

NOTES

MAY I AUTHOR MY FINAL CHAPTER? ASSISTED SUICIDE AND GUIDELINES TO PREVENT ABUSE

"Have a good trip", were the last words that Janet Adkins heard before she pushed a button that activated a motor that pumped a powerful barbiturate and deadly potassium chloride into her vein.¹ With the push of that button, a retired pathologist and an unresolved controversy were jettisoned back into the limelight.² By assisting Janet Adkins commit suicide, Dr. Jack Kevorkian has forced society to once again consider the legal, moral and ethical issues surrounding doctor assisted active euthanasia.³

Although there are strong arguments both for and against doctor assisted active euthanasia,⁴ reports indicate that doctor-assisted suicide has already today become de facto acceptable in some places within the United States.⁵ Thus this Note addresses the concerns and the possible abuses that could arise under such

1. D'Arcy Jenish, *The Right to Die*, MACLEAN'S, June 25, 1990, at 24.

2. The Kevorkian case was a controversial Michigan District Court case in which Dr. Jack Kevorkian was charged with first degree murder for assisting Janet Adkins commit suicide on June 4, 1990. Adkins, suffering from Alzheimer's disease, sought out Kevorkian and his suicide machine. Kevorkian assisted by providing a "suicide machine" which he attached to Adkins and a Volkswagen van for Adkins to end her life in. The murder charge was eventually dismissed. Isabel Wilkerson, *Prosecutors Seek to Ban Doctor's Suicide Device*, N.Y. TIMES, Jan. 5, 1991, at § 1, p.6, c.5.

3. Since this incident, Dr. Kevorkian has assisted two other women to commit suicide. On Friday, February 27, 1992, the court ordered Dr. Kevorkian to stand trial for first degree murder. The arraignment is scheduled for March 12, 1992. Michael L. Millenson, *"Suicide" Doctor to Be Tried for Two Murders*, CHIC. TRIB., Feb. 29, 1992, at A.1, p.3.

4. See *infra* notes 37-47 and accompanying text.

5. This theory was recently bolstered by the Kevorkian case in which a first-degree murder charge, brought against Dr. Kevorkian for helping Janet Adkins commit suicide, was dismissed because Michigan has no law against assisted suicide. Furthermore, "[a] new national survey, conducted in April [1990] by the Roper Organization, showed strong public support for euthanasia. The poll showed that nearly two-thirds of Americans believe physicians should be allowed to end the lives of patients with painful, terminal illnesses who ask to die." Joyce Price, *Debate Grows Over Approval of Euthanasia*, WASH. TIMES, June 26, 1990, § A, at A7. See appendix for entire poll as well as a comparison to a similar poll conducted in 1988 which indicates growing support for doctor assisted active euthanasia; See *infra* notes 34-36 and accompanying text. More recently, this was evidenced in the fact that the best-selling suicide guide "Final Exit", written by the Hemlock Society's Derek Humphry, stayed at number 1 on the New York Times hardcover advice best-seller list for several weeks in August and September of 1991. Mike Snider, *Final Exit: Suicide Guide*, USA TODAY, August 12, 1991, at 1D.

There are numerous accounts of doctors assisting patients commit suicide. Among these is the story of Dr. Timothy Quill. In March, 1990, Dr. Quill, an internist in Rochester, N.Y., wrote a letter which appeared in The New England Journal of Medicine. He recounted how he helped a leukemia patient take her own life. In July 1991, a grand jury refused to indict Dr. Quill on criminal charges. Katrine Ames, *Last Rights*, NEWSWEEK, Aug. 26, 1991, at 40.

Even more startling were the results of a poll conducted in July, 1990, by Physician's Management Magazine. In response to their poll regarding doctor assisted suicide, 10 percent of the 500 physicians responding stated that they had "deliberately taken clinical actions that would directly cause a patient's death," and 3.7 percent said they had "provided information that could be used to cause a patient's death." B.D. Colen, *Doctors Who Help Patients Die; MDs reveal a secret practice: aiding suicides, mercy killing*, NEWSDAY, September 29, 1991, at 4.

circumstances.⁶ The history of the right to die which has led to the circumstances surrounding doctor assisted suicide will be examined. This Note will then briefly analyze the arguments for and against doctor assisted active euthanasia. Finally, this Note will focus on guidelines to prevent abuses that could be prevalent with such acts if one assumes that such acts will become an acceptable part of society. (This Note does not attempt to deal with the difficult ethical and moral questions surrounding this issue.)

I. TERMINOLOGY

Euthanasia is defined as "the act or practice of killing or permitting the death of hopelessly sick or injured individuals . . . in a relatively painless way for reasons of mercy."⁷ Euthanasia, when performed by the terminally ill patient, is an act of suicide. When someone assists the patient take his life, however, the assisted suicide is often called murder.⁸

Relevant to doctor assisted euthanasia is the distinction between active and passive euthanasia. Although recent legislation and case law allow passive euthanasia,⁹ an act intended to allow the dying process to conclude, most states impose criminal sanctions on anyone actively assisting another in the act of euthanasia.¹⁰ This distinction between active and passive euthanasia, however, has been severely criticized and may soon be obsolete. As Justice Scalia stated in *Cruzan v. Director, Missouri Dept. of Health*,¹¹ "[i]t would not make much sense to say that one may not kill oneself by walking into the sea, but may sit on the beach until submerged by the incoming tide."¹² This nondifferential approach will aid

6. The decision to end one's life should be made in a voluntary and competent manner. The patient should have total control over this decision. The problem, however, is that weakened patients could be coerced into involuntarily consenting to the euthanasia.

7. WEBSTER'S NINTH NEW COLLEGIATE DICTIONARY 429 (1988).

8. See *supra* note 2.

9. In re Quinlan, 70 N.J. 10, 355 A.2d 647 (1976); In re Schiller, 148 N.J. Super. 168, 372 A.2d 360 (Ch. Div. 1977); Cruzan v. Director, Missouri Dept. of Health, 110 S. Ct. 2841 (1990).

Although 39 states presently have "living will" laws, the contents of these laws are often quite divergent. For instance, nearly half of them specifically exclude artificial feeding from the treatments that may be refused. *What Is the "Good Death"?*, THE ECONOMIST, July 20, 1991, at 21.

In December 1991, the Patient Self-Determination Act of 1990 will go into effect. "[The Act] requires hospitals participating in Medicare or Medicaid to ask all adult inpatients if they have advance directives such as living wills." Katrine Ames, *Last Rights*, NEWSWEEK, Aug. 26, 1991, at 40.

10. Commonwealth v. Hicks, 118 Ky. 637, 82 S.W. 265 (1904); Persampieri v. Commonwealth, 343 Mass. 19, 175 N.E.2d 387 (aff'd 1961); ALASKA STAT. § 11.41.120 (1990); ARIZ. REV. STAT. ANN. § 13-1103 (1989); COLO. REV. STAT. § 18-3-104 (1990); CONN. GEN. STAT. § 53A-56 (1989); DEL. CODE ANN. tit. 11, § 645 (1990); FLA. STAT. ANN. § 782.08 (West 1989); HAWAII REV. STAT. §§ 707-702 (1990); KAN. STAT. ANN. § 21-3406 (1988); ME. REV. STAT. ANN. tit. 17-A, § 204 (1989); MINN. STAT. ANN. § 609.215 (West 1990); MISS. CODE ANN. § 97-3-49 (1990); MO. ANN. STAT. § 565.021 (Vernon 1979); MONT. CODE ANN. § 45-5-105 (1989); NEB. REV. STAT. § 28-307 (1989); N.H. REV. STAT. ANN. § 630:4 (1989); N.J. STAT. ANN. § 2C:11-6 (West 1989); N.M. STAT. ANN. § 30-2-4 (1990); N.Y. PENAL LAW § 120.35 (McKinney 1990); OKLA. STAT. ANN. tit. 21, § 815 (1989); OR. REV. STAT. § 163.125 (1989); 18 PA. CONS. STAT. ANN. § 2505 (Purdon 1989); S.D. CODIFIED LAWS ANN. § 22-16-37 (1990); TEX. PENAL CODE ANN. § 22.08 (Vernon 1989); WASH. REV. CODE ANN. § 9A.36.060 (1990); WIS. STAT. ANN. § 940.12 (West 1987-1988).

11. 110 S. Ct. 2841 (1990).

12. 110 S. Ct. 2841, 2861 (1990) (Scalia, J., concurring). *Cruzan* has been hailed as the landmark "right to die" case. Although the battle over the "right to die" has raged for years, the Supreme Court has just now decided to confront the issue. The Supreme Court, however, left several critical issues unanswered, including doctor assisted active euthanasia. See *infra* notes 22-30 and accompanying text.

advocates of doctor assisted active euthanasia as they argue that individuals have a constitutional right to such an act. In addition to this basic terminology, an understanding of the history of the "right to die" will also be useful in this analysis.

II. HISTORY

Doctor assisted active euthanasia is just one link in the "right to die" chain. Over the years, courts have struggled with "right to die" issues and have chosen different avenues to support their decisions to allow individuals to discontinue or refuse treatment. The seminal right to die case is *In re Quinlan*.¹³

In the *Quinlan* case, Karen Quinlan suffered severe brain damage and entered a persistent vegetative state.¹⁴ Karen's father sought judicial permission to remove his daughter from the respirator that kept her alive. The New Jersey Supreme Court granted his request, holding that Karen had a constitutional right of privacy to terminate the treatment. The court noted, however, that this right was not absolute. The court struck a balance between Karen's right to privacy and the State's interest in life, stating that the State's interest "weakens and the individuals's right to privacy grows as the degree of bodily invasion increases and the prognosis dims. Ultimately, there comes a point at which the individual's rights overcome the State interest."¹⁵ The court concluded that the State interests had to give way in this case. The court further ruled that due to Karen's incompetence her right to privacy could be asserted on her behalf by her guardian.¹⁶

"After *Quinlan*, however, most courts have based a right to refuse treatment either solely on the common law right to informed consent or on both the common law right and a constitutional privacy right."¹⁷ In *Superintendent of Belchertown State School v. Saikewicz*,¹⁸ the Supreme Judicial Court of Massachusetts permitted the withholding of chemotherapy from a profoundly-retarded sixty-seven year old terminally ill leukemia victim. The court relied on both the right of privacy and the right of informed consent in making its decision. It determined that "the individual's interest in the freedom to choose to reject, or refuse to consent to, intrusions of his bodily integrity and privacy"¹⁹ outweighed the State's interests. The court further stated that "[t]he constitutional right to privacy . . . is an expression of the sanctity of individual free choice and self-determination as fundamental constituents of life. The value of life as so perceived is lessened . . . by the failure to allow a competent human being the right of choice."²⁰

Not all courts, however, were content with basing a patient's right to terminate treatment on the constitutional right to privacy. In *In re Eichner*,²¹ the

13. 70 N.J. 10, 355 A.2d 647 (1976).

14. An individual in a persistent vegetative state was defined in *Quinlan* as "a 'subject who remains with the capacity to maintain the vegetative parts of neurological function but who . . . no longer has any cognitive function.'" 70 N.J. 10, 355 A.2d 647, 654 (1976).

15. *Id.* at 664.

16. *Id.*

17. *Cruzan v. Director, Missouri Dept. of Health*, 110 S. Ct. 2841, 2847 (1990).

18. 373 Mass. 728, 370 N.E. 2d 417 (1977).

19. *Id.* at 744-45, 370 N.E.2d at 427.

20. *Id.* at 742, 370 N.E.2d at 426.

21. 102 Misc. 2d 184, 423 N.Y.S.2d 580 (N.Y. Sup. Ct. 1979).

court permitted the termination of treatment; yet it rejected the right to privacy analysis. In *Eichner*, an eighty-three year old heart attack victim suffered brain damage and had entered into a vegetative state. As a result, he was incompetent to consent to the removal of his respirator. The court, rejecting the right to privacy analysis for fear of unrestrained application, based its decision on the common law principle of self-determination.²²

As the previously discussed courts all looked for ways to support their decisions, something remained lacking. What remained lacking was the fact that the Supreme Court of the United States had yet to address this "right to die" issue. In June, 1990, the Supreme Court finally confronted the "right to die" issue and gave its opinion in the landmark case of *Cruzan v. Director, Missouri Dept. of Health*.²³

In *Cruzan*, the Court was faced with the issue of whether the United States Constitution granted a "right to die." Nancy Cruzan suffered severe brain damage in an automobile accident and as a result was in a persistent vegetative state.²⁴ She had been in this condition since 1983 and her parents petitioned the Missouri Supreme Court to remove the feeding and hydration tube that kept her alive. The court recognized her right to refuse treatment, but given the state's living will statute, it felt that this right could only be exercised under state law by clear and convincing evidence that the patient would have refused the treatment. The court concluded that such clear and convincing evidence was not present. Nancy's parents appealed this decision, and the United States Supreme Court decided to delve into the "right to die" quagmire.²⁵

The Supreme Court held that "a competent person has a liberty interest under the Due Process Clause in refusing unwanted medical treatment."²⁶ It further held, however, that "whether [this] constitutional right [had] been violated must be determined by balancing the liberty interest against relevant state interests."²⁷ The problem in this case, however, was that Nancy Cruzan was not a

22. Steven J. Wolhandler, *Voluntary Active Euthanasia for the Terminally Ill and the Constitutional Right to Privacy*, 69 CORNELL L. REV. 363 (1984). A more recent case has also upheld a patient's right to refuse medical treatment based on the common-law right to self-determination. In *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985), the court stated that "on balance, the right to self-determination ordinarily outweighs any countervailing state interests, and competent persons generally are permitted to refuse medical treatment, even at the risk of death." *Id.* at 353, 486 A.2d, at 1225. The court further held that this right of self-determination is not lost due to incompetence. Instead, a surrogate decisionmaker could be appointed to exercise this right "when there was clear evidence that the incompetent would have exercised it. Where such evidence was lacking, the court held that an individual's right could still be invoked in certain circumstances under objective 'best interest' standards." *Cruzan v. Director, Missouri Dept. of Health*, 110 S. Ct. 2841, 2848 (1990) (referring to *In re Conroy*, 98 N.J. 321, 361-368, 486 A.2d 1209, 1229-1233 (1985)). Recently, however, "the Court of Appeals of New York refused to accept less than the clearly expressed wishes of a patient before permitting the exercise of her right to refuse treatment by a surrogate decisionmaker." *Cruzan v. Director, Missouri Dept. of Health*, 110 S. Ct. 2841, 2849 (1990) (referring to *In re Westchester County Medical Center on behalf of O'Connor*, 72 N.Y.2d. 517, 534 N.Y.S.2d 886, 531 N.E.2d 607 (1988)).

23. 110 S. Ct. 2841 (1990).

24. The Court defined a persistent vegetative state as "a condition in which a person exhibits motor reflexes but evinces no indications of significant cognitive function." *Id.* at 2842.

25. *Cruzan*, 110 S. Ct. 2841, 2842-2843 (1990).

26. *Id.* at 2843.

27. *Id.* The Court specifically noted that the state's interests include the protection and preservation of human life.

competent individual and could, therefore, not make an informed and voluntary decision to terminate the feeding and hydration which kept her alive. As a result, the Court was faced with the more difficult question of whether Missouri may require clear and convincing evidence that the incompetent patient would have wanted the lifesaving treatment discontinued.²⁸ The Court held that "a State may apply a clear and convincing evidence standard in proceedings where a guardian seeks to discontinue nutrition and hydration of a person diagnosed to be in a persistent vegetative state."²⁹ The Court felt that the state's interests in life were strong enough to allow it to impose a clear and convincing standard in order to guard against potential abuses and erroneous decisions.³⁰ In rendering their decision, however, the Court left several critical issues unanswered, including doctor assisted active euthanasia.³¹

Three weeks prior to the *Cruzan* decision, Dr. Kevorkian and his suicide machine hit the headlines.³² It is clear that the Supreme Court intentionally avoided giving an opinion that would encompass doctor assisted active euthanasia.³³ The Supreme Court has apparently left this issue to the legislatures and the lower courts. As a result of the immense confusion on this issue, private groups have been lobbying to get some sort of doctor assisted active euthanasia legislation passed. There are presently four states in which pro-euthanasia initiatives are or have been advanced: Washington, Oregon, Florida and California.³⁴ Of these four, Washington State's Initiative 119 was the closest to becoming a reality.³⁵ On November 5, 1991, however, Initiative 119 was rejected by the

28. *Cruzan* at 2852.

29. *Id.* at 2854.

30. *Id.* at 2854-2856. In other words, a person has a Constitutional right to die that may be exercised by their guardian, but a state may impose rigorous evidentiary standards, including that of clear and convincing.

31. An argument can be made from this line of cases, however, that since a person has a constitutionally protected right to end his life, an individual who assists him should also be protected from criminal sanction since he is just assisting the patient exercise his constitutional right. The court in *Quinlan* stated:

"the exercise of a constitutional right . . . is protected from criminal prosecution. [This] constitutional protection extends to third parties whose action is necessary to effectuate the exercise of that right where the individuals themselves would not be subject to prosecution or the third parties are charged as accessories to an act which could not be a crime."

In re *Quinlan*, 70 N.J. at 52, 355 A.2d at 670 (citing *Eisenstadt v. Baird*, 405 U.S. 438, 445-46 (1972), and *Griswold v. Connecticut*, 381 U.S. 479, 481 (1965)); See generally Steven J. Wolhandler, *Voluntary Active Euthanasia for the Terminally Ill and the Constitutional Right to Privacy*, 69 CORNELL L. REV. 363, 375-76 (1984).

32. See *supra* notes 1-4 and accompanying text.

33. *Cruzan* at 2851. The Court stated that an individual has a constitutional right to have treatment withheld. In other words, a patient has a constitutional right to passive euthanasia. Now that the Court has recognized this constitutional right, it appears that in time, the court may also allow a right to cross the line into "active euthanasia". Furthermore, proponents of active euthanasia argue that quickly ending one's suffering is more humane than increasing one's suffering by starving them to death. See *supra* notes 10-11 and accompanying text, and note 31.

34. Eric Harrison, *Man Helps Wife In Suicide, Now Faces Murder Charges; Mercy Death: Californians Thought Michigan Law Was Lenient. They Picked The Wrong State At The Wrong Time*, L.A. TIMES, Sept. 8, 1990, § A at 1-A, col. 1.

35. Although the Washington Citizens for Death with Dignity collected more than the 150,001 necessary signatures to get the initiative on the 1991 ballot, their efforts proved fruitless. Some would argue, however, that the country has finally been forced to consider this issue, as well as its ramifications.

citizens of Washington State. If it would have passed, it would have been the first law in this country which legalized doctor assisted active euthanasia.³⁶

III. THE ARGUMENTS PRO AND CON

Many arguments have been proffered both for and against doctor assisted active euthanasia. Those people who object to it do so on both religious and nonreligious grounds. Although many argue that it would be unethical for doctors to actively assist in euthanasia,³⁷ the main objection to be dealt with in this Note is that in such a procedure the risks of abuse outweigh the minor benefits.

Yale Kamisar raised the major nonreligious objections to active euthanasia. His first concern is what he refers to as the "parade of horrors." He foresees a slippery slope in which society, accepting voluntary euthanasia, will have no way to limit it and prevent its abuse. He argues that the greatest "danger [is] that [the] legal machinery initially designed to kill those who are a nuisance to themselves may some day engulf those who are a nuisance to others."³⁸ He foresees this involuntary active euthanasia as being analogous to that of Nazi Germany.³⁹

Proponents of doctor assisted active euthanasia feel that Kamisar's fears are blown out of proportion and that the courts and legislatures could establish workable guidelines that would protect against such abuses.⁴⁰ Although the

36. The controversial provision of Initiative 119 provided the right to adult patients who are terminally ill and who are conscious and mentally competent. For these persons, the initiative provided for a new medical procedure called aid-in-dying. This procedure would be carried out by a licensed physician and would be available on a completely voluntary basis to qualified patients. To qualify, a patient would need to be examined by two physicians, both of whom would have to state in writing that, in their reasonable judgment, death would occur within six months. Additionally, the patient would need to make a written request for aid-in-dying at the time such procedure is desired, and the request would need to be witnessed by two disinterested persons. Finally, aid-in-dying could not be administered at the request of anyone other than the patient. Memorandum from the Washington Citizens for Death with Dignity, *About Initiative 119* (1990).

37. The chairman of the American Medical Association (AMA) expressed the views of the AMA when he stated that "under no circumstances should a physician intentionally cause death." The AMA does, however, permit acts of passive euthanasia. D'Arcy Jenish, *The Right to Die*, MACLEAN'S, June 25, 1990, at 24. The AMA's view, however, is not universally accepted by all doctors. "In January 1988 the Journal of the American Medical Association printed a letter from an anonymous doctor who had administered a lethal injection to a young woman dying of ovarian cancer." "In March 1989 12 doctors were co-authors of an article in The New England Journal of Medicine about treating the terminally ill, 10 of them came out in favor of assisted suicide." Daniel Golden, *A Time to Die*, BOSTON GLOBE, Oct. 7, 1990, (Magazine), at 16. In addition, 250 doctors responded to a harshly critical Medical Tribune article regarding doctor assisted active euthanasia. Of the 250 responses, about 45 percent approved of doctor assisted active euthanasia. Cynthia Gorney, *'Dr. Death's' Life Obsession*, WASH. POST, Dec. 20, 1990, at D1.

38. Yale Kamisar, *Euthanasia Legislation: Some Non-Religious Objections*, in EUTHANASIA AND THE RIGHT TO DEATH, 87 (1969).

This fear almost became a reality in Minneapolis when the physicians at the Hennepin County Medical Center petitioned the Hennepin County Court to remove Helga Wanglie's respirator, against the wishes of her husband. Oliver Wanglie, acting as his wife's guardian, wished to continue this life-sustaining care, despite the fact that she had been in a persistent vegetative state for over a year. Hennepin County Judge Patricia Belois ruled that Mr. Wanglie was the proper legal guardian and would not be disqualified. Judge Belois's decision followed the 15 year trend which holds that decisions to withhold or withdraw life-sustaining care are personal, ethical matters, to be made by patients, their guardians or next of kin, rather than by physicians. B.D. Colen, *Hospital Can't Pull Plug; Rights of kin affirmed in life-support case*, NEWSDAY, July, 2, 1991, at 15.

39. *Id.* at 116.

40. Williams, *Euthanasia Legislation: A Rejoinder to the Non-Religious Objections*, in EUTHANASIA AND THE RIGHT TO DEATH, 144-145 (1969).

legislatures would have to carefully draft these guidelines, and the courts would have to carefully make their rulings, both groups are presently under similar constraints on any one of many given matters that they face daily.

Kamisar's second concern is that the minor benefits are outweighed by the potential for mistake and abuse.⁴¹ He feels that the area most vulnerable to abuse is that of voluntariness. His concern is that a weakened patient would be coerced for improper reasons to consent to euthanasia. This coercion could be intentional or unintentional. He feels that "a doctor may react more emotionally and less objectively"⁴² when dealing with terminally ill patients. Thus, the doctor's professional judgment may be clouded. In addition, family members may grow resentful of the patient while caring for him or her and may not keep the patient's best interests in mind.⁴³ As a result of being unable to identify the patient's true intentions, Kamisar would forbid doctor assisted active euthanasia.

Once again, the proponents of doctor assisted active euthanasia feel that Kamisar's fears are blown out of proportion. Their view is based on the fact that the courts are often called upon to determine a person's true intentions.⁴⁴ Furthermore, the proponents feel that the courts and legislatures could establish workable guidelines that would protect against such abuses.

Kamisar also considers the possibility of mistake.⁴⁵ The argument being that a patient may have been misdiagnosed. In addition, there is the possibility that a cure may be discovered before the patient would die naturally.

Conversely, proponents would argue that these considerations would be two factors that the informed patient would have to consider when deciding on doctor assisted active euthanasia. In addition, legislation could demand standards such as more than one or two diagnosis.

An argument can also be made that since the Supreme Court held that "a competent person has a liberty interest under the Due Process Clause in refusing unwanted medical treatment,"⁴⁶ it is the patient's constitutional right to be able to choose doctor assisted active euthanasia. Furthermore, since a person has a constitutionally protected right to end his life, an individual who assists him should also be protected from criminal sanction since he is just assisting the patient exercise his constitutional right.⁴⁷

Although there are compelling arguments both for and against doctor assisted active euthanasia, our goal, as stated before, is not to judge them but to analyze some guidelines which have been discussed so as to prevent abuses if legislatures implemented such a system.

41. Yale Kamisar, *Euthanasia Legislation: Some Non-Religious Objections*, in EUTHANASIA AND THE RIGHT TO DEATH, 87 (1969).

42. *Id.* at 97.

43. *Id.*

44. The most striking example is in the area of criminal law. In this area courts go as far as the imposition of the death penalty based on inferred determinations of intent. Steven J. Wolhandler, *Voluntary Active Euthanasia for the Terminally Ill and the Constitutional Right to Privacy*, 69 CORNELL L. REV. 363, 378 n.86 (1984).

45. Yale Kamisar, *Euthanasia Legislation: Some Non-Religious Objections*, in EUTHANASIA AND THE RIGHT TO DEATH, 97 (1969).

46. *Cruzan*, 110 S. Ct. 2841, 2843 (1990).

47. See *supra* note 31.

IV. GUIDELINES ANALYSIS

Although the controversy surrounding these measures continues to increase, several important considerations must be addressed before the government should legislate such a policy. (Note that this work deals only with political and legal ramifications and does not attempt to address the serious issues of morality which arise from this topic, such as whether humans should make the decision as to when one should die.) Among these considerations must be how to control the enormous abuse potential of such a policy. Towards this end, this Note will now analyze some guides for legally regulating doctor-assisted suicide and will also assess their ability to monitor such a policy.

A. Guidelines

Among some of the more common and more frequently discussed guidelines are:

1. Any practicing physician or licensed telostriician may provide aid-in-dying techniques only to terminally-ill patients who have consciously requested such treatment (either at the time or by means of a directive) which can be proven by clear and convincing evidence;⁴⁸
2. Any written directive will be good for a maximum of two years;⁴⁹
3. In any aid-in-dying treatment, doctors may only use least active means to effectuate death;⁵⁰
4. All aid-in-dying treatments must be reported within one week of the incident to an Aid-in-Dying Medical Board.⁵¹

B. Assessment of Guidelines

1. Guideline Number 1.

The first guideline establishes the groundwork for several important questions, which any aid-in-dying treatment legislation will have to answer. These questions are: (1) Who may choose to die? (2) Who may request the aid-in-dying treatment? (3) Who may cause or initiate the death? and (4) What level of evidence will be necessary to prove that an aid-in-dying treatment request has been made if disagreements in the case should occur? To fully understand the impact of an aid-in-dying treatment, it is worth examining the repercussions of each question both in light of its overall significance and in light of what the proposed regulation attempts to do.

48. Seminar, *Model Aid-in-Dying Act*, 75 IOWA L. REV. 125, 150 (1989). This model act articulated several clauses which addressed many of the particular issues with which we are concerned. The recommended guidelines presented here answer some of these issues, but in a different way. The Model Aid-in-Dying Act diverges from most proposed ideas in that it also includes "non-terminally ill individuals who are dependent on life-sustaining technology" and also "persons who suffer from an intolerable dependency." *Id.* at 136, 166-67.

49. Seminar, *Model Aid-in-Dying Act*, 75 IOWA L. REV. 125, 150 (1989). This Act discusses the duration of a valid directive. This proposed Act allowed directive to be effective for ten years.

50. *Id.* at 190.

51. *Id.* at 179-82. This Act discusses the jurisdiction and operation of such a Board. The Model Aid-in-Dying Act proposes several responsibilities for such a Board, but perhaps the most important responsibility, would be to file and monitor reported uses of the Aid-in-Dying treatment. This function would provide a continuous monitoring system of this treatment.

a. *Who May Choose To Die?*

The legislative answer to this question has the most far-reaching ramifications because how the legislature answers this question defines the scope of the aid-in-dying treatment. The two sides are greatly divided on this issue. On one side, people argue that individuals do not have a right to choose to die - that this decision goes beyond any rights which humans may have.⁵² These people believe that taking one's life - or suicide - has no place in a civilized culture where the goal is to enhance life and to live life to its fullest.⁵³ Furthermore, since suicide is viewed as having no place in society, any assistance to the act of suicide whether by doctors or others is also viewed negatively.

On the other hand, people argue that if individuals are truly free to live and seek their own happiness, then a right which they must possess is the right to choose to die and the right to choose when to die.⁵⁴ They argue that in order for society to be humane, individuals must be able to decide and to choose to stop their pain and suffering and to request the aid-in-dying treatment. The extremes on this side would likely argue that all people, regardless of their present state, have the right to choose to die. The authors think, however, that most advocates of this position, would establish some limits and would not likely argue for an open aid-in-dying policy.

Guideline number one above attempts to set such a limit. The limit is that only terminally-ill patients could request aid-in-dying treatments. For purposes of this guideline, a terminally-ill patient would be any patient whom two doctors would agree likely has less than six months left to live.⁵⁵ This guideline seeks to limit the application of such treatment. Some proposed acts seek to extend its application. The Model Aid-in-Dying Act extends application to non-terminally-ill patients in some circumstances.⁵⁶

Several advantages arise from such a limiting guideline. First and foremost, this guideline sets in black and white the extent to which such an aid-in-dying treatment could be used. This guideline would deter the gradual movement towards unlimited use. Yale Kamisar posits as one of the most serious problems the "Wedge Theory" which states that "Once society accepts that life can be terminated because of its diminished quality; there is no rational way to limit euthanasia and prevent its abuse."⁵⁷ The authors recognize that the trend in

52. State interests against suicide are: preservation of life, the protection of the parties, the prevention of suicide, and the maintenance of ethical integrity of the medical profession. Robert F. Weir and Larry Gostin, *JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION* 1846, 1850 (October 10, 1990). See also *Saikewicz* and *Conroy* cases.

53. "Whenever confronted by life or death choices, Divine Revelation teaches us to choose life (Deut. 30:19) and our American bishops mandate respect for life in all of its mystery (Origin 14:526, 1985)" *ETHICS & MEDICS* 3, 4 (April 1989).

54. The right to self-determination and the right to privacy are the primary reasons to support this position. *Roe v. Wade*, 410 U.S. 113 (1973), *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E. 2d 417 (1977), *In re Quinlan*, 70 N.J. 10, 355 A. 2d 647 (1976). See also Steven J. Wolhandler, *Voluntary Active Euthanasia for the Terminally Ill and the Constitutional Right to Privacy*, *CORNELL L.REV.* 363, 369 (1984).

55. Seminar, *Model Aid-in-Dying Act*, 75 *IOWA L. REV.* 125, 142 (1989). See also definition of terminally-ill in Washington Initiative 119.

56. *Id.* at 167, 168. See *supra* note 48.

57. Yale Kamisar, *Euthanasia Legislation: Some Non-Religious Objections*, in *EUTHANASIA AND THE RIGHT TO DEATH* (1969).

society appears to accept the idea that life can be terminated in certain circumstances, but also recognizes Mr. Kamisar's fears. Therefore, this guideline attempts to do what Mr. Kamisar says is irrational, and that is to limit. If any aid-in-dying act is accepted, it seems clear that limits will be essential. A clear guideline which spells out specifically who could undergo this aid-in-dying treatment must be set because otherwise the potential abuse and trend could destroy society. Secondly, the above limit attempts to allow only those cases where death is imminent and pain and suffering are likely the greatest and, therefore, attempts to avoid the problems of the "Wedge Theory". Instead of terminating lives because of the diminished quality of life, such a guide may be premised on the humane care of limiting the pain and suffering of the terminally-ill. By adopting a guideline which allows only for terminally-ill patients to have aid-in-dying treatment, the legislature is not allowing itself or the doctors to decide if a person should die, but rather it is allowing the dying process, which has already become present in terminally ill patients, to be speeded up. Whatever the legislature premises such a guide on, if it decides to implement such a policy, it is paramount that strict and clear limits are set; otherwise, Mr. Kamisar's fears may be realized.

People on both sides may be upset because this regulation either allows too much or does not allow enough. People may make strong arguments that an Aids patient or an Alzheimer patient or a person in a vegetative state who cannot be said to be going to die within six months have just as much right to die as the ones allowed for.⁵⁸ The problem is that as we allow this line of argument we fall exactly into the trap of Yale Kamisar and no rational limit can be drawn. Any type of suicide would be allowable. As stated above, a clear limit must be an essential part of any aid-in-dying policy. To set a limit which speeds up the dying process is arguably different than allowing people to decide when the process begins.

Problems do exist with this guideline, however, beyond these basic differences of opinion. The first problem is whether doctors can legitimately and accurately know if a patient will die within the next six months.⁵⁹ Doctors just cannot know this with certainty. A second problem involves the role of the family or guardians and the hospital in the decision-making process.⁶⁰ This problem will be more fully explored in question two.

b. Who May Request The Aid-in-Dying Treatment?

This question analyzes the role of others in making this request. Presently, the courts, while not dealing specifically with doctor-assisted suicide, have nonetheless dealt with a patient's right to decide to die, in which the family has made the request⁶¹ and also in which the hospital and doctors have made the request.⁶² Since *Cruzan*, where the Supreme Court said that the family could make the request for the patient if there was clear and convincing evidence that the patient

58. See *supra* note 55; see also Washington Initiative 119.

59. Bernard Lo, Fenella Rouse, and Laurie Dornbrand, *Family Decision Making on Trial*, NEW ENGLAND JOURNAL OF MEDICINE, 1229 (April 26, 1990).

60. *Law and Medicine*, NEW ENGLAND JOURNAL OF MEDICINE, 1228, 1230 (April 26, 1990).

61. *Cruzan v. Director, Missouri Dept. of Health*, 110 S. Ct. 2841 (1990).

62. See *supra* note 38.

would have so chosen, many people have gone and executed living wills and authorized durable power-of-attorney to let their intentions be known.⁶³ (Several problems, however, exist with living wills.⁶⁴)

Guideline number one pulls back on the current trend and limits the choice to terminally-ill patients who have consciously (either now or in the past) requested such treatment. This puts the decision in the hands of the patient and will eliminate the potential abuses of ill-family or physician intentions.⁶⁵

Many will argue that this is unfair and unjust because many of the people who are in a position of dying within six months no longer are conscious and, therefore, would not be able to exercise their right to choose aid-in-dying treatments. However, the time frame to be discussed later can help in such cases. Others will also argue that guardians or attorneys or others are often able to make decisions for people who are incompetent or unconscious, etc.⁶⁶ However, one important aspect sets this decision apart from any other decision a person could make for someone else - this decision is final. No second chances exist in this case. In such cases to allow another person to decide, no matter how closely related, is an injustice to the terminally-ill patient. No two people think exactly alike and if this person felt so strongly about the matter, sufficient means would be available under the guidelines to express these views. Legislatures must be careful of who has the power to make this decision. Guideline number one seems to provide an important limitation on this power. This limitation would seem to work to ensure that the dignity of the person and the person's wishes govern this process.

c. *Who May Cause Or Initiate The Death?*

If an aid-in-dying treatment becomes part of societal practice, questions exist as to who can initiate or cause the death. Questions arise as to whether doctors, family, other individuals, or the person themselves should be allowed to perform this treatment. Guideline number one places it in the hands of a doctor or a telostriician. A telostriician "is a person who is licensed by the [Department of Health] to provide aid-in-dying in this [state]"⁶⁷ By placing the treatment here, this regulation hopes to maintain the ethical and professional treatment of the patient to the time of death. By having the patient under the care of a physician or telostriician, hospital care can be assured. In addition, this lends itself to the necessity that the least active means to effectuate the death be employed. Concerns

63. *Q. & A. on the Hemlock Society*, Hemlock Quarterly 5 (1989). "This document (legitimized by 38 states is a written request from patient to doctor not to be put on life-support equipment - or to be taken off it - if the patient is hopelessly ill and wants to die without further medical intervention".

64. *The Living Will Revisited*, ETHICS AND MEDICS, (April 1988).

65. The *Cruzan* Court feared that other patients might be harmed by unscrupulous families who wanted to discontinue treatment inappropriately, 110 S. Ct. 2841 (1990). The alternative argument is that the court failed to recognize other safeguards, which make it more difficult for other family members to get treatment stopped. Bernard Lo, Fenella Rouse, and Laurie Dornbrand, *Family Decision Making on Trial*, NEW ENGLAND JOURNAL OF MEDICINE, 1228, 1231 (April 26, 1990).

66. This is the argument behind allowing Durable Power of Attorney contracts. See HEMLOCK QUARTERLY 5 (January, 1989).

67. Seminar, *Model Aid-in-Dying Act*, 75 IOWA L. REV. 125, 142, 188-189 (1989). The term "telostriician" was "first coined by Roger Crisp and is derived from the Greek 'telos,' which means end." *Id.* at 145. See also Roger Crisp, *A Good Death: Who Best to Bring It?*, 1 BIOETHICS 74, 78-79 (1987).

do exist, however, as to whether a doctor, who is trained to save lives, should now have the job of ending a person's life. It would be important not to force doctors to have to perform this aid-in-dying treatment because it would be a type of treatment tied with great emotional and moral concerns. An alternative idea would be to grant to the new telosticians the sole power and authority to end a terminally-ill patient's life. This alternative would avoid the problem of placing doctors in the dilemma of ending a person's life rather than trying to save it.

d. What Level Of Proof Will Be Necessary To Prove That Aid-in-Dying Treatment Request Has Been Made If Disagreements In This Case Should Occur?

Guideline number one attempts to follow the way the Supreme Court has leaned. While the Supreme Court has not directly held what burden of proof would be necessary in a doctor-assisted aid-in-dying treatment case, the Supreme Court has held in regards to the right-to-die in *Cruzan* that the burden of proof can be held to be clear and convincing evidence.⁶⁸ In extending this burden to doctor-assisted suicide cases, the guideline suggests that at least clear and convincing evidence should be required concerning the person's conscious request.

In regards to the presented guidelines, the terminally-ill patient would be able to show clear and convincing evidence by his own oral statements requesting the treatment and through earlier written directives,⁶⁹ (which will be discussed more fully later). As to the evidence presented by family members and friends, this evidence may supplement the patient's actual request or directive but will not have enough weight in and of itself to meet the actual request requirements which were discussed above.

With future cases, the courts may redefine what standard of evidence is necessary, but under these proposed guidelines - the actual request or directive - calls for surety, and clearly cuts down on the potential for misguided or unfounded requests or other abuses.

2. Guideline Number 2.

The second guideline undertakes to assure two important qualifications, the first is to assure that the terminally-ill patient does in fact choose to use the aid-in-dying treatment and the second is to assure that this decision remains current and accurate throughout the person's life.

To assure Aid-in-Dying treatment is what the terminally-ill patient has chosen is an important concern for legislatures if they are to develop such guidelines to insure that the dignity of the individual is preserved. The most obvious way legislatures could assure this aim would be to limit the aid-in-dying treatment to those who consciously request it. However, one major problem exists with such a stance, and that is that a person meeting the terminally-ill definition may not be in a conscious condition - physically or mentally able to make such a decision. The directive allowance seeks to overcome this problem. Living wills and durable power-of-attorney certificates have increased since the *Cruzan* case. These docu-

68. *Cruzan v. Director, Missouri Dept. of Health*, 110 S. Ct. 2841 (1990)

69. *Id.* at 2841.

ments, despite their problems, do express directly the choice of the patient - the actual person to be affected. Patients can consciously execute a directive which will express their choice in such a manner as to be within the guideline requirements. This requirement restricts the abuses which may occur when a person, such as a family member or hospital worker or a friend, seeks to make a decision for the terminally-ill patient. In this case, the terminally-ill patient will have chosen his own fate.

Significant to assuring that the patient's decision is informed and fully accurate of the patient's intention, a time requirement is also necessary.⁷⁰ The guideline suggests two years for this time measure. This time period is important because such a time scale works to maintain the legitimacy and accuracy of the person's decision. If a person must renew his directive every two years, then it is an issue with which the person must continue to grapple with and think about. In addition, except in cases of emergencies where the person cannot decide, it focuses the person to make the decision in proximity to its result.

Only by forcing such proximity can the person make a more informed decision. The observant reader notices, however, that the terminally-ill patient can never make a fully informed decision because no one knows exactly the amount of pain to be had, what the results would be without the aid-in-dying treatment, and what death holds. This guideline, however, seeks to make sure that this decision is as informed and as timely as possible.

3. Guideline Number 3.

The Third Restriction Seeks To Humanize The Process And Assume That The Medical Profession's "Oath To Promote Health And Betterment" Of Individuals Will Be Maintained.⁷¹ The significance of this guideline is to markedly separate the aid-in-dying treatment from suicide. The essential effort is to continue to remember that aid-in-dying is only one of several treatments which doctors may use. Doctors, under rules and ethical codes of the American Medical Association, would be expected and required to practice in a professional way.⁷² Part of this professionalism dictates humaneness and efforts to minimize pain. The aid-in-dying treatment would likely be a traumatic moment for all involved, particularly family members. To require doctors to use the least active means to effectuate death would help this process. Most importantly, however, such means would assure that the dignity of the person is maintained and preserved throughout the illness until the time of death.

The least active means would be decided by the American Medical Association in conjunction with the Board on the Aid-in-Dying.⁷³ Doctors, employing means other than those prescribed by these medical bodies, would be prosecuted.⁷⁴

4. Guideline Number 4.

70. Seminar, *Model Aid-in-Dying Act*, IOWA L. REV. 125, 150 (1989).

71. See American Medical Association Rules and Regulations.

72. See *supra* note 71.

73. Seminar, *Model Aid-in-Dying Act*, 75 IOWA L. REV. 125, 190 (1989).

74. The penalty for such violations will have to be determined, but because of the risks of abuse of power, the authors recommend that violating doctors lose their license if the doctor employs this treatment wrongly. This measure should provide a strong incentive not to abuse this process.

The fourth guideline requires that all doctors who have practiced an Aid-in-Dying treatment must report the treatment to the Board. This reporting is important for several reasons. Among these reasons are that this treatment would less likely be abused if the doctors realized that they were being overseen. It would also allow people to view statistics, and from these statistics, judge the potential of such acts and what the future potential of such treatment may be. Finally, such an overseeing Board would work to maintain the legitimacy of such a form of treatment.⁷⁵

Some opponents of such a Board may argue that it is unnecessary as there is not a board for other forms of medical treatment or that such a Board may hinder a doctor's approach to treating certain terminally-ill patients. With someone watching over a doctor's shoulder, they may not act as they would otherwise. In response, to the first argument, it is clear that aid-in-dying treatment is unlike any other treatment that a doctor may use. In other efforts, a doctor seeks to prolong the life of the individual; in this remote treatment, the doctor is called upon not to prolong life, but instead to diminish the life expectancy of an individual. To maintain legitimacy in the profession, and in the eyes of the public, such a Board is necessary. Legislators should avoid placing this decision in the hands of individual doctors. These doctors must be acting within certain well-defined and stringent parameters.

In response to the second argument, the fact that such a Board may hinder a doctor's actions or cause him to rethink his views, such as whether the terminally-ill patient will die within six months, is anything but an evil. In such an important and decisive decision, the more thought and the more surety that a doctor can bring to his decision can only help prevent abuses to this treatment.

The above guidelines, and questions concerning these guidelines, have been analyzed only to continue to invoke thought about potential problems and solutions arising from a possible act allowing doctor-assisted suicide. The legal decisions of various courts, and the de facto policy of some doctors indicate that doctor-assisted suicide may in fact not be that far away. The guidelines for such a policy must make sure that this act, which is claimed to be done for human's sake, does not end up engulfing our humanness. Whenever a person dies it is tragic, but when one person is allowed to legally partake in either his own death or the death of another, numerous questions must be asked and answered. Throughout all of the future debate on this topic, one must always hold to and ensure the dignity of the human being.

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75. The pragmatics of such a Board could be clarified by joint efforts of the legislature and the American Medical Association.

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APPENDIX
THE 1988 ROPER POLL
on Attitudes toward Active Voluntary Euthanasia

The following question was asked of 1,982 Americans in March, 1988: when a person has a painful and distressing terminal disease, do you think doctors should or should not be allowed by law to end a patient's life if there is no hope of recovery and the patient requests it?

I. Should be allowed by law:

Protestant	Catholic	Jewish	Other	None	Don't Know	Total
575	352	35	78	108	8	1156
55%	61%	69%	56%	69%	39%	58%

II. Should Not be allowed by law:

294	159	8	51	26	8	545
28%	27%	15%	37%	16%	39%	27%

III. Don't Know/no answer:

169	69	8	10	22	4	282
16%	12%	16%	7%	14%	22%	14%

IV. Totals:

1038	580	51	138	156	20	1982
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THE 1990 ROPER POLL
on Attitudes toward Active Voluntary Euthanasia

The following question was asked of 1,978 Americans in April, 1990: when a person has a painful and distressing terminal disease, do you think doctors should or should not be allowed by law to end a patient's life if there is no hope of recovery and the patient requests it?

I. Should be allowed by law:

Protestant	Catholic	Jewish	Other	None	Don't Know	Total
645	344	48	116	106	4	1264
65%	62%	70%	61%	65%	49%	64%

II. Should Not be allowed by law:

230	137	12	45	38	3	465
23%	25%	17%	24%	23%	39%	24%

III. Don't Know/no answer:

121	70	9	28	20	1	248
12%	13%	13%	15%	12%	12%	13%

IV. Totals:

996	551	69	189	164	9	1978
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