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Active Voluntary Euthanasia: The Ultimate Act of Care for the Dying

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ACTIVE VOLUNTARY EUTHANASIA: THE ULTIMATE ACT OF CARE FOR THE DYING*

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We are, by some strange habit of mind and heart, willing to impose death but unwilling to permit it: we will justify humanly contrived death when it violates the human integrity of its victims, but we condemn it when it is an intelligent voluntary decision. If death is not inevitable anyway, not desired by the subject, and not merciful, it is righteous! If it is happening anyway and is freely embraced and merciful, then it is wrong!
- Joseph Fletcher¹

* In loving memory of my sister, Helen, for whom there was no choice. Her illness, suffering, and death made me truly appreciate that life is more than mere existence, and that permitting death to occur can be the ultimate sign of respect for human life in certain circumstances.

¹ J. FLETCHER, *MORALS AND MEDICINE* 181 (1954).

I. INTRODUCTION

On January 30, 1987, Hector Rodas petitioned the Colorado District Court for the right to request and receive a lethal injection to cause his death.² Paralyzed from the neck down as the result of a drug overdose, Rodas had just received permission from the same court to refuse insertion of a gastrostomy tube for nutrition and hydration.³ He sought to take his right of bodily self-determination one step further by exercising his right to choose when to die.⁴ Rodas sought the good death of euthanasia,⁵ but controversy about the voluntariness of his decision led to dismissal of his suit.⁶ Fifteen days later Rodas died of dehydration and starvation.⁷

Hector Rodas sought to establish that euthanasia was not a criminal act to be denied one facing a prolonged and painful dying process.⁸ Euthanasia literally means death without suffering⁹ and was originally concerned with the type of death experienced rather than the means of death.¹⁰ A good death was ideal, even if achieved by way of suicide, for instance.¹¹

The principle of euthanasia became distorted over the years, mainly as a result of Christian views on suicide and the sanctity of life.¹² Today, "death without suffering" means a natural death¹³ while "euthanasia" is more readily associated with direct killing.¹⁴ Given the contemporary understanding of euthanasia, anyone who would have given Rodas the lethal injection he desired would have been susceptible to prosecution for murder, even though Rodas requested help in dying.¹⁵

The issue raised by Rodas did not disappear with the dismissal of his suit.¹⁶ This Note explores whether modern society can embrace the con-

² Rodas v. ErkenBrack, No. 87CV142 (Dist. Ct. Mesa County, Colo. filed Jan. 30, 1987). For a review of the case, see Nota Bene, *Rodas v. ErkenBrack*, 2 ISSUES L. & MED. 481 (1987). Death by lethal injection upon request is referred to as active euthanasia. See *infra* Section II.C.1.

³ *In re Rodas*, No. 86PR139 (Dist. Ct. Mesa County, Colo. Jan. 22, 1987). For a review of the case, see Nota Bene, *In re Rodas*, 2 ISSUES L. & MED. 471 (1987).

⁴ The American Civil Liberties Union, which represented Rodas, argued that he had a right to receive a lethal injection grounded in the constitutional right to privacy. *Medical Treatment for Older People and People with Disabilities: 1987 Developments*, 3 ISSUES L. & MED. 333, 343 (1988) [hereinafter *Medical Treatment*].

⁵ See *infra* Section II.A.

⁶ *Medical Treatment*, *supra* note 4.

⁷ *Id.*

⁸ *Id.* at 343 n.58.

⁹ P. RAMSEY, *THE PATIENT AS PERSON* 149 (1970).

¹⁰ See *infra* note 24.

¹¹ See *infra* Section II.A.

¹² See *infra* Section II.B.

¹³ Note, *Death with Dignity: Implementing One's Right to Die*, 64 U. DET. L. REV. 557, 566-67 (1987).

¹⁴ DEATH, DYING, AND EUTHANASIA xix (D. Horan & D. Mall eds. 1977) ("euthanasia is a high-falutin' word for murder").

¹⁵ See *infra* note 49.

¹⁶ Witness the case of Larry McAfee, who has been paralyzed from the neck down since a May 1985 motorcycle accident and remains hooked up to a ventilator. *Quadriplegic Ruled Entitled to Kill Self*, *The Plain Dealer*, Sept. 7, 1989, at D1, col. 3. McAfee was granted permission by a Fulton County, Georgia, Superior Court judge in September 1989 to modify his ventilator so that he can turn it off

cept of euthanasia as "death without suffering" to the full extent of the term. Section II explores the distortion of the concept of euthanasia from an historical perspective. Section III provides insight into the practice of euthanasia in the Netherlands, the only country in the world which allows people to request and receive aid-in-dying, i.e., active euthanasia.¹⁷ Section IV reviews the American judicial and legislative response to the active euthanasia issue, and analyzes the Death With Dignity Act,¹⁸ a model law which would permit a terminally ill adult to request and receive active euthanasia and simultaneously protect the physician honoring such request from civil, administrative and criminal sanctions.¹⁹ Careful and intelligent consideration of the Dutch experience and the proposed Death With Dignity Act suggests that the United States should make active euthanasia a reality for terminally ill persons.

II. EUTHANASIA: FROM A MODE OF DYING TO A KIND OF KILLING

A. Ancient Greek and Roman Attitudes

Euthanasia is a troublesome word²⁰ whose original meaning—good death²¹—can be traced back to ancient Greece and Rome.²² For the Greeks and Romans, euthanasia signified a quiet and easy death, one without suffering.²³ The principle of euthanasia emphasized the type of death experienced as opposed to the means by which death occurred.²⁴ Thus,

using a device he designed. *Id.* Although the judge has ordered that the decision be appealed to the Georgia Supreme Court, McAfee does not have to wait to have the ventilator fitted with the switch-off device. *Id.* Thus, as noted by his attorney, McAfee has been given the right to choose when to die without being pressured to take his life. Anderson, *The Right to Choose Death: Atlanta Judge Allows Quadriplegic to Turn Off His Ventilator*, A.B.A. J. 18 (Dec. 1989). Unfortunately, this very choice was denied Rodas.

¹⁷ See *infra* Section II.C.1.

¹⁸ See *infra* Section IV.D.

¹⁹ See *infra* note 278.

²⁰ The word "euthanasia" is troublesome in the sense that it has too many meanings. For a brief commentary on the different meanings of euthanasia and the need to clarify what one means when talking about euthanasia, see Hilton, *Euthanasia is Hardly a 4-Letter Word*, San Francisco Examiner, Jan. 21, 1988, at E-3 (photo. reprint courtesy The National Hemlock Society).

²¹ Euthanasia is derived from the Greek *eu* ("good") and *thanatos* ("death"). Humphry, *The Case for Rational Suicide*, 17 SUICIDE AND LIFE-THREATENING BEHAVIOR 335, 335 (1987) (reprint courtesy The National Hemlock Society).

²² Other ancient civilizations which practiced euthanasia include India and Sardinia. Note, *The Right of the Terminally Ill to Die, with Assistance if Necessary*, 8 CRIM. JUST. J. 403, 404 (1986). Voluntary euthanasia was both morally acceptable and customary in these civilizations in the case of the aged or infirm. *Id.*

²³ Paul Ramsey, a Christian ethicist, suggests that the concept of death without suffering extends only to caring for the dying. P. RAMSEY, *supra* note 9. See also YOUR DEATH WARRANT? 15 (J. Gould & Lord Craigmyle eds. 1971) [hereinafter DEATH WARRANT]. But see Admiraal, *Justifiable Euthanasia*, 3 ISSUES L. & MED. 361, 362 (1988) (euthanasia is "the ultimate act of care for the dying").

²⁴ J. WILSON, DEATH BY DECISION 17 (1975). Euthanasia provided the opportunity to choose a dying process that was good or happy for the one experiencing it. Foot, *Euthanasia*, in DEATH AND DECISION 86 (E. McMullin ed. 1978). Today, "type" and "means" refer to whether euthanasia is classified as voluntary, involuntary or nonvoluntary, or as active or passive, respectively. S. MCLEAN & G. MAHER, MEDICINE, MORALS AND THE LAW 44 (1983). See *infra* Section II.C.1.

the concept of dying well overrode the general disapproval of suicide,²⁵ and an incurably ill person with unbearable suffering had the right to choose a quick and painless death as an alternative to a lingering and degrading one.²⁶

B. Changing Attitudes Through the 19th Century

The influence of Christianity, conflicts raised by the Hippocratic Oath,²⁷ and the resultant distinction between passive and active euthanasia²⁸ played key roles in the growing disapproval and distortion of euthanasia.

The rise of Christianity brought with it an absolute ban on killing human beings, including oneself,²⁹ grounded in the doctrine of the sanctity of life.³⁰ The ban on suicide necessarily included a ban on euthanasia³¹ since killing oneself was not justified for any reason.³² Human life was considered sacred, a gift from God subject only to his power.³³ The effect on the suicide rate was immense—by the 4th century A.D. the limited tolerance of suicide associated with classical Greek and Roman civilization had virtually disappeared.³⁴

St. Augustine (354-430 A.D.) vigorously condemned suicide as "intrinsically sinful" because it went against man's inherent tendency to preserve his existence. Suicide was viewed as the most mortal of sins since it denied the victim a chance for salvation.³⁵ Church law denied a Christian burial to anyone who took his own life.³⁶ Civil laws also reflected

²⁵ Ancient Greeks and Romans generally disapproved of suicide, although they viewed an absolute ban on suicide as unreasonable. J. RACHELS, *THE END OF LIFE* 8 (1986). The Romans, in fact, were more tolerant of suicide than the Greeks, although Roman law specifically forbade suicide. Marzen, O'Dowd, Crone & Balch, *Suicide: A Constitutional Right?*, 24 DUQ. L. REV. 1, 26 (1985) [hereinafter Marzen]. In both civilizations, suicide was justifiable as a means to achieve a good death. D. HUMPHREY & A. WICKETT, *THE RIGHT TO DIE* 4-5 (1986).

²⁶ J. RACHELS, *supra* note 25.

²⁷ The Hippocratic Oath, a standard of ethics for the medical profession, dates back to 400 B.C. in ancient Greece. Mannes, *Euthanasia vs. The Right to Life*, 27 BAYLOR L. REV. 68, 70 (1975). For a copy of the Oath, see O. RUTH RUSSELL, *FREEDOM TO DIE* 285 (rev. ed. 1977). Two duties contained in the Oath are seemingly incompatible, i.e., the promise to relieve suffering and the promise to prolong and protect life. J. FLETCHER, *supra* note 1, at 172.

²⁸ See *infra* Section II.C.1.

²⁹ The ban was against killing man and, as a man, one could not kill oneself any more than one could kill another man. J. RACHELS, *supra* note 25, at 11-12. The Church eventually modified its position in the case of war and capital punishment, reasoning that killing in such cases was for the good of the State. *Id.* at 10-11.

³⁰ For a detailed explanation of this doctrine and how it relates to medical, moral and legal issues, see S. MCLEAN & G. MAHER, *supra* note 24, at 1-19.

³¹ Euthanasia and suicide are coinherent because in order to achieve a good death one had to kill oneself or permit another to do so. This understanding of euthanasia and suicide is captured in the definition offered by Dr. Joseph Fletcher, a prominent theologian and advocate of euthanasia: "Suicide is choosing to die when one chooses to, either with or without assistance." Fletcher, *The Right to Choose When to Die*, HEMLOCK Q., Jan. 1989 at 3.

³² D. HUMPHREY & A. WICKETT, *supra* note 25, at 7.

³³ J. WILSON, *supra* note 24, at 24.

³⁴ Marzen, *supra* note 25.

³⁵ *Id.* at 27-28.

³⁶ J. WILSON, *supra* note 24, at 23.

the intolerance of suicide—a suicide victim's property was seized by civil authorities and his body buried in the highway, impaled by a stake.³⁷ The Christian view on suicide dominated the Western hemisphere throughout the Middle Ages.

The influence of Christian opposition to suicide began to weaken by the 17th century. Robert Burton and John Donne, both Anglican clergymen, questioned the ironclad ban on suicide in their respective publications, *The Anatomy of Melancholy*,³⁸ and *Biathanatos*.³⁹ That these men constituted a minority was evidenced by the force of the outcry against them at the pulpit and in counter publications. Despite such renewed opposition, the once-negligible suicide rate began to climb.⁴⁰

During the 17th century, society began to associate euthanasia with the medical treatment rendered to dying patients. Philosophers and essayists, such as Bacon, Montaigne and Donne, advocated a merciful release from unnecessary suffering.⁴¹ Bacon, in fact, urged physicians to become skilled in the means of helping dying patients attain "a fair and easy passage."⁴²

The 18th century was a period marked by skepticism and religious indifference known as the "Age of Reason." The suicide controversy had escalated, and atheistic arguments in defense of suicide began to outnumber deistic arguments in opposition thereof. Some actually succeeded in simultaneously condemning suicide from a religious viewpoint while justifying it from a purely human perspective.⁴³ It was this attitude that eventually prevailed.⁴⁴

The medical profession began to acknowledge its responsibility to the dying patient during the 18th century.⁴⁵ Physicians focused their efforts not on terminating life, but on using their skills to alleviate the suffering of the incurably ill. The Greek concept of an easy death as an alternative to unbearable suffering began to give way to death that was made as natural and humane as possible but not intentionally brought about. This attitude prevailed throughout the 18th and 19th centuries.⁴⁶

By the end of the 19th century, however, the death experience itself as the focal point of euthanasia was cast aside in favor of the act of attaining death. Euthanasia was promoted as the merciful act of taking another's life to end their suffering, i.e., mercy killing.⁴⁷ Emphasis had shifted from

³⁷ D. HUMPHRY & A. WICKETT, *supra* note 25, at 6.

³⁸ Marzen, *supra* note 25, at 31. In *The Anatomy of Melancholy*, Burton "questioned the accepted position that those who commit suicide are eternally damned." *Id.*

³⁹ *Id.* at 31-32. Donne argued that "each suicide must be judged individually, and in some cases the suicide is justified and acceptable to God." *Id.* at 32.

⁴⁰ *Id.* at 31-33.

⁴¹ D. HUMPHRY & A. WICKETT, *supra* note 25, at 9.

⁴² Mannes, *supra* note 27, at 69.

⁴³ Marzen, *supra* note 25, at 33-34.

⁴⁴ *Id.* at 56.

⁴⁵ D. HUMPHRY & A. WICKETT, *supra* note 25, at 9.

⁴⁶ J. WILSON, *supra* note 24, at 27. This can be seen as early recognition of what is now referred to as the distinction between active and passive euthanasia. See *infra* Section II.C.1.

⁴⁷ Mercy killing is defined as "[t]he affirmative act of bringing about immediate death allegedly in a painless way and generally administered by one who thinks that the dying person wishes to die because of a terminal or hopeless disease or condition." BLACK'S LAW DICTIONARY 511 (abr. 5th ed. 1983).

justifying a terminally ill person's means of dying to justifying another's act of killing them. The compassion inherent in allowing an incurably ill person to choose an easy death ("euthanasia") was displaced by the notion of allowing a second party to kill that person as an act of mercy ("mercy killing").

Some proponents of euthanasia at this time suggested that physicians had a duty not merely to alleviate suffering but to put hopelessly ill persons to death through quick and painless means.⁴⁸ Fear of criminal liability tempered wholesale acceptance of this idea,⁴⁹ but the damage was done. Mercy killing and euthanasia had become synonymous for the act of directly killing an incurably ill person to end his suffering. The distortion of euthanasia "as a kind of killing rather than a mode of dying"⁵⁰ would undermine future efforts to restore to the terminally ill the right to choose a death without suffering regardless of the means of dying.

C. *The 20th Century: A Focus on the United States*

The means and type of death remain central to a contemporary understanding of euthanasia. However, instead of euthanasia as an easy death (type) being justified regardless of how the death occurred (means), the focus today is on (1) the involvement of a second party as being active or passive (means), and (2) whether the victim participated in the euthanasia decision at all (type).⁵¹

1. Active-Passive Distinction

The distinction between active and passive euthanasia is often framed in terms of the killing-letting die dichotomy, which provides that it is morally wrong to intentionally take a life, but alright to allow the inevitable to happen by withdrawing or withholding treatment.⁵² This is too simplistic an explanation, however, especially in light of the fact that

⁴⁸ J. WILSON, *supra* note 24, at 27. The problem with this suggestion was that it made no provision for the doctor who conscientiously objected to euthanasia on religious or other grounds. It also failed to make clear whether the physician was to respond to a patient's request for death or take it upon himself to make the euthanasia decision.

⁴⁹ Suicide is not a crime in the United States, but assisted suicide is a statutory crime in 22 states, classified either as a unique offense or a type of murder or manslaughter. Shaffer, *Criminal Liability for Assisting Suicide*, 86 COLUM. L. REV. 348, 348, 353 (1986). A person who provides the means to commit suicide is guilty of assisted suicide. *Id.* at 351 n.30. A person who participates in a suicide by performing the act causing death, even if done at the request of the victim, is guilty of murder, based on the criminal law theory that, in the United States, consent to homicide is not an affirmative defense to the killing of another human being. *Id.* at 351. See *infra* Section IV.

⁵⁰ Velasquez, *Defining Suicide*, 3 ISSUE L. & MED. 37, 39-40 (1987).

⁵¹ S. McLEAN & G. MAHER, *supra* note 24, at 44, 50.

⁵² Potts, *Looking for the Exit Door: Killing and Caring in Modern Medicine*, 25 Hous. L. REV. 493, 500 (1988). For a discussion of the underlying logic of the killing-letting die dichotomy, see Walton, *Active and Passive Euthanasia*, 86 ETHICS 343 (1976).

approval or disapproval of euthanasia in the United States hinges more on whether it is active or passive than on whether it is voluntary, involuntary or nonvoluntary.⁵³

Active euthanasia generally refers to steps taken to deliberately induce death whereas passive euthanasia infers doing nothing, that is, letting nature take its course.⁵⁴ By definition then, each involves an "act"—active euthanasia, an act of commission; passive, an act of omission.⁵⁵ Each act results in the death of the person earlier than would have been the case without such act.⁵⁶

The doctrine of double effect⁵⁷ best illustrates the distinction between active and passive euthanasia in the sense of the killing-letting die dichotomy. Double effect is an intention-driven doctrine which provides that "in certain circumstances, where the intention behind an action is good, the action is permissible even although [sic] it is known that undesirable consequences will also follow."⁵⁸ Double effect therefore condones the administration of a lethal injection so long as the intent behind the act is to alleviate suffering rather than to hasten death, even though life is shortened as a secondary effect of the effort to alleviate suffering.⁵⁹

The reason for the active-passive distinction is not grounded in morality⁶⁰ but lies rather in concern for the actor's culpability as the cause of death.⁶¹ The culpability of the actor is irrelevant, however, as to the patient who desires a good death,⁶² except to the extent that the actor acts without the permission of said patient. The real concern, therefore,

⁵³ Witness the handful of doctors prosecuted in the United States for the mercy killing of their patients, many of whom defended themselves on the theory of lack of causation. See *infra* Section IV.A. The degree of patient participation in the decision to perform euthanasia ran the gamut of the voluntary-involuntary-nonvoluntary distinction, yet all but one of the doctors who have stood trial were acquitted of murder; the doctor found guilty of murder received a lenient punishment. *Id.*

⁵⁴ Rachels, *Euthanasia, Killing, and Letting Die*, in *ETHICAL ISSUES RELATING TO LIFE AND DEATH* 148 (J. Ladd ed. 1979).

⁵⁵ O. RUTH RUSSELL, *supra* note 27, at 19-20. Professor George Fletcher argued that there is a difference between an act of commission and an act of omission grounded in the common understanding of the legal consequences of causing something to happen versus permitting it to occur. Fletcher, *Prolonging Life*, 42 WASH. L. REV. 999 (1967) [hereinafter *Prolonging Life*]. Thus, one can grasp why the person performing euthanasia would want to distinguish between its active and passive forms—passive euthanasia distances him from legal responsibility for the resultant death more so than does active euthanasia.

⁵⁶ Rachels, *supra* note 54, at 151.

⁵⁷ For a brief explanation, see Potts, *supra* note 52, at 513. For a more detailed treatment, see J. RACHELS, *supra* note 25, at 16-17.

⁵⁸ S. MCLEAN & G. MAHER, *supra* note 24, at 52.

⁵⁹ *Id.*

⁶⁰ Rachels, *supra* note 54, at 147. See also Fletcher, *supra* note 31. Contra O'Rourke, *Active and Passive Euthanasia: The Ethical Distinctions*, HOSPITAL PROGRESS, Nov. 1976, at 68 ("From an ethical or moral point of view, causing something to happen when it can and should be prevented (active euthanasia) is very different from allowing something to happen when there is no moral obligation to prevent it (passive euthanasia).").

⁶¹ *Prolonging Life*, *supra* note 55.

⁶² Gelfand, *Euthanasia and the Terminally Ill Patient*, 63 NEB. L. REV. 741, 753 (1984).

should focus on ensuring that euthanasia is performed at the voluntary request of the person seeking aid-in-dying.⁶³

2. Voluntary-Involuntary-Nonvoluntary Distinction

While the active-passive distinction is irrelevant as to the patient requesting euthanasia, the voluntary-involuntary-nonvoluntary distinction is of utmost importance to the patient. Euthanasia is classified as voluntary, involuntary or nonvoluntary depending on the extent of the patient's participation, if any, in the euthanasia decision.⁶⁴

Voluntary euthanasia is performed at the express request or with the informed consent of a legally competent patient.⁶⁵ The patient's right to decide what is done with his body is best protected when his choice of death is honored, whether that choice requires withdrawal of life support equipment or administration of a lethal injection, because it is the most important expression of personal autonomy.

Involuntary euthanasia is done against the will or without the consent of a patient possessing the capacity to make a meaningful decision on the subject. In other words, a competent patient is either not consulted on the subject or his decision to forego euthanasia is ignored. Involuntary euthanasia is the worst alternative for the patient from an autonomy point of view, although it is conceded that such a scenario might be economically feasible and, therefore, technically the best decision.⁶⁶

The gray area between voluntary and involuntary euthanasia has been dubbed nonvoluntary euthanasia. Nonvoluntary euthanasia is performed at the request of the legal guardian and/or family of one who is unable to participate in the decision due to incompetence.⁶⁷ Such a patient may have always been incompetent (e.g., severely retarded) or may have become incompetent as the result of injury or disease (e.g., comatose patients, head injury victims).⁶⁸ Nonvoluntary euthanasia brings the concept of substituted judgment⁶⁹ into play by requiring the guardian "to put himself in the shoes of the incompetent patient and decide as the patient would if competent."⁷⁰

⁶³ "[T]here is a profound moral difference between euthanasia administered at the patient's own request and acts done of the actor's 'own head.'" Silving, *Euthanasia: A Study in Comparative Criminal Law*, 103 U. PA. L. REV. 350, 389 (1954). See also Wolhandler, *Voluntary Active Euthanasia for the Terminally Ill and the Constitutional Right to Privacy*, 69 CORNELL L. REV. 363, 368 (1984) ("The law should rest upon the [patient's] status and not upon the degree of second-party assistance.").

⁶⁴ S. MCLEAN & G. MAHER, *supra* note 24.

⁶⁵ Wolhandler, *supra* note 63, at 366. "In the euthanasia context, legal competence is the incurable's ability to understand that in requesting *active* euthanasia he is choosing death over life." *Id.* at 367 (emphasis added).

⁶⁶ S. MCLEAN & G. MAHER, *supra* note 24, at 44-45.

⁶⁷ O. RUTH RUSSELL, *supra* note 27, at 21.

⁶⁸ Potts, *supra* note 52, at 499.

⁶⁹ The leading case on the concept of substituted judgment is the landmark decision handed down in *In re Quinlan*, 70 N.J. 10, 41, 355 A.2d 647, 664, *cert. denied*, 429 U.S. 922 (1976) (guardian to render best judgment as to whether patient would exercise her right of privacy under the circumstances).

⁷⁰ Agrawal, *In re Conroy: Forging a Path to Death with Dignity*, 67 B.U.L. REV. 365, 370 (1987).

D. Summary

The active-passive distinction is irrelevant as to the right of a terminally ill person to choose when to die because the consequences of both acts are the same.⁷¹ Emphasis should be placed on whether the patient has voluntarily requested euthanasia. The Netherlands provides an example of a country that originally placed great emphasis on the active-passive distinction⁷² but shifted toward acceptance of the voluntary-involuntary-nonvoluntary distinction as equally important.⁷³ Today, the Netherlands permits physicians to perform active euthanasia without risk of liability provided certain judicially-created criteria are satisfied,⁷⁴ among which is the requirement that the doctor carefully weigh the suffering of the patient as part of the euthanasia decision.⁷⁵

III. ACTIVE VOLUNTARY EUTHANASIA: A REALITY IN THE NETHERLANDS

The Dutch Penal Code of 1886 operates on two premises; namely, (1) "a misdeed is punishable only if it has been made punishable by name in the law,"⁷⁶ and (2) there is "no punishment without guilt."⁷⁷ The Penal Code contains general grounds for exculpation and specific grounds for increasing or decreasing the punishment under a particular law.⁷⁸ Article 293 of the Penal Code states that "[h]e who robs another of life at his express and serious wish, is punished with a prison sentence of at most twelve years"⁷⁹ The punishment for mercy killing imposed under Article 293 is less severe than the punishment for murder⁸⁰ due to the request of the victim.⁸¹ The reasoning behind this diminished punishment

⁷¹ This is the approach of a consequentialist, as opposed to that of an absolutist, who believes that there is an absolute distinction between killing and letting die. See Ladd, *Positive and Negative Euthanasia*, in *ETHICAL ISSUES RELATING TO LIFE AND DEATH* 165 (J. Ladd ed. 1979).

⁷² In 1973 a Dutch Health Council committee recommended that "[t]he euthanasia-problem [sic] . . . be resolved via the distinction active/passive and not voluntary/involuntary." Driesse, van der Kolk, van Nunen-Forger & de Marees van Swinderen, *Euthanasia and the Law in the Netherlands*, 3 *ISSUES L. & MED.* 385, 393 (1988) [hereinafter Driesse].

⁷³ See *infra* Section III.A.

⁷⁴ See *infra* note 85.

⁷⁵ D. HUMPHRY & A. WICKETT, *supra* note 25, at 179.

⁷⁶ Driesse, *supra* note 72, at 385.

⁷⁷ *Id.*

⁷⁸ *Id.*

⁷⁹ *Id.* at 386.

⁸⁰ Murder is defined at Article 289 of the Penal code as "deliberate killing with malice aforethought" and is punishable with either life in prison or a temporary sentence of up to 20 years in prison. *Id.*

⁸¹ When the motive behind a killing is the desire to comply with the victim's request, then the homicide is categorized as "homicide upon request". Silving, *supra* note 63, at 363. Several modern continental European criminal codes, including that of the Netherlands, recognize homicide upon request as being less culpable than murder. *Id.* The United States does not formally recognize homicide upon request. *Id.* at 352.

is the fact that murder violates the life of a particular person, whereas mercy killing violates respect for human life in general.⁸²

In addition, the "Penal Code assumes that situations can develop in which overstepping a norm may not be laid to one's charge and gives the judge the possibility and the duty to ascertain what brought this person to this deed in these circumstances."⁸³ This aspect of the Penal Code was the apparent driving force behind a series of judicial decisions over the past 17 years which ultimately provided a way for physicians to circumvent Article 293. Today, "[t]he verdict [in a euthanasia case] can be guilty but with no punishment"⁸⁴ provided that the physician acted in accordance with certain criteria.⁸⁵

How did the Netherlands, a small nation which successfully resisted the first step toward cooperation with the Nazi program of involuntary euthanasia during World War II,⁸⁶ "become the [world] leader in voluntary euthanasia"?⁸⁷ Euthanasia became a generally accepted part of medical practice, even though not codified,⁸⁸ due to a number of factors, the most important being willingness to confront the issue.⁸⁹ The Dutch did not let the potential for abuse prevent them from permitting active voluntary euthanasia to take its proper place as the right thing to do in certain situations.

A. *The Physician as Mercy Killer: An Analysis of Dutch Case Law*

Although the first case in which a physician was convicted but not punished under Article 293 occurred in 1950,⁹⁰ it was a 1971 incident

⁸² Driesse, *supra* note 72, at 387. The consent of the victim apparently serves to lessen the weight of disrespect for human life. The distinction between a crime against the person and a crime against life is important in the euthanasia context because Dutch doctors are not required to report crimes against life. Verbatim, *Guidelines for Euthanasia*, 3 ISSUES L. & MED. 429, 437 (1988) [hereinafter *Guidelines*].

⁸³ Driesse, *supra* note 72, at 390.

⁸⁴ Sagel, *Voluntary Euthanasia*, THE LANCET, Sept. 20, 1986, at 691 (letter to the editor).

⁸⁵ "The most important criteria are that euthanasia has been administered by a physician at the repeated request of a well-informed, hopelessly suffering patient and after consultation with a second physician." *Id.*

⁸⁶ D. HUMPHRY & A. WICKETT, *supra* note 25, at 171. Dutch physicians collectively refused to comply with Nazi directives on sterilization, euthanasia, and deportation. Despite threats that their medical licenses would be revoked, as well as the arrest and imprisonment in concentration camps of 100 Dutch physicians, the Dutch medical profession successfully resisted Nazi efforts to implement such programs in the Netherlands. *Id.* at 170-71.

⁸⁷ F. Clines, *With Courts Paving the Way, Holland Quietly Takes the Lead in Euthanasia*, 99 L.A.D.J. Dec. 3, 1986, at 18, col. 5. "[I]t is precisely in the field of euthanasia that Holland has the dubious honor of being the most advanced country in the world." Schepens, *Euthanasia: Our Own Future?*, 3 ISSUES L. & MED. 371, 371 (1988).

⁸⁸ *Id.* at 378.

⁸⁹ D. HUMPHRY & A. WICKETT, *supra* note 25, at 172.

⁹⁰ The first case in which a doctor was prosecuted under Article 293 occurred in 1950 and illustrates the court's ability to consider the circumstances before

which sparked the beginning of the Dutch move toward legalization of active voluntary euthanasia.⁹¹ The incident involved Dr. Geertruida Postma, who was charged under Article 293 in October 1971.⁹² Dr. Postma admitted⁹³ injecting 200 milligrams of morphine into the veins of her 78 year old terminally ill mother, who died within minutes.⁹⁴ At the time Postma was brought to trial, it was not unusual for the "average physician in the Netherlands"⁹⁵ to manipulate medications in order to alleviate the unbearable suffering of an incurably ill patient, even if that course of action would shorten the patient's life.⁹⁶

The court adopted the professional medical standard as a guide,⁹⁷ and

imposing sentence. The case involved a physician who gave a combination of painkillers and sleeping pills to his incurably ill brother who had requested to have his life ended. The doctor, who faced a maximum 12 years in prison, received a one year suspended sentence. Thus, although the doctor was convicted under Article 293, the court apparently considered the relationship between the doctor and patient, as well as other circumstances, significant enough to warrant the suspended sentence. O. RUTH RUSSELL, *supra* note 27, at 254-55. It is of note that at the same time in the United States, Dr. Hermann Sander was charged with first-degree murder in the death of Abbie Burotto, a cancer patient on the verge of death. Dr. Sander was accused of injecting air into Burotto's veins. Despite the lack of motive or consent as a defense to murder generally, Sander was acquitted after a three week jury trial. *See infra* Section IV.A.

⁹¹ "The Dutch are extremely sensitive to the notion that they 'legalized euthanasia.' They hasten to point out that 'it goes unpunished,' which they argue is different from legalization—a point some observers find moot." D. HUMPHRY & A. WICKETT, *supra* note 25, at 175. *See also* Sagel, *supra* note 84.

⁹² D. HUMPHRY & A. WICKETT, *supra* note 25, at 171-72.

⁹³ Dr. Postma explained what happened to the director of the nursing home. Instead of signing the death certificate, he reported Postma to the police. *Id.* at 172.

⁹⁴ Dr. Postma's mother was a nursing home resident suffering from a cerebral hemorrhage, partial paralysis, speech difficulty, pneumonia and deafness. She had repeatedly asked for help in dying and had even attempted suicide without success. *Id.* at 171-72.

⁹⁵ Verbatim, *Euthanasia Case Leeuwarden - 1973*, 3 ISSUES L. & MED. 439, 439 (1988) [hereinafter *Leeuwarden*].

⁹⁶ *Id.* at 439-40. This methodology will hereinafter be referred to as a "course of alleviation." The course of alleviation methodology was considered appropriate by the medical profession to relieve suffering completely or to the extent possible when the following five conditions were present:

- A. [When] it concerns a patient who is incurable because of illness or accident . . . or who must be regarded as incurably ill from a medical standpoint;
- B. subjectively, his physical or spiritual suffering is unbearable or serious to the patient;
- C. the patient has indicated in writing, it could even be beforehand, that he desires to terminate his life, in any case that he wants to be delivered from his suffering;
- D. according to medical opinion the dying phase has begun for the patient or is indicated; and
- E. action is taken by the doctor, that is, the attending physician or medical specialist, or in consultation with that physician.

Id. at 439.

⁹⁷ *Id.* at 440. The court did not believe that alleviation of suffering should be withheld from a patient until the dying phase had begun and, therefore, did not adopt "D" as one of the requisite criteria triggering commencement of a course of alleviation for an incurably ill person with unbearable suffering. *Id.*

acknowledged that the requisite conditions for a course of alleviation were present, but that Postma had deviated from the standard by bypassing the course of alleviation and opting instead for immediate termination of her mother's life.⁹⁸ Dr. Postma was given a conditional sentence of one week with a probationary period of one year.⁹⁹

The Postma case illustrates the doctrine of double effect in action. The doctrine of double effect condones the administration of drugs to relieve suffering even if the result is to shorten the patient's life; administration of drugs with the intent to bring about immediate death, however, is forbidden.¹⁰⁰ The key, therefore, is the intent of the actor, i.e., relieve suffering or shorten life, and not the consequences of his actions, i.e., death earlier than would have been the case. If Dr. Postma had manipulated her mother's medication over a course of time in order to relieve her suffering—as opposed to using a fatal injection without recourse to alleviation—her actions would not have been punished even though they served to hasten her mother's death. This dichotomy lends confusion to interpretation of her case. Was the court merely sanctioning double effect or did it mean to go one step further, formulating specifications under which a doctor could avoid punishment under Article 293? The court's emphasis on the fact that Postma did not “even attempt to pursue this course [of alleviation], [but] instead administer[ed] a lethal dose *all at one time*”¹⁰¹ implied that it was legally acceptable for a doctor to end a qualified patient's¹⁰² suffering so long as she did not resort to lethal means without first pursuing a course of alleviation.¹⁰³

The Postma case afforded a terminally ill person with unbearable suffering the right to request and receive aid-in-dying from his attending physician. A 1981 ruling took a giant leap forward in expanding the right to the non-terminally ill.¹⁰⁴ The case, which involved a lay volunteer who helped a woman commit suicide, was tried before the Criminal Court in Rotterdam.¹⁰⁵ The court promulgated standards for noncriminal aid-in-dying, the most significant of which was that a person need not be terminally ill to request and receive such aid, but need only have unbearable physical and spiritual suffering which is continuous.¹⁰⁶ The court acknowledged the patient's right to self-determination¹⁰⁷ by allowing active voluntary euthanasia on request provided certain criteria were satisfied,¹⁰⁸ and demonstrated its intent to protect such right by convicting

⁹⁸ *Leeuwarden*, *supra* note 95, at 441.

⁹⁹ *Id.* at 442. The sentence was light considering Postma faced a maximum 12 years in prison. Driesse, *supra* note 72, at 386.

¹⁰⁰ *Supra* note 57.

¹⁰¹ *Leeuwarden*, *supra* note 95, at 441 (emphasis added).

¹⁰² A qualified patient being one who met the criteria adopted by the court. *See supra* note 97.

¹⁰³ *Contra* Driesse, *supra* note 72, at 393 (“According to some writers this pronouncement did not go farther than tolerating an earlier entry of death as a side effect of pain alleviation.”).

¹⁰⁴ *Id.* at 394.

¹⁰⁵ Diekstra, *Suicide Should Not Always Be Prevented*, in *DEATH AND DYING* 56 (1980).

¹⁰⁶ D. HUMPHRY & A. WICKETT, *supra* note 25, at 176-77. For a copy of the rules, see *id.* at 177.

¹⁰⁷ *Abstracts, 3 ISSUES L. & MED.* 455, 456 (1988).

¹⁰⁸ Driesse, *supra* note 72, at 393.

the defendant for failure to comply with the standards developed by the court.¹⁰⁹

The next important case re-emphasized the right to self-determination¹¹⁰ and, in fact, further expanded the right to choose active voluntary euthanasia, requiring only continuous suffering without reference to it "being unbearable as an independent condition."¹¹¹ The case, which was tried before the Alkmaar Court in 1983, involved a 94 year old woman who had deteriorated over a five year period to the point where her physician, Dr. Schoonheim, acknowledged that there was no hope for improvement.¹¹² She had repeatedly pleaded with him for help in dying during this period and continued to do so after the diagnosis. After consulting with her family and another physician, Schoonheim administered a lethal injection.¹¹³

Dr. Schoonheim was prosecuted¹¹⁴ but the trial court acquitted him¹¹⁵ based on the doctrine of the absence of material illegality.¹¹⁶ Material illegality can be absent to the extent that an action is not undesirable as a matter of law. The trial court found that Schoonheim had acted with the greatest possible care, giving serious consideration to the persistent suffering of his patient before making the decision to perform euthanasia. Accordingly, the court ruled that his actions were not legally undesirable and, therefore, not materially illegal under Article 293.¹¹⁷

The ruling also served to acknowledge the patient's right to self-determination.¹¹⁸ For the first time the issue of whether the suffering of the patient in and of itself could be the deciding factor in justifying the

¹⁰⁹ Diekstra, *supra* note 105. It is not clear which rules were violated although the rules were specifically mentioned in the sentence imposed by the court. *Id.*

¹¹⁰ *Abstracts, supra* note 107 ("the . . . judge . . . acknowledged the right of self-determination in 1983 as had the Court of Rotterdam in 1981").

¹¹¹ Driesse, *supra* note 72, at 394.

¹¹² Garbesi, *The Law of Assisted Suicide*, 3 ISSUES L. & MED. 93, 108-109 (1987). For a review of the case and its implications as to Article 293 by the Advocate General at the Court of Justice in the Hague, see *Abstracts, supra* note 107, at 455-68.

¹¹³ Garbesi, *supra* note 112.

¹¹⁴ Being one of the few doctors who reported his participation in a euthanasia procedure at the request of a patient, Schoonheim ended up among the handful of cases brought to the Public Prosecutor's attention which actually wind up in court. See *infra* note 167. It is believed that thousands of violations of Article 293 occur annually but that only a small percentage of them reach the Public Prosecutor's office due to the prevalence of false death certifications by the Dutch medical profession in order to avoid investigation. *Abstracts, supra* note 107, at 467. It is likely that the number of cases reported to the Public Prosecutor will increase as the result of the 1987 court decision which provided that physicians cannot falsify death certificates in the case of death due to active voluntary euthanasia. *Id.* at 468. For a translation of the court opinion, see Nota Bene, *Court of the Hague (Penal Chamber), April 2, 1987*, 3 ISSUES L. & MED. 451 (1988).

¹¹⁵ D. HUMPHRY & A. WICKETT, *supra* note 25, at 178. "This was the first time that a lower court had acquitted a physician [under Article 293]." *Id.*

¹¹⁶ *Abstracts, supra* note 107.

¹¹⁷ *Id.*

¹¹⁸ *Id.* The right of self-determination is a corollary to the absence of material illegality in that it is the patient who finds the action desirable and to exempt the physician based on the doctrine of absence of material illegality necessarily is to acknowledge the patient's right of self-determination. Driesse, *supra* note 72, at 393-94.

euthanasia decision was pertinent to the outcome of the case.¹¹⁹ As noted above, the Rotterdam Court had required continuous and unbearable suffering of a physical and spiritual nature as part of the criteria for justification of the euthanasia decision.¹²⁰ The Alkmaar Court departed from this standard in two respects, namely, requiring only continuous suffering without "reference to [the] suffering being unbearable as an independent condition,"¹²¹ and acknowledging that the psychological (mental) suffering of the patient could itself be significant enough to tip the scale in favor of euthanasia.¹²² The court's greater emphasis on the patient's suffering bolstered the right to self-determination without jeopardizing the protection afforded a physician who participated in a euthanasia procedure.¹²³

The Amsterdam Court of Appeal overturned the decision, rejecting the doctrine of the absence of material illegality outright.¹²⁴ The court determined that while the doctor's actions might have been desirable, especially in terms of the patient's right to self-determination, such actions were still illegal, and the doctor still accountable, under Article 293.¹²⁵ Accordingly, the appellate court declared Schoonheim guilty but imposed no punishment, reasoning that while it was doubtful Schoonheim had acted out of necessity, it was nonetheless evident that he had acted with integrity and due caution.¹²⁶ The appellate court seemed most concerned with making it known that although doctors might escape punishment under Article 293, they were not exempt from the law.

The Schoonheim case ultimately reached the Dutch Supreme Court, which affirmed the appellate court's analysis as to the absence of material illegality, but remanded the case to another trial court,¹²⁷ the Court of the Hague, to determine if Schoonheim's actions were justified under the doctrine of necessity.¹²⁸ The Supreme Court acknowledged the conflicting duties faced by Schoonheim and developed three criteria to be considered by the Court of the Hague in its review of the interplay between the patient's suffering and the doctor's actions: "1. [w]hether, and to what extent, there is reason to fear further deterioration and/or that already unendurable suffering would increase? 2. [w]hether, considering potential

¹¹⁹ *Abstracts*, *supra* note 107. This is especially important in light of the fact that previously a combination of physical and psychological suffering was most common to euthanasia cases. *Id.*

¹²⁰ *See supra* note 106.

¹²¹ Driesse, *supra* note 72, at 394.

¹²² *Abstracts*, *supra* note 107.

¹²³ *Id.*

¹²⁴ *Id.* at 456-57.

¹²⁵ *Cf. People v. Conley*, 64 Cal.2d 310, —, 411 P.2d 911, 918, 49 Cal. Rptr. 815, 822 (1966) ("[O]ne who commits euthanasia bears no ill will toward his victim and believes his act is morally justified, but he nonetheless acts with malice if he is able to comprehend that society prohibits his act regardless of his personal belief.").

¹²⁶ *Abstracts*, *supra* note 107, at 457.

¹²⁷ Garbesi, *supra* note 112, at 109.

¹²⁸ *Abstracts*, *supra* note 107, at 457-58. "The doctrine of necessity in the common law refers to a choice between competing values, where the ordinary rule has to be departed from in order to avert some greater evil." O. RUTH RUSSELL, *supra* note 27, at 126.

deterioration, it is probable that the patient is now unable to die with dignity? 3. [w]hether, and to what extent, it is still possible to alleviate suffering?"¹²⁹

The Court of the Hague dismissed the case against Schoonheim, finding that although there was no medical consensus as to the permissibility of active voluntary euthanasia, his actions were "justified according to *reasonable* medical insight."¹³⁰ The court in effect said that the primary responsibility for deciding to proceed with euthanasia lay with the medical profession as opposed to the judiciary.¹³¹ At the same time, the court reinstituted recognition and protection of the patient's right to self-termination by requiring that the second criteria in a necessity situation was dependent on the patient herself, i.e., did the patient believe that she could no longer die with dignity?¹³²

The effect of the Schoonheim case was that active voluntary euthanasia rendered by a physician would stand up in court even as against Article 293, provided that the physician had acted in accordance with professional medical standards and had carefully weighed the suffering of the patient as part of the euthanasia decision.¹³³ No blanket exemption was afforded physicians, and the justifiability of a doctor's decision to administer euthanasia was becoming increasingly dependent on the patient's needs and desires with respect to dying. Concern was shifting from an emphasis on the doctor's right to perform euthanasia in a given instance to whether euthanasia was the right thing to do from the patient's perspective in that instance.

Over the course of a decade, the courts had moved rapidly along the spectrum of permissibility in determining euthanasia cases. The courts removed early criteria of terminal illness and unbearable suffering, expanding the patient's ability to control the dying process to the point that someone experiencing continuous mental suffering as the result of illness or disease had the right to request and receive aid-in-dying from the attending physician, provided such aid was rendered in accordance with professional medical standards as well as the norms of judicial precedent. A 1986 ruling may have gone too far, however, in the weight given the patient's suffering when it ruled that a doctor who succumbed to the pressures of the patient's distress could be excused from liability under Article 293.¹³⁴

The case involved a 73 year old non-terminal multiple sclerosis patient whose physician-friend gave her a fatal dose of morphine after repeated and insistent requests for aid-in-dying. Although the doctor was found guilty of active euthanasia, no punishment was imposed by the trial court.

¹²⁹ Garbesi, *supra* note 112, at 110.

¹³⁰ *Abstracts*, *supra* note 107, at 462 (emphasis in original).

¹³¹ D. HUMPHRY & A. WICKETT, *supra* note 25, at 178.

¹³² *Abstracts*, *supra* note 107, at 463.

¹³³ D. HUMPHRY & A. WICKETT, *supra* note 25, at 179.

¹³⁴ Nota Bene, *The High Court of the Hague Case No. 79065, October 21, 1986*, 3 ISSUES L. & MED. 445, 445-46 (1988).

The Leeuwarden Court of Appeal reversed the decision, imposing a conditional sentence of two months with two years' probation. The High Court of the Hague vacated the appellate judgment and remanded the case for further consideration consistent with its opinion.¹³⁵

The High Court agreed with the appellate court that active euthanasia was not a medical exception to Article 293, and that judicial precedent did not set Article 293 aside as to physicians.¹³⁶ The High Court disagreed with the appellate court's outright rejection of the physical and mental suffering of the patient and resultant mental duress of the physician as conditions justifying the euthanasia decision. The High Court held that the dire distress of the non-terminal patient and the mental duress of the physician should be considered as mitigating factors which could justify the decision to perform euthanasia.¹³⁷

At a glance, the High Court's decision may appear to be nothing more than an affirmation of the Schoonheim ruling; however, a commentary on the case by Dutch Attorney General Remmelink suggests otherwise.¹³⁸ Remmelink is concerned not so much with the dire distress of the patient but with the acceptance of mental duress as a defense under Article 293.¹³⁹ Remmelink points out the fundamental difference between the appellate court's treatment of the duress issue and that of the High Court:

For the High Court the moment of duress occurred at the time when the accused had to decide to carry out the wish of her friend to terminate her life. The accused was acting as the patient's friend rather than as her doctor in the judgment of the Appeals Court; the accused should not have promised to take the life of her friend, that was her *culpa in causa*. It was unfortunate and wrong . . . the High Court by-passed (sic) this fundamental issue . . . [finding that] the moment of duress occurred when the doctor decided to carry out the euthanasia procedure which she had promised. There is no *culpa in causa* because of the appeal to duress.¹⁴⁰

The problem here is not so much with a doctor who concludes that euthanasia is the right thing to do under the circumstances, as was the case in Schoonheim, but with a doctor who succumbs to the pressure of a repeated and insistent request for euthanasia without stopping to consider if it *is* the right thing to do for the patient. In other words, a doctor who believes that he *has* to administer euthanasia can now avoid liability under Article 293 just as readily as one who believes he *should* administer euthanasia because it is a higher good in a particular instance.

¹³⁵ *Id.* at 445.

¹³⁶ *Id.* at 446.

¹³⁷ *Id.* at 445-46.

¹³⁸ *Id.* at 448-50.

¹³⁹ Nota Bene, *supra* note 134, at 450. Remmelink finds the appeal to distress "fraught with hazards." *Id.* He cites expansion of the appeal to others, such as nursing personnel, as an example of the danger inherent in such an appeal. *Id.*

¹⁴⁰ *Id.*

The Dutch courts have led the way in making active voluntary euthanasia a reality in the Netherlands. From an initial decision permitting active voluntary euthanasia in the case of an incurably ill person with continuous and unbearable suffering, the right to request and receive physician aid-in-dying expanded rapidly to include the non-terminally ill patient with continuous physical, spiritual and/or mental suffering. The medical profession was charged with the primary responsibility for deciding to proceed with euthanasia. Their judgment was dependent on a decisionmaking process which emphasized the patient's right to self-determination. The strides made by the courts reflected public support for limited acceptance of active euthanasia, yet the trend in case law was diametrically opposed to the absolute ban imposed by Article 293.

The divergence between case and statutory law left the government, medical profession, and Public Prosecutor without firm ground to stand on, and caused concern among opponents of euthanasia that the practice would soon stretch into the realm of involuntary euthanasia. Rather than stand passively by and let this happen, the government, medical profession, and Public Prosecutor took steps to bridge the gap in the law.

B. The Policy of the Dutch Government on the Matter of Euthanasia

The Queen of Holland created a State Commission on Euthanasia in 1982¹⁴¹ to determine "the future policy of the [Dutch] government in the matter of euthanasia . . . in particular with respect to legislation and the application of the law."¹⁴² On July 9, 1985, the Commission issued a report advising the Queen that Article 293 should be revised to legalize voluntary euthanasia.¹⁴³ The Commission proposed statutory reform that would allow a doctor to avoid punishment under Article 293 provided the euthanasia procedure was performed at the request of the patient and in accordance with the conditions outlined by the Commission.¹⁴⁴

A bill was presented to Parliament in December 1985 in response to the Commission's report.¹⁴⁵ The bill, known as the D66 proposal, sought to allow the practice of euthanasia on request, and provided that a doctor would not be punished if he used care in helping a person in a hopeless situation to die.¹⁴⁶ The government responded with its own proposal, the Trial Proposal, in January 1986.¹⁴⁷ The Trial Proposal was more con-

¹⁴¹ Schepens, *supra* note 87, at 374.

¹⁴² Driesse, *supra* note 72, at 394-5.

¹⁴³ Schepens, *supra* note 87, at 375 n.15.

¹⁴⁴ Driesse, *supra* note 72, at 395. For a copy of the conclusions on which the Committee based its findings, see Garbesi, *supra* note 112, at 110-11. The Commission had considered but apparently was unable to reach agreement on "the additional condition that the death of the patient . . . be inevitable and imminent." Driesse, *supra* note 72, at 395. The absence of a dying phase was in accord with case law. See *supra* note 97.

¹⁴⁵ Driesse, *supra* note 72, at 395.

¹⁴⁶ *Abstracts*, *supra* note 107, at 464-65.

¹⁴⁷ *Id.* at 464.

servative in its approach, providing that a doctor would not be punished under Article 293 if he performed euthanasia "as a part of careful care of a patient who is dying if the patient is suffering unbearably, and there is also a concrete death expectation, and no reasonable goal will be served by further treatment."¹⁴⁸ The government's legislative proposal was less progressive than the then-current judicial norm,¹⁴⁹ most notably in that a dying patient¹⁵⁰ and unbearable suffering¹⁵¹ were prerequisites to the serious consideration of a request for euthanasia.

Despite an attempt by certain government officials to quell the reform effort, both bills were introduced to the Council of State for review.¹⁵² In July 1986 the Council of State advised the government to refrain from modifying Article 293 until the body of case law had developed further.¹⁵³ The Council's recommendation was in direct conflict with the Commission report of one year previous which had concluded that statutory reform was necessary because it would take years to achieve the clarity desired in the law if the issue remained solely within the purview of the judiciary.¹⁵⁴

The Council's recommendation did not prevent the government from requesting and receiving advice on euthanasia from the General Health Council.¹⁵⁵ In its official statement of advice, the General Health Council set forth the following criteria to guide doctors in the practice of euthanasia:

1. The doctor must inform the patient regarding the condition of his/her health and the prognosis of his/her illness and the therapeutic possibilities.
2. The doctor and the patient must be convinced that it is the latter who has requested and persists in requesting, after mature reflection and without outside pressure, that the doctor terminate his life.
3. The doctor may terminate a patient who is no longer able to comply with point 2, if there is a previously written declaration of the patient requesting the termination of his or her

¹⁴⁸ *Id.* at 465.

¹⁴⁹ *Id.* The divergence between case law and the government's proposal is illustrated by a 1985 decision involving Dr. Pieter V. Admiraal, a leading practitioner of euthanasia. Dr. Admiraal had performed euthanasia at the persistent request of a young multiple sclerosis patient experiencing physical and mental suffering. There was no concrete death expectation. The Hague Court dismissed the case on the basis of criteria outlined in the Schoonheim decision. The pending government proposal apparently had no impact on the court's decision and, for some reason, the Public Prosecutor chose not to press the issue, perhaps missing a golden opportunity to bridge the gap between the law on the books and the law in practice. *Id.*

¹⁵⁰ The dying phase requirement had been rejected by the judiciary as early as the Postma decision. *See supra* note 97.

¹⁵¹ "Unbearable" as an independent criteria of suffering was dropped by the Schoonheim court. *See Driesse, supra* note 72, at 394.

¹⁵² *Id.* at 395-96. The Council of State is "the highest advisory organ of the [Dutch] government." Sagel, *supra* note 84.

¹⁵³ *Abstracts, supra* note 107, at 446.

¹⁵⁴ *Id.* at 464. *See also* Driesse, *supra* note 72, at 395.

¹⁵⁵ Schepens, *supra* note 87, at 377.

life. This proved the doctor must be convinced that this declaration was freely written and that there is no other solution for this patient's problem.

4. The doctor must consult with a colleague.

5. The doctor must make a report recording the matters of points 1, 2 and 3, and give the name of the colleague requested in point 4. This report must be kept for five years.

6. If the patient is less than sixteen years old, termination may not take place before the doctor has asked the patient whether he/she has a valid objection to informing his/her parents on this matter. The latter are to be included in the decision process unless there is such an objection.¹⁵⁶

These protocols were more progressive in certain respects than the criteria developed by case law, for example, the implicit approval of voluntary euthanasia for minors without parental consent. Yet despite this and other government efforts to reconcile case and statutory law, euthanasia remains an offense under Article 293.¹⁵⁷

C. The Medical Profession's Response to Developments in the Law

Critics of legalized voluntary euthanasia argued that the courts had vested tremendous responsibility in the medical community when in fact there was no medical consensus on the permissibility of euthanasia.¹⁵⁸ Their argument lost steam when in 1987 the Royal Netherlands Society for the Promotion of Medicine ("KNMG") and Recovery, Interest Society for Nurses and Nursing Aids (the Dutch nurses' union) issued a joint paper which served to establish practical guidelines for health care professionals participating in the euthanasia decision.¹⁵⁹ The two groups were not necessarily saying that euthanasia was permissible, but were providing official guidance for those doctors who chose to perform euthanasia

¹⁵⁶ *Id.* These so-called "carefulness requirements" were published in a report issued by the General Health Council on March 26, 1987, entitled "Proposal of Advice Concerning Carefulness Requirement in the Performance of Euthanasia." *Id.*

¹⁵⁷ An April, 1988 news report indicated that the Netherlands was nearing approval of a legislative proposal submitted for review in December 1987. J. Gray, *Life-and-Death Issue: Netherlands Expected to Approve Bill Providing Euthanasia Defense*, *Globe & Mail*, April 26, 1988, at 1 (photo. reprint courtesy The National Hemlock Society). The proposal would not make mercy killing legal, but would provide a defense for a physician who performed euthanasia at the voluntary request of an incurably ill patient who was fully informed of his condition, including the possibility of palliative treatment. *Id.* The exception to these criteria would be the case of a now-incompetent patient who had executed a written directive within the previous five year period. *Id.* According to Derek Humphry, who visited Holland in mid-1989, the law remains unchanged. Note from Derek Humphry to Deborah A. Wainey (July 24, 1989).

¹⁵⁸ Nota Bene, *supra* note 134, at 449. See also, *Abstracts*, *supra* note 107, at 458-59, 462-63.

¹⁵⁹ Schepens, *supra* note 87, at 378. For an English translation of the professional guidelines, see *Guidelines*, *supra* note 82.

and the nursing staff who might assist in the procedure.¹⁶⁰

The medical profession had responded to the responsibility vested in it by the courts by providing the consensus critics claimed was lacking. Of significance is the fact that the guidelines served not only to protect doctors and nurses against unfounded investigation and prosecution under Article 293, but also to protect the patient, for instance, by sanctioning only voluntary euthanasia¹⁶¹ and requiring that a complete written record of the entire decisionmaking process be included in the patient's medical file.¹⁶² The guidelines did not calm the fears of doctors who were leery of a court that could reverse its trend at any time; active euthanasia remained a surreptitious practice.

D. Striking a Balance Between Case and Statutory Law

Despite court rulings, General Health Council guidelines, and professional medical guidelines, Dutch physicians continued to conceal their participation in active euthanasia for fear of investigation and prosecution.¹⁶³ Since doctors are not required to report crimes against life,¹⁶⁴ mercy killings involving physicians go unnoticed unless the doctor reports the crime¹⁶⁵ or is turned in to the Public Prosecutor by others.¹⁶⁶ Only a handful of cases come to the attention of the Public Prosecutor annually.¹⁶⁷

Efforts to ensure equal and fair application of the law for even the handful of investigations conducted by the Public Prosecutor were hampered by the disparity between statutory and case law.¹⁶⁸ To rectify the situation, the Public Prosecutor decided to enforce Article 293 within the parameters set forth by the courts.¹⁶⁹ A five member committee was

¹⁶⁰ The guidelines acknowledged that only doctors could perform euthanasia according to case law, but expressed concern for those nursing personnel who assisted the doctor at some point in the euthanasia process. *Guidelines*, *supra* note 82, at 430. The guidelines concluded that if a doctor was not prosecuted, nursing personnel who assisted him should be treated likewise. *Id.* at 436. The proposed Death With Dignity Act protects physicians as well as other health care professionals from criminal, civil and administrative liability when aid-in-dying is performed in compliance with the terms of the Act. *See infra* note 278.

¹⁶¹ *Guidelines*, *supra* note 82, at 431.

¹⁶² *Id.* at 432.

¹⁶³ D. HUMPHRY & A. WICKETT, *supra* note 25, at 176.

¹⁶⁴ *See supra* note 82.

¹⁶⁵ This was the case with Dr. Schoonheim, who filed a death certificate listing "unnatural death" and also advised the police of his actions. D. HUMPHRY & A. WICKETT, *supra* note 25, at 178. The Public Prosecutor investigates all cases of death attributed to other than natural causes. Nota Bene, *supra* note 114, at 452. In the case of active euthanasia, the Dutch courts have ruled that the death certificate cannot indicate that death was the result of natural causes. *Id.* at 451. Nonnatural death must be declared in such a situation. *Id.*

¹⁶⁶ Recall that Dr. Postma was reported to the authorities by the director of the nursing home where her mother was a resident. *See supra* note 93.

¹⁶⁷ Approximately 2,000 doctors practice euthanasia in the Netherlands, but only 36 cases were reviewed by the Public Prosecutor between 1982 and 1984. D. HUMPHRY & A. WICKETT, *supra* note 25, at 176.

¹⁶⁸ *Abstracts*, *supra* note 107, at 467.

¹⁶⁹ D. HUMPHRY & A. WICKETT, *supra* note 25, at 176 (quoting Anka Sutorius, a Dutch judge).

formed to centralize review of all euthanasia cases brought to the attention of the Public Prosecutor.¹⁷⁰ The majority of cases investigated by the committee are dismissed.¹⁷¹

Doctors are not yet comfortable being open about their participation in active euthanasia. There is hope that the 1987 ruling forbidding falsification of death certificates, coupled with the General Health Council protocols and professional medical guidelines, will encourage honesty in the practice of active euthanasia.¹⁷² The fact that the Public Prosecutor has taken steps to bridge the gap in the law is also encouraging, especially considering that 80% of the euthanasia cases investigated are dismissed.¹⁷³ But as doctors become less secretive about their actions, the burden on the Public Prosecutor will increase,¹⁷⁴ making it ever more difficult to ensure equal and fair application of the law.¹⁷⁵ Unless statutory reform is accomplished, the individual efforts of the judiciary, government, medical profession, and Public Prosecutor will remain at odds and continue to frustrate the Public Prosecutor's attempts to enforce a law which has been emasculated by the courts.

E. Summary

Article 293 should be revised to provide an exemption for physicians. Homicide upon request would remain a crime under Article 293, but a doctor who killed a patient at the patient's request in order to end unbearable suffering ("mercy killing") would not be prosecuted unless he violated statutory criteria justifying exemption. This would parallel the Dutch penal system, which recognizes motive and consent as mitigating factors in the killing of another human being upon his request.

Statutory reform would benefit the Netherlands by providing a sound legal instrument which protects both patient and physician, while allowing the Public Prosecutor to enforce the law. Doctors would be more confident working under the protection of statutory guidelines and the public would be secure in the knowledge that those who violate the law are convicted *and punished* if found guilty under Article 293. In addition, the guidelines currently followed by the medical profession would have the benefit of legal force. This would lend weight to the court's decision to vest primary responsibility for the euthanasia decision in the medical community.

Report and recordkeeping requirements would ensure that all cases of active euthanasia are brought to the attention of the Public Prosecutor.

¹⁷⁰ Sagel, *supra* note 84.

¹⁷¹ Of the 36 cases investigated between 1982 and 1984, 28 were dropped immediately and 5 were dismissed after judicial inquiry. D. HUMPHRY & A. WICKETT, *supra* note 25, at 176. In other words, the Public Prosecutor took no action in approximately 80% of the cases. *Id.*

¹⁷² *Abstracts, supra* note 107, at 468.

¹⁷³ *See supra* note 171.

¹⁷⁴ *Abstracts, supra* note 107, at 468.

¹⁷⁵ *Id.*

Although the number of reported cases would probably increase dramatically, the Public Prosecutor would have the benefit of a sound legal instrument to enforce the law. The Public Prosecutor could, in fact, decentralize the review of euthanasia cases if the five member committee became overwhelmed by the sheer volume of reported cases.¹⁷⁶

Finally, the patient himself would benefit from such reform because it is designed to prevent the kind of abuse which might lead to repetition of the involuntary euthanasia program advanced by the Nazis.¹⁷⁷ The voluntary request of a fully informed patient is a key factor in reform proposals. As long as other criteria designed to limit the availability of active euthanasia are satisfied, the final decision to choose a good death would rest with the patient.¹⁷⁸ This is the ultimate sign of respect for personal autonomy and the sanctity of life because it recognizes that being alive is not necessarily important absent the ability to have a life.¹⁷⁹

The Dutch have permitted the practice of active voluntary euthanasia on a limited basis for almost two decades, during which time they came to appreciate the vast potential for abuse in an unregulated system.¹⁸⁰ Pending legislation is expected to bring the practice out into the open. The ability to regulate and monitor the practice should allow the Dutch to stem the tide of abuse which some fear is just around the corner. The United States should examine the Dutch experience and use it to resolve the issue on the American front before it becomes mired in the cogs of the American court system. The issue of active voluntary euthanasia did not die with the dismissal of the *Rodas* case.¹⁸¹ The United States would be well-advised to take the upper hand in this matter, responding to the issue before it becomes unmanageable.

IV. FACING THE CHALLENGE OF ACTIVE VOLUNTARY EUTHANASIA IN THE UNITED STATES

The United States operates on a criminal law system different from that of the Netherlands. In the United States, motive is considered irrelevant in substantive criminal law,¹⁸² and is not regarded as an affirmative defense no matter how laudable the motive in a particular instance.¹⁸³ Likewise, a victim's consent is generally not an affirmative

¹⁷⁶ But see Garbesi, *supra* note 112, at 109, n.87. ("[T]he risk of unjust prosecution is not as great as it might be in a decentralized system like that in the United States.")

¹⁷⁷ See *supra* note 86.

¹⁷⁸ Although doctors can refuse to comply with a patient's request, they cannot frustrate the choice made by the patient by refusing to refer him to another doctor willing to honor the request. See *Guidelines*, *supra* note 82, at 436. Cf. *Bouvia v. Super. Ct.*, 179 Cal. App.3d 1127, 1144, 225 Cal. Rptr. 297, 305 (1986) ("It is incongruous . . . for medical practitioners to assert their right to preserve a life that someone else must live, or, more accurately, endure . . .").

¹⁷⁹ J. RACHELS, *supra* note 25, at 26. See also O. RUTH RUSSEL, *supra* note 27, at 220 (differentiate between the person and the body).

¹⁸⁰ Potts, *supra* note 52, at 502.

¹⁸¹ See *supra* note 2.

¹⁸² W. LAFAVE & A. SCOTT, *HANDBOOK ON CRIMINAL LAW* 204 (1972).

¹⁸³ *Id.* "A good motive may result in leniency by those who administer the criminal process." *Id.* (emphasis added). See note 192 and accompanying text.

defense in a criminal prosecution.¹⁸⁴ Where the Netherlands treats mercy killing as "homicide upon request,"¹⁸⁵ a less culpable crime than murder, in the United States consent to criminal homicide has never been a defense.¹⁸⁶ Therefore, in the United States "[o]ne who intentionally kills another human being is guilty of murder, though he does so at the victim's request and his motive is the worthy one of terminating the victim's sufferings from an incurable and painful disease."¹⁸⁷

Theoretically, under this schematic, a physician who administered a fatal overdose to end a terminally ill patient's suffering, at the patient's request, would be susceptible to prosecution for murder. However, in the United States, mercy killers are rarely indicted¹⁸⁸ and, when prosecuted, there is great inconsistency of results.¹⁸⁹ Mercy killing cases involving physicians aptly illustrate the uneven application of the law.¹⁹⁰

The disparity between the law in theory and the law in practice is grounded in the ability of the prosecutor, judge and jury to defy the law on the books. The public often sympathizes with a mercy killer,¹⁹¹ and such sentiment has crept into the actions of the prosecutor, judge and jury. Motive necessarily plays a key role in the compassionate response of the judicial system to the mercy killer.¹⁹²

The United States has established a pattern of circumventing the law in the case of mercy killers, especially in the case of physicians.¹⁹³ This sends a mixed message to its citizens, i.e., mercy killing is illegal and punishable as murder yet the chance of escaping a murder conviction and/or prison sentence is good.¹⁹⁴ The disparity in the law is on a collision course with itself. Americans must deal with the issue of active voluntary euthanasia by channeling their compassion toward statutory reform which would grant terminally ill persons "the right to choose *when* to die"¹⁹⁵ and protect those physicians who help them exercise that choice.

¹⁸⁴ W. LAFAYE & A. SCOTT, *supra* note 182, at 408. See also Silving, *supra* note 63, at 380.

¹⁸⁵ See *supra* note 81.

¹⁸⁶ Silving, *supra* note 63, at 380. See also Survey, *Euthanasia: Criminal, Tort, Constitutional and Legislative Considerations*, 48 NOTRE DAME LAW, 1202, 1205 (1973). Consent of the patient should be the key in euthanasia cases more so than the motive of the second party actor. See *supra* note 63.

¹⁸⁷ W. LAFAYE & A. SCOTT, *supra* note 182, at 205.

¹⁸⁸ Survey, *supra* note 186, at 1213.

¹⁸⁹ D. HUMPHRY & A. WICKETT, *supra* note 25, at 221 n*.

¹⁹⁰ *Eight Doctors On Euthanasia Charges*, HEMLOCK Q., Jan. 1989, at 6 [hereinafter *Eight Doctors*]. Of eight doctors charged in the mercy killing of a terminally ill patient or family member, five were acquitted of murder charges, one committed suicide shortly after arrest, one was found guilty of murder but received no prison sentence, and one awaits trial. See *infra* Section IV.A.

¹⁹¹ Survey, *supra* note 186, at 1213-15.

¹⁹² W. LAFAYE & A. SCOTT, *supra* note 182, at 207.

¹⁹³ See *supra* note 190.

¹⁹⁴ D. HUMPHRY & A. WICKETT, *supra* note 25, at 218-19. For a statistical analysis of the type of punishment imposed on mercy killers from 1920-1985, see Wickett, *Most Mercy Killings in Living Will States*, HEMLOCK Q. Apr. 1986 (reprinted in COMPASSIONATE CRIMES, BROKEN TABOOS 70 (D. Humphry ed. Fall 1986) [hereinafter COMPASSIONATE CRIMES]).

¹⁹⁵ Fletcher, *supra* note 31.

A. The Physician as Mercy Killer: An Analysis of American Case Law

Despite rejection of every proposal to legalize voluntary active euthanasia to date,¹⁹⁶ Americans have demonstrated a tolerance, if not an acceptance, of same, especially in the case of physicians prosecuted for killing patients to release them from suffering as an act of mercy.¹⁹⁷ Although the judicial system has shown compassion in the handful of mercy killing cases involving physicians, it has been at the expense of dealing with the issue of euthanasia.¹⁹⁸

The 1950 case of Dr. Hermann Sander was the first mercy killing case in the United States involving a medical doctor and, as such, was expected to be a test case for euthanasia.¹⁹⁹ However, this was the first of several such cases which would successfully circumvent the law by avoiding the issue.

Sander was charged with first-degree murder for injecting air into the veins of a cancer patient, Mrs. Abbie Burotto, who was on the verge of death.²⁰⁰ Dr. Sander did not deny his actions and, in fact, noted in hospital records that Mrs. Burotto died about ten minutes after the injection.²⁰¹ When questioned about the incident, Sander reportedly said that he acted at the persistent request of the patient's husband and out of compassion for Mrs. Burotto's suffering.²⁰²

Sander represented a clear case of mercy killing, yet the issue was never raised at trial.²⁰³ As was the case in previous mercy killing cases, none of which involved a physician, emphasis was shifted to another issue, this time lack of causation, in an attempt to avoid the harsh reality of the law.²⁰⁴ After a three week trial, the jury acquitted Sander on the ground that there was insufficient proof of causation between his actions and the death of Mrs. Burotto.²⁰⁵ The issue of mercy killing had been suppressed in the courtroom,²⁰⁶ but the verdict indicated that the jury had made motive the central issue in the case.²⁰⁷

The spectre of physician as mercy killer did not reappear on the American judicial scene for over two decades.²⁰⁸ But in 1973, Dr. Vincent Mon-

¹⁹⁶ See *infra* Section IV.B.

¹⁹⁷ See *supra* note 190.

¹⁹⁸ *Id.*

¹⁹⁹ *State v. Sander*, N.Y. Times, March 10, 1950, at 1, col. 6. See also J. WILSON, *supra* note 24, at 38.

²⁰⁰ O. RUTH RUSSELL, *supra* note 27, at 105-6.

²⁰¹ Survey, *supra* note 186, at 1214.

²⁰² D. HUMPHRY & A. WICKETT, *supra* note 25, at 43.

²⁰³ Recent Decisions, *Criminal Law - Humanitarian Motive as a Defense to Homicide*, 48 MICH. L. REV. 1199, 1201 (1950).

²⁰⁴ Silving, *supra* note 63, at 353.

²⁰⁵ Recent Decisions, *Criminal Law - Proof of the Corpus Delicti by the Use of ExtraJudicial Confessions*, 48 MICH. L. REV. 1197, 1197 (1950).

²⁰⁶ D. HUMPHRY & A. WICKETT, *supra* note 25, at 43.

²⁰⁷ J. WILSON, *supra* note 24, at 39.

²⁰⁸ Hospital Surgeon Charged with Mercy Killing of N.Y. Patient, June 29, 1973 (reprinted in COMPASSIONATE CRIMES, *supra* note 194, at 22).

temarano was indicted for murder in the death of Eugene Bauer, a comatose throat cancer patient given two days at most to live.²⁰⁹ Montemarano was accused of injecting potassium chloride, a deadly but undetectable chemical solution, into the veins of Mr. Bauer, who died within five minutes.²¹⁰ Initially the District Attorney called the death a mercy killing,²¹¹ but Montemarano was tried on "a straight murder charge,"²¹² with the District Attorney arguing that he had killed Bauer as a matter of convenience so that he would not have to return at a later time to pronounce Bauer dead.²¹³

Once again, lack of causation was raised as a defense and once again, a jury acquitted a physician accused of murder in the mercy killing of a patient.²¹⁴ The case may not have been tried on the ground of motive, but, as noted in a news report of the verdict, "the jury and spectators . . . cut through all the technical stuff, straight to the heart of the human and moral issue."²¹⁵

The 1980's brought four cases involving physicians charged with killing a patient or family member who was terminally ill.²¹⁶ The 1985 case of Dr. John Kraai, who was charged with second-degree murder in the death

²⁰⁹ *Id.*

²¹⁰ Goldsmith, *The Montemarano Case: Physician Acquitted of Charges of Murdering Patient*, 2 J. LEGAL MED. 47 (1974) [hereinafter Goldsmith]. Dr. Montemarano was indicted several months after Mr. Bauer's death based on the allegations of a practical nurse who said that she saw the doctor inject his patient with a lethal dose of potassium chloride. *Id.* at 47. However, the nurse's credibility was shattered at trial when the defense produced a statement signed by her which indicated "that she had not seen the injection being given." *Id.* at 48.

²¹¹ D. HUMPHRY & A. WICKETT, *supra* note 25, at 104.

²¹² Lerner, *The Right to Live—And the Right to Die* (reprinted in COMPASSION-ATE CRIMES, *supra* note 194, at 22).

²¹³ Goldsmith, *supra* note 210, at 48.

²¹⁴ Unlike Sander, however, "the defense [in Montemarano] never conceded that an injection had been given." D. HUMPHRY & A. WICKETT, *supra* note 25, at 104. This approach, in fact, was the key to the defense's strategy. Goldsmith, *supra* note 210, at 48.

[It] permitted the case to be defended on two levels. The prosecution had to prove that an injection had been given if there was to be a murder at all. If the prosecution was able to prove that an injection had been given, it would then have to prove that the injection killed the patient and that he was dead as a result of the injection and that he had not died of natural causes.

Id.

²¹⁵ See *supra* note 212.

²¹⁶ *Eight Doctors*, *supra* note 190. Two other doctors, Robert Nedjil and Neil Barber, were charged with murder and conspiracy to commit murder in the death of Clarence Herbert. Barber v. Superior Ct., 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983). The doctors had removed life support equipment and intravenous tubes providing hydration and nutrition at the request of the patient's family. *Id.* at 1010, 195 Cal. Rptr. at 486. The doctors were acquitted of all charges. *Id.* at 1022, 195 Cal. Rptr. at 493. Since this case deals with withdrawal/withholding of life-sustaining procedures, and is more commonly associated with passive euthanasia, it will not be considered in this discussion of doctors charged with murder wherein the doctor performed what is known as active euthanasia via a lethal dose of drugs.

of his friend and patient, Frederick Wagner, ended with the suicide of Kraai three weeks after he was arrested.²¹⁷ In 1986, Dr. Joseph Hassman was found guilty of murder in the death of his mother-in-law, Esther Davis, who suffered from Alzheimer's disease.²¹⁸ Hassman was "sentenced to two years probation, fined \$10,000 and ordered to perform 400 hours of community service."²¹⁹

Dr. Peter Rosier was charged with first-degree murder in the 1986 death of his wife, who was suffering from lung cancer.²²⁰ Pat had requested her husband's help in committing suicide, and he, along with other family members, participated in her plan to kill herself via an overdose of sleeping pills. The sleeping pills did not have the desired effect, however, so Dr. Rosier injected his wife with morphine. The morphine also had no effect, and she was eventually suffocated by her stepfather, Vincent Delman, in order to end the botched suicide attempt. Delman bargained for immunity before confessing his responsibility for Pat's death.²²¹ Dr. Rosier stood trial for his part in her death, but the jury acquitted him, apparently on the basis of lack of causation, as was the result in the *Sander* and *Montemarano* cases.²²²

In 1988, Dr. Donald Caraccio was accused of the poisoning and murder of a 74 year old patient. Dr. Caraccio allegedly injected the patient with potassium chloride. He awaits trial; his defense is unknown at this time.²²³

B. 20th Century Efforts to Legalize Active Voluntary Euthanasia

The first attempt to legalize active voluntary euthanasia in the United States failed.²²⁴ A bill was introduced into the Ohio state legislature in January 1906²²⁵ which proposed

²¹⁷ D. HUMPHRY & A. WICKETT, *supra* note 25, at 140-42, 218-20.

²¹⁸ *Eight Doctors*, *supra* note 190. Hassman acted at the request of the family, injecting the 80 year old woman with a fatal dose of Demerol. *Id.*

²¹⁹ *Id.*

²²⁰ 'I Helped Her on Her Way', *NEWSWEEK*, Nov. 7, 1988, at 101 [hereinafter 'I Helped Her'].

²²¹ *Id.* According to news reports, there was testimony that Pat Rosier would have recovered from the overdose and morphine, although she might have been impaired. *Id.*

²²² *Botched Suicide Led to Murder Trial*, *HEMLOCK Q.*, Jan. 1989, at 7, 8. Rosier actually stood trial on three charges, murder one, conspiracy to murder, and attempted murder. The jury acquitted Rosier on all three counts and also declined to consider five lesser counts offered by the judge. *Id.* Derek Humphry, head of the National Hemlock Society, believes Rosier should have been charged with assisted suicide under FLA. STAT. ANN. § 782.08 (West 1981) ("Every person deliberately assisting another in the commission of self-murder shall be guilty of manslaughter . . ."). *Dr. Rosier's Acquittal Both a Victory and a Warning*, *HEMLOCK Q.*, Jan. 1989, at 1. The prosecutor apparently perceived a difference between assisted suicide and murder, but since the cause of death was not due to the morphine, Humphry's belief is accurate. *See supra* note 47.

²²³ *Eight Doctors*, *supra* note 190. Dr. Caraccio was arraigned in the 36th District Court in Detroit, Michigan. *Id.*

²²⁴ O. RUTH RUSSELL, *supra* note 27, at 60.

²²⁵ *Id.* Apparently this was the first such bill introduced into the legislature of an English-speaking country. *Id.*

that when an adult of sound mind had been fatally hurt or was so ill that recovery was impossible, or if he was suffering from extreme physical pain without hope of recovery, his physician, if not a relative and if not interested in any way in his estate, might ask him in the presence of three witnesses if he wished to die. If he indicated that he did, then three other physicians were to be summoned in consultation and if they agreed that the case was hopeless, they were to make arrangements to put the person out of pain and suffering with as little discomfort as possible.²²⁶

The bill was referred to the Committee on Medical Jurisprudence for study, where it was rejected by a vote of 78 to 22.²²⁷

After failure of the initial proposal in Ohio, no further significant efforts to legalize active voluntary euthanasia occurred until the 1930's.²²⁸ A bill introduced into the Nebraska state legislature in February 1937 was sent to a committee for consideration, but review was postponed and the bill was never acted upon.²²⁹ The 1930's also brought the founding of the Euthanasia Society of America (hereinafter "ESA"). This group, formed in 1938, was the first euthanasia society established in the United States.²³⁰ Its goal was to crusade for legalization of euthanasia on "the belief that with adequate safeguards, the choice of immediate death rather than prolonged agony should be available to the dying."²³¹ As noted, nothing came of the Nebraska bill, and a similar proposal by ESA in New York in January, 1939 failed to reach the state legislature.²³²

Legislative efforts died down during World War II;²³³ realization of Nazi atrocities²³⁴ tempered Americans' willingness to actively support such efforts.²³⁵ As the war came to a close, however, ESA renewed its efforts. A proposal was prepared by ESA in 1945 and submitted to the New York

²²⁶ *Id.* at 61.

²²⁷ D. HUMPHRY & A. WICKETT, *supra* note 25, at 12.

²²⁸ DEATH WARRANT, *supra* note 23, at 24.

²²⁹ J. WILSON, *supra* note 24, at 32-33.

²³⁰ *Id.* at 33.

²³¹ O. RUTH RUSSELL, *supra* note 27, at 72.

²³² *Id.* at 74.

²³³ *Id.* at 87.

²³⁴ The Nazi programs consisted of compulsory sterilization and eugenics to purify the German race. This so-called euthanasia program was imposed on unwitting victims and was anything but a happy death experience for the person being killed. The euthanasia label, therefore, is wrongly tagged on the Nazi programs to kill those deemed unworthy of German heritage. On the contrary, the Nazi programs were nothing more than a cold-blooded attempt by a madman to purify the German race through a secret program of mass genocide. *See generally*, D. HUMPHRY & A. WICKETT, *supra* note 25, at 20-32.

²³⁵ Americans feared legalization of active voluntary euthanasia would lead to a repeat of the horrors of Nazi Germany. O. RUTH RUSSELL, *supra* note 27, at 90-94. This line of reasoning is known as the wedge or slippery slope argument. For a discussion of this argument, including an analogy to Nazi Germany, see J. RACHELS, *supra* note 25, at 170-80. *Contra* J. WILSON, *supra* note 24, at 35-36 (results of public opinion polls indicate that Americans' views on legalization of active voluntary euthanasia were not affected by events in Nazi Germany).

state legislature in 1947.²³⁶ This proposal was supported by 1,776 physicians and 54 clergymen.²³⁷ The proposal provided that

(1) any sane person over twenty-one years old, suffering from an incurably painful and fatal disease, may petition a court of record for euthanasia, in a signed and attested document, with an affidavit from the attending physician that in his opinion the disease is incurable; (2) the court shall appoint a commission of three, of whom at least two shall be physicians, to investigate all aspects of the case and to report back to the courts whether the patient understands the purpose of his petition and comes under the provisions of the act; (3) upon a favorable report by the commission the court shall grant the petition, and *if it is still wanted by the patient* euthanasia may be administered by a physician or any other person chosen by the patient or by the commission.²³⁸

Two years of lobbying and additional petition drives failed to get the bill introduced into the New York state legislature.²³⁹ A final petition effort in 1952 also failed and the proposal was shelved.²⁴⁰

After the failure in New York, ESA turned its energy to educating the public on the topic of euthanasia.²⁴¹ ESA did not work for legislation during the 1950's and 1960's, although it did establish the Euthanasia Education Fund in 1967 to prepare and distribute the Living Will,²⁴² a document which provides that no artificial means nor heroic measures be used to keep the person signing the document alive in the event he becomes unable to make such decisions in the future²⁴³ due to terminal illness, injury or disease.²⁴⁴ While ESA had abandoned its efforts to legalize active voluntary euthanasia, three states independently sponsored active euthanasia bills,²⁴⁵ none of which became law.

²³⁶ D. HUMPHRY & A. WICKETT, *supra* note 25, at 33-34.

²³⁷ J. WILSON, *supra* note 24, at 36.

²³⁸ Fletcher, *supra* note 1, at 187-88 (emphasis in original).

²³⁹ O. RUTH RUSSELL, *supra* note 27, at 96-97.

²⁴⁰ D. HUMPHRY & A. WICKETT, *supra* note 25, at 47.

²⁴¹ The ESA provided speakers and literature in response to requests from across the country. O. RUTH RUSSELL, *supra* note 27, at 111.

²⁴² *Id.* at 180-82. This group specifically endorsed passive euthanasia, i.e., "the removal of supportive measures when there is no reasonable hope for real recovery." *Id.* at 180. This is in stark contrast to the original goals of ESA—to legalize active voluntary euthanasia—and signified the beginning of the active-passive distinction as a major weapon in the euthanasia debate. Today, 38 states (not including Ohio) and the District of Columbia have living will statutes, no two of which are exactly alike. Condie, *Comparison of the Living Will Statutes of the Fifty States*, 14 J. CONTEMP. L. 105, 106-7 (1988).

²⁴³ *Id.* at 105.

²⁴⁴ *Id.* at 111. A living will basically provides as follows: "If the situation should arise in which there is not reasonable expectation of my recovery from physical or mental disability, I request that I be allowed to die and not be kept alive by artificial means or heroic measures." BLACK'S LAW DICTIONARY, *supra* note 47, at 823.

²⁴⁵ O. RUTH RUSSELL, *supra* note 27, at 188. The three states were Idaho, Montana and Oregon. For a review of these bills, see *id.* at 192-94.

The American public has yet to face and answer the question of whether a terminally ill person has the right to choose an easy death as an alternative to a prolonged dying phase that is nothing more than a mockery of life. Continued defiance of the law on the books will not make the issue disappear; rather, it will enhance the potential for abuse, leaving patient and physician alike unprotected.

C. The Problems Inherent in Ignoring the Issue

Stanley Rosenblatt, defense counsel for Dr. Rosier, contended that physicians frequently help patients to die by giving them fatal doses of drugs, but hide behind the official shield of an "intent to make comfortable" rather than admit an "intent to hasten death."²⁴⁶ The fact that four doctors have been indicted in the 1980's is indicative of the fact that Rosenblatt is not entirely off the mark. The lenient treatment afforded the six doctors who have stood trial for murder since 1950 sends a clear signal to physicians that it is alright to kill a terminally ill patient via a lethal injection, with or without their consent, but fails in the provision of equal and fair application of the law.

Clearly, some kind of reform is needed to bridge the gap between the law on the books and the law in action.²⁴⁷ By focusing on culpability of actor rather than consent of victim, in an after-the-fact fashion, America has taken the first step on the slippery slope²⁴⁸ it so fears. What America needs is a practical law which gives a terminally ill patient the right to choose active euthanasia while at the same time granting immunity to the physician who acts in accordance with such law. The Death With Dignity Act²⁴⁹ is such a law. It best protects the autonomy of the patient by ensuring that the patient has requested active euthanasia, and also requires the State to recognize the motive of euthanasia as a defense to criminal homicide without need to revamp the entire criminal law system.

D. The Death With Dignity Act: Making The Right to Choose When to Die a Reality in the United States

Over eighty years after the first attempt in the United States to pass a law permitting active voluntary euthanasia,²⁵⁰ the National Hemlock

²⁴⁶ *I Helped Her*, *supra* note 220. American Medical Association guidelines condone this attitude. See Council on Ethical and Judicial Affairs, *Current Opinions of the Council on Ethical and Judicial Affairs of the American Medical Association* (1986), S 2.18 at 12.

²⁴⁷ Survey, *supra* note 186, at 1215.

²⁴⁸ See *supra* note 235.

²⁴⁹ See *supra* note 255.

²⁵⁰ See *supra* note 225.

Society,²⁵¹ through its affiliate, Americans Against Human Suffering²⁵² (hereinafter "AAHS"), has once again thrust endorsement of active voluntary euthanasia into the legislative arena. AAHS seeks passage of state laws giving the terminally ill the right to choose active euthanasia and granting immunity to physicians administering same.²⁵³ AAHS is also lobbying for a congressional resolution encouraging states to enact such legislation.²⁵⁴ AAHS has developed a model act, the Death With Dignity Act²⁵⁵ (hereinafter "DWDA"), which can be adapted for use on a state-by-state basis.²⁵⁶

The DWDA confronts the numerous arguments offered by anti-euthanasiasts without losing sight of the patient. Adequate safeguards are provided to prevent abuse while at the same time protecting the patient's right of self-determination. This section presents a critical assessment of the DWDA in light of the terminally ill patient²⁵⁷ requesting active euthanasia.

The DWDA combines the concept of a living will²⁵⁸ with that of a durable power of attorney²⁵⁹ to provide adults the ability to make a legal decla-

²⁵¹ The National Hemlock Society is a right-to-die organization which supports both passive and active voluntary euthanasia. It was founded in 1980 by Derek Humphry, and devotes its efforts to research and publication in order to educate the public about euthanasia, especially active voluntary euthanasia. *Q. and A. on the Hemlock Society*, HEMLOCK Q., Jan. 1989 at 4. The National Hemlock Society can be contacted by writing P. O. Box 11830, Eugene, Oregon 97440-3900.

²⁵² AAHS is the political arm of the National Hemlock Society. Humphry, *Legislating for Active Voluntary Euthanasia*, THE HUMANIST, March/Apr. 1988, at 10, 11. AAHS can be contacted by writing P. O. Box 11001, Glendale, California 91206.

²⁵³ R. RISLEY, A HUMAN AND DIGNIFIED DEATH: A NEW LAW PERMITTING PHYSICIAN AID-IN-DYING vii (1987).

²⁵⁴ *Id.* AAHS has a representative located in Washington, D.C. Letter from William C. Robison to Deborah A. Wainey (Nov. 9, 1988) (discussing AAHS efforts to legalize active voluntary euthanasia) [hereinafter Letter].

²⁵⁵ Formerly known as the *Humane and Dignified Death Act*. For a copy of the model Act, as adapted for use in Oregon, see Appendix I. A similar act was recently developed by participants in a year-long seminar on aid-in-dying conducted by Professors Sheldon F. Kurtz and Michael J. Saks at the University of Iowa College of Law. *Et Al*, STUDENT LAWYER, Sept. 1989, at 12. The proposed Model Aid-in-Dying Act will be published in an upcoming issue of the IOWA LAW REVIEW and is being distributed to all 50 state legislatures. *Id.*

²⁵⁶ R. RISLEY, *supra* note 253. AAHS was unable to gather the signatures necessary to put the Act on the California ballot in November 1988. Letter, *supra* note 254. Efforts are underway, however, to qualify the Death With Dignity Act (hereinafter "DWDA") through the initiative process for the ballot in Oregon in 1990, in Washington in 1991, and in California in 1992. *Three States Move to Legalize Physician Aid-in-Dying*, HEMLOCK Q., July 1989 at 1. Similar plans are in process for Florida. *Florida Initiative in 1992?*, HEMLOCK Q., July 1989 at 2.

²⁵⁷ A terminally ill patient is one who has been certified by two physicians as having an incurable or irreversible condition with death expected to occur within six months. DWDA § 2525.2(f)(g).

²⁵⁸ See *supra* note 244. Ohio does not have a living will statute. *Id.* For a discussion of the status of living will legislation in Ohio, see Young, *Living-Will Legislation*, OHIO LAW., Nov./Dec. 1988, at 26.

²⁵⁹ OHIO REV. CODE ANN. § 1337.11 (Page's 1990). For a discussion of the history of the durable power of attorney in Ohio, see Fabens, *Ohio's Durable Power of Attorney*, OHIO LAW., Nov./Dec. 1988, at 9.

ration as to their wishes with respect to passive and active euthanasia. The DWDA provides for recognition by the State of an adult's right to authorize his physician to withdraw or withhold life-sustaining procedures, or, if he has been adjudged terminally ill, to administer aid-in-dying by way of a humane medical procedure,²⁶⁰ with lethal injection being the usual mode of aid.²⁶¹ Authorization is in the form of a written directive to be provided the physician and made a part of the patient's medical records.²⁶² The DWDA addresses only voluntary euthanasia as requested by a competent adult person via a written directive. Absent a written directive from the patient, a doctor cannot take steps to perform either passive or active euthanasia.²⁶³

The patient must sign the directive in the presence of two witnesses, neither of whom can be a blood or marital relation, or stand to share in the estate of the patient.²⁶⁴ The attending physician, his employees and the employees of any health care facility housing the patient cannot act as witnesses to the directive, nor can anyone with a claim against the patient's estate. This ensures that the patient has not been coerced by family members nor prodded by the medical profession to choose aid-in-dying.²⁶⁵

The patient may appoint an agent to make health care decisions for him in case he becomes incompetent.²⁶⁶ The agent can be given the power to make decisions regarding passive and/or active euthanasia.²⁶⁷ In such a case of active nonvoluntary euthanasia, a committee of three persons must review the agent's request for same to ensure that the patient is qualified to receive aid-in-dying and that the directive complies with the requirements of the DWDA.²⁶⁸ Committee review of the agent's request ensures that he is acting in the best interest of the patient he represents and has not merely chosen active euthanasia for personal gain.²⁶⁹

The Act requires the physician to make the directive a part of the patient's medical record,²⁷⁰ to maintain a record detailing the exercise of euthanasia in accordance with such directives, and to report such cases

²⁶⁰ DWDA § 2525.1.

²⁶¹ Potts, *supra* note 52 ("The usual method is lethal injection.").

²⁶² DWDA § 2526.4(b).

²⁶³ Preventing a physician from administering euthanasia absent a written directive protects against opening the door to unacceptable expansion of euthanasia, i.e., succumbing to the wedge or slippery slope argument. *See supra* note 235.

²⁶⁴ DWDA § 2525.3. Additional safeguards are provided for nursing home residents, namely, that one of the witnesses must be a certified ombudsman. *Id.* at § 2525.4.

²⁶⁵ *Id.* at § 2525.3. There is no guarantee that a scheming relative or doctor will not be able to circumvent the DWDA, but the DWDA is designed to prevent such coercion.

²⁶⁶ DWDA § 2525.2(i).

²⁶⁷ *Id.*

²⁶⁸ *Id.* at § 2525.10.

²⁶⁹ The agent may be related to the person signing the directive. *Id.* at § 2525.2(i). Committee review of the agent's decisions safeguards against abuse of the power delegated to him.

²⁷⁰ *Id.* at § 2526.4(b).

to the state health department on an annual basis.²⁷¹ These requirements will bring the practice out into the open and enable the state to track and regulate the practice of active euthanasia.²⁷²

The DWDA is permissive legislation²⁷³—it allows a terminally ill patient to choose a quick and painless death over prolonged and unbearable suffering, but does not prevent him from changing his mind later. The DWDA provides for revocation of the directive by the patient at any time, even if incompetent.²⁷⁴ The patient can express his intent to revoke the directive by destroying it, or by cancelling it in writing or orally.²⁷⁵ Written and oral revocations must be communicated to the physician in order to become effective and shall be made a part of the patient's medical record.²⁷⁶ A person who acts in accordance with a directive that had been revoked by the patient shall not be liable for his actions unless he had actual knowledge of such revocation.²⁷⁷

Licensed physicians and health care professionals acting under their direction who honor a directive shall not be guilty of violating existing criminal laws nor shall they be subjected to civil or administrative damages or penalties.²⁷⁸ Likewise, they will not be liable for failure to honor a directive absent willful refusal to refer the patient to a physician willing to comply with the terms of the directive.²⁷⁹ Thus, licensed professionals who comply with a terminally ill patient's request for aid-in-dying will not be penalized and those who conscientiously object to active euthanasia will not be forced to perform same against their will.²⁸⁰

²⁷¹ *Id.* at § 2526.4(a).

²⁷² A major concern in the Netherlands is the inability to track the practice of active voluntary euthanasia. J. Gray, *supra* note 157. The United States can learn from the Dutch experience by enacting legislation which enables the State to monitor the practice of active voluntary euthanasia. *Contra* Bostrom, *Euthanasia in the Netherlands: A Model for the United States?*, 4 ISSUES L. & MED. 467 (1989). Bostrom argues that the Netherlands' failure to monitor active voluntary euthanasia is proof that active voluntary euthanasia is uncontrollable. *Id.* at 477. However, it is difficult to comprehend how Bostrom can label uncontrollable that which the Netherlands has never seriously attempted to control.

²⁷³ The DWDA is permissive in the sense that "euthanasia is allowable if requested." Kaplan, *Euthanasia Legislation: A Survey and a Model Act*, 2 AM. J. L. & MED. 41, 51 (1976) (emphasis in original).

²⁷⁴ DWDA § 2525.5(a).

²⁷⁵ *Id.* at §§ 2525.5(a)(1), (2), (3).

²⁷⁶ *Id.* at §§ 2525.5(a)(2), (3).

²⁷⁷ *Id.* at § 2525.5(b).

²⁷⁸ *Id.* at § 2525.7.

²⁷⁹ DWDA at § 2525.9(b).

²⁸⁰ See *supra* note 260. The American Medical Association not only opposes active voluntary euthanasia, but also the requirement, as provided in the DWDA, that a physician opposed to performing same refer the patient to another physician willing to comply with the request for active voluntary euthanasia. American Medical Association, *Proceedings: House of Delegates*, Res. 79, Dec. 1987 (copy available from AMA Library & Information Management, 535 North Dearborn Street, Chicago, Illinois 60610). *Contra* Wanzer, et al., *The Physician's Responsibility Toward Hopelessly Ill Patients: A Second Look*, 320 N. ENG. J. MED. 844 (1989) [hereinafter *Physician's Responsibility*]. A majority of the authors (ten out of a panel of twelve doctors) concluded "that it is not immoral for a physician to assist in the rational suicide of a terminally ill person." *Id.* at 848.

E. Summary

The Death With Dignity Act is a carefully drafted law designed to accommodate those times when euthanasia is the right thing to do, without subjecting the physician performing the procedure to liability under existing laws. Careful and intelligent consideration of the Death With Dignity Act, especially in light of the Dutch experience outlined above, suggests that passage of the Act is in order.

V. CONCLUSION

Every effort to legalize active voluntary euthanasia in the United States has failed, despite the fact that a large percentage of Americans believe terminally ill people should be allowed to choose a quick and painless death instead of waiting in agony for death to arrive.²⁸¹ When it comes to legally approving such a choice, Americans have backed off from the issue for fear of showing disrespect for life, especially that of the terminally ill. Americans hide behind a wall of arguments that avoid the real issue, i.e., whether a terminally ill patient must continue to suffer through mere existence or be allowed to say "enough already" and choose a truly dignified end to their suffering. The inability of others to fully confront this issue leaves the patient's life literally hanging in the balance.

Case law demonstrates a tendency to respond compassionately to one accused of mercy killing, regardless of whether the victim requested death or not. Americans have established a pattern of ignoring the real issues—whether the victim wanted to die and whether euthanasia was the right thing to do. By ignoring these issues America stands poised to slide down the slippery slope²⁸² toward an increasingly abusive practice of euthanasia.

America has the opportunity to meet the issue of active voluntary euthanasia head-on, and should take advantage of the learning experience of the Dutch in order to remain in control of the issue. Adoption of the Death With Dignity Act would raise America to the level of the Netherlands as an example of a country not afraid to let its terminally ill citizens say "when", but smart enough to have learned that regulation goes hand-in-hand with granting the terminally ill the right to choose when to die.

Although it's too late for Hector Rodas, it's not too late for the multitude of terminally ill persons across America imprisoned in bodies wracked with pain. A vote for the Death With Dignity Act is not a vote for killing terminally ill people as a matter of policy, but rather is a vote for allowing the terminally ill to choose when to die. There is a distinction—a distinction which deserves legal recognition in the form of the Death With Dignity Act.

DEBORAH A. WAINEY

²⁸¹ R. RISLEY, *supra* note 253, at xii. Opinion polls indicate that over 60% of Americans favor active voluntary euthanasia as proposed in the DWDA. *Id.* See also *Physician's Responsibility*, *supra* note 280, at 844 (68% of poll respondents indicate that incurably ill persons should be allowed to end their lives before their illness runs its natural course).

²⁸² See *supra* note 255.

APPENDIX I

An Initiative to the Voters in 1990

The Oregon Death With Dignity Act

(Similar to the Acts of the same name in California and Washington. Formerly known as the Humane and Dignified Death Act.)

SEC. 1. This Act is added to and made a part of Oregon Revised Statutes, Chapter 97, to read:

2525. ORS _____ to _____ shall be known and may be cited as The Oregon Death With Dignity Act (herein cited as "Act").

2525.1. Self-determination is the most basic of freedoms. The right to die at the time and place of our own choosing when we are terminally ill is an integral part of our right to control our own destinies. That right should be established in law but limited to ensure that the rights of others are not affected. The right should include the ability to make a conscious and informed choice to enlist the help of the medical profession in making death as painless and quick as possible.

Adult persons have the fundamental right to control the decisions relating to the rendering of their own medical care, including the decisions to have life-sustaining procedures withheld or withdrawn or when suffering from a terminal condition, as defined herein, to request a physician to administer aid-in-dying.

Modern medical technology has made possible the artificial prolongation of human life beyond natural limits. This prolongation of life for persons with terminal conditions may cause loss of patient dignity and unnecessary pain and suffering, while providing nothing medically necessary or beneficial to the patient.

In recognition of the dignity and privacy which patients have a right to expect, the State of Oregon shall recognize the right of an adult terminally ill person to make a written directive instructing his or her physician to administer aid-in-dying or to withhold or withdraw life-sustaining procedures.

The purpose of this Act is to create a legal right to request and receive physician aid-in-dying, and to protect and exonerate physicians who voluntarily comply with the request. No one is required to take advantage of this legal right or participate if they are morally or ethically opposed.

2525.2. The following definitions shall govern the construction of this Act:

- (a) "Attending physician" means the physician selected by, or assigned to, the patient and who has primary responsibility for the treatment and care of the patient.
- (b) "Directive" means a written document and Durable Power of Attorney voluntarily executed by the declarant in accordance with the requirements of Section 2525.3 in the form set forth in Section 2526.5.
- (c) "Declarant" means a person who executes a directive, in accordance with this title.
- (d) "Life-sustaining procedure" means any medical procedure or intervention which utilizes mechanical or other artificial means to sustain, restore, or supplant a vital function, including nourishment and hydration

which, when applied to a qualified patient, would serve only artificially to prolong the moment of death. "Life-sustaining procedure" shall not include the administration of medication or the performance of any medical procedure deemed necessary to alleviate pain.

- (e) "Physician" means a physician and surgeon licensed by the Board of Medical Examiners of the State of Oregon.
- (f) "Qualified patient" means an adult patient who has executed a directive as defined in this Act, which directive is currently valid, who is suffering and has been diagnosed and certified in writing by two physicians to be afflicted with a terminal condition. One of said physicians shall be the attending physician, who has personally examined the patient.
- (g) "Terminal condition" means an incurable or irreversible condition which, will in the opinion of two certifying physicians exercising reasonable medical judgment, result in death within six months.
- (h) "Aid-in-dying" means any medical procedure that will terminate the life of the qualified patient swiftly, painlessly, and humanely.
- (i) "Attorney-in-fact" means an agent of the person or patient signing the directive, appointed for the purpose of making decisions relating to the patient's medical care and treatment, including withdrawal of life-sustaining procedures and physician aid-in-dying, in the event the patient becomes incompetent to make those decisions. An attorney-in-fact shall be an adult, who may, but need not, be related to the person or patient, but an attorney-in-fact need not be an attorney at law or a lawyer.
- (j) "Health-care provider" means a person licensed, certified, or otherwise authorized by the law of this State to administer health care in the ordinary course of business or practice of a profession.

2525.3. An adult individual of sound mind may at any time execute a directive governing the withholding or withdrawal of life-sustaining procedures or administering aid-in-dying and appoint an attorney-in-fact. The directive shall be signed by the declarant and witnessed by two individuals, not related to the declarant by blood or marriage and who would not be entitled to any portion of the estate of the declarant upon his/her death under any will of the declarant or codicil thereto then existing, or, at the time of the directive, by operation of law then existing. In addition, a witness to a directive shall not be the attending physician, an employee of the attending physician who is involved in any

way with the treatment of the individual, or an employee of a health care facility in which the declarant is a patient, or any person who, at the time of the execution of the directive, has a claim against any portion of the estate of the declarant upon his or her death. The directive shall be in the form contained in Section 2526.

2525.4. A directive shall have no force or effect if the declarant is a patient in a skilled nursing facility as defined in ORS 442.015 (13) (c) (A) and intermediate care facilities or community care facilities at the time the directive is executed unless one of the two witnesses to the directive is an ombudsman certified by the Long Term Care Ombudsman for this purpose pursuant to any other applicable provision of law. The certified ombudsman shall have the same qualifications as a witness under Section 2525.3.

The intent of this section is to recognize that some patients in skilled nursing facilities may be so insulated from a voluntary decision-making role, by virtue of the custodial nature of their care, as to require special assurance that they are capable of willfully and voluntarily executing a directive.

2525.5. (a) A directive may be revoked at any time by the declarant, without regard to his or her mental state or competency, by any of the following methods:

- (1) By being canceled, defaced, obliterated, or burned, torn, or otherwise destroyed by the and at the direction of the declarant to revoke the directive.
- (2) By a written revocation of the declarant expressing his or her intent to revoke the directive, signed and dated by the declarant. This revocation shall become effective only upon communication to the attending physician by the declarant or by a person acting on behalf of the declarant. The attending physician shall record in the patient's medical record the time and date when he or she received notification of the written revocation, and the identity of the communicator.
- (3) By a verbal expression by the declarant to revoke the directive. The revocation shall become effective only upon communication to the attending physician by the declarant or by a person acting on behalf of the declarant. The attending physician shall confirm with the patient that he or she wishes to revoke and shall record in the patient's medical record the time, date, and place of the revocation and the time, date, and place, if different, that he or she received notification of the revocation, and the identity of the notifier.

(b) There shall be no criminal, civil, or administrative liability on the part of any person for following a directive that has been revoked unless that person has actual knowledge of the revocation.

2525.6. (a) Except as provided in subdivision (b), a directive shall be effective for seven years from the date of execution thereof unless revoked prior to the end of the seven-year time period in the manner prescribed in Sec-

tion 2525.5. This Act shall not prevent a declarant from re-executing a directive at any time in accordance with Section 2525.3, including re-execution subsequent to a diagnosis of a terminal condition. If the declarant has executed more than one directive, the seven-year time period specified in this section shall be deemed to commence on the date of execution of the last directive known to the attending physician.

(b) If the declarant becomes comatose or is otherwise rendered incapable of communicating with the attending physician before the end of the seven-year period, the directive shall remain in effect for the duration of the comatose condition or until such time as the declarant's condition renders him or her able to communicate with the attending physician.

2525.7. No physician or employee of a health care facility who, acting in accordance with the requirements of this Act, causes the withholding or withdrawal of life-sustaining procedures from, or administers aid-in-dying to, a qualified patient, shall be subject to civil, criminal, or administrative liability therefore. No licensed health care professional, such as a nurse, acting under the direction of a physician, who participates in the withholding or withdrawal of life-sustaining procedures from, or administers aid-in-dying to, a qualified patient in accordance with this Act shall be subject to any civil, criminal, or administrative liability. No physician, or other person acting under the direction of a physician, who acts in accordance with the provisions of this Act, shall be guilty of any criminal act or of unprofessional conduct because he or she participates in the withholding or withdrawal of life-sustaining procedures, or because he or she administers aid-in-dying. Fees for administering aid-in-dying shall be fair and reasonable.

(a) The certifying physicians shall not be partners or shareholders in the same practice.

2525.8. (a) Nothing herein requires a physician or licensed health professional, such as nurses, to administer aid-in-dying if he or she is morally or ethically opposed. Neither shall privately owned hospitals be required to permit the administration of physician aid-in-dying in their facilities if they are morally and ethically opposed.

(b) With the consent of a qualified patient, the attending physician who is requested to give aid-in-dying may request a psychiatric or psychological consultation if said physician has any question about the patient's competence.

2525.9. (a) Prior to withholding or withdrawing life-sustaining procedures from, or administering aid-in-dying to, a qualified patient pursuant to a directive, the attending physician shall determine that the directive complies with Section 2525.3, and that the directive and all steps proposed by the attending physician to be undertaken are in accord with the desires of the qualified patient, as expressed in the directive.

- (b) If the declarant is a qualified patient, the directive shall be conclusively presumed, unless revoked, to be the directions of the patient regarding the withholding or withdrawal of life-sustaining procedures. No physician, and no person acting under the direction of a physician, shall be criminally, civilly, or administratively liable for failing to effectuate the directive of the qualified patient, unless he willfully fails to transfer the patient upon request.
- 2525.10 (a) The decision of an attorney-in-fact to request a physician to administer aid-in-dying shall first be reviewed by a hospital committee of three persons to assure all of the following:
- (1) The directive was properly executed and witnessed.
 - (2) The directive has not been revoked by the patient.
 - (3) The physicians have certified the patient is terminal.
 - (4) The time of death is properly decided by the attorney-in-fact and the physician.
- (b) In reviewing the decision of an attorney-in-fact, the decision of a majority of the committee shall control.
- (c) If the declarant is in a hospital, the three-person committee shall be the ethics committee of that hospital, or three members thereof, or if that hospital does not have an ethics committee, any three persons appointed by the hospital administrator. If the declarant is not in a hospital, the committee shall be selected by the attending physician, and consist of three persons from a hospital ethics committee of a hospital with which the attending physician is affiliated, or three reputable physicians.
2526. (a) The withholding or withdrawal of life-sustaining procedures from, or administering aid-in-dying to, a qualified patient in accordance with this Act shall not, for any purpose, constitute a suicide.
- (b) The making of a directive pursuant to Section 2525.3 shall not restrict, inhibit, or impair in any manner the sale, procurement, or issuance of any policy of life or health insurance, nor shall it affect in any way the terms of an existing policy of life or health insurance. No policy of life or health insurance shall be legally impaired or invalidated in any manner by the withholding or withdrawal of life-sustaining procedures from, or administering aid-in-dying to, an insured qualified patient, notwithstanding any term of the policy to the contrary.
- (c) No physician, health facility, or other health-care provider, and no health-care service plan, insurer issuing disability insurance, self-insured employee welfare benefit plan, or nonprofit hospital service plan shall require any person to execute a directive as a condition for being insured for, or receiving, health-care services, nor refuse service because of the execution, the existence, or the revocation of a directive.
- (d) A person who requires or prohibits the execution of a directive as a condition for being insured for, or receiving, health-care services is guilty of a misdemeanor.
- (e) A person who coerces or fraudulently induces another to execute a directive under this Act is guilty of a misdemeanor, or if death occurs as a result of said fraud or coercion, is guilty of a felony.
- 2526.1. This Act shall not impair or supercede any legal right or legal responsibility which any person may have to effect the withholding or withdrawal of life-sustaining procedures or administering aid-in-dying in any lawful manner. In this respect the provisions of this Act are cumulative.
- 2526.2. Any person who willfully conceals, cancels, defaces, obliterates, or damages the directive of another without the declarant's consent shall be guilty of a misdemeanor. Any person who falsifies or forges the directive of another, or willfully conceals or withholds personal knowledge of a revocation as provided in Section 2525.5, with the intent to cause a withholding or withdrawal of life-sustaining procedures or to induce aid-in-dying procedures contrary to the wishes of the declarant, and thereby, because of such act, directly causes life-sustaining procedures to be withheld or withdrawn and death thereby to be hastened or aid-in-dying to be administered, shall be subject to prosecution for unlawful homicide as provided in ORS Chapter 163.
- 2526.3. Compliance with a qualified patient's directive pursuant to this Act, even if this compliance results in hastening the death of the qualified patient, is not a crime. No person who participates in any manner in the compliance with the directive shall be liable for any civil or administrative damages or penalties because of his or her participation or of the death of the qualified patient.
- 2526.4. (a) Hospitals and other health-care providers who carry out the directive of a qualified patient shall keep a record of the number of these cases, and report annually to the State Department of Human Resources the patient's age, type of illness, and the date the directive was carried out. In all cases, the identity of the patient and the attorney-in-fact shall be strictly confidential and shall not be reported.
- (b) The directive, or a copy of the directive, shall be made a part of a patient's medical records in each institution involved in the patient's medical care.
- 2526.5. In order for a directive to be valid under this Act, the directive shall be in the following form:

DIRECTIVE TO PHYSICIANS

Warning to Patient

This is an important legal document. Before executing this document, you should know these important facts:

Powers to Agent

This document gives your agent (the attorney-in-fact) when you are in a coma or otherwise unable to act or decide for yourself:

1. The power to decide the time of your death for you. However, your agent must act consistently with your desires, as stated in this document or otherwise made known to him or her.
2. The power to direct your physician to administer aid-in-dying, if you have been diagnosed by two licensed physicians as terminal.
3. Authority to consent or refuse consent to any treatment, service or procedure for diagnosis or treatment of any physical or mental condition. This power is limited by your desires contained in this statement. You can provide in this document the type of treatment that you desire or do not desire.
4. The right to examine your medical records and consent to their disclosure unless you limit this right in this document.

Duration

The power granted by this document shall exist for seven years from the date it is signed unless you specify a shorter period. If you are unable to decide the appropriateness of instructing your physician to administer aid-in-dying at the time this seven-year period ends, the power will continue to exist until the time you become able to make a decision for yourself or your agent decides to honor the directive.

Revocation

You may revoke the authority of your agent and his or her power by notifying him or her, or your treating physician, hospital, or other health-care provider, orally or in writing.

This document revokes any prior directive to withhold or withdraw life-support systems, or to administer aid-in-dying.

Procedures

You must follow the witnessing procedures described at the end of this form. If you fail to follow the procedures, this document will not be valid.

Your agent may need this document immediately in an emergency. Therefore keep it where it is immediately available to your agent. It is recommended that you give your agent a signed copy. You may also wish to give your doctor a signed copy.

Limitations

The court can take away the power of your agent to make health-care decisions, to act in your behalf, and to direct your physician to administer aid-in-dying if he or she acts contrarily to your known desires.

Do not use this form if you are a conservatee and you want to appoint your conservator as your agent. Notwithstanding your instructions in this directive, life support systems may not be withdrawn or withheld when necessary to keep you alive if you or your agent object at the time.

Instructions

This directive is made this _____ day of _____ (month) _____ (year).

I, _____ being of sound mind, willfully and voluntarily make known my desire

- (a) ☐ That my life shall not be artificially prolonged and
- (b) ☐ That my life shall be ended with the aid of a physician under the circumstances set forth below, and do hereby declare:
(You must initial (a) or (b), or both.)

1. If at any time I should have a terminal condition or illness certified to be terminal by two physicians, and they determine that my death will occur within six months,

- (a) ☐ I direct that life-sustaining procedures be withheld or withdrawn, and
- (b) ☐ I direct that my physician administer aid-in-dying in a humane and dignified manner. (You must initial (a) or (b), or both.)
- (c) ☐ I have attached Special Instructions on a separate page to the directive. (Initial if you have attached a separate page.)

The action taken under this paragraph shall be at the time of my own choosing if I am competent.

2. In the absence of my ability to give directions regarding the termination of my life, it is my intention that this directive shall be honored by my family, agent (described in paragraph 5), and physician(s) as the final expression of my legal right to

- (a) ☐ Refuse medical or surgical treatment, and
- (b) ☐ To choose to die in a humane and dignified manner. (You must initial (a) or (b), or both and you must initial one box below.)
☐ If I am unable to give directions, I do not want my attorney-in-fact to request aid-in-dying.
☐ If I am unable to give directions, I do want my attorney-in-fact to ask my physician for aid-in-dying.

3. I understand that a terminal condition is one in which I am not likely to live for more than six months.

4. a. I, _____ do hereby designate and appoint _____

as my attorney-in-fact (agent) to make health-care decisions for me if I am in a coma or otherwise unable to decide for myself as authorized in this document. For the purpose of this document, "health-care decision" means consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition, or to administer aid-in-dying.

b. By this document I intend to create a Durable Power of Attorney for Health Care under The Oregon Death With Dignity Act and ORS Section 126.407. This power of attorney shall not be affected by my subsequent incapacity, except by revocation.

c. Subject to any limitations in this document, I hereby grant to my agent full power and authority to make health-care decisions for me to the same extent that I could make these decisions for myself if I had the capacity to do so. In exercising this authority, my agent shall make health-care decisions that are consistent with my desires as stated in this document or otherwise made known to my agent, including, but not limited to, my desires concerning obtaining, refusing, or withdrawing life-prolonging care, treatment, services and procedures, and administration of aid-in-dying.

5. This directive shall have no force or effect seven years from the date filled in above, unless I am incompetent to act on my own behalf and then it shall remain valid until my competency is restored.

6. I recognize that a physician's judgment is not always certain, and that medical science continues to make progress in extending life, but in spite of these facts, I nevertheless wish aid-in-dying rather than letting my terminal condition take its natural course.

7. My family has been informed of my request to die, their opinions have been taken into consideration, but the final decision remains mine, so long as I am competent.

8. The exact time of my death will be determined by me and my physician with my desire or my attorney-in-fact's instructions paramount.

I have given full consideration and understand the full import of this directive, and I am emotionally and mentally competent to make this directive. I accept the moral and legal responsibility for receiving aid-in-dying.

This directive will not be valid unless it is signed by two qualified witnesses who are present when you sign or acknowledge your signature. The witnesses must not be related to you by blood, marriage, or adoption; they must not be entitled to any part of your estate; and they must not include a physician or other person responsible for, or employed by anyone responsible for, your health care. If you have attached any additional pages to this form, you must date and sign each of the additional pages at the same time you date and sign this power of attorney.

Signed: _____

City, County, and State of Residence _____

(This document must be witnessed by two qualified adult witnesses. None of the following may be used as witnesses: (1) a health care provider who is involved in any way with the treatment of the declarant, (2) an employee of a health care provider who is involved in any way with the treatment of the declarant, (3) the operator of a community care facility where the declarant resides, (4) an employee of an operator of a community care facility who is involved in any way with the treatment of the declarant.

I declare under penalty of perjury under the laws of Oregon that the person who signed or acknowledged this document is personally known to me (or proved to me on the basis of satisfactory evidence) to be the declarant of this directive; that he or she signed and acknowledged this directive in my presence, that he or she appears to be of sound mind and under no duress, fraud, or undue influence; that I am not a health-care provider, an employee of a health-care provider, the operator of a community-care facility, nor an employee of an operator of a community-care facility where the declarant resides.

I further declare under penalty of perjury under the laws of Oregon that I am not related to the principal by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

Date: _____

Witness's Signature: _____

Print Name: _____

Residence Address: _____

Date: _____

Witness's Signature: _____

Print Name: _____

Residence Address: _____

STATEMENT OF CERTIFIED OMBUDSMAN

(If you are a patient in a skilled nursing facility, one of the witnesses must be a certified ombudsman. The following statement is required only if you are a patient in a skilled nursing facility—a health-care facility that provides the following basic services: skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. The certified ombudsman must sign both parts of the "Statement of Witnesses" above AND must also sign the following statement.)

I further declare under penalty of perjury under the laws of Oregon that I am an ombudsman as certified by the Long Term Care Ombudsman and that I am serving as a witness as required by Section 2525.4 of this Act.

Signed: _____

2526.6. The fact that a patient is a burden or is incompetent shall not be a factor in any decision to withhold or withdraw life-sustaining procedures, or to administer aid-in-dying.

Sec. 2. ORS 97.050 through 97.090 shall not be effected hereby. The sanctions provided in this Act do not displace any sanction applicable under other law, except as specifically provided.

Sec. 3. MERCY KILLING NOT CONDONED. Nothing in this Act shall be construed to condone, authorize, or approve mercy killing, or to permit any affirmative or deliberate act or omission to end life other than the withholding or withdrawal of health-care pursuant to a Durable Power of Attorney for Health Care so as to permit the natural process of dying or enlisting physician aid-in-dying under the provisions of this Act.

Sec. 4. ORS Section 163.125 (b) is amended to read: "(b) Every person who deliberately aids, or advises, or encourages another to commit suicide, is guilty of a felony. Death resulting from a request for aid-in-dying or from a withholding or withdrawing of treatment pursuant to ORS

_____ through _____ shall not constitute suicide nor is a licensed physician who lawfully administers aid-in-dying or who lawfully withdraws or withholds treatment, or a health-care provider or health professional acting under the direction of a physician, liable under this section. Death resulting from the withholding or withdrawal of a life-sustaining procedure or aid-in-dying pursuant to a directive in accordance with The Oregon Death With Dignity Act does not, for any purpose, constitute a suicide or homicide."

Sec. 5. This Act may be amended only by a statute passed by a two-thirds vote of each house of the legislature and signed by the Governor.