A Right to Die with Dignity: Using International Perspectives to Formulate a Workable U.S. Policy

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As medical technology lengthens man's natural life-span, the right to die with dignity has moved to the forefront of contentious American societal issues. The United States should not hesitate to look at right to die legislation on the international stage, prudently sifting through novel and bold approaches that may or may not work in our country.

After analyzing the U.S. legal opinions on the right to die, this Comment examines pertinent international judicial opinions and legislation that could be useful in guiding the debate in the United States. The American discussion is often crowded with polemical debates that obfuscate the issues; this Comment will attempt to place these arguments into proper perspective. This Comment closes with suggestions of several bold, but rudimentary, reforms that should be implemented in the United States before any further discussions on right to die issues proceed.

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I. INTRODUCTION

When the new congressional term begins this spring in Washington, D.C., a bill that has already passed the House of Representatives awaits its turn in the Senate: a bill that would preempt the states from legalizing any form of physician-assisted suicide. However, a law permitting physician-assisted suicide is already on the books in one state, Oregon, and Maine is holding a referendum this fall to approve or deny its own physician-assisted suicide statute.[1] The euthanasia debate will likely be a key issue this fall as the presidential candidates are forced to weigh in on one side or the other.[2] However, like the abortion debate, the euthanasia debate is often sidetracked by emotional rhetoric. International perspectives on this issue are key to forming a sound policy for the United States. This Comment will examine the American legal debate on the right to die with dignity using moral, religious, and historical references and international perspectives to suggest alternative approaches to this sensitive issue.

II. A HISTORICAL PERSPECTIVE OF THE RIGHT TO DIE

> My mother's face was swollen beyond recognition. Her lips were raw from the respirator.
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> A young doctor called to say that my mother had died. Momentary relief overshadowed anger. Now anger will linger for a long time:
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> Anger at a system that makes torture legal. Anger at the medical profession that fights hard to protect its own prerogatives but has shown little courage in fighting inhumane legal restrictions which make doctors accomplices in torture.
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> Anger at doctors who are so wedded to charts and monitors that they seem oblivious of patients' pain.
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> At the funeral parlor I was told that I would be required to identify my mother. A few minutes later the men who were dealing with the body

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1. Maine voters will be asked: "Should a terminally ill adult who is of sound mind be allowed to ask for and receive a doctor's help to die?" A statewide survey shows that 66% of respondents support the right to die for the terminally ill. *See Assisted Suicide: Maine Referendum Likely Next Year*, AMERICAN HEALTH LINE, Dec. 2, 1999.

2. In a New Hampshire town meeting, Steve Forbes claimed that he believes all life is sacred. He stated, "Holland, for example, now allows doctors to practice euthanasia, and they now routinely kill patients without the patient's permission because they want a hospital bed." Anne-Marie O'Connor, *Forbes Blasts Dutch over Euthanasia*, LOS ANGELES TIMES, Jan. 30, 2000, at A15. Later, in the Republican debates, Bush stated, "We must protect life including that of the elderly against physician-assisted suicide." *Larry King Live: The South Carolina Republican Debates* (CNN television broadcast, Feb. 15, 2000).

> reversed that. They wanted to spare me a final look at the havoc modern medicine had wreaked on her.[3]

There are four categories by which a patient's life may be terminated, (1) withdrawal from artificial life-support mechanisms or refusal of treatment at the request of the patient or at the request of a party named in advance by the patient to make such decisions on the patient's behalf; (2) physician-assisted suicide wherein a doctor provides the means for a patient to end his or her own life, but the doctor does not actively do so him or herself; (3) euthanasia wherein a *doctor* terminates a patient's life upon the patient's request; and (4) a situation wherein a physician terminates life without the specific request of the patient (usually referred to as "non-requested euthanasia" or "nonvoluntary physician-assisted suicide"). However, any debate on euthanasia and the right to die should first start with a 'proper' definition and a historical overview.

The Merriam Webster's Dictionary defines "euthanasia" as "the act or practice of killing or permitting the death of hopelessly sick or injured individuals (as persons or domestic animals) in a relatively painless way for reasons of mercy," from the Greek for "easy death."[4] In spite of its rather benign definition, it is understandable that many people may connote the word with the horrible "euthanasia campaign" that occurred in Nazi Germany during the 1930s and 1940s. The German efforts to popularize euthanasia were based not on the good of the patient, but on the "good" of society to be rid of patients. Although this notion gained widespread support in Germany based on the "science" of racial purity, it would be ridiculous to argue that these reasons have any foundation in the modern-day debate and their positions must be viewed in historical and sociological perspective as an anomaly.[5] Putting the Nazi debacle aside, there are

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3. *See* RONALD P. HAMEL & EDWIN R. DUBOSE, MUST WE SUFFER OUR WAY TO DEATH? CULTURAL AND THEOLOGICAL PERSPECTIVES ON DEATH 23 (1996) (quoting Fred M. Hechinger, *They Tortured My Mother*, N.Y. TIMES, Jan. 24, 1991, at A22). The author's ninety-four-year-old mother had survived surgery for colon cancer and although resuscitation was expressly rejected in writing, before surgery, she was placed on a respirator after surgery. To facilitate doctors evaluating her situation, she was not given sedation that could have eased her pain. Her hands, swollen to three times their normal size, were strapped down to prevent her from removing the tubes feeding into her body. She contracted pneumonia and was treated with antibiotics. The family was not informed of the further treatment but, inadvertently, found out two days later. After weeks of torture, her kidneys could no longer hold out and she finally died.

4. MERRIAM WEBSTER'S COLLEGIATE DICTIONARY (visited Feb. 14, 2000) <http://www.m-w.com/cgi-bin/dictionary>.

5. *See* Thane Josef Messinger, Note, *A Gentle and Easy Death: From Ancient Greece to Beyond Cruzan Toward a Reasoned Legal Response to the Societal Dilemma of Euthanasia*, 71 DENV. U.L. REV. 175, 177, 216 (1993) (quoting Helen Silving, *Euthanasia: A Study in Comparative Criminal Law*, 103 U. PA. L. REV. 350, 356 n.21 (1954)). In an attempt to explain

many historic examples of euthanasia being practiced out of mercy or respect for physical autonomy.

The philosophers of ancient Greece were among the first to recognize and condone euthanasia.[6] In fact, certain cities in Athens kept a supply of hemlock which was obtainable to anyone who could justify to the Senate his wish to die.[7] The rules for obtaining hemlock were as follows:

> Whoever no longer wishes to live shall state his reasons to the Senate, and after having received permission shall abandon life. If your existence is hateful to you, die; if you are overwhelmed by fate, drink the hemlock. If you are bowed with grief, abandon life. Let the unhappy man recount his misfortune, let the magistrate supply him with the remedy, and his wretchedness will come to an end.[8]

Plato stated that Socrates viewed painful disease and suffering as a justification for euthanasia and cited Asclepius with approval, the god of healing and medicine, who stated that, "[h]e did not want to lengthen out good-for-nothing lives . . . . Those who are diseased in their bodies, physicians will leave to die, and the corrupt and incurable souls they will put an end to themselves."[9]

The Romans inherited the Greek attitude toward euthanasia and viewed it as a matter of dominant will and rational choice.[10] Punishment was only warranted in cases where an individual acted irrationally, and suicide in the face of terminal illness was viewed as rational.[11] Aside from what was occurring in "Western Civilization," euthanasia was widely practiced worldwide.

In Eskimo societies, the infirm and aged were, at their own request, set adrift on an iceberg; to comply with the request for euthanasia by a loved one was a sign of being a "good family."[12] In

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the depraved atrocities committed by some of the most educated of the world's medical practitioners in exterminations and medical experimentation, George Ables of the Nazi Health Office reportedly commented, "We're not thinking of individuals but of the race. The race is bigger than the individual." *Id.* at n.177 (quoting O. RUTH RUSSELL, FREEDOM TO DIE: MORAL AND LEGAL ASPECTS OF EUTHANASIA 92 (rev. ed. 1977)).

6. *See id.* at 182.

7. *See id.* (citing DEREK HUMPHRY & ANN WICKETT, THE RIGHT TO DIE: UNDERSTANDING EUTHANASIA 4 (1986)).

8. *See id.* (quoting EMILE DURKHEIM, SUICIDE: A STUDY IN SOCIOLOGY 330 (John A. Spaulding & George Simpson trans., 1951)).

9. *See id.* (quoting HUMPHRY & WICKETT, *supra* note 7, at 4; *see also* PLATO, THE PORTABLE PLATO 398, 401 (Scott Suchanan ed. & Benjamin Jowett trans., Viking Press 1966)).

10. *See id.* at 183 (quoting ALFRED ALVAREZ, THE SAVAGE GOD: A STUDY OF SUICIDE 56, 62 (1973)).

11. *See id.*

12. *See id.* (quoting HUMPHRY & WICKETT, *supra* note 7, at 2). "Abandonment is not as cruel as it may at first seem. Hypothermia (exposure to extreme cold) normally causes an

the society of Aymara Indians of Bolivia and Peru, if an elderly person requested assistance in dying, his friends and family were gathered to decide whether to withhold nourishment until he fell unconscious and died.[13] In similar circumstances, the Khoikhoin tribe of southern Africa would give a banquet followed by "ceremonial abandonment in the wilderness."[14] Other cultures were less humane; the Ethiopian elderly were tied to wild bulls, the Amboyna feasted on their dying, and the Congolese stomped the elderly to death.[15]

However, these arcane historical examples shed little light on what transpired in Europe forever tainting the American debate on dying with dignity: the rise of Christianity. "For Christians, the value of life, which for the Greeks and Romans was determined by the quality of life, was reinterpreted to mean that life *per se* was valuable regardless of the circumstances;"[16] every suicide was wrong regardless of the degree or length of suffering.[17] The premise was that to decide with free will to end one's life suborned the authority of God; it was God's decision who would die and when and where death should occur, and to usurp that authority was a grave sin.[18] Saint Augustine[19] and Saint Thomas Aquinas, the leading religious authorities of their day, spoke strongly against suicide: "suicide is a detestable and damnable wickedness"[20] and "a sin against God, as life

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anesthetized state as the body slowly shuts down its non-critical (exterior) systems in favor of heating the body core, resulting in spreading numbness. Pain results usually only during reheating." *See id.* at 251 n.90 (quoting AMERICAN MEDICAL ASSOCIATION, ENCYCLOPEDIA OF MEDICINE 562-63 (1989)); THE MERCK MANUAL OF DIAGNOSIS AND THERAPY 2361-63 (15th ed. 1987)). "Religious beliefs are also relevant here, as many Eskimos believe that anyone who has courageously faced death spends eternity in the highest heaven." *See id.* 251 at n.90 (quoting HUMPHRY & WICKETT, *supra* note 7, at 2).

13. *See id.* at 185 (quoting HUMPHRY & WICKETT, *supra* note 7, at 2). "Interestingly, medical examinations of these deaths indicates that death was caused not by starvation or thirst, but rather, by the simple will to die." *See id.* at 251 n.92 (quoting HUMPHRY & WICKETT, *supra* note 7, at 2).

14. *See id.* at 183 (quoting HUMPHRY & WICKETT, *supra* note 7, at 2).

15. *See id.* at 184 (quoting HUMPHRY & WICKETT, *supra* note 7, at 2).

16. *See id.* at 184 (quoting JERRY B. WILSON, DEATH BY DECISION: THE MEDICAL, MORAL, AND LEGAL DILEMMAS OF EUTHANASIA 23 (1975)).

17. *See id.* (quoting HUMPHRY & WICKETT, *supra* note 7, at 6).

18. *See id.* at 187 (quoting HUMPHRY & WICKETT, *supra* note 7, at 6).

19. Saint Augustine averred that women should not, as early martyrs of the Church had done, commit suicide to avoid rape at the hands of "enemy heathens." He stated that the putative rapes were the design of God and that "some lurking infirmity" in the women must have caused God to visit such violence upon them. *Id.* at 251 n.115 (citing SAINT AUGUSTINE, THE CITY OF GOD 31, 33-34 (Marcus Dods trans., 1950)).

20. *Id.* at 186 (quoting SAINT AUGUSTINE, *supra* note 19, at 30). Saint Augustine made exceptions to the Sixth Commandment for "deaths resulting from wars fought in obedience to divine commands, or in conformity with God's laws" (making no mention of the method of

was a gift and subject only to God's powers."[21] The lone proeuthanasia voice was that of statesman and theologian Sir Thomas More. In his book, *Utopia*, he stated in regard to euthanasia:

> [I]f the disease be not only incurable, but also full of continual pain and anguish; then the priests and the magistrates exhort the man, seeing he is not able to do any duty of life, and by outliving his own death is noisome and irksome to others and grievous to himself, that he will determine with himself no longer to cherish that pestilent and painful disease. And seeing his life is to him but a torment, that he will not be unwilling to die, but rather take a good hope to him, and either dispatch himself out of that painful life, as out of a prison, or a rack of torment, or else suffer himself willingly to be rid of it by others. And in so doing they tell him he shall do wisely, seeing by his death he shall lose no commodity, but end his pain . . . . *But they cause none such to die against his will, nor they use no less diligence and attendance about him, believing this to be an honourable death.*[22]

Although the public ridiculed Sir Thomas More's opinion that taking one's own life was not necessarily wicked, it was later accepted by such philosophical illuminaries as Francis Bacon,[23] John Donne,[24] and David Hume.[25] The debate has only heightened as medical technology has developed.

As early as the Renaissance, medical professionals realized the dilemma that the ability to maintain life did not guarantee the ability to preserve the value of that life.[26] In spite of this disconnect, from the Enlightenment into the twentieth century, Anglo-American tradition has strictly adhered to the religious precepts of Western Civilization. As seen in the Supreme Court's opinions and the anti-right-to-die crusade, the religious emphasis on life at any cost—life in

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communication from God necessary to divinely command a war). *See id.* at 251 n.111 (quoting SAINT Augustine, *supra* note 19, at 27).

21. *Id.* at 187 (quoting HUMPHRY & WICKET, *supra* note 7, at 7).

22. *Id.* (quoting ST. THOMAS MORE, UTOPIA 114 (Edward Surtz ed., 1964), *reprinted in* O. RUTH RUSSELL, FREEDOM TO DIE: MORAL AND LEGAL ASPECTS OF EUTHANASIA 55-56 (rev. ed. 1977) (emphasis added)).

23. Francis Bacon argued that doctors should facilitate dying patients to "make a fair and easy passage from life." *See id.* at 251 n.128 (quoting HUMPHRY & WICKETT, *supra* note 7, at 8).

24. John Donne, as Dean of St. Paul, argued on behalf of voluntary euthanasia. *See id.* at 251 n.129 (quoting HUMPHRY & WICKETT, *supra* note 7, at 8).

25. *Id.* at 251 n.130 (quoting DAVID HUME, DIALOGUES CONCERNING NATURAL RELIGION AND THE POSTHUMOUS ESSAYS OF THE IMMORTALITY OF THE SOUL AND OF SUICIDE 103-04 (Richard H. Popkin ed., 1980)) ("In his 1777 *Essay on Suicide*, David Hume stated that if a person cannot promote any societal interest but is a burden, his withdraw from life is not only innocent but laudable. In withdrawing from life he does no harm, but only ceases to do good.").

26. *See id.* at 251 n.132 (citing JERRY B. WILSON, DEATH BY DECISION: THE MEDICAL, MORAL, AND LEGAL DILEMMAS OF EUTHANASIA 17-45 (1975)).

which God, not man, is the final arbiter—is reflected throughout the modern-day debate over euthanasia and physician-assisted suicide.

III. A RIGHT TO DIE? THE AMERICAN DEBATE

A. In the Circuit Courts

In *Compassion in Dying v. State of Washington*, later renamed *Glucksberg*, the Ninth Circuit Court of Appeals held unconstitutional a Washington statute that stated, "[a] person is guilty of promoting a suicide when he knowingly causes or aids another person to attempt suicide."[27] Although the Ninth Circuit recognized a state interest in safeguarding life and preventing abuse, where terminal illness is concerned, the court found a "constitutionally recognized 'right to die'" based on a due process liberty interest to privacy and autonomy.[28] Therefore, the court held that "terminally ill competent adults who wish to hasten their deaths with medication prescribed by their physicians" could do so within the confines of the law.[29]

Across the country, the Second Circuit was considering a similar question in *Quill v. Vacco*, where the court struck down a New York law that outlawed "intentionally . . . aid[ing] another person to commit suicide."[30] Several years previous, in *Cruzan v. Director, Missouri Department of Health*, the case that propelled the American legal debate on a right to die all the way to the Supreme Court, the Court held that a person may refuse treatment, including food and hydration, and that this right belongs to the patient alone, not surrogates or family members.[31] However, the state may require clear and convincing evidence that this is what the patient requested.[32]

Using *Cruzan* as a guiding precedent, the Second Circuit considered *Quill* not as a fundamental rights case, but as an equal protection case.[33] The court found that the law creates a distinction between those patients who can end their lives by legal removal of life support machinery, as in *Cruzan*, and those who are similarly situated, but not on life support, and must therefore suffer slowly unless they are permitted to self-administer life ending drugs.[34]

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27. Compassion in Dying v. Washington, 79 F.3d 790, 794 (9th Cir. 1996) (en banc), *cert. granted sub nom.* Washington v. Glucksberg, 521 U.S. 702 (1997).
28. *See id.* at 816.
29. *See id.* at 837.
30. *See* Quill v. Vacco, 80 F.3d 716 (2d Cir. 1996), *cert. granted*, 521 U.S. 793 (1997).
31. Cruzan v. Director, Missouri Dep't of Health, 497 U.S. 261 (1990).
32. *Id.*
33. *See Quill*, 80 F.3d at 801.
34. *See id.* at 802.

B. The Circuit Courts Are Overturned

The Supreme Court overturned both *Glucksberg* and *Quill*.[35] As for *Glucksberg*, the Ninth Circuit framed the issue as "whether there is a liberty interest in determining the time and manner of one's death."[36] Chief Justice Rehnquist's majority opinion rejected this phraseology and restated the issue as "whether the 'liberty' specially protected by the Due Process Clause includes a right to commit suicide which in itself includes a right to assistance in doing so."[37] The Chief Justice rejected the Ninth Circuit's reliance on not only *Cruzan*, but also *Planned Parenthood of Southeastern Pennsylvania v. Casey*, stating "that although *Casey* recognized that many of the rights and liberties protected by the Due Process Clause sound in personal autonomy, it does not follow that any and all important, intimate, and personal decisions are so protected . . . *Casey* did not suggest otherwise."[38] Chief Justice Rehnquist observed that "for over 700 years, the Anglo-American common law tradition has punished or otherwise disapproved of both suicide and assisted-suicide."[39] The majority view was that there was no due process liberty interest in committing suicide, and certainly not a fundamental one.[40] The only interests that can be called "fundamental" are those that are "fundamentally rooted in this Nation's history and tradition."[41]

Chief Justice Rehnquist went on to summarily distinguish *Cruzan* as recognizing refusal of life-sustaining treatment which is not a "new" fundamental interest, but one long-recognized by the common law. *Cruzan* recognizes "the common law rule that forced medication was a battery, and the long legal tradition protecting the decision to refuse unwanted medical treatment," which is "entirely consistent with this Nation's history and constitutional traditions."[42] Although the interest in physician-assisted suicide "may be just as personal and profound as the decision to refuse unwanted medical treatment, . . . it has never enjoyed similar legal protection."[43]

After establishing that there was no fundamental liberty interest in physician assisted suicide, Chief Justice Rehnquist stated that states

35. *See* Compassion in Dying v. Washington, 79 F.3d 790 (9th Cir. 1996).
36. *Id.* at 816.
37. *See* Washington v. Glucksberg, 521 U.S. 702, 738 (1997).
38. *See id.* at 727 (citing Planned Parenthood of Southeastern Pa. v. Casey, 505 U.S. 833 (1992)).
39. *See id.*
40. *See id.*
41. *Id.*
42. *Id.*
43. *Id.*

must only show a rational reason why such practices should be banned in their states and proceeded to outline several such reasons.[44] First, Chief Justice Rehnquist stated that Washington state had an "unqualified interest in the preservation of human life."[45] As those who attempt suicide often suffer from depression and other mental disorders, Chief Justice Rehnquist concluded that "legal physician-assisted suicide could make it more difficult for the State to protect depressed or mentally ill persons, or those who are suffering from untreated pain, from suicidal impulses."[46] Next, Chief Justice Rehnquist claimed that the States have an "interest in protecting the integrity and ethics of the medical profession."[47] He feared that physician-assisted suicide could "undermine the trust that is essential to the doctor-patient relationship by blurring the time-honored line between healing and harming."[48] Next, the Chief Justice noted a state interest in "protecting vulnerable groups, including the poor, the elderly, and disabled persons, from abuse, neglect, and mistakes."[49]

The majority expressed concern for "the many individuals in our society whose autonomy and well-being are already compromised by poverty, lack of access to good medical care, advanced age, or membership in a stigmatized social group."[50] The Court was concerned that the elderly and the terminally ill would somehow become less valued in society when held in comparison with the young and healthy members of society.[51] Lastly, the Court's majority made the "slippery slope" argument expressing fear that "permitting assisted suicide will start it down the path to voluntary and perhaps even involuntary euthanasia."[52] The Court cited the Court of Appeals

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44. *See id.*

45. *Id.* at 729-30 (quoting Cruzan v. Director, Missouri Dep't of Heath, 497 U.S. 261, 282 (1990)).

46. *Id.* at 732 (quoting NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT 13-22, 126-28 (May 1994) [hereinafter NEW YORK TASK FORCE]). More than 95% of those who commit suicide had a major psychiatric illness at the time of death; among the terminally ill, uncontrolled pain is a "risk factor" because it contributes to depression. *See id.*

47. *Id.* at 732.

48. *Id.* (quoting Assisted Suicide in the United States, *Hearing before the Subcommittee on the Constitution of the House Committee on the Judiciary*, 104th Cong., 2d Sess., 355-56 (1996) [hereinafter *House Hearing*] (testimony of Dr. Leon R. Kass) ("The patient's trust in the doctor's whole-hearted devotion to his best interests will be hard to sustain.").

49. *See id.*

50. *See id.* at 732 (quoting NEW YORK TASK FORCE, *supra* note 46, at 120). "[A]n insidious bias against the handicapped—again coupled with a cost-saving mentality—makes them especially in need of Washington's statutory protection." *Id.*

51. *See id.*

52. *See id.*

language to voice its concern that "what is couched as a limited right to 'physician-assisted suicide' is likely, in effect, a much broader license, which could prove extremely difficult to police and contain."[53] The Court was referring to the Court of Appeal's expansive ruling that permitted not only physicians, but loved ones, such as family members, to assist a suicide.[54] Based on the above arguments, the majority concluded that Washington's ban on assisted suicide was at least rationally related to a host of governmental interests.[55]

Although the majority of the justices felt that there was not a fundamental right to assisted suicide, the concurring opinions differed in their rationales. Justice O'Connor stated that a right to assisted suicide may exist if the state did not make palliative care available to alleviate the suffering of a terminally ill patient.[56] However, Justice O'Connor's conclusion that there was "no need" to address lack of palliative care failed to recognize or address overwhelming evidence that "adequate pain relief and palliative care are *not* provided in many cases."[57]

Justice Stevens agreed with Justice O'Connor that pain relief was at the heart of the issue, but he went on to state that there is a liberty "to define one's own existence. . . ."[58] He stated that "there are situations in which an interest in hastening death is legitimate . . . and there are times when it is entitled to constitutional protection."[59] He likened the situations where assisted suicide would be practicable to the Court's decisions regarding capital punishment: "conclusion[s] that capital punishment is not always unconstitutional did not preclude later decisions holding that it is sometimes impermissibly cruel, so is it equally clear that a decision upholding a general statutory prohibition of assisted suicide does not mean that every possible application of the statute would be valid."[60] While Justice

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53. *Id.*

54. *See id.* (citing Compassion in Dying v. Washington, 79 F.3d 790, 832 n.140 (9th Cir. 1996).

55. *See id.* at 735.

56. *See id.* at 737-38.

57. *Id.* According to a study conducted by the New York State Task Force, "the delivery of pain relief is grossly inadequate in clinical practice." *See* NEW YORK STATE TASK FORCE, *supra* note 46, at 43; *see also* MARILYN J. FIELD & CHRISTINE K. CASSEL, APPROACHING DEATH: IMPROVING CARE AT THE END OF LIFE (1997) (stating that "[i]n a year long review, [a] twelve member committee found that 40% to 80% of patients with cancer, AIDS, and other diseases report inadequately treated pain").

58. *Id.* at 745 (citing Planned Parenthood v. Casey, 505 U.S. 833, 851 (1990)).

59. *See id.* at 741.

60. *Id.*

Stevens agreed with the Chief Justice that *Cruzan* was not controlling precedent, Justice Stevens argued that *Cruzan* did demonstrate that in some instances, where a person is already on the brink of death, he or she may have a right to assisted suicide that countervails any possible state interest in maintaining that life.[61] Justice Stevens recognized that some people may find value in a life of suffering, probably based on religious convictions. However, some may prefer terminal sedation or withdrawal from life-support systems. The interest of the state in such cases is "about the quality of life that a particular individual may enjoy."[62] It is not a choice of whether to live, but how to die.[63]

Justice Stevens also countered Chief Justice Rehnquist's assertion that physician-assisted suicide would erode confidence in medical practitioners.[64] For patients with long-standing relationships with their physicians, such frankness may be appreciated.[65] In fact, "[a] doctor's refusal to hasten death 'may be experienced by the [dying] patient as an abandonment, a rejection, or an expression of inappropriate paternalistic authority.'"[66] Justice Stevens further noted that while the use of palliative care is of utmost importance, it cannot alone alleviate all pain and suffering.[67] In these cases, the State's interest in preventing assisted suicide wane.[68]

Justice Souter recommended an altogether different test stating that the "question is whether the statute sets up one of those 'arbitrary impositions' or 'purposeless restraints' at odds with the Due Process Clause of the Fourteenth Amendment."[69] Justice Souter felt that these two factors should determine the unconstitutionality of a statute even if no violation of a fundamental interest could be pinpointed.[70] However, Souter stressed that the Court should respect the legislature's judgment unless it fell outside of the "zone of reasonableness," thus permitting the issue to be tossed back to the state legislatures or Congress for a final resolution of the matter.[71]

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61. *See id.* at 745.
62. *See id.* at 729 (quoting Cruzan v. Director, Missouri Dep't of Heath, 497 U.S. 261, 282 (1990)).
63. *See id.* at 748.
64. *See id.*
65. *See id.*
66. *See id.* (quoting BLOCK & BILLINGS, PATIENT REQUEST TO HASTEN DEATH 154 (1994)).
67. *See id.* at 747 (quoting David Orentlicher, *Legalization of Physician Assisted Suicide: A Very Modest Revolution*, 38 B.C. L. REV. 443 (1997)).
68. *See id.*
69. *Id.* at 752 (quoting Poe v. Ullman, 367 U.S. 497, 543 (1961) (Harlan, J., dissenting)).
70. *See id.*
71. *See id.* at 764.

Justice Breyer also disagreed with the reasoning behind the Court's decision. Justice Breyer took umbrage with the language used by Chief Justice Rehnquist in describing the right asserted by the plaintiff as the "right to commit suicide with another's assistance."[72] Justice Breyer preferred to refer to the issue as a "right to die with dignity," or " . . . personal control over the manner of death, professional medical assistance, and the avoidance of unnecessary and severe physical suffering. . . ."[73] However, Justice Breyer felt there was no need to decide whether a right to die was a fundamental right.[74] He agreed with Justice O'Connor that until a state infringed upon the right of a patient to access palliative care, the fundamental right issue need not be addressed.[75]

In short, Chief Justice Rehnquist's majority opinion is "cautious and traditional" and concludes that there is no fundamental right to physician-assisted suicide, "accepting, almost without question, the state's description of its interests and the validity of those interests."[76] There seems little hope that a case challenging a ban on physician-assisted suicide based on a due process claim would succeed in light of *Glucksberg*.[77]

In *Vacco v. Quill*, the Second Circuit Court of Appeals held that the New York statute banning physician-assisted suicide was a violation of the Equal Protection Clause of the Fourteenth Amendment.[78] It held that "ending or refusing lifesaving medical treatment is nothing more nor less than assisted suicide," therefore, to draw a distinction is discriminatory.[79] However, the Supreme Court, relying heavily on its arguments presented in *Glucksberg*, overturned the decision.[80]

Chief Justice Rehnquist, again speaking for the majority, averred that the New York statutes "neither infringed fundamental rights nor involved suspect classifications," therefore, New York's interest in enacting such as law was valid as the challenged statutes easily satisfied the rational basis test.[81] The Chief Justice drew the

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72. *Id.*
73. *Id.* at 791.
74. *See id.*
75. *See id.*
76. David A. Pratt, *Too Many Physicians: Physician-Assisted Suicide After Glucksberg/Quill*, 9 ALB. L.J. SCI. & TECH. 161, 173 (1999).
77. *See id.*
78. *See id.*
79. *See* Vacco v. Quill, 521 U.S. 793, 797 (1997).
80. *See* Pratt, *supra* note 76, at 175.
81. *See Quill*, 521 U.S. at 792, 797.

distinction between a case involving the withdrawal of life-support and one concerning a forbidden physician-assisted suicide. "[W]hen a patient refuses life-sustaining medical treatment, he dies from an underlying fatal disease or pathology; but if a patient ingests legal medication prescribed by a physician, he is killed by that medication."[82] Moreover, the Court stated that it was well-established law to differentiate between causation and intent which is what the New York statute was trying to do.[83] The majority reasoned that withdrawal of life-sustaining treatment by the physician purposefully intends only to honor the patient's desire "to cease doing useless and futile or degrading things to the patient when [the patient] no longer stands to benefit from them."[84] On the other hand, a physician-assisted suicide requires that a doctor "must, necessarily and indubitably, intend primarily that the patient be made dead."[85]

Justice Stevens, although concurring in the judgment, disagreed with the Court's reasoning on the intent issue noting that he was "not persuaded that in all cases there will in fact be a significant difference between the intent of the physicians, the patients or the families in the two situations . . . in both situations, the patient is seeking to hasten a certain, impending death."[86]

The result of the Supreme Court's analysis of the euthanasia issue seems to state that although the Court may not recognize a fundamental right to assistance in dying, the issue is not entirely settled. Chief Justice Rehnquist's opinion in *Glucksberg* closed by stating that, "throughout the Nation, Americans are engaged in an earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a democratic society."[87] On the

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82. *Quill*, 521 U.S. at 801. *See, e.g.*, People v. Kevorkian, 527 N.W.2d 714, 728 (1994), *cert. denied*, 514 U.S. 1083 (1995); *Matter of Conroy*, 486 A.2d 1209, 1226 (1985) (explaining that when feeding tube is removed, death "result[s] . . . from [the patient's] underlying medical condition"); *In re* Colyer, 660 P.2d 738, 743 (1983) ("[D]eath which occurs after the removal of life sustaining systems is from natural causes").

83. *See id.*

84. *Quill*, 521 U.S. at 801-02 (quoting *House Hearing*, *supra* note 48, at 368).

85. *See House Hearing*, *supra* note 48, at 367. However, in a strange twist of semantics, the Chief Justice reasoned that "just as a State may prohibit assisting suicide while permitting patients to refuse unwanted lifesaving treatment, it may permit palliative care related to that refusal, which may have the *foreseen but unintended* 'double effect' of hastening the patient's death." *Quill*, 521 U.S. at 807 n.11 (citing New York State Task Force 163 (emphasis added)).

86. *Quill*, 521 U.S. at 807; Timothy E. Quill et al., *The Rule of Double Effect-A Critique of Its Role in the End-of-Life Decision Making*, 337 N. ENG. J. MED. 1768, 1769 (1997) (averring that it is the patient's action, not the physician's, that directly causes death in the case of physician-assisted suicide).

87. Washington v. Glucksberg, 521 U.S. 702, 735 (1997).

same note, Justice O'Connor acknowledged that "states are presently undertaking extensive and serious evaluation of physician-assisted suicide and other related issues."[88] She further stated that "the . . . challenging task of crafting appropriate procedures for safeguarding . . . liberty interests is entrusted to the 'laboratory' of the States . . . in the first instance."[89] Justice Souter suggested that due to disagreement over the interpretation of data and a dearth of legislative fact-finding upon which the Court could rely, "the Court should accordingly stay its hand to allow reasonable legislative consideration."[90] Although the justices expressed that under certain circumstances a person may have a right to die that outweighs the State's interest in preserving that life, they indicated a preference to have Congress or State legislatures decide the particulars.

IV. INTERNATIONAL PERSPECTIVES ON THE RIGHT TO DIE

Under the Dutch criminal code it remains a crime to end someone's life, even if they explicitly request aid in doing so.[91] However, the Dutch law creates an important exception where a physician is compelled by *force majeure*.[92] Pain, humiliation, and the deep desire to die with dignity are the main reasons why patients request physician-assisted suicide, and under certain circumstances, these factors may constitute *force majeure*.[93] A physician may invoke the *force majeure* exemption from the criminal law only under certain circumstances: it must be invoked in order to relieve unbearable suffering and in compliance with criteria listed in Article 9 of the Regulations governing the regional euthanasia review committees

88. *Id.* at 737-38 (O'Connor, J., concurring).

89. *Id.* at 737 (quoting Cruzan v. Director, Missouri Dept. of Health, 497 U.S. 261, 292 (1990) (O'Connor, J., concurring) (citing New State Ice Co. v. Liebmann, 285 U.S. 262, 311 (1932)).

90. *Id.* at 789.

91. "Any person who takes another person's life at that person's express and earnest request shall be liable to a term of imprisonment not exceeding twelve years or a fine of NLG 100,000 (approximately USD 50,000)." WETBOEK VAN STRAFRECHT [Criminal Code][WvS] art. 293 (Neth.).

92. "Any person compelled by *force majeure* to commit a criminal act shall not be criminally liable." WETBOEK VAN STRAFRECHT [Criminal Code] [WvS] art. 40 (Neth.). *Force majeure* is an event or effect that can be neither anticipated nor controlled; the term includes both acts of nature (such as floods or hurricanes) and acts of people (such as riots, strikes, or wars). BLACK'S LAW DICTIONARY 263 (pocket ed. 1996).

93. *Netherlands Ministry of Foreign Affairs: The End of Life in the Netherlands* (visited Jan. 9, 2000) <http://www.bz.minbuza.nl/English/Policy/c_euthen-A.html> [hereinafter *Netherlands Ministry*]. Citizens of the Netherlands are fully insured under the state social security system and have no concerns about the cost of treatment. *Id.*

("regional ethics boards") of May 27, 1998.[94] Article 9 requires that, (1) the patient made voluntary, well-considered, and persistent requests for euthanasia; (2) according to prevailing medical opinion, the patient's suffering was unbearable and without prospect of improvement; (3) the doctor consulted at least one other physician with an independent viewpoint; and (4) euthanasia was performed in accordance with good medical practice.[95] The Public Prosecution Service is instructed to not prosecute physicians who were compelled by *force majeure* and complied with the criteria of Article 9.[96] However, if a physician is noncompliant, he may be charged under Article 293 of the Criminal Code and prosecuted for homicide.[97]

In addition, the Dutch government draws a distinction between cases of euthanasia and assisted suicide and cases of medical intervention to terminate a life without the patient's request. Any time a physician-assisted suicide or euthanasia (upon request) occurs, the physician is required to complete a notification procedure.[98] Although

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94. *Id.*

95. *Id.* Regarding a second physician's opinion, the Dutch government, in cooperation with the Royal Dutch Medical Association and the Amsterdam Family Doctors' Association has established a network of physicians to provide physicians somewhere to turn for advice or assistance in cases where a patient has requested a physician-assisted suicide. *Id.*

96. *Id.*

97. *Id.*

98. The notification questionnaire is quite detailed, but is reproduced here to demonstrate that the Dutch wish to punish cases of possible abuses.

(1) From what disorder(s) was the patient suffering, and since when?
(2) What medical treatments were attempted?
(3) Could the patient be cured?
(4) What was the nature of the patient's suffering?
(5) Could his/her suffering be relieved? If so, what was the patient's view of these alternatives?
(6) How long do you estimate the patient would have lived had his/her request for euthanasia or assisted suicide not been granted?
(7) When did the patient request euthanasia or assistance with suicide? When did he/she repeat this request?
(8) In whose presence did the patient make this request?
(9) Did the patient have a living will? If so, on what date? (please enclose the living will with the report) If not, why not?
(10) Are there any indications that the patient made the request under pressure from or the influence of others?
(11) Was there any reason to doubt that the patient was fully aware of the implications of his/her request and of his/her physical condition at the time he/she made the request?
(12) Did you consult the nursing staff/the patient's cares about terminating the patient's life? If so, whom did you consult and what was their view? If not, why not?
(13) Did you consult with the patient's family about terminating his/her life? If so, whom did you consult and what was their view? If not, why not?
(14) Which physician(s) was/were consulted?

the notification procedure was established in 1990, it was not officially adopted until 1994. Regarding termination of a patient's life without his or her request, the doctor may still invoke *force majeure*, but only under extreme circumstances. Since any doctor who does so would not be in compliance with Article 293, the Public Prosecution Service will likely commence criminal proceedings under Articles 287 or 289 of the Criminal Code.[99] The case will then be passed on to the court to decide on the *force majeure* issue. "Senile dementia, old age or disability alone can never constitute grounds for a doctor to invoke *force majeure*."[100] A national committee comprised of medical, legal, and ethical experts ("national ethics boards") will also be appointed to deal with cases of nonrequested euthanasia.[101] These national ethics boards will conduct an evaluation of the physician's actions and will forward the results to the courts.[102] Cases where a physician may be permitted to act without a patient's consent include patients who have previously expressed a desire to die under specific circumstances, patients in a coma, and new-born babies suffering from congenital birth defects that have little or no chance of survival.[103] In the case of new-born babies, the decision to terminate life is made in conjunction with the parents.[104]

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(15) In what capacity? (general practitioner, specialist, psychiatrist, other) Was/were there physician(s) attending the patient? What is their relation to you?

(16) When did the physician(s) examine the patient? If the physician(s) did not examine the patient, why not?

(17) Please enclose the written report compiled by the consultant physician(s) confirming that the patient had no prospect of improvement, that his/her suffering was unbearable, and that his/her request was both explicit and well-considered. If the physician(s) did not compile a written report: what were their findings in respect to the points referred to above?

(18) Was this a case of euthanasia? or assistance with suicide? Who actually performed the euthanasia?

(19) What substances were used, and how were these administered?

(20) Did you gain information on the method to be applied, and if so, from whom?

(21) Who else was present when the patient died?

(22) Do you have any other comments you wish to make to the regional review committee?

99. "Any person who intentionally take another person's life shall be guilty of manslaughter and liable to a term of imprisonment not exceeding fifteen years or a fine of NLG 100,000." WETBOEK VAN STRAFRECHT [Criminal Code] [WvS] art. 287 (Neth.). "Any person who intentionally and premeditatedly takes another person's life shall be guilty of murder and liable to life imprisonment or to a determinate term of imprisonment not exceeding twenty years or a fine of NLG 100,000." *Id.* art. 289.

100. *Netherlands Ministry*, *supra* note 93.

101. *Id.*

102. *Id.*

103. *Id.*

104. *Id.* "It occurs an estimated fifteen times a year in the Netherlands that the parents and the doctor decide in such circumstances to take active steps to hasten death." *See id.*

Although the previously described system remains in effect, the Dutch parliament is poised to make the Netherlands the first state in the world to legalize euthanasia and physician-assisted suicide for the terminally ill.[105] The new law will remove euthanasia from the realm of criminal law.[106] However, the notification procedure and the review by the special regional ethics boards will remain in force.[107] The Dutch government has averred that lifting the criminal ban on euthanasia and physician-assisted suicide will not lead to the abandonment of government monitoring.[108] The goal is not to extend the use of euthanasia, but to reassure the public that such practices are properly supervised by regional ethics boards, not public prosecutors.[109] Promulgation of the new law is supported by ninety percent of the population.[110]

In other Western European nations, euthanasia and physician-assisted suicide are not as widely accepted, primarily due to the influence of the Roman Catholic Church (the Netherlands is largely Protestant).[111] However, this apparently anti-euthanasia sentiment is often held only by those in government and clergy with the population at large supporting a right to die with dignity.[112] In France, the administering of a lethal dose of medication "to a terminally ill patient is 'quite common.'"[113] Similarly, in England, although the public is "overwhelmingly in favor of euthanizing severely ill patients the law does not specifically permit this."[114]

The Swiss and German legal systems embrace an altogether, albeit more enlightened, approach than those of France and England. Switzerland and Germany have a "motive-oriented approach [to homicide] which provides for the punishment based on a thoughtful consideration of all facts and circumstances, including the defendant's

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105. *See* Patrick Smyth, *Right to Die In Dignity Boosted By Euthanasia Debate*, IRISH TIMES, Nov. 16, 1999, at 14.

106. *Netherlands Ministry*, *supra* note 93.

107. *See id.*

108. *See* Smyth, *supra* note 105, at 14.

109. *See id.*

110. *See id.*

111. Ronald Kaniuk, Note, *European Perspectives Towards Euthanasia and Physician-Assisted Suicide*, 9 N.Y. INT'L L. REV. 85, 91 (quoting JAMES M. HEOFLER, DEATHRIGHT: CULTURE, MEDICINE, POLITICS AND THE RIGHT TO DIE 21 (1994)).

112. *See id.*

113. John Warden, *Euthanasia Around the World*, 304 BRIT. MED. J. 6818 (1982).

114. Kaniuk, *supra* note 111, at 92 (quoting JAMES M. HEOFLER, DEATHRIGHT: CULTURE, MEDICINE, POLITICS AND THE RIGHT TO DIE 25 (1994)). "While the legalization of euthanasia has been considered, it has been consistently rejected by the English Parliament." *Id.* at 92.

motive for the crime."[115] So while euthanasia remains illegal, just as in the Netherlands, the motive behind the "murder" can mitigate any possible punishment that may be meted out. The judge will focus not on deliberation and premeditation, but rather on motive, with the "'true mark of a murder[er] [being] the depraved mind (base attitudes or mentality) or the dangerousness of the actor.'"[116]

Swiss law prosecutes only those who assist suicide for a "selfish motive," but does not allot a punishment for anyone else.[117] Therefore, in Switzerland, one need not necessarily be a physician to assist a suicide.[118] Recently, a Swiss government-appointed commission has suggested that euthanasia should be expressly decriminalized, but as of yet, no steps have been formally taken to do so.[119]

In Japan, the *Tokunaga* case, decided in 1995, has outlined a strict legal framework under which a physician-assisted suicide may occur: (1) the patient is in intolerable physical pain; (2) the patient's death is inevitable, and his end is near; (3) there remains no viable medical alternative for further treatment; and (4) there is a clear declaration of intent[120] by the patient that he or she wishes to die.[121]

However, there is debate in Japan over the precise application of the *Tokunaga* standard for physician-assisted suicide. It is important to note that the Japanese require no independent evaluation of the patient by a second physician or psychiatrist, as the law requires in the Netherlands and in Oregon.[122] The court noted that it would be

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115. *See id.* at 94 (quoting Mustafa Sayid, *Euthanasia: A Comparison of the Criminal Laws of Germany, Switzerland, and the United States*, 6 B.C. INT'L & COMP. L. REV. 533, 534 (1983)). "Germany and Switzerland are two nations which have express provisions of their penal codes that might mitigate the sentence of an individual who has practiced euthanasia. These countries consider motive an integral element in determining culpability for a crime." *Id.*

116. *See id.* at 95 (quoting Mustafa Sayid, *Euthanasia: A Comparison of the Criminal Laws of Germany, Switzerland, and the United States*, 6 B.C. INT'L & COMP. L. REV. 533, 551 (1983)).

117. *See* Clare Kapp, *Swiss Allow Assisted Suicide, But What About Euthanasia?*, THE LANCET, Dec. 11, 1999, at 2059.

118. *See id.*

119. *See id.*

120. Intent should be based on informed consent of the *patient*. In Japan, only one in five patients is told the name and actual prognosis of his or her affliction. In the *Tokunaga* case, the patient and his wife did not even know that he had terminal cancer. The request for physician-assisted suicide came from his son who was aware of his father's grave condition. *See* Alison Hall, *To Die With Dignity: Comparing Physician Assisted Suicide in the United States, Japan, and the Netherlands*, 74 WASH. U. L.Q. 803 n.211 (1996) (quoting Judgment of Mar. 28, 1995, MINSAI GEPPO [District Court], *reprinted in* 1530 JURISUTO 28 (Japan)).

121. *See id.* at 803 n.202 (quoting Judgment of Mar. 28, 1995, MINSAI GEPPO [District Court], *reprinted in* 1530 JURISUTO 28 (Japan)).

122. *See id.*

"*desirable* to be repeatedly diagnosed by several doctors when deciding whether the situation is one in which the patient's death is inevitable."[123]

The *Tokunaga* case made people rethink their ideas regarding the proper application of medical services, and the idea that a patient should be able to have a right to die.[124] In a recent survey, seventy percent of Japanese say that they are "very interested" in learning more about assisted-suicide and euthanasia.[125] Although medical issues and diagnoses are often not openly discussed, suicide in Japan does not carry a stigma or provoke religious hostility as it does in the West.[126]

On March 25, 1995, the Northern Territory of Australia dramatically entered the death with dignity fray by passing legislation that legalized physician-assisted suicide by terminally ill patients. The Rights of the Terminally Ill Act became effective in the Northern Territory of Australia on July 1, 1996, only to be repealed by the Australian National Assembly on March 25, 1997.[127] Between July 1996 and March 1997, four people exercised their right to die under the Act causing a stir of outrage from religious leaders worldwide;[128] for example, "the Vatican condemned Australia's Act as a revolt against God."[129]

Due to internal and external pressures from religious groups, the Australian government withdrew the otherwise popular law. However, due to the fact that "seventy-five percent of Australian citizens support euthanasia and because physicians are likely to continue to practice euthanasia despite the legislative ban, the repeal seems little more than a symbolic formality."[130]

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123. *See id.* at 803 n.207 (quoting Judgment of Mar. 28, 1995, MINSAI GEPPO [District Court], *reprinted in* 1530 JURISUTO 28 (Japan) (emphasis added)).

124. *See id.* at 803, 831. Japan has the highest rate of longevity in the world—76 years for men and 82 years for women—and an estimated 16% percent of the Japanese population is now over the age of 65. *Id.* at 831 n.188.

125. *See id.* at 831 n.193 (quoting *Only One in Five Cancer Patients Told About Disease*, JAPAN ECONOMIC NEWSWIRE, May 1, 1995, *available in* LEXIS, Asiapc Library, Japan file).

126. *See id.* 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).

127. *See* Andrew Plattner, *Australia's Northern Territory: The First Jurisdiction to Legislate Voluntary Euthanasia, and the First to Repeal It*, 1 DEPAUL J. HEALTH CARE L. 645, 645 (1997).

128. *See id.* at 650.

129. *Id.*

130. *See id.* (quoting *Australia Euthanasia Vote*, REUTERS FINANCIAL SERV., Mar. 24, 1997).

Back in Europe, the Belgian Senate has recently opened debates to follow in the footsteps of their Dutch neighbors. A recent survey shows that eighty percent of Belgians favor legislation that would legalize euthanasia in certain circumstances.[131] The Belgians have conducted their debate in the same fashion as their Dutch counterparts, focusing not on "strident or absolutist . . . terms of the sacredness of human life, [but on the] dignity and control by patients of their care and differing views of the potential of modern pain relief."

Dignity and control by patients were also key issues in the decision by the Constitutional Court of Columbia which held that a "humanitarian killing with the previous consent of the patient can under certain circumstances be justified in cases of terminally-ill patients."[132]

However, in spite of the recent right to death with dignity advancements in the Netherlands, Belgium, and Colombia, there remain many opponents on the international scene. In Russia, the Moscow Patriarchate's Council of Clergy and Lay-persons on Biomedical Ethics avers that the emergence of support for euthanasia is directly linked to "'moral pluralism,' which recognizes the existence of different types of value orientations."[133] In spite of the Council's statement, roughly half of all Russian physicians favor euthanasia.[134] In fact, recent estimates indicate that as many as eighty to ninety percent of Russian medical students favor the practice.[135]

The debate is also far from over in Italy. In recent surveys, only 17.9% of Italian physicians favored euthanasia or assisted suicide for terminally ill patients, with "religious beliefs" rather than "fear of legal repercussions" being cited as the primary reason.[136] However,

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131. *See* Smyth, *supra* note 105, at 14.

132. *See* James Underwood, *The Supreme Court's Assisted Suicide Opinion in International Perspective: Avoiding a Bureaucracy of Death*, 73 N.D. L. REV. 641, 642 (quoting *Colombian Court Approves Limited Forms of Euthanasia*, REUTERS WORLD SERV., May 20, 1997, *available in* LEXIS, World Library, CURNWS File).

133. *See Euthanasia and Medicine: A Compatibility Problem*, MEDITSINSKAYA GAZETA, Oct. 8, 1999, at 11.

134. *See id.* (quoting Yudiin S. Bykova & L. Yasnaya, *Eitanazia: Mneniye Vrachei* [Euthanasia: Physician's Options], *in* CHELOVEK [The Human Being], No.2, 1994, at 148).

135. *See Euthanasia and Medicine: A Compatibility Problem*, MEDITSINSKAYA GAZETA, Oct. 8, 1999, at 11.

136. *See* L. Grassi et al., *Attitudes of Italian Doctors to Euthanasia and Assisted Suicide for Terminally Ill Patients*, THE LANCET, Nov. 27, 1999, at 1876. Religious beliefs were cited by 59.9% while only 27.7% cited fear of legal repercussions as deterrents to facilitating death. *Id.*

86.6% of all physicians would use a morphine drip to relieve suffering, even if it may hasten the patient's death.[137]

Finally, in England, a bill has been introduced before Parliament that would, contrary to the common law, ban the withdrawal of medical treatment and forbid patients to refuse treatment.[138] Although the British Medical Association (BMA) opposes euthanasia and physician-assisted suicide, it is vehemently attacking the current bill as a quashing of the autonomy of patients.[139] The BMA provides an example based upon "a patient on kidney dialysis who develops cancer that becomes terminal. If the hypothetical patient asks for the dialysis to be withdrawn, any doctor who agreed could be open to a charge that he or she was hastening death."[140] The bill is still being debated before Parliament.

Although nations around the world are now entering the fray regarding right-to-die laws, the international examples demonstrate that the Netherlands is the leader in reexamining the reactionary policies of the Church and the political right.[141]

> [T]he Netherlands is moving into uncharted realms of the post-religious attitude towards death, in which [death] can be seen not simply as an enemy to be fled at all costs or a portal to the next world but, in certain limited circumstances, an individual right to be claimed. Death could be, in fact, the ultimate medical procedure.[142]

It remains to be seen if the United States will follow in the footsteps of the Netherlands and her liberal retinue or stymie the debate with preemptive Congressional legislation.

V. POLEMICAL DEBATES

A. Pain, Suffering, and the "Sanctity of Life"

As opponents to physician-assisted suicide point out, unbearable pain is not the only reason cited by those who chose life-ending alternatives. "Although pain is one of the reasons cited by forty-six percent of Dutch patients requesting assistance in dying, only three percent of requesting patients cited pain as the *only* reason."[143] The

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137. *See id.*

138. *See* Jeremy Laurance, *MP's Urged to Block Anti-Euthanasia Bill*, THE INDEPENDENT (London), Jan. 24, 2000, at 9.

139. *See id.*

140. *Id.*

141. *See Suffer the Little Children*, THE GUARDIAN (London), Nov. 10, 1999, at 2.

142. *Id.*

143. *See* LINDA L. EMANUEL, REGULATING HOW WE DIE: THE ETHICAL, MEDICAL, AND LEGAL ISSUES SURROUNDING PHYSICIAN-ASSISTED SUICIDE 155 (1998) (emphasis added).

top cited reasons were current loss of dignity (fifty-seven percent) and anticipated loss of dignity (forty-six percent).[144] Studies done in the state of Washington in the United States seem to mirror these results with "future loss of control (seventy-seven percent), being a burden (seventy-five percent), being dependent (seventy-four percent), and loss of dignity (seventy-two percent)" being the top reasons given for desiring assisted suicide.[145] In fact, seventy percent of those surveyed in Washington were experiencing "less than severe pain."[146]

However, in 1986 the World Health Organization agreed that in nearly ten percent of cancer patients, even maximum pain relief efforts would not give sufficient relief.[147] In fact, almost forty-eight percent of American oncologists stated that they would request euthanasia or physician assisted suicide for *themselves* suggesting a lack of faith in the "relief" granted by palliative care.[148] Similarly, in the Netherlands, fifty-five percent of physicians disagree that "adequate alleviation of pain and/or symptoms and personal care of the dying patient make euthanasia unnecessary."[149]

The definition of pain, however, is highly subjective, and the focus on pain is a red herring. Reams of empirical data are irrelevant when considering how each individual assesses the dignity and value of his or her life and what he or she may consider "painful." As one scholar has stated, "objective measures do not determine what is dignified and what is not."[150] The subjectivity of suffering is aptly described as follows: "[O]ne's physical suffering may result simply from being immobile or from constantly undergoing medical procedures. Psychological suffering results when one is unable to work, to participate in ordinary family and social life, to give to others as well as receiving from them."[151] Hence, the focus of the debate should be not on "pain," but on "suffering" as viewed by the individual.[152]

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144. *See id.*
145. *See id.*
146. *See id.*
147. *See id.*
148. *See id.* at 155 (emphasis added).
149. *See id.* at 154.
150. *See id.* at 172.
151. *See* HAMEL & DUBOSE, *supra* note 3, at 61.
152. *See id.* In a survey of parents of 103 children who died of cancer between 1990 and 1997, 92 children suffered "a great deal" or "a lot" from at least one symptom. More than half suffered significantly from at least three symptoms. More than 80% of the children hurt. Most were given palliative treatment, but only 27% felt better. Fifty of the children were still getting cancer treatments, such as radiation, chemotherapy or bone-marrow transplants, in their last month alive. Seven died in the bone-marrow transplant unit. Doctors are so conditioned to

Some American critics of euthanasia and physician-assisted suicide refuse to recognize the suffering of patients, arguing that allowing physician-assisted suicide for patients who are not in excruciating physical pain would be to venture onto a slippery slope where physicians kill on a whim. However, fearing that physicians will kill on a whim is antithetical to allowing the patient to determine whether he or she is suffering enough to want to die—a decision made entirely independent of the physician.

However, it is true that there are extremely rare instances in the Netherlands where the physician is called upon to assist a suicide without the patient's consent. But the statistics still do not back up the macabre predictions of physicians sliding down the slope of wholesale murder. The rate of nonvoluntary physician-assisted suicides performed in the Netherlands was 0.8% in 1990 and that number has remained nearly constant holding at 0.7% in 1995.[153]

American opponents of euthanasia and physician-assisted suicide also cite a gross lack of respect for human life in the Netherlands that contributes to euthanizing so many people. However, "[t]he legalization of abortion apparently did not put Holland on a slippery slope"[154] and any arguments proclaiming America's moral superiority regarding the "life issue" are absurd. While the United States has one of the highest abortion rates in the world, "[t]he Netherlands' abortion rate is the lowest for any Western country."[155]

Adversaries of the right to die with dignity further proclaim that there is good in suffering in that it unites one with Christ, allowing the sufferer "to make up for sins committed by themselves and others, to earn blessings for loved ones, and to merit a reward in the afterlife."[156] The anti-euthanasia groups call on the terminally ill or suffering to accept what they do not understand because it is being meted out by

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"cure" the patient that they often are oblivious to the suffering. *See Dying Kids Suffer Needlessly* (visited Feb. 4, 2000) <http://www/V3/newsfeed/stories/s/print/sufferingchildren.htm>.

153. *Netherlands Ministry*, *supra* note 93. Note also that many of these nonvoluntary physician-assisted suicides were performed on newborn babies who were in severe distress, pain, and nonviable and that the procedure to terminate life was painless and done with the approval of the parents. *See id.*

154. EMANUEL, *supra* note 143, at 161.

155. EMANUEL, *supra* note 143, at 161; HAMEL & DUBOSE, *supra* note 3, at 161. Approximately 6.5 out of 1000 women between the ages of 15 and 44 have abortions in the Netherlands, whereas the number has ranged from a high of 24 out of 1000 (1980) to a record low of 20 out of 1000 (1995) in the United States. The Netherlands has the third lowest rate of abortion in the West—the countries with the lowest rates, Ireland and Spain, outlaw abortion altogether. *Fox News: 46 Million Abortions Worldwide Each Year* (visited Apr. 20, 2000) <http://reagan.com/HotTopics.main/HotMike/document-1.22.1999.5.html>

156. *See* HAMEL & DUBOSE, *supra* note 3, at 62.

God, and therefore, it must have some good in it.[157] Any legal argument based on a moral repulsion grounded in religious beliefs is untenable and should be per se unconstitutional.[158] To adhere to a religious perspective of euthanasia is to premise standards based upon beliefs not accepted by all Americans, "which is as directly opposed to the Constitution and our special social leniency's as is likely to be found."[159] The United States of America is not a theocracy and the law is not faith based.[160] Divine revelation regarding euthanasia is accepted on faith—and any arguments based on faith "are constrained by their necessary reference to contested bases of analysis."[161]

Therefore, the right to die debate is viewed by some as all or nothing: "[T]here is no middle ground to the sanctity of human life."[162] However, in spite of claims that euthanasia is anomalous in placing valuations on the sacrosanctity of life, the sacrosanctity of life is challenged daily by a criminal justice system that ascribes more value to some lives than others.[163] For example, "persons convicted of murdering police officers face more severe punishments."[164] This differentiation between a police officer and a citizen is based on the fact that society has made a value judgment regarding police in relation to citizens.[165] The inverse is true when a citizen kills a felon in self-defense—no punishment is given to the citizen.[166] It is clear from these examples that society attributes hierarchical worth to human life every day—"[i]t is for civilization to justify those distinctions."[167]

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157. *See id.*

158. Although not always mutually exclusive, religious faith and morality are two distinct concepts. "With [religious] faith, people make decisions based on an authority—a deity, a prophet or even a book. With morality, the tools are reason and experience." INDIANAPOLIS STAR, Dec. 16, 1999, at A28 (quoting Mal Watkins, professor emeritus of philosophy at the Air Force Academy).

159. *See* Messinger, *supra* note 5, at 249.

160. *See id.*

161. *See id.* at 240.

162. *See id.* "Last year, when Michigan had an assisted-suicide initiative on the ballot, the Catholic Church spent five million dollars to defeat the issue—a sum that was sixty-six times what the Hemlock Society and other proponents could raise." INDIANAPOLIS STAR, Dec. 16, 1999, at A28.

163. *See* Messinger, *supra* note 5, at 225.

164. *See* TEX. PENAL CODE ANN. art. 19.03(1) (West 1974).

165. *See* Messinger, *supra* note 5, at 225.

166. *See* TEX. PENAL CODE ANN. art. 9.32 (West 1974).

167. *See* Messinger, *supra* note 5, at 226.

B. History and Tradition: A "Values-Oriented" Refusal to Grapple with the Unpleasant By-Products of Modern Medicine

The Court's reliance on "history and tradition" is often nothing more than a thinly veiled adherence to the Judeo-Christian values of our forefathers. The *Glucksberg* court cited *Hales v. Petit*, which states that "[suicide] is an Offence against Nature, against God, and against the King."[168] Such an argument holds no weight in a twenty-first century multicultural society where concepts of what is natural or "against God" (or Allah, Vishu, Buddha, etc.) are unresolved.

"While many of us may believe that suffering and physical humiliation are meaningful life experiences, we cannot prescribe them for those who do not agree with our views."[169] The founder of the Euthanasia Society of America, the Reverend Dr. Charles F. Potter, pointed out the hypocrisy of religious arguments that euthanasia violated the Sixth Commandment:

> It seems that if the killing is done wholesale and in anger and bitter hate, the Ten Commandments can be set aside; but when you come to an individual case, and the killing is done in mercy, to release a sufferer from intolerable agony, the Ten Commandments are suddenly in force again.[170]

Furthermore, the majority of Americans support a right to physician-assisted suicide and to be free of machinery and "life-saving" contraptions that were not even conceived of in the mid-sixteenth century when *Hales v. Petit* was decided.[171] Dr. Harry E. Fosdick,

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168. *See Glucksberg*, 521 U.S. at 712 n.10 (quoting Hales v. Petit, 75 Eng. Rep. 387, 400 (1561-62)).

169. *See* HAMEL & DUBOSE, *supra* note 3, at 127.

170. *See* Messinger, *supra* note 5, at 7 (quoting O. RUTH RUSSELL, FREEDOM TO DIE: MORAL AND LEGAL ASPECTS OF EUTHANASIA 73 (rev. ed. 1977).

171. *See* HAMEL & DUBOSE, *supra* note 3, at 127. The National Opinion Research Center conducting a General Social Survey through the University of Chicago asked:

> When a person has a disease that cannot be cured, do you think doctors should be allowed, by law, to end the patient's life by some painless means if the patient and his family request it? In 1977, 60% of those surveyed responded yes. By 1991, 72% responded positively. According to a survey conducted by the Harris Association in late 1993, a majority of the public (72%) approves even Dr. Jack Kevorkian's notorious and sensational actions in assisting suicides by several people, most of whom did not have terminal illness.

Id. Exemplifying a shift in public opinion on suicide was an announcement by Hallmark Cards in January, 1998, that it would launch a line of cards aimed at consoling those left behind after a suicide. The cards were tested in six major cities in the United States and Hallmark reported an "overwhelmingly positive response." According to a Hallmark spokesperson, the cards "celebrate all experiences, beautiful and painful," but startlingly the cards break with the

minister of the Riverside Church in New York, further refuted the proposition that God has the right to determine the end of life "by pointing out that man ha[s] been responsible for increasing the average lifespan from approximately thirty years during early colonial days to well over seventy years today."[172]

In a recent article, Ezekiel Emmanuel argued that carbon monoxide inhalation to commit suicide is "available to anyone with a car."[173] Aside from the fact that this comment is patently offensive, it only serves to further the argument for those wanting to die with dignity. Many people do not wish to die in the garage with the car running, nor are many terminally ill patients even able to be moved to the garage (not to mention that some people do not have cars).

Mr. Ezekiel avers that "[m]oreover, dying patients do not live with empty medicine cabinets. Almost all dying patients—and certainly those dying of cancer and AIDS—have more than enough narcotics and sleeping pills to end their own lives."[174] Once again the argument focuses not on the individuals involved, but rather on allowing the State, or Mr. Ezekiel, or some other nonconcerned party, to decide the value of someone else's life and how that person's life must be played out to the bitter end.

In light of the exorbitant life-saving measures often exercised at the expense of quality of life, to want to control our own demise is not eccentric or selfish as many opponents of euthanasia and physician-assisted suicide claim.[175] In fact, such a desire, in certain circumstances, may reflect that the patient "[seeks] meaning, some existential relationship to that most profound event, in a social context

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Christian doctrine of suicide as a sin by reassuring the recipient "our compassionate Creator understands the suicide" and has "already welcomed" the loved one "home." *See DeathNET* (visited Feb. 14, 2000) <http://www.rights.org/deathnet/open.html>.

172. *See* Messinger, *supra* note 5, at 224 n.419 (quoting O. RUTH RUSSELL, FREEDOM TO DIE: MORAL AND LEGAL ASPECTS OF EUTHANASIA 112 (rev. ed. 1977)).

173. *See* Ezekiel Emmanuel, *The Future of Euthanasia and Physician-Assisted Suicide: Beyond Rights Talk to Informed Public Policy*, 82 MINN. L. REV. 983, 991 (1998).

174. *See id.* at 992. Mr. Ezekiel offers no empirical evidence to support his groundless claim. Anecdotally, having known and worked with many People With AIDS (PWAs), I have never known a single PWA with narcotics or sleeping pills in their medicine cabinets. Moreover, many PWAs would not have the strength to walk to their medicine cabinets even if they possessed such a stash (and to retrieve the medication on their behalf would constitute a criminal offense).

175. *See* HAMEL & DUBOSE, *supra* note 3, at 126. Lack of control is a fundamental concern for terminally-ill Americans and "[d]ying in modern contexts connotes a fear of losing control, which is antithetical to a core American value. The option to be killed restores control." *Id.* at 34.

that threatens to degrade the event to the purely corporeal and anonymous."[176]

VI. THE FIRST STEPS DOWN THE PATH OF RECOGNIZING A RIGHT TO DIE

In spite of all of the arguments for and against euthanasia and physician-assisted suicide, it remains that we as a society must come to a solution. Although medical technology has made miraculous advances in the past fifty years, some say that a result of this progress is the lengthening of life beyond what some patients desire. In resolving the debate over dying with dignity, American legislators should consider a few examples learned from abroad in shaping new legislation. The following are my proposals:

A. Universal Health Care

To prevent any interjection of financial concerns or concern by the patient of being a "burden," health care must be universal and comprehensive.[177] Although Justice O'Connor cannot fathom a state statute that would allow people to suffer by withholding palliative care, this is precisely the regime under which many Americans currently live. Prescription drugs or surgery that may alleviate pain or lengthen life are expensive options and often unavailable, even assuming that the patient has the financial resources to see a physician to obtain the prescription in the first place.

The most important facet of the slippery slope argument when comparing the United States to the Netherlands is that Americans do not have a national health insurance system.[178] With so many patients uninsured, the financial pressures on the patient and the patient's family can be staggering, with the elderly and minorities (the bulk of suffering uninsureds) most at risk.[179] However, instead of using this argument as a reason to prohibit physician-assisted suicide, it should be a call for "right-to-life" and religious groups to refocus their energies on reforming the health care system that allows such

176. *See id.*

177. According to the Health Insurance Association of America, 43.5 million Americans currently lack health insurance. That number is expected to grow by an additional ten million by 2007. *See Channel 2000-Uninsured Americans Increasing* (visited Feb. 20, 2000) <http://www.channel2000.com/news/health/stories/news-health-981210-914315.html>. According to the Census Bureau on 9/29/98, an estimated 125,000 Americans lose their health insurance each month. *Americans Without Health Insurance* (visited Feb. 20, 2000) <http://www.uhcan.org/files/data/uninsured.html>.

178. *See* HAMEL & DUBOSE, *supra* note 3, at 133.

179. *See id.*

disparate treatment.[180] Surely, a "right to life" encompasses a right to a healthy life free of preventable and treatable diseases—a life where medication that could provide the palliative care that adversaries of euthanasia call for would actually be affordable to millions of Americans unable to fill their prescriptions due to financial limitations. This conflict is described as follows: "It's as if we have to construct moral limits for ourselves because we cannot, in another realm, do something that our country ought to do. We hold dying patients hostage to the moral failing of our society."[181] Currently in the United States there exists a covert practice of "allowing to die" the poor and uninsured.[182] For instance, "the poor and disadvantaged already receive fewer expensive and potentially lifesaving interventions such as coronary bypass surgery."[183] Hence, in America, there exists a pernicious system wherein wealth, not the suffering of the patient, provides a justification for non-voluntary physician-assisted suicide. The same system that provides adequate health care only for the privileged also further erodes the argument that "legalizing assisted dying would lead to a loss of trust in the medical profession because patients would never know whether their doctor might kill them." It could be argued that patients already lack trust in a system that allows the poor and elderly to die unceremoniously for lack of insurance. Many insured patients live with the palpable fear of denied insurance claims or losing coverage altogether. This fear breeds distrust in the health care system and furthers fears that "their doctor might kill them" more than the legalization of physician-assisted suicide could ever do. Once again, the debate in this area has focused on the symptom rather than the cure.

B. I Own My Body

Under Roman law, "willful disregard of another's personality" was universally recognized as an infringement on one's right to privacy.[184] This concept has been influential in shaping the modern civil law of France, Switzerland, and Germany, which all recognize an actionable right against invasion of privacy.[185] However, the notion of

180. *See id.*
181. *See id.*
182. *See id.* at 134.
183. *See id.* at 134 (quoting K. Langa & E. Sussman, *The Effect of Cost-Containment Policies on Rates of Coronary Revascularization in California*, 329 NEW ENG. J. MED. 1784, 1784-89 (1993).
184. *See* Messinger, *supra* note 5, at 230 n.458.
185. *See id.*

a fundamental right to privacy is a concept relatively foreign to the common law. Although a presumption of bodily integrity was recognized early on, as seen in John Stuart Mill's assertion that a state has no dominion over members of a civilized community save to prevent harm to others, there existed no actionable defense based on invasion of privacy.[186] The focus of the modern right to privacy argument should be based fundamentally in property law,[187] using the civil law as our guide, with the pivotal question being: do we own ourselves?[188]

The common law adheres to the Judeo-Christian tradition which suggests that man possesses usufructory rights over his body, but that the religious entity is the true owner of man.[189] Typifying the Judeo-Christian philosophy is the statement by Mary C. Senander of the International Anti-Euthanasia Task Force:

> When you ask for social and legal approval of killing, you're asking ME to participate in YOUR death, to share a communal responsibility and burden. And guilt. And blame. And I won't do it! Now you're meddling with MY choices and MY conscience. Don't expect me to be silent when these issues of public policy are debated; I have MY rights too.[190]

Unfortunately, Ms. Senander asserts a faulty premise that a right to die with dignity violates a right of citizens at large to be free from immoral infringements by fellow citizens (according to the moral leanings of the complaining party).[191] All societies condone customs that some may find objectionable, but this does not necessarily mean that we have "participated" in them by virtue of our existence in society.[192] By asserting her right to "choice," Ms. Senander interferes with another person's right to bodily integrity, a person whose

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186. *See id.* at 236 (quoting Samuel D. Warren & Louis D. Brandeis, *The Right to Privacy*, 4 HARV. L. REV. 193, 200-12 (1890)). *See also* J.S. Mill, *On Liberty*, *in* 43 GREAT BOOKS OF THE WESTERN WORLD 267, 271 (Robert Hutchens ed., 1952).

187. Mr. Messinger's article provides an interesting explanation that our use of possessive pronouns is indicative of private proprietary interests analogous to fee simple ownership of our own minds and bodies. Referring to relatives as "my child" or "my mother" connotes, above all, possession, but a possession grounded in a deep sense of emotional bonding and belonging. The "sphere of integrity" around this unit should be protected, like property owned in fee simple, against uninvited intrusion. The law now must decide how far the sphere extends. *See* Messinger, *supra* note 5, at 234 n.479. *See generally* Margaret J. Radin, *Property and Personhood*, 34 STAN. L. REV. 957 (1982).

188. *See* Messinger, *supra* note 5, at 235.

189. *See id.* at 235 n.481.

190. *See id.* at 220 (quoting MARY C. SENANDER, DEATH ON DEMAND: DON'T COUNT ME IN!(1988)).

191. *See id.* at 220.

192. *See id.*

suffering is unknown to Ms. Senander and who has no responsibilities to her sensitive conscience.

However, if one rejects the Judeo-Christian norm, the question becomes tautological (if we do not own ourselves, who does?), leading one to the ultimate conclusion that man owns himself.[193]

"Defining the body as property is not only *not* foreign to legal property constructs, but strongly analogous to common property laws. The general rule relating to the enjoyment of property assumes a right of use, with government limitations only with cause."[194] Furthermore, to refer to our bodies as property is not immoral or unseemly, as our American experience with slavery would suggest; in fact, "slavery is antithetical to the concept of self-ownership."[195]

Suffering, not pain, should be the focus of a patient's right to die. One can suffer immensely from not being able to enjoy life, yet not be in extreme pain. The decision regarding value of life directly implicates the patient's proprietary right. Hence, the government should only be permitted to interfere with the right to die upon showing cause that the government's interest in maintaining the life outweighs the property interest of the individual in choosing to end that life.

C. Reform the Homicide Laws

Much of the current debate could be resolved by instituting reforms in the criminal law that would seek to differentiate "active" euthanasia or physician-assisted suicide from homicide. Although the law permits "passive" euthanasia while vilifying "active" euthanasia, the "passive" form, usually the withdraw of food and water, is often barbaric torture at its worst.[196] Society mainly condemns homicide

193. *See id.*
194. *See id.* at 234 n.479 (emphasis added).
195. *See id.*
196. The progressive effects of withholding food and water:

(1) The mouth dries out and becomes caked or coated with thick material.
(2) The lips become parched and cracked or fissured.
(3) The tongue becomes swollen and might crack.
(4) The eyes sink back into their orbits.
(5) The cheeks become hollow.
(6) The lining of the nose might crack and bleed.
(7) The skin hangs loosely on the body and becomes scaly.
(8) The urine becomes highly concentrated, burning the bladder.
(9) The lining of the stomach dries out, causing dry heaves and vomiting.
(10) Hyperthermia develops.
(11) The brain cells begin drying out, causing convulsions.

because "it violates a person's interest in continuing to live."[197] However, euthanasia involves a person who no longer has an interest in continuing to live, therefore falling outside of the need for protection by the criminal justice system.[198] Although euthanasia necessarily involves causing the death of another, like homicide, there are differences that the criminal justice system should take into account.[199]

Humanitarian motives should be considered legitimate justifications for homicide.[200] Although motive is not a consideration under American homicide law, it is "unofficially relevant in prosecutorial discretion, grand jury indictments, jury verdicts, and sentencing."[201] However, it is anathema to the rule of law to force defendants to rely upon the good graces of prosecutors, judges, and juries.[202]

The motives of the person who desires to die should also be taken into consideration.[203] If a person has suffered a medical tragedy and has asked to die, this can be easily corroborated by witnesses and should be a factor in determining whether the death was euthanistic or unlawful.[204]

The approach of the American legal system to physician-assisted suicide should be changed to resemble the German and Swiss

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(12) The respiratory tract dries out, causing very thick secretions which can plug the lungs and cause death.

(13) Eventually, the major organs fail, resulting in death.

See id. at 243 n.532 (citing Rita Marker, *Euthanasia Part III: Starvation and Dehydration as Treatment*, STEUBENVILLE REGISTER, Nov. 13, 1987, at 12 (description by Judge David H. Kopelman of Massachusetts)). The American Medical Association supports a patient's right to request the withdrawal of treatment, but vehemently condemns "active" euthanasia. *See id.* at 242-43 (quoting Rita Marker, *Euthanasia Part III: Starvation and Dehydration as Treatment*, STEUBENVILLE REGISTER, Nov. 13, 1987, at 12).

197. *See id.* at 237.

198. *See id.*

199. Active euthanasia perfectly fits the definition of premeditated murder. The only contested issue is the meaning of "malice aforethought." *See id.* at 238 n.498 (citing WAYNE R. LAFAVE & AUSTIN W. SCOTT, CRIMINAL LAW § 7.1 (2d ed. 1986)). In common law and statutory definitions of felonious homicide, "malice" is synonymous with "intent," distinguishing intentional homicide from manslaughter. *See id.* at 238 n.498. Therefore, a participant in active euthanasia falls squarely within the category of intentional homicide, no matter how "noble" his motive. *Id.*

200. *See id.* at 238.

201. *See id.*

202. *See id.* As currently practiced, euthanasia leads coroners to falsify reports, prosecutors to refuse to prosecute, juries to acquit in spite of the law, and judges to compensate in sentencing. The only certainty in the law is the uncertainty of its application. *See id.* at 238 n.499.

203. *See id.* at 239.

204. *See id.*

systems, which focus on motive as a mitigating circumstance to any legal violation in carrying out a physician-assisted suicide.

D. Health Care Advance Directives Should Be Respected and Enforced in the Court

Health care advance directives can be divided into two categories: (1) a living will which permits competent adults to make known in advance their views on extraordinary treatment and (2) durable powers of attorney which allow a proxy to make a health choice on behalf of someone who is unable to do so. As of July 1, 1999, forty-seven states and the District of Colombia[205] had living will statutes and thirty-four states had Emergency Medical Service—Do Not Resuscitate statutes.[206] The current trend is to amalgamate the statutes authorizing living wills and durable powers of attorney into a comprehensive advance directive statute. Fifteen states have already done so.[207]

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205. States permitting a living will include: Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virgin Islands, Washington, West Virginia, Wisconsin, and Wyoming. *See End of Life Care Legislative Directions—1999* (visited Feb. 20, 2000) <http://www.abanet.org/elderly/end.html>. Five states have authorized the department of motor vehicles to place a notice on drivers' licenses indicating if the individual has an advance directive or a proxy (Alaska, Illinois, Minnesota, Missouri, South Dakota, and Texas). *See id.*

206. States permitting a Emergency Medical Service-Do Not Resuscitate order include: Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Kansas, Kentucky, Maryland, Michigan, Montana, Nevada, New Hampshire, New Mexico, New York, North Carolina, Ohio, Oklahoma, Rhode Island, South Carolina, Tennessee, Texas, Utah, Virgin Islands, Washington, West Virginia, Wisconsin, Wyoming. *See End of Life Care Legislative Directions—1999* (visited Feb. 20, 2000) <http://www.abanet.org/elderly/end.html>. The EMS-DNR statutes remedy a problem created by the fact that EMS personnel are generally required to administer cardio-pulmonary resuscitation or other life-saving measures in the absence of a physician's express order to withhold such treatment. The EMS-DNR statutes allow the EMS personnel to honor advance directives. The laws provide specific identification requirements, procedures, and protocols; or they permit development of a protocol by the state health department. Note that in Oregon the DNR statute is incorporated into the law without special legislation. *See id.* Do-not-resuscitate orders create a curious legal conundrum. A DNR order to refuse cardio-pulmonary resuscitation always "hastens death," therefore such a DNR order written by a physician is a physician-assisted suicide. *See* Emmanuel, *supra* note 174, at 214.

207. The states that have enacted a general advance directive statute include: Alabama, Arizona, Connecticut, Delaware, Florida, Kentucky, Maine, Maryland, Minnesota, Mississippi, New Jersey, New Mexico, Oklahoma, Oregon, Virginia. *See End of Life Care Legislative Directions—1999* (visited Feb. 20, 2000) <http://www.abanet.org/elderly/end.html>. The Minnesota statute is unique in its broad approach, not limiting the declarant to placing "check-marks" in blanks, it reads, in part:

But in spite of the progress in legalizing living wills and durable powers of attorney, the majority of Americans do not exercise their right to a health care advance directive. Without an advance directive, in the case of debilitating illness, the patient moves into the murky legal waters of surrogate consent provisions. Although thirty-six states and the District of Colombia recognize the right of a surrogate to make decisions on the patient's behalf,[208] application of the right of a surrogate is rarely without debate.[209] Usually close family members make such decisions on behalf of the patient. However, the debate rages as to whether the decision by the husband or wife of the patient

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> I want you to know these things about me to help you make decisions about my health care:
> My goals for my health care:
> My fears about my health care:
> My spiritual or religious beliefs and traditions:
> My beliefs about when life would be no longer worth living:
> My thoughts about how my medical condition might affect my family:
> Many medical treatments may be used to try to improve my medical condition or to prolong my file. Examples include artificial breathing by a machine connected to a tube in the lungs, artificial feeding or fluids through tubes, attempts to start a stopped heart, surgeries, dialysis, antibiotics, and blood transfusions. Most medical treatments can be tried for a while and then stopped if they do not help.
> I have these views about my health care in these situations:
> (Note: You can discuss general feelings, specific treatments, or leave any of them blank)
> If I had a reasonable chance of recovery, and were temporarily unable to decide or speak for myself, I would want:
> If I were permanently unconscious and unable to decide or speak for myself, I would want:
> If I were completely dependent on others for my care and unable to decide or speak for myself, I would want:
> In all circumstance, my doctors will try to keep me comfortable and reduce my pain. This is how I feel about pain relief if it would affect my alertness or if it could shorten my life:
> There are other things that I want or do not want for my health care, if possible:
> Who I would like to be my doctor:
> Where I would like to live to receive health care:
> Where I would like to die and other wishes I have about dying:
> My wishes about donating parts of my body when I die:
> My wishes about what happens to my body when I die (cremation, burial):
> Any other things:

See id. (quoting MINN. STAT. §§ 145C.01-.15 (Supp. 1998), the enactment of this Health Decisions Act replaces the former Living Will and Durable Power Acts.

208. States with a surrogate consent statute include: Alaska, Arizona, Arkansas, California (limited), Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indian, Iowa, Kentucky, Louisiana, Maine, Maryland, Mississippi, Montana, Nevada, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, South Carolina, South Dakota, Texas, Utah, Virgin Islands, Washington, West Virginia, Wyoming. *See End of Life Care Legislative Directions—1999* (visited Feb. 20, 2000) <http://www.abanet.org/elderly/end.html>.

209. *See* HAMEL & DUBOSE, *supra* note 3, at 1123.

should trump the decision of a blood relative. The law is not equipped to decide, for example, between differing choices by two surrogates of equal standing (two children with differing opinions on the fate of a parent). Nor is the law prepared to deal with the rights of a life-partner in comparison to long recognized "familial" rights.[210] State laws regarding surrogate rights are novel and widely varied. Hopefully, over time an established method will develop in the laboratory of the states that can be emulated by all states.

However, in spite of the decisions made by the patient in an advance directive or by concerned parties as surrogates, many physicians ignore or bypass the orders.[211] To enforce the choice of patients and their surrogates, patients and families should sue physicians, hospitals, and nursing homes for money damages when treatment is administered against express will.[212] A recent survey indicated that "fewer than half of the treating physicians even knew their patients did not want resuscitation; half of the patients who died in the hospitals were in moderate to severe pain at least half of the time; more than a third of those patients spent at least the last ten days of life in intensive care, comatose, or on a ventilator against their wishes; and many of those patients had spent their entire life savings.[213]

The results of this study confirm that the United States must follow the lead of countries like the Netherlands in opening up dialogue regarding death issues. Battery and wrongful life suits for damages would help force this dialogue so feared in the United States. Those Americans who focus on the reverence of life should learn, like the Dutch, to accept the reverence of death; accepting death is something we all must do at one point, and "creating better rituals, talking about death, and exploring the dimensions of its personal

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210. This becomes particularly important in the modern era as homosexual AIDS patients fall ill and their partners are forced to accept the decisions of family members. However, the same situation applies to unmarried heterosexual couples. Only two states, Arizona and New Mexico, recognize "domestic partners" (Arizona) and "individual[s] in a long-term spouse-like relationship" (New Mexico). However, these states permit a "majority rules" approach if disagreement arises, so the partner can easily be overruled. *See End of Life Care Legislative Directions—1999* (visited Feb. 20, 2000) <http://www.abanet.org/elderly/end.html>.

211. *See* EMANUEL, *supra* note 143, at 77.

212. *See generally* Kellen F. Rodriguez, *Suing Health Care Providers for Saving Lives*, 20:1 J. LEGAL MED. (1999).

213. *See American Medical Association, A Controlled Trial to Improve Care for Seriously Ill Hospital Patients: The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT)*, 274 J.A.M.A. 1591 (1995).

meaning might give us a renewed appreciation for the meaning of life . . . ."[214]

VII. CONCLUSION

As medical technology lengthens man's natural life-span, the right to die with dignity has moved to the forefront of contentious American societal issues. Americans must open themselves up to carry on a dialogue about death and what death with dignity means to each of us as individuals. We should not hesitate to look at right to die legislation on the international stage, prudently sifting through novel and bold approaches that may or may not work in our country.

However, there are reforms that must be instituted before any debate on a right to die with dignity can begin in earnest. First, universal healthcare is a prerequisite to any debate on right to die. Without a healthcare system that respects all Americans, regardless of income, there will always be inherent abuses of patients notwithstanding any concerns over abuses of euthanasia. Second, we should recognize that each individual has a proprietary right to his or her own body. The government should not interfere with these rights absent showing cause. Third, the homicide laws in the United States should be reformed to allow humanitarian motives to be a mitigating factor for homicide. Last, the decisions of patients, proxies, and surrogates must be respected by physicians and adhered to in order to avoid suits for money damages. Hopefully, if we take the first daring steps towards reform, the debate can open up in earnest to allow all voices to be heard and respected regarding this sensitive issue.

214. *See id.*