




CSU
College of Law Library

1993

Has the Time Come for Doctor Death: Should Physician-Assisted Suicide Be Legalized?

Wendy N. Weigand

Follow this and additional works at: <https://engagedscholarship.csuohio.edu/jlh>

 Part of the [Health Law and Policy Commons](#), and the [Medical Jurisprudence Commons](#)
[How does access to this work benefit you? Let us know!](#)

Recommended Citation

Note, Has the Time Come for Doctor Death: Should Physician-Assisted Suicide Be Legalized?, 7 J.L. & Health 321 (1992-1993)

This Note is brought to you for free and open access by the Journals at EngagedScholarship@CSU. It has been accepted for inclusion in Journal of Law and Health by an authorized editor of EngagedScholarship@CSU. For more information, please contact library.es@csuohio.edu.

HAS THE TIME COME FOR DOCTOR DEATH: SHOULD
PHYSICIAN-ASSISTED SUICIDE BE LEGALIZED?

I. INTRODUCTION321

II. HISTORY OF EUTHANASIA323

III. EUTHANASIA IN THE NETHERLANDS333

IV. MODERN ATTEMPTS TO LEGALIZE THE RIGHT TO DIE IN THE
UNITED STATES337

V. SHOULD PHYSICIAN-AID-IN-DYING BE LEGALIZED?342

VI. SOME SUGGESTIONS FOR THE FUTURE—ANALYSIS OF THE
ARGUMENTS346

I. INTRODUCTION

On June 4, 1990, Janet Adkins, a fifty-four year old Alzheimer's patient from Portland, Oregon, committed suicide with Dr. Jack Kevorkian's so called "Suicide Machine" in his rusty Volkswagon van at a county park near Holly, Michigan.¹ In the March 7, 1991 edition of the *New England Journal of Medicine*, a Rochester, New York physician described how he helped a terminally ill cancer patient commit suicide by referring her to the Hemlock Society when she made known to him her desire to take her life when the time came. He also assented to her request for barbiturates, knowing full well that they were an essential ingredient to a Hemlock Society suicide.² If on November 5, 1991, Initiative 119 had passed by a majority of voters, the people of Washington State would have been the first in the world to legalize physician-aid-in-dying. These events, and others like them, have sparked a national furor and debate over the issue of doctor-assisted suicide and the right-to-die.

The fear of death, and the desire to control the events surrounding it, have always existed.³ Today, the looming question is: How far can patients and

¹Kevorkian Chronology, THE DETROIT NEWS, Feb. 5, 1992, available in LEXIS, Nexis Library, UPI File *2.

²Dr. Timothy E. Quill, M.D., *Death and Dignity: A Case of Individualized Decision Making*, 324 NEW ENG. J. MED. 691, 692-693 (1991).

³In ancient Greece and Rome, suicide was an accepted way to end life. Seneca, the famed Roman Stoic philosopher, was 67 when he opened the veins in his wrist and drank a potion of the poisonous hemlock plant. A physician eased him into a warm bath. His death was prompted not by a terminal illness but a message from the volatile emperor Nero to disappear. Still, he was ready. 'I have lived long enough,' he had written a friend. 'I have had my fill. I await death. Farewell.'

Abigail Trafford, *Society's View of Suicide*, THE WASHINGTON POST, August 20, 1991, § Z, at 11.

doctors go to control the dying process? Euthanasia has been part of the vocabulary of death since ancient times. The word "euthanasia" is derived from Greek roots: "eu" meaning well, and "thanatos" meaning death.⁴ Black's Law Dictionary defines euthanasia as "The act or practice of painlessly putting to death persons suffering from incurable and distressing disease; an easy or agreeable death."⁵ Euthanasia is also called "mercy killing".

Euthanasia is divided into two categories: active euthanasia and passive euthanasia. Active euthanasia involves a direct act, such as lethal injection, intended to kill the patient. Passive euthanasia involves an act intended to allow the dying process to conclude, such as the discontinuation of a respirator or the removal of a feeding tube.⁶ The distinction between active and passive euthanasia is thought to be crucial for medical ethics. The idea accepted by most doctors is that "it is permissible, at least in some cases, to withhold treatment and allow a patient to die, but it is never permissible to take any direct action designed to kill the patient."⁷ The House of Delegates of the American Medical Association (hereinafter AMA) endorsed a statement on December 4, 1973 saying in part:

The intentional termination of the life of one human being by another mercy killing is contrary to . . . the policy of the American Medical Association.

The cessation of the employment of extraordinary means to prolong the life of the body when there is irrefutable evidence that biological death is imminent is the decision of the patient and or his immediate family. The advice and judgment of the physician should be freely available to the patient and or his immediate family.⁸

⁴WEBSTER'S NEW WORLD DICTIONARY 484 (2d ed. 1986).

⁵BLACK'S LAW DICTIONARY 654 (4th ed. rev. 1968).

⁶B.D. Colen, *Doctors Who Help Patients Die; MD's Reveal a Secret Practice: Aiding Suicides, Mercy Killing*, NEWSDAY, September 29, 1991, (News), at 4.

Euthanasia, either active or passive, can be further divided into voluntary or involuntary acts, depending on whether the ending of the life of the suffering patient is with her consent or by her request. Percy Foreman, *The Physician's Criminal Liability For the Practice of Euthanasia*, 27 BAYLOR L. REV., 54, 58 (1975).

⁷James Rachals, *Active and Passive Euthanasia*, in MORAL PROBLEMS IN MEDICINE 286 (Samuel Gorovitz et al. eds., 2d ed. 1983).

⁸*Id.* at 286. The problem with this statement lies in the fact that there continues to be debate over what is the accepted definition of death for determining exactly when death occurs. Medical, legal, social, religious, moral and ethical segments of our society are all attempting to establish an acceptable definition of death from both the medical and legal standpoint. In *Thomas v. Anderson*, 215 P.2d 478, 482 (1950), the court said, "[D]eath occurs precisely when life ceases and does not occur until the heart stops beating and respiration ends. Death is not a continuing event [but] an event that takes place at a precise time." This definition of death, which uses the only the heart as the life-measuring organ, is almost universally considered outmoded. Rowine Hayes Brown, M.D., J.D. & Richard B. Truitt J.D., *Euthanasia and the Right to Die*, 3 OHIO N.U. L. REV. 615, 628-629 (1976).

A "true" doctor-assisted suicide can be distinguished from euthanasia in that the patient is actually bringing his or her own life to an end. The doctor in some way facilitates the action, either by providing the means for the suicide, such as in the *New England Journal of Medicine* article,⁹ or by giving the patient some kind of instruction as to the best way of carrying out the act. The difference lies in the fact that it is the patient killing him or herself with the help or advice of a physician, not the physician acting directly to shorten the life of a patient, as in euthanasia. The distinction becomes blurred in reality, however, because often there are no reliable witnesses to the "suicide" to verify that the doctor took no affirmative steps to end the life of the patient. In other instances, the patient may desperately want to kill him or herself but is too weak to do so; thus the doctor actually carries out the life-shortening act. Therefore, any discussion of doctor-assisted suicide must include a discussion of euthanasia, because the two are often indistinguishable.

II. HISTORY OF EUTHANASIA

To understand doctor-assisted suicide in its present context, one must understand that the debate about euthanasia is by no means new. Rather, it has been intensified by technological advances in the medical world. People perceive these advances as taking away from their autonomy at the end of life,

Today, the majority of states have adopted a dual statutory definition of death based on either the Model Definition of Death Act drafted in 1975 by the Law and Medicine Committee of the American Bar Association (hereinafter ABA), the Uniform Brain Death Act drafted in 1978 by the National Conference of Commissioners on Uniform State Laws (hereinafter NCCUSL), or the Model Determination of Death statute created by the AMA in 1979. In general, these acts provide that an individual who has sustained either irreversible cessation of circulatory and respiratory functions or irreversible cessation of all functions of the entire brain, including the brainstem, is dead. This determination must be made in accordance with accepted medical standards. The overwhelming majority of cases will continue to be determined according to part one, the circulatory and respiratory criteria. Under the part two criteria, the entire brain must cease to function irreversibly. The "entire brain" includes the brain stem as well as the neocortex. The concept of "entire brain" distinguishes determination of death under this Act from "neocortical death" or "persistent vegetative state." These are not deemed valid medical or legal bases for determining death.

The interest in these statutes arises from modern advances in lifesaving technology. A person may be artificially supported for respiration and circulation after all brain functions cease irreversibly. The medical profession, also, has developed techniques for determining loss of brain functions while cardiorespiratory support is administered. At the same time, the common law definition of death cannot assure recognition of these techniques. The common law standard for determining death is the cessation of all vital functions, traditionally demonstrated by an absence of spontaneous respiratory and cardiac functions. There is, then, a potential disparity between current and accepted biomedical practice and the common law which is why a new definition of death [is] necessary.

MONT CODE ANN. tit. 50, § 22-101 (1991).

⁹Quill, *supra* note 2, at 693.

and being able to sustain life past the point where they would like it to continue.¹⁰

It is widely believed that in Greek culture the practice of euthanasia, in the sense of mercy killing, was not an exceptional experience. "[G]enerally attitudes toward both passive and active euthanasia were strikingly different from modern ethical and legal considerations."¹¹ The then-current religious and secular medical practices required the physician to do away with the sufferings of the sick, to lessen the violence of their diseases, and to refuse to treat those who were overwhelmed by their diseases, because they realized that in such cases medicine was powerless. Furthermore, it was the physician's duty to treat only patients he could help.¹²

¹⁰Two examples of technological advances perceived as taking away personal autonomy are *Cruzan v. Director, Missouri Dept. of Health*, 110 S.Ct. 2841 (1990), and *In re Quinlan*, 355 A.2d 647 (1976), *cert. denied sub nom.*, *Garger v. New Jersey*, 429 U.S. 922 (1976), *c.f.*, *In re Conroy*, 486 A.2d 1209 (N.J. 1985). In *Cruzan*, Nancy Beth Cruzan lay in a persistent vegetative state for eight years following an automobile accident, kept alive only as a result of artificial nutrition and hydration. 110 S. Ct. at 2841. Hospital employees refused, without court approval, to honor the request of Cruzan's parents to terminate the life-sustaining measures, because such termination would result in her death. *Id.* at 2842. The United States Supreme Court held that a competent person has a liberty interest under the Due Process Clause in refusing unwanted medical treatment, including such treatment as lifesaving nutrition and hydration. *Id.* at 2852-3. When a patient is incompetent, however, he or she does not possess the same right, since such a person is unable to make an informed or voluntary choice to exercise that right. 110 S.Ct. at 2852. While a surrogate may, in some situations, act for the patient in electing to withdraw hydration and nutrition and thus cause death, the state may establish procedural safeguards to assure that the surrogate's action conforms as best it may to the wishes expressed by the patient while competent. *Id.*

Therefore the Due Process Clause does not require a State to accept the "substituted judgment" of close family members in the absence of substantial proof that their views reflect the patient's. *Id.* at 2852-3. Since the Missouri Supreme Court found that Nancy Beth Cruzan had not established by clear and convincing evidence that she would want not to be sustained by artificial means, the hospital could continue such treatment and did not have to defer to her parents' wishes to discontinue treatment. *Id.* at 2856.

In *Quinlan*, *supra*, the father of Karen Ann Quinlan sought to be appointed her guardian. 355 A.2d at 651. Karen Ann was in a persistent vegetative state and her father sought the express power to authorize the discontinuance of all extraordinary procedures for sustaining his daughter's vital processes. *Id.* at 651, 655. The Supreme Court of New Jersey held that a decision "by Karen Ann to permit [a] noncognitive, vegetative existence to terminate by natural forces" was "a valuable incident of her right to privacy which could be asserted on her behalf by her guardian." *Id.* at 664. The court also held that upon the concurrence of the guardian and the family, should the attending physicians conclude there was no reasonable possibility of Karen Ann's ever emerging from her comatose condition to a cognitive, sapient state, the life-support systems should be withdrawn and the action would be without any criminal or civil liability. *Id.* at 671-2.

¹¹Darrell W. Amundsen, *History of Medical Ethics: Ancient Greece and Rome*, 3 *ENCYCLOPEDIA OF BIOETHICS*, 930, 934 (Warren T. Reich, ed., 1978).

¹²JERRY B. WILSON, *DEATH BY DECISION: THE MEDICAL, MORAL, AND LEGAL DILEMMAS OF EUTHANASIA*, 19 (1975).

[I]t is safe to say that a physician who prolonged the life of a person who could not ultimately recover his or her health was considered to be acting unethically.¹³ In deciding whether or not to treat, prognosis was the most valuable tool . . . this was not its only function; it also won the physician respect, secured the confidence of . . . patients, and absolved the physician from blame.¹⁴

In the context of Greek conceptions of the value and purpose of human life, the Platonic principle of *kalokagathia* was implicit. This principle stressed the perfect balance of the physical and the mental in man. In accordance with this ideal, health became the goal and standard of the good life. Illness became the curse that made beauty and happiness impossible.¹⁵ Against this background, it is easier to understand the justifications for the practice of terminating the lives of the terminally ill. In the culture of ancient Greece, suicide, often by means of poison provided by physicians, was an everyday reality. Although Athenian law did not sanction this practice as a release from pain or illness, neither did it define suicide as a criminal offence. Suicide for any reason was not generally prohibited by law, except by soldiers or slaves.¹⁶ One can find only very rarely a suggestion that a terminally ill person deserved reprobation for putting an end to his misery. The writings of Seneca, a Stoic, are especially representative of this point of view:

It makes a great deal of difference whether a man is lengthening his life or his death. But if the body is useless for service, why should one not free the struggling soul? Perhaps one ought to do this a little before the debt is due, lest, when it falls due, he may be unable to perform the act.¹⁷

Nor was a physician generally criticized for assisting even a healthy person in committing suicide, either by administering poison or by other means. Some were even praised for devising quick and painless means.¹⁸ For most physicians, helping a man commit suicide would not have been construed as violating the aphorism "to help or at least not to do harm."¹⁹ This is in direct contradiction to the passage in the Hippocratic Oath which states "I will neither

¹³Amundsen, *supra* note 11, at 934, citing, PLATO REPUBLIC 406A, DEMOSTHENES, THIRD OLYNTHIAC 33, PLUTARCH, MORALIA, 23(A).

¹⁴*Id.* at 934.

¹⁵Wilson, *supra* note 12, at 20.

¹⁶Amundsen, *supra* note 11, at 934.

¹⁷Wilson, *supra* note 12, at 22, (citing SENECA, EPISTULAE MORALES, Vol. I, lvii 32-36, at 407-9).

¹⁸Amundsen, *supra* note 11 at 934 (citing Danielle Gourevitch, *Suicide Among the Sick in Classical Antiquity*, 43 BULL. OF THE HISTORY OF MEDICINE 501-518 (1969)).

¹⁹Benjamin B. Page, *History of Medical Ethics: Ancient Greece and Rome*, 3 ENCYCLOPEDIA OF BIOETHICS, 934 (Warren T. Reich, ed., 1978).

give a deadly drug to anybody, not even if asked for it, nor will I make a suggestion to this effect."²⁰ Although this prohibition in the Oath is consonant neither with what is usually encountered in the ancient medical literature nor with the vast majority of the laymen represented in the sources, it is not a completely anomalous position. Edelstein²¹ finds the prohibition compatible with Pythagorean conceptions of purity and holiness, but this system was not the only one in classical antiquity that

held suicide as an opprobrious action and some individual physicians undoubtedly would not help a patient to end his life. Aretaeus (second century A.D.), for example, writes that some patients, while suffering from a particularly painful disease, still shrink from death while others beg for death to come. In respect to the latter, he writes that it is still not morally right for the physician to cause their death but it is morally right to drug such patients in order to relieve their anguish.²²

It probably can be concluded, however, that Aretaeus and the author of the Oath represented the minority position.²³

Neoplatonism, which arose around the third century A.D., along with Christianity and Judaism were the movements largely responsible for the erosion of this attitude about suicide. Neoplatonism did not approve of suicide for any reason, based on the belief that man should not abandon his post assigned by God and on the belief that suicide adversely affected the life of the soul after death.²⁴ Christians interpreted the commandment "Thou shalt not kill" to refer to suicide as well as to all other forms of taking human life.²⁵ Augustine argued that no passage of Scripture could be found to sanction suicide in order to avoid temporal evils.²⁶ Judaism, too, condemned any active hastening of death because of the belief that every life is of supreme and infinite value.²⁷

Christianity and Judaism changed the focus of the value of life away from the quality of life to the belief that life itself was valuable regardless of the circumstances. In Christianity, as a result, suicide was denounced and anyone who committed suicide was denied a Christian burial. In the medieval period, Thomas Aquinas said suicide was sinful because it violated the commandment

²⁰*Id.* (following Kudlien's translation, p. 118, note 47.)

²¹Ludwig Edelstein, *The Hippocratic Oath: Text, Translation and Interpretation* 15 (1943), cited in 3 *ENCYCLOPEDIA OF BIOETHICS*, *supra* note 11, at 935.

²²3 *ENCYCLOPEDIA OF BIOETHICS*, *supra* note 13, at 935.

²³*Id.*

²⁴*Id.*

²⁵Gerald J. Gruman, *Death and Dying: Euthanasia and Sustaining Life*, 3 *ENCYCLOPEDIA OF BIOETHICS*, 261 (Warren T. Reich, ed., 1978).

²⁶Wilson, *supra* note 11, at 23.

²⁷3 *ENCYCLOPEDIA OF BIOETHICS*, *supra* note 11, at 794.

"Thou shalt not kill". He claimed it was "against the law of nature and contrary to charity which every man should have for himself."²⁸ He also maintained that suicide was unlawful because each man belongs to the community [and that] taking one's own life was a sin against God because life is a gift of God and is subject to his power.²⁹

The Jewish tradition recognizes a duty to protect life and health based on the law "You shall not stand upon your neighbor's blood."³⁰ Because of this, anyone in a position to rescue another person from any danger to life or limb, who refuses to do so, is guilty of a serious offense. Even in respect to one's own body, the law rules emphatically "It is forbidden to rely on miracles or to endanger one's own life."³¹

The sanctity of human life has a very specific connotation in Jewish law. It regards every human life as absolute and infinite in value.

By mathematical definition, infinity can no more be increased by multiplication than it can be reduced by division. Hence, a physically or mentally handicapped life, in whatever state of debility, is worth no less than a full and healthy life. . . . [B]y the same token, one person has the same value as a million people.³²

The law of Maimonides says: "He who kills, whether [the victim be] a healthy person or a sick person approaching death or even a patient already in his death-throes, is treated as a capital criminal."³³ Therefore,

however much Judaism cares about the mitigation of human pain, often even at the expense of modifying its own most sacred observances, what it cannot do is to purchase relief from suffering at the cost of life itself. For any sanction of euthanasia could not but

²⁸Wilson, *supra* note 12, at 24.

²⁹*Id.*

³⁰*Leviticus* 19:16.

³¹3 *ENCYCLOPEDIA OF BIOETHICS*, *supra* note 11, at 793.

³²*Id.* at 794.

The argument is as simple as it is compelling. If a person who has only another hour to live would lose his absolute title to life-presumably because it is all but worthless-it would follow that a patient expected to live for two more hours would enjoy twice this infinitesimal value. As the expectancy of life increases to, say, a week, or a year, or five years, so would its worth appreciate correspondingly. Consequently, no two human beings would have the same value. The worth of all would become relative, relative to their expectancy of life, or their state of health, or their usefulness to society, or any other arbitrary criterion. This would be the thin end of the wedge dividing mankind into people of superior and inferior worth, into those who have a greater and others who have a smaller claim to life.

Id.

³³*Id.*

cheapen life generally by making its preservation contingent upon considerations of expediency or relative merit.³⁴

With the reaffirmation of Greek and Roman values in the Renaissance, an "easy death" once again came to be regarded as an ideal. According to the Renaissance humanist, Luigi Cornaro, if one utilizes his "vital substance" with restraint in the course of a long life, death will be "natural" and "benign".³⁵ But if one's animating principle is consumed by unnatural, inordinate activity or disease, dying is agonized. This classical idea of easy dying was imbued by humanists with the values and rewards of Christian conduct: thus, "natural" was connoted a better or higher kind of death.³⁶ Cornaro emphasized an easy death in advanced years and the prospect of a longer life.³⁷

In contrast to Cornaro, Francis Bacon regarded the "promise of planned experimental research" as the main ingredient to prolong life or to terminate it effortlessly.³⁸ He considered long life as the most noble purpose of biomedicine and he considered euthanasia an essential area of medical skill. Relief of suffering was the mainstay to terminal care and, therefore, the physician could conceivably hasten death.³⁹

Thomas More's *Utopia* outlined the first organized system of euthanasia where patients with a terminal disease were advised by priests and magistrates to embrace suicide or other forms of hastened death.⁴⁰ *Utopia* depicts a perfect society in which voluntary euthanasia is officially sanctioned. It is uncertain whether More himself approved of euthanasia, but groups such as the Mercantilists proclaimed the right to die rather than to endure prolonged suffering.⁴¹ Mercantilism favored the individual: More's advisors ruled as "the will of God".⁴² Thus, Humanist individual independence was downplayed by a Mercantilist sort of "heroic self-sacrifice."⁴³

One person who blocked these Mercantilist tendencies toward euthanasia was John Locke. In his philosophy, life preservation, liberty and the pursuit of property were inextricably related.⁴⁴ He was, therefore, mistrustful that

³⁴*Id.*

³⁵3 ENCycLOPEDIA OF BIOETHICS, *supra* note 11, at 262.

³⁶*Id.*

³⁷3 ENCycLOPEDIA OF BIOETHICS, *supra* note 11, at 262.

³⁸*Id.*

³⁹*Id.*

⁴⁰*Id.* at 263.

⁴¹3 ENCycLOPEDIA OF BIOETHICS, *supra* note 11, at 262.

⁴²*Id.*

⁴³*Id.* at 263.

⁴⁴*Id.*

humanity would relinquish their "God-given and natural prerogatives."⁴⁵ Thus he did not condone a freedom to die.⁴⁶

Others, such as John Donne, argued in favor of suicide as a form of voluntary euthanasia, but Donne refrained from proposing rules of instances to justify the practice, because he felt that "the limits are obscure, and steepy and slippery and narrow, and every error deadly,"⁴⁷ echoing the fears of many in the present time. By the end of the eighteenth century, members of the medical profession were also calling attention to their responsibility to make death as "natural" and as human as possible. This emphasis on natural euthanasia continued up through the beginning of the twentieth century, but most who argued in favor of it desired only to make death easy, rather than to terminate life.⁴⁸

In the twentieth century, the first bill to address the legalization of active euthanasia, was introduced in the Ohio legislature in 1906.⁴⁹ Voluntary euthanasia for adults of sound mind who were fatally hurt, terminally ill, or suffering extreme pain would have been legalized, had the bill ever passed.⁵⁰ The issue continued to be discussed in the press in response to a number of controversial cases of mercy killing.⁵¹

⁴⁵*Id.*

⁴⁶*Id.*

Something that is 'inalienably' invested cannot be disposed of at pleasure, just as the steward or servant of a merchant must guard and augment the wealth of his employer. This stewardship of life and property, to be accumulated rather than enjoyed, initiated hard-working industrial expansion but not greater personal freedom.

Id. at 263.

⁴⁷Wilson, *supra* note 12 at 26, (citing John Donne, *Biathanatos*, 215-216, (1930).

⁴⁸*Id.* at 27.

⁴⁹*Id.*

⁵⁰*Id.* at 28.

⁵¹Wilson, *supra* note 12 at 28. In 1915, the question of euthanasia was posed by the death of the Bollinger baby. Dr. H.J. Haiselden, with the consent of the parents, refused to perform an operation on the baby that would have extended its life, because the child would have been radically deformed, partially paralyzed, and probably mentally impaired. There was mixed reaction to the Doctor's actions, but he was expelled from the Chicago Medical Society. One response to this case appeared in the *New Statesman* and warned that, "if we grant the principle that doctors have the right to destroy life, we have no guarantee that they might not be swept off their feet someday by some pseudoeugenics (the movement devoted to improving the human species through the control of hereditary factors in mating) which would involve the widespread destruction of human life." The events in Nazi Germany proved this article to be prophetic.

In 1920, the question of aiding suicide out of mercy was an issue in the case of *The People v. Roberts*, 335 N.W.2d 27 (1920), *app. denied*, 342 N.W.2d 519. Mr. Roberts, at the insistence of his wife who suffered with multiple sclerosis and who had attempted suicide previously, prepared a glass of water with Paris green (a poison), from which she drank and subsequently died. As a result, Roberts was convicted of willful murder and sentenced to life imprisonment at hard labor and solitary confinement.

The case of Dr. Herman N. Sander in New Hampshire was especially significant, because it was the first case involving a medical doctor. Dr. Sander was tried for having killed Mrs. Abbie Borrato, a patient who was dying with cancer.⁵² On December 4, 1949, the medical records showed that Dr. Sander had injected 10 cc. of air into her veins.⁵³ According to the attending nurse, Mrs. Borrato died ten minutes later.⁵⁴ Dr. Sander explained that he had acted out of pity. Motive was the central issue in the public discussion surrounding the trial. It also seems to have been a primary factor in the jury's acquittal of Dr. Sander.⁵⁵ Although it was thought that this case would decide the legality of euthanasia, the court did not face that issue directly.⁵⁶

In January 1974, for the first time since *Sander*, a "mercy killing" suit was filed against a physician.⁵⁷ Dr. Vincent A. Montemarano, the chief surgical resident of the Nassau County Medical Center, administered a lethal dose of potassium chloride to Eugene Bauer, a patient who was dying of throat cancer and who

Not all cases were treated with the same severity, however. In 1925, Dr. Harold E. Blazer was tried in Colorado for killing his daughter, who had been an incurable invalid for thirty-two years. The jury was unable to reach a verdict and his case was dismissed. Several years later in Los Angeles, Ruth B. Weiner was freed by a jury before which she admitted having shot her sister who had begged to be killed. In 1933 a coroner's jury in Atlanta found that Allie Stephens, who had suffered for five or six years from cancer, died of natural causes rather than from the violent blow given at her request by a nephew. In 1938, a New York grand jury refused to indict Harry C. Johnson for asphyxiating his wife, who had cancer and apparently wanted to die. The next year, Louis Greenfield was acquitted by a jury in the Bronx, New York, from a charge of first-degree manslaughter in the death of his seventeen-year-old son, who was paralyzed and mentally retarded.

In *Repouille v. United States*, 165 F.2d 152 (2d Cir. 1947), Mr. Repouille was indicted for manslaughter in the first degree. On October 12, 1939, Mr. Repouille deliberately put his son to death by means of chloroform. The boy was thirteen. He had suffered a brain injury at birth, which left him "an idiot and a physical monstrosity malformed in all four limbs." The child was blind, mute, and deformed; he had to be fed; the movements of his bladder and bowels were involuntary and his entire life had been spent in a crib. The jury brought in a verdict of manslaughter in the second degree with a recommendation of the utmost clemency. The judge sentenced him to not less than five years in prison, nor more than ten, execution to be stayed and the defendant to be placed on probation.

Even though euthanasia was not legal, and any attempts to sanction its practice met with strong opposition, it is clear from the cases that were prosecuted, juries tended to take the circumstances into account in reaching their decisions. Wilson, *supra* note 12 at 28-30.

⁵²*Id.*

⁵³*Id.*

⁵⁴*Id.*

⁵⁵Wilson, *supra* note 12 at 28-30.

⁵⁶State v. Sander, (N.H. 1950) (cited in 3 OHIO N.U. L. REV. 615, 620 (1976)).

⁵⁷Wilson, *supra* note 12 at 28-30.

was comatose.⁵⁸ Dr. Montemarano later stated the injection was given for the patient's condition rather than to kill him. He was indicted on a charge of willful murder and found not guilty.⁵⁹

Whatever the legal basis, mythical or real, upon which the defendants were acquitted in the above cases, they have strongly embedded in the public's mind that prosecutions involving "mercy killings" by doctors, do not lead to convictions.⁶⁰ Moreover, nullification is a predictable result.⁶¹ One commentator believes that such nullification serves a useful function as it creates a safety valve of mercy while at the same time upholding criminal law, thus limiting euthanasia.⁶² The problem with administering the law this way is that public confidence in the law requires consistency of judgment and guidance as to moral conduct, neither of which are provided by "safety valve" adjudicating.

Two cases of assisted suicide brought the issue into the spotlight in the 1990's. In both 1990 and 1991, Dr. Jack Kevorkian assisted women in committing suicide.⁶³ The first woman, Janet Adkins, was a fifty-four year old victim of Alzheimer's who preferred taking her life to slowly losing her mind. She had read about Dr. Kevorkian and had seen him on the "Donahue" show.⁶⁴ She and her husband flew two thousand miles from Portland, Oregon to discuss his suicide machine over dinner. Then on June 4, 1990, Dr. Kevorkian inserted a needle into her arm and started saline flowing. She pressed a button which sent potassium chloride to her heart, killing her.⁶⁵ The case raised many wrenching questions. She was a young, vital and athletic woman, who avidly played tennis.⁶⁶ Experts were concerned that she might have been misdiagnosed, and that even if she were not, she could have enjoyed many more productive years. Her family said she wanted to take her own life immediately upon hearing the diagnosis, but waited a year and underwent experimental treatment, talked

⁵⁸*Id.*

⁵⁹Brown & Truitt, *supra* note 8, at 621. This incident could well have been the first euthanasia case to be carried through to an eventual appeal before the United States Court. However, the case was not appealed, presumably because, when the body was exhumed, there were no traces of the alleged "death drug" found in the body.

⁶⁰*Id.*

⁶¹Book Note, *Death, Dying and the Law*, 30 RUTGERS L. REV. 300, 313 (1977).

⁶²Yale Kamisar, *Some Non-Religious Views Against Proposed Mercy Killing Legislation*, 42 MINN. L. REV. 969, 971 (1958).

⁶³Besides Adkins, Miller and Wantz, Dr. Kevorkian has also assisted in numerous other people's deaths, and, to date, has never been convicted of any type of murder.

⁶⁴*Id.*

⁶⁵*The Doctor's Suicide Van*, NEWSWEEK, June 18, 1990, (society) at 46.

⁶⁶*Id.*

with her minister and underwent family counseling with her sons.⁶⁷ In response to this, a Michigan judge issued a preliminary injunction against Kevorkian again using his suicide device. On December 3, 1990, Kevorkian was charged with first degree murder, but the charges were dropped by a judge who ruled no crime was committed because suicide is legal in Michigan and there was no law on the books criminalizing assisting suicide. On February 5, 1991, the same judge who dismissed the charges, issued a permanent injunction against using the suicide device again.⁶⁸

On October 23, 1991, two women, Sherry Miller and Marjorie Wantz, died in a cabin in a state park near Lake Orion, Michigan. Wantz died by lethal injection and Miller by inhaling carbon monoxide gas. Dr. Kevorkian assisted in their deaths. The day before, they videotaped themselves announcing their plans to kill themselves with Kevorkian's help.⁶⁹

In response to this, Kevorkian's license to practice medicine was revoked by the State Board of Medicine, for "negligence, incompetence, and administering drugs for other than lawful diagnostic or therapeutic purposes."⁷⁰ On February 3, 1991, a grand jury returned a murder indictment and on February 5, 1991, Kevorkian was arrested and arraigned on two murder counts and for delivery of a controlled substance. On February 28, 1991, District Judge James Sheehy dismissed the drug trafficking charge against Kevorkian, but ordered him to stand trial for first-degree murder. In response to this, Kevorkian said, "I am a physician, unconditionally dedicated to the honorable and ethical practice of alleviating hopelessly irremediable physical suffering."⁷¹ Since there was still no law against assisting suicide in Michigan, the charges were dropped,⁷² but the debate rages on.⁷³

⁶⁷*Id.*

⁶⁸*Kevorkian Chronology, supra*, note 1.

⁶⁹*Id.*

⁷⁰*Id.*

⁷¹Brenda Day, *Physician who Guided Suicides Will Be Tried On Murder Charges*, THE PLAIN DEALER, February 29, 1992, at 1A.

⁷²The judge who dismissed the first-degree murder charges against Dr. Kevorkian, Judge David Breck, said "Suicide is not a crime in Michigan, so a person assisting in one is not criminally responsible." "If a person can refuse life-sustaining treatment, then that person should have the right to insist on treatment which will cause death, providing the physician is willing to assist and the patient is lucid. The distinction between assisted suicide and the withdrawal of life support is a distinction without merit." Mike Williams, *Medical Community Seeking Consensus on Assisted Suicide*, 35 AMERICAN MEDICAL NEWS 2, (1992).

Oakland County Prosecutor, Richard Thompson, has declined to press homicide charges for some of the deaths, because the first three were thrown out. He calls the deaths, "an embarrassment to the state of Michigan", and reiterated his call for action on the part of the state legislature. Of lawmakers, he said, "Shame on them. . . . It's a disgraceful disregard of their responsibilities. They have not provided the guidance-to

III. EUTHANASIA IN THE NETHERLANDS

Any discussion of legalized or sanctioned euthanasia must begin with the practice of the Netherlands. Although euthanasia has never been formally legalized,⁷⁴ a "pattern of jurisprudence has developed since the first court case in 1973 that has allowed physicians to practice euthanasia under certain strict conditions."⁷⁵ Both the Royal Dutch Medical Association and the government-appointed state commission have advised that the current law be changed to formally allow doctors to perform euthanasia in certain cases, subject to strict guidelines, without the threat of criminal liability.⁷⁶ In the interim, however, "a number of Dutch institutions have developed procedures and policies to enable physicians and health care providers to participate in active euthanasia in an acceptable and controllable manner." However, many Dutch physicians remain uncomfortable with the professional and public tolerance of this practice.⁷⁷

Although perceptions of the prevalence of euthanasia in the Netherlands are overblown and there is a widespread misconception that euthanasia is legal, the fact remains that it is illegal, yet it is practiced in a more open manner than anywhere else in the world.⁷⁸ The conditions that surround euthanasia and the frequency with which it is practiced, however, remain unclear. It has not been decided whether the practice deserves legal protection and ethical, moral, social, and legal arguments that might justify euthanasia remain a matter for public debate.⁷⁹ It is an ongoing struggle which physicians, nurses, patients, hospital administrators, judges, and politicians must deal with on a daily basis.⁸⁰

the public or to police-that is needed." James A. McClear, *Kevorkian Assists "Medicide" of 6th Suicide Patient*, THE DETROIT NEWS, November 24, 1992.

⁷³The Michigan legislature has taken affirmative steps to criminalize assisting suicides, and to make it possible to prosecute people like Dr. Kevorkian. On November 24, 1992, by a vote of 72 to 29, the Michigan House of Representatives passed a bill making it a "felony to provide the physical means or to participate in a physical act that helps someone carry out a suicide wish." *Id.* Such participation would be punishable by up to four years in prison. *Id.* A state commission is going to study the matter and make recommendations for final legislation, a process which may take up to fifteen months. *Id.*

⁷⁴M.A.M. de Wachter, PhD., *Active Euthanasia in the Netherlands*, 262 JAMA 3316, (1989) (citing Penal Code of the Netherlands § 293).

⁷⁵*Id.* at 3316.

⁷⁶*Id.* at 3316, 3318.

⁷⁷de Wachter, *supra* note 71 at 3316.

⁷⁸Marcia Angell, M.D., *Euthanasia*, 319 NEW ENG. J. MED., 1348, 1349 (1988); de Wachter, *supra* note 53 at 3316.

⁷⁹de Wachter, *supra* note 71, at 3316.

⁸⁰*Id.*

The guidelines which have developed for the practice of euthanasia are strict. Four essential conditions must be met:⁸¹

1. The patient must be competent.⁸²
2. The patient must request euthanasia.⁸³
3. The patient must be suffering intolerably, with no prospect of relief, although there need not be a terminal disease.⁸⁴
4. Euthanasia must be performed by a physician in consultation with another physician not involved in the case.⁸⁵

While there are no official statistics on the incidence of euthanasia, there are reportedly between 2,000 and 10,000 cases per year.⁸⁶ A 1991 *Chicago Tribune* article cited a government-commissioned report which found that doctors complied with an average of 2,300 euthanasia requests each year and assisted 400 suicides.⁸⁷ The reporting rates, however, are inaccurate for a number of reasons. First, a person can only be buried or cremated if the doctor has issued a death certificate declaring that the patient died of natural causes.⁸⁸ Second, doctors who participate in euthanasia want to protect themselves and family members of the deceased from questioning by coroners and the police.⁸⁹ Third, there is a fear of judicial consequences and potential investigations which are upsetting and disruptive of privacy.⁹⁰

Despite the fact that euthanasia remains a crime punishable by up to twelve years in jail, it is still widely practiced, probably because it is so seldomly

⁸¹ Angell, *supra* note 75, at 1349.

⁸² Angell, *supra* note 75, at 1349. "This requirement excludes many groups of patients for whom the question of withholding life-sustaining treatment has been most contentious in the United States, . . . such as patients with Alzheimer's, the mentally handicapped, newborn babies and those who are in a persistent vegetative state." *Id.*

⁸³ Angell, *supra* note 75, at 1349. The requests must be "voluntar[y], consistent, and repeated over a reasonable time, and the request must be well documented. This requirement prevents euthanasia in response to an ill-considered or impulsive request." *Id.*

⁸⁴ Angell, *supra* note 75, at 1349. Thus, conditions for which there is treatment, such as depression, would not be a reason for euthanasia, while a chronic but not terminal disease such as multiple sclerosis, for which there is no cure, might be adequate reason. *Id.*

⁸⁵ Angell, *supra* note 75, at 1349. "The usual method is to induce sleep with a barbiturate, followed by a lethal injection of curare." *Id.*

⁸⁶ de Wachter, *supra* note 71, at 3316.

⁸⁷ *Dutch Propose Law on Euthanasia; Critics Call It Confusing*, CHICAGO TRIBUNE, Nov. 10, 1991, (Zone C), at 26.

⁸⁸ de Wachter, *supra* note 71, at 3317.

⁸⁹ *Id.*

⁹⁰ *Id.*

prosecuted.⁹¹ A formal loophole which can be used to get around the criminal sanction against euthanasia, is section 40 of the Penal Code which states that "someone is not punishable if the person who commits that act is driven by an 'overwhelming power' - a sudden conflict of duties or interests in a situation in which a choice must be made."⁹²

Two important cases have been the precipitating factors in the discussion of euthanasia and formulations of guidelines for its practice. The first, in 1973, involved a physician who was prosecuted for participating in active euthanasia.⁹³ The physician was convicted for administering a lethal dose of morphine to a patient, who had made repeated requests for the lethal dosage and was sentenced to one week in jail.⁹⁴ The court stated that the act would have been acceptable had six conditions been met, four of which evolved into the guidelines set out above.⁹⁵ In response to this case, The Royal Dutch Medical Association issued a provisional statement on euthanasia:

[L]egally euthanasia should remain a crime, but . . . if a physician, after having considered all the aspects of the case, shortens the life of a patient who is incurably ill and in the process of dying, the court will have to judge whether there was a conflict of duties which could justify the act of the physician.⁹⁶

The second case, in 1984, involved a physician who "had given a series of lethal injections to his patient, a ninety-five year old woman who was seriously ill and had no chance of improving."⁹⁷ Two years earlier, she had extensively discussed her deteriorating condition with her doctor.⁹⁸ In 1980, "the patient signed a living will, stating that she requested active euthanasia if she were to be in such a condition that no recovery to a reasonable and dignified state of life was to be expected."⁹⁹

At the age of 94, she fractured her hip, lost many of her sensory perceptions and was occasionally unable to speak.¹⁰⁰ Her condition continued to deteriorate to the point where she was unable to eat or drink and was

⁹¹de Wachter, *supra* note 71, at 3317. One attorney estimated that of the 130 active euthanasia cases reported in only 1% to 2% were prosecuted. *Id.*

⁹²*Id.* at 3317 (quoting Penal Code of the Netherlands S40).

⁹³*Id.* at 3317.

⁹⁴*Id.* (The jail sentence was suspended).

⁹⁵de Wachter, *supra* note 71 at 3317.

⁹⁶*Id.* at 3317 (quoting Gevers JKM, *Legal Developments Concerning Active Euthanasia on Request in the Netherlands*, 1 *BIOETHICS* 158 (1987)).

⁹⁷*Id.* at 3318 (citing 106 *Nederlandse Jurisprudentie*).

⁹⁸*Id.* at 3318.

⁹⁹de Wachter, *supra* note 71 at 3318.

¹⁰⁰*Id.*

unconscious.¹⁰¹ Four days before her death, she regained consciousness and stated she did not want to live through a similar experience.¹⁰² After discussing the matter with an assistant physician and the woman's son, all agreed that active euthanasia should be performed.¹⁰³ After a final conversation with the patient confirming her wish to die "as soon as possible", the physician administered a lethal injection.¹⁰⁴ The lower court's acquittal of the physician was reversed by an Amsterdam court of appeals.¹⁰⁵ The case was appealed to the Supreme Court where it was reversed and remanded to the court of appeals in The Hague, with instructions to consider the conflict of duties of the physician.¹⁰⁶ The Hague acquitted the physician again, finding that "the appeals court of Amsterdam failed to investigate not only his subjectively experienced conflict of conscience . . . but also the conflict of duties . . . , which he resolved, according to the High Court, by reasonably and responsibly making an objective and justified decision."¹⁰⁷

In order to deal with the impact these cases had on the medical, legal and ethical community, the Netherlands established a State Commission on Euthanasia to advise the government on these matters. "[I]t was asked to make concrete recommendations for law and jurisprudence in the matters of active euthanasia. The commission was comprised of fifteen members: 7 lawyers, 3 physicians, 2 psychiatrists, 1 nurse, and 2 theologians."¹⁰⁸ Thirteen of the fifteen members accepted the proposal that euthanasia should not be a criminal offense if it is performed by a physician upon a patient who has no hope of improvement and within strict guidelines which require that (i) the patient be informed about the seriousness of her condition; (ii) the patient makes the request, and (iii) the physician consults with a colleague.¹⁰⁹

The report was criticized for the following reasons: (1) for not addressing the issue of the government's role with regard to an individual's choice; (2) for not addressing the issue of "obliging others to stay alive"; (3) for not coming to a final majority decision on the definition of *terminal illness*; (4) for not unanimously acknowledging that a conflict between dying with dignity and the protracted humiliation of the dying process sometimes justifies euthanasia, at least as a lesser evil; and (5) for allowing active euthanasia, at the family's

¹⁰¹*Id.*

¹⁰²*Id.*

¹⁰³de Wachter, *supra* note 71 at 3318.

¹⁰⁴*Id.* at 3318 (quoting 106 Nederlandse Jurisprudentie (1984)).

¹⁰⁵*Id.* at 3318.

¹⁰⁶*Id.*

¹⁰⁷de Wachter, *supra* note 71, at 3318, (*citing* 106 Nederlandse Jurisprudentie (1986)).

¹⁰⁸*Id.* at 3318.

¹⁰⁹*Id.* at 3318.

request, of irreversibly comatose patients once useless treatment has been terminated.¹¹⁰

In April 1989 a decisive debate over two legislative proposals to deal with the government commission's recommendations was supposed to take place. One proposal would have legalized euthanasia, the other would have kept it a criminal offence, except in cases of overwhelming circumstances. The debate did not take place because the coalition government fell apart that same spring. Because of the failure to implement any concrete legislative guidelines about euthanasia, many questions remain. This lack of any ethical or legal framework has left many people uncomfortable with the tolerance of euthanasia, and only time will tell what the outcome will be. In the meantime, the practice will continue with the same uncertainty and misconceptions as before. The practice in the Netherlands, however, provides a useful foundation for the discussion of euthanasia in the United States, in that it shows where many confusions lie and what concerns need to be addressed.

IV. MODERN ATTEMPTS TO LEGALIZE THE RIGHT TO DIE IN THE UNITED STATES

Modern advances in medical technology have led many to fear that the end of their lives will be out of their control. This nightmare of American medicine, to be kept alive in a hospital bed, sustained by machines and tubes, with little hope of recovery and no legal power to end treatment is the scenario which has led to a growing movement of patient empowerment. This movement includes documents and procedures such as living wills, "Do Not Resuscitate Orders" (DNR's) written into patient charts, power of attorney forms appointing someone else to make the decisions, and an effort toward clear communication among clinicians, patients and their families.

The nature of medicine is changing because of rapid technological advancement, the possibility of human gene therapy, new treatments, new drugs, AIDS, an ever-increasing aging population and dwindling financial resources. As these developments are incorporated into the practice of medicine, new ethical and legal territory is being charted. The relationship between clinician and patient has changed so much in the past twenty years that some problems being considered today would have been difficult to envision two decades ago. In the United States, the patient's right of refusal of treatment, including the formerly competent through surrogates and guardians, is very well established.¹¹¹

¹¹⁰*Id.* at 3317.

¹¹¹Merle S. Goldberg, *The Right to be Right; Ethics Issues Grow in Number and Capacity*, THE WASHINGTON TIMES, June 3, 1991, (International Health Perspectives '91), at M3.

The court cases that have defined this right include *Quinlan*,¹¹² *Brophy*,¹¹³ and *Cruzan*.¹¹⁴ Also, on December 1, 1991, the federal "Patient Self-Determination Act"¹¹⁵ went into effect. This new law requires that all hospitals, nursing homes, hospices and health maintenance organizations advise patients of their legal options in refusing or accepting treatment. What is still being debated, however, is the physician's and hospital's involvement in that decision. Each day about 6,000 deaths occur in this country. The American Hospital Association estimates that seventy percent of those deaths are timed or negotiated.¹¹⁶ At the same time, about 10,000 persons are lying in nursing homes and hospitals in a persistent vegetative state,¹¹⁷ making this debate an area of contention whose parameters need to be better defined both medically and legally.

One state which tried to provide a legal framework for doctors' and patients' rights in the dying process was Washington State, whose citizens voted on an initiative¹¹⁸ which would have legalized "physician-aid-in-dying." Initiative

¹¹²*In re Quinlan*, 355 A.2d 647 (NJ 1976).

¹¹³*Brophy v. New England Sinai Hosp.*, 497 N.E.2d 626 (Sup. Judicial Ct. of Mass. 1986) (holding that the substituted judgment of patient in persistent vegetative state that artificial maintenance of his nutrition and hydration be discontinued would be honored. Thus, while the hospital could refuse to remove or clamp the G-Tube, the guardian was authorized to remove his ward from that hospital into the care of other physicians who would honor the patient's wishes).

¹¹⁴*See Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261 (1990).

¹¹⁵42 U.S.C.A. § 1395cc *et seq.*

¹¹⁶Andrew H. Malcolm, *Our Towns*, N.Y. TIMES, Oct. 11, 1991, at B2. ("This means that instead of simply accepting fate, virtually everyone will someday be called upon to participate in decisions to forgo some life-sustaining technology, to let nature take its course, to, in effect, participate in the death of a loved one".)

¹¹⁷*See Cruzan, supra* 110 at 266. ("A vegetative state describes a body which is functioning entirely in terms of its internal controls. It maintains temperature. It maintains heart beat and pulmonary ventilation. It maintains digestive activity. It maintains reflex activity of muscles and nerves for low level conditioned responses".) *Id.*

¹¹⁸Phil Reeves, *Dignified Death or Legal Killing?*, THE INDEPENDENT, Nov. 5, 1991, at 19.

The criminal law, under the United States Constitution, is largely a matter for each state to decide upon. Some western states adopted early in this century a practice of the 'initiative'. This means that if enough citizens petition for a proposition to be put on the ballot and it is then carried, it becomes state law . . . The initiative process is used in twenty-one states. To get on a ballot in Washington state 150,000 signatures had to be collected. The pro-euthanasia lobby gathered more than 223,000 . . . After an initiative is passed, there is a two year period in which it can only be changed by the legislature if there is a two-thirds majority in support. But politicians are unlikely to intervene: They are acutely aware of the electoral consequences of interfering with laws passed directly by the people—especially uncomfortable "life and death" issues such as euthanasia.

Id.

119 as it was called, read: "Shall adult patients who are in a medically terminal condition be permitted to request and receive aid-in-dying?"¹¹⁹ If it had received a majority vote, Washington would have been the first place in the world to legalize any form of active euthanasia.

Initiative 119 would have changed Washington's Natural Death Act to make it the first government in the world to legalize physician-assisted death. It would also have clarified state law to say that withholding or removing tubes that artificially provide nutrition and water is allowed if the patient requests it in a living will. The initiative said other "life-sustaining measures" could be refused, including cardiac resuscitation and respirators.

The initiative required that, to receive "aid-in-dying", two physicians would have had to certify that the patient would die naturally within six months or was in an irreversible coma or persistent vegetative state without hope of recovery. Two disinterested people would have had to witness the patient's voluntary request in writing. Aid-in-dying was defined as: "a medical service, provided in person by a physician, that will end the life of a conscious and mentally competent qualified patient in a dignified, painless and humane manner." The aid could have been a lethal injection or prescribed medication.

Supporters of the initiative included the Hemlock Society which manifested its support with widespread financial contributions from its national organization, Physicians for Yes on 119, the Seattle King County Bar Association, the Northwest AIDS Foundation, Washington State Labor Council, Puget Sound Council of Senior Citizens, and the King County Women's Political Caucus.¹²⁰ They argued that 119 would have permitted "physician aid in death with dignity", stressing that a dignified, painless death is a central tenet of individual freedom.¹²¹ They said that 119 would have made people secure in their control over death, knowing they were allowed, under certain circumstances, to ask doctors for lethal drugs to end the hopeless final days of terminal illness. They referred to the drawn out deaths of Karen Ann Quinlan and Nancy Cruzan as evidence for the need to legalize these rights.

Other supporters of 119 were drawn to it because of stories of terminally ill people who endure agonizing deaths.¹²² Many thought it their own business to decide with how much pain and suffering they could deal. Although most people do not die painful deaths, they argued that no one should have to.¹²³

¹¹⁹Washington Issues—Statewide Initiatives—Initiatives 119: Death With Dignity, THE SEATTLE TIMES, Oct. 31, 1991, at C2.

¹²⁰*Id.*

¹²¹*Id.*

¹²²See generally Reeves, *supra* note 114, at 19.

¹²³Joseph P. Shapiro, *A Vote on Legal Euthanasia*, 111 U.S. NEWS AND WORLD REPORT, Sept. 30, 1991, at 32.

Polls show that 50 to 70 percent of Americans favor right-to-die laws, depending on how the question is worded. That level of support exists

They stated that doctors ignore the wishes of patients and families and use extraordinary measures, not because they will bring about a cure, but from a fear of being sued.¹²⁴

Opponents of the initiative, which included the Washington State Catholic Conference, the Washington State Medical Association delegates, the Washington State Hospital Association, the Human Life League of Washington, The Washington Right to Life Committee, and Washington Physicians Against 119, argued that life and death were not humankind's to dispense, and that legalizing euthanasia would mean society had finally crossed the critical line; that legalizing euthanasia would "blow up centuries of ethical bedrock that says doctors are givers of life, not instruments of death,"¹²⁵ and make Washington the first place in the Western World allowing doctors to kill.

Those against 119 were also afraid of what they perceived to be loopholes in the law. The proposed law did not require physicians to be specialists in terminal illness meaning an eye doctor could facilitate a patient's death as long as he or she met the other guidelines. There was no reporting requirement. Doctors would not have had to notify authorities or patients' families about assisted suicides. Doctors would be completely immune from prosecution. There was no requirement to investigate whether a person who requested death was suffering from depression. Opponents also painted pictures of Washington State becoming the suicide capital of the world since there was no residency requirement.¹²⁶

There was also the fear that passage would put even more pressure on doctors to consider the spiralling costs of the health care system when making treatment decisions. They asked "how do you legislate to ensure that this consideration is never allowed to intrude on a physician's decision to agree to help a patient die?" "How do you ensure that the elderly and poor are protected from the pressure of financial worries?" "How do you protect patients from misdiagnosis?" All are questions that the initiative did not address, and which made its opponents very uneasy. Such issues have led some elderly people in the Netherlands to carry ID cards expressly stating that they do not want euthanasia.¹²⁷

The proposed legislation also left many unanswered questions for hospitals and members of the medical community. Although hospitals would not be obligated or required to permit a doctor-assisted suicide, what would it mean to make a "good faith" effort to refer the patient to a facility that would? Would the failure to make a referral subject the doctor or hospital to claims of civil

even though most do not die in great pain. A recent study showed that 69 percent are on no pain medication the day before dying.

Id.

¹²⁴*Id.* at 34.

¹²⁵Deann Glamser, *Suicide Aid: Agonizing Struggle*, USA TODAY, Nov. 4, 1991, at 3A.

¹²⁶Reeves, *supra* note 114 at 19.

¹²⁷*Id.*

damages? Even though the patient alone would make the decision to die, what effect would family members' objections have on the request for aid-in-dying, and, should it have any effect at all?¹²⁸ These were some of the unanswered questions which are difficult to grapple with and even more difficult to legislate.

California, too, tried to pass proposition 161, the Death With Dignity Act in November 1992. "The controversial measure would have allowed dying adults who are mentally competent to ask their doctors to end their lives by lethal injection or other means."¹²⁹ The bill stated that a competent individual must fill out prior written directives authorizing "aid-in-dying."¹³⁰ "Then, after having been diagnosed by two physicians as being terminally ill with less than six months to live, the patient must make at least two requests to have 'aid-in-dying' administered."¹³¹ The California measure had some striking differences from the Washington initiative, but they were not enough to facilitate the proposition's passage.

The California initiative required that if the patient who requested to die was in a nursing home, one of the two required witnesses would have to have been a patient advocate or ombudsman designated by the state's Department of Aging. Arguably, this would have prevented voluntary euthanasia from ever becoming involuntary euthanasia, and would have given doctors some help in deciding when voluntary euthanasia was appropriate. The Washington law did not specify who the witnesses had to be, other than that they had to be disinterested. Although there was no reporting requirement *per se* in proposition 161, the dying directive would become part of the patient's medical record, since "aid-in-dying" was considered a medical procedure and any medical procedures in California must be recorded in patient records.¹³² Intentionally left out of the California proposal, was the requirement that any physician who refused to participate would face repercussions. The drafters of the initiative did not want to put that burden on physicians.¹³³ Hospitals were free to refuse to allow the practice.¹³⁴ Although the outcome of the California initiative was negative, this is not a subject that is going to be resolved any time soon; it may well be one of the most important issues in our lifetime.

¹²⁸Warren King, *Clinic Heads Worry About Init. 119*, THE SEATTLE TIMES, Oct. 26, 1991, at A9.

¹²⁹Lori Olszewski, *Right-to-Die Law Apparently a Loser*, THE SAN FRANCISCO CHRONICLE, Nov. 4, 1992, at A12.

¹³⁰B.D. Colen, *California is Voting on the Right to Die; Act Would Legalize Some Forms of Mercy Killings*, NEWSDAY, Oct. 29, 1992, (News) at 23.

¹³¹Colen, *supra* note 126, at 23.

¹³²*Id.*

¹³³*Id.*

¹³⁴Colen, *supra* note 126, at 23.

The failure of Initiative 119 in Washington State and Proposition 161 in California, sends a useful message to other states who are considering the same kinds of legislation: legal euthanasia or physician aid-in-dying is an immensely emotional subject which will not be easily resolved. The dialogue on the subject and the education of people about their health care rights is extremely important since there are so many unanswered questions which are not going to be resolved simply by the passage of laws.

V. SHOULD PHYSICIAN-AID-IN-DYING BE LEGALIZED?

A recent Boston Globe/Harvard poll indicates that a strong majority of Americans, increasingly worry about the manner of their dying, are ready to reject the ancient taboo against physicians killing their patients, and want the option of dying with a doctor's help.¹³⁵ The poll showed that sixty-four percent of Americans favor physician-assisted suicide for terminally ill patients upon request.¹³⁶ Almost eighty-percent of adults under age thirty-five support the idea.¹³⁷

Sixty-four percent of respondents think doctors should be allowed to administer lethal drugs or injections directly.¹³⁸ Clearly, most Americans think doctors should be involved if a terminally ill patient chooses to end her life. In stark contrast to the number of respondents who would allow doctors to administer lethal injections, only "thirty-seven percent think it should be legal for a relative or close friend to assist in ending a terminally ill patient's life, and only fourteen percent say they themselves would help a terminally ill relative or friend commit suicide to end her suffering."¹³⁹ The support for physicians' assistance in the dying process is probably due to the fact that people would like to restrict its practice to a group which can be overseen, and whose professional training and guidelines lead people to think that they are less likely to abuse the process. Also, "doctors have the technical expertise to make sure assistance is being given only in the appropriate circumstances."¹⁴⁰

This argument, however, is one that many find disturbing because it would "authorize physicians to break the two thousand year taboo",¹⁴¹ based on the

¹³⁵Richard A. Knox, *Poll: Americans Favor Mercy Killing*, THE BOSTON GLOBE, Nov. 3, 1991, at 1. This was a national opinion poll sponsored by the Globe and the Harvard School of Public Health.

¹³⁶*Id.*

¹³⁷*Id.*

¹³⁸*Id.*

¹³⁹Knox, *supra* note 131, at 1.

¹⁴⁰*Id.*

¹⁴¹Dennis L. Breo, *MD-Aided Suicide Voted Down; Both Sides Say Debate to Continue*, 266 JAMA 2895, 2896 (1991).

Hippocratic Oath,¹⁴² that tells them they cannot kill their patients. Opponents of physician-aid-in-dying believe that assisting in patients' deaths would dangerously blur physicians' role as healers. They argue that physicians should not be involved in the process at all because there is an enormous role conflict and it undermines the physician-patient relationship which is based on trust.

When a physician actively participates in a patient's plans to kill herself, he trades the role of healer for the role of, at the least, accomplice to self-murder, which is, of course, the definition of suicide. . . . This is not to say that individuals do not have the right to take their own lives. But the question of whether they have the right to directly involve physicians in that act is another matter entirely.¹⁴³

People also wonder whether, once the dialogue about assisted-death has begun, the patient will have the same degree of confidence in the physician's commitment to his or her care as before and whether the patient will feel entirely free to resist a suggestion from the physician that suicide would be appropriate, especially since this is the person whose medical judgment the patient relies on.¹⁴⁴

The implications of legalizing euthanasia for the medical profession and the potential for abuses are very troubling. Before public policy or legislation is formulated, the ethical issues inherent in the practice of euthanasia must be critically examined.

A major issue is "whether there is a valid moral distinction between killing a terminally ill patient and withdrawing or withholding life-support measures—now legally and, many believe, morally permissible."¹⁴⁵ Euthanasia advocates argue there is no moral distinction as long as the intent and result are the same.¹⁴⁶ For those who see a distinction, though, including the AMA, the question is not "what will the outcome be?" but "what treatment is appropriate to the particular case?" A cancer specialist describes it this way:

If all the feasible therapies have been administered and a patient shows signs of rapid deterioration, the continuation of therapy can cause more discomfort than the [condition]. From that time on I recommend [treatment] only as a means of relieving pain The decision to cease . . . treatment is never irrevocable, [as is euthanasia] and often the desire to live will push a patient to try for . . . a few more days of life.¹⁴⁷

¹⁴²The critical part of the Hippocratic Oath reads "I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect." CARLETON B. CHAPMAN, *PHYSICIANS, LAW AND ETHICS* 22 (1975).

¹⁴³B.D. Colen, *The Slippery Slope of Jack Kevorkian*, *NEWSDAY*, June 12, 1990, at 13.

¹⁴⁴David Orentlicher, *Physician Participation in Assisted Suicide*, 262 *JAMA* 1844 (1989).

¹⁴⁵Edmund D. Pellegrino, *Ethics*, 261 *JAMA* 2843 (1989).

¹⁴⁶*Id.*

The decision to cease treatment cannot be construed as a decision that the patient die, or as the intentional termination of life. It is a decision to provide the most appropriate treatment for that patient at that time. That cessation of treatment may, in some cases, lead to death, does not equate it with intentional killing, because the act is not done to kill the patient, it is just no longer the proper course of action. "The physician who withdraws care from a patient is simply acknowledging the limitations of medicine, and is allowing a disease process to run its course."¹⁴⁸ Because it is sometimes permissible to withhold life-prolonging treatment does not mean that, all other things being equal, it is permissible to kill.

A related issue to be addressed is, "what limits, if any, should be placed on patient autonomy? Does the state have a legitimate interest in protecting human life or does a person's dominion over his or her life transcend law, ethics or morality?"¹⁴⁹

It is well established that

'the right to refuse medical treatment is basic and fundamental. . . . [A] patient has the right to refuse any medical treatment or medical service, even when such treatment is labelled 'furnishing nourishment and hydration.' This right exists even if its exercise creates a 'life threatening condition.' It is recognized as a part of the right of privacy protected by both the state and federal constitutions. Its exercise requires no one's approval. It is not merely one vote subject to being overridden by medical opinion.'¹⁵⁰

The state does have an interest in protecting human life, but when it involves a person of adult years and in sound mind, in the exercise of control over her own body by refusing treatment, the state must defer. This does not mean, however, that people have the right to demand that a doctor help them carry out their death. The right of refusal of treatment is not the same as the right to demand death. That right has never been legally recognized.

The question arises, what if the doctor wants to assist the patient who is asking for aid-in-dying? When a doctor begins the practice of medicine, he or she takes an oath to do no harm to a patient but to do all that is necessary to cure and/or to alleviate suffering. This oath clearly distinguishes between relief of pain and causing death; it sanctions one and condemns the other. When a doctor begins to practice, his or her mission is to treat patients, to cure patients

¹⁴⁷*The Intentional Termination of Life* (1979), cited in, *Moral Problems In Medicine*, *supra* note 7, at 292.

¹⁴⁸Colen, *supra* note 139 at 13.

¹⁴⁹Pellegrino, *supra* note 141 at 2843.

¹⁵⁰*Bouvia v. The Superior Court of Los Angeles*, 225 Cal. Rptr. 297, 300-01 (1986), *aff'd*, *Bouvia v. County of Los Angeles*, 241 Cal. Rptr. 239 (1987) (citing *Griswold v. Connecticut*, 381 U.S. 479, 484 (1965); *Bartling v. Superior Court*, 209 Cal. Rptr. 220 (1984)).

if possible, and to alleviate suffering, not to help a patient kill him or her self. If in the course of relieving suffering, the patient's death is also caused, the doctor has done his or her duty if the only way to effectively treat that patient's pain was to give a dosage of medicine which caused death. This is not the same as acquiescing to a patient's request for death. Even if a doctor wants to help a patient carry out his or her death, that is not his or her mission, and, for now, the prohibitions against it should stand.

A third issue focuses on the societal consequences of legalization of aid-in-dying. "Opponents of euthanasia predict a slide down the moral 'slippery slope'."¹⁵¹ As a result, euthanasia might be offered to many non-terminally ill persons for a variety of reasons.¹⁵² Voluntary euthanasia, it is argued, could become involuntary euthanasia for handicapped infants, the aged, the poor or the retarded.¹⁵³ Some say that euthanasia would replace pain control.¹⁵⁴ It is argued that if euthanasia is sanctioned, the elderly, the chronically ill or the poor, as well as the terminally ill, would be under pressure to exercise the option.¹⁵⁵ Analogies are made to the Nazi death camps.¹⁵⁶ Proponents, however, see no evidence of a moral slippery slope. They believe that with careful regulations, any violations could be avoided.

A similar argument is the "wedge" argument which says decriminalizing assisted suicide or aid-in-dying would be "dangerous for society because it would take a step that might be an opening wedge for other kinds of allowed homicides."¹⁵⁷ But proponents counter that this would be no more of a wedge than capital punishment, police shooting fleeing felons, and killing in self-defense.¹⁵⁸

While it would be easier to have definitive answers to all the questions physician-aid-in-dying raises, that is unlikely to be the case in the foreseeable future. Both proponents and opponents of assisted suicide and euthanasia say the same things. "Both worry about introducing euthanasia into a medical system increasingly driven by economic pressures and incentives. Both insist that dying, pain-ridden or anguished patients must be given compassionate

¹⁵¹Pellegrino, *supra* note 141, at 2844; "The adherents of the slippery slope theory argue that once society steps onto the slope, it is difficult, if not impossible, to climb back up and prevent an ever faster ride to the bottom." Colen, *supra* note 100, at 13.

¹⁵²*Id.*

¹⁵³*Id.*

¹⁵⁴*Id.*

¹⁵⁵Pellegrino, *supra* note 141, at 2844.

¹⁵⁶*Id.*

¹⁵⁷James Vorenberg, *Washington State's Euthanasia Referendum: Mercy and Its Limits; Going Gently With Dignity*, N.Y. TIMES, Nov. 5, 1991, at A25.

¹⁵⁸*Id.*

care rather than simple prolongation of their lives through technology."¹⁵⁹ The difference lies in the fact that proponents believe that giving doctors the power to release people from a life of pain is a necessary form of compassionate care, which in itself serves as an essential check on high-tech medicine.¹⁶⁰ For opponents, it is submitting to technology, and an uneasy replacement for compassion.¹⁶¹

VI. SOME SUGGESTIONS FOR THE FUTURE—ANALYSIS OF THE ARGUMENTS

It is the author's assertion that the legalization of assisted suicide and/or physician-aid-in-dying is not the proper course of action at this time. There are too many other options available to doctors, nurses, hospitals and other health care institutions which must be exercised to their fullest extent before any form of active euthanasia is legalized.

What can be gleaned from the opinion polls is that it seems most people do not really want to be put to death as they near the end of their lives, they just want to be able to exercise some control over the whole process. Much of the movement toward more permissive intervention by doctors is fueled by the sense of terror people feel about being overtreated technologically, or just as bad, about being kept alive but then allowed to slowly deteriorate in a nursing home full of strangers. Modern medicine is not reassuring people about their dying, and that must be the highest priority for the medical community above all else.

The Globe/Harvard survey found that, of the fifty-two percent who favor the option of suicide or assisted death, only half would consider asking their doctor for an injection or lethal drugs.¹⁶² Overall, only twenty-five percent are prepared to take these steps themselves.¹⁶³ Dr. Elizabeth Latimer¹⁶⁴ says that

of the four thousand dying patients she has cared for, only five have ever asked her to kill them. Sick and dying people rarely request euthanasia. . . . They want to live until they die, they want to be reassured physicians will control their symptoms, be gentle, and be a companion along the way.¹⁶⁵

¹⁵⁹Peter Steinfels, *At Crossroads, U.S. Ponders Ethics of Helping Others Die*, N.Y. TIMES, Oct. 28, 1991, at § A 1.

¹⁶⁰*Id.*

¹⁶¹*Id.*

¹⁶²Knox, *supra* note 131 at 1.

¹⁶³*Id.*

¹⁶⁴"[Dr.] Latimer is [the] director of the palliative-care program at Hamilton Civic Hospitals, coordinator of the regional program and past founding chairperson of the section on palliative care for the Ontario Medical Association." Suzanne Morrison, *Death-With-Dignity Debate Omits the Dying, Doctor Says*, VANCOUVER SUN, Nov. 20, 1991, at A6.

¹⁶⁵*Id.*

Dr. Latimer believes that it is not the dying or chronically ill who are the impetus behind the euthanasia movement, but those whose own deaths are distant and can talk more comfortably of death.¹⁶⁶ If there was some way to make people less fearful of the dying process and to reassure them that they will have as much autonomy as possible at the end of life, there might not be so much public support for assisted death.

The fear of pain and the fear of being left alone and powerless are concerns which can be addressed without resorting to legalized euthanasia or physician-assisted suicide. There are other ways, safer and more legally and ethically acceptable ways, to help people who are experiencing drawn-out deaths than euthanasia or assisted suicide. Many ethicists argue that by condoning suicide, and sanctioning its assistance, society is abandoning its responsibility to improve conditions for the hopelessly ill and elderly. The pressure and focus should be on doctors and society to provide appropriate and humane treatment and care settings like hospices, that can make life worth living. It is no wonder that the euthanasia movement is gaining so much support when it seems more appealing to have people dead than to provide more costly care, and have them in appropriate surroundings with good nursing care. If the health-care system would concentrate less on technologies which prolong dying and more on making natural death comfortable, people might not perceive such a need for assistance in dying.

The hospice model provides this kind of care, yet it is rarely used by those with Alzheimer's and other non-malignant terminal illnesses. The hospice movement was originally designed to provide out-of-hospital care, including home care, for cancer patients. Its success in providing kind and supportive care very cost-effectively should be studied by all health care workers and institutions and its programs implemented to make the end of life more comfortable.

While hospice care is probably the best alternative to euthanasia or assisted suicide, it does not provide all the answers. First, hospice care relies heavily on volunteers and nursing staff, who must be willing to perform some non-traditional types of care. It is not easy to staff hospices for this reason, which in turn, makes them not as widely available as traditional hospital care.

Before 1990, there were no formal hospice training programs for physicians. . . . Two years ago the Academy of Hospice Physicians set up a physician training program that focuses on aspects of hospice care including ethical and legal issues, symptom control, patient-doctor communication, reimbursement and funding of hospice programs, as well as issues related to death and dying. . . . Earlier in 1992, the University of Texas, M.D. Anderson Cancer Center, in collaboration with the Hospice at Texas Medical Center, Houston, established a one-year fellowship in hospice medicine to create awareness among

¹⁶⁶*Id.*

physicians about symptom control and patient comfort in terminal illness.¹⁶⁷

Obviously, however, these programs are the exception in medical education and not the rule, so there is still a long way to go in being able to adequately staff hospices around the country.

Further, hospice is designed around the terminally ill. It is a place to go to die in peace. It is not traditionally a place for those who are in chronic pain but not terminally ill. Thus, for the Janet Adkins, Sherry Millers, and Marjorie Wantzs of the world, whose deaths were not imminent, hospice is not seen as an alternative. The hospice model and philosophy are available, however, to help people such as Adkins, Miller and Wantz, deal with their pain in a caring and supportive environment. The hospice model can help them formulate a dialogue about their illnesses, the probable courses their illnesses will take, and the likely scenarios of their deaths. It is the general unwillingness to discuss topics such as these which make many chronically and terminally ill people fear their future. Hospice can also help the family deal with the issues of death and also with the issues of care. Many ill people see themselves as a burden to their families. Home hospice care along with active participation by family members can make this time seem less burdensome.

Hospice does not consider discussions of this sort as a failure on the part of the medical community, but as a recognition that death and disease are part of the human experience which need to be dealt with. It is obvious that Janet Adkins was in no way being debilitated by her disease at the time she died. From what can be seen by accounts of the events surrounding her death, she was afraid of what would happen as the disease progressed. Unfortunately there is no cure for Alzheimer's, but no one knows what progress will be made in the coming years—years in which Janet Adkins could have lived a happy and productive life. No matter what options are available to sick people, there will still be some who want to die. It is imperative, however, that options such as hospice, which already exist, be available as a viable alternative for anyone who wants it.

Another problem is that physicians are not well educated enough in pharmacology and drug therapy or in palliative care. In fact, Ken Miller, medical director of the Montgomery County Hospice, indicated that doctors do not generally receive adequate training in palliative care.¹⁶⁸ During his ten years of medical education and training, he had only one lecture on pain control.¹⁶⁹

¹⁶⁷*Physicians Need More Hospice Training*, CANCER WEEKLY, Aug. 17, 1992, at 13.

¹⁶⁸*Id.*

¹⁶⁹*Id.*

In March of 1992, the Agency for Health Care Policy and Research issued a blueprint affirming the right of every American to proper pain relief.¹⁷⁰ While the content of the blueprint was somewhat self-evident, in practice such has not been the case. For some reason, Americans are backward in their thoughts and beliefs about pain management. There is an apparent reluctance on the part of regulators, physicians and patients to acknowledge that pain accompanying illness is, in many cases, manageable. The biggest stumbling block is the mystique surrounding narcotic analgesics—a mystique fostered by legal and social prohibitions against their use.¹⁷¹ The blueprint is, in part, a way to try to dispel these beliefs.

Kenneth Casey, a professor of neurology and physiology at the University of Michigan Medical School, says "pain is generally undertreated, underrecognized, mishandled and misdiagnosed."¹⁷² He says, too, that although the disease accompanying such pain usually cannot be cured, it can often be slowed down and the symptoms alleviated by treating pain effectively.¹⁷³ To do this, doctors should be willing to prescribe as much medicine as necessary to keep a patient comfortable. No one should have to suffer terrible pain at the end of life and it should be the primary goal of the physician, when there are no more treatment options available, to make a patient comfortable by every means possible.

Further, clearer guidelines must be implemented about the use of life-support systems. Doctors should not keep a patient artificially alive because they fear legal repercussions. Doctors should be confident that, when all other treatment is useless, life support systems should be abandoned if that is what the patient wants or, in the case of an incompetent patient, if that is what the patient indicated he or she wanted while they were competent. This too will help alleviate patient fears.

Although the extension of hospice care to those with Alzheimer's and other chronic and terminal illnesses would be expensive at first, it would save money overall because Medicare and other funds for the hopelessly ill would be used only for procedures and interventions whose goal is to minimize suffering.¹⁷⁴ More importantly though, by emphasizing the quality of life remaining instead of one's length of life, the health care community would be providing solace and support.¹⁷⁵ It would make clear that physicians are devoted to sympathetic

¹⁷⁰Cynthia Starr, *The Politics of Pain: A New Attitude Toward Treatment*, 136 DRUG TOPICS 60 (1992).

¹⁷¹*Id.*

¹⁷²*Id.*

¹⁷³*Id.*

¹⁷⁴John Sergeant, *Toward a New Philosophy of Life and Death*, THE SAN FRANCISCO CHRONICLE, June 21, 1990, at § A23.

¹⁷⁵*Id.*

care rather than to the mechanics of prolonging life, which, all should agree, would be upholding the highest professional ideals.¹⁷⁶

Before we legalize a person's right to die, it is important that we do all we can to affirm a right to live; to live comfortably and without pain, in a supportive atmosphere, secure in the knowledge that one has autonomy in what is done to his or her body. The hospice model is an excellent starting point, but it is also necessary for a person to do all he or she legally can to make sure his or her wishes are carried out at the end of life. This is important regardless of the legalization of assisted death because, if a person is incompetent at the end of life, the options of euthanasia and/or assisted-suicide will not be available to them except in very limited circumstances. For this reason, it is important that people make out living wills, that they give someone they trust their power of attorney in case of incompetency, that they make known their wish to not be resuscitated, or put on life-support or be exposed to any "last stand" measures. Before the health care community does anything else, it must make patients aware of their legal rights while they are capable of exercising them. This will take much of the pressure off doctors and nurses and medical staff and make patients feel more in control of their own destinies. Before we give patients the right to die, we must give them the right to live life to the fullest, secure in the knowledge that they are in control until the end, and that they will not have to be in pain. We must recognize that death is part of the human condition in which the quality of care we get is at least as important as the quality of life and the quality of decisions we make.

Although some form of active euthanasia and/or assisted suicide will probably be legalized within the next ten to twenty years, this should be the last option in health care. It is imperative that all other options be exercised and that people participate in honest and open discussions of choices available to them and of all the implications of choosing active euthanasia or assisted suicide. Only after all other measures have been exhausted to improve the health care system, should active euthanasia be allowed. Hopefully, if the health care community makes a concerted effort to change its attitudes about death, the care of the dying, and pain relief, steps such as legalizing euthanasia or assisted suicide will never be necessary or at least will be an option only in very limited circumstances.

WENDY N. WEIGAND

¹⁷⁶*Id.*