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PHYSICIAN-ASSISTED SUICIDE: STATE LEGISLATION TEETERING AT THE PINNACLE OF A SLIPPERY SLOPE

Physician-assisted suicide has become the subject of a hotly contested legal and political debate, both in the United States and abroad. In 1997, the United States Supreme Court rendered two decisions concerning physician-assisted suicide, and two states recently enacted legislation on this issue: Oregon in 1997 and Virginia in 1998. Nevertheless, the legality of physician-assisted suicide remains unclear as doctors, pharmacists, legal commentators, and a growing segment of the general population continue to argue over the line between "letting die" and "killing." This Note analyzes both the constitutional and political aspects of the right-to-die debate, focusing primarily on the political arguments and reasons why the assisted suicide issue should be resolved in the political arena.

* * *

"Assisted suicide is a flight from compassion, not an expression of it. It should be suspect not because it is too hard, but because it is too easy."¹

"We have begun to descend the slippery slope. It did not take long."²

INTRODUCTION

The controversy over physician-assisted suicide and the right-to-die movement has plagued American society for decades. Critics consider euthanasia one of the "most legally complex and culturally sensitive areas of civil rights to emerge in our time."³

With a recent onslaught of claims that challenged state legislation in the privacy arena, the United States Supreme Court issued a number of decisions that recognized a constitutional protection of rights not enumerated in the

¹ Richard A. McCormick, *Physician-Assisted Suicide: Flight from Compassion*, in ARGUING EUTHANASIA: THE CONTROVERSY OVER MERCY KILLING, ASSISTED SUICIDE, AND THE "RIGHT TO DIE" 133, 135 (Jonathan D. Moreno, Ph.D., ed., 1995).

² James R. DeFurio, *Questioning the Wisdom of Oregon's Death with Dignity Act*, TAMPA TRIB., Apr. 5, 1998, at 3, available in LEXIS, News Library, Tamtrb File.

³ JAMES M. HOEFLER & BRIAN E. KAMOIE, DEATHRIGHT: CULTURE, MEDICINE, POLITICS, AND THE RIGHT TO DIE 1 (1994).

Constitution.⁴ Although the Framers did not explicitly provide a right to privacy in the Bill of Rights, the Court found such a right in a penumbra derived from a number of explicit guarantees, including the First Amendment right of association and the Ninth Amendment reservation of unenumerated rights for the people.⁵

The argument against state government infringement upon personal rights has entered the health care arena with a "right to die" agenda. In 1990, the heated euthanasia debate leveled off with the Supreme Court's decision in *Cruzan v. Director, Missouri Department of Health*.⁶ Chief Justice Rehnquist, writing for the majority, stated that the Constitution permits state requirements for clear and convincing evidence of an incompetent's wishes with respect to the withdrawal of life-sustaining treatment.⁷ The Court held that, because there was no such evidence of the patient's desire to have extraordinary treatment withdrawn,⁸ her parents lacked the authority to effectuate such a request.⁹ The *Cruzan* case was emblematic of the Court's permissive stance on "passive" euthanasia.¹⁰ The decision reflected merely a lack of sufficient evidence which indicated that the patient would have refused treatment.¹¹

Recently, the euthanasia movement recharged and leapt over the line between letting die and killing; scholars currently are debating the issues that surround physician-assisted suicide.¹² Activists attempt to extend the penumbral privacy debate to encompass an unenumerated right to die. They believe such a right licenses physicians to assist in suicides. Opponents, on the other hand, assert that these beliefs exemplify the preface to a slippery slope transaction.

⁴ See *Griswold v. Connecticut*, 381 U.S. 479 (1965) (declaring a state law that forbade contraceptive use a violation of the penumbral right to privacy); see also *Roe v. Wade*, 410 U.S. 113, 153 (1973) (holding that the right to privacy encompasses a woman's decision to terminate her pregnancy).

⁵ See *Griswold*, 381 U.S. at 485.

⁶ 497 U.S. 261 (1990).

⁷ See *id.* at 280.

⁸ The patient, Nancy Cruzan, lay for six years in a persistent vegetative state, "a condition in which a person exhibits motor reflexes but evinces no indications of significant cognitive function." *Id.* at 266.

⁹ See *id.* at 286.

¹⁰ See *infra* note 127.

¹¹ See *Cruzan*, 497 U.S. at 285.

¹² See generally Rachel D. Kleinberg & Toshiro M. Mochizuki, *The Final Freedom: Maintaining Autonomy and Valuing Life in Physician-Assisted Suicide Cases*, 32 HARV. C.R.-C.L. L. REV. 197 (1997). "In an aging population, with the medical profession's ability to extend 'life' at rapidly increasing social and economic costs, the problems incident to euthanasia and long-term health care are accumulating at a rapid pace." EUGENE F. SCOLES & EDWARD C. HALBACH, JR., PROBLEMS AND MATERIALS ON DECEDENTS' ESTATES AND TRUSTS 125 (5th ed. 1993).

This Note will analyze the physician-assisted suicide debate briefly from a constitutional perspective, and then primarily from a political angle. Under a strict construction of the Constitution, assisted suicide is not a constitutional issue because the plain language of the Constitution does not embrace any notion of a right to die. Therefore, originalists believe the Supreme Court has no authority to uphold any protection or permission of a so-called right to die because this right falls outside the purview of the Constitution.¹³

Part I of this Note will examine whether the issue should remain in the political arena amidst the states' Tenth Amendment guarantees.¹⁴ Part I will continue by following a chronology of legislative events surrounding Oregon's Death with Dignity Act.¹⁵

In Part II, this Note will analyze the political arguments both opposing and supporting physician-assisted suicide by grounding the issue in the history of suicide. Part III will introduce the right-to-die advocacy groups, consider the motivational aspects of physicians, and attempt to clarify the line between "letting die" and "killing." It will examine the potential effects on the medical profession if the states condone physician-assisted suicide, further define the slippery slope argument, and attempt to dispel the misguided parallels that critics have made between abortion and assisted suicide.

Part IV will recommend (1) the assisted suicide issue remain in the political arena, separate from the federal court system; and (2) the states exercise caution in their decisions to sanction or prohibit assisted suicide by recognizing the inherent dangers related to patient autonomy and by learning from the widespread unauthorized killings that have occurred in the Netherlands as a result of the slippery slope.

I. CONSTITUTIONAL ANALYSIS

In a landmark decision in 1816, the United States Supreme Court defined its powers of appellate review: "The government . . . of the United States, can claim no powers which are not granted to it by the [C]onstitution, and the powers

¹³ See, e.g., *Cruzan*, 497 U.S. at 293 (Scalia, J., concurring):

[T]he federal courts have no business in this field . . . the point at which life becomes 'worthless,' and the point at which the means necessary to preserve it become 'extraordinary' or 'inappropriate,' are neither set forth in the Constitution nor known to the nine Justices of this Court any better than they are known to nine people picked at random. . . .

¹⁴ The Tenth Amendment provides, "The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people." U.S. CONST. amend. X.

¹⁵ Oregon is the first and only state to legalize physician-assisted suicide. See OR. REV. STAT. § 127.805 (1997).

actually granted, must be such as are expressly given, or given by necessary implication."¹⁶ Following the doctrine of *stare decisis*, the Supreme Court acts as the sole and final arbiter of issues within its constitutional arm's length. Recently, the Supreme Court recognized that physician-assisted suicide falls outside that zone;¹⁷ a right to die is not mentioned expressly in the Constitution, nor is any such protection "given by necessary implication."¹⁸ Therefore, the issue of physician-assisted suicide remains currently within the confines of state power.¹⁹

A. *Recent Action by the Supreme Court*

In two decisions in 1997, the Supreme Court explicitly refused to find a fundamental liberty interest in physician-assisted suicide. In *Vacco v. Quill*, the Court upheld New York's prohibition on assisted suicide because it did not violate the Equal Protection Clause of the Fourteenth Amendment, infringe on fundamental rights, or involve suspect classifications.²⁰ In *Washington v. Glucksberg*, three terminally ill patients brought suit against the state of Washington to seek a declaratory judgment that a statutory prohibition of assisted suicide violated the Due Process Clause.²¹ Chief Justice Rehnquist, writing for the majority in *Glucksberg*, held that because there was no fundamental liberty interest at issue, the state's ban did not constitute a violation of due process.²² In these cases, the Court found no basis for strict scrutiny review because neither a suspect class nor a fundamental right was at stake.²³ Therefore, the Court employed a more lenient rational basis standard of review.

¹⁶ *Martin v. Hunter's Lessee*, 14 U.S. (1 Wheat) 304, 326 (1816).

¹⁷ *See, e.g., Vacco v. Quill*, 117 S. Ct. 2293 (1997) (refusing to abolish state legislation concerning assisted suicide because it neither burdens a fundamental right nor targets a suspect class); *Washington v. Glucksberg*, 117 S. Ct. 2258, 2271 (1997) (holding that there is no "fundamental liberty interest" in assisted suicide).

¹⁸ *Martin*, 14 U.S. at 326.

¹⁹ *See Glucksberg*, 117 S. Ct. at 2275. ("Throughout the Nation, Americans are engaged in an earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a democratic society.").

²⁰ *See Quill*, 117 S. Ct. at 2297.

²¹ *See Glucksberg*, 117 S. Ct. at 2261.

²² *See id.* at 2271.

²³ *See id.* Chief Justice Rehnquist declared that, in order to find a "liberty interest in determining the time and manner of one's death," the Court would have to "reverse centuries of legal doctrine and practice, and strike down the considered policy choice of almost every State." *Id.* at 2269; *see also Vacco v. Quill*, 117 S. Ct. 2293, 2297 (1997) ("If a legislative classification or distinction 'neither burdens a fundamental right nor targets a suspect class, we will uphold [it] so long as it bears a rational relation to some legitimate end.'") (quoting *Romer v. Evans*, 517 U.S. 620, 631 (1996)).

The Court's explicit refusal to acknowledge a fundamental right to die in *Glucksberg* and *Quill* clearly distinguished the assisted suicide debate from that of any protected privacy interest. This theory, in fact, coincided with the landmark *Cruzan* decision. In *Glucksberg*, the Court narrowly construed the 1990 *Cruzan* decision: "[A]lthough *Cruzan* is often described as a 'right to die' case, . . . we were, in fact, more precise: we assumed that the Constitution granted competent persons a 'constitutionally protected right to refuse lifesaving hydration and nutrition.'"²⁴ Thus, in both cases the Court found no fundamental right to die or right to suicide; it recognized merely a right to refuse life-prolonging measures.²⁵ In Part III, this Note will expand further on the distinction between "killing" and "letting die."

B. Oregon's Death with Dignity Act²⁶

In October 1997, the Court denied certiorari to a class action suit that challenged the constitutionality of Oregon Measure 16, known as the Death with Dignity Act²⁷—the first law in the United States to authorize assisted suicide.²⁸ The Court left decisions concerning this issue to state sovereignty.²⁹

The Oregon measure was adopted by state voters on November 8, 1994³⁰ "as the result of a statewide referendum, and passage was secured by the narrowest of margins, 51 percent to 49 percent."³¹ To the dismay of the Act's proponents, the Oregon legislature responded by scheduling a new referendum to take place in November 1997. Additionally, the legislature proposed Measure 51, which would repeal the Act.³² By a sixty percent to forty percent margin, the Oregon voters denied this attempt to repeal the Death with Dignity Act.³³ The Act

²⁴ *Glucksberg*, 117 S. Ct. at 2269 (quoting *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 279 (1990)).

²⁵ *See id.*

²⁶ OR. REV. STAT. § 127.805 (1997).

²⁷ *See Lee v. Oregon*, 107 F.3d 1382 (9th Cir. 1997), *cert. denied sub nom. Lee v. Harclerod*, 118 S. Ct. 328 (1997). *See also* § 127.805.

²⁸ *See* Kenneth R. Thomas, *The Right to Die: Where Do We Go From Here?*, 44 FED. LAW. 22, 25 (1997).

²⁹ *See Harclerod*, 118 S. Ct. at 328.

³⁰ *See* International Ass'n of Defense Counsel, *Current Decisions: Challenges to Assisted Suicide Act Rejected*, 64 DEF. COUNS. J. 455, 455-56 (1997).

³¹ Thomas, *supra* note 28, at 25.

³² *See* Laurie Asseo, *Maryland Loses Traffic Stop Case on Appeal to the Supreme Court; High Court Refuses to Let Police Detain Passenger in Car without Cause, Also Weighs Oregon Assisted Suicide Case*, DAILY REC. (Baltimore, Md.), Oct. 15, 1997, at 17, available in LEXIS, Legnew Library, Dlyrec File; *see also* Thomas, *supra* note 28, at 25.

³³ *See Assisted Suicide Fights for its Life in the States*, NAT'L L.J. (New York), Dec. 29, 1997, at B13, available in LEXIS, News Library, Ntlawj File.

established a statutory regime under which mentally competent adults who were diagnosed with a terminal illness, and who voluntarily expressed a desire to die, could request medication from a physician for the purpose of ending their lives.³⁴

Before the Act took effect, a group of physicians, patients, and residential care facilities challenged its facial validity in a class action, which alleged, in part, a violation of their equal protection and due process rights.³⁵ The United States District Court for the District of Oregon granted a preliminary injunction.³⁶

A few months later, the district court ruled that Oregon's Death with Dignity Act violated the Equal Protection Clause and granted the plaintiffs' motion for summary judgment.³⁷ The Court of Appeals believed implementation of the Act would discriminate between similarly situated groups of patients;³⁸ terminally ill patients would be able to seek assisted suicide, whereas others could not.³⁹ Interestingly, this reasoning failed under the Supreme Court's review in *Vacco v. Quill*.⁴⁰

In 1997, the Ninth Circuit addressed *Lee v. State of Oregon* when it vacated the prior injunction on a procedural issue. The court held that none of the plaintiffs had standing to sue.⁴¹

³⁴ See OR. REV. STAT. § 127.805 (1997); Jonathan R. Rosenn, *The Constitutionality of Statutes Prohibiting and Permitting Physician-Assisted Suicide*, 51 U. MIAMI L. REV. 875, 898 (1997). See also International Ass'n of Defense Counsel, *supra* note 30, at 455-56. Specifically, under Oregon's Death with Dignity Act, any competent Oregon resident was allowed to make a written request for lethal medication if he or she surpassed the procedural hurdles. The Act required the individual to be terminally ill, as diagnosed by two physicians, and to express voluntarily a wish to die. See Thomas, *supra* note 28, at 25. "A 'terminal disease' is defined as an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months." *Id.* at 25-26.

³⁵ See *Lee v. Oregon*, 869 F. Supp. 1491, 1503 (D. Or. 1994) (granting plaintiffs' motion for preliminary injunction of Measure 16, which later became Oregon's Death with Dignity Act). Along with the Equal Protection and Due Process Clauses of the Fourteenth Amendment, the plaintiffs asserted that the Death with Dignity Act violated the Americans with Disabilities Act, as well as their statutory and First Amendment rights to freedom of religion and association. See *id.* at 1493.

³⁶ See *id.* at 1503.

³⁷ See *Lee v. Oregon*, 891 F. Supp. 1429, 1437 (1995) (holding that the Act failed a rational basis review because it did not ensure that a patient's decision to commit suicide was rationally and voluntarily made at the time of death), *vacated and remanded by* 107 F.3d 1382 (9th Cir. 1997), *cert. denied sub nom. Lee v. Harclerod*, 118 S. Ct. 328 (1997).

³⁸ See *id.*

³⁹ See *id.*

⁴⁰ See *Vacco v. Quill*, 117 S. Ct. 2293 (1997) (holding that New York's proscription of assisted suicide did not violate the Equal Protection Clause).

⁴¹ See *Lee v. Oregon*, 107 F.3d 1382, 1390 (9th Cir. 1997), *cert. denied sub nom. Lee v. Harclerod*, 118 S. Ct. 328 (1997).

Many courts, including the Supreme Court, believe no fundamental rights, nor even any constitutional rights, support the argument for assisted suicide.⁴² One scholar noted that “[u]ltimately, the viability of a statute such as the Death with Dignity Act is more likely to be tested in the political arena than it is to be successfully second-guessed by the courts.”⁴³

II. THE HISTORY OF SUICIDE

Scholars have reported that “in almost every western democracy[,] it is a crime to assist a suicide.”⁴⁴ Even though these findings address the current situation in the United States, commentators debate over whether history supports the prohibition or approval of assisted suicide.

A. *Opponents' Views*

Opponents of assisted suicide have asserted that the states' bans on assisted suicide are “longstanding expressions of the States' commitment to the protection and preservation of all human life.”⁴⁵ These laws which prohibit suicide originated in Judeo-Christian values, particularly the principle of the sanctity of life.⁴⁶

Over the past seven hundred years, Anglo-American common law has both frowned upon and condoned suicide.⁴⁷ In the year 673 A.D., the English adopted an ecclesiastical prohibition of suicide which King Edgar reaffirmed in 967 A.D.⁴⁸ The North American colonies later maintained a medieval English policy that criminalized suicide.⁴⁹ At common law, one who assisted in a suicide was criminally punishable as an accessory to suicide and charged with murder or

⁴² See, e.g., Thomas, *supra* note 28, at 23 (stating that the *Glucksberg* and *Quill* rulings “dashed any expectation that the [C]ourt would extend constitutional protections to the act of providing lethal medication to patients in serious medical condition”).

⁴³ *Id.* at 27.

⁴⁴ *Washington v. Glucksberg*, 117 S. Ct. 2258, 2263 (1997) (citing *Compassion in Dying v. Washington*, 79 F.3d 790, 847, 847 nn.10-13 (9th Cir. 1996) (Beezer, J., dissenting) (“In total, forty-four states, the District of Columbia and two territories prohibit or condemn assisted suicide.”)).

⁴⁵ *Id.* at 2263 (citing *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 280 (1990)).

⁴⁶ See Peter G. Daniels, Comment, *An Illinois Physician-Assisted Suicide Act: A Merciful End to a Terminally Ill Criminal Tradition*, 28 LOY. U. CHI. L.J. 763, 765 n.24 (1997).

⁴⁷ See *Glucksberg*, 117 S. Ct. at 2263.

⁴⁸ See *id.* at 2264 n.9.

⁴⁹ See Daniels, *supra* note 46, at 765 (citing *Compassion in Dying v. Washington*, 79 F.3d 790, 809 n.39 (9th Cir. 1996), *cert. granted*, 117 S. Ct. 37 (1996)).

manslaughter.⁵⁰ Additionally, when the Fourteenth Amendment was adopted, case law considered assisted suicide a criminal offense.⁵¹

Over time, however, the states universally decriminalized suicide for practical reasons.⁵² A great inconsistency in carrying out the criminal sanction existed: an effective suicide became unpunishable, while failed attempts remained within the reach of the law.⁵³ Legislators felt these emotionally disturbed individuals who failed in their attempts needed psychological attention rather than criminal punishment.⁵⁴

Opponents of assisted suicide have argued that “decriminalization . . . did not come about because society approved of suicide or considered it a human right.”⁵⁵ They assert that this change merely reflects the view that punishment was unfair to the suicide victim’s relatives, and those who attempt suicide suffer from mental illness.⁵⁶

Therefore, the abolition of suicide laws did not affect substantially society’s disdain for assisted suicide; many states proceeded to enact laws against assisted suicide,⁵⁷ such as the legislation the Supreme Court reviewed in *Glucksberg* and *Quill*.⁵⁸

B. *Proponents’ Views*

Proponents of assisted suicide, on the other hand, have asserted different historical attitudes toward suicide.⁵⁹ In *Compassion in Dying v. Washington*,

⁵⁰ See *id.* at 765 (citing ROLLIN M. PERKINS, CRIMINAL LAW 585 (1957)).

⁵¹ See Thomas J. Marzen et al., *Suicide: A Constitutional Right?*, 24 DUQ. L. REV. 1, 76 (1985) (“In short, twenty-one of the thirty-seven states, and eighteen of the thirty ratifying states prohibited assisting suicide. Only eight of the states, and seven of the ratifying states, definitely did not.”), cited in *Cruzan v. Director, Mo. Dep’t of Health*, 497 U.S. 261, 294 (1990).

⁵² See Daniels, *supra* note 46, at 765-66 (citing 2 WAYNE R. LAFÀVE & AUSTIN W. SCOTT, JR., SUBSTANTIVE CRIMINAL LAW § 7.8, at 649 (2d ed. 1986)).

⁵³ See *id.* at 766 (citing Richard S. Myers, *An Analysis of the Constitutionality of Laws Banning Assisted Suicide from the Perspective of Catholic Moral Teaching*, 72 U. DET. MERCY L. REV. 771, 775 (1995)).

⁵⁴ See *id.*

⁵⁵ HERBERT HENDIN, M.D., *SEDUCED BY DEATH: DOCTORS, PATIENTS, AND THE DUTCH CURE* 155 (1997).

⁵⁶ See *id.*

⁵⁷ See Daniels, *supra* note 46, at 766 (citing 2 WAYNE R. LAFÀVE & AUSTIN W. SCOTT, JR., SUBSTANTIVE CRIMINAL LAW § 7.8(c), at 651-52 (2d ed. 1986)).

⁵⁸ See generally *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997) (upholding Washington’s prohibition on assisted suicide as a statute rationally related to legitimate government interests); *Vacco v. Quill*, 117 S. Ct. 2293 (1997) (ruling that New York’s ban on assisted suicide was not violative of the Equal Protection Clause of the Fourteenth Amendment).

⁵⁹ See *Compassion in Dying v. Washington*, 79 F.3d 790, 806-10 (9th Cir. 1996), *cert.*

Judge Reinhardt, writing for the majority, noted that “[t]he first of all literary suicides, that of Oedipus’ mother, Jocasta, [wa]s made to seem praiseworthy, an honorable way out of an insufferable situation.”⁶⁰ He further contended that Socrates’ fatal sip of hemlock inspired others to end their lives.⁶¹ The Stoics glorified suicide; “Cato, who killed himself to avoid dishonor when Caesar crushed his military aspirations, was the most celebrated of the many suicides among the Stoics.”⁶² Reinhardt’s analysis continued by describing the early Christian impulse to martyrdom.⁶³ He argued that “[e]ven staunch opponents of a constitutional right to suicide acknowledge that ‘there were many examples of Christian martyrs whose deaths bordered on suicide.’”⁶⁴

Judge Reinhardt criticized the criminalization of suicide under the English common law.⁶⁵ He stated that the “traditional English experience was . . . shaped by the taboos that have long colored our views of suicide and perhaps still do today.”⁶⁶

III. THE POLITICAL DEBATE

A. *Right-to-Die Advocacy Groups*

The happy-death movement is a familiar term to most right-to-die advocates.⁶⁷ In the United States, groups of activists advance “death with dignity” and the notion of voluntary death as peaceful.⁶⁸ Scholars proclaim this movement began in 1954 with Joseph Fletcher’s publication of *Morals and Medicine*, which addressed the possibility of “good death” and patient autonomy.⁶⁹

These scholars have asserted that the development of nuclear technology and the prospect of nuclear war were instigating factors in the rediscovery of death in the United States:⁷⁰ “From the eerie bleating of air raid sirens of the 1950s to the residential bomb shelters of the 1960s (stocked with food and, in case things

granted, 117 S. Ct. 37 (1996) (commenting on ancient attitudes that honored suicide).

⁶⁰ *Id.* at 806.

⁶¹ *See id.* at 807.

⁶² *Id.*

⁶³ *See id.* at 808.

⁶⁴ *Id.*

⁶⁵ *See id.* at 809.

⁶⁶ *Id.*

⁶⁷ *See* HOEFLER & KAMOIE, *supra* note 3, at 125.

⁶⁸ *See id.*

⁶⁹ *See id.*

⁷⁰ *See id.* at 127.

went badly, suicide pills) to the nuclear-freeze movement of the 1980s, the American attempt to reckon with death was evident.”⁷¹

One of the earliest right-to-die interest groups was the Euthanasia Society of America, which preceded the “happy-death movement”⁷² and developed in New York City in 1938.⁷³ This radical group supported active euthanasia, which included both assisted suicide, in which the dying principal took an active part in the death, and mercy killing, in which another party was primarily responsible for causing the death of the principal.⁷⁴

Currently, the Hemlock Society⁷⁵ is the leading right-to-die organization in the United States; Derek Humphry and his second wife, Ann Wickett, founded the group in the 1980s.⁷⁶ Humphry was a British journalist who involved himself in suicide issues in 1975 after he helped his first wife commit suicide to end her bout with bone cancer.⁷⁷ Initially, Humphry claimed “he would never send through the mail instructions on how to commit suicide because the information might get into the wrong hands.”⁷⁸ Ironically, he later published *Final Exit*, a how-to-commit-suicide manual which immediately became a best-seller.⁷⁹ To explain the contradiction between the sale of his book and his original statement, Humphry replied, “I simply changed my mind.”⁸⁰

1. *The Hemlock Society’s Political Agenda*

The Hemlock Society actively has asserted its “happy death” views in the political arena. It entered briefs as *amici curiae* in two recent cases, *Quill v.*

⁷¹ *Id.* at 127-28.

⁷² *See supra* text accompanying notes 67-69.

⁷³ *See* HOEFLER & KAMOIE, *supra* note 3, at 138.

⁷⁴ *See id.* at 243-44 n.23.

⁷⁵ The Hemlock Society claimed its name from the legacy of Socrates. *See* DONALD W. COX, HEMLOCK’S CUP: THE STRUGGLE FOR DEATH WITH DIGNITY 21 (1993). In Athens, Greece, in 399 B.C., the famous philosopher Socrates found himself on trial for allegedly propagating religious heresies among the masses. He was found guilty, condemned, and his punishment was suicide. *See id.* His condemners forced him to drink from a cup of poison hemlock, which has given rise to the literary phrase, “drink the cup of Hemlock.” *Id.* at 21 n.1. One author anxiously distinguished the involuntary nature of Socrates’ execution from the foundation of the Hemlock Society by stating that the organization believed in the “voluntary, free choice of ending one’s life with the aid of a living will and a lethal drug prescription.” *Id.*

⁷⁶ *See* HOEFLER & KAMOIE, *supra* note 3, at 139.

⁷⁷ *See id.*

⁷⁸ HENDIN, *supra* note 55, at 32 (citing ASSISTED SUICIDE: THE COMPASSIONATE CRIME 32 (Derek Humphry ed., 1982)).

⁷⁹ DEREK HUMPHRY, FINAL EXIT (1991).

⁸⁰ HENDIN, *supra* note 55, at 32.

*Vacco*⁸¹ and *Compassion in Dying v. Washington*.⁸² Similarly, the Hemlock Society had a hand in initiating the current debate over Oregon's Death with Dignity Act.⁸³ During the 1991 legislative session, the organization submitted a bill to the Oregon State Senate to legalize aid in dying.⁸⁴ In addition, the Hemlock Society has aided in the publication of several books about active euthanasia, and it currently publishes a newsletter called the *Hemlock Quarterly*.⁸⁵

One critic described the newsletter publication as "nothing less than pro-suicide propaganda extolling self-destruction as a morally correct and an empowering experience."⁸⁶ Wesley Smith may have authored *Forced Exit* in part to respond to Derek Humphry's 1991 how-to-commit-suicide book, *Final Exit*.⁸⁷ Smith wrote that the "seeds" for his book, and his own efforts as an anti-euthanasia activist, were "sown" when his depressed friend Frances committed suicide.⁸⁸ He blamed the Hemlock Society's newsletter for influencing Frances and causing her death.⁸⁹ Frances had compiled a suicide file of clippings from the *Hemlock Quarterly* that promoted suicide as "uplifting, enjoyable fun."⁹⁰ In his book, Smith declared the Hemlock Society had fostered in Frances a "romanticism about suicide that helped her move to consummation."⁹¹

Smith is not alone in his belief that the happy-death movement has influenced a rise in suicide rates in the United States.⁹² Herbert Hendin, author, psychiatrist, and director of the American Foundation for Suicide Prevention, emphasized the

⁸¹ 80 F.3d 716, 718 (2d Cir. 1996), *cert. granted*, 117 S. Ct. 36 (1996), *rev'd by* 117 S. Ct. 2293 (1997).

⁸² 850 F. Supp. 1454, 1456 (W.D. Wash. 1994), *rev'd by* 49 F.3d 586 (9th Cir. 1995), *cert. granted sub nom.* *Washington v. Glucksberg*, 117 S. Ct. 37 (1996), *rev'd by* 117 S. Ct. 2258 (1997).

⁸³ See Courtney S. Campbell, *When Medicine Lost its Moral Conscience: Oregon Measure 16*, in ARGUING EUTHANASIA: THE CONTROVERSY OVER MERCY KILLING, ASSISTED SUICIDE, AND THE "RIGHT TO DIE" 140, 140-41 (Jonathan D. Moreno, Ph.D., ed., 1995). In 1989, the *Hemlock Quarterly*, published by the Hemlock Society, announced the group's intention to sponsor three citizen initiatives to legalize "aid in dying" in Oregon, Washington, and California. *Id.* The campaigns proceeded in both Washington and California and resulted in defeat, but the movement stirred enough emotion in Oregon to begin a continuing controversy. *Id.* at 141.

⁸⁴ See *id.* at 141.

⁸⁵ See HOEFLER & KAMOIE, *supra* note 3, at 139.

⁸⁶ WESLEY J. SMITH, *FORCED EXIT: THE SLIPPERY SLOPE FROM ASSISTED SUICIDE TO LEGALIZED MURDER* at xvi (1997).

⁸⁷ See *id.* at 11.

⁸⁸ *Id.* at xiii.

⁸⁹ See *id.* at xvi.

⁹⁰ *Id.* at xvi-xvii.

⁹¹ *Id.* at xviii.

⁹² See *id.* at xviii.

chaotic aftermath of the publication of Humphry's *Final Exit*. He singled it out for causing a "significant rise in the number of people—some of them young people found dead with the book nearby—who asphyxiated themselves with plastic bags, a method recommended by Humphry."⁹³

B. *The Career of Dr. Kevorkian*

Another notorious euthanasia and assisted suicide proponent is Jack Kevorkian, who is also known as Dr. Death.⁹⁴ He is a licensed medical doctor trained in clinical pathology, but he chose to forgo his clinical practice and advance assisted suicide in its stead.⁹⁵ Kevorkian named his occupation obitriatry, defined as the practice of planned death.⁹⁶

In 1990, he began his mission by assisting in a string of suicides.⁹⁷ His first patient was Janet Adkins, an Alzheimer's patient; he used a suicide machine which he had constructed from flea market parts.⁹⁸ Kevorkian named it the Mercitron.⁹⁹

As of December 1993, Kevorkian had assisted in the deaths of twenty patients, including four instances of double suicide.¹⁰⁰ After he assisted in the death of his second patient, Michigan suspended Kevorkian's medical license, which made the purchase of toxic chemicals for the Mercitron very difficult.¹⁰¹ As a result, he replaced his Mercitron with a new contraption that emitted carbon monoxide.¹⁰² The carbon monoxide gas flowed "from a canister, through plastic tubing, and into a mask placed securely over the patient's face."¹⁰³

To rationalize his assisted suicide practice, Kevorkian once quipped that "as a 'compassionately hypocritical society,' we deny ' . . . access to dignified, humane and extremely beneficial means [for suicide]. . . .' The result is that ' . . . tormented lives continue to be ended by all kinds of makeshift, violent, messy

⁹³ HENDIN, *supra* note 55, at 32-33 (citation omitted).

⁹⁴ See HOEFLER & KAMOIE, *supra* note 3, at 151; JOAN BROVINS & THOMAS OEHMKE, DR. DEATH: DR. JACK KEVORKIAN'S R: DEATH 10 (1993).

⁹⁵ See HOEFLER & KAMOIE, *supra* note 3, at 151.

⁹⁶ See BROVINS & OEHMKE, *supra* note 94, at xiii.

⁹⁷ See HOEFLER & KAMOIE, *supra* note 3, at 151.

⁹⁸ See *id.*; see BROVINS & OEHMKE, *supra* note 94, at 3.

⁹⁹ See BROVINS & OEHMKE, *supra* note 94, at 2. The Mercitron was far from merciful. It had an intravenous line that fed a harmless saline solution into the arm of the victim. When the patient pressed a button on the home-made contraption, the line carrying the innocuous flow of saline was shut off and automatically replaced by a steady flow of deadly thiopental, the barbiturate used for executions. See HOEFLER & KAMOIE, *supra* note 3, at 151.

¹⁰⁰ See HOEFLER & KAMOIE, *supra* note 3, at 157.

¹⁰¹ See *id.* at 159.

¹⁰² See *id.*

¹⁰³ *Id.*

and torturous methods.”¹⁰⁴ He promoted each of his death contraptions as a means toward making suicide “quick, painless and neat.”¹⁰⁵

In 1997, Kevorkian and a terminally ill individual brought an action for injunctive relief and a declaratory judgment either to enjoin a Michigan county prosecutor from prosecuting Kevorkian for assisted suicide or to declare Michigan’s assisted suicide law unconstitutional.¹⁰⁶ The court denied the plaintiffs’ request for injunctive relief, and declared that a terminally ill patient had no liberty, due process, or equal protection interests in assisted suicide.¹⁰⁷

One of Kevorkian’s most recent patients was a woman from Roanoke, Virginia. On March 5, 1998, sixty-one-year-old Patricia Blount Graham died in Michigan with the assistance of Dr. Kevorkian.¹⁰⁸ A note which indicated that she suffered from rheumatoid arthritis, “a painful and crippling, but *nonfatal*, disease,” accompanied the body of the Roanoke native.¹⁰⁹

Charles Hite, director of biomedical ethics for Carilion Health Systems in Roanoke, summarized many physicians’ opinions regarding Kevorkian’s actions.¹¹⁰ He stated that “[w]hile ‘there are some physicians who would vote to allow for some type of physician assistance under certain highly regulated circumstances,’ even most of those are ‘appalled’ by Kevorkian’s lack of accountability.”¹¹¹

C. *Motivational Aspects of Physician-Assisted Suicide*

Many advocates of physician-assisted suicide rely on the doctrine of double effect, which reflects the belief that “occasionally the obligation to alleviate suffering should outweigh a mechanical extension of life.”¹¹² Supporters have claimed “foreseeable but unintended causations of death are not culpable if the good effect one aims to achieve warrants one’s chosen conduct.”¹¹³ “The key premise is that if the harmful effect is not intended, then the action can, under

¹⁰⁴ BROVINS & OEHMKE, *supra* note 94, at 15 (citation omitted in original).

¹⁰⁵ *Id.*

¹⁰⁶ *See* Kevorkian v. Thompson, 947 F. Supp. 1152, 1152 (E.D. Mich. 1997).

¹⁰⁷ *See id.* at 1179.

¹⁰⁸ *See* Cody Lowe, *Letter to the Editor Expresses Woman’s Last Public Words; Patient Turned to Dr. Kevorkian for Relief*, ROANOKE TIMES & WORLD NEWS (Roanoke, Va.), Mar. 12, 1998, at A1, available in LEXIS, News Library, Roanok File.

¹⁰⁹ *Id.* (emphasis added).

¹¹⁰ *See id.*

¹¹¹ *Id.*

¹¹² Daniels, *supra* note 46, at 767.

¹¹³ Luke Gormally, *Walton, Davies, Boyd and the Legalization of Euthanasia*, in EUTHANASIA EXAMINED: ETHICAL, CLINICAL AND LEGAL PERSPECTIVES 113, 116 (John Keown ed., 1995).

certain circumstances, be justified.”¹¹⁴ With this defensible approach, these right-to-die proponents place the mission of painkilling above the preservation of a certain kind of life.¹¹⁵

In recent years, there has been great debate over the plausibility of the doctrine of double effect,¹¹⁶ commentators have found it difficult to distinguish the intended from the merely foreseen.¹¹⁷ For example, the President’s Commission rejected the use of such a distinction in assigning moral responsibility because it believed reliance on that distinction could make it difficult for courts to determine an actor’s intention.¹¹⁸

Many of these right-to-die activists have attacked prohibitive assisted suicide laws as examples of both religious oppression and the imposition of sectarian religious beliefs on the people.¹¹⁹ A Dutch doctor, Pieter Admiraal, once stated that religion is the only ground for denying euthanasia.¹²⁰ Jack Kevorkian labeled his opponents “religious fanatics” and accused them of participation in “Salem-style ‘witch-hunts.’”¹²¹

The prominent opponents of assisted suicide, however, claim their opposition to legalization rests on secular reasoning.¹²² They believe euthanasia is a “vital public-policy issue” rather than a religious issue.¹²³ Dr. Herbert Hendin, psychiatrist and director of the American Foundation for Suicide Prevention, was a “fervent agnostic” who wrote an opposition piece based on nonreligious concepts.¹²⁴ Writer Nat Hentoff emphasized the inaccuracy of the religious label:

Proponents try to paint euthanasia as an issue of religious belief because they perceive accurately that most people don’t want to be told what to do by churches. In that way, they hope that people won’t look to the substance of the issue but rather, will accept euthanasia as a means of opposing church-state involvement.¹²⁵

¹¹⁴ Kevin P. Quinn, S.J., *Assisted Suicide and Equal Protection: In Defense of the Distinction Between Killing and Letting Die*, 13 ISSUES L. & MED. 145, 160 (1997).

¹¹⁵ See Gormally, *supra* note 113, at 116.

¹¹⁶ See Quinn, *supra* note 114, at 161.

¹¹⁷ See *id.*

¹¹⁸ See President’s Comm’n for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Deciding to Forego Life-Sustaining Medical Treatment: A Report on the Ethical, Medical, and Legal Issues in Treatment Decisions*, 65-72 (U.S. Government Printing Office 1983).

¹¹⁹ See SMITH, *supra* note 86, at 201.

¹²⁰ See *id.*

¹²¹ *Id.*

¹²² See *id.* at 202.

¹²³ *Id.*

¹²⁴ *Id.*

¹²⁵ *Id.* at 201.

To further his proposition, Hentoff proclaimed, "I can't base my opposition to euthanasia on religion. I am an atheist!"¹²⁶

D. *The Line Between Letting Die and Killing*

Commentators have argued that a clearly definable boundary between passive euthanasia¹²⁷ and assisted suicide exists.¹²⁸ The former entails a removal of heroic technological measures in an effort to allow nature to continue its course when death is inevitable.¹²⁹ "This [distinction] implies a personal and socially reasonable judgment about the inherent limits of medical science."¹³⁰ Assisted suicide, on the other hand, reaches beyond natural means and represents an intentional, arbitrary shortening of a person's life, "a direct intervention in the natural course of an individual's life."¹³¹

One critic noted "[t]he line between letting die and killing was not drawn arbitrarily or unthinkingly. . . . 'To be or not to be' has never been a matter of personal choice in the long run."¹³² Another author, in support of this theory, presumed "there is and will always remain a fundamental difference between what nature does to us and what we do to one another."¹³³

¹²⁶ *Id.* at 202.

¹²⁷ Passive euthanasia is a term for the act of withholding life-prolonging measures. Active euthanasia, in contrast, involves direct intervention. See John Harris, *Euthanasia and the Value of Life*, in EUTHANASIA EXAMINED: ETHICAL, CLINICAL AND LEGAL PERSPECTIVES 6 (1995).

The category of active euthanasia can be broken down further into voluntary, nonvoluntary, and involuntary euthanasia. See Jonathan D. Moreno, ARGUING EUTHANASIA: THE CONTROVERSY OVER MERCY KILLING, ASSISTED SUICIDE, AND THE "RIGHT TO DIE" 11, 21 (Jonathan D. Moreno, Ph.D. ed., 1995). Active voluntary euthanasia is performed at the patient's request. Active nonvoluntary euthanasia is performed on an incompetent patient or one who has not requested it. Active involuntary euthanasia refers to mercy killing against the patient's wishes. See *id.*

Euthanasia, in general, refers to "actions or omissions that result in the death of a person who is already gravely ill." *Id.* at 20. One author has called it the "killing of one person by another (usually but not always a doctor) because the person killed has a serious disease or injury, is disabled, is emotionally or mentally disturbed, is anguished, or is elderly." SMITH, *supra* note 86, at xxv. Literally, euthanasia means good death in Latin. See *id.*

¹²⁸ See, e.g., Quinn, *supra* note 114, at 168-69. Assisted suicide occurs when a person "actively participates in, assists in, and/or facilitates" the termination of the life of another. SMITH, *supra* note 86, at 202. For example, if a doctor knowingly prescribes drugs for an individual to commit suicide, he participates in physician-assisted suicide. See *id.*

¹²⁹ See *supra* notes 112-18 and accompanying text.

¹³⁰ Susan R. Martyn & Henry J. Bourguignon, *Physician-Assisted Suicide: The Lethal Flaws of the Ninth and Second Circuit Decisions*, 85 CAL. L. REV. 371, 385 (1997).

¹³¹ *Id.*

¹³² *Id.*

¹³³ DANIEL CALLAHAN, THE TROUBLED DREAM OF LIFE: LIVING WITH MORTALITY 76 (1993).

Critics of assisted suicide have stated that “[t]he purpose of medicine is to heighten and support a person’s natural response to disease or injury, not to inflict death.”¹³⁴ “[T]he right to refuse medical treatment may be distinguished from a hypothesized right to assisted suicide in that the former has its origins in the Fourth and Fifth Amendments’ guarantee of privacy, or a right to be left alone, and not be compelled by the government to do anything.”¹³⁵ A right to assisted suicide has no constitutional basis, as decided by the Supreme Court in 1997.¹³⁶

E. *Effects on the Medical Profession*

Physicians commonly are known as healers,¹³⁷ but the current debate continues regarding whether their assistance with suicide deems them killers. Opponents have criticized the legalization of physician-assisted suicide by clarifying a state interest in “‘preserving the integrity’ of the medical profession.”¹³⁸ They argue that the current trend toward permitting physician-assisted suicide may taint the healing reputation of these professionals.¹³⁹

Critics also argue about the applicability of the Hippocratic Oath to physician-assisted suicide.¹⁴⁰ Although contemporary scholars believe modern technology has rendered strict adherence to the oath counterproductive,¹⁴¹ some

¹³⁴ Martyn & Bourguignon, *supra* note 130, at 385.

¹³⁵ Rosenn, *supra* note 34, at 904.

¹³⁶ See *Vacco v. Quill*, 117 S. Ct. 2293 (1997); *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997).

¹³⁷ See, e.g., AMERICAN MED. ASS’N, COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, CODE OF MEDICAL ETHICS: CURRENT OPINIONS WITH ANNOTATIONS § 2.211 (1994) (contending that physicians are healers, not killers); AMERICAN MED. ASS’N, COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, *Decisions Near the End of Life*, 267 JAMA 2229, 2233 (1992) (asserting that physicians should not assist suicides).

¹³⁸ Laura Trenaman-Molin, Comment, *Physician-Assisted Suicide: Should Texas Be Different?*, 33 HOUS. L. REV. 1475, 1488 (1997) (citing *Compassion in Dying v. Washington*, 49 F.3d 586, 592 (9th Cir. 1995)).

¹³⁹ See HENDIN, *supra* note 55, at 163.

¹⁴⁰ Traditionally, medical doctors took the Hippocratic Oath during their medical school graduation exercises. The oath, which originated from the ancient Greek Hippocrates, was essentially a pledge to “first, do no harm” to one’s patients. See HOEFLER & KAMOIE, *supra* note 3, at 157.

Critics of the oath, including medical historian Ludwig Edelstein, have claimed that it was not authored by Hippocrates, but rather distilled from parts of Hippocrates’ writings, as well as Pythagoreanism and Orphism, in the fifth century B.C. See DR. JACK KEVORKIAN, *PRESCRIPTION: MEDICINE—THE GOODNESS OF PLANNED DEATH* 160 (1991).

¹⁴¹ See COX, *supra* note 75, at 22-23. In light of his pro-“happy death” campaign, it is interesting to note that Dr. Jack Kevorkian never took the Hippocratic Oath. See KEVORKIAN, *supra* note 140, at 160.

opponents of assisted suicide assert, in these circumstances, that the intent of the oath should continue to be honored.¹⁴²

In *Compassion in Dying v. Washington*, Ninth Circuit Judge Reinhardt, writing for the majority, stated that "the Hippocratic Oath can have no greater import in deciding the constitutionality of physician[-]assisted[.]suicide than it did in determining whether women had a constitutional right to have an abortion."¹⁴³ Judge Reinhardt noted the American Medical Association's ("AMA") shift in its stance on the authority of the Hippocratic Oath with respect to abortions and analogized it to the AMA's position on assisted suicide.¹⁴⁴ Twenty years ago, the AMA contended that performing abortions violated the Hippocratic Oath, and Reinhardt implied that the AMA's similar assertions regarding assisted suicide should have been dismissed as well.¹⁴⁵ The Judge concluded, "As *Roe* shows, a literalist reading of the Hippocratic Oath does not represent the best or final word on medical or legal controversies today."¹⁴⁶

One author criticized Judge Reinhardt's logic that "abortion is now allowed despite the Hippocratic Oath; ergo physician-assisted suicide should also be allowed."¹⁴⁷ The author argued that even though the Hippocratic Oath has fallen into desuetude, "there is ample evidence that the Hippocratic Oath's prohibition of physician-assisted suicide remains compelling to medical practitioners today."¹⁴⁸ In support of this claim, the author noted that the AMA's Code of Medical Ethics upholds part of the Hippocratic Oath by making physician-assisted suicide fundamentally incompatible with the physician's role as healer.¹⁴⁹ Such commentators, therefore, believe the Hippocratic Oath is still vital "in its AMA guise."¹⁵⁰

Opponents of assisted suicide agree that viewing euthanasia and assisted suicide as correctives misconstrues the nature of the doctor-patient relationship.¹⁵¹ Regarding the role of patient autonomy, Leon Kass succinctly summarized the physician's role by stating: "[T]he physician serves the sick not because they have rights or wants or claims, but because they are sick. . . .

¹⁴² See Dwight G. Duncan & Peter Lubin, *The Use and Abuse of History in Compassion in Dying*, 20 HARV. J.L. & PUB. POL'Y 175, 182-83 (1996) (analyzing Judge Reinhardt's dismissal of the Hippocratic Oath in *Compassion in Dying*).

¹⁴³ *Compassion in Dying v. Washington*, 79 F.3d 790, 829 (9th Cir. 1996).

¹⁴⁴ See *id.*

¹⁴⁵ See *id.*

¹⁴⁶ *Id.*

¹⁴⁷ Duncan & Lubin, *supra* note 142, at 182.

¹⁴⁸ *Id.* at 182-83.

¹⁴⁹ See *id.* at 183.

¹⁵⁰ *Id.*

¹⁵¹ See Leon R. Kass, *Neither for Love Nor Money: Why Doctors Must Not Kill*, PUB. INTEREST, Winter 1989, at 25-46.

Healing is thus the central core of medicine: to heal, to make whole, is the doctor's primary business."¹⁵²

Commentators have propounded upon such matters of public policy. They have asserted that the secularization of medicine is an ill-fated trend.¹⁵³ This secularization, they believe, results from physicians emulating business people rather than caregivers.¹⁵⁴ Over time, medicine has become "increasingly independent of the values that make health care a human service," and the profession has grown more preoccupied with "factors that are peripheral to and distract from care."¹⁵⁵

One critic argued that this secularization has resulted in an overemphasis on autonomy.¹⁵⁶ He concluded that the "absolutization of autonomy and the secularization of the medical profession are twin sisters."¹⁵⁷ This absolutization of autonomy is the cornerstone of right-to-die advocacy. These scholars assume the goals of the physician-assisted suicide movement, if realized, would further the secularization of medicine and place a dark cloak on the respected profession.¹⁵⁸

In addition, one critic indicated that a measure permitting physician-assisted suicide would impose a moral dilemma on other medical professionals, namely pharmacists.¹⁵⁹ Even though a doctor-patient agreement over a lethal dose of medication may exist, Courtney Campbell argued, the pharmacist who is expected to fill the prescription may have ethical problems with the controversial issue.¹⁶⁰

For example, Oregon's Death with Dignity Act¹⁶¹ neglects the role of pharmacists in filling prescriptions.¹⁶² Scholars have described the measure as professionally demeaning because it views the pharmacist "simply as the technical arm of the physician's practice."¹⁶³ The pharmacist has no way of knowing if the patient has received proper consultation regarding his or her

¹⁵² *Id.* at 39.

¹⁵³ *See, e.g.,* McCormick, *supra* note 1, at 135. "Secularization" in this context has been defined as "the divorce of the profession of medicine from a moral tradition." *Id.*

¹⁵⁴ *See id.*

¹⁵⁵ *Id.* For example, the profession has become consumed with concerns over insurance premiums, competition, accountability structures, government controls, bureaucratic mechanisms, and malpractice liability. *Id.*

¹⁵⁶ *See id.* at 136.

¹⁵⁷ *Id.*

¹⁵⁸ *See, e.g.,* McCormick, *supra* note 1, at 136.

¹⁵⁹ *See* Campbell, *supra* note 83, at 158.

¹⁶⁰ *See id.*

¹⁶¹ OR. REV. STAT. § 127.805 (1997).

¹⁶² *See* Campbell, *supra* note 83, at 158.

¹⁶³ *Id.*

ultimate decision to die.¹⁶⁴ Campbell proffered the following question: “[I]f presented with a prescription for a lethal dose of medication, how will the pharmacist be able to determine whether the physician and patient have complied with all the provisions of [the applicable state laws] prior to the visit to the pharmacist?”¹⁶⁵ She further commented that Oregon’s permissive measure overlooks the significant role of the pharmacist and fails to require physicians to inform pharmacists that a prescription has been drafted with the intent to end a life.¹⁶⁶

One court recognized the pharmacist’s interest in the assisted suicide debate.¹⁶⁷ The Michigan Circuit Court in *Hobbins v. Attorney General* gave the pharmacist a means by which to challenge an assisted suicide statute.¹⁶⁸ The pharmacist had standing in the litigation because the court deemed him a pharmacist whose “professional duties required that he fill prescriptions of physicians.”¹⁶⁹ It appears natural that these professionals should have a say in the matter, be it for or against assisted suicide, when their duties under the Act may place them in a controversial position.

F. *The Slippery Slope*

Scholars have warned the states to look to the imminent consequences of their decisions on assisted suicide.¹⁷⁰ One columnist and social critic argued: “When the states legalize the deliberate ending of certain lives . . . it will eventually broaden the categories of those who can be put to death with impunity.”¹⁷¹

¹⁶⁴ *See id.*

¹⁶⁵ *Id.*

¹⁶⁶ *See id.* at 159.

¹⁶⁷ *See Hobbins v. Attorney Gen.*, No. 93-306-178CZ, 1993 WL 276833, at *1 (Mich. Cir. Ct. May 20, 1993) (determining whether a pharmacist has standing to challenge Michigan’s assisted suicide statute), *aff’d in part, rev’d in part* by 518 N.W.2d 487 (Mich.), *appeal granted* by *People v. Kevorkian*, 521 N.W.2d 4 (Mich.), *aff’d in part, rev’d in part* by 527 N.W.2d 714 (Mich. 1994).

¹⁶⁸ *See Trenaman-Molin, supra* note 138, at 1500 n.205.

¹⁶⁹ *Hobbins*, 1993 WL 276833, at *3.

¹⁷⁰ *See, e.g.,* Marshall B. Kapp, *Old Folks on the Slippery Slope: Elderly Patients and Physician-Assisted Suicide*, 35 DUQ. L. REV. 443, 453 (1996) (concluding that “[I]egalizing physician-assisted suicide, particularly through judicial fiat, would probably destroy health care professionals’ incentive to take . . . needed initiatives and expose vulnerable, fearful elders to the serious and unnecessary risk of being prematurely deprived of the fullness of their days”).

¹⁷¹ Nat Hentoff, *The Slippery Slope of Euthanasia*, in ARGUING EUTHANASIA: THE CONTROVERSY OVER MERCY KILLING, ASSISTED SUICIDE, AND THE “RIGHT TO DIE” 110 (Jonathan D. Moreno, Ph.D. ed., 1995).

1. *Advance Directives*

The American Geriatrics Society is a proactive group that publicly has proposed health care alternatives in response to the potential dangers of active euthanasia.¹⁷² In a 1990 policy statement, the organization called for improvements in the formal care system and specifically defined the need for better supportive care in an attempt to curb a patient's compulsion to request deliberate death.¹⁷³ "Although the Society concedes that some might benefit from 'active' euthanasia, the risk that others may be abused is too great to press for its legalization."¹⁷⁴

Another preventive measure that health care experts have proposed is improved pain management.¹⁷⁵ Pain control experts have asserted that existing treatments have the capacity to relieve adequately the pain of nearly every terminally ill patient.¹⁷⁶ Although doctors who use modern drug therapy can manage over ninety percent of the pain experienced by cancer patients,¹⁷⁷ experts have said that the National Cancer Institute continues to make pain research a low budget priority.¹⁷⁸

2. *The Netherlands: Descending the Slippery Slope*

Many scholars believe voluntary assisted suicide poses a danger that may lead to involuntary euthanasia, a term for the act of "terminating the life of competent patients without their explicit consent."¹⁷⁹ Opponents of assisted

¹⁷² See BARBARA J. LOGUE, *LAST RIGHTS: DEATH CONTROL AND THE ELDERLY IN AMERICA* 214 (1993).

¹⁷³ See *id.* An excerpt of the policy statement read: "Patients may choose active euthanasia primarily because they lack access to effective supportive care. . . . Caring for the terminally ill through the widespread availability of supportive care must be a high priority. This our society has yet to do. Abandoning the effort without even having tried cannot be justified." *Id.*

¹⁷⁴ *Id.* ("According to Dame Cicely Saunders, a pioneer in the hospice movement, hospice care 'is the alternative to the negative and socially dangerous suggestion that a patient with an incurable disease likely to cause suffering should have the legal option of actively hastened death.'" (citing Dame Cicely Saunders, *Foreward*, in Jack McKay Zimmerman, *Hospice: Complete Care for the Terminally Ill* (1986)).

¹⁷⁵ See, e.g., McGonnigal, *infra* note 200, at 109-10 (asserting that successful pain relief treatment for terminally ill patients exists).

¹⁷⁶ See Yale Kamisar, *Against Assisted Suicide—Even a Very Limited Forum*, 72 U. DET. MERCY L. REV. 735, 744 (1995), cited in McCormick, *supra* note 1, at 110 & n.64.

¹⁷⁷ See Susan D. Block & J. Andrew Billings, *Patient Requests to Hasten Death: Evaluation and Management in Terminal Care*, ARCHIVES OF INTERNAL MED., Sept. 26, 1994, at 2039, cited in McCormick, *supra* note 1, at 110 & n.65.

¹⁷⁸ See McCormick, *supra* note 1, at 136.

¹⁷⁹ *Washington v. Glucksberg*, 117 S. Ct. 2258, 2274 (1997) (recognizing that "the State may

suicide have reinforced the slippery slope argument with data from a 1991 study by the Dutch government which outlined "the potentially disastrous consequences of stepping over the boundary that separates 'allowing to die' from active killing."¹⁸⁰

In the Netherlands, the slippery slope is already a reality,¹⁸¹ the Rummelink study shows the "annual numbers of involuntary mercy killings now surpass the numbers of voluntary assisted suicide and euthanasia," and "mental suffering is now an acceptable reason for granting physician-assisted suicide."¹⁸² Such evidence suggests that imposed or involuntary euthanasia regularly occurs in the Netherlands today.¹⁸³ The Rummelink Commission chose not to distinguish competent from incompetent patients;¹⁸⁴ Hendin wrote that the Dutch system is biased toward protecting doctors rather than patients.¹⁸⁵

Reports show the danger regarding consent has become a reality in the Netherlands.¹⁸⁶ In 1993, a Dutch court heard the trial of Dr. Boudewijn Chabot, who had assisted in the suicide of a patient whom he believed was not physically or mentally ill.¹⁸⁷ Chabot was acquitted, "adding to Dutch case law the precedent that a patient a physician claims is not suffering from either psychiatric or physical illness can receive assisted suicide simply because he or she is unhappy."¹⁸⁸

Chief Justice Rehnquist, in his majority opinion in *Glucksberg*, recognized the problematic situation in the Netherlands.¹⁸⁹ He reported that the Rummelink study revealed 2,300 cases of voluntary euthanasia, 400 cases of assisted suicide, and more than 1,000 cases of euthanasia without an explicit request, as well as an additional 4,941 cases in which physicians administered lethal morphine doses without the patient's explicit consent.¹⁹⁰ Rehnquist concluded:

fear that permitting assisted suicide will start it down the path to voluntary and perhaps even involuntary euthanasia"). See also *supra* note 127.

¹⁸⁰ Trenaman-Molin, *supra* note 138, at 1490.

¹⁸¹ See Robert G. Twycross, *Where There Is Hope, There Is Life: A View from the Hospice*, in *EUTHANASIA EXAMINED: ETHICAL, CLINICAL AND LEGAL PERSPECTIVES* 141, 160 (John Keown ed., 1995).

¹⁸² Trenaman-Molin, *supra* note 138, at 1490 (citation omitted); see also Twycross, *supra* note 181, at 160.

¹⁸³ See Twycross, *supra* note 181, at 160 (stating that "a majority of cases of euthanasia involves no explicit request by the patient" (footnote omitted)).

¹⁸⁴ See HENDIN, *supra* note 55, at 90.

¹⁸⁵ See *id.*

¹⁸⁶ See *id.* at 67.

¹⁸⁷ See *id.* at 66-67.

¹⁸⁸ *Id.* at 68.

¹⁸⁹ See *Washington v. Glucksberg*, 117 S. Ct. 2258, 2274 (1997) (citing the Dutch Rummelink study).

¹⁹⁰ See *id.*

This study suggests that, despite the existence of various reporting procedures, euthanasia in the Netherlands has not been limited to competent, terminally ill adults who are enduring physical suffering, and that regulation of the practice may not have prevented abuses in cases involving vulnerable persons, including severely disabled neonates and elderly persons suffering from dementia.¹⁹¹

The fact that unrequested euthanasia is a “widespread reality” in Holland lends validity to the slippery slope argument.¹⁹² Opponents of assisted suicide maintain that, because it has happened in the Netherlands, there can be no certainty that the United States is immune.¹⁹³

3. *Patient Autonomy: A Risky Factor*

In some recorded instances, such right-to-die zeal has clouded the free judgment of patients, as well as their assistants, and resulted in involuntary death.¹⁹⁴ Derek Humphry, founder of the Hemlock Society, participated in coercive activity which even his wife and co-founder of the Society, Ann Wickett, found questionable.¹⁹⁵

In her book, *Double Exit*, her letters, conversations with friends, and her own taped suicide “note,” . . . Wickett[] made clear that she was tormented by having actively participated with Humphry in the suicide pact of her parents. Although her ninety-two-year-old father may have been ready to die, she knew that her seventy-eight-year-old mother was not.¹⁹⁶

Herbert Hendin summarized: “Such pacts have been romanticized and considered rational suicides, but published case reports confirm my own clinical experience that in most such pacts a man who wishes to end his life coerces a woman into joining him.”¹⁹⁷

After co-founding the Hemlock Society, Wickett herself publicly attacked Humphry and the Society.¹⁹⁸ At one point, Humphry left a message on Wickett’s

¹⁹¹ *Id.* (concluding that Washington’s ban on assisted suicide is at least reasonably related to the promotion and protection of state interests).

¹⁹² Twycross, *supra* note 181, at 161.

¹⁹³ *See id.*; *see also* Trenaman-Molin, *supra* note 138, at 1490.

¹⁹⁴ *See* HENDIN, *supra* note 55, at 33.

¹⁹⁵ *See id.*

¹⁹⁶ *Id.* (citing ANN WICKETT, *DOUBLE EXIT* (1989); Trip Gabriel, *A Fight to the Death*, N.Y. TIMES MAG., Dec. 8, 1991, at 46).

¹⁹⁷ HENDIN, *supra* note 55, at 33.

¹⁹⁸ *See id.* Her marriage to Humphry had gone sour; she claimed that he abandoned and

answering machine which threatened to reveal that Wickett had physically restrained her own mother while assisting in her suicide.¹⁹⁹

How a physician can determine whether a patient's request for assistance with suicide is voluntary and competent remains a crucial issue. One author responded rather colorfully:

The typical victim of physician-assisted suicide is not the cool-headed, non-depressed, non-pressured, life-loving patient who is both terminally ill and in intractable pain. Instead, the victims are reacting to overwhelming social and emotional pressures of which they are unaware and do not understand. At the end, most people will be less like Socrates with the hemlock and more like the teenager in the tattoo parlor.²⁰⁰

Some measures do not require the physician to obtain the opinion of a mental health professional before prescribing a lethal dose of medication.²⁰¹ Many physicians, however, cannot recognize clinical depression in a patient, and unless that depression is treated, some depressed individuals will obsess about suicide.²⁰² Opponents argue that, for these reasons, legalization of assisted suicide would facilitate the deaths of clinically depressed individuals before their mental health could be restored.²⁰³ They argue that a law permitting assisted suicide could feed irrational decisions, thus devaluing human life.²⁰⁴ In the words of Jay Katz:

Human beings are subject to the influence of reason and unreason, with the relative strength of either being affected by many innate, developmental, and situational factors. Moreover, capacities for reason are impaired whenever human beings are in pain, in love, in mourning, or in the throes of biological, environmental, or social crises.²⁰⁵

divorced her when she developed breast cancer. *See id.* (citing Trip Gabriel, *A Fight to the Death*, N.Y. TIMES MAG., Dec. 8, 1991, at 46; Anne Fadiman, *Death News: Requiem for the Hemlock Quarterly*, HARPER'S MAG., Apr. 1994, at 74-82).

¹⁹⁹ *See* HENDIN, *supra* note 55, at 33.

²⁰⁰ Michael McGonnigal, *This Is Who Will Die When Doctors Are Allowed To Kill Their Patients*, 31 J. MARSHALL L. REV. 95, 98 (1997) (footnote omitted).

²⁰¹ *See* Hentoff, *supra* note 171, at 111.

²⁰² *See id.*

²⁰³ *See id.* at 112.

²⁰⁴ *See id.*; *see also* Trenaman-Molin, *supra* note 138, at 1489 (noting that "the elderly, the poor, minorities, and the disabled may be particularly susceptible to assisted suicide manipulation" (citation omitted)).

²⁰⁵ McGonnigal, *supra* note 200, at 108 (quoting JAY KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* 110 (1996)).

In the context of private conversations between doctor and patient, scholars have warned that there is no way to ensure an objective assessment of the patient's consent and competence. The doctors cannot be trained to recognize any rigid standard of competence; many of these physicians, who would assist in suicide, are unknown to the public. Commentators are acutely aware that legalization may result in the extension of assisted suicide to non-terminally ill patients.²⁰⁶ One author asserted:

The most vulnerable members of our society will be subjected to the predilections of a group with the ability to manufacture consent. In many cases, if the doctor makes a mistake, the only other person who knows about the mistake will be dead. That this suspicious and cynical generation would grant any profession the right to play God demonstrates our inherent hunger for blind faith.²⁰⁷

Some experts have hypothesized that gender may become an issue in patient competence assessments. Barbara Logue wrote that women may be at a greater disadvantage than men.²⁰⁸ "Cultural images of women as helpless, childlike, irresponsible in money matters, and easy prey for swindlers and con artists may help make declarations of incompetence and petitions for guardianship more likely for them than for their male counterparts."²⁰⁹ Logue believed such female stereotypes could influence physicians during competency assessments of female patients and lead doctors to mistakenly strip women of their right to consent to assisted suicide.²¹⁰

4. *Is Technology the Culprit?*

Activists have criticized scientism, which is defined as "the belief in the beneficence and efficacy of technology,"²¹¹ for causing modern medicine's "obsession with death prevention."²¹² These right-to-die proponents zealously have opposed the application of what they call "technological gadgetry" and "heroic therapies."²¹³

Although this platform seems to support the movement for passive euthanasia, which is the cessation of artificial resuscitation procedures, the theory

²⁰⁶ See Trenaman-Molin, *supra* note 138, at 1489.

²⁰⁷ McGonnigal, *supra* note 200, at 102-03 (footnote omitted).

²⁰⁸ See LOGUE, *supra* note 172, at 270.

²⁰⁹ *Id.* at 270-71.

²¹⁰ See *id.*

²¹¹ HOEFLER & KAMOIE, *supra* note 3, at 81.

²¹² *Id.*

²¹³ *Id.*

directly contradicts the rationale for active euthanasia or assisted suicide.²¹⁴ If technology is the evil, physician-assisted suicide is no better. In fact, it promotes the evil that technology is said to engender. Assisted suicide is just as unnatural as life-sustaining respirators. Time-of-death control by the intentional causation of death is a step even further beyond death prevention. Deciding one's time of death goes beyond any act of "playing God" that our society has executed up to this point. Criticism for temporary life-prolonging measures cannot be reconciled with advocacy of death control.²¹⁵ The two theories move in opposite directions.

G. *The Misguided Perception of a Relationship Between Abortion and Assisted Suicide*

Advocates of euthanasia and assisted suicide have compared their cause to the pro-choice abortion movement.²¹⁶ One opponent commented, "They believe that by coupling euthanasia as the caboose to abortion's locomotive, they can benefit the euthanasia cause and gain the same public acceptance for euthanasia that they perceive currently exists for the right of a woman to terminate her pregnancy."²¹⁷

According to pro-choice legal scholar Yale Kamisar, linkage of the two issues is a legal fiction:

In *Roe v. Wade*, the Court cleared the way for its ultimate holding [which documented a right to abortion] by rejecting the argument that a fetus is "a person" within the meaning of the Constitution. . . . But terminally ill persons, for example, a cancer patient who despite our best medical efforts, is likely to die in four or five months, is incontestably a "person" or "human being."²¹⁸

Kamisar noted another distinction: pro-choice legal scholars who view the fetus as a person have "maintained that the right to abortion is grounded on principles of sexual equity, rather than due process or privacy."²¹⁹ Gender, therefore, is not a player in the right to die controversy.²²⁰

²¹⁴ See discussion *supra* note 127.

²¹⁵ See generally Quinn, *supra* note 114.

²¹⁶ See SMITH, *supra* note 86, at 210.

²¹⁷ *Id.*

²¹⁸ *Id.* at 210-11 (citation omitted).

²¹⁹ *Id.* at 211.

²²⁰ See *id.* at 211.

H. *Virginia's Position on Assisted Suicide*

Earlier this year, the Virginia legislature adopted a prohibitive stance on the issue of assisted suicide. The Commonwealth took a responsible step in the right direction. On April 15, 1998, Virginia enacted legislation that penalized the act of assisted suicide.²²¹ The new law, which took effect on July 1, 1998, applies to any "licensed health care provider" in the Commonwealth of Virginia.²²² The Act further provided for: the potentially permanent revocation of a health care provider's license; an injunction to prevent a violation or attempted violation; and a cause of action for damages suffered by the spouse, parent, child, or sibling of the person attempting suicide.²²³

During their assessment of the Act, a number of Democratic Assembly members found themselves voting conservatively.²²⁴ There were indications that "[s]ome senators felt the legislation was needed to send a message that behavior like Dr. Jack Kevorkian's . . . would not be tolerated in this state."²²⁵ Democratic Delegate A. Donald McEachin of Richmond summarized: "What you see is a growing realization that these bills are reflective of the values of the people who put us here."²²⁶ Another Democrat, Charlottesville Senator Emily Couric, emphasized that "[n]o one in the medical profession . . . should assist with anyone's death."²²⁷

IV. RECOMMENDATIONS

To place the controversy in the proper perspective, it is interesting to note:

People are not allowed to dig coal in dangerous mines, work for less than the minimum wage, or waive the right to social security benefits or workers compensation. They cannot buy cars without seatbelts or drugs that have not been tested[, b]ut now courts are being asked to discover, and lawmakers are being asked to create, an absolute right

²²¹ See Act of April 15, 1998, ch. 624, 1998 Va. Adv. Legis. Serv. 38 (Va. 1998).

²²² *Id.* The term "[l]icensed health care provider" means a physician, surgeon, podiatrist, osteopath, osteopathic physician and surgeon, physician assistant, nurse, dentist or pharmacist licensed under the laws of this Commonwealth." *Id.*

²²³ See *id.*

²²⁴ See Laura LaFay & Warren Fiske, *Assembly Embraces Conservative Issue*, VIRGINIAN-PILOT (Norfolk, Va.), Mar. 12, 1998, at A1, available in LEXIS, Regnews Library, Vapilt File.

²²⁵ *Id.*

²²⁶ *Id.*

²²⁷ *Id.*

for a person to contract to have a third person kill them, or, as it has been more delicately put, "assist in their suicide."²²⁸

The Supreme Court was correct in its recent decisions to reserve the assisted suicide issue for state legislation. There is no fundamental right to assisted suicide enumerated anywhere in the Constitution, and even broad constructionists should agree that the penumbral right to privacy cannot be so vast as to include a right to end life.

The Supreme Court has drawn the line between "killing" and "letting die," and its logic is clear. The drafters of the Constitution did not contemplate the technological lifesaving treatments that exist today. Therefore, courts may address the refusal of such extraordinary measures. Similarly, the toleration of such actions does not defy the conscience.

Physician-assisted suicide, on the other hand, is a proposition contrary to nature: it involves the intentional alteration of the normal course of life. Additionally, not all physicians are capable of giving adequate pre-death counseling. "Given the stage of life at which physician-assisted suicide is likely to be an option, thousands of confused patients will be considered candidates for poisoning."²²⁹ "The notion that we can master death by orchestrating it is a conceit of the highest order."²³⁰

Politically speaking, the states should be cautious in their decisions regarding assisted suicide because of the mortal dangers involved. Confused and depressed patients may be targeted as suicide candidates when their ailments are treatable.²³¹ The voluntary consent issue provides too many loopholes for errors in judgment, and may result in the use of coercive techniques.

Oregon has taken the fatal first step down the slippery slope. Commentators believe other states will follow and, eventually, "the debate over assisted suicide will shift from whether to allow the practice to when."²³² Oregon's action already has provided an incentive for patients to engage in forum-shopping for suicide assistance. Even in Michigan, which does not permit assisted suicide, Dr. Kevorkian was able to welcome a candidate all the way from Virginia.²³³

²²⁸ McGonnigal, *supra* note 200, at 97.

²²⁹ *Id.* at 115.

²³⁰ *Id.* at 108.

²³¹ See DeFurio, *supra* note 2. According to news accounts, the first patient to die under the auspices of Oregon's Death with Dignity Act did not take the lethal drug because she was in pain, but rather, she desired to be "relieved of all the stress" that a diagnosis of breast cancer had caused her. She could no longer "walk very good" or work in her garden. *Id.*

²³² Rob Eure, *Some Expect Other States to Follow Oregon*, PORTLAND OREGONIAN, Mar. 27, 1998, at A18, available in 1998 WL 4193511 ("At some point, people will say this is a reasonable medical procedure. Then they will begin to question why we limit the law to those who have six months to live. What is the magic in six months?").

²³³ See Lowe, *supra* note 108 and accompanying text.

It is crucial that the states make their decisions on assisted suicide legalization or prohibition with acute insight into the inherent dangers of euthanasia and assisted suicide. As Chief Justice Rehnquist noted, the slippery slope is apparent in other cultures;²³⁴ the United States must both note its existence and heed its warning. The citizens of this country should feel fortunate that the right-to-die movement has not advanced as far as it has in the Netherlands.

At this crucial point in the national debate over assisted suicide, it is imperative that the citizens of the United States learn from the Dutch experience and pull in the reins on the right-to-die movement before its position at the slope's summit advances over the edge. Legalization can lead only to an avalanche of subjective determinations by physicians on patient competency, which would permit discriminatory practices and numerous unnecessary deaths.

CONCLUSION

The Supreme Court has dispelled the notion of a constitutional right to die. Because the Court has left the issue for the individual states to decide in the midst of a heated controversy, it is vital to American society, and for the protection of patient autonomy, that citizens and lawmakers recognize the inherent dangers of a legal prescription for assisted suicide. In light of the numerous hazards to the patient and the potential denigration of the medical profession, the voting public must proscribe this license to kill before the slippery slope takes full effect.

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²³⁴ See *Washington v. Glucksberg*, 117 S. Ct. 2258, 2274 (1997) (commenting on the widespread euthanasia killings permitted in the Netherlands).