medical Association (AMA), state legislatures and the judicial system oppose the practice of physician assisted suicide. See *AMA Delegates Vote Overwhelmingly to Oppose Physician Assisted Suicide*, BNA HEALTH CARE DAILY, June 26, 1996; *infra* notes 51-149 and accompanying text. In other nations, a patients' request to die is honored. See *infra* note 163-72 and 194-203 and accompanying text.

6. The case of ANJ is partly based on the experience of Betty Rollin, who was diagnosed with a terminal illness and detailed her experience in a book. BETTY ROLLIN, *LAST WISH* (1985). ANJ is also based on the experience of another terminally ill patient, the late Eric Straumanis. Straumanis was diagnosed with myeloma in 1993. After three years of aggressive cancer treatments, his physicians informed him that they had exhausted all treatment alternatives. Straumanis attended meetings of the local Hemlock Society chapter from the time he was diagnosed, and at the Society's request, he agreed to be the plaintiff in a test case challenging a Florida state law that makes assisted suicide a crime. The 1995 complaint asked the court to block the state from prosecuting Dr. Cecil McIver, a physician who was willing to assist Straumanis. It also asked that Florida's Board of Medicine be prohibited from disciplining McIver if he assisted Straumanis in hastening his death. Jeanne Malmgren, "*I Want to Have the Option to Do It Myself*," ST. PETERSBURG TIMES, Jan. 1, 1996, at 1A. The complaint asserted that a physician has a "constitutionally protected liberty . . . to practice medicine consistent with his best professional judgment. This interest includes the right to assist a competent, terminally ill adult patient such as Straumanis to hasten his death by prescribing suitable medication for self-administration by the patient." *Id.* Interestingly, although Straumanis was in great pain and found that "getting out of bed is really a chore," he did not want to die. Instead, he wanted the right to have the option to choose physician assisted suicide. *Id.* Less than a week after filing the complaint, Straumanis died of natural causes on January 3, 1996. Jeanne Malmgren, *Right to Die Plaintiff Dies "Naturally"*, ST. PETERSBURG TIMES, Jan. 4, 1996, at 1A.

7. Families faced with a suffering member are often asked for aid and support in the individual's decision to die. In many cases, the family helps the terminally ill loved one commit suicide. For example,

"I'm not afraid to die but I am afraid of this [cancer], and what it is doing to me. I'm not better [and I never will be]. I'm worse. There's never any relief from it now. Nothing but nausea and pain . . . Who does it benefit if I die slowly? . . . I'm stuck—stuck in life. I don't want to be here anymore. I don't see why I can't get out."⁸

The physician's response to ANJ's request would vary depending on the country in which ANJ resides.⁹ If ANJ were in a United States hospital, her request to die would be futile.¹⁰ In a majority of the states, her physician would face criminal prosecution if he were to comply,¹¹ and therefore she would probably continue suffering until death.¹² In the Netherlands, ANJ

George Delury helped his wife of 22 years commit suicide to end her suffering. Although he was charged with manslaughter, he said, "We knew it was illegal for me to help. We also knew it was impossible if I didn't." Laurel Shackelford, *Dignified Death and Euthanasia: Some Difficult Questions*, COURIER-JOURNAL, July 30, 1995, at 2D.

8. ROLLIN, *supra* note 6.

9. This Note examines physician assisted suicide in the United States, Japan and the Netherlands. The Netherlands has a reputation for liberal social policies on abortion, drug use, euthanasia, and prostitution. Because the Netherlands is the only nation where physician assisted suicide is routinely recognized, the Netherlands represents one extreme in the spectrum of physician assisted suicide. The other extreme is best illustrated by the United States (as well as other Western European nations such as Great Britain) where there is a strong right to life movement. Japanese social policies traditionally favor values such as group harmony and cohesion. Japan is also viewed as a more conservative society. Therefore, in examining the recent Japanese decision on dying with dignity, this Note hopes to present lessons from the Japanese and Dutch positions that the United States can use as a guide when confronted with physician assisted suicide issues. Also, although the scope of this Note only covers the United States, Japan and the Netherlands, it is interesting to note other international views on physician assisted suicide. For example, in Australia's Northern Territory, terminally ill patients are allowed to end their lives after an assessment by two doctors, including one with a diploma in psychological medicine. In Hong Kong, the government is currently considering whether to allow euthanasia. In Great Britain, the practice is illegal, and it is thought to be "wholly outside [the doctor's] . . . duty to shorten life in order to relieve suffering." Mariana Wan, *Right to Die is Open to Debate*, S. CHINA MORNING POST, July 15, 1995, at 17. However, in November 1993, Britain's highest court allowed a physician to end his patient's life, reasoning that the patient's life was no benefit to him. Peter Singer, *Is Our Changing Definition of Death for the Better? Yes: We Need to Make Better Quality of Life Decisions—With Safeguards*, USA TODAY, May 18, 1995, at 15A. Moreover, in Singapore, the government recently recognized the right to die for terminally ill patients. Wan, *supra*.

10. For example, although Oregon passed a law permitting physician assisted suicide, the courts initially struck it down. See *infra* notes 115-21 and accompanying text. Although the Second and Ninth Circuits have recently held that bans against physician assisted suicide are unconstitutional, until the debate is decided by the Supreme Court, the legality of physician assisted suicide will be questioned. See *infra* notes 122-49 and accompanying text. ANJ would most likely be granted her request if she had a physician like Dr. Timothy Quill, see *infra* notes 97-102 and accompanying text, or Dr. Jack Kevorkian, see *infra* note 85 and accompanying text, willing to assist her despite the potential criminal sanctions.

11. ANJ's physician could face the charge of murder. In Michigan, Dr. Kevorkian faced murder charges for his suicide assistance. The charges were dropped, however, because Michigan did not have a law banning assisted suicide. See *infra* note 85.

12. If ANJ had a physician willing to assist her despite the threat of criminal prosecution, her request could be fulfilled. At the time of this writing, Dr. Jack Kevorkian has assisted in 42 deaths. For example, Dr. Jack Kevorkian assisted in the death of his 27th patient on January 29, 1996. Linda Henslee suffered from

would see an end to her suffering after she and her physician have complied with numerous requirements.¹³ Similarly, in Japan, her physician would be able to assist her and end her suffering once four specific requirements were met.¹⁴

As terminally ill patients such as ANJ well know, today's medical technology is a double-edged sword. The medical advances made in this century allow scientists to create life in test tubes and sustain life, despite horrible illness, for longer than ever before possible. However, "medicine can not turn life into an everlasting state of happiness, and it should not strive to do so."¹⁵ Moreover, the combination of the graying of the globe and medical advances will result in the international problem of a large aging population and an increasingly older population in the next twenty years.¹⁶ The recent surge of serious diseases without cures, such as AIDS,¹⁷ and increasing cancer rates further contribute to a population of terminally ill patients who may request physician assistance with their deaths.¹⁸

This Note examines physician assisted suicide in an international context

multiple sclerosis and traveled from her home in Beloit, Wisconsin to Michigan, for Dr. Kevorkian's assistance. Mrs. Henslee had suffered from the disease for more than 20 years and was paralyzed. Kevorkian's attorney noted that "she had pain all over and huge open ulcers. Dr. Kevorkian had tried to encourage her to continue, to go on for a while longer, but she was unwilling." *Kevorkian Attends Another Death; Woman's Body is Left in Van*, N.Y. TIMES, Jan. 30, 1996, at A11. See also Michael D. Lemonick, *Defining the Right to Die: Courts Open the Way to Physician-Assisted Suicide, Now Doctors Have to Figure Out What that Means*, TIME, Apr. 15, 1996, at 82.

13. See *infra* note 167 and accompanying text.

14. See *infra* notes 202-03 and accompanying text.

15. Johannes J.M. van Delden et al., *The Rummelink Study: Two Years Later*, 23 HASTINGS CTR. REP. 24, 28 (1993).

16. There are more older individuals today than at any time in history. There are approximately 31 million people age 65 and older in the United States alone. Estimates project that this number will double to 60 million in the next 20 years. Moreover, there are now 20 times as many people age 85 and older as there were in 1900. From 1960 to 1980 the 85 and older age group increased 156%. Estimates project that group will exceed 13 million by the year 2040. Nancy J. Osgood, *Assisted Suicide and Older People—A Deadly Combination: Ethical Problems in Permitting Assisted Suicide*, 10 ISSUES IN L. & MED. 415, 417-418 (1995). This age expansion is not limited to the United States. In Japan, for example, medical advances have created record longevity rates—76 years for men and 82 for women. By the year 2000, people over 65 will make up 16% of the population. *Fast-Aging Japan Debates the Right to Die*, Reuters North American Wire, Nov. 4, 1992, available in LEXIS, Asiapc Library, Japan file.

17. AIDS victims are 12 times more likely to seek assisted suicide. In the Netherlands, 35% of all AIDS deaths are expedited by a physician. Mark O'Keefe, *Dutch Doctors' Tales of Death on Request*, S.F. EXAMINER, Feb. 20, 1995, at A1. Fifty-five percent of HIV-infected patients consider physician assisted suicide as an option for themselves. *Interest in Physician-Assisted Suicide Among Ambulatory HIV-Infected Patients*, AIDS WEEKLY PLUS, Mar. 18, 1996.

18. In a telephone poll of 1000-3000 randomly selected adults, 93% of those with personal experience with the terminally ill thought euthanasia should be legalized. Robert J. Blendon et al., *Should Physicians Aid Their Patients in Dying?*, 267 JAMA 2658 (1992).

to illustrate what insight the United States can gain from the Japanese and Dutch experiences. Increased media coverage of Dr. Jack Kevorkian,¹⁹ consideration of assisted suicide measures in the legislatures, and popular entertainment figures supporting assisted suicide²⁰ demonstrate that the controversy over physician assisted suicide is mounting in the United States.²¹ Despite opponents' wishes, the requests of the terminally ill for physician assistance in ending their lives will increase in the future. Thus, the United States needs to address this issue and, incorporating lessons learned from abroad, set a standard for physician assisted suicide.

II. ASSISTED SUICIDE IN THE UNITED STATES

Many Americans will confront, or already have confronted, the difficult and sensitive issues surrounding their desires for medical treatment and end-of-life decisions. The decisions become more difficult when an individual is terminally ill and constantly suffering. The issue of physician assisted suicide first took the nation by storm in 1990 when Dr. Jack Kevorkian began to help people commit suicide.²² Since then, the debate on physician assisted suicide has accelerated. It has been fueled by review of state laws,²³ recent news stories,²⁴ talk shows, literature, Dr. Kevorkian's trials, the major decisions by

19. At the time of this writing, Dr. Jack Kevorkian has helped 42 individuals commit suicide with his "death machine." The story of Janet Adkins is typical: on June 4, 1990, 54-year-old Adkins ended her life lying on a cot in the rear of a van in a Michigan suburb. Aided by retired pathologist Kevorkian, Adkins had a needle inserted in her arm which first started saline flowing, and then, when she pushed a button on the machine, released a sedative followed by deadly potassium chloride into her system. Adkins flew from her home in Oregon to have Kevorkian assist her in ending her life rather than dealing with senile dementia. See Osgood, *supra* note 16, at 415.

20. Popular *60 Minutes* journalist Mike Wallace states a preference for physician assisted suicide over suffering: "I'd be the first, if necessary, to go to Kevorkian . . . you have the right as a human being to do what you want to do with yourself." *People in the News*, SUN-SENTINEL, June 23, 1996, at 2A.

21. The pervasiveness of physician assisted suicide is evident. Besides Dr. Kevorkian, assisted suicide measures such as California's Proposition 161 and Oregon's Measure 16 illustrate the popularity of physician assisted suicide. Also, court challenges to physician assisted suicide in several states and before federal appellate courts demonstrate that the debate over physician assisted suicide will probably come before the United States Supreme Court in the near future. See *infra* notes 122-49 and accompanying text.

22. *Decisions Near the End of Life*, 267 JAMA 2229, 2229-33 (1992).

23. Many states expressly prohibit suicide assistance in criminal codes. See, e.g., ARIZ. REV. STAT. ANN. § 13-1103 (1989); FLA. STAT. Ch. 782.08 (1976); N.Y. PENAL LAW § 125.15 (Consol. 1984). Also, many states have homicide laws that are read to bar assistance. See, e.g., CAL. PENAL CODE § 187(a) (West 1988) (prohibiting the "unlawful killing of a human being . . . with malice aforethought"). Consent of a victim is usually not a defense to criminal prosecution. See WAYNE R. LAFAVE & AUSTIN W. SCOTT, JR., SUBSTANTIVE CRIMINAL LAW § 5.11, at 687.

24. See John W. Dalbey Donahue, Note, *Physician Assisted Suicide: A "Right" Reserved for Only the Competent?*, 19 VT. L. REV. 795 (1995). In another incident, Dr. Timothy Quill helped a terminally ill patient die by prescribing a lethal dose of barbiturates. He then published the account in the *New England*

the Second and Ninth Circuits, and President Clinton's endorsement of living wills. Moreover, nationwide polls indicate increasing support for patient autonomy, especially among the elderly.²⁵ While Oregon is the only state thus far to legalize physician assisted suicide, Washington and California have come close with proposed initiatives that garnered almost fifty percent of the popular vote.²⁶ At least five other states have introduced similar measures that were closely defeated: California, Maine, New Hampshire, Iowa and Michigan.²⁷ Challenges to physician assisted suicide measures have been turned down by the Ninth and Second Circuit Courts of Appeal, and test cases in some states challenge the state and federal constitutional prohibition of the right to die with assistance, likely requiring the Supreme Court to decide the debate.²⁸

Journal of Medicine. Timothy E. Quill, *It's Over Debbie*, 324 NEW ENG. J. MED. 691 (1991).

25. See, e.g., Richard A. Knox, *Poll: Americans Favor Mercy Killing*, BOSTON GLOBE, Nov. 3, 1991 (City Edition), at 1, available in LEXIS, News Library, Bglobe File. Physician assisted suicide is an important issue for older Americans who are more likely to be stricken with terminal illness. The suicide rate for U.S. citizens age 65 and older was 20.5% in 1990. Seventy-five percent (75%) of the 2 million people who died in 1985 were over 65. Sixty-four percent (64%) of people involved in euthanasia were over 60, and 51% were over 70. See Osgood, *supra* note 16, at A16.

26. See Jane Gross, *Voters Turn Down Mercy Killing Idea*, N.Y. TIMES, Nov. 7, 1991, at B16; *infra* notes 84, 116-21 and accompanying text.

27. James Podgers, *Matters of Life and Death: Debate Grows Over Euthanasia*, A.B.A.J., May 1992, at 60, 61. See also *Legislative Update*, TIMELINES (Hemlock Society, Denver, Co.), Mar.-Apr. 1996, at 4.

28. See generally Donahue, *supra* note 24. A recent Florida case challenging physician assisted suicide is typical: Charles Hall, diagnosed with AIDS; Robert Cron, who has mesothelioma, cancer of the lining of the chest cavity; C.B. "Chuck" Castonguay, who has cancer of the esophagus; and Cecil McIver, a physician, filed suit in February 1996 challenging Florida's 128-year-old law that charges those who help someone commit suicide with manslaughter. The three terminally ill men replace Eric Straumanis, an original plaintiff in the case who died before adjudication. See *supra* note 6. The three terminally ill men feel that if their pain becomes unbearable, they would like to be able to end their lives with a physician's help. Hall argues that "we have the right to live and pay taxes. We should also have the right to choose our own death." Hall got AIDS from a 1981 blood transfusion during surgery. The disease has progressed to the state where he can no longer work, suffers constant pain, has vision problems, and must use a wheelchair or stay in bed. His attorney, Robert Rivas, argues that "the government should not be forcing terminal patients to linger as their physical and mental facilities deteriorate. Instead, such patients should be given the right to die with dignity at a time and setting of their choosing." Like Eric Straumanis, see *supra* note 6, Hall only desires the option of physician assisted suicide to be available, noting that it would be a comfort to him as his disease progresses. The lawsuit asks that McIver not be prosecuted criminally or disciplined by the Board of Medicine if he assists in the plaintiffs' deaths. It cites individual privacy rights guaranteed in the Florida state constitution. The parties decided to file in state court so that the state supreme court would be involved in the debate over physician assisted suicide. The parties feel an Oregon suit, see *infra* notes 115-21 and accompanying text, is headed for the United States Supreme Court. Jeanne Malmgren, *Three Fla. Men Challenge Euthanasia Law*, ST. PETERSBURG TIMES, Feb. 17, 1996, at 1A. Moreover, two federal courts with jurisdiction over one-third of the population struck down prohibitions against physician assisted suicide. See *infra* notes 122-49, and accompanying text. These rulings, according to some, almost assure that the Supreme Court will take up the issue in the near future. David G. Savage, *U.S. Court Strikes Down N.Y. Ban on Assisted Suicide*, L.A. TIMES, Apr. 3, 1996, at A1. See also Joan Biskupic, *U.S. Appeals Court Overturns*

A. Policy Arguments Against Physician Assisted Suicide

Opponents of physician assisted suicide argue that it is a symbol of decaying societal values, and that it robs people of the right to live.²⁹ They fear that the practice will change the role of medicine.³⁰ Physicians will no longer be healers; instead, the medical profession will compromise its values by participating in killing.³¹ Critics argue that there would be increased rates of misdiagnosis with physician assisted suicide, and patients would thus be involuntarily killed.³² Opponents also suggest physician assisted suicide would hinder the future development and promotion of life-sustaining techniques.³³ Finally, the most common argument suggests that allowing physician assisted suicide creates a slippery slope that will eventually wreak havoc on societal and moral values.³⁴

Opponents of physician assisted suicide have legitimate concerns. Many questions arise when assisted suicide is legally sanctioned.³⁵ However,

New York Assisted-Suicide Ban, WASH. POST, Apr. 3, 1996; Frank Bruni, *Court Quashes Parts of New York Law that Ban Assisted Suicide*, N.Y. TIMES NEWS SERVICE, Apr. 3, 1996. At the time of this writing, the Supreme Court's docket includes *Vacco v. Quill*, 80 F.3d 716 (1996), the challenge to the Second Circuit's ruling on physician assisted suicide, see *infra* notes 137-49, 64 U.S.L.W. 45 (1996). Moreover, the American Medical Association (AMA) has called on the Supreme Court to rule on the "misguided and unethical practice" of physician assisted suicide. Mark Mueller, *AMA Seeks High Court Assisted Suicide Ruling*, BOSTON HERALD, Aug. 24, 1996, at 001.

29. Especially in the context of the elderly, opponents argue that physician assisted suicide devalues old age and reflects societal fears of aging. See Osgood, *supra* note 16, at 418. See also Derek Humphrey, *Rational Suicide Among the Elderly*, in *SUICIDE AND THE OLDER ADULT* 125 (A.B. Downing ed., 1969) (noting that suicide is a "preemptive alternative to growing old" even for those not suffering from terminal illness). But see BARRY R. FURROW ET AL., *HEALTH LAW* §17-69 (1995) (arguing that there is a fear of devaluation of the disabled); Paul Wilkes, *The Next Pro-Lifers*, N.Y. TIMES MAGAZINE, July 21, 1996, at 22.

30. FURROW ET AL., *supra* note 29. Although the Hippocratic Oath currently states that a physician should not contribute to a patient's death, the Oath formerly stated that a physician would not participate in abortion. This section was removed after abortion became more prevalent.

31. See Osgood, *supra* note 16, at 429.

32. See FURROW ET AL., *supra* note 29.

33. *Id.*

34. *Id.* Critics of physician assisted suicide argue that if personal choice and autonomy are the only criteria for restricting physician assisted suicide to the terminally ill, then the patient's medical condition and motive for suicide are irrelevant. For example, a 21-year-old student depressed over a failed romance or a 48-year-old executive going through a midlife crisis would have as much right to commit suicide under an autonomy argument as an 80-year-old patient with terminal cancer. Mark E. Chopko & Michael F. Moses, *Assisted Suicide: Still A Wonderful Life?*, 70 NOTRE DAME L. REV. 519, 527 (1995).

35. See generally Donahue, *supra* note 24. But cf. Chopko & Moses, *supra* note 34 (arguing that assisted suicide is a renunciation of a freedom); Osgood, *supra* note 16, at 427 (arguing that older people will, out of desperation and loneliness, choose physician assisted suicide to escape their problems); Yale Kamisar, *Are Laws Against Assisted Suicide Unconstitutional?*, 23 HASTINGS CTR. REP. 32 (1993) (asserting that permitting assisted suicide will lead to a slippery slope, thereby allowing any person to commit suicide legally); Stephen L. Carter, *Rush to a Lethal Judgment*, N.Y. TIMES MAG., July 21, 1996, at 28; Tony Snow,

preventing the rampant abuses and scores of suicides that the proponents of the slippery slope envision is possible when considering assisted suicide as public policy. Public policy, through legislative creation of state statutes, can ensure proper safeguards to allay the critics' fears.³⁶ State statutes can create rigid, mandatory guidelines that would not only permit the patient to die with dignity, but also protect against abuses. Thus, such guidelines would prevent the young, the mentally unstable, the incompetent, or the healthy but depressed individual from participating in physician assisted suicide.³⁷

B. Policy Arguments For Physician Assisted Suicide

Proponents of physician assisted suicide desire legislation that would permit more personal control over the quality of a terminally ill patient's life and death.³⁸ According to this argument, each dying patient should be free to choose physician assisted suicide as a matter of personal liberty.³⁹ The choice should not be made by the government or any court. Instead, the choice should be made by the terminally ill individual because the decision only affects that patient's life.⁴⁰ John Stuart Mill's⁴¹ concept of rationality⁴² permits

Assisted Suicide Shows No Caring, DETROIT NEWS, Aug. 10, 1995, available in LEXIS, News Library, Detnws File (noting that death is not an easy subject and cannot be solved by pills).

36. Safeguards against abuse of physician assisted suicide should encompass the following: "1) Does the action enhance the dignity of the person?, 2) Is it a result of a person's self determination?, 3) Does it reflect compassion for the person and others?" Catherine L. Bjorck, *Physician Assisted Suicide: Whose Life is it Anyway?*, 47 SMU L. REV. 371, 378 (1994) (quoting William McCord, *Dignity, Choice, and Care*, SOCIETY, July/Aug. 1992, at 20-23).

37. See *infra* notes 221-34 and accompanying proposal. For additional rebuttals to opponents' arguments, see Faye J. Girsh, *Physician Aid in Dying, What Physicians Say, What Patients Say* (available from the Hemlock society). Moreover, as Judge Posner of the Seventh Circuit Court of Appeals has argued, suicide rates would probably decrease if physician assisted suicides were legal. According to Posner, terminally ill patients "would be inclined to postpone their decision . . . if they know that they do not have to depend on themselves to do it." M.A. Stapleton, *Posner Sees Merit in Legal Physician-Assisted Suicide*, CHICAGO DAILY LAW BULLETIN, Oct. 5, 1994, at 1. Also, Posner does not see physicians pushing people to death if "they are willing to pay for life-extension service." *Id.*

38. See Donahue, *supra* note 24, at 6. Justice Blackmun articulated the personal autonomy argument in *Bowers v. Hardwick*: "This case is about 'the most comprehensive of rights and the right most valued by civilized men,' namely, 'the right to be let alone.'" *Bowers v. Hardwick*, 478 U.S. 186, 199 (1986) (Blackmun, J., dissenting) (citing *Olmstead v. United States*, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting)).

39. See Donahue, *supra* note 24. Federal District Court Judge Barbara J. Rothstein of the Western District of Washington ruled unconstitutional Washington's prohibition against physician assisted suicide in part because each dying patient should be free to choose or reject it as a matter of liberty. See *Compassion in Dying v. State of Washington*, 850 F. Supp. 1454 (W.D. Wash. 1994), *aff'd*, 79 F.3d 790 (9th Cir. 1996).

40. See Donahue, *supra* note 24. This argument originates in the principle that people should be free to live their lives as they desire, free of restraints on their liberty. Although liberty is not an absolute right, the argument states that an individual's liberty should only be restricted to prevent people from harming others.

a terminally ill patient who is suffering and wishes to end her life the ability to do so.⁴³ This choice cannot be interfered with on the grounds that it is "immoral" or that others "are acting for the patient's own good" in preventing death. As long as the patient is not harming anyone, she cannot be forced to conform her beliefs of right or wrong to those of another.⁴⁴ Physician assisted suicide is also permissible because Mill's principle of liberty not only applies to people acting alone, but also to groups of individuals who agree to act together.⁴⁵ Thus, proponents of physician assisted suicide argue that if the liberty of dying patients is to be respected, the right to enter into aid-in-dying agreements with their physicians must be encompassed within this liberty.⁴⁶

An additional argument for physician assisted suicide asserts that the patient's interest in self-determination outweighs all other interests in keeping her alive.⁴⁷ Because in today's medical industry it is acceptable to withhold treatment and allow a patient to die slowly, proponents of physician assisted suicide question why it is not more merciful and humane to let the patient end

Id.

41. An argument for physician assisted suicide is supplemented by the theories of other philosophers besides Mill. For example, the Scottish philosopher David Hume did not think that suicide was a moral offense. Also, John Donne argued against the traditional Christian prohibition against suicide and asserted that such a decision must be made on theological precepts. Martin B. Berman, *Whose Rite Is It Anyway?: The Search for a Constitutional Permit to Die*, 22 SW. U. L. REV. 105, 114 (1992).

42. Mill wrote:

[T]he only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because, in the opinions of others, to do so would be wise or even right. . . . Over himself, over his own body and mind, the individual is sovereign.

JOHN STUART MILL, *ON LIBERTY AND OTHER WRITING* 13 (Cambridge University Press 1989) (1859).

43. Mill's concept is not only found in philosophy books. Courts have relied on Justice Cardozo's argument of this principle since 1917: "[E]very human being of adult years and sound mind has a right to determine what shall be done with his own body. . . ." *Canterbury v. Spence*, 464 F.2d 772, 780 (D.C. Cir.) (1971), *cert. denied*, 409 U.S. 1064 (1972) (quoting *Schloendorff v. Society of N.Y. Hosp.*, 105 N.E. 92 (N.Y. App. Term 1914)).

44. See Donahue, *supra* note 24, at 807.

45. *Id.*

46. *Id.* The argument respecting liberty applies to those patients who are in irreversible comas or who are permanently incompetent. The individual may create a living will indicating that should a particular situation arise, she wishes to die or be aided in dying by her physician. This decision should be equally respected as a liberty choice. Following Mill's principle, the right of an individual to leave such instructions is simply one implication of the right to control one's own behavior and actions. *Id.*

47. Another argument made for physician assisted suicide is economic. As health care costs rise annually at double the rate of inflation, sustaining life to the ultimate extent creates questions of how best to ration medical care. Thus, questioning whether expensive technology should always be used to prolong the dying process for everyone is common. This argument is the least favorable for promoting physician assisted suicide because of its calculating appearance. *Id.*

life swiftly by taking a lethal dose of drugs.⁴⁸ Those in favor of physician assisted suicide further maintain that although a patient's right of autonomy and self-determination is not absolute, its existence does not, and should not, depend on the physician's actions.⁴⁹ A patient has a single interest in controlling what happens to her own body, whether by withdrawal of treatment or through the assistance of the physician.⁵⁰

C. Physician Assisted Suicide Does Exist Within The Current Right To Die Doctrine

Although two federal appeals courts have recognized the legality of physician assisted suicide, further appeals and challenges to these decisions persist.⁵¹ Nevertheless, current right-to-die case law establishes a right of self-determination for patients that protects an interest in physician assisted suicide.⁵² Currently, courts allow patients to refuse life saving care to permit patients to "die with dignity"⁵³ and to protect "the patient's status as a human being."⁵⁴

1. The Common Law And Precedential Core Of Assisted Suicide Law

Common law recognizes that a competent adult person has the fundamental right to control her own person, free from all restraint and

48. *Id.*; see also *infra* note 82 and accompanying text. In these cases, the emphasis is on the patient's desires and decisions instead of the physician's actions.

49. Donahue, *supra* note 24.

50. *Id.* Opponents argue that assisting death is fundamentally different from withdrawal of treatment. This argument relies on the alleged distinction between killing and allowing a person to die (active as opposed to passive euthanasia). This affects what doctors will do for a patient because the American Medical Association (AMA) condemns mercy killing (active euthanasia), but allows withdrawal of treatment measures for the terminally ill (passive euthanasia). However, in practice, each hastens the death of the patient and is the result of an act or omission. The AMA stated that there is no difference between withdrawal of treatment, an act, and withholding treatment, an omission. Therefore, arguing that there is an ethical distinction between the act of physician assisted suicide as opposed to the omission of letting the patient die after suffering is flawed. Moreover, in *Compassion in Dying v. State of Washington*, the court ruled that from a constitutional perspective, the distinction between refusing treatment and providing physician assisted suicide is hollow under the law. 850 F. Supp. 1454, 1467 (W.D. Wash. 1994), *aff'd*, 79 F.3d 790 (9th Cir. 1996).

51. See *infra* notes 122-49 and accompanying text.

52. Note, *Physician Assisted Suicide and the Right to Die with Assistance*, 105 HARV. L. REV. 2021, 2023 (1992).

53. *Rasmussen v. Flemming*, 741 P.2d 674, 678 (Ariz. 1987).

54. *Superintendent of Belchertown St. Sch. v. Saikewicz*, 370 N.E.2d 417, 424 (Mass. 1977). These cases carved out a sphere where only the patients, not the state or the physician, can decide when they will die.

interference from others.⁵⁵ This idea of self-determination manifests in the tort doctrine of informed consent.⁵⁶ Physicians must obtain informed consent before administering medical treatment.⁵⁷ Thus, a patient's ability to control her bodily integrity also encompasses the corollary—a patient has the right not to consent, or the right to informed refusal of treatment.

Courts began to characterize a patient's right to self-determination as a privacy interest in the 1976 case of *In re Quinlan*.⁵⁸ The New Jersey Supreme Court implicitly determined that when an individual is afflicted with terminal illness that offers no hope of reversal, that person effectively has a right to die.⁵⁹ The decision allowed Karen Quinlan's father to withdraw the respirator that was keeping her alive.⁶⁰ The court held that criminal law could not punish him for the free exercise of her constitutional right of privacy.⁶¹ After *Quinlan*, most courts, physicians, and the public came to accept the idea that patient autonomy, in certain circumstances, extends to life-or-death treatment decisions.⁶²

55. *Union Pacific Ry. v. Botsford*, 141 U.S. 250 (1891).

56. A definition of informed consent is as follows:

Informed consent is a general principle of law that states that a physician has a duty to disclose what a reasonably prudent physician in the medical community in the exercise of reasonable care would disclose to his patient as to whatever risks of injury might be incurred from a proposed course of treatment, so that the patient, exercising ordinary care for his own welfare, and faced with a choice of undergoing the proposed treatment, or alternative treatment, or none at all, may intelligently exercise his judgment by reasonably balancing the probable risks against the probable benefits.

BLACKS LAW DICTIONARY 779 (6th ed. 1990).

57. *See Canterbury v. Spence*, 464 F.2d 772, 780 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); *Cobbs v. Grant*, 502 P.2d 1, 9 (Cal. 1972); *Natanson v. Kline*, 350 P.2d 1093, 1104 (Kan. 1960); *see also* *Schloendorff v. Society of N.Y. Hosp.*, 105 N.E. 92 (N.Y. App. Term 1914) (stating that "every human being of adult years and sound mind has a right to determine what shall be done with his own body"), *overruled on other grounds by* *Bing v. Thunig*, 143 N.E. 2d 3, 10 (N.Y. 1957). "There are three prerequisites for informed consent: the patient must have the capacity to reason and make judgments, the decision must be made voluntarily and without coercion, and the patient must have a clear understanding . . . of the nature of the disease and the prognosis." *In re Conroy*, 486 A.2d 1209, 1222 (N.J. 1985) (quoting *Wanzer et al., The Physician's Responsibility Toward Hopelessly Ill Patients*, 310 NEW ENG. J. MED. 955, 997 (1984)).

58. 355 A.2d 647 (N.J.), *cert. denied sub nom.* *Garger v. New Jersey*, 429 U.S. 922 (1976).

59. *Id.*; *see also* *George P. Smith II, All's Well That Ends Well: Toward a Policy of Rational Suicide or Merely Enlightened Self-Determination?*, 22 U.C. DAVIS L. REV. 275 (1989).

60. *See Quinlan Dies—Decade in a Coma*, USA TODAY, June 12, 1985, at A1, col. 2.

61. *Quinlan*, 355 A.2d at 699-70. This constitutional recognition grew out of the holding of *Griswold v. Connecticut*, which reasoned there was a right of privacy that, although not set forth in the literal wording of the Constitution, was nonetheless an inherent concept derived from many of the first fourteen amendments. 381 U.S. 479 (1965). *Quinlan* and its progeny illustrate that more courts are respecting acts of enlightened self-determination by competent patients to withhold or withdraw life-sustaining medical treatments, even though death may result. *See* *Smith*, *supra* note 59, at 384-408.

62. *See Developments in the Law—Medical Technology and the Law*, 103 HARV. L. REV. 1519, 1643-44 (1990). Since *Quinlan*, the method courts most often use to decide when a person has a right to die

Courts also characterize an individual's right to self-determination as a constitutionally protected due process liberty interest.⁶³ The core notion of due process liberty is that the individual has a right to freedom from governmental interference in personal decisions.⁶⁴ The right to privacy, which state courts often cite as the basis for the right to die, also originates in the idea of individual autonomy.⁶⁵ In *Planned Parenthood of Southeastern Pennsylvania v. Casey*,⁶⁶ the Supreme Court described certain areas of individual choice that are private and protected by the Due Process Clause. They include: matters that involve the most intimate and personal choices an individual makes in a lifetime; and choices that are central to personal dignity and autonomy. These choices are central to the liberty interest protected by the Fourteenth Amendment.⁶⁷ Thus, the essence of liberty is the right to define one's own existence.⁶⁸ Hence, because the Court arguably recognized the right to die in *Cruzan v. Director, Missouri Department of Health*, the liberty interest described in *Casey* extends to assisted suicide.⁶⁹

balances the patient's interest in self-determination against competing state interests in preserving life, protecting third parties, and preserving the ethical image of the medical profession. See Note, *supra* note 52. Using this balancing approach, the courts have recognized the right to die in a number of situations. See *Bouvia v. Superior Court*, 225 Cal. Rptr. 297, 299-300 (Cal. Ct. App. 1986) (finding a right to die where a patient was not terminally ill); *Satz v. Perlmutter*, 379 So. 2d 359, 360 (Fla. 1980) (recognizing a right to die for a patient who is terminally ill); *Brophy v. New England Sinai Hosp.*, 497 N.E.2d 626, 637-38 (Mass. 1986) (right to die in case of "ordinary" care); *Superintendent of Belchertown St. Sch. v. Saikewicz*, 370 N.E.2d 417, 419 (Mass. 1977) (holding a right to die exists for a patient in an incompetent mental state who receives "extraordinary" care); *In re Farrell*, 529 A.2d 404, 407 (N.J. 1987) (right to die recognized for a patient of competent mental state in his home). In general, a competent patient suffering from a terminal illness has a right to die by withholding or withdrawing life-sustaining treatment. See also Note, *supra* note 52, at 2022.

63. See *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 277 (1990); *McKay v. Bergstedt*, 801 P.2d 617, 622 (Nev. 1990). Although *Cruzan* suggested that a right to refuse treatment can be found in the Due Process Clause of the Fourteenth Amendment, the Court did not prohibit the states from recognizing other sources, such as "state constitutions, statutes, and common law." *Cruzan*, 497 U.S. at 277.

64. *Carey v. Population Servs. Int'l*, 431 U.S. 678, 684-85 (1977); *Loving v. Virginia*, 388 U.S. 1, 12 (1967); *Meyer v. Nebraska*, 262 U.S. 390, 399-400 (1923).

65. See, e.g., *In re Quinlan*, 355 A.2d 647, 633 (N.J.), *cert. denied sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976). Privacy rights protect an individual from government interference in fundamental personal decisions, such as those involving family relationships, education, and abortion. See *Roe v. Wade*, 410 U.S. 113, 152-53 (1973); *In re Browning*, 568 So.2d 4, 10 (Fla. 1990) (describing the "fundamental right of privacy" as "the right to be free from intrusion or coercion, whether by the government or by the society at large" (quoting Gerald B. Cope, Jr., *To Be Let Alone: Florida's Proposed Right of Privacy*, 6 FLA. ST. U. L. REV. 671, 677 (1978))).

66. 505 U.S. 833 (1992).

67. Kathy T. Graham, *Last Rights: Oregon's New Death with Dignity*, 31 WILLAMETTE L. REV. 601, 619-20 (1995).

68. *Id.* at 619.

69. 497 U.S. 261 (1990). The right to die also arguably may have been recognized by the federal district court in *Compassion in Dying v. Washington*, 850 F. Supp. 1454 (W.D. Wash. 1994), *aff'd*, 79 F.3d

In *Cruzan*, the Court sustained the state's power to keep Nancy Anne Cruzan, an incompetent patient in a vegetative state, alive over her family's wishes.⁷⁰ The majority opinion assumed that a competent person has a constitutionally protected right to refuse lifesaving nutrition and hydration if the refusal outweighs the interests of the state.⁷¹ Furthermore, in a lone concurring opinion, Justice Scalia analogized a patient's termination of life sustaining medical treatment to "ordinary" suicide.⁷² Thus, the narrow ruling of the Supreme Court in *Cruzan* left the due process limits of future legislatively assisted suicide regulatory schemes undefined.⁷³ Moreover, because the Supreme Court based its *Cruzan* decision on the due process clause, the validity of several lower court decisions before and after *Cruzan* that base their protection of an individual's right to die on a privacy right remains undecided as well.⁷⁴

2. Distinctions Between Physician Assisted Suicide And The Withdrawal Or Refusal Of Treatment Fail

Physician assisted suicide, like the right to die, protects a patient's interest in self-determination.⁷⁵ Terminally ill patients request assistance in committing suicide for the same reason that others request not to have life-

790 (9th Cir. 1996). See Graham, *supra* note 67.

70. *Cruzan*, 497 U.S. at 261. The state of Missouri claimed an interest in sustaining life, regardless of the quality of the life. *Id.*

71. *Id.* at 280. The Court, however, rejected the petitioner's claim that an incompetent person, such as Cruzan, should have the same right. Moreover, although the majority opinion stated that a person has a right, it declined to characterize this right as "fundamental," which would have required the state to offer a compelling justification for the right's restriction (a test the state can rarely satisfy). Instead, the majority characterized the right as a Fourteenth Amendment liberty interest. In doing so, the Court may have implicitly allowed states to restrict this liberty interest upon a lesser showing of need (e.g., any reasonable state interest) than if characterized as a fundamental right. John A. Robertson, *Cruzan and the Constitutional Status of Nontreatment Decisions for Incompetent Patients*, 25 GA. L. REV. 1139, 1174-75 & n.132 (1991). See also Yale Kamisar, *Are Laws Against Assisted Suicide Unconstitutional?*, 23 HASTINGS CTR. REP. 32, 40 n.132 (1993). Kamisar speculates that the Court, in assessing the constitutionality of a ban against assisted suicide, would give great deference to the state legislature. If the legislative scheme "furthered some coherent conception of the public good, that would probably suffice." *Id.* at 40.

72. *Cruzan*, 497 U.S. at 299-300.

73. See also Mark E. Haddad, *Cruzan and the Demands of Due Process*, 8 ISSUES IN L. & MED. 205 (1992).

74. See, e.g., *Rasmussen v. Flemming*, 741 P.2d 674, 682 (Ariz. 1987); *Bouvia v. Superior Ct.*, 225 Cal. Rptr 297, 301 (Cal. Ct. App. 1986); *In re Guardianship of Barry*, 445 So. 2d 365, 371 (Fla. Dist. Ct. App. 1984); *In re Quinlan*, 355 A.2d 647 (N.J.), *cert. denied sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976).

75. *Bouvia*, 225 Cal. Rptr. at 306 (noting that a desire to terminate one's life is probably the ultimate exercise of one's right to privacy).

saving medical treatment: they want control over when and where they die, and their physical and mental state at the time of death.⁷⁶ Thus, unless overriding public policy interests exist,⁷⁷ the principle of self-determination requires the state to respect a patient's judgment about how much pain and suffering she wishes to tolerate before dying.

The current distinction between withdrawal or refusal of treatment and physician assisted suicide fails because no substantive distinctions exist between letting a patient die and assisting a patient's suicide. Dividing a patient's interest in dying between an interest in refusing treatment and an interest in receiving treatment is impossible.⁷⁸ Instead, the patient alone has an interest in controlling what happens to her body.⁷⁹ The right to self-determination, although subject to some higher state interests, does not cease to exist somewhere between having life saving treatment withdrawn and receiving suicide assistance.⁸⁰ In permitting patients to control withdrawal of life-sustaining care, the courts allow patients, in a sense, to commit suicide with the assistance of physicians.⁸¹ Therefore, because this type of physician assisted suicide is permissible, the courts should create similar exceptions in cases where a terminally ill patient requests assistance in the form of prescription drugs.⁸²

76. See, e.g., Timothy E. Quill, *Death and Dignity—A Case of Individualized Decision Making*, 324 NEW ENG. J. OF MED. 691, 693 (1991) (describing a terminally ill patient who chose assisted suicide because "it was extraordinarily important to her to maintain control of herself and her own dignity during the time remaining to her").

77. In *Bouvia*, the court said they did not think it was "the policy of this State that all and every life must be preserved against the will of the sufferer." 225 Cal. Rptr. at 305. The state may have an overwhelming interest in keeping a person alive, but the state interest is not absolute.

78. See Note, *supra* note 52, at 2028.

79. *Id.*

80. *Id.*

81. *Id.*

82. *Id.* Cf. *Bouvia v. Superior Court*, 225 Cal. Rptr. 297, 305 (Cal. Ct. App. 1986) (rejecting the state's argument that a non-terminally ill patient was committing suicide by refusing a feeding tube); *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 299 (1990) (Scalia, J., concurring) (equating withdrawal of medical treatment to suicide). Alternatively, the substituted judgment doctrine—which accepts that a terminally ill individual's right to personal autonomy requires the help of others—combined with the recent cases permitting the withdrawal of life sustaining food and fluids from patients who are not terminally ill but are profoundly disabled, indicates judicial acceptance of translating the right to die by refusing medical treatment into the right to die with or without assistance. Bjorck, *supra* note 36; see, e.g., *In re Gardner*, 534 A.2d 947, 951 (Me. 1987) (holding there was "no reason" to disregard a patient's personal autonomy and allowing withdrawal of food from a patient who was neither terminally ill nor dying based on prior statements of the patient); *In re Guardianship of Doe*, 583 N.E.2d 1263, 1269 (Mass. 1992) (using substituted judgment doctrine by holding that a patient in a persistent vegetative state could refuse treatment that overrode the state's interest in preserving life); *In re Lawrence*, 579 N.E.2d 32, 41 (Ind. 1991) (holding that an incompetent patient could refuse nutrition and hydration because "respect for patient autonomy does not end when the patient becomes incompetent"). See generally Bjorck *supra* note 36.

D. The Current Legal Status Of Physician Assisted Suicide

The divergence of laws regarding assisted suicide has led to confusion and disorder.⁸³ Physician assisted suicide legislation is currently under consideration in several states, and many challenges to assisted suicide measures and actions are in the courts.⁸⁴ Recent case law in Michigan, Oregon, Washington and New York dealt directly with physician assisted suicide issues yet failed to develop a coherent judicial consensus.

The treatment of Dr. Jack Kevorkian and the issue of physician assisted suicide in Michigan illustrates that states must expressly address the need for laws legalizing physician assisted suicide for the terminally ill. Dr. Kevorkian began assisting individuals with their suicide requests in 1990.⁸⁵ In response,

83. Twenty-five states have statutes expressly prohibiting assisted suicide: ALASKA STAT. § 11.41.120(a)(2) (1992); ARIZ. REV. STAT. ANN. § 13-1103A.3 (1991); ARK. CODE ANN. § 5-10-104(a)(2) (Michie 1992); CAL. PENAL CODE § 401 (Deering 1993); COLO. REV. STAT. § 18-3-104(1)(b) (1993); CONN. GEN. STAT. § 53a-56(a) (1993); DEL. CODE ANN. tit. 11, § 645 (1987 & Supp. 1992); FLA. STAT. ANN. § 782.08 (West 1992); KAN. STAT. ANN. § 21-3406 (1988); ME. REV. STAT. ANN. tit. 17-A, § 204 (West 1992); MINN. STAT. § 609.215 (1987 & Supp. 1992); MISS. CODE ANN. § 97-3-49 (1991); MONT. CODE ANN. § 45-5-105 (1991); NEB. REV. STAT. § 28-307 (1989); N.H. REV. STAT. ANN. § 630:4 (1991); N.J. REV. STAT. § 2C:11-6 (1991); N.M. STAT. ANN. § 30-2-4 (Michie 1992); N.Y. PENAL LAW § 120.30 (Consol. 1992); N.D. CENT. CODE § 12.1-16-04 (1991); OKLA. STAT. tit. 21, § 813 (1991); OR. REV. STAT. § 163.125 (1)(b) (1991); 18 PA. CONS. STAT. § 2505(B) (1990); S.D. CODIFIED LAWS ANN. § 22-16-37 (1992); TEX. PENAL CODE ANN. § 22.08 (West 1989); WIS. STAT. § 940.12 (1989-1990). The remaining 25 states do not have legislative provisions that mention assisted suicide. Thus, confusion erupts when the situation occurs, demonstrating the need for the United States to come to terms with the issue of assisted suicide in the very near future.

84. For example, in California, where assisted suicide is presently a felony, Proposition 161, which would have legalized physician assisted suicide, was on the ballot in November 1992. Proposition 161 was a proposed amendment to CAL. PENAL CODE § 401 (1992). Although the measure was defeated by a margin of only 8%, 46% of the voters voted for Proposition 161. Those who did not vote for the measure cited mainly religious reasons or concerns that the proposed law was flawed. In fact, many of the opponents believed it was lacking safeguards against abuse and needed more restrictions, such as a waiting period and a psychological exam. However, many in California assert that although Proposition 161 was defeated, the issue was not. California doctor Ronald Koons believes that "it is only a question of time before some form of doctor-assisted suicide is law." See Bjorck, *supra* note 36, at 385. Indeed, many supporters cite disproportionate campaign funding as the main reason for the measure's defeat. The Roman Catholic Church and the medical establishment bombarded voters at the last hour with a media blitz that proved effective. Yet despite these well funded opposition messages, a significant number of California voters, 4,557,037 in all, approved the idea of making assisted suicide legal. See *id.* at 384-86. Moreover, in Florida, a challenge to the state's ban on assisted suicide was filed in early 1996. See *id.* at 384-85.

85. In 1990, Dr. Kevorkian helped his first patient, Janet Adkins, who was suffering from Alzheimer's, by providing and explaining the use of his suicide machine which allowed her to "intentionally self administer" a lethal dosage of drugs. As a result, he was charged with first-degree murder. The charges were later dropped because Michigan did not have any specific law prohibiting physician assisted suicide. Dr. Kevorkian has continued to assist others in committing suicide. See Bjorck, *supra* note 36, at 380. He asserts he is on a crusade for the right of terminally ill people to end their lives on their own terms. Dr. Kevorkian himself argues that he will defy any law designed to stop him:

the Michigan House of Representatives voted in November 1992 that assisted suicide was a felony and passed a temporary law aimed at stopping Dr. Kevorkian.⁸⁶ Dr. Kevorkian was charged under the law in 1993.⁸⁷

In *People v. Kevorkian*,⁸⁸ the trial court held that decisional privacy includes, in some circumstances, a constitutional right to commit suicide. The court found *Casey's*⁸⁹ reasoning that the Fourteenth Amendment liberty interest includes "the right to define one's own concept of existence" instructive.⁹⁰ The court invalidated the prohibition on assisted suicide, holding that an individual's interest in dying trumps the state's interest in preventing suicide.⁹¹

The Michigan Supreme Court in *People v. Kevorkian*⁹² reversed this

The Nuremberg Tribunal said the first thing you do is check the morality of the law and if it's immoral, you disobey it. Ladies and Gentlemen, I do that. You pass any law against assisted suicide . . . and I will disobey it. I state it openly. Because it is immoral medically. I follow the Nuremberg Tribunal. Have you got a higher one to overcome that? To supersede it? No.

Don Gonyea, *Prosecutor Expects Suicide Doctor to be Acquitted Again*, CNN: MORNING EDITION, Feb. 15, 1996, available in LEXIS, Nexis Library, News file. When asked his thoughts recently on physician assisted suicide, Dr. Kevorkian stated "It may be immoral, it may be unethical, it may be a sin, but it's not a crime!" *Headline News* (CNN television broadcast, Feb. 24, 1996). At the time of this writing, Dr. Kevorkian had been acquitted five times of criminal charges for assisting death. Jeff Stryker, *A Bedside Manner for Death and Dying*, N.Y. TIMES, May 19, 1996, § 4, at 3. Kevorkian has also continued to assist suicides, *Emboldened, Dr. Kevorkian Speeds Up*, ST. PETERSBURG TIMES, June 22, 1996, at A1. In a recent suicide he attended the patient was not terminally ill but suffered from a debilitating muscle illness. Thomas Maier, *Kevorkian Case Ruled a Homicide*, NEWSDAY, Aug. 27, 1996, at A08.

86. B.D. Colen, *Gender Question in Assisted Suicide*, NEWSDAY, Nov. 25, 1992, at 17. Kevorkian called the new law "immoral" and refused to obey it, assisting others since its passage. *Suicide Doctor Helps Two More End Lives*, Reuters, Dec. 15, 1992, available in LEXIS, Nexis News Library, REVNA file. Critics of the law assert that it takes away individual freedom of choice. See Bjorck, *supra* note 36, at 382.

87. *Kevorkian Faces Charge That Will Test Suicide Law*, DALLAS MORNING NEWS, Aug. 18, 1993, at A1. On Mar. 9, 1996, a jury acquitted Kevorkian of violating a Michigan law banning assisted suicide for the second time. The measure was written specifically to stop Kevorkian. After the verdict Kevorkian said: "This is not a victory for me but for all who are suffering. This is not for me, but for the very essence of human existence. And let me give you a promise: what I do will always be for human welfare. I will not abuse it." Jack Lessenberry, *Kevorkian Again Not Guilty of Aiding Suicide*, N.Y. TIMES, Mar. 9, 1996, at 7.

88. No. 93-11482, 1993 WL 603212 (Mich. Cir. Ct. Dec. 13, 1993), *rev'd sub nom.* Hobbins v. Attorney Gen., 518 N.W.2d 487 (Mich. Ct. App. 1994), *aff'd in part and rev'd in part sub nom.* *People v. Kevorkian*, 527 N.W.2d 714 (Mich. 1994), *cert. denied*, 115 S. Ct. 1795 (1995).

89. 505 U.S. 833 (1992).

90. *People v. Kevorkian*, 1993 WL 603212 at *13 (quoting *Planned Parenthood v. Casey*, 505 U.S. at 851 (1992) (joint opinion of O'Connor, Kennedy, and Souter, J.J.)).

91. *Id.* at *19-*20.

92. *People v. Kevorkian*, 527 N.W.2d 714 (Mich. 1994), *cert. denied*, 115 S. Ct. 1795 (1995). The Michigan Court of Appeals also disagreed with the trial court ruling in *Hobbins v. Attorney Gen.*, 518 N.W.2d 487 (Mich. Ct. App.), *aff'd in part and rev'd in part sub nom.* *People v. Kevorkian*, 527 N.W.2d 714 (Mich. 1994), *cert. denied*, 115 S. Ct. 1795 (1995). Here, the court considered the claims of two terminally ill persons who argued that the Michigan law violated their constitutional rights and a similar claim by Dr. Kevorkian. The court held that "the scope of rights encompassed by the concept of ordered

ruling one year later. The court majority conducted a historical inquiry and found no historical approval of suicide. In addressing the liberty interest claim, the court held that the claim was internally incoherent because recognizing human dignity by measuring the value of a person's life on the basis of her physical and mental condition is impossible.⁹³ Hence, the right of personal autonomy is nonexistent because it requires a recognition of human dignity.⁹⁴ The court further argued that because all persons have a right to personal autonomy, regardless of mental or physical condition, all people would have a right to suicide, not only the terminally ill.⁹⁵ Although the majority found the liberty interest argument unpersuasive, the dissent advocated a test balancing the interest of those seeking a painless and prompt death against the public interest in preventing suicide assistance.⁹⁶

In *Quill v. Koppell*,⁹⁷ Dr. Timothy Quill⁹⁸ and two other physicians challenged a New York law criminalizing assisted suicide. The physicians relied on *Casey*⁹⁹ and *Cruzan*,¹⁰⁰ arguing that a patient's liberty interest includes the right to die.¹⁰¹ The New York appellate court disagreed, holding that the physicians read *Casey* and *Cruzan* too broadly, and found no liberty interest mandating a recognition of assisted suicide.¹⁰²

In *Compassion in Dying v. State of Washington*,¹⁰³ the plaintiffs¹⁰⁴ asked the court to overturn a Washington statute criminalizing assisted suicide.¹⁰⁵ The court held that the total ban on physician assisted suicide violated the

liberty does not include the right to commit suicide, much less the right to assisted suicide. . . . [A] right to terminate one's life is not a logical extension of the catalog of rights [already recognized]." *Id.* at 492.

93. *People v. Kevorkian*, 527 N.W.2d at 727 n.41.

94. *Id.*

95. *Id.*

96. *Id.* at 727 n.37.

97. 870 F. Supp. 78 (S.D.N.Y. 1994).

98. Dr. Quill created headlines when he published his account of helping his patient, Diane, commit suicide in the *New England Journal of Medicine*. *Suicide Assistance Gains New Backing*, N.Y. TIMES, Nov. 5, 1992, at A32. Quill admitted he assisted but retained his medical license after appearing before a panel of his peers on an ethics charge. *Id.* Quill also faced a criminal indictment for this assistance, but the grand jury refused to indict him even in the face of a New York law against assisted suicide. See Bjorck, *supra* note 36, at 387. These incidents illustrate that there is some public acceptance of physician assisted suicide.

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

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

101. *Quill*, 870 F. Supp. at 83. See also *Casey*, 505 U.S. at 83; *Cruzan*, 497 U.S. at 261; *Roe v. Wade*, 410 U.S. 113 (1973).

102. *Quill*, 870 F. Supp. at 83.

103. 850 F. Supp. 1454 (W.D. Wash. 1994), *aff'd*, 79 F.3d 790 (9th Cir. 1996) (en banc).

104. The plaintiffs included three terminally ill patients, five physicians who routinely treat the terminally ill, and Compassion in Dying, a support organization that provides counseling and assistance to competent, terminally ill adults considering suicide. *Id.* at 1456.

105. *Id.*

plaintiffs' liberty interest protected under the Due Process Clause to choose when to end their own lives.¹⁰⁶ Thus, the court held that "a competent, terminally ill adult has a constitutionally guaranteed right under the Fourteenth Amendment to commit physician assisted suicide."¹⁰⁷ The court analogized this right to the liberty interest recognized in *Casey*,¹⁰⁸ and concluded that both involve "the most intimate and personal choices a person, may make in a lifetime . . . choice[s] central to personal dignity and autonomy."¹⁰⁹ Moreover, the court followed *Cruzan's*¹¹⁰ recognition of a terminally ill patient's liberty interest in refusing unwanted medical treatment.¹¹¹

The Ninth Circuit initially reversed the *Compassion in Dying* decision.¹¹² As in the Michigan cases, the Ninth Circuit found that the extension of privacy rights beyond *Casey* was "an unwarranted extension of abortion jurisprudence."¹¹³ The court considered the *Cruzan* precedent unpersuasive, and found a distinction between the refusal of medical treatment and physician assisted suicide.¹¹⁴

Subsequently, in November 1994, Measure 16, the Death with Dignity Act, passed in Oregon, thereby legalizing physician assisted suicide.¹¹⁵ Although the measure had been approved by the voters, a federal district court judge enjoined the state from enforcing the Act.¹¹⁶ The district court

106. The court found that the ban on assisted suicide "places an undue burden on the exercise of a constitutionally protected liberty interest." *Id.* at 1465.

107. *Id.* at 1462.

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

109. *Compassion in Dying*, 850 F. Supp. at 1460 (quoting *Casey*, 505 U.S. at 851).

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

111. *Compassion in Dying*, 850 F. Supp. at 1462. The holding in *Cruzan* that a competent person has a right to refuse medical treatment allowed the court to extend the Due Process Clause to protect the liberty interests of patients who choose death over further medical treatment for terminal illness. *Id.* at 1461.

112. *Compassion in Dying v. State of Wash.*, 49 F.3d 586 (9th Cir. 1995), *rev'd*, 79 F.3d 790 (9th Cir. 1996) (en banc) (holding that *Casey* and *Cruzan* provide a constitutionally recognized right to die that overrides a state interest in preserving life when a competent, terminally ill person wishes to end his or her life with the assistance of a physician).

113. *Id.* at 591. Writing for a 2-1 majority, Judge John Noonan stated: "If at the heart of the liberty protected by the Fourteenth Amendment is this uncurtailable ability to believe and act on one's deepest beliefs about life, the right to suicide and the right to assistance to suicide are the prerogative of at least every sane adult." *Id.*

114. *Id.* at 593.

115. The Act gives terminally ill, adult patients the choice of obtaining a physician prescription for a lethal dose of medication to end their lives. Measure 16, Death with Dignity Act.

116. *Lee v. Oregon*, 869 F. Supp. 1491 (D. Or. 1994). Plaintiffs claimed Measure 16 violates the Equal Protection and Due Process Clauses of the Fourteenth Amendment, the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973. *Id.* at 1493. Health care providers argued that the Act violates the First Amendment rights of freedom to exercise religion because their religious beliefs could be violated if

held the Act unconstitutional on equal protection grounds.¹¹⁷ The court expressed concern about the lack of procedure for determining whether a patient is competent to choose assisted suicide.¹¹⁸ The court also criticized a safety provision in the Act because it required the treating physician to evaluate the patient and perform all other responsibilities under a reasonable standard of care used for all patients instead of a heightened standard of care.¹¹⁹ As a result, the court held that Measure 16 withholds from the terminally ill the same protections from suicide that are enjoyed by the majority.¹²⁰ The court reasoned that although the suffering of the terminally ill is the basis of a compassionate argument for physician assisted suicide, these “good results” are not sanctioned under a system that fails to provide safeguards against the premature death of terminally ill patients who want to live.¹²¹

However, shortly thereafter, two federal appeals courts sent shock waves through the medical and legal communities by striking down state bans on physician assisted suicide.¹²² On March 6, 1996, the Ninth Circuit Court of Appeals ruled that a key provision of a Washington statute banning physician assisted suicide is an unconstitutional violation of the Due Process Clause of the Fourteenth Amendment.¹²³ The court overturned the earlier ruling by a three-judge panel of the Ninth Circuit that upheld the prohibition¹²⁴ and affirmed the 1994 decision by the United States District Court for the Western District of Washington.¹²⁵

The Ninth Circuit identified a broad constitutional right in allowing

they were forced to allow physician assisted suicide on their premises even though their religious beliefs prohibit it. *Id.* at 1493, 1500.

117. *Lee v. Oregon*, 891 F. Supp. 1429 (D. Or., 1995). The court held it was not necessary to decide the motions related to the other claims. *Id.* at 1437.

118. *Id.* at 1438. The court questioned the lack of a requirement for an additional evaluation by a mental health specialist. *Id.*

119. *Id.*

120. *Id.* The court seemed to indicate that if Measure 16 could limit “rational suicide” to the “hard cases” it would pass harsh scrutiny under the equal protection argument. *Id.*

121. *Id.* at 1438-39.

122. Legal and medical experts assert that the two rulings indicate a historical shift in judicial opinion on an issue that has become highly controversial. Arthur Caplan, director of the Center for Bioethics at the University of Pennsylvania, argues that legalization of physician assisted suicide should be established but believes that the process will take decades instead of resulting from a “sea change—overnight—in public policy. . . .” Frank Bruni, *Court Overturns Ban in New York on Aided Suicides; U.S. Court Clears Way for Doctors in New York to Aid in Some Suicides*, N.Y. TIMES, Apr. 3, 1996, at A1.

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

124. See *supra* notes 112-14 and accompanying text.

125. See *supra* notes 103-11 and accompanying text.

physician assisted suicide.¹²⁶ The court analogized abortion and other right-to-die cases to the issues raised in physician assisted suicide because those areas also “arouse similar religious and moral concerns” and “present basic questions about an individual’s right of choice” in determining if there is a liberty interest in the time and manner of one’s death.¹²⁷ Following *Roe v. Wade*,¹²⁸ *Casey*,¹²⁹ and *Cruzan*,¹³⁰ the court ruled that a liberty interest in controlling the time and manner of one’s death is protected by the Due Process Clause of the Fourteenth Amendment because abortion, right-to-die and physician assisted suicide cases all involve “decisions that are highly personal and intimate, as well as of great importance to the individual.”¹³¹

After determining that a liberty interest was at stake, the court weighed the extent to which the state could limit the “constitutionally recognized ‘right to die’” for terminally ill patients.¹³² Although the court recognized six primary state interests in opposing physician assisted suicide, the court did not find those interests, singly or as a whole, sufficiently compelling to offset the liberty interest in determining how to end one’s own life.¹³³ The court found that the state’s interests in preventing physician assisted suicide are no stronger than in other forms of death-hastening medical intervention.¹³⁴ Thus, by permitting an individual to exercise a right to physician assisted suicide,

126. Judge Reinhardt’s majority opinion in *Compassion in Dying*, 79 F.3d at 793, acknowledged the complex legal and ethical issues posed by the decision: “It requires us to confront the most basic of human concerns—the morality of self and loved ones—and to balance the interest in preserving human life against the desire to die peacefully and with dignity.”

127. *Id.* at 801.

128. 410 U.S. 113 (1973).

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

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

131. *Compassion in Dying*, 79 F.3d at 813. The court noted that prohibiting a terminally ill patient from hastening his death could have a more profound impact on life than forcing a woman to carry a pregnancy to term. The court argued that for terminally ill patients “wracked by pain and deprived of all pleasure, a state-enforced prohibition on hastening their deaths condemns them to unrelieved misery or torture.” *Id.* at 814.

132. *Id.* at 816.

133. *Id.* at 816-20. The six state interests noted by the court are: 1) a general interest in preserving life; 2) a more specific interest in preventing suicide; 3) an interest in avoiding the involvement of third parties and in precluding the use of arbitrary, unfair, or undue influence; 4) an interest in protecting family members and loved ones; 5) an interest in protecting the integrity of the medical profession; and 6) an interest in avoiding adverse consequences that might ensue if the statutory provision at issue is declared unconstitutional. *Id.* at 816-17.

134. *Id.* at 833. The court noted that in *Cruzan*, the states did have a legitimate role to play in regulating the process of refusing or terminating life-sustaining treatment; however, this role does not extend to prohibition. The court noted that the guiding principle is found in the words of Justice O’Connor: “[T]he more challenging task of crafting appropriate procedures for safeguarding . . . [terminally ill patients]’ liberty interests is entrusted to the ‘laboratory’ of the states in the first instance.” *Id.* (quoting *Cruzan*, 497 U.S. at 287, 292 (O’Connor, J., concurring) (internal citation omitted)).

the court said “we are following the constitutional mandate to take such decisions out of the hands of the government, both state and federal, and to put them where they rightly belong, in the hands of the people.”¹³⁵ The court concluded by asserting that neither the state nor a majority of its people can impose upon the individual a ban that is offensive to “personal dignity and autonomy.”¹³⁶

Unlike the Ninth Circuit, the Second Circuit declined to decide the issue under a right-to-privacy analysis. Instead, the Second Circuit held that bans on physician assisted suicide could not be maintained because allowing some terminally ill people to disconnect life-support systems while forbidding others to end their lives with physician prescribed medication amounts to irrational and unlawful discrimination under the Equal Protection Clause of the Constitution.¹³⁷ The court overruled a New York appellate court ruling that had decided the issue under Fourteenth Amendment liberty interest analysis.¹³⁸ The Second Circuit, like the New York appellate court before it, declined to extend the rulings in *Roe*,¹³⁹ *Casey*,¹⁴⁰ and *Cruzan*¹⁴¹ to the case of physician assisted suicide.¹⁴² Instead, the court applied an equal protection analysis to the New York statutes that banned physician assisted suicide.¹⁴³

The court noted that the right of competent, terminally ill patients to refuse medical treatment had long been recognized in New York, and extended to

135. *Id.* at 839.

136. *Id.* (quoting *Casey*, 505 U.S. at 351.) The court also concluded that persons who believe strongly that physician assisted suicide is wrong cannot force this belief on all the other members of society and compel those “whose values differ with theirs to die painful, protracted, and agonizing deaths.” *Id.*

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

138. *See supra* notes 97-102 and accompanying text.

139. 410 U.S. 113.

140. 505 U.S. 833.

141. 497 U.S. 261.

142. The court argued that the Supreme Court has been “reluctant to . . . expand this particular list of federal rights, and it would be most speculative for a lower court to do so.” The court found that there was no cognizable basis for the right to physician assisted suicide in the Constitution’s language or design. Therefore, it did not identify a new fundamental right in absence of clear direction from the Supreme Court. *Quill*, 80 F.3d at 724.

143. The court found the following:

1) the statutes in question fall within the category of social welfare legislation and are therefore subject to rational basis scrutiny upon judicial review; 2) New York law does not treat equally all competent persons who are in final stages of fatal illness and wish to hasten their deaths; 3) the distinctions made by New York law with regard to such persons do not further any legitimate state purpose; and 4) accordingly, to the extent that the statutes in question prohibit persons in the final stages of terminal illness from having assistance in ending their lives by the use of self-administered, prescribed drugs, the statutes lack any rational basis and are violative of the Equal Protection Clause.

Id. at 727.

the right to refuse life-support systems.¹⁴⁴ The court reasoned that the Supreme Court approved this idea in *Cruzan*,¹⁴⁵ stating “[t]he principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions.”¹⁴⁶ The court concluded that New York law does not treat similarly circumstanced people alike, arguing that terminally ill people are treated differently depending on if they have life-support systems attached to them when they seek to hasten their deaths.¹⁴⁷ The court argued by analogy that the withdrawal of life support was no more natural than writing a prescription to hasten death.¹⁴⁸ Finally, the court suggested that the state had no interest “in requiring the prolongation of a life that is all but ended,” and asserted that the state interest lessens as the potential for life diminishes.¹⁴⁹

E. Application Of Law In The United States

For ANJ, living in America today would mean that in most states she could not legally have her physician assist in her death. Case law illustrates a strong argument for the right to physician assisted suicide; however, most courts have struck down proposals because of slippery slope concerns.¹⁵⁰ Although the Second and Ninth Circuits have held that states cannot ban physician assisted suicide, until the Supreme Court squarely addresses the

144. The court relied on Justice Cardozo, who wrote that “[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body” in *Scholendorff v. Society of N.Y. Hosp.* 105 N.E. 92, 93 (N.Y. App. Term 1914), *overruled on other grounds* by *Bing v. Thunig*, 143 N.E.2d 3, 10 (N.Y. 1957), and on the holding of *In re Eichner*, 420 N.E.2d 64 (N.Y.), *cert. denied*, 454 U.S. 858 (1981), which established that a terminally ill patient had a right to withdraw life sustaining treatment.

145. 497 U.S. 261.

146. *Quill*, 80 F.3d at 728 (quoting *Cruzan*, 497 U.S. at 278).

147. *Id.* at 729.

148. The court wrote:

The withdrawal of nutrition brings on death by starvation, the withdrawal of hydration brings about death by dehydration, and the withdrawal of ventilation brings upon death by respiratory failure. By ordering the discontinuance of these artificial life sustaining processes or refusing to accept them in the first place, a patient hastens his death by means that are not natural in any sense. . . . Moreover, the writing of a prescription to hasten death, after consultation with a patient, involves a far less active role for the physician than is required in bringing about death through asphyxiation, starvation and/or dehydration. . . . The ending of life by these means is nothing more nor less than assisted suicide. It simply cannot be said that those mentally competent, terminally-ill persons who seek to hasten death but whose treatment does not include life support are treated equally.

Id. at 729.

149. *Id.* The court also accepted the idea from *Casey* that the state has no right to interfere in a mentally competent patient’s right to “define [his] own concept of existence, of meaning, of the universe, and of the mystery of human life.” *Id.* at 730 (quoting *Casey*, 505 U.S. 833, 851 (1992)).

150. See *supra* notes 83-121 and accompanying text.

issue, these recent decisions will be called into question. ANJ's best alternative is to find a physician, such as Dr. Quill or Dr. Kevorkian, who will assist her illegally.¹⁵¹

III. DUTCH TREATMENT OF PHYSICIAN ASSISTED SUICIDE

The Netherlands openly practices physician assisted suicide.¹⁵² Assisted suicide is illegal according to the Penal Code of the Netherlands.¹⁵³ However, Dutch law recognizes the growing need for the practice and will not prosecute physicians who follow a strict procedure required by the Royal Dutch Medical Association (RDMA).¹⁵⁴ The RDMA and other health officials believe the best control for physician assisted suicide is through "legalization and openness."¹⁵⁵ Dutch physicians do not advocate assisted suicide as a treatment option; it is considered only when all other options for the terminally ill patient are exhausted.¹⁵⁶ Instead, physicians first actively attempt to change the painful circumstances for the patient.¹⁵⁷ Also, Dutch physicians do not immediately comply with a patient's request; physicians must participate in a time-consuming process that tests the patient's desire to have the request fulfilled.¹⁵⁸ Further, at the last moment the Dutch physician must reconfirm the request before handing over the medication.¹⁵⁹

151. In the United States, anecdotal evidence suggests that assisted suicide is infrequently but increasingly being committed, particularly by patients with AIDS. David Ormlicher, *Physician Participation in Assisted Suicide*, 262 JAMA 1844 (1989).

152. The Netherlands has a worldwide reputation for tolerant policies on controversial issues such as drug use, prostitution, abortion and euthanasia. Critics interpret this as a loss of fundamental values that invariably leads to the disintegration of society. However, examining the Dutch physician assisted suicide procedures allows the United States to learn from the mistakes and build on the successes of the Dutch system.

153. See FURROW ET AL., *supra* note 29, § 17-70 (citing Penal Code § 293 (Neth.)).

154. Judy Siegel-Itzkovich, *A Dutch Crime Without Punishment*, JERUSALEM POST, May 14, 1995, at 5.

155. See Bjorck, *supra* note 36. Some Dutch commentators argue that physician assisted suicide does not occur more often in the Netherlands than in any other nation; the difference is that the Dutch are willing to speak about it openly and honestly. See Furrow, *supra* note 29, § 17-70.

156. Most Dutch physicians consider the Hippocratic oath outdated in the case of terminally ill patients. They say the only way to help the suffering patients is to assist them in their requests to die. However, Dr. Pieter Admiraal, considered the medical father of the Dutch euthanasia movement, asserts that physician assisted suicide is the last option but that it must be an option. See O'Keefe, *supra* note 17.

157. Dr. Admiraal explained "First what a doctor should do is try and change the circumstances. If it's pain, send him to a pain specialist. If the man is lonely, find him terminal care at a home." *Id.*

158. Dr. Frits Schmidt argues physician assisted suicide "is not something you do in the afternoon. It takes weeks and months. There is lots of talking. You see the patient is in [a] lot of pain. He desperately wants to die. It's not his wife or his neighbor. It's him. He must say 'I want to die, I want to die, I want to die.' There can be no alternatives. Then there can be a moment when as a doctor you say, 'I will help.'" *Id.*

159. "At the final moment, I still say, 'Do you still want to die?' He can always say, 'Not now.'" *Id.*

This process reflects the Dutch view that if medical technology can create and extend life, it should prepare to end it as well.¹⁶⁰ In the Netherlands, the role of a physician is best understood not as the guardian of life, but as the healer of personal life wishes.¹⁶¹ Moreover, most Dutch physicians do not see physician assisted suicide as an abandonment of their religious faith. Instead, the desire to help ease or end the suffering of the terminally ill patient is of utmost importance to most Dutch physicians.¹⁶²

A. Dutch Procedure For Physician Assisted Suicide

In the 1973 *Leewarden* case,¹⁶³ the Dutch high court excluded physicians who assisted patients from criminal sanctions if they carefully and prudently followed the guidelines of the RDMA.¹⁶⁴ The court found the doctrine of “force majeure,” something that compels the physician to act, persuasive.¹⁶⁵ The *Leewarden* decision illustrated the Dutch consensus that physicians should not endeavor to prolong life under all circumstances.¹⁶⁶

The RDMA guidelines standardized the physician assisted suicide procedure in 1990.¹⁶⁷ The Minister of Justice agreed with the guidelines in

160. *Id.*

161. Dr. Rob Dillman of the RDMA says physician assisted suicide “can best be understood as healing life, healing personal life, healing personal wishes.” *CNN: The Fight to Die, Part Three—The Dutch Experience* (CNN television broadcast, Aug. 19, 1995). Personal life wishes refers to the desires of the patient for her personal autonomy.

162. In the Netherlands, the majority of the population is Catholic. However, religious interests are secondary to the interests of the patient. Dr. Ben Crul believes “you have to help people. Who—who are you to tell a patient, tell a person, ‘you have to suffer some more weeks.’ I don’t believe in a God who would say, ‘Well, no, you have to go on suffering for two more weeks.’” *Id.*

163. *The Dutch Way of Death; Euthanasia is Accepted But It’s Not Easy*, WASH. POST, Jan. 31, 1995, at B01. The District Attorney brought a suit against a doctor who terminated the life of her severely ill mother. The court issued a suspended sentence. *Id.*

164. Johannes J.M. van Delden, *The Rummelink Study: Two Years Later; Assisted Suicide*, 23 HASTINGS CTR. REP. 24, 25 (1993).

165. *Id.* The doctor must be involved in a case of force majeure—in which he or she is forced by a patient’s unbearable suffering to violate the law. “It’s just like driving faster than the speed limit to take your wife to the hospital to give birth. You know it’s illegal, but its urgent that you do it. It’s force majeure.” See Siegel-Itzkovich, *supra* note 154.

166. *Id.*

167. To escape prosecution the physician must meet several criteria of due care:

1. a voluntary request of the patient;
2. a well-informed and well-considered request;
3. a durable wish;
4. unacceptable suffering without alternatives for relief;
5. consultation of a colleague.

See van Delden, *supra* note 164.

1990.¹⁶⁸ In 1991, amendments to the Burial Act included a four step notification procedure for cases of assisted suicide.¹⁶⁹ Thus, the notification procedure for assisted suicide has statutory authority, even though the unrevised Penal Code does not legally permit physician assisted suicide.¹⁷⁰ In August of 1995, the RDMA issued revised guidelines, which favor physician assisted suicide over euthanasia through lethal injection.¹⁷¹ The revisions aim to alleviate the emotional stress physicians felt when performing euthanasia and to clarify the responsibility of physician and patient throughout the process.¹⁷²

B. Lessons From Dutch Physician Assisted Suicide Practices

Although the RDMA intended for physicians to assist only terminally ill patients in immense and incurable pain, the original guidelines have extended to encompass other groups of patients.¹⁷³ In 1994, the Dutch High Court

168. *Id.*

169. *Id.*

170. *Id.*

171. *Dutch Group Favors Distancing Doctors from Euthanasia*, 38 AM. MED. NEWS 12 (1995).

172. *Id.* The revisions include three parts:

- 1) Any physician who takes part in euthanasia should have, where possible, patients administer the fatal drug to themselves rather than by injection or through an IV. This makes death the patients' decision, and they take responsibility for the action. The change is a reflection of physicians expressing moral concerns with the decision making process at the time of death;
- 2) The consulting physician must not have a professional or family relationship with the primary physician. This is not a matter of ill will, but since every physician becomes involved with a patient, a fresh perspective is good;
- 3) When a physician is opposed to euthanasia, that doctor must put the requesting patient in touch with someone who does not have a moral objection to the practice.

Marlise Simons, *Dutch Doctors to Tighten Rules on Mercy Killings*, N.Y. TIMES, Sept. 11, 1995, at A3.

A leading Dutch attorney thinks that physician assisted suicide will eventually take the place of active euthanasia. *Id.* Also, a spokesman for the RDMA, Roelof Mulder, stated that the new emphasis on patient responsibility aims to alleviate the emotional stress the physician experiences. "The responsibility for requesting lies with the patients, and they should be held responsible for carrying out the practice as much as possible. . . ." *Dutch Group Favors Distancing Doctors from Euthanasia*, 38 AM. MED. NEWS 12 (1995). Critics and proponents of physician assisted suicide in the Netherlands welcomed the revisions. Karel Gunning of the anti-euthanasia Dutch Doctors Union supports revisions stating that "if our society decides that killing patients is all right, then the doctors should be the last people able to do so." A physician in favor of physician assisted suicide agreed, saying that because patients administer the practice, "doctors might be more prepared to grant their wishes." *Id.*

173. Critics argue that the Netherlands has given in to death on demand. They cite the following: the *Assen* case, see *infra* notes 174-75 and accompanying text (a man who was HIV positive, but not yet suffering the physical symptoms of the disease was given suicide assistance by his physician because he was afraid of developing AIDS), and babies born mentally retarded or with birth defects euthanized in their cribs at the parents' request. Wesley J. Smith, *Sliding Down Euthanasia's Slippery Slope*, LEGAL TIMES, June 13, 1994, at 26. A recent Dutch court dismissed a murder charge against a doctor accused of killing a severely

found no criminal liability for a physician who assisted a severely depressed but otherwise healthy woman to end her life.¹⁷⁴ The court equated the patient's severe psychic pain to severe physical pain, thereby freeing the physician from criminal prosecution despite his departure from the guidelines.¹⁷⁵ As a result, opponents argue the Netherlands has headed down a slippery slope.

Furthermore, critics contend that the request requirement and the other RDMA guidelines are not always followed by the physician.¹⁷⁶ For example, in 1990 the Rummelink Report¹⁷⁷ disclosed 1000 cases of involuntary euthanasia¹⁷⁸ in the Netherlands.¹⁷⁹ Opponents fear that there are a substantial

deformed baby girl. The court ruled he had no choice. Although he did not meet the formal guidelines, "he had no choice but to end the infant's life after the medical treatment proved futile." The infant had Trisomy 13 syndrome, and experts testified that she was in severe pain and would not live until her first birthday. *Court Throws Out Murder Charge*, ST. LOUIS POST DISPATCH, Nov. 14, 1995 at A6.

174. Herbert Hendin, *Seduced By Death: Doctors, Patients and The Dutch Cure*, 10 ISSUES IN L. & MED. 123 (1994). In 1993, a court of three judges in the town of Assen acquitted a psychiatrist who assisted a woman in suicide. The woman had been abused by her husband, lost her two sons, was recently divorced and very depressed when she ended her life. She did not respond to counseling and refused medication. Her physician consulted with 7 colleagues, and they decided her prognosis was dim. He assisted her by giving her pills with which to kill herself. This was the first reported instance of a physician assisting a depressed but otherwise healthy patient. *Id.* In 1985, Dr. Pieter Admiraal was tried for killing a young woman with multiple sclerosis who, although suffering, was not terminally ill. The charges were dismissed because the act fell within the criteria developed by a High Court, specifically that the disability, although not fatal, was incurable. Michael Fumento, *What the Dutch Can Teach Us About Euthanasia*, WASH. TIMES, Mar. 19, 1995, at B3.

175. This case substantiates slippery slope concerns. Anastasia Toufexis, *Killing the Psychic Pain*, TIME, July 4, 1994, at 61. Moreover, a man with AIDS successfully committed suicide through physician assistance. Although he was HIV positive, he was not in pain. He expressed fear of the pain in the future. *See Smith, supra* note 173.

176. Dutch physicians were not requested to assist sick and deformed newborns who were killed. *See Fumento, supra* note 174.

177. In 1990, the Dutch government appointed a committee to investigate medical decisions regarding the end of life. The committee, chaired by the then attorney general of the Dutch Supreme Court, Professor J. Rummelink, interviewed physicians concerning approximately 10,000 deaths (the total number of deaths per year in the Netherlands is approximately 129,000). The committee found that "most of the doctors" found assisted suicide acceptable under "special circumstances." Fifty-four percent had performed assisted suicide at some time, 34% would consider the practice if a patient requested. Twelve percent stated they would absolutely refuse to assist, but two-thirds of this group would refer the patient to another physician who would assist them. The remaining 4% staunchly refused to have anything to do with the requests. The committee found that physician assisted suicide accounted for 400 of all the deaths in 1990. The committee also found 1000 cases where death was hastened without the request of the patient. *See van Delden, supra* note 164.

178. *See supra* note 4.

179. Critics argue that this illustrates that acceptance of the practice leads to encouragement of non-voluntary mercy killing and neglect in care for the terminally ill. Michael Coren, *Euthanasia is Simply Wrong, Wrong and Wrong Again*, FIN. POST, Aug. 30, 1995, at 11. Also, opponents of the practice argue that the 1000 deaths illustrate that the Dutch have fallen down the slippery slope and will allow anyone to be killed. The research group of the Rummelink committee disagrees. They assert that the cases where no

number of assisted deaths that remain unreported each year in the Netherlands.¹⁸⁰ These facts substantiate slippery slope concerns.

However, the arguments of those opposed to physician assisted suicide derive primarily from cases of euthanasia instead of physician assisted suicide, and do not reflect the experience under the revised 1995 guidelines for physician assisted suicide.¹⁸¹ Moreover, opponents' arguments do not outweigh the favorable public and physician opinion towards physician assisted suicide.¹⁸² Thus, although Dutch case law recognizes physician assisted suicide, there is no implication that the law will tolerate life terminating acts without the explicit request of the patient—a fact often overlooked by press accounts in the United States.¹⁸³ Dutch physicians agree that although ending a life feels contradictory at times, physician assisted suicide is the best alternative to letting a patient suffer in dehumanizing pain.¹⁸⁴

explicit request was made became known only recently through the report, thus creating the impression that “the Dutch began by hastening the end of life on request and ended up with life-terminating acts that the patient had not explicitly requested.” See van Delden, *supra* note 164. However, the group argues that the frequency of unrequested life terminating acts is unknown and to demonstrate a slippery slope, one would need to show that something changed after introducing a certain practice. Since the Rummelink study was the first of its kind, no such comparison can be made. However, the group points to physician opinion on physician assisted suicide when asked if their opinion had changed over the years. Thirty-nine percent had moved from extreme positions to more moderate positions as a result of actual experience with dying patients. Nearly all physicians who became more permissive could envision a situation where they would assist. This confirms the Rummelink conclusion that most Dutch physicians are prepared to assist, but only if certain conditions are met. *Id.*

180. Editorial, *Going Dutch*, DETROIT NEWS, Sept. 16, 1995, at C7.

181. Physicians only grant two thirds of the explicit requests, illustrating that they are responsible moral agents, not simply instruments of their patient's will. The system is based on autonomy and beneficence. See van Delden, *supra* note 164.

Also, a study on the results of the Rummelink report two years later found that most physicians find euthanasia acceptable under special circumstances. Also, the Rummelink study does not indicate that there is a slippery slope. Surveys show physicians are not becoming more permissive. Instead they now can conceive of times when the practice is necessary. *Id.*

182. Only 1.8% of the deaths in the Netherlands are due to this practice. The Journal of the American Medical Association says in a survey of public and physician opinion, most physicians support the practice, especially those with more than 20 years of practice. Moreover, the majority of the public supports physician assisted suicide, including those who are Catholic. This acceptance is similar to the growing numbers who accept the idea of physician assisted suicide in the United States. Paul J. van der Maas et al., *Changes in Dutch Opinion on Active Euthanasia, 1966 through 1991*, 273 JAMA 1411 (1995).

183. See van Delden, *supra* note 164.

184. *The Dutch Way of Death: Euthanasia is Accepted But It's Not Easy*, WASH. POST, Jan. 31, 1995, at B01. Wendy Wolfe, a doctor studying to be a specialist in family medicine, objects to characterizing the practice as anything but an extension of human compassion. “I have seen people literally rot in bed with disease. I have seen a woman in her forties with [rotting] tumors from breast cancer. Her children couldn't visit her anymore because of the stench. It was so horrific. That was the day I decided [assisted suicide] was a good thing.” *Id.* Primetime Live aired excerpts of the Dutch documentary on the mercy killing of 63-year-old Kees van Wendel who was suffering from Lou Gehrig's disease. The physician and van Wendel's wife

C. Application Of The Dutch Guidelines

If ANJ, the woman suffering from cancer, lived in the Netherlands, her physician could help her end her life. Following the RDMA guidelines,¹⁸⁵ her physician would first determine that she was competent. If her physician tried all alternatives and informed ANJ of her condition and prognosis, the physician could declare ANJ's situation as one of intolerable, hopeless suffering. If another physician similarly thinks the assistance is justified, ANJ's primary physician could prescribe a lethal dose of drugs. ANJ could then take the drug with her own hand and end her suffering.¹⁸⁶

IV. THE JAPANESE EXPERIENCE WITH PHYSICIAN ASSISTED SUICIDE

As modern medicine creates new ways to extend life artificially, more Japanese, like the Dutch, are opting for simpler and, as many believe, more dignified death. The Tokyo-based Japan Society for Dying with Dignity receives increasing requests for membership each day as the Japanese continue to debate whether they should allow the terminally ill to choose their own death.¹⁸⁷

decided his death was beautiful and more humane than continued suffering after watching him "go to sleep" after the lethal injection. *Primetime Live: "Death on Request"—Physician Assisted Suicide Abroad* (ABC television broadcast, Dec. 8, 1994). Also, the Dutch think the American prohibition on physician assisted suicide is hypocritical, because the United States has a health insurance problem. Although many Americans do not care that there are millions of uninsured without any medical care whatsoever, many object to trying to help someone out of pain. See O'Keefe, *supra* note 17.

185. See *supra* notes 167, 172 and accompanying text.

186. The day before Keese van Wendel died through the assistance of his physician, he painstakingly wrote the following message to his wife:

Dear Antoinette,

Our 20 years together were musical ones. There were dissonant notes, but the beautiful sounds we heard together overwhelmed them. . . . I thank you for wanting to give me so very much and for meaning so much to me. Without you, the music would have been far less sweet. . . . It was a wonderful time, thanks to you, and that is why it is so hard for me to say good-bye. I hope the memory of these beautiful years will give you the consolation and the strength to make the loneliness bearable. Your grateful bookend, Keese.

This illustrates that although critics claim that individuals requesting physician assisted suicide are mentally ill, there are many individuals who are in genuine pain and make a very difficult, yet rational, decision to end life. *Primetime Live: Death on Request* (ABC television broadcast, Dec. 8, 1994).

187. Membership in the Japan Society for Dying with Dignity increased ten-fold since Emperor Hirohito died after a prolonged illness in 1989. The Emperor was kept alive for 111 days after being diagnosed with pancreatic cancer. Hirohito's weight dwindled to 66 pounds before he was allowed to die. During his long "death agony," neither he nor the Japanese people were told the truth about his condition. Catherine Rosair, *Fast Aging Japan Debates the Right to Die*, Reuters, Nov. 4, 1992, available in LEXIS, Asiapc Library, Japan file. The death of former U.S. Ambassador to Japan Edwin Reischauer also attracted attention to the right to die issue. Reischauer refused terminal care. *Death with Dignity Becoming Hot Topic*,

The right to die issue is particularly pertinent in Japan, where medical advances for a large elderly population have resulted in the highest global rate of longevity.¹⁸⁸ Proponents argue that death with dignity is part of the Japanese tradition,¹⁸⁹ while critics counter that dangers exist in permitting physicians to aid patients in dying.¹⁹⁰ As in the United States, Japan recognizes the withdrawal of life-sustaining treatment, provided the patient previously stated opposition to such life prolonging measures.¹⁹¹ However, after the airing of the controversial documentary of a Dutch physician assisted suicide,¹⁹² most Japanese are very interested in the debate and reaching a resolution of physician assisted suicide issues.¹⁹³

Report from Japan, Nov. 8, 1991, available in LEXIS, Asiapc Library, Japan file. After these highly publicized deaths, membership in the society exceeded 50,000 in 1992. The Society argues that people should be allowed to choose their own death. *Id.* Members sign a living will and agree to the Society's creed. The three basic tenets of the creed are: rejection of medical treatment to prolong the lives of patients with incurable diseases; rejection of life-sustaining systems for patients in a vegetative state; and the absolution of doctors for any responsibility in allowing terminally ill patients to die peacefully. The wishes of the patient are only made public if they suffer medical conditions corresponding to those stated in their will. If physicians choose to defy the will, the society will make efforts to persuade them to comply with the stated wishes of the member. Takeshi Ozaki, "Living Wills" Gaining in Popularity, THE NIKKEI WEEKLY, May 9, 1992, at 24.

188. The Japanese live longer than any other people on earth—76 years for men and 82 for women. By the year 2000, 16% of the Japanese population will be over 65, one of the highest rates in the world. Japan also has the highest rate of suicide among elderly women. See Rosair, *supra* note 187.

189. Japan's main religions, Shinto and Buddhism, consider suicide an acceptable solution to problems of suffering when faced with physical pain or disease. Steven J. Wolhandler, Note, *Voluntary Active Euthanasia for the Terminally Ill and the Constitutional Right to Privacy*, 69 CORNELL L. REV. 363, 364 (1984).

190. Otohiko Kaga, a novelist and psychiatrist, argues that the Japanese have a cultural tradition with suicide and death, citing harakiri (ceremonial suicide) and kamikaze (suicidal attack in battle). He asserts that when they lost World War II, the Japanese became ashamed of death. In 1970, when Yukio Mishima committed harakiri, the traditional sentiment was revived "in [the Japanese] subconscious." However, the president of the Japan Association of Bioethics argues that the idea is "dangerous" and "[w]hatever the patient's desire, the doctor should avoid letting the patient die without doing the best with the methods available." See Rosair, *supra* note 187.

191. In 1994, Japan Science Council approved the choice of patients hooked up to hospital machines with no hope of regaining consciousness to die with dignity. The dean of Okayama University, Futami Kosaka stated: "We came to the conclusion that it is time to recognize cutting off artificial nutrition, taking into account the opinions of those who advocate death with dignity and recent precedents from the United States and Europe." *Science Council Backs Euthanasia for Patients in Coma*, Japan Economic Newswire, May 26, 1994, available in LEXIS, Asiapc Library, Japan file.

192. The Tokyo Broadcasting System (TBS) aired the controversial Dutch documentary of 63-year-old Kees van Wendel's death by physician assisted suicide. See *supra* notes 184-86 and accompanying text. The broadcast in Japan was the first airing outside the Netherlands. TBS stated "it is the right time for the entire Japanese society to seriously think" about this issue. The documentary was complemented by interviews and reports about van Wendel's case, and followed by studio discussions of the critics' and proponents' arguments on physician assisted suicide. *TBS to Air Controversial Dutch Mercy Killing Film*, Japan Economic Newswire, Nov. 14, 1994, available in LEXIS, Asiapc Library, Japan file.

193. According to a Health and Welfare Ministry survey in May 1995, more than 70% of respondents

A. Recent Japanese Case Law

In 1962, the Nagoya High Court specified six conditions under which euthanasia was not considered illegal.¹⁹⁴ Although the court ruled that euthanasia was legal if a patient suffering from an incurable disease requested it,¹⁹⁵ the decision has recently been criticized by physicians who called the ruling vague and outdated.¹⁹⁶ Moreover, the Nagoya requirements, governing the condition of the patient and method of euthanasia, were so strict that no cases were ever publicly carried out.¹⁹⁷

The right-to-die debate accelerated in 1991¹⁹⁸ after a physician at the Tokai University School of Medicine Hospital (Tokai Daigaku) administered a lethal dose of potassium chloride to a fifty-eight-year-old, terminally ill cancer patient.¹⁹⁹ Prosecutors sought a three year sentence for Dr. Masahito

indicated that they were "very interested" in the ongoing debate about assisted suicide and forms of euthanasia. The survey was nationwide and is based on the answers of bereaved families of patients who died in 1994. *Only One in Five Cancer Patients Told About Disease*, Japan Economic Newswire, May 1, 1995, available in LEXIS, Asiapc Library, Japan file. According to a 1989 survey by the Japan Medical Association, 70.7% of doctors thought that requests of a patient in regard to death should be respected. See Ozaki, *supra* note 187.

194. "Death with Dignity" Conference Opens in Kyoto, Japan Economic Newswire, Oct. 23, 1992, available in LEXIS, Asiapc Library, Japan file.

195. *Doctor Indicted for Murder in Mercy Killing*, Report from Japan, July 3, 1992, available in LEXIS, Asiapc Library, Japan file.

196. *Japan Court Ruling Lays Down Euthanasia Guidelines*, Reuters, Mar. 28, 1995, available in LEXIS, Asiapc Library, Japan file.

197. *Fast Aging Japan Debates the Right to Die*, Reuters, Nov. 4, 1992, available in LEXIS, Asiapc Library, Japan file. In 1992, a physician in Tochigi, north of Tokyo, flouted government guidelines for establishing brain death and allowed a son to turn off his mother's life support systems. The physician cited the patient's living will as the reason he ignored the guidelines. The guidelines require at least two specialists to confirm five specific conditions regarding brain waves and coma twice in a six-hour period before pronouncing brain death. The incident created a controversy in Japan. Some experts argued that the physician should have at least switched the life support off himself, citing a requirement from the 1962 Nagoya ruling. Dr. Katsumi Honda said "[d]octors must always be the one responsible." "Right to Die" Doctor Sparks Controversy, Reuters, Oct. 18, 1992, available in LEXIS, Asiapc Library, Japan file.

198. After the 1962 Nagoya Court ruling, there were several other cases dealing with the right to die: Kochi District Court Decision, September 17, 1990; Osaka District Court decision, November 30, 1977; Kobe District Court Decision, October 29, 1975; and Kagoshima District Court Decision, October 1, 1975.

199. Dr. Masahito Tokunaga was alone with the son of the patient on April 13, 1991. The son pleaded with Tokunaga to "help put my father to rest as quickly as possible." *Japan's 1st Euthanasia Trial Bad News for All Involved*, MAINICHI DAILY NEWS, Apr. 9, 1995, at 11. The patient was suffering from myeloma, a form of terminal cancer, and was in a painless coma at the time of his death. After the request, Tokunaga complied with the son's wishes by disconnecting all life-support devices. However, the patient continued to snore audibly, so Tokunaga injected medication intended to suppress breathing functions. Tokunaga then left the hospital to have dinner but was called back by his pager. Upon returning, he was confronted by the son, who said, "What the hell are you doing? My father is still breathing. Our family can't take any more of this. Please, put him to rest. We want to take him back home today." Tokunaga then injected potassium chloride and the patient was pronounced dead. The son then bowed deeply to Tokunaga and expressed his thanks. *Id.*

Tokunaga and accused him of “behavior that betrayed the nation’s faith in doctors.”²⁰⁰ The Yokohama District Court sentenced Tokunaga to a two year suspended prison term.²⁰¹ The court established a legal framework strictly limiting a physician’s actions in assisting patient death.²⁰² The court emphasized that the patient must express a clear wish to end life before a doctor may assist the request.²⁰³

B. Lessons From The Japanese Experience

Although the 1995 ruling in the *Tokai Daigaku* case established a clear legal standard, the continuing national debate over the case illustrates the troubling aspects of the decision.²⁰⁴ The court noted the dilemma of the physician when faced with a request to assist in a patient’s suicide.²⁰⁵ Unlike

For a complete and detailed account of the complicated facts of the *Tokai Daigaku* case, see generally Judgment of Mar. 28, 1995, Minsai Geppo [District Court], *reprinted in* 1530 *Juristo* 28 (Japan) [hereinafter Judgment of Mar. 28, 1995].

200. *Japan Doctor First to be Tried for Euthanasia*, Reuters, Nov. 7, 1994, available in LEXIS, Asiapc Library, Japan file. In opening arguments, the prosecution argued that Tokunaga, who had been dismissed by the Tokai University, “committed an act of murder unconnected to euthanasia that strayed far beyond [the bounds] of medical ethics.” *Id.* Tokunaga’s lawyers said that his actions only slightly hastened the death of the terminally ill patient and he did not deserve criminal punishment for his act. There have been seven trials in Japan involving mercy killing, but Tokunaga was the first doctor charged with criminal responsibility. *Doctor in Mercy-Killing Case Denies Intention to Kill*, Japan Economic Newswire, Sept. 28, 1992, available in LEXIS, ASIAPC Library, Japan file.

201. Tokunaga was found guilty of murder. *Court Sentences Doctor, Lists Mercy Killing Conditions*, Japan Economic Newswire, Mar. 28, 1995, available in LEXIS, ASIAPC Library, Japan file.

202. The court outlined four conditions for physician assisted suicide: 1) the patient is in intolerable physical pain; 2) the patient’s death is inevitable, and his end is impending; 3) every method has been tried, and there are no other alternative left; and 4) there is a clear declaration of intent giving consent to the shortening of the patient’s life. See Judgment of Mar. 28, 1995, *supra* note 199. Judge Matsura held that Tokunaga’s action did not meet these conditions because the patient made no clear expressions about physical pain and made no request for death. *Id.* The court permitted this extension of physician assisted suicide on the basis of a “self-decisive right.” *Id.*

203. The court also indicated that the wishes of the family must be honored, which caused many experts concern over the ruling. Editorial, *Euthanasia Ruling Should be Praised*, THE DAILY YOMIURI, Apr. 5, 1995, at 6.

204. The court noted that:

This incident made people rethink how medical services should be provided, and the idea that the patient himself has the right to decide the course of his treatment became popular. The issue of quality of life appeared, and people began to question how treatment should be administered to terminally ill patients who have no hope of recovery . . . it seems there is a new trend of thought concerning so-called euthanasia which has arisen as a result of the realities of modern medical services.

See Judgment of Mar. 28, 1995, *supra* note 199.

205. Tokunaga testified that his mental state was as if his “heart had been clutched by a black hand and torn from [his] chest.” *Japan’s 1st Euthanasia Trial Bad News for All Involved*, MAINICHI DAILY NEWS, Apr. 9, 1995, at 11.

the Dutch, the Japanese guidelines do not specify that the patient should administer the lethal drug with her own hand.²⁰⁶ Moreover, the guidelines do not require patient evaluation by several physicians and psychiatrists.²⁰⁷

The court expressed dissatisfaction with the lack of hospice facilities and other pain elimination techniques that would obviate the necessity of physician assisted death.²⁰⁸ The decision noted that patients would not wish for death if their pain could be alleviated.²⁰⁹ The decision does establish the patient's right to have her wishes regarding death fulfilled. Nonetheless, the court limited the absolute right of the patient to choose death to prevent "a general trend to think lightly of human life."²¹⁰ Moreover, the court addressed the critics' concern that the patient must have a clear and voluntary declaration of intent.²¹¹ The decision and ensuing public debate attracted attention to the insufficiencies in the Japanese system, as well as promoting discussion on the right to die.²¹²

206. As a result, Japanese physicians may experience more personal problems and dilemmas when complying with a patient request for assistance. The *Tokai Daigaku* court changed the 1962 Nagoya High Court requirement from "in principle, euthanasia should be performed by a doctor," to "when no other alternative means are left for the removal or easing of the patient's pain." See Judgment of Mar. 28, 1995, *supra* note 199.

207. The court noted that end-of-life decisions are difficult to judge, and more than one physician should be involved in an evaluation of a terminally ill patient's request. "[I]t is desirable to be repeatedly diagnosed by several doctors when deciding whether the situation is one in which the patient's death is inevitable." *Id.*

208. In hospice facilities, terminally ill patients can die peacefully. The court expressed concern that there was not an environment that allowed physician cooperation in patient care. *Editorial: Euthanasia Ruling Should be Praised*, THE DAILY YOMIYURI, Apr. 5, 1995, at 6. The court felt the Tokai hospital had "an insufficiently equipped system for terminal medical care, and there was also insufficient functioning of the medical team in charge of terminal medical care." See Judgment of Mar. 28, 1995, *supra* note 199.

209. Some experts claim nearly 90% of terminally ill patients pain can be eased by morphine. *Editorial: Euthanasia Ruling Should be Praised*, THE DAILY YOMIYURI, Apr. 5, 1995, at 6. Many argue that pain is the source of the mental distress and humiliation of losing one's faculties that lead to the request for death. If pain can be controlled, the numbers of patients requesting assistance will decrease. See Rosair, *supra* note 187. A survey by the Health and Welfare Ministry indicates that "most respondents wanted doctors to concentrate on reducing a patient's suffering." *Only One in Five Cancer Patients Told About Disease*, Japan Economic Newswire, May 1, 1995, available in LEXIS, Asiapc Library, Japan file.

210. See Judgment of Mar. 28, 1995, *supra* note 199. The court reasoned that "[T]he patient should not be allowed to choose death itself or to die. He should only be allowed to choose a process that will result in his death or how to die, and it should not go beyond that." The court noted that although the patients are terminally ill, physicians and the medical profession still have a duty to provide treatment. This reasoning illustrates the court's recognition of slippery slope concerns. *Id.*

211. The court held that intent should be based on informed consent by the patient. This is particularly important in Japan where only one in five patients is told the name and true prognosis of his or her disease. In the *Tokai Daigaku* case, the patient and his wife did not know he had cancer. The patient's son knew the full extent of the diagnosis but requested that the physicians not inform his father and mother of his father's condition. See Judgment of Mar. 28, 1995, *supra* note 199; see also *Only One in Five Cancer Patients Told About Disease*, Japan Economic Newswire, May 1, 1995, available in LEXIS, Asiapc Library, Japan file.

212. Taneo Oki argues that the Tokai Daigaku incident occurred because of the "insufficiency of

C. Application Of The Japanese Guidelines

If ANJ suffered from terminal cancer in Japan, she could request that her physician assist her to die with dignity. In accordance with the guidelines the *Tokai Daigaku* court established, because ANJ is suffering unbearable physical pain from a terminal illness that has no alternative treatment, she can request physician assistance. After she clearly requests to die, her physician could assist her either by prescribing a lethal dose of medication or by giving a lethal injection to end her life.

V. PROPOSAL: LEGISLATIVE GUIDELINES PERMITTING PHYSICIAN ASSISTED SUICIDE

The current debate over physician assisted suicide requires attention to what is often ignored in policy debates: the social side of human nature; the responsibilities that must be borne by citizens, individually and collectively, in a regime of rights; and the long-term effects and consequences of decisions.²¹³ Concluding that there are no limits on the government's power to act in the area of suicide is faulty, as is reasoning that there is a firm historical basis for assisted suicide in the Constitution. Instead, state legislatures should acknowledge the legitimacy, and inevitability, of social choice in assisted suicide and encourage public debate. The issue should be decided through public support for legislatively drawn physician assisted suicide initiatives.²¹⁴ Courts should retain a role, insisting that legislatures

medical education and the medical care system." *Doctor Indicted for Murder in "Mercy Killing,"* Japan Economic Newswire, July 2, 1992, available in LEXIS, Asiapc Library, Japan file. Oki thinks "people should stop treating death as a taboo and start thinking about it over tea." See Ozaki, *supra* note 187.

213. This approach is categorized as the "communitarian alternative." The communitarian movement is defined by a commitment to analysis that balances individual and community interests regarding rights and responsibilities. See generally Donald L. Beschle, *The Role of the Courts in the Debate on Assisted Suicide: A Communitarian Approach*, 9 NOTRE DAME J.L. ETHICS & PUB. POL'Y 367 (1995).

214. In *Cruzan*, Justice Scalia stated this sentiment:

While I agree with the Court's analysis today, and therefore join in its opinion, I would have preferred that we announce, clearly and promptly, that the federal courts have no business in this field; . . . that the point at which life becomes "worthless" and the point at which the means necessary to preserve it become "extraordinary" or "inappropriate," are neither set forth in the Constitution nor known to the nine Justices of this Court any better than they are known to nine people picked at random from the Kansas City telephone directory; and hence, . . . it is up to the citizens of Missouri to decide, through their elected representatives, whether that wish will be honored. It is quite impossible (because the Constitution says nothing about the matter) that those citizens will decide upon a line less lawful than the one we would choose; and it is unlikely (because we know no more about 'life-and-death' than they do) that they will decide upon a line less reasonable.

justify their actions with rational arguments and adequate protections for citizens.²¹⁵

If the issue of physician assisted suicide is before a court, the court should engage in a balancing of concerns.²¹⁶ A balancing approach allows the court to formulate rules that address the goals underlying right-to-die law.²¹⁷ Balancing also increases flexibility, allowing the court to take recent medical developments into consideration.²¹⁸ Most importantly, a balancing approach places greater weight on the patient's interest in dying, thereby ensuring significant patient autonomy.²¹⁹ Therefore, through balancing the courts should recognize that where a restriction on physician assisted suicide set by the legislature plausibly protects the interest of the patient as well as society, it should be upheld.²²⁰

The following is a set of guidelines for dealing with physician assisted suicide.²²¹ To prevent criminal liability, physicians should demonstrate compliance with these guidelines. In sum, the patient must be a terminally ill, competent adult in unbearable, untreatable pain who makes informed, voluntary, and repeated requests for physician assistance in dying.

Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261, 293 (1990) (Scalia, J., concurring).

215. Legislatures must act rationally when restricting liberty, even in the absence of a fundamental right. The courts must ensure that the government does act rationally. However, when determining whether or not a particular practice is implicated in the concept of ordered liberty, the judiciary should not solve social problems such as physician assisted suicide by insinuating personal policy preferences into the decision. *See* Beschle, *supra* note 213. Instead, courts should address the realities of end of life decisions, realizing that death for the terminally ill is inevitable. *See supra* notes 122-49 and accompanying text.

216. A balancing approach compels the courts to consider the values and assumptions that motivate social decision. Especially in the area of physician assisted suicide, social decision is based on numerous ethical, medical, religious, and political concerns. *See* Note, *supra* note 52, at 2021.

217. Therefore, a court can consider arguments of those opposed to and in favor of physician assisted suicide. If these concerns are insubstantial compared to the legislative protection, the court can rule in favor of the patient's interest in dying. *Id.*

218. With the rise in cancer and AIDS rates, medical technology and medical ethics have changed greatly even in the last decade. *See* JAMES F. CHILDRESS, WHO SHOULD DECIDE? PATERNALISM IN HEALTH CARE 175-81 (1982).

219. *Developments in the Law—Medical Technology and the Law*, 103 HARV. L. REV. 1519, 1658-61, 1676 (1990).

220. *See supra* notes 209-10 and accompanying text. The court should test whether a legislature has acted rationally by examining the situation. A legislative solution that imposes extreme suffering on an individual who will not share in the benefit gained constitutes cruelty. If a state enacts a legislative procedure permitting physician assisted suicide only in a narrowly defined category of cases, the courts should defer.

221. The following guidelines attempt to incorporate lessons learned from the Dutch and Japanese experience, as well as recent U.S. measures on physician assisted suicide. *See also* HASTINGS CENTER REPORT, GUIDELINES ON THE TERMINATION OF LIFE SUSTAINING TREATMENT AND THE CARE OF THE DYING (1987). For an excellent set of comprehensive guidelines see Charles H. Baron et al., *A Model Act to Authorize and Regulate Physician Assisted Suicide*, 33 HARV. J. ON LEGIS. 1 (1996).

1. The patient must be a terminally ill adult.²²² At least two independent corroborative medical opinions²²³ must agree that all other treatment options have been exhausted and the patient has less than one year left to live.²²⁴
2. The patient must undergo two rigorous psychiatric consultations to ensure legal competence.²²⁵ A patient's decision to end life should not be caused by depression or other concerns, such as being a burden to family or society.²²⁶
3. The patient must be in extreme pain that cannot be alleviated. The physician must concentrate on the pain and suffering of the patient, considering hospice care and other treatments.²²⁷ If all means have

222. The patient must be an adult to prevent cases like those in the Netherlands where infants were euthanized because of birth defects. This also prevents an unhappy teenager distraught over a failed romance from falling into the class.

223. In termination-of-treatment cases, courts and hospitals use the standard safeguard of verifying prognoses through two independent medical opinions. *See, e.g.,* *Severns v. Wilmington Medical Ctr., Inc.*, 421 A.2d 1334, 1337 (Del. 1980) ("highly skilled and respected neurosurgeon" and "highly skilled and respected neurologist" testified about patient's comatose state); *In re Quinlan*, 348 A.2d 801, 811-12 (N.J. 1975) (court received testimony from seven doctors on patient's mental and physical state); *In re Lydia E. Hall Hosp.*, 455 N.Y.S.2d 706, 708-10 (N.Y. Sup. Ct. 1982) (court heard testimony about patient's physical condition from two physicians); *State Dep't of Human Services v. Northern*, 563 S.W.2d 197, 203, 205 (Tenn. Ct. App.) (chancellor below relied on statement of two physicians and appeals court heard testimony of three doctors), *appeal dismissed*, 436 U.S. 923 (1978).

224. The requirement of terminal illness would prevent any healthy but depressed individual from proceeding with physician assisted suicide. Also, it would prevent deaths of any individuals who cannot commit suicide on their own. This would preclude two recent deaths assisted by Dr. Kevorkian: a 42 year old woman who suffered from domestic abuse, and a man with a debilitating muscle illness. *See* Maier, *supra* note 85.

225. The Massachusetts legislature is currently considering assisted suicide, and the proposed legislation requires that each patient be examined by three doctors, one of whom is a psychiatrist. Physicians must be satisfied that the patient is capable before providing assistance. *See Massachusetts Enters Assisted Suicide Debate*, STATESMAN J. (Salem, Or.), Feb. 5, 1995, at 5A. *See also* *Lane v. Candura*, 376 N.E.2d 1232, 1235 n.5 (Mass. App. Ct. 1978) (testimony from two psychiatrists); *In re Lydia E. Hall Hosp.*, 455 N.Y.S.2d 706, 709 (N.Y. Sup. Ct. 1982) (accepting "comprehensive and detailed testimony" of several family members and hospital procedures requiring competency examinations by more than one psychiatrist).

226. This condition would prevent cases where a depressed person is given physician assistance in suicide, as in the Netherlands. It should also quell the fears of those who think that the terminally ill will request physician assistance just to ease the burden on caretakers.

227. Since many physicians believe that hospice and other treatment methods can alleviate the pain of most terminally ill patients, the physician should concentrate on these alternatives first, granting the request for assistance as a last resort. Recent experience in Oregon, where voters approved an assisted suicide initiative currently embroiled in court appeals, suggests that expanding a right to assisted suicide may encourage physicians to provide better end-of-life care for their terminally ill patients. Since the referendum in 1994, referrals to Oregon hospices have increased 20%. Seminars on care for the dying, sparsely attended in the past, are now oversubscribed, especially by primary care physicians. Moreover, doctors, patients, and

been exhausted and the patient is facing her remaining time suffering, the request for physician assisted suicide is valid.

4. The decision to end life must be informed.²²⁸ A patient should be aware of the progression of the illness, the procedure for the assistance, and any other medically relevant information. Full disclosure is essential for the unobstructed exercise of the right of self-determination.

5. The decision must be voluntary. A patient's decision is only voluntary if made free of coercion. Factors such as pain, debilitation, and the quality of remaining life should be weighed by each individual patient.²²⁹ The choice should be discussed with, but not influenced by the opinions of, family and friends.²³⁰ The decision to request physician assisted suicide must be the patient's own choice. The request should be made by signing a request form in the presence of two independent witnesses.²³¹

6. The request for physician assistance must be repeated. The physician should not immediately render assistance after one request. The physician may grant assistance only after the patient has requested at least three times, with significant intervals between each request.²³²

families speak more openly about end of life decisions. Dr. Susan Tolle of the Oregon Health Sciences University asserts that "the vote was a tremendous wake-up call to medicine about care of the dying. It changed things for the better." Joseph P. Shapiro, *Expanding a Right to Die*, U.S. NEWS & WORLD REP., Apr. 15, 1996, at 63.

228. Upon initial diagnosis of the terminal illness the patient should be informed of the prognosis, all available treatments, and possibility of recovery. This disclosure allows the patient to fully consider all options before the pain affects the decisionmaking process.

229. This requirement prevents physician assisted suicide when a patient is coerced by someone to end her life.

230. Cancer victim Eric Straumanis, *see supra* note 6, discussed the option of physician assisted suicide with his wife and family.

231. The Hemlock Society suggests that a witness may not be:

- 1) one who signed the declaration at the behest of the declarant;
- 2) related to the declarant by blood or marriage;
- 3) entitled to any part of the estate of the declarant, whether by statute or by will;
- 4) directly, financially responsible for the declarant's medical care; or
- 5) the attending physician, an employee of the attending physician, or an employee of a health care facility in which the declarant is a patient.

Hemlock Manifesto 1, at 4 (1992) (available from the Hemlock Society).

232. Since the patient is terminal, the time intervals cannot be months, but the repeated requests cannot be on consecutive days. There must be a consequential time period between requests. In three recent suicides attended by Dr. Jack Kevorkian, for example, the patients consulted him for seven months to a year before their deaths. *See* Jack Lessenberry, *Once Again, Jurors Weigh Kevorkian's Fate*, N.Y. TIMES, May 11, 1996,

Moreover, during the intervals between requests, the patient should consult with a group of people representing society's collective wisdom regarding the decision.²³³

7. The actual assistance must be a prescription for a lethal dosage of medication administered by the patient's own hand. Before handing over the prescription, the physician should ask the patient once again if she fully understands the outcome of her act. If there is any hesitation, the physician should not prescribe the medication. This allows the patient complete autonomy. Because the final act is performed by the patient, there is little ambiguity about the nature of her decision.²³⁴

If these seven conditions are satisfied, physicians and the judicial system should respect the legislative framework and honor a terminal patient's decision regarding the time and manner of her death.

VI. CONCLUSION

Physician assisted suicide confronts Americans with a difficult societal issue. Since all controversial societal issues inevitably become legal issues, there is growing pressure on the courts and legislatures to allow physician assisted suicide. As the experiences of Japan and the Netherlands illustrate, express legislation on physician assisted suicide is necessary to protect the interests of terminally ill patients and their physicians and to address this issue openly and honestly. However, the Japanese and Dutch rules should not be adopted in the United States without significant modification to correct their excesses and inherent problems. State legislatures should develop guidelines restricting physician assisted suicide to prevent repeating the Japanese and Dutch mistakes.²³⁵ The proper safeguards could eliminate opponents' fears of physician assisted suicide, and terminally ill patients could benefit from

§ 1, at 20; *Kevorkian Aids New Suicide*, SACRAMENTO BEE, June 21, 1996, at A20.

233. This group of people, comprising educators, lay persons, civic leaders, clergy, philosophers, or lawyers, should be a group that the individual admires and chooses for their thoughtfulness, restraint, sensitivity, and ability to command respect. This independent group can help the patient evaluate this important decision at a very critical time. Sherwin Nuland, *When to Die*, USA WEEKEND, Feb. 5, 1995, at 4.

234. The patient has clearly chosen a quick, painless death over a long, debilitating one.

235. See notes 173-86, 204-12 and accompanying text. This Note argues that the United States should learn from and incorporate the mistakes of the Japanese and Dutch rules on physician assisted suicide into a set of restrictive guidelines that will allow adult, competent, terminally ill individuals to die with dignity. This Note does not argue that the Japanese and Dutch rules should be transplanted into the United States without modification.

individual control over their lives and deaths. Based on recent developments, it appears that American society is moving toward a rough consensus that legalization of physician assisted suicide is the most humane and enlightened policy.²³⁶ The legal system must now accept the responsibility of transforming that consensus into legislation that incorporates the lessons from the Japanese and Dutch and ultimately affords terminally ill patients, such as ANJ, the choice to end their suffering through physician assisted suicide.

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236. See Smith, *supra* note 59.