Don't Ask--Don't Tell: The Secret Practice of Physician-Assisted Suicide

Julia Pugliese
Note

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by

Julia Pugliese*

It hath often been said that it is not death but dying that is terrible.¹

Introduction

Initially, Dr. Ethan Green² was opposed to assisted suicide.³ However, he was forced to reevaluate his position when a patient with AIDS, Michael Ellis, asked him for help in ending his life. Dr. Green thought he would be able to dissuade Michael by suggesting an aggressive pain treatment plan. After consultation the patient refused to accept the treatment option. Michael wanted to die.

Dr. Green agonized over whether he should help Michael. He initially told Michael that he needed to know more about him and his views and about the situation before he could make a decision to help. Dr. Green learned that Michael had “had AIDS for five years, . . . nursed his lover through the end stages of AIDS, and . . . talked about his own plans for assisted suicide with friends.”⁴ Dr. Green then consulted with a psychiatrist who “reported that the patient was not depressed, but steady and rational.”⁵ A little more than a month later, after much thought, Dr. Green decided to help.

The next step was to plan a method by which to conduct the assisted suicide. Although Dr. Green did consult with a doctor whom he trusted,

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2. The names of the doctor and the patient have been changed.
4. Id.
5. Id.
he was generally uncomfortable discussing assisted suicide with colleagues. Instead, he turned to books. Based on much research, Dr. Green devised a plan by which Michael would take an overdose of medication. Dr. Green wrote the patient a prescription for a month's supply of barbiturates. One week later he wrote a prescription for a potent narcotic elixir for pain. Two days after receiving the second prescription, Michael decided the time had come to effectuate his decision.

Michael called Dr. Green to his home. Several of Michael's friends were there to say their final goodbyes. Michael said goodbye to Dr. Green and thanked him. He then took all of the pills and drank the narcotic. Michael lied down and Dr. Green stepped out of the room. When Dr. Green returned, Michael was dead.

Dr. Green remained at the home after the death to deal with remaining formalities. At this point, Dr. Green realized that he had not thought his assistance completely through. If Dr. Green reported suicide as the cause of death on the death certificate, the medical examiner would have to be notified and an autopsy would have to be conducted. Dr. Green wanted to avoid an autopsy for the sake of the family and for his own interests. He knew that at least at some level what he did was illegal. Thus, Dr. Green classified the death as natural, resulting from AIDS. As he filled out the death certificate he knew he was stretching the truth.

In addition to the entries on the death certificate, Dr. Green was forced to take other precautions to avoid any detection of what had occurred. Throughout the two months he was with the patient, he did not keep any official record of their plan. Also, after the death, he removed all of the empty pill and narcotic containers from the scene. Thus, through lies and coverups, Dr. Green was able to protect himself while fulfilling the desire of his patient to end his life.

Dr. Green is just one example of the many doctors that have become involved in the secret practice of physician-assisted suicide.

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6. Many terms have been used to describe assisted suicide, including “physician-assisted suicide,” “rational suicide,” “self-deliverance,” “passive euthanasia,” “active voluntary euthanasia,” and “mercy killing.” “Self-deliverance” is the term used by the Hemlock Society, an organization formed in 1980 in Los Angeles to campaign for the right of a terminally ill person to choose assisted suicide. DEREK HUMPHRY, FINAL EXIT 201 (1991). “Mercy killing” is defined as euthanasia or the “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 988 (6th ed. 1990).

A distinction is often made between assistance involving an affirmative act by the person helping, whether it be a doctor, family member, or friend, and passive assistance in the form of providing information or the means necessary to commit the act. Both the New England Journal of Medicine and the Journal of the American Medical Association distinguish physician-assisted suicide (as passive) from euthanasia (as active): “Assisted suicide . . . differs from euthanasia in the extent to which the physician participated in the process. In assisted suicide,
nately, this secret practice of assisted suicide "has left little information available on the perilous realities of this controversial and officially condemned practice: how a doctor decides; what criteria were used; and, finally, how death is assisted."  

Despite participants’ secrecy, however, the controversy over physician-assisted suicide has heated up with the failure of recent legislative attempts at legalizing physician-assisted suicide and the constant news coverage about Dr. Jack Kevorkian, dubbed "Doctor Death" and "the Suicide Doctor." While the right to refuse treatment has gained legal acceptance, disagreement still exists over the legality of providing affirmative assistance to a patient in ending her life. However, the objectives of both procedures are so similar that to criminalize the latter while constitutionally protecting the former is arguably hypocritical. Additionally, despite the prohibition of assisted suicides in most states, the acts still often occur, and the current law does not protect the interests of those involved. 

The United States Supreme Court recently recognized that the "right to refuse treatment is encompassed by a generalized constitutional right to privacy." Recognizing that patients have the right to refuse treatment provides a first step toward assuring terminally ill patients the right to autonomy and self-determination. In fact, some commentators have argued that the constitutional right to privacy includes the right to assisted suicide. The Supreme Court has never accepted this view. Other commentators have suggested that international human rights law...
protecting individual autonomy should encompass assisted suicide, at least for the terminally ill. Lastly, some commentators have proposed assisted suicide as "good public policy based on principles of autonomy and self-determination—the right to control one's body, destiny, and health care."  

This Note does not attempt to resolve the issues of whether assisted suicide is constitutionally or internationally protected. Instead, it focuses on the need for legislation in this area of the law. The issue of physician-assisted suicide involves fundamental public policy questions which are more appropriately resolved by the legislature and not the judiciary. Recently, there has been an increase in societal support for the concept of legalized assisted suicide. Citizens, through their elected representatives, should enact laws which permit the terminally ill to legally choose physician-assisted suicide as a means to end their pain and suffering. If the question is left to the judiciary, courts may have difficulty finding a "right" to assisted suicide rooted in the Constitution. Moreover, even if courts could find a constitutional basis for such a right, they would have difficulty providing explicit guidelines to describe the extent of the right.

On the other hand, if the states legislate thorough guidelines regarding physician-assisted suicide, courts will only have to determine whether an assisted suicide was done in accordance with set standards. Legislators could hold hearings and consider the opinions of professionals to create legislation allowing legalized physician-assisted suicide in accordance with specific guidelines.

State legislatures have already taken steps toward allowing patients autonomy and control over their health care. State legislatures must now take the next logical step. They must decide what to do about competent, terminally ill patients who are in great pain and wish to end their suffering, yet can survive without extraordinary medical treatment.

This Note attempts to show why this legislation is needed and proposes a plan for legislatures to follow. Part I of this Note examines the reality of assisted suicides and the probable rise in their frequency with technological advances in medicine. Based on this realization, Part I argues that state legislatures must confront the inevitability of assisted suicide by providing realistic guidelines that will protect the interests of patients and doctors and will deter abuses. Part II addresses current

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15. Garbesi, supra note 13, at 10 n.81.


17. See infra notes 207-212 and accompanying text.

18. See infra text accompanying notes 145-149.

legal, medical, and public views about physician-assisted suicide. Part III considers past attempts at legislation of physician-assisted suicide and possible reasons for their failure. Additionally, it briefly analyzes the recent legalization of assisted suicide in the Netherlands as a potential guideline for the United States. Finally, Part IV proposes legislation that would allow physician-assisted suicide to be performed in a safe and controlled manner.

I. Questioning the Law

Currently, most states have laws prohibiting assisted suicide.\(^\text{20}\) However, the effectiveness of these laws is questionable. Without any legal alternatives for the terminally ill to end their pain and indignation through death, patients are left with the Hobson's choice of either suffering or evading the law. Subpart A of Part I discusses the current laws against assisted suicide. Subpart B describes the overall lack of enforcement of these laws. Subpart C explains the dangers involved when terminally ill people attempt to bypass the law. Subpart D exposes the fact that, despite the laws, numerous doctors currently assist terminally ill patients in dying. Finally, Subpart E describes people who choose to end their suffering by killing themselves. Terminally ill people who choose to evade the law, either through the help of family, friends, or a sympathetic doctor, are faced with numerous risks, both for themselves and those from whom they ask for help. Physician-assisted suicide must be legalized and carefully regulated to eliminate these risks and to protect everyone involved.

A. Laws Prohibiting Assisted Suicide

A majority of states currently have statutes prohibiting assisted suicide. These statutes either categorize successfully aiding suicide as murder or manslaughter, or they create a specific crime. For example, California’s statute against assisted suicide, unchanged since its adoption in 1873, provides that “every person who deliberately aids or advises, or encourages another to commit suicide is guilty of a felony.”

Some states make a distinction between aiding a suicide and murdering a willing victim. Oregon, for example, will charge a person who provides another with the means to commit suicide under the states’ assisted suicide statute. However, a person who actually commits the act that results in the death of another is charged with murder, instead of aiding a suicide.

The Model Penal Code suggests another approach: varying the punishment depending on the intent of the assistant and the outcome. The Model Penal Code finds criminal homicide when a person “purposely causes . . . suicide by force, duress or deception.” If the person merely “aids or solicits another to commit suicide,” the charge depends on the result of the aid. If a suicide or attempted suicide results from a person’s aid or solicitation, the crime is a second degree felony. If no suicide or attempted suicide results, the crime is a misdemeanor.

By prohibiting assisted suicide these state statutes and the Model Penal Code prevent the terminally ill from requesting aid from others without also requesting that they break the law. Since “the consent of

24. The distinction, according to the Oregon Supreme Court, is as follows: [The Oregon statute on assisted suicide] does not contemplate active participation by one in the overt act directly causing death. It contemplates some participation in the events leading up to the commission of the final overt act, such as furnishing the means of bringing about death—the gun, the knife, the poison, or providing the water, for the use of the person who himself commits the act of self-murder. But where a person actually performs, or actively assists in performing, the overt act resulting in death, such as shooting or stabbing the victim, administering the poison, or holding one under water until death takes place by drowning, his act constitutes murder, and it is wholly immaterial whether this act is committed pursuant to an agreement with the victim, such as a mutual suicide pact.
25. OR. REV. STAT. § 163.125(1)(b).
26. Shaffer, supra note 19, at 351 n.32.
27. Id.
29. Id.
30. Id.
31. Id.
the victim of a homicide is not of itself a defense to a charge of murder . . . an expressed desire or plea for another to end one's life will not avail the defendant.” Purportedly, these statutes are designed to protect the suicidal individual by providing a bright line rule against improper motives of or undue influence by those who assist. However, given the inevitability of assisted suicide, these statutes fail to address the real interests of the terminally ill patient who wants to die. By criminalizing all assisted suicide, these statutes fail to “provid[e] some guiding framework for a terminally-ill patient seeking choices for relieving his or her pain.” Legislatures must create laws that continue to protect against potential abuse but also provide the means for competent terminally ill patients to rationally choose assisted suicide.

B. Lack of Enforcement of the Laws

Despite the prohibition against assisting suicide, there appears to be a lack of enforcement of the law. One author noted:

The current law is being ignored. Police are not reporting mercy killings and assisted suicides; district attorneys are not prosecuting them; grand juries are not indicting; and, when a rare case does go to trial, juries are acquitting. Is this better than having a law that would provide regulations about a practice that desperate people are exercising surreptitiously?

The reasons for this lack of enforcement are multifarious. Most of the documented reports of assisted suicides do not come from case law, but from newspaper articles and personal accounts, possibly indicating prosecutors' decisions not to prosecute these cases. Prosecutors have broad discretion in deciding whether to bring charges for assisting in a suicide. For example, “[a] member of the New York County District Attorney's office in Manhattan observed that a case-by-case method is used to evaluate suicide incidents brought under specific state laws

32. Garbesi, supra note 13, at 95-96.
33. Shaffer, supra note 19, at 358.
34. See infra Part I.B-E.
37. From 1930 to 1985 no state court decisions on actual prosecution for assisted suicide appeared in any of the official state reporters. Shaffer, supra note 19, at 358. Similarly, as of 1982, “[n]o published American opinions . . . reported convictions of physicians for aiding, abetting, or assisting suicide.” Engelhardt & Malloy, supra note 22, at 1029.
38. For example, “[o]ne reporter profiled a woman with 'Lou Gehrig's disease' whose death was secretly arranged, at her request, to occur 'on a couch at home.'” Shaffer, supra note 19, at 369 & n.120 (citing Andrew H. Malcolm, To Suffer a Prolonged Illness or Elect to Die: A Case Study, N.Y. TIMES, Dec. 16, 1984, § 1, at 1); see also infra notes 42-52 and accompanying text.
prohibiting either aiding or abetting suicide." It appears that many prosecutors will not prosecute if they believe that the act was done out of compassion for an ailing loved one. In 1977, it was reported that no charges were brought against a man who reported to the District Attorney that he had permitted a 75-year-old friend who suffered from Parkinson's disease to use his home to commit suicide by taking an overdose of drugs. The decedent, the man said, had been a friend for over 39 years.

Even when charges are brought, sympathetic juries often refuse to convict. For example, in 1992, after only ninety minutes of deliberation, a jury acquitted Dick Bauer of manslaughter for "giving his chronically ill mother the gun that she used to kill herself a few minutes later." Similarly, physicians prosecuted for assisted suicide traditionally have not been convicted. In 1950, a New York Times article reported that a doctor was acquitted after injecting "a fatal air embolism into the blood vessels of a carcinoma patient, who had repeatedly urged him to end her misery." In 1973, a New York doctor was found not guilty of assisting suicide after administering a lethal injection to a comatose patient. More recently, a grand jury decided not to indict Dr. Timothy Quill, who admitted in the New England Journal of Medicine that he aided a terminally ill patient in committing suicide by prescribing the barbiturates she used to end her life. One author noted that "[i]n a

43. "Even if there is a full-blown trial, experience of recent euthanasia trials points to ... 'jury nullification' . . . . There is now a considerable record of grand juries refusing to indict, and juries refusing to convict, in euthanasia trials." Derek Humphry, Dr. Kevorkian's Assisted Suicide Tactics Could Derail Law Reform, HEMLOCK Q., Apr. 1992, at 5; see, e.g., Doctor Freed in Wife's Death, N.Y. TIMES, Dec. 2, 1988, at A20; Florida Doctor Acquitted in Mercy Killing of Wife, CHI. TRIB., Dec. 2, 1988, § 1, at 21.
44. Acquittal in Aided Suicide, N.Y. TIMES, Feb. 15, 1992, § 1, at 10.
45. Engelhardt & Malloy, supra note 22, at 1029 & n.127 (citing N.Y. TIMES, Mar. 7, 1950, at 1).
46. Id. at 1029 (citing HOUSTON CHRON., June 22, 1973, § 4, at 10).
47. Robert J. Blendon et al., Should Physicians Aid Their Patients in Dying?, 267 JAMA 2658, 2658 (1992); see also David R. Schanker, Of Suicide Machines, Euthanasia Legislation, and the Health Care Crisis, 68 IND. L.J. 977, 986 n.41 (1993) (citing DEREK HUMPHRY, EUThANASIA 129-35 (1991)) ("In Michigan in 1989, Dr. Donald Carraccio pleaded guilty to the murder by lethal injection of a comatose 74-year-old woman; he received 5 years probation with community service.").
state where individuals convicted of assisted suicide could face between five and ten years in prison, the grand jury's decision was an important indicator of the general direction of the debate over euthanasia in this country.\textsuperscript{48}

In the unusual instance when someone is convicted for assisting suicide, the sentence tends to be light and the defendants generally receive probation time.\textsuperscript{49} For example, a retired Florida man assisted his cancer-ridden wife in committing suicide by preparing an overdose of sedatives and then helping her put a plastic bag over her head.\textsuperscript{50} When he confessed two years later, he was sentenced to only one year of probation, forty hours of community service, and continued psychiatric treatment under a statute which had a possible fifteen year maximum penalty.\textsuperscript{51}

C. Dangers in Bypassing the Law

The failure of state legislatures to confront the realities of assisted suicide dooms suicidal patients to inadequate means by which to accomplish their goals. Since no states have legalized physician-assisted suicide, usually terminally ill people who wish to end their suffering through

\textsuperscript{48} Blendon, supra note 47, at 2658.
\textsuperscript{49} "Jesse James Quinn, age eighty-seven, was arraigned on January 23, 1992, for helping his wife commit suicide by leaving a gun on her nightstand. The case was resolved by the judge without a guilty or innocent plea; Mr. Quinn agreed to undergo counseling for a year and give up his firearms in return for eventual dismissal of charges." Cheryl K. Smith, \textit{What About Legalized Assisted Suicide?}, 8 ISSUES L. & MED. 503, 508 (1993) (citing SACRAMENTO BEE, Jan. 24, 1992, at B1).

Wallace Cooper pled guilty to voluntary manslaughter for giving a lethal injection of morphine and the heart drug digoxin to his uncle, who was suffering from three terminal illnesses: congestive heart failure, kidney failure, and chronic intestinal bleeding. \textit{Love and Death: A Mercy Killer's Anguish}, L.A. TIMES, Jan. 30, 1986, at 1. The Superior Court Judge sentenced Cooper to five years probation, finding that his actions were motivated by compassion and not malice. \textit{Id}.

Prosecutors dropped a murder charge and recommended probation of Jay McFadden, who pleaded guilty to a lesser charge in the "mercy killing" of his wife, who had been suffering from multiple sclerosis. \textit{Murder Charge Dropped in Mercy Killing}, L.A. TIMES, Sept. 19, 1986, at 1.


A Michigan court convicted a man of manslaughter after he helped his 65-year-old ailing wife commit suicide with carbon monoxide. N.Y. TIMES, Jan. 14, 1975, at B5. He was sentenced to 30 months probation and fined $3,750. \textit{Id}.

An elderly woman received a six year suspended sentence after a no contest plea to a voluntary manslaughter charge based on her assistance to her 81-year-old sister suffering from a painful, deteriorating heart condition. Candee Wilde, UPI, May 26, 1982, \textit{available in LEXIS}, Nexis library, UPI File.

\textsuperscript{50} Shaffer, supra note 19, at 360 n.79 (citing UPI, Sept. 11, 1984).
\textsuperscript{51} \textit{Id}. 
death have only family and loved ones to turn to for assistance.\textsuperscript{52} As a result, a request for assistance presents a unique dilemma to those asked to assist: assisting suicide is illegal, yet refusing to assist would deny a terminally ill loved one relief from pain and distress.

Even if a friend or family member agrees to assist in the suicide, they might not know what to do or have the courage to complete the action. For example, a 1992 \textit{San Francisco Chronicle} article featured Steven Shiflett, an AIDS patient who planned his death by requesting a friend to administer a lethal injection.\textsuperscript{53} Steven thought he had chosen an appropriate and reliable friend to help him die because the friend was also infected with the AIDS virus and “spoke confidently of how he had helped four other AIDS patients die, smothering one by holding his hand over his mouth and pinching his nose.”\textsuperscript{54} When the time came for the friend to administer the lethal injections, however, he lost his nerve and deserted Steven with the job only half finished.\textsuperscript{55} Fortunately, other friends were present. They called Steven’s doctor, who knew of Steven’s desire to die and who told them how to complete the assisted suicide.\textsuperscript{56} Reflecting on the situation, the doctor felt as if he had “crossed the line” by instructing Steven’s friends, but he realized that “Steven was looking to shorten his death, not to shorten his life.”\textsuperscript{57}

D. Physicians Assisting Suicide

Until assisted suicide is legalized, the most capable assistants, physicians, will be even more hesitant than family or friends to assist terminally ill patients in death. When physicians make the choice to assist in suicide, they risk not only potential criminal liability, but also damage to their careers. Moreover, physicians who agree to assist with a suicide violate the medical profession’s published guidelines as well as the law.\textsuperscript{58}

Despite the risks to their careers, many doctors have reported assisting terminally ill patients in dying.\textsuperscript{59} Dr. Jack Kevorkian is the most publicized physician performing assisted suicide. In 1990, Kevorkian assisted Janet Adkins, a fifty-four-year-old woman with early Alzheimer’s disease, in ending her life by the use of his “suicide machine.”\textsuperscript{60} Murder

\textsuperscript{52} \textit{See supra} notes 42-44 and accompanying text.


\textsuperscript{54} \textit{Id.}

\textsuperscript{55} \textit{Id.}

\textsuperscript{56} \textit{Id.}

\textsuperscript{57} \textit{Id.}

\textsuperscript{58} \textit{See} Fred Rosner et al., \textit{Physician-assisted Suicide}, 92 N.Y. St. J. Med. 388, 391 (1992) (explaining that the American Medical Association takes the position that “physicians should not perform euthanasia or participate in assisted suicide”).

\textsuperscript{59} \textit{See text infra} at notes 110-113.

\textsuperscript{60} Yeates Conwell & Eric D. Caine, \textit{Rational Suicide and the Right to Die}, 325 \textit{N. Eng. J. Med.} 1100, 1100 (1991). Kevorkian’s original suicide machine consisted of an intra-
charges were brought against the doctor. However, since Michigan did not at that time have a statute prohibiting assisted suicide and Kevorkian did not affirmatively act to assist in Adkins’s death, the charges were dismissed. A Michigan circuit court held that “in the absence of specific laws against assisting suicide, there could be no probable cause that the doctor had committed murder.”61 The court did, however, invoke Michigan criminal law and the Public Health Code to support an injunction prohibiting Kevorkian from using his “suicide machine” in the future.62 Nevertheless, Kevorkian indicated that he intended to use his machine on other occasions and to establish a practice of rational suicide.63

Kevorkian’s actions led to the suspension of his Michigan medical license in 1991.64 Ignoring the suspension of his license and the injunction prohibiting him from assisting suicides, Kevorkian assisted in the deaths of two more women in 1992.65 Following Kevorkian’s actions, legislation was signed by the Michigan governor establishing assisted suicide as a felony punishable by up to four years in prison and a $2,000 fine.66 The law was scheduled to take effect ninety days after its passage. In the meantime, Kevorkian continued assisting others.67

venous tube connected to three bottles containing three different solutions. Kevorkian inserted the tube into Janet Adkins’s arm and began a drip of harmless saline solution through it. Adkins then pressed a button which replaced the saline with thiopental, a coma-inducing drug. A minute later the machine switched solutions again to potassium chloride, which stopped her heart and caused her death within minutes. Lisa Belkin, Doctor Tells of First Death Using His Suicide Device, N.Y. TIMES, June 6, 1990, at A1. After Kevorkian’s medical license was suspended, see infra note 64 and accompanying text, he could no longer obtain potassium chloride so he switched to carbon monoxide gas as a means of death. To begin the flow of gas, the individual would pull a string attached to a clip on a plastic tube running from the carbon monoxide to the mask covering her face. Within minutes, the person would be dead. David Margolic, Doctor Who Assists Suicides Makes Macabre Mundane, N.Y. TIMES, Feb. 22, 1993, at A1.


63. Marcinko, supra note 35, at 628.

64. In Wake of 3 Suicides, Dr. Kevorkian Loses Michigan License, CHI. TRIB., Nov. 21, 1991, at C16 (stating that on November 20, 1991, the Michigan Medical Association suspended Kevorkian’s license to practice medicine in that state). Additionally, California revoked Dr. Kevorkian’s medical license on April 27, 1993. Steve Marshall, “Dr. Death” Loses California License, USA TODAY, April 28, 1993, at 3A. In a telephone interview with the Associated Press, Kevorkian stated, “The license is immaterial to me as long as I can help suffering humans.” Id.


66. Id.

claimed that even after the law took effect on March 30, 1993, he would continue to assist people in ending their lives.68

In an effort to halt Kevorkian's actions, the Michigan Senate and House of Representatives approved legislation that would move the effective date of the ban against assisted suicide up to February 25, 1993.69 The governor signed the new legislation hours after its approval.70 Almost immediately, the American Civil Liberties Union (ACLU) announced plans to challenge the new law.71 The ACLU filed a suit on behalf of some terminally ill cancer patients, at least six physicians who treat fatal illnesses, and the Michigan chapter of the American Association of Retired Persons.72

The same day that the legislation was signed, Michigan police searched Kevorkian's home and the home of his assistant, Neal Nicol.73 The police stated that they were conducting a murder investigation for the death of Hugh Gale, the thirteenth person to die with Kevorkian's assistance.74 The investigation was prompted by a report retrieved by a member of the Christian Defense Coalition, an offshoot of Operation Rescue, from the trash outside Nicol's home.75 The report stated that while Gale had asked Kevorkian to stop the procedure twice, Kevorkian only had removed the mask supplying carbon monoxide the first time.76 Gale's widow and Kevorkian's attorneys denied that there was ever a request to stop the procedure.77 They claimed that the report was an erroneous description of what had happened, which was discarded once the errors were discovered.78 The police found a second report in Kevorkian's apartment which did not refer to any second request.79

Macomb County prosecutor Carl Marlinga stated that prosecuting Kevorkian would be difficult, even if they could prove that the report of the second request was accurate.80 Marlinga explained, "Even assuming we could prove that Mr. Gale was asking that the mask be removed . . .

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68. See, e.g., Suicide Doctor Assists in 10th, 11th Deaths, supra note 67.
70. Id.
71. Id.
72. Id.
73. Id.
74. Id.
75. Id.
76. Id.
77. Edward Walsh, Prosecutor, Kevorkian Mull Next Step; Critics Say Man Tried to Abort His Suicide, WASH. POST, Feb. 27, 1993, at A3; Widow Says Husband Did Not Ask Kevorkian to Stop, STAR TRIB. (Detroit), Feb. 27, 1993, at 7A.
78. Walsh, supra note 77, at A3.
79. Id.
80. Carol J. Castaneda, Aided-Suicide Ban Faces Challenge; ACLU Says the Decision to Die an Individual Right, USA TODAY, Mar. 1, 1993, at 6A.
that still doesn’t mean we could move to a homicide charge without analyzing what Kevorkian’s legal obligations were in that situation.”

Since the Michigan law prohibiting assisted suicide was not in effect at the time of Gale’s death, Kevorkian could not be prosecuted under that law. Kevorkian never was charged with Gale’s death.

Marlinga found that “[t]hose present at the time of [Gale’s] death did nothing more than provide a means for him to accomplish a result he desired.” Marlinga’s decision not to prosecute was made while the ACLU’s suit challenging Michigan’s newly enacted law was still pending.

Kevorkian was arrested again after his sixteenth assisted suicide. It was the first assisted suicide in which he participated since Michigan’s ban took effect. Kevorkian’s action was contrary to his earlier statements that he would wait until the ACLU had completed its constitutional challenge to the law before performing any additional suicides. However, before Kevorkian could be charged with committing a felony, Judge Cynthia Stevens, a Wayne County Circuit Court judge, struck down the law on technical grounds. She ruled that it had been passed before the required legislative hearings were held.

The court of appeal subsequently stayed Judge Stevens’ decision. Consequently, the legal status of the Michigan assisted suicide law has been undetermined. With the law in a state of flux, Kevorkian has dared authorities to prosecute him by assisting in the death of a seventeenth person. The day after the death, Kevorkian provided details of the suicide in an effort to speed up the arrest process so that the issue of assisted suicide would be resolved. Kevorkian “supplied the carbon

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81. Id.
82. Id.
83. Marshall, supra note 64.
84. Carol J. Castaneda, Kevorkian Defies Law, Aids Suicide, USA TODAY, May 17, 1993, at 1A.
85. Id.
86. Carol J. Castaneda, Kevorkian Tests Michigan Law; Arrested After Aiding 16th Suicide, USA TODAY, May 17, 1993, at 3A.
88. Id.
89. Id.
90. Id. Thomas W. Hyde, the youngest person (age 30) to commit suicide with Kevorkian’s assistance, was suffering from Lou Gehrig’s disease. Id.
91. Suicide Doctor Tries to Speed Up Own Arrest, S.F. CHRON., Aug. 6, 1993, at A3.

Kevorkian stated:

I drove [Hyde] to Belle Isle. I supplied the gas. I supplied the tubing and the mask and all necessary equipment. I connected the tubing to the tank. I put the clip on the tubing. I put the mask over Mr. Hyde’s face because he could not move that much. I turned on the gas by the main valve on the tank. I asked him one more time if he was sure what he was doing. He looked up with a sort of pleasant face and pleasant eyes and a moan or two and I thought I heard him say, ‘I’m fine.’
monoxide, tubing, face mask and other equipment for Thomas Hyde to take his life.”\textsuperscript{92} Additionally, he “put the mask over Hyde's face because [Hyde] could not move.”\textsuperscript{93} However, Hyde himself pulled the string that released the flow of deadly gas into the mask.\textsuperscript{94}

On August 17, 1993, John O'Hair, Wayne County prosecutor, decided to prosecute Kevorkian under Michigan's assisted-suicide law.\textsuperscript{95} O'Hair stated that Kevorkian violated the existing law and therefore must be prosecuted. However, despite his obligation under the law to prosecute Kevorkian, O'Hair stated that he supported the idea of legalized physician-assisted suicide and that he would recommend its legalization to a state panel studying the issue.\textsuperscript{96} O'Hair hoped that prosecuting Kevorkian would incite the state legislature and the courts to resolve the issue of physician-assisted suicide.\textsuperscript{97}

On September 9, 1993, Kevorkian was ordered to stand trial for assisting in the death of Thomas Hyde.\textsuperscript{98} Detroit District Judge Willie G. Lipscomb, Jr. set arraignment for September 24, 1993.\textsuperscript{99} The Washington Post reported that Lipscomb stated that Kevorkian was “a very courageous person” for “bringing this issue to the forefront.”\textsuperscript{100} Additionally, Judge Lipscomb reportedly stated in his ruling that he supported the idea of having state legislatures regulate physician-assisted suicide instead of leaving it to the discretion of individual doctors and their patients.\textsuperscript{101}

Kevorkian remained free on a personal bond pending his trial.\textsuperscript{102} A few hours after Judge Lipscomb's order to stand trial, Kevorkian participated in his eighteenth suicide.\textsuperscript{103} As a result of his action, Kevorkian faced a second felony charge. This time the assistant prosecutor handling the case asked for a $250,000 cash or surety bond in an effort to keep Kevorkian in jail.\textsuperscript{104} Judge Richard Manning instead imposed a $10,000 cash bond with the explicit condition that Kevorkian refrain

92. \textit{Suicide Doctor Tries to Speed up Own Arrest}, supra note 91.
93. \textit{Id.}
94. \textit{Id.}
96. \textit{Id.} at A13.
97. \textit{Id.}
99. \textit{Id.}
100. \textit{Id.}
101. \textit{Id.}
102. \textit{Kevorkian Charged in Latest Suicide}, CHI. TRIB., Sept. 15, 1993, at 3M.
103. \textit{Id.}
104. David Zeman, \textit{Kevorkian Charged, Remains Free; Bond Posted in 2nd Suicide Case}, DET. FREE PRESS, Sept. 15, 1993, at 1B.
from assisting in any additional suicides while the case was pending.\textsuperscript{105} It seems unlikely that this mandate will affect any of Kevorkian’s future decisions regarding helping someone to die. In an interview, Kevorkian stated, “‘As long as there’s one suffering patient, if only person supports me, I would still do this. . . . I couldn’t live with myself otherwise, because it’s right.’”\textsuperscript{106}

Although Kevorkian has helped to bring the issue of physician-assisted suicide into the limelight, many commentators question his actions and judgment. Many people who support physician-assisted suicide do not support his methods.\textsuperscript{107} One commentator noted, “[Kevorkian has] ignited debate, just as he sought to do. But his clumsy suicide machines, turned over to patients he barely knows, with the entire spectacle replayed on TV, make a mockery of the term.”\textsuperscript{108} These commentators believe that Kevorkian’s actions actually hinder the movement toward legalizing physician-assisted suicide.

While Kevorkian’s physician-assisted suicides have received the most publicity, he is not the first physician to assist terminally ill patients in dying.\textsuperscript{109} Kevorkian’s tactics have helped to focus America’s attention on the debate but he is not alone in the practice of physician-assisted suicide. It is unknown exactly how many physicians participate in assisted suicide, but it is certainly not an uncommon occurrence.\textsuperscript{110} “[M]any physicians privately admit that they helped patients with incurable illnesses by injecting overdoses or writing prescriptions for drugs potent enough to end their patients’ suffering.”\textsuperscript{111} In one study, forty percent of the doctors surveyed said that they had aided at least one terminally ill patient in dying.\textsuperscript{112} Another survey found that forty-five

\textsuperscript{105} Id.

\textsuperscript{106} David Zeman, Kevorkian’s Bond May be Shaky; Angry Prosecutor May Jail Him Following 18th Assisted Suicide, DET. FREE PRESS, Sept. 11, 1993, at 3A.

\textsuperscript{107} HUMPHRY, supra note 6, at 153 (noting that even those from the progressive wing of the medical profession, who supported Kevorkian initially, later withdrew their support). For a response to Kevorkian’s actions, see Isabel Wilkerson, Opponents Weigh Action Against Doctor Who Aided Suicides, N.Y. TIMES, Oct. 25, 1991, at A10.

\textsuperscript{108} Kevorkian May Harm Death-With-Dignity Cause, USA TODAY, Mar. 4, 1993, at 12A.

\textsuperscript{109} See supra note 43 and accompanying text.

\textsuperscript{110} Shaffer, supra note 19, at 370 (“In the area of ‘negotiated death’—the consensual termination with doctors, lawyers, and family members of a terminally ill or comatose person’s life—indications are that cases of suicide assistance are common.”).


\textsuperscript{112} Patty Fisher, Whose Death Is It Anyway?, SAN JOSE MERCURY NEWS, Oct. 4, 1992, at 7P.
percent of the physician respondents had taken clinical actions that would indirectly cause a patient’s death, while 9.4 percent took actions that directly caused death.\textsuperscript{113}

Interviews this year by \textit{The Boston Globe} uncovered doctors who engage in the hidden practice of physician-assisted suicide.\textsuperscript{114} One doctor, a veteran oncologist at one of Boston’s leading hospitals, admitted to helping as many as twenty-five patients to die over the past two decades.\textsuperscript{115} He was assisted by his nurse, who administered a lethal mix of morphine patches, tablets, and elixirs to the patient.\textsuperscript{116} The doctor noted that if authorities were to compare his escalating morphine prescriptions, which are recorded with the Food and Drug Administration, with the obituaries, they probably would become suspicious.\textsuperscript{117} However, he knows that he could cover himself by stating that his patient was in terrible, unremitting pain and that he merely tried to comfort her.\textsuperscript{118}

Although some physicians practice assisted suicide, legally they are in an awkward position. Doctors must “either ignore [the law] and quietly perform euthanasia—creating an unregulated and unpolic ed area of medicine—or . . . avoid performing medically acceptable acts of assistance for fear of liability.”\textsuperscript{119} Without the legalization of the process, physicians must act secretly, without the benefit of consultation with colleagues regarding whether a patient’s choice is rational,\textsuperscript{120} and without established guidelines for the process itself. Proper legislation could establish guidelines for what is a currently an unregulated practice.

E. Self-Assisted Suicide

Until assisted suicide is legalized, some patients will take matters into their own hands, rather than subject their doctor or loved ones to possible criminal prosecution. To help these patients achieve their goals, a number of do-it-yourself suicide manuals, which provide guidelines for committing suicide, have been published. The Society for the Right to Die With Dignity (EXIT) published the first manual in London.\textsuperscript{121} Subsequently, two French authors, members of the French Association for the Right to Die in Dignity (ADMA), co-authored \textit{Suicide: Operating

\begin{footnotes}
\item[114.] Dick Lehr, \textit{Increasingly, Secretly, Physicians are helping the Incurable Ill to Die, Boston Globe}, Apr. 25, 1993, at 1.
\item[115.] \textit{Id.}
\item[116.] \textit{Id.}
\item[117.] \textit{Id.}
\item[118.] \textit{Id.}
\item[119.] Note, \textit{supra} note 111, at 2039.
\item[120.] Wanzer et al., \textit{supra} note 6, at 848.
\item[121.] Smith, \textit{supra} note 40, at 303 & n.199 (citing \textit{Society for the Right to Die With Dignity (EXIT), A Guide to Self-Deliverance} 1 (1981)).
\end{footnotes}
Instructions. In 1991, Derek Humphry, founder and director of the National Hemlock Society, wrote Final Exit: The Practicalities of Self-Deliverance and Assisted Suicide for the Dying. This book provides a step-by-step description of how to commit suicide and includes tables describing the proper drugs and amounts necessary to end one's life. Final Exit became the number one best-selling nonfiction hardcover book in America in 1991 and topped the New York Times' best-seller list for eighteen weeks, demonstrating the public interest in this area.

In June of this year, Humphry led a seminar in San Francisco where he discussed "which drugs to use for suicide, how to avoid a botched attempt and whether to involve . . . loved ones and doctors." The seminar was attended by over 150 people. A few of those attending had cancer or were friends or relatives of someone who did, but most of those in attendance were gay men with AIDS. Humphry's presentation included a demonstration of how to use a plastic bag and a rubber band for self-asphyxiation. Despite California's statute prohibiting aiding, encouraging, or assisting another to commit suicide, seminars and books on assisting suicide are "widely assumed to be protected by the Constitution's free speech guarantees." Furthermore, a newly organized group, called Compassion in Dying, announced plans to offer terminally ill patients the names of drugs that could be deadly. The group will not, however, assist in administering the drugs.

While these organizations and guides may provide valuable information that is difficult to obtain elsewhere, the use of such information could result in unsuccessful attempted suicides. As a result of an unsuccessful attempted suicide, the patient could be left in a debilitative, undignified, and dependent situation equal to or worse than that which she was trying to avoid. One physician describes the problem as follows:

An overdose of drugs taken orally is uncertain. The patient may vomit the drugs or may fall into a deep sleep only to wake again to the problem. The patient may have to rush to the end for fear of losing control of the situation with hospitalization. Unfortunately, without a cooper-

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122. Id. at 307 & n.236.
123. HUMPHRY, supra note 6.
124. Id. at 121-30.
125. Id. at xv.
126. Hemlock Society Holds Seminar for Those Diagnosed with AIDS, STAR TRIB. (Detroit), June 21, 1993, at 7A.
127. Id.
128. Id.
129. Id.
131. Hemlock Society Holds Seminar, supra note 126.
132. Elisabeth Dunham, New Group is Offering Life-or-Death Advice, L.A. TIMES, July 25, 1993, at 6B.
133. Id.
ating physician, the patient has insufficient information on which to base his decision.\textsuperscript{134}

Additionally, with the self-help approach, the dying patient must end her life in a secretive and unsupportive condition, instead of in a peaceful manner surrounded by loved ones. One author notes that often “the terminally ill are forced to spend their last hours alone in order to protect the ones they love from criminal or civil actions,” which “deprives them of a peaceful and dignified ending” to their lives.\textsuperscript{135}

Thus, statutes criminalizing assisted suicide often lead to increased pain, suffering, and loss of dignity for the terminally ill. While it is important to protect the terminally ill from potential abuse of assisted suicide, legislatures should work toward enacting statutes that “will both protect the innocent and help the competent terminally ill.”\textsuperscript{136} Statutes allowing physician-assisted suicide would serve these interests.

III. Self-Determination or Self-Destruction?: Current Opinions Regarding Physician-Assisted Suicide

The legal community, the medical community, and the public are moving toward acceptance of legalized physician-assisted suicide. Courts are focusing more on patient autonomy in health care decisions;\textsuperscript{137} surveys indicate that a majority of physicians favor legalized assisted suicide as a health care option;\textsuperscript{138} and public opinion polls demonstrate continually increasing societal support for physician-assisted suicide as a legal choice.\textsuperscript{139} Expanding support for assisted suicide is a natural response of an individualistic society in which people strive to be in control of their fate—especially when it involves life and death issues. Legalizing physician-assisted suicide would accommodate this desire for self-determination by providing individuals with an option.\textsuperscript{140}

Much of the opposition to legalization of physician-assisted suicide is based on the contention that assisted suicide is inherently immoral. These arguments focus on the idea that society has a strong interest in


\textsuperscript{137} See infra notes 167-173 and accompanying text.

\textsuperscript{138} See infra notes 192-193 and accompanying text.

\textsuperscript{139} See infra notes 208-213 and accompanying text.

\textsuperscript{140} John O'Hair, the attorney prosecuting Dr. Jack Kevorkian, supports legalization of physician-assisted suicide. In a plea to the Michigan Commission on Death and Dying to repeal the state's ban on assisted suicide, he argued that “a majority of people want to chart their own fate. They want to make their own choice.” Lori Montgomery, \textit{Panel Won’t Fight Assisted Suicide Ban; O’Hair Seeks Repeal of Law Aimed at Kevorkian}, Det. Free Press, Sept. 2, 1993, at 1B.
protecting all human life regardless of the wishes or beliefs of the person concerned.\footnote{See infra note 160 and accompanying text.} This Note does not attempt to argue that an individual is not entitled to her own moral belief about the sanctity of life and the value of preserving life. To the contrary, this Note attacks the imposition of those individuals' beliefs on other individuals who do not share them. This Part demonstrates that, as the goals of patient autonomy and self-determination become a more integral part of our social fabric, those opposing legalized physician-assisted suicide are becoming a minority. The moral beliefs of a minority of individuals should not dictate the actions of all of society.\footnote{Prosecuting attorney John O'Hair argued, "If I cannot end my own pain because somebody's morality would be offended, I find that offensive." Montgomery, supra note 140.} The laws of a society must reflect the moral views of a majority of its members. Furthermore, when society's views change, legislatures have a duty to address those changes. One judge noted, "If mores have changed to the extent that [euthanasia] can now be sanctioned, I would let that change arrive through the moral judgment of the people as expressed through their duly elected legislators . . . "\footnote{In re Grant, 747 P.2d 445, 458 (Wash. 1987) (Andersen, J., dissenting in part), vacated, 757 P.2d 534 (Wash. 1988). Although the case involved the withdrawal of nutrition and hydration, Judge Andersen found those actions to be equivalent to euthanasia.} Especially in light of the current secret practice of assisted suicide, legislatures are derelict in their duty by failing to respond to the dire need for regulation in this area.

A. Legal Opinions on Physician-Assisted Suicide

(1) Current Legislation Increasing Autonomy in Health Care Decisions

Currently, no statutes expressly permit physician-assisted suicide. However, a trend has developed in recent legislation granting patients more autonomy and personal choice in their health care decisions. Many years ago, Justice Cardozo stated that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body."\footnote{Schloendorff v. Society of New York Hosp., 105 N.E. 92, 93 (N.Y. 1914).} Legislatures have now begun enacting laws that will enable competent adults to exercise this right. For example, almost every jurisdiction has living will or natural death legislation.\footnote{See Charles P. Sabatino, Death in the Legislature: Inventing Legal Tools for Autonomy, 19 N.Y.U. REV. L. & SOC. CHANGE 309, 312 n.6 (1991-92).} These devices govern "the withholding or withdrawal of life-sustaining treatment from an individual in the event of an incurable or irreversible condition that will cause death within a relatively short time, and when such person is no longer able to make decisions regarding his or her medical treatment."\footnote{BLACK'S LAW DICTIONARY 1599 (6th ed. 1990).} Thus, competent individuals are permitted to state in ad-
vance their desire to have treatment withheld or withdrawn if they later become incompetent.

In addition to the living will, the durable power of attorney, which has been enacted in most states, enhances patient control. This instrument is commonly referred to as a proxy for health care decision making. A health care power of attorney "establishes a decision maker, chosen by the principal, who can fully weigh all the circumstances affecting any health care decision at the time they occur and act in accordance with the known wishes and values of the principal." These statutes enable the decision maker to instruct the physician to withhold life-sustaining treatments. Thus, current legislation mainly addresses the right of terminally ill patients to direct the withholding or withdrawal of treatment. The trend has been to grant patient autonomy. In keeping with this trend legislatures must now address the issue of terminally ill patients who do not require machines to survive, but who wish to avoid extreme suffering or the loss of dignity.

(2) Extending the Right to Withdraw or Withhold Treatment to Assisted Suicide Cases

Recent laws and court decisions focus mainly on the right to withhold or withdraw treatment, yet many scholars argue that assisted suicide is not fundamentally or morally different than withholding or withdrawing medical treatment. Some commentators argue that by assisting a patient in suicide, the doctor directly causes death. By withdrawing treatment, on the other hand, the doctor merely allows the illness to run its course. In fact, distinguishing withdrawal of nutrition and hydration that results in death of a patient from a lethal injection that merely hastens this result is arguably an illusory distinction. Much of the rationale used by courts in cases involving the withdrawal of treatment applies directly to cases of assisted suicide. One court rec-

147. See Sabatino, supra note 145, at 312 n.7.
148. Id. at 314.
149. McCoy, supra note 135, at 446 (citing CAL. CIV. CODE §§ 2400-2407 (West Supp. 1989)).
151. See Engelhardt & Malloy, supra note 22, at 1023 n.89; Rosenblum & Forsythe, supra note 16, at 25; Smith, supra note 40, at 337; Note, supra note 111, at 2029-31; Note, supra note 136, at 368-69.
154. See Note, supra note 111, at 2021, 2033 (arguing that "courts should evaluate physician-assisted suicide cases under the doctrinal framework that courts have established for
ognized that "the issue is not whether, but when, for how long, and at what cost to the individual [a] life may be briefly extended."\textsuperscript{155}

The distinction between assisting suicide and permitting an illness to fatally progress is becoming more blurred as medical technology advances.\textsuperscript{156} Even doctors reason that "[I]logically and emotionally, we cannot intervene at one phase and then be inactive at another, more painful phase. We cannot modify nature and then plead that nature must be allowed to run its unhindered course."\textsuperscript{157} If a physician withdraws or withholds treatment, the inevitable result of which is the patient's death, the physician is assisting in the patient's death. Instead of dying with a physician's aid, however, the terminally ill patient who is not dependent on some treatment must suffer through a painful death resulting from the illness. Unfortunately, "the ways diseases kill people are far more cruel than the way physicians kill patients when performing euthanasia or assisting in suicide."\textsuperscript{158} One author notes:

if society is willing to allow a terminally ill person to gasp away her life for an hour after a respirator is removed, why not permit her death through a doctor[s]' . . . administration of a lethal drug dosage? If, under certain circumstances, suicide can be viewed as permissible and even sympathetic, then surely speedy, humane methods for committing the act should be permissible.\textsuperscript{159}

Assisted suicide is the next logical step in granting patients the right of self-determination. Assisted suicide legislation would allow patients to end their lives peacefully, instead of suffering through what may be a slow and painful death.

Those who oppose physician-assisted suicide argue that states have a valid interest in protecting all human life.\textsuperscript{160} However, many others believe that when a person is so ill that "his or her life is without quality, purpose, or contribution and instead is filled with anxiety and pain,"\textsuperscript{161} this state interest is diminished.\textsuperscript{162} At least one court has recognized there is more to life than mere "corporeal existence."\textsuperscript{163} Some commen-
tators argue that other important qualities of life include "autonomy, human dignity, intellectual capability, physical fitness, and other aspects that contribute to personal well-being." Unfortunately, the terminally ill patient often relinquishes these important aspects of life, not only to an unremitting illness but also to a "therapy" that is limited to sedating pain control and minor symptomatic relief. In effect, many patients, families, and physicians must question if the treatment is worse than the disease. One physician who treats AIDS and cancer patients noted that physicians "can't control all of the pain. This issue is not just about pain but about quality of life and dignity as well as control of your own destiny." Therefore, decisions about patient care must address the mental and physical health of the individual. In Bouvia, the court further articulated the need to incorporate the patient's overall well-being into the state's interest of "preserving life" by stating:

it is [not] the policy of this State that all and every life must be preserved against the will of the sufferer. It is incongruous, if not monstrous, for medical practitioners to assert their right to preserve a life that someone else must live, or more accurately, endure, for "15 to 20 years." We cannot conceive it to be the policy of this State to inflict such an ordeal upon anyone.

Although Bouvia concerned the right to refuse medical treatment, its rationale is equally compelling in the realm of physician-assisted suicide.

The language of a recent California Supreme Court case regarding the withdrawal of treatment could similarly apply to physician-assisted suicide. In Thor v. Superior Court, the court held that "a competent, informed adult has a fundamental right of self-determination to refuse or demand the withdrawal of medical treatment of any form irrespective of the personal consequences." The distinction between treatment withdrawal and physician-assisted suicide blurs with the court's acknowledgment that "since death is the natural conclusion of all life, the precise moment may be less critical than the quality of time preceding it." While the court recognized a state interest in the preservation of life, it stated that "the state has not embraced an unqualified or undifferentiated policy of preserving life at the expense of personal autonomy." It also reasoned that the state's interest in the prevention of suicide is "a limited interest at best since it imposes no criminal or civil sanction for inten-

166. Bouvia, 255 Cal. Rptr. at 305 (Compton, J., concurring) (extending the majority's analysis of the right to refuse medical treatment to include assisted suicide).
168. Id. at 378.
169. Id. at 384.
170. Id.
171. Id.
tional acts of self-destruction." The language of *Thor* indicates the California Supreme Court's willingness to emphasize personal autonomy in health care decisions.

One judge has openly admitted his support for the right to assisted suicide. In *Bouvia*, Judge Compton stated in his concurring opinion:

The right to die is an integral part of our right to control our own destinies so long as the rights of others are not affected. That right should, in my opinion, include the ability to enlist assistance from others, including the medical profession, in making death as painless and quick as possible. The lesson from these cases is simple: States should not seek to preserve human life to the exclusion of all competing interests. Instead, states must balance the state's interest in preserving life and the patient's interest in quality of life.

Even if this view were accepted, many commentators do not feel that the courthouse is the proper forum in which to create this balance. One court noted that "[u]nlke the Legislature, the courts are neither equipped nor empowered to prescribe substantive or procedural rules for all, most, or even the more common contingencies." Additionally, the court in Dr. Kevorkian's trial requested legislative action to resolve the current debate about voluntary euthanasia. It acknowledged that "dying with dignity" can be condoned in certain situations, but that "it mandates a controlled environment that can be properly and professionally monitored by competent persons and in a manner that is acceptable to society." The court then called upon the medical profession and the state legislature to work together to resolve the issue. Unfortunately, the response taken by the Michigan legislature was to criminalize assisted suicide.

Opponents of physician-assisted suicide fear that if legislation is passed, it will not be limited to the sympathetic cases of the terminally ill, but will also be used to encourage the elderly or disabled to choose death rather than become a burden. As one commentator points out, how-

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172. *Id.* at 385.
174. *In re Storar*, 420 N.E.2d 64, 67 (N.Y.), *cert. denied*, 454 U.S. 858 (1981); *see also* *Smith*, *supra* note 40, at 415 ("Always cognizant of their role as interpreters of the law, thus making them reluctant to be bold, creative architects, the courts need strong and unequivocal legislation to assist them in interpreting the law within a framework of contemporary values.").
178. *Id.*
ever, "[T]he fear of the 'slippery slope' has accompanied every new re-
lease of knowledge, scientific or otherwise." Legalization of assisted
suicide could actually reduce the likelihood of any abuse by providing
well-established safeguards. Once legalized, assisted suicide could be dis-
cussed openly between physicians and their patients to ensure that the
choice is informed and is truly voluntary. Additionally, physicians could
discuss assisted suicides with their colleagues to ensure the medical
soundness of the decision.

Another shortcoming of the slippery slope argument is that it ig-
nores the nature of the legal system, which functions to create distinc-
tions. Legislation that draws the line between proper and improper
motives, and that outlines methods of assisting suicide, would inhibit
abuses. In the present unregulated environment, the potential for abuse
is much higher and the consequences more grave.

Opponents further express their concern for abuse by comparing its
practice to that of abortion: Legalized assisted suicide, like abortion,
would become routine and would not be limited to the extreme cases. If an analogy to abortion is to be made, however, such a comparison
would surely support rather than refute the need for legalized assisted
suicide. Before Roe v. Wade, women who desired an abortion were
forced either to choose a "back-alley" abortion or to find a physician who
would violate the law. Similarly, assisted suicides will continue to occur
in an unsafe and uninformed manner until they are legalized. Furthermore, access to abortion in the pre-Roe era was typically limited to white
women with the money and resources necessary to find doctors who
would perform abortions. Similarly, physician-assisted suicide is cur-
currently a "white middle-class issue." Dr. Nicolas Parkhurst Carbal-
leira, director of the Boston-based Latino Health Institute, stated, "I am
sure that there are people in my community . . . who want assistance

ForNotes:
181. Smith, supra note 40, at 417 (footnote omitted).
182. Rosenblum & Forsythe, supra note 16, at 27 ("If legalized, [doctor assisted suicide]
will become available, and if available, it will become . . . a 'reasonable' option for anyone.").
184. See, e.g., Olszewski, supra note 53, at A5 (explaining that when an assisted suicide
failed, friends of an AIDS patient realized that he “had misunderstood the fatal dose” and
"instructed his surrogate to inject him with less of the drug than was necessary").
185. See Susan R. Estrich & Kathleen M. Sullivan, Webster v. Reproductive Health Ser-
(arguing that in the years before Roe v. Wade, poor and minority women were virtually pre-
clued from obtaining safe, legal abortions while white women had access through private
hospital services).
186. Lehr, supra note 3 (quoting Professor George J. Annas of Boston University, a health
law scholar who has studied physician-assisted death).
from a doctor in a suicide, but who don’t have the same access a white middle-class person has—and that’s a shame.”

The debate over the issue of assisted suicide also mirrors the emotional intensity of the abortion debate. It is very difficult to achieve consensus on life and death issues because these issues involve deeply ingrained social and religious beliefs. The problem is that “neither side [is] able to find good arguments to persuade the other.” However, the minority of people morally opposed to assisted suicide should not preclude its availability as a choice.

The hundreds of people who have requested help from Dr. Kevorkian in the last few years represent the number of people overall who wish to have medical assistance in ending their lives. Since legislatures have failed to provide proper channels of counseling and assistance for those who wish to die, these people must plan their deaths without adequate information or advice. Providing sufficient safeguards and adequate guidelines would allow competent, rational people to die with dignity, without risking the health and legal consequences of a “back-alley” suicide.

B. Medical Opinions Regarding Physician-Assisted Suicide

A 1988 survey by the San Francisco Medical Society revealed that most physicians believe patients should have the legal right to assisted suicide. When asked whether they felt that “patients should have the option of requesting active euthanasia when faced with an incurable terminal illness,” seventy percent responded affirmatively, twenty-three percent negatively, and seven percent were unsure. Although physicians seemed willing to grant patients the right to active voluntary eutha-

187. Id.
188. Some anti-abortion and religious fundamental groups vowed to fight against the legalization of physician-assisted suicide. Reverend Patrick Maloney, a Presbyterian minister who heads the Christian Defense Coalition in Washington, stated, “We were silent 20 years ago when abortion was legalized. We are not going to be silent about assisted suicide.” Castaneda, supra note 86.
189. Id. (quoting Howard Brody, director of Michigan State University’s Center for Ethics and Humanities in the Life Sciences).
190. Suicide Doctor Assists in 10th, 11th Deaths, S.F. CHRON., Feb. 5, 1993, at A3 (“[T]here has been a flurry of requests for the doctor’s help in dying before a temporary state ban on assisted suicide takes effect March 30.”).
192. Steve Heilig, The SFMS Euthanasia Survey: Results and Analysis, S.F. MED., May 1988, at 24. The respondents represented the full range of medical specialties, with the largest percentages coming from internists (22%) and psychiatrists (13%). Id.
193. Id.
nasia, they were less convinced that physicians should be the ones to carry out such requests.\textsuperscript{194} Fifty-four percent responded affirmatively, stating physicians should carry out such requests; twenty-six percent responded negatively, eleven percent were unsure, and nine percent did not answer.\textsuperscript{195} Of those that responded negatively, most seemed to fear diminishing the integrity of the profession or being viewed as killers.\textsuperscript{196} Similarly, other opponents of physician-assisted suicide fear that legalization will cause patients to lose trust in their physicians as devoted solely to a patient's health or healing.\textsuperscript{197}

These fears are based in part on misconceptions of the doctor-patient relationship. If physician-assisted suicide is legalized, patients will actually place more trust in physicians because they will know that physicians have the ability to more completely respect their wishes about health care choices.\textsuperscript{198} Doctors could provide their terminally ill patients with an overall health care program. Doctors and patients would be able to have an open and honest discourse regarding the patient's wishes. Patients desiring the most vigorous treatment plan available could request it. Similarly, patients who want certain treatments withdrawn or withheld could make that request. Finally, those patients who honestly feel that there would be a point in their illness when their quality of life would be so diminished that they would not want to continue living could discuss the option of assisted suicide with their physician. By creating a range of acceptable treatment plans, patients would be comforted knowing they would receive a health care program that accurately reflected their wishes.\textsuperscript{199}

Furthermore, legalization of assisted suicide might paradoxically prolong the lives of competent, terminally ill patients. Such patients would be secure in the knowledge that if they chose to have a physician-assisted suicide, when the time came they would receive proper assistance. Physician-assisted suicide would allow patients to avoid taking premature, active steps to end their lives before the illness reached a

\textsuperscript{194} Id.
\textsuperscript{195} Id.
\textsuperscript{196} Id. \textit{See also} Rosenblum & Forsythe, \textit{supra} note 16, at 25 (arguing that the role of doctors will change from healer to killer).
\textsuperscript{197} David Orentlicher, \textit{Physician Participation in Assisted Suicide}, 262 JAMA 1844, 1845 (1989).
\textsuperscript{198} The group Physicians for YES on Washington Initiative 119 reported that its members in active practice noted no ill effects on their businesses, and had, in fact, gained new patients seeking out doctors who supported Initiative 119. Ralph Mero, \textit{Fear Campaign Beat the Washington Initiative}, HEMLOCK Q., Jan. 1992, at 5.
\textsuperscript{199} \textit{See} Thor v. Superior Court, 855 P.2d 375, 386 (Cal. 1993) ("Patient autonomy and medical ethics are not reciprocals; one does not come at the expense of the other. The latter is a necessary component and complement of the former and should serve to enhance rather than constrict the individual's ability to resolve a medical decision in his or her best \textit{overall} interest.") (emphasis in original).
point when they would no longer have the competence or means to die with dignity.200

Supporters of physician-assisted suicide also argue that "[p]hysicians are the appropriate ones [to carry out requests], as only the physician has the judgment which includes sensitivity to prognosis, alternative treatment options, the emotional stability of the patient, the sincerity of the family, and the anticipated quality of projected life."201 Additionally, many doctors view assisted suicide as "the last act in a continuum of care provided for the hopelessly ill patient."202 In 1989, ten of the twelve physician authors of a New England Journal of Medicine article agreed that "it is not immoral for a physician to assist in the rational suicide of a terminally ill person."203 They described a rational suicide as one undertaken by a patient "beyond all help and not merely suffering from a treatable depression of the sort common in people with terminal illnesses."204 They acknowledged that "[i]f there is no treatable component to the depression and the patient's pain or suffering is refractory to treatment, then the wish for suicide may be rational."205

C. Public Opinion Regarding Physician-Assisted Suicide

Legislative proposals or initiatives on physician-assisted suicide have been and will most likely continue to be submitted to the public for approval in the near future.206 Thus, the view of the general public will largely determine whether physician-assisted suicide will be legalized. Surveys reveal an increase in the public acceptance of physician-assisted suicide over the years.207 For example, a survey taken by the National Opinion Research Center asked, "When a person has a disease that cannot be cured, do you think that doctors should be allowed by law to end the patient's life by some painless means if the patient and his family request it?"208 In 1947, only thirty-seven percent of the respondents an-

200. See Michael White, California Campaign Off to a Good Start, HEMLOCK Q., Jan. 1992, at 2 (reasoning that Janet Adkins may not have turned to Dr. Kevorkian so quickly had she known that it would be lawful for a physician to assist in her death).

201. Id. at 25.

202. Wanzer et al., supra note 6, at 848.

203. Id.

204. Id. at 848 n.2.

205. Id.

206. In 1992, "four states introduced physician aid-in-dying bills into their legislature—New Hampshire, Iowa, Maine, and Michigan. Each bill calls for an advance directive (signed and witnessed) that would enable a physician to provide in one form or another, aid to a terminally ill patient who wishes to die." Abigail Gleicher, Four New Bills Demand Physician Assisted Dying, HEMLOCK Q., Apr. 1992, at 3. However, none of these bills were passed. See infra note 209 and accompanying text.

207. Blendon, supra note 47, at 2659.

208. Shaffer, supra note 19, at 367 n.114 (citing N.Y. TIMES, Sept. 23, 1984, § 1, at 1).
swered affirmatively, compared to sixty-three percent in 1983.\textsuperscript{209} In 1990, the Roper Poll conducted a survey that asked, "When a person has a painful and distressing terminal disease, do you think doctors should or should not be allowed by law to end the patient's life if there is no hope of recovery and the patient requests it?"\textsuperscript{210} Sixty-four percent said that it should be allowed by law, twenty-four percent said that it should not be allowed, and thirteen percent did not know.\textsuperscript{211} A 1991 poll of the West Coast shows an even higher rate: Sixty-eight percent favor physician assisted-suicide as a legal concept.\textsuperscript{212} Additionally, \textit{The Washington Post} reported that recent "opinion polls in Michigan have shown consistently strong support for [the] crusade to legalize physician-assisted suicide."\textsuperscript{213}

These polls reflect growing public support for legalized physician-assisted suicide for the terminally ill. Legislators must now confront this issue and change the law to reflect societal changes. Assisted suicide is a life-and-death issue. It must be given top priority on the legislative agenda.

\section*{IV. Attempts at Legislation}

In the last few years, several attempts have been made to legalize physician-assisted suicide for terminally ill patients. None have yet succeeded, however, for a number of different reasons. The initial attempt at legislation was the 1988 California Humane and Dignified Death Initiative.\textsuperscript{214} This initiative required certification of a patient as competent and her illness as terminal before she could request aid in dying. The initiative was never put to a vote because supporters of the initiative failed to acquire the necessary 450,000 verified signatures to get it on the ballot.\textsuperscript{215}

\begin{thebibliography}{99}
\bibitem{209} Id.
\bibitem{210} \textit{The Roper Organization}, \textit{Roper Report 90-5}, \textit{in Hemlock Q.}, July 1990, at 5. The 1990 Roper Poll was "taken by the Roper Organization [of New York City] of a nationwide cross section of 1,978 men and women, 18 and over, interviewed in face-to-face interviews in respondent's homes between April 21-28, 1990. Percentages are rounded to the nearest whole percent. . . . Weighting has been applied to ensure that age, sex, education, and income are represented in their proper proportions." Id.
\bibitem{211} \textit{Id.}
\bibitem{213} Walsh, \textit{supra} note 77, at A3.
\bibitem{215} McCoy, \textit{supra} note 135, at 440 n.8.
\end{thebibliography}
In 1992, state legislatures introduced bills legalizing physician-assisted suicide in Iowa, Maine, Michigan, and New Hampshire. None of the bills passed.

A. Washington Initiative 119

In 1991, the state of Washington attempted to legalize physician-assisted suicide by introducing Initiative 119, the Aid in Dying Act. The question presented to voters was, "Shall adult patients who are in a medically terminal condition be permitted to request and receive aid-in-dying?" Under the initiative, a patient requesting such assistance would have to be terminally ill or have an irreversible condition that, in the opinion of two doctors, would result in death within six months. The patient would also have to be conscious and mentally competent, and would have to voluntarily request the assistance in writing at the time it would be rendered. The initiative was narrowly defeated, with 46.4 percent for the initiative and 53.6 percent against it.

Proponents of 119 claimed that last-minute television advertisements, mainly financed by the Right to Life movement and Roman Catholic groups, distorted the truth about the statute and lead to its defeat. Others urge that Dr. Kevorkian's actions may have also contributed to the defeat because, in the final weeks before the vote was to occur, Dr. Kevorkian helped two women die. Many people linked Dr. Kevorkian to the proposal and feared that he would be able to bring his "suicide machine" to Washington if the proposal passed.

Alternatively, Derek Humphry, founder and executive director of the Hemlock Society, believed that the two main reasons for the defeat of the initiative were its semantic shortcomings and lack of safeguards.

217. S.P. 885, 115th Leg. (Me. 1992) (regarding the terminally ill).
220. The Iowa and Maine legislation died during the 1992 sessions. The Michigan Act died in the House Committee on the Judiciary. New Hampshire's Act was sent to "interim study," a process whereby a committee must consider the legislation, but is not required to act on it. The New Hampshire legislation has remained in interim study, effectively killed.
221. Initiative 119 (amending WASH. REV. CODE §§ 70.122.010-.122.905 (1990)).
224. Id.
225. Id. The voter turnout rate was 66%.
226. See McCoy, supra note 135, at 440 n.8; Ralph Mero, Fear Campaign Beat the Washington Initiative, HEMLOCK Q., Jan. 1992, at 5.
227. Mero, supra note 226, at 5.
228. Humphry, supra note 222, at 4.
He argued that the law was written too broadly. For example, Humphry noted, the campaign's reference to "aid-in-dying" could mean anything from a physician's lethal injection, to prescribing drugs that a patient could use to commit suicide, to providing moral support during a patient's death. The people who proposed the initiative intended to sit down with representatives of the medical and legal professions after it passed to create specific guidelines. Humphry believed that the public was unwilling to pass a law which lacked built-in safeguards.

Washington's initiative was the first attempt to legalize physician-assisted suicide presented to voters. Voters may have been apprehensive, not because of misgivings about the practice of assisted suicide, but rather because the initiative was drafted inadequately. Defeat by such a narrow margin demonstrates that a high percentage of voters do favor laws regarding physician-assisted suicide. Legislators need to work toward developing a law that voters will accept on a theoretical and practical basis.

B. California Proposition 161

One year after the defeat of the Washington initiative, California attempted to pass Proposition 161. The proposed law would have allowed mentally competent adults to instruct their physicians in writing to provide aid-in-dying upon their request when they became terminally ill. "Terminal illness" was defined as an irreversible condition that would result in death within six months in the opinion of two physicians (including the patient's attending physician). Like the Washington initiative, the proposition failed by a close margin of fifty-two percent to forty-eight percent. The California initiative had more safeguards built in than the Washington proposal. One commentator remarked:

The California Initiative differs from the Washington proposal in that the request for aid-in-dying must be an 'enduring' request; it has special protections for persons in skilled nursing facilities, prohibitions against intimidation and tampering, ... limitations on fees, and recordkeeping requirements.

Despite the additional safeguards, many believe voters rejected the initiative because they viewed the safeguards as insufficient. Apparently,

229. Id.
230. Id.
231. Death with Dignity Act (to be codified at CAL. CIV. CODE §§ 2525-2525.24 (West 1992)).
233. Id.
many voters who agree with the concept of physician-assisted suicide nevertheless rejected the practical terms of the proposal. 236

Interestingly, the debate over the initiative in California had a different tone than that in Washington. In Washington the opponents debated on a more emotional level, addressing "the ethics of the physician-patient relationship." 237 In contrast, one commentator noted that "the majority of the medical voices raised in opposition to the [California] initiative focused more on procedure, attacking the proposal's safeguards as inadequate." 238 Medical professionals complained that the proposal lacked a specified waiting period, psychiatric evaluations, family notification, and adequate protections against misdiagnosis. 239

Others complained that the terms in the California initiative were vague. For example, a "terminal condition" was defined as "an incurable or irreversible condition which will, in the opinion of two certifying physicians exercising reasonable medical judgment, result in death within six months or less." 240 Some commentators argued that the language did not clearly state "whether a patient must exhaust all forms of mitigating treatment before being certified as terminal." 241 The term "attending physician" also proved ambiguous, despite its definition as "the physician selected by, or assigned to, the patient who has primary responsibility for the treatment and care of the patient." 242 As stated by one commentator, the difficulty in this definition is that "[i]n a teaching hospital, each patient has at least three doctors assigned to him: an intern, a resident, and a faculty member." 243 Under such circumstances, it would be unclear who was acting as the attending physician.

Additional complaints focused on the lack of adequate reporting procedures. While Proposition 161 required that hospitals and health care providers report the overall number of physician-assisted deaths to the State Department of Health Services, it did not require reporting of individual patient names. 244 Additionally, physicians would be allowed to report on the death certificates that the cause of death was the underlying disease and not a drug overdose or a lethal injection. 245 Many found these reporting measures insufficient because they failed to create a

236. See supra text accompanying note 213.
238. Id.
239. Id. at 39.
240. Death with Dignity Act § 2525.2(j).
241. Diane M. Gianelli, Analysis of Initiative Highlights Concerns About Physician Liabil-
ity, AM. MED. NEWS, Nov. 2, 1992, at 40.
242. Death with Dignity Act § 2525.2(a).
244. Id. at 39.
245. Id.
system of checks and balances to safeguard against abuses within the system.

Others noted that patients requesting assisted suicide could refuse to submit to a psychiatric evaluation, without which doctors might find it "difficult to assess competency and voluntariness." Some felt doctors were "ill equipped to assess the presence and effect of depressive illness in older patients." Many voters were unwilling to pass an initiative that lacked the safeguard of a psychiatric evaluation to determine whether a patient had made a rational choice.

Finally, doctors were concerned that the initiative did not bar a professional liability insurer from raising premiums or refusing coverage of doctors based on whether they performed assisted suicide or euthanasia. While physicians might have been protected from criminal liability under Proposition 161, they would still be exposed to professional liabilities, such as medical malpractice suits and increased insurance coverage.

These serious concerns regarding the initiative's lack of specific definitions, guidelines, and safeguards ultimately lead to its failure. To avoid a similar fate, future legislation must provide specific guidelines that maintain a proper balance between patient autonomy and necessary safeguards.

C. Legislation in the Netherlands

Since physician-assisted suicide can not be legally practiced anywhere in the United States, the Netherlands provides a useful example of a country allowing physician-assisted suicide under specific guidelines. While assisted suicide is officially a crime in the Netherlands, the Netherlands Supreme Court has established that a doctor may practice assisted suicide in certain situations. The court's rationale for allowing assisted suicide was that

in such situations doctors have two conflicting duties. On the one hand, they have the duty to uphold the laws of the land (which do not allow a doctor to kill a patient); on the other hand, doctors have a duty to put the patient's interest first. Since doctors cannot do both... they cannot be held criminally liable for choosing to do what a doctor's

246. Id.
247. Conwell & Caine, supra note 60, at 1101.
249. "The Penal code of the Netherlands section 293 states that anyone who takes another person's life, even at his explicit and serious request will be punished by imprisonment of at the most 12 years or a fine ..." M. A. M. de Wachter, Active Euthanasia in the Netherlands, 262 JAMA 3316, 3317 (1989).
professional duty demands—namely to act in the patient’s best interests.250

After the decision, the Dutch Government Commission on Euthanasia was established to create a report on assisted suicide. The Commission reached the following conclusions:

1. That active voluntary euthanasia was possible without penalty.
2. That only medical doctors, using proper medical methods which can be verified, may assist another in dying. The execution of the decision in ending the life may not be delegated to anyone else.
3. The patient must be “in a hopeless emergency condition.”
4. A written request may be relied upon if the patient is no longer able to express her will. The request must be emphatic and serious.
5. That assisting a rational suicide should be governed by these same rules.
6. Consultation must be made with another medical officer nominated by a government ministry.
7. In cases of irreversibly comatose patients, where continuance of normal treatment is pointless and has terminated, and after consultation with another doctor, euthanasia should be permitted.
8. It is not considered terminating life or assisting a suicide if any life sustaining treatment is not instituted or is stopped at a patient’s request, or if further treatment is pointless according to sound medical judgment.
9. The body must be preserved for official examination; and no death certificate may be issued.
10. The doctor must report the full circumstances to the public prosecutor.
11. No one may be coerced into participating in euthanasia against her conscience. A doctor who refuses must make information available to the patient concerning organizations or professionals with a different view.251

Despite the fact that the Commission outlined guidelines for allowing physicians to practice assisted suicide, no movement was then made to change the law prohibiting physician-assisted suicide.252

Recently, however, the Dutch Parliament has moved to codify specific guidelines under which assisted suicide may be practiced.253 On February 9, 1993, the lower house of parliament voted ninety-one to forty-five to attach their guidelines for allowing physician-assisted suicide to the 1955 “Disposal of the Dead Act.”254 The legislation still must be passed by the upper house and approved by the crown, but both actions

251. Wanzer et al., supra note 6, at 848.
252. Id.
are considered formalities. Once passed, this legislation will ensure immunity from prosecution for physicians who practice assisted suicide as long as they follow a detailed, twenty-eight point checklist. The checklist will require, among other things, that the patient have a terminal illness, suffer from unbearable pain, and wish to die. The guidelines "stipulate that anyone other than a physician is forbidden to perform euthanasia." Other guidelines or "carefulness requirements" include the stipulation that the request "be made entirely of the patient's own free will and not under pressure from another." To ensure the decision is voluntary, the physician must confer with the patient individually. Additionally, the patient must be well-informed about her situation and all possible alternatives. Also, the patient's request must express a "lasting longing for death" and may not be "made on impulse or based on a temporary depression." The patient "must experience his or her suffering as perpetual, unbearable and hopeless." The guidelines recognize that the criteria are somewhat subjective but focus on the physician's responsibility to reasonably conclude that the patient experiences her suffering as unbearable.

The physician attending to the patient must consult at least one colleague regarding the patient's request. Additionally, the physician must submit a well-documented report of the entire procedure to the district coroner's office after the death, including a history of the patient's illness, an explanation of why euthanasia was chosen, and a description of how it was carried out. The prosecutor considers the case closed so long as "an administrative review finds that all the requirements were satisfied and no malpractice was evident." The new law is expected to go into effect in early 1994.

V. Proposal

State legislatures should follow the Netherlands' lead by developing guidelines by which physicians can legally practice assisted suicide for their terminally ill patients. Assisted suicide should only be permitted by licensed physicians because physicians are best able to analyze the patient's physical condition and inform the patient of all possible treat-

255. Id.
256. Drozdiak, supra note 253.
259. Id.
260. Id.
261. Id.
262. Dutch Liberalize Euthanasia Law, supra note 254.
263. Jones, supra note 257.
264. Drozdiak, supra note 253.
ments and options. Allowing assisted suicide only under regulated situations will decriminalize a compassionate act while preventing abuses such as false claims of assisted suicide. Moreover, under regulated conditions patients will be able to end their suffering with the supervision of a qualified professional and in the comfort of friends and family.

State legislatures should adopt legislation that combines the most useful elements of the Netherlands legislation and previously proposed American legislation. The following proposal attempts to combine these elements, creating a cohesive procedure for physician-assisted suicide.

First, a patient request for physician-assisted suicide should be denied unless the patient is diagnosed as terminally ill and that diagnosis is confirmed by another physician of the appropriate specialty. Terminal illness should be defined as a disease that causes the patient intolerable suffering and from which there is no prospect for relief. Because it is often difficult for doctors to provide an accurate prognosis regarding how long a patient has left to live, the law should not restrict assisted suicide to those who will die within a short period of time. Instead, the focus should be on the patient's degree of suffering and quality of life. New Hampshire's proposal serves as a guideline:

"Terminal condition" means an incurable and irreversible condition, the end stage of a disease for which there is no known treatment which will alter its course to death, and which, in the opinion of the attending physician and a second physician competent in that disease category, both of whom shall have personally examined the patient, will result in death.

The definition of terminal illness must require the attending physician who diagnoses the patient's illness to consult a colleague for a confirmation of the diagnosis. Both physicians shall certify in writing that the patient has a terminal illness as defined by the legislation. This requirement avoids possible misdiagnosis by "offer[ing] a means to confirm the correctness of diagnosis and prognosis."

The legislation must require that the patient requesting the physician-assisted suicide be a competent adult. The Netherlands plan requires the request to be voluntary and of one's own free will. If the patient is not competent, the request cannot be said to be voluntary. If there is a question about the competence of the patient, it should be re-

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265. Cf. Death with Dignity Act § 2525.2(j) (defining "terminal condition" as "an incurable or irreversible condition which will, in the opinion of two certifying physicians [one of whom must be the patient's attending physician] exercising reasonable medical judgment, result in death within six months or less"); Aid in Dying Act (same).


267. de Wachter, supra note 249, at 3317.

268. "One who is incompetent by whatever test . . . cannot commit suicide because she is unable to form the intent prerequisite to performing a legal act." Garbesi, supra note 13, at 102 n.81.
solved by a psychiatrist. In that situation, the psychiatrist should be re-
quired to make a written psychiatric evaluation before the request is
granted. Many terminally ill patients are depressed, but have an in-
dependent, rational reason for choosing assisted suicide. If the psychia-
trist determines that depression is the sole cause for the request, then
depression management and pain control should be recommended and
pursued vigorously. However, the focus of the psychiatric evaluation
should be on the patient's quality of life. The psychiatrist should recog-
nize that different people have different levels of tolerance for suffering.
As long as the request is based on a rational decision determined by the
patient's personal assessment of her current quality of life and severity of
suffering, the psychiatrist should recommend that the request be
granted.

The patient's decision must be informed. As with any important
health care decision, the patient should be informed of all risks, benefits,
and possible alternatives. Some patients may no longer wish to receive
intensive treatment from the hospital, but may be willing to switch to
hospice care or home treatment. If the patient still wishes to die after
being informed of all of her options, her request for assisted suicide
should be considered. A patient should not be forced to succumb to any
treatment that she feels violates her personal autonomy or results in a
loss of dignity.

The patient's request for assisted suicide must be signed and wit-
nessed. The request should be entirely of the patient's own free will.
To ensure that the patient truly wishes to die and is not under any du-
ress, the physician should be required to discuss the request alone with
the patient. It is also imperative that the patient be aware that the
request may be withdrawn at any time.

After a request is confirmed by the attending physician, a second
physician in the appropriate specialty, and the psychiatrist, if necessary,
the request should be advanced to a “medical ethics committee or like
body of the health care facility.” The committee's function should not
be to make a substantive decision regarding the validity of the patient's

269. “Psychiatrists deal regularly with the assessment of depression and suicide, and by
training and experience they are better equipped than most to determine whether a decision to
commit suicide is colored by mental illness.” Conwell & Caine, supra note 60, at 1102.
examined [the petitioner] . . . found him depressed about his quadriplegic condition but men-
tally competent to understand and appreciate his circumstances.”).
271. See Timothy Quill, Assisted Suicide Ban: The Wrong Answer to the Wrong Question,
DET. FREE PRESS, April 19, 1993, at 11A (arguing that the solution to the patient's fear of a
“high-tech death in a hospital intensive care unit” is hospice care “where treatment is devoted
to alleviating physical, psychological, social, and spiritual suffering”).
272. Drozdiak, supra note 253, at A15.
273. Id.
request, but rather, to ensure that the proper procedures have been followed. The committee must determine that all of the requirements—terminal illness, competence, informed written consent, and a second opinion—have been satisfied.

The committee should have from three days to a week to decide whether to grant or refuse the patient’s request. This evaluation period strikes a balance between the requirement of a waiting period to allow the patient to fully consider her request and the desire to avoid prolonging the suffering of the patient.

If the committee reaches a consensus, that decision will be referred to the head of the department and the director of the hospital. If there is not a consensus, the committee will explain which part of the procedure was not fulfilled (for example, a psychiatric evaluation had not been conducted). The physician and patient should then have the opportunity to satisfy the condition and resubmit the request for approval.

After the request has been granted and with the consent of the patient, family members should be notified of the patient’s decision, but should not be able to encourage or veto that decision. As the Court in *Cruzan* stated, “[T]here is no automatic assurance that the view of close family members will necessarily be the same as the patient’s.”275 Thus, the terminally ill patient should be allowed to request assisted suicide without the consent or approval of her family just as a competent adult may request withholding or withdrawing treatment independently.

The physician actually assisting the suicide should be the attending physician.276 The attending physician should be the physician that is ultimately responsible for the patient. In a teaching hospital, patients may have a number of people assisting in their care, including medical students, interns, residents, and nurses. However, the licensed attending physician with the ultimate responsibility for the patient should be the person to handle any requests for assisted suicide. The attending physician need not be the family physician, since many people today do not have their own family doctor. However, the attending physician must be the physician currently responsible for the patient’s care. This will ensure that the physician who knows the most about the patient’s condition will perform the assisted suicide.277

The assistance should be performed in the least active way possible, with the ultimate timing and method of the death exclusively within the control of the patient. If the patient agrees to and is able to ingest an oral

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276. If the attending physician is unable or unwilling to perform the assisted suicide, she should be required to refer the patient to another physician in an appropriate specialty who is willing to assist.
277. *Cf. Death with Dignity Act § 2525.2(a), (e)* (allowing any physician “licensed by the Medical Board of California” to be attending physician, thus failing to restrict the types of physicians who are permitted to assist suicide).
drug, this method should be used to effectuate the greatest amount of patient control. This will provide added assurance that the patient fully understands her actions and desires to end her suffering. However, for some patients, it will be uncomfortable or even impossible to ingest the drugs necessary to end their lives. Thus, patients should have the option to request a lethal injection instead of medication.

Regardless of the method used for the voluntary euthanasia, there should be at least two witnesses present—the attending physician or physician administering the drug and a medical examiner. This requirement would help prevent potential abuses and provide qualified, experienced physicians to monitor the procedure.

Additionally, the euthanasia should be performed within the schedule of one hospital shift. This will enable the entire procedure to be completed by one physician to ensure safety through continuity.

When an assisted suicide occurs, there should be accurate and detailed reporting. The act of assisted suicide as well as the identity of the acting physician should be written on the patient's chart. Once the act is completed, the hospital physician should report the assisted suicide to the coroner and the State Department of Health Services. So long as all procedures were followed properly, no further investigation into the death need ensue.

The death certificate should state that the death was caused by active voluntary euthanasia, either listing the drug overdose or the lethal injection. However, it should also list the underlying disease that would have eventually caused the patient's death.

Furthermore, since physician-assisted suicide under the above guidelines will be considered valid medical care, insurance companies should not be allowed to discriminate against physicians or health care organizations who engage in the practice by either increasing their insurance premiums or denying them coverage. Insurance companies should be required to act as if the patient died of the underlying disease for purposes of the insurance plan, since generally suicides are not covered by insurance but death by illness is. Additionally, hospital administrators and other health care employers would be prohibited from denying

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278. See Marcinko, supra note 8, at 633-34.
279. de Wachter, supra note 249, at 3318-19.
280. Cf. Death with Dignity Act (requiring the physician or hospital to file annual reports regarding cases of physician-assisted suicide to the Department of Health Services, but not requiring that they reveal the patient's identity).
281. de Wachter, supra note 249, at 3318-19.
282. Id. at 3317 ("Under current regulations, the Dutch physician, after practicing active euthanasia, is not allowed to complete that death certificate with reference to 'natural cases.' Either the physician or the coroner reports to the police that euthanasia has taken place. The police, in turn, report to the district attorney [who decides] to prosecute or not to prosecute.")
privileges or otherwise limiting the physicians' practice based on their participation in or avoidance of physician-assisted suicide.

These requirements provide accurate reporting methods and detailed procedural guidelines that would serve as a check against potential abuses of discretion among doctors. These guidelines address many of the problems that led to the defeat of earlier Washington and California initiatives, thus providing a vehicle for voters to pass legislation that the majority conceptually support.

VI. Conclusion

The resolution of physician-assisted suicide rests with the legislature, not with the judiciary, press, or medical administration. Dr. Kevorkian's tactics have focused attention on the debate over physician-assisted suicide, but his lawless approach is not the best solution to the problem. Other physicians are being forced to secretly break the law in order to allow their patients to die with dignity. Some terminally ill patients try to evade the law by turning to family or friends or by attempting suicide themselves. Unfortunately, these attempts often result in more tragic consequences: Some may fail in their attempt, resulting in greater pain for patients and their families. In situations where the assisted suicides are successful, physicians, family members, or friends may be subject to criminal charges. Without the legalization of assisted suicide and without proper guidelines and procedures for assisting in death, terminally ill people will continue to evade the law and suffer the legal, medical, and emotional consequences in order to seek out relief.

The legalization of physician-assisted suicide is the next logical step in granting freedom and personal autonomy for terminally ill patients who wish to control their lives, even if that means ending their lives. States and legislators must confront this issue. One author noted that without the allowance of assisted suicide, "the problem of very ill or disabled persons who would rather take their own lives than eke out what they perceive as a miserable existence does not go away—it is simply buried." The criminalization of assisted suicide without any exceptions made for the terminally ill leads to circumvention of the law. Patients who must face intolerable pain, diminished quality of life, and loss of personal autonomy should be able to receive assistance that could help them end their lives in a dignified manner. Proper guidelines would protect against potential abuses and yet allow physician-assisted suicide to exist as a legal and rational choice. Without such guidelines, we are reduced to an informal "don't ask, don't tell" status quo that renders

283. See supra notes 221-248 and accompanying text.
284. See supra notes 207-212 and accompanying text.
285. Shaffer, supra note 19, at 369.
286. See id.
many as unwilling prisoners of their medical condition and makes others unjustified prisoners of the legal system.