Denver Law Review

Volume 71 | Issue 1 Article 22

January 1993

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Thane Josef Messinger

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A GENTLE AND EASY DEATH: FROM ANCIENT GREECE TO BEYOND CRUZAN TOWARD A REASONED LEGAL RESPONSE TO THE SOCIETAL DILEMMA OF EUTHANASIA

THANE JOSEF MESSINGER*

To be, or not to be, that is the question:
Whether 'tis nobler in the mind to suffer
The slings and arrows of outrageous fortune,
Or to take arms against a sea of troubles
And by opposing, end them. To die, to sleep.
No more; and by a sleep to say we end
The heart-ache and the thousand natural shocks
That flesh is heir to; 'tis a consummation
Devoutly to be wish'd. To die,
to sleep.[1]

I. INTRODUCTION

The subject of euthanasia has presented societies throughout history with a deeply troubling dilemma of defining the meaning of death—and the value of life.[2] Advocates on both sides are pointed in their criticisms,

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* Associate, Oshima, Chun, Fong & Chung, Honolulu, Hawaii; J.D., University of Texas, 1991; M.B.A., Southwest Texas State University, 1985; B.A., California University of Pennsylvania, 1984.

I would like to express my appreciation to Drs. Milton Messinger, Joseph Kulhavy, David Ronin, Yvonne Cripps, and the Honorable Lynn Hughes for their review of, and insightful comments to, various drafts of this article.

I would also like to thank my wife, Bao-lan. 谢谢！ 我爱你。

1. WILLIAM SHAKESPEARE, THE TRAGEDY OF HAMLET PRINCE OF DENMARK act 3, sc. 1. Hamlet's soliloquy speaks timelessly well to both sides of the euthanasia debate; "the slings and arrows of outrageous fortune" captures the essence of what is normally considered by proponents necessary for euthanasia to be legitimate, while the "thousand natural shocks" are destined for all, and are thus not sufficient to warrant taking arms against one's own sea of troubles. *Id.* The operative words are "outrageous" on the one hand and "natural" on the other.

2. *See, e.g.*, DON V. BAILEY, THE CHALLENGE OF EUTHANASIA: AN ANNOTATED BIBLIOGRAPHY ON EUTHANASIA AND RELATED SUBJECTS (1990); DEREK HUMPHRY & ANN WICKETT, THE RIGHT TO DIE: UNDERSTANDING EUTHANASIA 1-130 (1986) (the authors are co-founders of The Hemlock Society, which advocates euthanasia); O. RUTH RUSSELL, FREEDOM TO DIE: MORAL AND LEGAL ASPECTS OF EUTHANASIA 53-214 (rev. ed. 1977); BETH SPRING & ED LARSON, EUTHANASIA: SPIRITUAL, MEDICAL & LEGAL ISSUES IN TERMINAL HEALTH CARE 105-34 (1988) (historical Christian perspective); SUICIDE AND EUTHANASIA: HISTORICAL AND CONTEMPORARY THEMES 9-216 (Barouch A. Brody ed., 1989) [hereinafter SUICIDE AND EUTHANASIA]; DAVID C. THOMASMA & GLENN C. GRABER, EUTHANASIA: TOWARD AN ETHICAL SOCIAL POLICY 85-86 (1990); ROBERT N. WENNBERG, TERMINAL CHOICES: EUTHANASIA, SUICIDE, AND THE RIGHT TO DIE 1-107 (1989); JERRY B. WILSON, DEATH BY DECISION: THE MEDICAL, MORAL, AND LEGAL DILEMMAS OF EUTHANASIA 17-45 (1975).

with little common ground for compromise.[3] The law often skirts the issues involved, primarily because society is unable deal with the explosive problems associated with euthanasia. Euthanasia, however, should not be viewed through the narrow lens of our own society or time. It is important to understand the historical and philosophical developments surrounding euthanasia if we are to strive to devise an acceptable legal structure to resolve these difficult problems.

Those opposed reject euthanasia on the ground that it places in jeopardy a fundamental inviolability of human life.[4] From Biblical proscriptions to "natural" law, human life is considered sacrosanct, and efforts to destroy even a fraction of our time on earth are a direct violation of God's will.[5] Suffering is itself seen as a positive influence.[6] The objection has two levels: first, rejecting the possibility that life can have negative value,[7] and second, rejecting the power of man to choose for himself to end his own life.[8] Further, opponents point to a parade of horribles, which they

3. *Compare* Nat Hentoff, *The Indivisible Fight For Life*, STUDIES IN L., MED. & SOC'Y 1-9 (1987) (pamphlet describing a "pro-life" position, published by Americans United for Life, which opposes euthanasia) (copy on file with DENV. U. L. REV.) *and* PAUL MARX, EXCERPTS FROM: THE MERCY KILLERS 1-7 (date unknown) (pamphlet distributed by Human Life International, which opposes euthanasia) (copy on file with DENV. U. L. REV.) *and* CALIFORNIA MEDICAL ASSOCIATION, VOLUNTARY ACTIVE EUTHANASIA: THE "HUMANE AND DIGNIFIED DEATH ACT" 2 (1988) (report concluding that the risks of active voluntary euthanasia outweigh the benefits) *with* GLANVILLE WILLIAMS, THE SANCTITY OF LIFE AND THE CRIMINAL LAW 311-50 (1957) (an early modern advocation of euthanasia by a leading legal scholar) *and* THE NATIONAL HEMLOCK SOCIETY, SUPPORTING THE OPTION OF ACTIVE VOLUNTARY EUTHANASIA FOR THE TERMINALLY ILL 1 (1990) (pamphlet describing the Hemlock Society's General Principles and Objectives) (copy on file with DENV. U. L. REV.) *and* AMERICAN CIVIL LIBERTIES UNION, POLICY #271 (1976) (supporting the legitimacy of Living Wills, while recognizing society's right to prevent suicide (Policy #213)) (*reprinted in* informational sheets distributed by the ACLU) (copy on file with DENV. U. L. REV.).

4. *Cf.* Basil Mitchell, *The Value of Human Life*, *in* MEDICINE, MEDICAL ETHICS AND THE VALUE OF LIFE 34-46 (1990). Western civilization has been indelibly marked by Christian influences, which have imbued an assumption that, to be civilized, a society must value human life absolutely. *See id.* at 38-39; *see also infra* note 78 and part II.B. *See generally* Joseph Boyle, *Sanctity of Life and Suicide: Tensions and Developments Within Common Morality*, *in* SUICIDE AND EUTHANASIA, *supra* note 2, at 221-47 (explaining that the sanctity, sacredness, or dignity of human life provides sufficient reason why one should not kill an innocent person).

5. *See infra* notes 112, 361-62, 365-67 and accompanying text. It is possible to object on non-religious grounds to euthanasia as immoral. *See infra* notes 367, 370 and accompanying text. Non-religious moral arguments often concentrate on the effects of condoned euthanasia, particularly concerning the element of "voluntariness" and its difficult definition. *See infra* parts IV.A.4-6; *see also infra* note 48 (noting an argument that "voluntary" euthanasia is oxymoronic, and necessarily involves varying degrees of coercion). These arguments are powerful because they do not rely for support on the self-referential nature of theological arguments, but instead look to the moral foundations of society. Objections on moral grounds, as distinguished from purely theological ones, are probably best enunciated through the slippery slope objection, *infra* part IV.A.2, and the effect on the euthanasia-candidate and his family, *infra* part IV.A.6.

6. *See infra* notes 217, 368, and accompanying text.

7. *See infra* note 101 and accompanying text; *cf. infra* notes 428-432 and accompanying text (arguing that life may indeed have a negative "value"). *But cf.* Mitchell, *supra* note 4, at 43-44 (noting that the authors of the Linacre Centre's report *Euthanasia and Clinical Practice* carefully avoided framing the issue in terms of the overall quality of the patient's life to avoid the moral morass there).

8. *See infra* text accompanying notes 107-08, 112.

fear will inexorably follow any loosening of proscriptions against killing.[9] One example often cited is the Nazi German debacle, during which millions died—hundreds of thousands under the auspices of "euthanasia" programs.[10] Opponents further argue that any legitimization of euthanasia will erode medical[11] and societal[12] values and will deprive the individual of the will to live.[13]

Against these contentions, proponents of euthanasia cite examples of human suffering that have become increasingly frequent as medical technologies improve.[14] Medicine can now save many who, arguably, should not be saved; some, in essence, outlive their own deaths.[15] The noble goal of medicine has proved a double-edged sword: in the race to preserve life, suffering is sometimes prolonged instead.[16] Those in favor of euthanasia must necessarily reject—or ignore—the theological arguments regarding the sanctity of life. Sanctity itself is, by definition, absolute.[17] This is an uncomfortable position for many, but an unavoidable one when faced with the very real problems of miserable deaths.

As with other issues that are inextricably linked to disparate moral, medical, philosophical, theological, and legal considerations, euthanasia provides little room for agreement.[18] Each side in the debate enters the arena with incompatible presuppositions; either one accepts theological precepts—and all that that implies—or one does not.[19] Progress in the

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9. Generally, proponents are also concerned about the possibilities for abuse, but stress instead the need for legal safeguards. *See, e.g.*, RUSSELL, *supra* note 2, at 272-80; Paul A. Drey & James J. Giszczak, *May I Author My Final Chapter? Assisted Suicide and Guidelines to Prevent Abuse*, 18 J. LEGIS. 331, 338-45 (1992) (noting several policy considerations that need to be addressed before legislation is passed). Further, abuses may be exacerbated by the secrecy caused by a lack of legal options. RUSSELL, *supra* note 2, at 226-27; *cf.* Robert A. Pletcher, *Assisted Suicide for the Terminally Ill: The Inadequacy of Legal Models to Rationally Analyze Voluntary Active Euthanasia*, 13 CRIM. JUST. J. 303, 304-15 (1992). Also objected to is the use of the slippery slope argument as an offensive shield; it can be raised against virtually any action. WILLIAMS, *supra* note 3, at 315; *see also infra* text accompanying note 141.

10. *See infra* notes 176-89, 371, and accompanying text.

11. *See infra* part IV.A.4.

12. *See infra* part IV.A.5.

13. *See infra* part IV.A.6.

14. *See* HUMPHRY & WICKETT, *supra* note 2, at 131-44.

15. *See* WENNBERG, *supra* note 2, at 77-78.

16. Robert N. Wennberg recounted a horror story based on a letter published in the *British Medical Journal* of February 17, 1968, in which a 68-year-old physician is diagnosed as having advanced stomach cancer, which spread quickly to the liver. He suffered constant pain despite increasing dosages of drugs. He developed a lung arterial clot, which was removed. After this, he specifically requested that no other actions be taken to prolong his life. Two weeks later he had a heart attack and was resuscitated. He had four heart stoppages that night, and was resuscitated each time. He lingered for another three weeks, while vomiting and suffering convulsions. Preparations were made for artificial respiration, but his heart beat them to it. *Id.* at 112.

17. *See* Boyle, *supra* note 4, at 221-47 (discussing the theological arguments behind sacrosanct life).

18. The fact that five U.S. Supreme Court opinions were written in the recent watershed case concerning Nancy Cruzan indicates the divisive nature of the debate. *See infra* notes 438-40 and accompanying text.

19. *See infra* notes 361-68 and accompanying text. For a discussion of non-religious objections to euthanasia see Yale Kamisar, *Some Non-Religious Views Against Proposed "Mercy-Killing" Legislation*, 42 MINN. L. REV. 969 (1958).

form of reasoned, balanced public debate and policies are unlikely. In this version of the zero sum game, one side will be the loser. Unfortunately, in this debate the loser won't be able to easily live—or die—with the loss.

Part II of this article focuses on the various meanings of "euthanasia" and related issues.[20] Part III traces the patterns of euthanasia practices and societal mores from ancient Greece and Rome[21] to early Christian attitudes,[22] and finally to contemporary history.[23] Part IV examines arguments on either side of the euthanasia controversy.[24] Parts V and VI examine the legal issues[25] and moral, medical, and economic considerations[26] surrounding the various facets of the euthanasia debate. Part VII briefly illustrates contemporary euthanasia policy in the Netherlands.[27] Finally, Part VIII recommends a redefinition of the right of privacy to include a property interest in one's own physical person, arguing that government must justify intervention in cases where euthanasia is considered.[28] Further, the criminal law should consider the humanitarian motives of the person who kills, the circumstances of the death, and the circumstances of the person who dies. These distinguish permissible euthanasia, under very limited circumstances, from homicide.[29]

II. DEFINING EUTHANASIA AND RELATED TERMS

The term "euthanasia" often connotes disguised murder, barbarism, uncaring elimination of "problem" people, or worse, planned genocide.[30] Many who advocate euthanasia define it as "death with dignity," "mercy killing," or "the right to die,"[31] while opposing groups, such as the International Anti-Euthanasia Task Force, see active[32] euthanasia as "death on

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20. *See infra* part II.
21. *See infra* part III.A.
22. *See infra* part III.B.
23. *See infra* part III.C.
24. *See infra* part IV.
25. *See infra* part V.
26. *See infra* part VI.
27. *See infra* part VII.
28. *See infra* part VIII.
29. *See infra* part VIII.
30. *See infra* notes 177, 189 and accompanying text.
31. *See* CHRISTIAAN BARNARD, GOOD LIFE GOOD DEATH: A DOCTOR'S CASE FOR EUTHANASIA AND SUICIDE 63 (1980); Arthur Dyck, *Beneficent Euthanasia and Benemortasia: Alternative Views of Mercy, in* BENEFICENT EUTHANASIA 117, 118 (Marvin Kohl ed., 1975); James Rachels, *Passive and Active Euthanasia Are Equally Acceptable, in* EUTHANASIA: OPPOSING VIEWPOINTS 42, 43 (Neal Bernards ed., 1989). *See Generally* ROBERT L. RISLEY, DEATH WITH DIGNITY: A NEW LAW PERMITTING PHYSICIAN AID-IN-DYING (1989); Peggy L. Collins, Note, *The Foundations of the Right to Die*, 90 W. VA. L. REV. 235 (1987). "Agathanasia" refers to a "better death." Kenneth L. Vaux, *Debbie's Dying: Mercy Killing and the Good Death, in* EUTHANASIA: THE MORAL ISSUES 30 (Robert M. Baird & Stuart E. Rosenbaum eds., 1989). Arthur Dyck believes the word "benemortasia," from the Latin *bene* (good) and *mors* (death), better describes how we ought to behave toward those who are dying or whose death would appear to be a merciful event. *See* Dyck, *supra*, at 124.
32. *See infra* text accompanying note 45.

demand," the moral equivalent of murder.[33] Importantly, euthanasia is not suicide; rather, it can be a limited subset of a general category of suicide.[34] Defining euthanasia precisely has become particularly problematic because it can encompass disparate actions, or omissions, as well as general philosophies of life and death. The emotions involved in this debate invariably affect, and are affected by, broader feelings, fears, and societal taboos.

The *Oxford English Dictionary* defines euthanasia simply as "[a] gentle and easy death."[35] *Black's Law Dictionary* defines euthanasia as "the act or practice of painlessly putting to death persons suffering from incurable and distressing disease as an act of mercy."[36] Of these definitions, *Oxford*'s is the most eloquent,[37] while *Black's* is more precise in addressing the current uses and connotations of the word, and in focusing the legal and ethical issues on the circumstances where euthanasia may or may not be appropriate.[38] For these reasons, *Black's* definition is intended throughout this Article.[39]

Euthanasia can be further subdivided according to the nature of the action ending life.[40] Passive[41] euthanasia ordinarily entails a refusal to

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33. *See* HUMAN LIFE CENTER, THE INTERNATIONAL ANTI-EUTHANASIA TASK FORCE: AN INTRODUCTION, (undated) (discussion of the organization's reasons for being); *see also* FR. PAUL MARX, AND NOW EUTHANASIA 14 (1985) (distributed by Human Life International, an organization that opposes euthanasia).

34. Suicide is "the act or an instance of taking one's own life voluntarily and intentionally." WEBSTER'S NEW COLLEGIATE DICTIONARY 1156 (1981). The motive for taking one's own life, central to the issue of euthanasia, is missing in the definition of suicide. *See infra* text accompanying notes 501-03 (discussing motive in the definition of homicide). It is also possible for euthanasia to not be suicide, as in involuntary euthanasia. *See infra* notes 49-52 and accompanying text.

35. VII OXFORD ENGLISH DICTIONARY 444 (2d ed. 1989). The definition includes "the means of bringing about a gentle and easy death," as well as the more recent use, "the action of inducing a gentle and easy death." *Id.*

36. BLACKS'S LAW DICTIONARY 554 (6th ed. 1990); *see also* AMERICAN MEDICAL ASSOCIATION, ENCYCLOPEDIA OF MEDICINE 424 (1989) (rejecting passive euthanasia as a subset of euthanasia).

37. It has the advantage also of being (relatively) apolitical. Etymologically derived from the Greek *eu* (good) and *thanatos* (death), it does not bear the burden of current sociological debate. *See* OXFORD ENGLISH DICTIONARY, *supra* note 35. *But cf.* C. Everett Koop, *The Challenge of Definition*, 19 HASTINGS CENTER REP. 2 (1989) (U.S. Surgeon General C. Everett Koop arguing that "euthanasia" is misleading when interpreted as a "good death," because such an interpretation rejects the Judeo-Christian axiom of absolute sanctity of life, and that the medical arena is no place to reverse societal values).

38. *See also* Philippa Foot, *Euthanasia*, *in* DEATH AND DECISION 85, 86 (Ernan McMullin ed., 1978) (underscoring the importance of understanding the meaning beyond that given by the Shorter Oxford English Dictionary, which is essentially the same as that of the Oxford English Dictionary); THOMASMA & GRABER, *supra* note 2, at 2-3 (discussing the role of "value" in the euthanasia debate).

39. Poetic license is requested for the title; BLACK's definition is hardly the stuff of an inspiring banner.

40. Many, particularly those opposed to euthanasia, refuse to recognize the following distinctions; they are seen as purposefully confusing distractions from the central issues. *See, e.g.*, MARX, *supra* note 33, at 14.

41. Also referred to as "negative" or "indirect" euthanasia, or "dysthanasia." *See* HUMPHRY & WICKETT, *supra* note 2, at 289; RUSSELL, *supra* note 2, at 19-20; WILSON, *supra* note 2, at 81 (citing Joseph Fletcher, who later replaced "dysthanasia" with "antidysthanasia").

make extraordinary efforts to keep a person alive.[42] Many do not consider this euthanasia. Rather, it is seen as merely leaving to nature the ordinary course of events that follow if extraordinary means are not used to maintain life.[43] Active[44] euthanasia, conversely, involves some deliberate action to cause death.[45] Distinguishing between passive and active euthanasia is often crucial because many who strongly oppose active measures support passive ones.[46] Others, however, see a false dichotomy between the ethics of passive and active euthanasia.[47]

Euthanasia can be either voluntary or involuntary. Voluntary euthanasia is the least complicated ethically, as the dying person can make a rational request, and be examined to ensure the validity of the request.[48]

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42. *But cf.* Rachels, *supra* note 31, at 43 (defining passive euthanasia as refraining from doing *anything* to keep the patient alive) (emphasis added). To avoid semantic difficulties, medical ethicists now often refer to "forgoing life-sustaining treatment" rather than the more controversial "passive euthanasia." *See* THOMAS SCULLY & CELIA SCULLY, PLAYING GOD: THE NEW WORLD OF MEDICAL CHOICES 112 (1987). *See generally* BY NO EXTRAORDINARY MEANS: THE CHOICE TO FORGO LIFE-SUSTAINING FOOD AND WATER (Joanne Lynn ed., 1986) (discussing the implications of a decision to forgo food and water).

43. *See, e.g.*, MARX, *supra* note 33, at 14; *see also* J. Gay-Williams, *The Wrongfulness of Euthanasia, in* EUTHANASIA: THE MORAL ISSUES 97, 98 (Robert M. Baird & Stuart E. Rosenbaum eds., 1989) (stating that a failure to continue treatment after it is recognized that the patient will not recover is not euthanasia).

44. Also referred to as "positive" euthanasia. *See* RUSSELL, *supra* note 2, at 19.

45. *See, e.g.*, BARNARD, *supra* note 31, at 27; Rachels, *supra* note 31, at 43.

46. This is particularly true in a religious context. For an excellent synthesis of various religious beliefs, see HUMPHRY & WICKETT, *supra* note 2, at 295 (containing a chart from GERALD LARUE, EUTHANASIA AND RELIGION (1985)). Nearly all religions cited accept passive euthanasia (albeit not necessarily with that label), while opposing active euthanasia. *See id.* Notably, this is not universally true; some religions consider *active* euthanasia to be a personal choice. *See id.*

47. *See* BARNARD, *supra* note 31, at 69, 80; Rachels, *supra* note 31, at 44; *see also* Dennis J. Doherty, *Physician-Assisted Suicide: What Constitutes Assistance?*, 65 WIS. LAW. 20, 20 (1992). Dr. Joseph Fletcher outlined a progression in degrees of euthanasia:

1. An absolute refusal to elicit any human initiative in the death or the dying. Life must always be considered as the ultimate human value.
2. A qualified refusal, in that the doctor can refrain from employing *extraordinary means* of preserving life but would nonetheless do whatever possible by ordinary means to keep life going.
3. Declining to start treatment in a patient who has an incurable disease and is suffering from a curable inter-current illness (for example, the terminally ill cancer patient with pneumonia). The doctor refuses to initiate treatment for the lung infection that can be cured and in this way may actually hasten death.
4. Stoppage of treatment, with consent, where it is the patient's wish not to be treated any further.
5. Stoppage of treatment, without consent, when the attending physician feels that further treatment can only prolong suffering.
6. Leaving the patient with an overdose of narcotic or sedatives, thus assisting the dying person to take his own life.
7. Prior permission is given by the patient to the doctor to administer an injection, under certain circumstances, from which the patient will not recover.
8. Without consent, and on his own authority, the doctor ends the patient's life with an overdose of drugs.

Paper given by Dr. Joseph Fletcher to the 1974 Euthanasia Conference in New York, *reprinted in* BARNARD, *supra* note 31, at 63-64. Barnard sees social attitudes regarding the various forms of euthanasia as hypocritical and illogical; man has long sanctioned and encourages massive deaths via war. *Id.* at 67; *see also* Justice Scalia's discussion in *Cruzan, infra* note 440.

48. *But cf.* Richard Fenigsen, *A Case Against Dutch Euthanasia*, 19 HASTINGS CENTER REP. 22, 24 (1989) (arguing that "voluntary" euthanasia is oxymoronic and necessarily involves varying degrees of coercion). This constitutes one of the strongest arguments of those op-

Involuntary[49] euthanasia has not been, but should be, further categorized into beneficent and malevolent involuntary euthanasia.[50] The distinction is a function of the motives behind, and the methods used, in the actions taken. On the one end is a decision made by the family and the courts with the best of intentions, and with full legal safeguards.[51] On the other is the purposeful disregard of human concerns, either in violation of legal processes, or with co-option of the legal system itself.[52]

As medical technologies extend life, the question of what constitutes death is itself becoming increasingly difficult to define.[53] This is particularly relevant to the issues of beneficent involuntary euthanasia where patients can be kept alive when arguably they should die.[54]

III. HISTORICAL CONTEXT

A. *Early Attitudes Toward Euthanasia*[55]

By necessity, ancient views of death often differed dramatically from

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posed to euthanasia on moral, but not necessarily religious, grounds in that the voluntariness of the euthanasia decision can never be truly ascertained, and decisions made because of subtle or not-so-subtle external pressures may poison the possibility for genuinely beneficent euthanasia. *See generally* VOLUNTARY EUTHANASIA: EXPERTS DEBATE THE RIGHT TO DIE (A.B. Downing & Barbara Smoker eds., 1986). One of the requirements for active euthanasia in the Netherlands is "voluntariness," defined as a persistent, conscious, and free request by the patient. *See* M.A.M. Wachter, *Active Euthanasia in the Netherlands*, 262 JAMA 3316, 3316 (1989); *infra* part VII.

49. "*In*voluntary" is a somewhat unfortunate term, as it can have two connotations as the antonym of "voluntary": it can mean either a decision made in the *absence* of free will, or a decision made *against* one's free will. The difference is critical, and here, the meaning is that of a decision made in the absence of free will. Euthanasia performed involuntarily in the Nazi German sense is neither intended nor the subject of current legal debate.

50. *See infra* notes 181, 191, 372.

51. If and when such safeguards apply remains a problematic issue in this debate. *See infra* part V.A.

52. *See infra* notes 176-89, 371 and accompanying text; *cf.* Donald R.A. Uges & Ben Greijdanus, *Euthanasia: A Challenge for the Forensic Toxicologist*, 35 J. FORENSIC SCI. 1424, 1425-30 (1990).

53. *See* ANN E. WEISS, BIOETHICS: DILEMMAS IN MODERN MEDICINE 79 (1985); BARNARD, *supra* note 31, at 31. *See generally* B.D. COLEN, HARD CHOICES: MIXED BLESSINGS OF MODERN MEDICAL TECHNOLOGIES 243-64 (1986); H. Tristram Engelhardt, Jr., *Definitions of Death: Where to Draw the Lines and Why*, *in* DEATH AND DECISION 15 (Ernan McMullin ed., 1978); Collins, *supra* note 31, at 236. BLACK'S LAW DICTIONARY defines death simply as "the cessation of life," which is hardly helpful in medical situations. BLACK'S LAW DICTIONARY 400 (6th ed. 1990). Even the second part, "permanent cessations of all vital functions and signs," is too vague for questions of when death occurs; medical sophistication in monitoring stages of death has grown far beyond the general diagnoses that have previously sufficed. *Id.* According to BLACK'S, characteristics of brain death (the "Harvard" definition) include: "(1) unreceptivity and unresponsiveness to externally applied stimuli and internal needs; (2) no spontaneous movements or breathing; (3) no reflex activity; and (4) a flat electroencephalograph reading after 24 hour period of observation." *Id.* at 188. A precise definition might not be possible, or even desirable. Death is a gradual process at the cellular level, with different tissues varying in their abilities to withstand deprivation of oxygen. *See* BARNARD, *supra* note 31, at 34. Brain cells are among the least able to withstand anoxia. *Id.*

54. *See, e.g.*, *infra* notes 296-307, 309-38 and accompanying text.

55. Historical illustrations are neither considered nor intended as justifications for modern practices or proposals. Rather, they are useful empirically as a reference for contemporary ideologies and as examples to be either criticized or espoused.

those of modern societies.[56] Whether as a result of injury, disease, or old age, death was treated as a natural part of life. Aiding death was often done out of respect, not contempt, for the impaired individual.[57] In ancient Greece, euthanasia appears to have been an accepted and prevalent practice. Indeed, many Hellenic philosophers advocated euthanasia.[58] As the Hellenics prospered, the Platonic principle of *kalokagathiá*, the ideal of a perfect balance of physical and mental well-being, gradually replaced the Homeric values of glory and victory.[59] Also involved was the underlying belief, prevalent as well in Roman thought, that man is the master of his own body, with the right to decide his own fate.[60] These values competed with the traditional disapproval of suicide that was based primarily on the individual's loyalty to the state, and the Greek taboo against killing one's kin.[61] Despite the Greek taboo, suicide was sometimes not only possible, but officially endorsed.

According to some historians, a custom existed on the island of Ceos[62] whereby very old citizens who had outlived their usefulness to society would gather annually, as if for a banquet, and drink together a lethal potion.[63] In one of Greece's oldest colonies,[64] as well as in Athens and Ceos, it was the custom for public magistrates to maintain a depository of poison[65] available for anyone who could justify his desire for death before

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56. We must be careful to avoid interpreting the actions and beliefs of ancient cultures according to present-day circumstances and ethical values. To comprehend fairly the policies then in existence, one must view the practices in relation to the then-current religious, social, and technological conditions.

57. *See, e.g.*, THOMASMA & GRABER, *supra* note 2, at 85-86.

58. *See* RUSSELL, *supra* note 2, at 53. *See generally* John Cooper, *Greek Philosophers on Euthanasia and Suicide*, in SUICIDE AND EUTHANASIA, *supra* note 2, at 9-32. John Cooper points out, however, that our English understanding of the words "euthanasia" and "suicide" are misleading in interpreting the opinions of Hellenic philosophers; suicide was more narrowly construed, and euthanasia in its contemporary meaning was never discussed. *Id.* at 9-11. The relevant issue was the person's ability to live a full, active life in furtherance of socially useful activities that he was previously suited for, not his medical conditions or suffering; their medical knowledge was insufficient to decide these matters with certainty. *Id.* at 11; *cf. infra* text accompanying notes 69-75. Indeed, to Plato, the question was an objective one; the patient's wishes were not controlling, or even elicited. *See* Cooper, *supra*, at 12-14. The result of a person who wishes to prolong his life is uncertain. *Id.* at 13; *cf. infra* note 182 and accompanying text. Interestingly, the aged are not included in Socrates' discussions; their efforts for the community are no longer expected. Cooper, *supra*, at 13. In Plato's Republic, they are due honor and respect, and do not fall under his restrictions against prolonging life. *Id.*

59. HUMPHRY & WICKETT, *supra* note 2, at 3; WILSON, *supra* note 2, at 20.

60. RUSSELL, *supra* note 2, at 53 (referring to historian Morris H. Safron of Rutgers Medical School).

61. *See* ALFRED ALVAREZ, THE SAVAGE GOD: A STUDY OF SUICIDE 56 (Bantam Books 1973) (1971). Taboos against the taking of one's own life also existed. Illegitimate suicide was an offense against the state, with penalties imposed. V THE ETHICS OF ARISTOTLE xi (J.A.K. Thomson trans., 1980); *see also* Cooper, *supra* note 58, at 19-23. Usually, the corpse's right hand was cut off, he was buried separately, his descendants were disenfranchised, and his family was dishonored. *See* HUMPHRY & WICKETT, *supra* note 2, at 3.

62. The birthplace of Hippocrates. RUSSELL, *supra* note 2, at 53.

63. *Id.*

64. What is now Marseilles.

65. Extracted from the infamous hemlock, which provides a painful and uncertain death. *See Introductory Letter from the National Hemlock Society* 2 (rec'd Aug. 10, 1990) (copy on file with DENV. U. L. REV.).

the Senate.[66] Libanius[67] is quoted as stating the rules for requesting permission:

> Whoever no longer wishes to live shall state his reasons to the Senate, and after having received permission shall abandon life. If your existence is hateful to you, die; if you are overwhelmed by fate, drink the hemlock. If you are bowed with grief, abandon life. Let the unhappy man recount his misfortune, let the magistrate supply him with the remedy, and his wretchedness will come to an end.[68]

According to Plato, Socrates saw painful disease and suffering as good reasons not to cling to life.[69] In the *Republic*,[70] Socrates praised Asclepius, the god of healing and medicine, for his more humane and practical policies. Bodies that disease had penetrated "through and through" Asclepius would not have attempted to cure: "[H]e did not want to lengthen out good-for-nothing lives. . . . Those who are diseased in their bodies, [physicians] will leave to die, and the corrupt and incurable souls they will put an end to themselves."[71]

A far more extreme view of appropriate social policy was sometimes advocated. Asclepius is said to have scorned weak fathers for begetting weaker sons.[72] Similarly, Socrates recommended infanticide: "[T]he offspring of the inferior, or of the better when they chance to be deformed, will be put away in some mysterious, unknown place, as they should be."[73] Socrates even condemned the physician Herodicus, the teacher of Hippocrates, for "the invention of lingering death."[74] Aristotle also endorsed infanticide to ensure the state of the worthiest citizens.[75] On Ceos, evidence indicates an ancient custom[76] requiring people over sixty to commit suicide—a "utilitarian practice."[77]

Perhaps the best evidence of euthanasia in Greece is the condemnation of the practice by others, such as the Pythagoreans,[78] Aristotelians,[79]

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66. *See* HUMPHRY & WICKETT, *supra* note 2, at 4.

67. Greek Sophist and rhetorician, who serves as a major source of historical information for the period. *See* VII THE NEW ENCYCLOPEDIA BRITANNICA 327 (15th ed. 1986).

68. EMILE DURKHEIM, SUICIDE: A STUDY IN SOCIOLOGY 330 (John A. Spaulding & George Simpson trans., 1951).

69. HUMPHRY & WICKETT, *supra* note 2, at 4.

70. PLATO, THE PORTABLE PLATO 398 (Scott Buchanan ed. & Benjamin Jowett trans., Viking Press 1966). Many physicians may have followed this policy, but for less noble reasons. Doctors of the time were itinerant and had the status of craftsmen. Their livelihoods demanded accurate diagnoses and effective cures—if at all. HUMPHRY & WICKETT, *supra* note 2, at 4; WILSON, *supra* note 2, at 19.

71. PLATO, *supra* note 70, at 398, 401.

72. *Id.* at 398.

73. *Id.* at 471.

74. PLATO, *supra* note 70, at 396. Socrates stated that Herodicus, "being a trainer, and himself of sickly constitution, by a combination of training and doctoring found out a way of torturing first and chiefly himself, and secondly the rest of the world." *Id.*

75. *See* HUMPHRY & WICKETT, *supra* note 2, at 3.

76. Possibly a legal requirement. *See* WILSON, *supra* note 2, at 20.

77. *Id.*

78. The Pythagoreans rigorously opposed suicide based on their religious belief that each man is assigned to his post in life by the gods, and cannot desert it regardless of the circumstances. *Id.* at 21; Cooper, *supra* note 58, at 32. The Pythagorean philosophy influ-

and Epicureans.[80] Perhaps most importantly, the Greeks elevated the subject to one susceptible to rational discourse.[81]

To the Romans, living nobly meant dying nobly. The appropriateness of suicide depended on the dominant will and a rational choice.[82] Consequently, aristocrats were often allowed suicide as an alternative to execution or enslavement.[83] Killing oneself was also acceptable as an escape from disgrace at the hands of an enemy.[84]

In Rome, suicide was punishable only if irrational. Killing oneself without cause was contemptible because "whoever does not spare himself would much less spare another."[85] Terminal illness, however, was considered good cause. The idea of dying well was a *summum bonum*, or extreme good.[86] Indeed, Marcus Aurelius defended the right of the individual to free himself from even the danger of "intellectual decrepitude."[87]

The Stoics favored suicide when life was no longer in accordance with nature, because of pain, grave illness, or physical abnormalities.[88] Seneca wrote:

> It makes a great deal of difference whether a man is lengthening his life or his death. But if the body is useless for service, why should one not free the struggling soul? Perhaps one ought to do this a little before the debt is due, lest, when it falls due, he may be unable to perform the act.[89]

Although less debated, in other areas of the world similar practices occurred. In some Eskimo tribes, an old or sick member would request of his family to die. If the family was a good one, it would comply by aban-

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enced later beliefs, and indeed, is reflected in the basic medical ethics of the Hippocratic Oath. WILSON, *supra* note 2, at 21.

79. Aristotle opposed suicide as contrary to the right rule of life, as an injustice against the state, and cowardly if done to escape suffering. WILSON, *supra* note 2, at 21; Cooper, *supra* note 58, at 19-23.

80. While the Epicureans believed that the soul ceased to exist at death, they did not value life absolutely. Epicurus urged men "to weigh carefully whether they would prefer death to come to them, or would themselves go to death." WILSON, *supra* note 2, at 21-22. Cicero attributes to Epicurus the thought that we may "serenely quit life's theatre, when the play has ceased to please us." Cooper, *supra* note 58, at 29. Still, Epicurus was insistent on the unreasonableness of suicide. *Id.*

81. HUMPHRY & WICKETT, *supra* note 2, at 5. John Cooper admires the Hellenic debates and believes that these philosophers have already said everything of value regarding the killing of one's self. Cooper, *supra* note 58, at 32.

82. ALVAREZ, *supra* note 61, at 62.

83. HUMPHRY & WICKETT, *supra* note 2, at 5.

84. *Id.* For interesting accounts of a classic example of 960 men, women, and children who consciously chose death rather than disgrace and certain execution or enslavement, see generally GEORGE C. BRAUER, JR., JUDAEA WEEPING: THE JEWISH STRUGGLE AGAINST ROME FROM POMPEY TO MASADA, 63 B.C. TO A.D. 73 (1970); MOSHE PEARLMAN, THE ZEALOTS OF MASADA: STORY OF A DIG (1967); ALFRED H. TAMARIN, REVOLT IN JUDEA: THE ROAD TO MASADA (1968).

85. HUMPHRY & WICKETT, *supra* note 2, at 5.

86. *Id.*

87. RUSSELL, *supra* note 2, at 54.

88. Cooper, *supra* note 58, at 24-25.

89. WILSON, *supra* note 2, at 22.

doning the Eskimo to nature or by killing him.[90] When an elderly Aymara Indian's[91] time came, relatives and friends were summoned for a death vigil. If death was slow, the elder could ask for assistance, whereupon his family would withhold food and drink until he slipped into unconsciousness and died.[92] Aboriginal Australians may have practiced their own form of euthanasia.[93] The Khoikhoin[94] of southern Africa would prepare a lavish feast before ceremonial abandonment in the wilderness.[95] Less sympathetically, the Ethiopian elderly were tied to wild bulls, the Amboyna ate their failing relatives out of a sense of charity, and the Congolese jumped on the tired and old until life was gone.[96] Formosans[97] would complete the process somewhat more humanely with strong drink—most likely a potent rice alcohol.[98]

B. *Early Christian Influences*

> *Yea, though I walk through the valley of the shadow of death, I will fear no evil: for thou art with me; thy rod and thy staff they comfort me.*[99]

In the second and third centuries, the growing influence of Christianity weakened Stoicism.[100] For Christians, the value of life, which for the Greeks and Romans was determined by the quality of life, was reinterpreted to mean that life per se was valuable regardless of the circumstances.[101] Church law followed the denunciation of suicide[102] by denying anyone who had taken his own life a Christian burial, a considerable punishment for the time.[103] Civil legislation was similarly influ-

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90. HUMPHRY & WICKETT, *supra* note 2, at 2. Abandonment is not as cruel as it may at first seem. Hypothermia (exposure to extreme cold) normally causes an anesthetized state as the body slowly shuts down its non-critical (exterior) systems in favor of heating the body core, resulting in spreading numbness. Pain results usually only during reheating. *Cf.* ENCYCLOPEDIA OF MEDICINE, *supra* note 36, at 562-63; THE MERCK MANUAL OF DIAGNOSIS AND THERAPY 2361-63 (15th ed. 1987). Religious beliefs are also relevant here, as many Eskimos believe that anyone who has courageously faced death spends eternity in the highest heaven. HUMPHRY & WICKETT, *supra*, at 2.

91. Of Bolivia. HUMPHRY & WICKETT, *supra* note 2, at 2.

92. *Id.* Interestingly, medical examinations of these deaths indicates that death was caused not by starvation or thirst, but rather, by the simple will to die. *Id.*

93. *See* Derrick J. Pounder, *A Probable Case of Euthanasia Amongst Prehistoric Aborigines at Roonka, South Australia*, 23 FORENSIC SCI. INT'L. 99, 101-08 (1983).

94. Pejoratively known as the Hottentots. VII OXFORD ENGLISH DICTIONARY, *supra* note 35, at 430.

95. *See* HUMPHRY & WICKETT, *supra* note 2, at 2.

96. *Id.*

97. In what is now Taiwan, remnants of the aboriginal culture remain in the mountainous central and eastern regions. *See* ROBERT STOREY, TAIWAN 10 (1987).

98. *See* HUMPHRY & WICKETT, *supra* note 2, at 2.

99. *Psalms* 23:4 (King James).

100. HUMPHRY & WICKETT, *supra* note 2, at 5.

101. *See* WILSON, *supra* note 2, at 23. *See generally* Darrel W. Amundsen, *Suicide and Early Christian Values*, *in* SUICIDE AND EUTHANASIA, *supra* note 2, at 77.

102. Suicide was considered diabolically inspired. WILSON, *supra* note 2, at 23; *see also* SPRING & LARSON, *supra* note 2, at 105; Joseph Sullivan, *The Immorality of Euthanasia*, *in* BENEFICENT EUTHANASIA 12, 19 (Marvin Kohl ed., 1975). Scripture, however, is silent on suicide. *See* Amundsen, *supra* note 101, at 77.

103. WILSON, *supra* note 2, at 23.

enced.[104] The deceased's property was confiscated, and the body was ignominiously buried on the highway, impaled by a stake.[105] There were no exceptions; every suicide was branded a *felo de se*, regardless of the extent or duration of suffering.[106] Christian leaders' interpretations of Christianity demanded that suicide was an abomination.[107] Killing oneself essentially took from God that which belongs to God; to decide one's own death thus violated God's will.[108] Still, suicides were not uncommon.[109]

In the fifth century, however, Saint Augustine[110] proclaimed that "suicide is a detestable and damnable wickedness."[111] He proposed several reasons to support his condemnation. First, taking one's own life was a violation of God's Sixth Commandment: "Thou shall not kill."[112] Second, suicide was a usurpation of the function of church and state.[113] Third, suicide deprived man of the opportunity of repentance.[114] Finally, life and its sufferings are divinely ordained by God and must be borne accordingly.[115] It should be noted that Saint Augustine was referring to suicide,

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104. *Id.*

105. HUMPHRY & WICKETT, *supra* note 2, at 6.

106. *Id. But cf.* Amundsen, *supra* note 101, at 78 (noting that early Christian condemnations of suicide were rare, and equivocal).

107. *See* HUMPHRY & WICKETT, *supra* note 2, at 6.

108. *Id.*

109. The general practice of suicide was perhaps fueled by Christian martyrdom. *Id.*; *see also* Amundsen, *supra* note 101, at 79-80; WILSON, *supra* note 2, at 25 (noting indications of ceremonial euthanasia in Scotland, Wales, Ireland, and England).

110. Leader of the early Christian Church and author of *City of God.* RUSSELL, *supra* note 2, at 54.

111. SAINT AUGUSTINE, THE CITY OF GOD 30 (Marcus Dods trans., 1950). Augustine saw two classes of exceptions: suicide would not be murder if it were justified either by a general law or by a special commission granted to some individual. *Id.* at 27; RUSSELL, *supra* note 2, at 54. In addition, deaths resulting from wars fought in obedience to divine commands, or in conformity with God's laws, were by no means violations of the Commandment that "Thou shall not kill." AUGUSTINE, *supra*, at 27 (making no mention of the method of communication from God necessary to divinely command a war). Under the second exception, Abraham's actions were to be applauded, because he was ready to slay his son in obedience to God, rather than to his own passion. *Id.* Similarly, Jephthah's killing of his daughter was merely in compliance with a command from God to kill the first to meet him as he returned from battle. *Id.*

112. Saint Augustine took pains to point out his interpretation of the Commandment "Thou shalt not kill" did not prohibit the killing of plant and animal life, but did prohibit the killing of other men and one's self. AUGUSTINE, *supra* note 111, at 26.

113. HUMPHRY & WICKETT, *supra* note 2, at 6. This could logically imply that both the church and state have the power to *enforce* suicide and homicide. It does, however, seem to suggest that the church and state have the sole, or ultimate, authority over a person's life and death.

114. *See* AUGUSTINE, *supra* note 111, at 30 ("Is it not better to commit a wickedness which penitence may heal, than a crime which leaves no place for healing contrition?").

115. *See id.* at 29-30. An argument used by Augustine in support of this proposition is arrived at by negative implication:

> For suicide we cannot cite the example of patriarchs, prophets, or apostles; though our Lord Jesus Christ, when He admonished them to flee from city to city if they were persecuted, might very well have taken that occasion to advise them to lay violent hands upon themselves, and so escape their persecutors. But seeing He did not do this, nor proposed this mode of departing this life, though He were addressing His own friends for whom He had promised to prepare everlasting mansions, it is obvious that such examples as are produced from the "nations that forget God," give no warrant of imitation to the worshippers of the one true God.

which encompasses a broader range of actions than euthanasia.[116] Saint Augustine may also have had practical considerations in mind: high birth and survival rates of Christians were crucial to the growth of Christianity.[117] Both church and criminal laws followed, intensifying the official disapproval of euthanasia.

Theological opposition to suicide culminated in the thirteenth century with Saint Thomas Aquinas.[118] In the *Summa Theologica*, he synthesized the medieval philosophical and theological arguments against suicide. Suicide was sinful, not merely because it violated the Sixth Commandment, but because it left no time for repentance.[119] Further, suicide was against the law of nature and contrary to charity.[120] Each man belongs to his community; it was thus unlawful to deprive society of his presence and activity. Finally, it was a sin against God, as life was a gift and subject only to God's powers.[121] While the Reformation altered the near-total authority of the Roman Catholic Church during the Middle Ages, the Reformers continued in their opposition to suicide, citing theological arguments.[122] Similarly, euthanasia was not an arguable moral issue. Some accounts, however, indicate a different treatment of the insane and deformed. According to three slightly variant accounts, a twelve-year-old congenitally abnormal boy was considered merely a monster or lump of flesh—a *massa carnis* without a soul—and should thus be drowned.[123]

In the Chrisian world, the noted sixteenth century British scholar and statesman Sir Thomas More[124] differed dramatically in his views. In *Utopia*, his vision of an ideal society, voluntary euthanasia was officially sanctioned:[125]

> The sick they see to with great affection, and let nothing at all pass concerning either physic or good diet whereby they may be restored again to their health. Them that be sick of incurable diseases they comfort with sitting by them, with talking with them, and to be short, with all manner of helps that may be. But if the disease be not only incurable, but also full of continual

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Id. at 28. For example, it is not for women to follow the example of earlier martyrs who avoided rape by suicide, or even to question the design of God in allowing such rapes by enemy heathens. *See id.* at 31, 33. Saint Augustine alluded to "some lurking infirmity" in the women which might have caused God to bring such outrages upon them. *Id.* at 33-34.

116. *See supra* note 34 and accompanying text.

117. *See* RUSSELL, *supra* note 2, at 54.

118. HUMPHRY & WICKETT, *supra* note 2, at 7; RUSSELL, *supra* note 2, at 55.

119. *See* HUMPHRY & WICKETT, *supra* note 2, at 7.

120. *Id.*

121. *Id.*

122. *See* WILSON, *supra* note 2, at 24. Two unusual forms of euthanasia were evidently practiced in the Jewish community during the period. Removal of a pillow from beneath a dying person was believed to hasten the process of dying. Alternatively, the synagogue keys were placed under the pillow of the dying as a means of easing death. Both practices were officially discouraged, either by law or condemnation. *Id.* at 25. The former practice was not peculiar to the Jewish community, and continued into the seventeenth century. *Id.*

123. *Id.* at 24. It was further believed that the devil resided in such persons in place of their soul. *See id.* at 25.

124. The Roman Catholic Church canonized Sir Thomas More in 1935, four centuries after his death. RUSSELL, *supra* note 2, at 55.

125. *See* HUMPHRY & WICKETT, *supra* note 2, at 7.

> pain and anguish; then the priests and the magistrates exhort the man, seeing he is not able to do any duty of life, and by outliving his own death is noisome and irksome to others and grievous to himself, that he will determine with himself no longer to cherish that pestilent and painful disease. And seeing his life is to him but a torment, that he will not be unwilling to die, but rather take a good hope to him, and either dispatch himself out of that painful life, as out of a prison, or a rack of torment, or else suffer himself willingly to be rid of it by others. And in so doing they tell him he shall do wisely, seeing by his death he shall lose no commodity, but end his pain. . . . But they cause none such to die against his will, nor they use no less diligence and attendance about him, believing this to be an honourable death.[126]

Sir Thomas More thus outlined a forerunner of contemporary proposals for the practice of euthanasia with legal safeguards.[127] His views met with strong opposition, but in succeeding centuries, others, including Francis Bacon,[128] John Donne,[129] and David Hume,[130] joined his criticism of the doctrine that taking one's own life was necessarily wicked.[131]

Medical knowledge grew throughout the Renaissance to such an extent that professionals began to recognize the paradox their knowledge brought them; abilities to maintain life sometimes brought suffering, which threatened to diminish the value of life.[132] In 1790, due primarily to the influence of Montesquieu, Voltaire, and Diderot, France enacted a statute legalizing suicide.[133] The common law of England, however, continued to regard suicide[134] as a crime, with the penalties of forfeiture and ignominious burial.[135]

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126. ST. THOMAS MORE, UTOPIA (Edward Surtz ed., 1964), *reprinted in* RUSSELL, *supra* note 2, at 55-56. Lawyers, interestingly enough, would play no part in the debate; truth would most easily come from the mouths of each citizen, "uncoached in deception" by lawyers, who would be banned from the mythical Utopia. *See* MORE, *supra*, at 114.

127. *See* RUSSELL, *supra* note 2, at 56.

128. Who insisted that doctors should help dying patients "make a fair and easy passage from life." HUMPHRY & WICKETT, *supra* note 2, at 8.

129. Dean of St. Paul's, who, in *Biathanatos*, argued in favor of voluntary euthanasia. *See id.*; RUSSELL, *supra* note 2, at 56.

130. In his 1777 *Essay on Suicide*, Hume argued that a man who retires from life does no harm to society; he only ceases to do good. DAVID HUME, DIALOGUES CONCERNING NATURAL RELIGION AND THE POSTHUMOUS ESSAYS OF THE IMMORTALITY OF THE SOUL AND OF SUICIDE 103-04 (Richard H. Popkin ed., 1980). Further, if a person cannot promote the interests of society but rather is a burden, his resignation from life is not only innocent but laudable. *Id. See generally* Tom L. Beauchamp, *Suicide in the Age of Reason*, *in* SUICIDE AND EUTHANASIA, *supra* note 2, at 183 (discussing of the views of Donne, Hume, and Kant).

131. *See* SUICIDE AND EUTHANASIA, *supra* note 2, at 183. *See generally* Gary B. Ferngren, *The Ethics of Suicide in the Renaissance and Reformation*, *in* SUICIDE AND EUTHANASIA, *supra* note 2, at 155 (discussing the evolution of opinion regarding suicide after Augustine).

132. *See* WILSON, *supra* note 2, at 26.

133. RUSSELL, *supra* note 2, at 56. From 1700 to 1789, only eighteen successful actions were taken against suicides in France. HUMPHRY & WICKETT, *supra* note 2, at 9.

134. Defined as one who "deliberately puts an end to his own existence, or commits any unlawful malicious act, the consequence of which is his own death." 4 WILLIAM BLACKSTONE, COMMENTARIES ON THE LAW OF ENGLAND 189 (The University of Chicago Press 1979). There was no exception for suffering: suicide was prohibited even when accomplished "to avoid those ills which [persons] had not the fortitude to endure." *Id.*

135. *See id.* at 189-90.

C. *Contemporary Historical Background*

1. The 1800s

The term "euthanasia" first appeared, in the contemporary sense of induced death, during the latter part of the nineteenth century.[136] Essays by S.D. Williams, and later by the Honorable Lionel A. Tollemache, refuted critical arguments and laid the groundwork for the formation of pro-euthanasia groups in England and elsewhere.[137] Williams insisted that it was the duty of the physician in cases of hopeless and painful illness "to destroy consciousness at once and put the sufferer to a quick and painless death."[138] He warned, however, that every effort should be made to prevent any possible abuse of this duty.[139] Tollemache incorporated his and Williams' arguments into his book *Stones of Stumbling,* in which he attributed much of the fear of death to the preachings of Christians regarding hell and suffering as a punishment for sins.[140] He criticized the slippery slope argument by commenting that "if we rejected all reforms which might lead to contingent and remote evils, no reform whatever would be passed and we should be in a state of . . . stagnation."[141] He further believed adequate safeguards were possible to prevent an abuse of power.[142] In the late 1800s, a society was formed in England to secure such a change in the laws, but was declared illegal and disbanded.[143] Additionally, Dr. William Munk[144] proposed, with little result, that the medical profession incorporate the study of euthanasia in medical training.[145]

2. The Early 1900s

In 1901, Dr. Charles Goddard[146] suggested that, beginning with the medical profession, a new attitude was needed regarding this "somewhat gruesome subject."[147] The first bill to legalize voluntary euthanasia for adults of sound mind who are fatally hurt, terminally ill, or suffering extreme pain was introduced in the Ohio legislature in 1906, but died in committee.[148]

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136. RUSSELL, *supra* note 2, at 57.
137. *See id.*
138. *See* WILSON, *supra* note 2, at 27.
139. *Id.*
140. *See* RUSSELL, *supra* note 2, at 57.
141. *Id.* at 58.
142. *Id.*
143. WILSON, *supra* note 2, at 27.
144. Fellow of the Royal College of Surgeons, who used the term "euthanasia" in its original meaning of a gentle or easy death. RUSSELL, *supra* note 2, at 58.
145. *See id.*
146. In an article entitled: *Suggestions in Favor of Terminatinatng Absolutely Hopeless Cases of Injury and Disease. Id.*
147. *Id.* at 60.
148. *Id.* The bill was described in a January 24, 1906 *New York Times* article as being requested by a Miss Anna Hall following her mother's miserable death. That a woman would draw up such a "cruel" bill dismayed the editor of the *Independent,* who, along with editors from the *New York Times,* condemned the bill. The January 25 *New York Times* editorial saw the Ohio proposal as "something considerably worse than ignorant folly—something that verges close upon, if not into, the criminal." RUSSELL, *supra* note 2, at 60-61.

In 1912, a woman suffering constant pain from an incurable disease petitioned the New York state legislature for permission for her physician to put her to death painlessly.[149] Her petition caused a sensation, eliciting a mostly hostile public reaction, and was unsuccessful.[150]

In 1917, Dr. Harry J. Haiselden of Chicago allowed a baby girl born with microcephaly to die when he could have saved her life.[151] Forty other physicians had examined the girl and agreed with Dr. Haiselden's decision.[152] Supported by fifteen doctors at trial, he was acquitted.[153]

In 1920, in *People v. Roberts*,[154] a Michigan man was convicted of willful murder in the preparation of a poisonous mixture for his wife, who was suffering from multiple sclerosis and had previously attempted suicide.[155] He was sentenced to life imprisonment at hard labor and solitary confinement.[156] His conviction was upheld on appeal to the Supreme Court of Michigan.[157]

In 1925, however, a Colorado physician who had killed his incurable invalid daughter whom he had nursed for thirty-two years was released after a jury was unable to reach a decision; the case was dismissed.[158]

3. The 1930s

The 1930s were an important decade for the debate on euthanasia. Books by two of Britain's most distinguished clergymen[159] challenged traditional beliefs and religious dogma. In 1931, Dr. C. Killick Millard, a health officer for the city of Leicester, England, intensified the debate in an address to the Society of Medical Officers of Health in London, and by a companion article in support of legalization of euthanasia.[160] In his address, Dr. Millard described euthanasia as a basic human right, and proposed a Voluntary Euthanasia Legislation Bill with the following provisions:

1. An application for a euthanasia permit may be filed by a dying person stating that he has been informed by two medical practitioners that he is suffering from a fatal and incurable disease and that the process of death is likely to be protracted and painful.
2. The application must be attested by a magistrate and accompanied by two medical certificates.
3. The application and certificates must be examined and the patient and relative interviewed by a "euthanasia referee."

149. *Id.* at 63.
150. *Id.*
151. RUSSELL, *supra* note 2, at 63.
152. *Id.*
153. *Id.*
154. 178 N.W. 690 (Mich. 1920).
155. WILSON, *supra* note 2, at 29.
156. *Roberts*, 178 N.W. at 692.
157. *Id.* at 694.
158. WILSON, *supra* note 2, at 29.
159. Dr. Willima Inge and Canon Peter Green. RUSSELL, *supra* note 2, at 64.
160. *Id.* at 65; *see also* HUMPHRY & WICKETT, *supra* note 2, at 13.

4. A court will then review the application, certificates, the testimony of the referee and any other representatives of the patient. It will then issue a permit to receive euthanasia to the applicant and a permit to administer euthanasia to a medical practitioner (or euthanisor).
5. The permit would be valid for a specified period within which the patient would determine if and when he wished to use it.[161]

From this point on, euthanasia became a subject of much debate.[162] In 1935, the British Voluntary Euthanasia Legislation Society was founded to promote a change in the law. Its supporters and critics were both represented by medical, educational, religious, and social leaders of Britain. The opponents succeeded in defeating the bill in the House of Lords by a vote of thirty-five to fourteen.[163]

In 1937, a similar bill was introduced in the Nebraska legislature.[164] It differed, however, in two respects. First, in addition to a person suffering from an incurable and fatal disease, it would have included those who were helpless and suffering from the infirmities of old age. Second, the next of kin would have been able to make an application on behalf of a mentally incompetent adult, and a parent or guardian could similarly apply on behalf of a minor whose condition was incurable or fatal.[165] The

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161. C. Killick Millard, *The Case for Euthanasia*, 120 FORT. REV. 708 (1930), *reprinted in* WILSON, *supra* note 2, at 31-32.

162. Dr. Harry Roberts, a highly regarded British physician and advocate of euthanasia, was critical of Dr. Millard's bill for two reasons. First, its safeguards were too cumbersome, and second, its scope was too limited. Regarding the former, Dr. Roberts wrote that "when our sympathy outweighs our fear of the law, let us act on it." He further felt it was important to permit euthanasia for hopelessly incapacitated or defective individuals, who may not be capable of making a request. RUSSELL, *supra* note 2, at 76. Dr. George W. Jacoby, in his 1936 book PHYSICIAN, PASTOR, AND PATIENT, criticized the influence of superstition and religion on medicine and the resulting effect on public policy. *Id.*

The suicide in 1935 of Charlotte Gilman, great-granddaughter of Lyman Beecher, sparked a public controversy. Named one of the greatest women in the world by Carrie Catt, she left both a note in which she called "justifiable suicide" the simplest of human rights, and an article for publication in which she wrote:

> Our mental attics are full of old ideas and emotions, which we preserve sentimentally but never examine. The advance of the world's thought is promoted by those whose vigorous minds seize upon inert doctrines and passive convictions and shake them into life or into tatters. This theory that suicide is a sin is being so shaken today.

Id. at 77. Ms. Gilman's suicide had a parallel in the suicide three years earlier of George Eastman, the manufacturer of cameras and patron of music and education. *Id.*

In response to her suicide, the editor of the *Forum* published a debate entitled *The Right to Die.* Dr. Abraham Wolbarst, a distinguished New York physician, advocated euthanasia, including cases of insanity which remained uncured for a period of time, such as ten years. He further urged consideration of the suffering of relatives and friends, particularly where hopelessness continues indefinitely. Dr. James Walsh argued the opposite position. He wrote: "Suffering is one of the great mysteries of life and we do not know the meaning of it. . . . Man who has suffered is more human." *Id.* at 78. He added that patients "recognize that they deserve some punishment for . . . slips from grace in past moments of weakness, and become persuaded that their pain may represent punishment." *Id.* at 78; *see also infra* note 368 and accompanying text.

163. WILSON, *supra* note 2, at 32.

164. RUSSELL, *supra* note 2, at 71.

165. WILSON, *supra* note 2, at 32.

bill was referred to a committee and indefinitely postponed.[166]

In 1938, the Euthanasia Society of America was formed in New York.[167] The Reverend Dr. Charles F. Potter,[168] its founder and first president, commented that euthanasia was a problem that, sooner or later, confronts every practicing physician.[169] Potter, responding to the religious argument that euthanasia violated the Sixth Commandment, stated:

> It seems that if the killing is done wholesale and in anger and bitter hate, the Ten Commandments can be set aside; but when you come to an individual case, and the killing is done in mercy, to release a sufferer from intolerable agony, then the Ten Commandments are suddenly in force again.[170]

Potter emphasized the safeguards that would prevent possible abuse by unscrupulous and impatient heirs who might wish to hasten their benefactor's demise.[171] Potter further advocated euthanasia for defective newborn babies and the chronically insane, but on advice from other members, limited the scope of proposed legislation to voluntary euthanasia only.[172]

In 1939, a bill to legalize euthanasia, similar to the British bill,[173] was proposed by the treasurer of the Euthanasia Society for the State of New York. It was, however, never introduced into the legislature, and the Second World War temporarily suspended efforts on its behalf.[174]

4. Nazi Germany and the 1940s–1950s

The practice of euthanasia took a radically tragic turn in Nazi Germany. The concept of *lebensunwerten Leben*[175] provided the underlying rationale for the Nazi practice of "euthanasia."[176] In stark contrast to most

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166. RUSSELL, *supra* note 2, at 72. Apparently, no action on this bill has been taken since.

167. *Id.* Its original name was: "The National Society for the Legalization of Euthanasia." *Id.*

168. Potter had left the Baptist Church to become a Unitarian minister and later a New Humanist and was regarded by some as an apostle of liberal religion. *Id.*

169. *Id.* at 73.

170. *Id.*; *cf. supra* note 111 (St. Augustine's exceptions to suicide as murder).

171. RUSSELL, *supra* note 2, at 73.

172. *Id.* at 74. Others in the Society were more radical in their views. Dr. Foster Kennedy, the second president, recommended "the release from living of those who should never have lived at all." Foster Kennedy, *Euthanasia: To Be or Not to Be*, COLLIERS, May 20, 1939, at 15. Regarding "nature's mistakes," Kennedy argued that "it would be for the general good that euthanasia be legalized for creatures born defective, whose present condition is miserable and whose future . . . hopeless." *Id.* at 16. Dr. Kennedy would, however, later modify his position, to limit the scope of acceptable euthanasia, because of the danger of errors. WILSON, *supra* note 2, at 33. Dr. Alexis Carrel, another advocate, was even more radical. "Sentimental prejudice," he had declared several years earlier, "should not obstruct the quiet and painless disposition of incurables, criminals, and hopeless lunatics." *The Right to Kill*, TIME, Nov. 18, 1935, at 54; *cf. infra* notes 176-89 and accompanying text.

173. *See supra* text accompanying note 161.

174. RUSSELL, *supra* note 2, at 74.

175. "Lives not worthy of life." HUMPHRY & WICKETT, *supra* note 2, at 22. The term, coined by Karl Binding and elaborated by Binding and Hoche, referred to a patient's objective uselessness to the community. WILSON, *supra* note 2, at 34. Also used during the war was the phrase, *unnutze Esser*, or "useless eater." HUMPHRY & WICKETT, *supra* note 2, at 22.

176. WILSON, *supra* note 2, at 34.

previous efforts to promote euthanasia based on a humanitarian compassion for individual suffering, the argument behind *lebensunwerten Leben* focused on the right of society to rid itself of those who were burdensome.[177] Although opposed by some religious leaders, the concept had popular support in Germany.[178] Germany, like most cultures, has a long history of obsession with racial purity.[179] This, coupled with Germany's humiliating defeat in World War I and the emphasis on a philosophy that subordinated the individual to the community, led to "eugenic euthanasia."[180] Interestingly, efforts for legal reform to sanction euthanasia for the benefit of the patient were rejected because they were based on *individual* rights, rather than for societal benefit.[181] Indeed, throughout

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177. *See* Helen Silving, *Euthanasia: A Study in Comparative Criminal Law* 103 U. PA. L. REV. 350, 356 n.21 (1954). In an attempt to explain the depraved atrocities committed by some of the most educated of the world's medical practitioners in exterminations and medical experimentation, George Ables of the Nazi Health Office reportedly commented: "We're not thinking of individuals but of the race. The race is bigger than the individual." RUSSELL, *supra* note 2, at 92. Medical experimentation was rationalized by the defense at the Nuremberg trials as justified "worthy medical questions." *Id.*

178. WILSON, *supra* note 2, at 34. According to a 1920 poll, seventy-three percent of the parents and guardians of mentally deficient children favored euthanizing the children. *Id.*

179. And thus, by illogical conclusion, racial superiority. The German concept of the *Volk*, or pure "Aryan" Germans who were destined to rule the world, had existed for centuries. HUMPHRY & WICKETT, *supra* note 2, at 21; *see also* CLARISSA HENRY & MARC HILLEL, OF PURE BLOOD 22 (Eric Mossbacher trans., 1976).

180. *See* HUMPHRY & WICKETT, *supra* note 2, at 21; WILSON, *supra* note 2, at 34. The use of both "eugenic" and "euthanasia" in this context is troublesome. "Eugenics," coined in 1883 by the English scientist Francis Galton, a cousin of Charles Darwin, refers to the science that deals with the improvement of hereditary qualities of a species or breed. WEBSTER'S NEW COLLEGIATE DICTIONARY 390 (1981). What is highly objectionable are the operant qualities defined by the Nazis, and their methods.

No reasonable conclusion regarding a positive correlation between a person's non-"Aryan" background and decreased intelligence or physical capabilities can be drawn from empirical (or any other) evidence. This assumes, parenthetically, that intelligence and physical characteristics are the crucial variables for the "improvement" of the human species. Further, eugenics has never required or intended extermination; selective breeding, or even selective *non*-breeding, is normally meant. For an excellent discussion of the relevant issues surrounding eugenics, see generally DANIEL J. KEVLES, IN THE NAME OF EUGENICS: GENETICS AND THE USES OF HUMAN HEREDITY (1985).

"Euthanasia" is similarly strained in meaning because the contemporary reference is from the perspective of the suffering individual; for the Nazis it was more a euphemism for a program of murder than anything remotely similar to the context normally argued either for or against. HUMPHRY & WICKETT, *supra* note 2, at 28 (argument by Professor Lucy Davidowicz that studying the Nazi experience does not enlighten us regarding the contemporary problems surrounding euthanasia). Similarly, philosopher Joseph Fletcher considers it merciless, not mercy, killing. *Id.* Philosopher Marvin Kohl agrees, adding:

> The motivation behind and the nature and consequences of acts of beneficent euthanasia are radically different. In the Nazi example, the motivation, aside perhaps from sadism, was solely that of maximizing "benefit" for the state. In cases of beneficent euthanasia the motivation is essentially and predominantly that of maximizing benefit for the recipient, of helping most where and when the individual needs it most. The Nazi form was involuntary; the form advocated here is voluntary.

Marvin Kohl, *Voluntary Beneficent Euthanasia, in* BENEFICENT EUTHANASIA 130, 137 (Marvin Kohl ed., 1975).

181. Silving, *supra* note 178, at 356 n.23. Further, there is no indication that later Nazi atrocities included putting to death those suffering intolerably from a fatal illness; the entire thrust of the government program was involuntary extermination of those the government considered undesirable. HUMPHRY & WICKETT, *supra* note 2, at 23.

the war, no law legalizing euthanasia[182] existed.[183]

Hitler wrote in *Mein Kampf* in 1924: "All who are not of good race in this world are chaff. And all occurrences in world history are only the expression of the races' instinct of self-preservation, in the good or bad sense."[184] In 1939, Hitler signed a directive initiating a Nazi euthanasia program, with the result of secret institutions that carried out Hitler's directive with usual German efficiency.[185] In contrast to a national program of sterilization,[186] the "euthanasia" program operated secretly.[187] By the end of the war, the Germans had "euthanized" at least 275,000 people, in

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182. In the sense of death given to relieve suffering.

183. RUSSELL, *supra* note 2, at 116.

184. ADOLF HITLER, MEIN KAMPF 296 (Ralph Manheim trans., 1943).

185. WILSON, *supra* note 2, at 35. Initial gassings occurred at *Brandenburg an der Havel*, the first of many such sites. Covert organizations in Berlin arranged transportation of the victims, dealt with financial and legal affairs, and sent false letters to next of kin. The letters often read:

> We regret to inform you that your _____, who was recently transferred to our institution by ministerial order, unexpectedly died on _____, of _____. All our medical efforts were unfortunately without avail.
>
> In view of the nature of his serious, incurable ailment, his death, which saved him from a lifelong institutional sojourn, is to be regarded as a release.
>
> Because of the danger of contagion existing here, we were forced to have the deceased cremated at once.

HUMPHRY & WICKETT, *supra* note 2, at 22. Alternately, the letter might conclude: "For purposes of avoiding the outbreak or the communication of an infectious disease, the local police authorities, as per § 22 of the ordinance concerning the combating of communicable diseases, have ordered the immediate cremation of the corpse and the disinfection of any remaining effects." *Id.* at 23. An urn containing the supposed ashes of the deceased was forwarded to the family. Expenses were often paid by unwilling relatives, who were warned against demanding further explanations or spreading "false rumors." *Id.*; WILSON, *supra* note 2, at 35. Administrative errors did occur, but little was allowed to come from them. HUMPHRY & WICKETT, *supra*, at 23. The program was slowed, however, probably in response to growing awareness of the government's actions and concern that the elderly would be next. Public morale deteriorated to the extent that in late 1940, Heinrich Himmler, head of the SS, wrote to a Reich official:

> I hear that there is great unrest in the Wurttemberg mountains on account of the Grafeneck Institution. The people know the grey SS bus and they think they know what happens in the crematory with its ever-smoking chimney. What does happen there is a secret, and yet it is a secret no longer. The public temper is ugly and in my opinion there is nothing to do but to stop using this particular institution. Possibly one might initiate a skillful and reasonable program of enlightenment by running films on hereditary and mental disease in this particular region. May I ask you to let me know how this difficult problem was solved.

Id. at 24.

186. Shortly after assuming office in 1933, the Nazis enacted a compulsory sterilization program for all persons with hereditary illnesses. HUMPHRY & WICKETT, *supra* note 2, at 21.

187. *Id.* at 22. Hitler insisted on distancing himself officially from the project. In late October 1939, he signed a secret decree, backdated to September 1, 1938, which read: "Reich leader Bouhler and Dr. Brandt are charged with the responsibility for expanding the authority of physicians, to be designated by name, to the end that patients considered incurable in the best available human judgment, after critical evaluation of their state of health, may be granted a merciful death." *Id.* (quoting ALEXANDER MITSCHERLICH, DOCTORS OF INFAMY: THE STORY OF THE NAZI MEDICAL CRIMES 92 (1949)). "Granted" was hardly the appropriate word; the exterminations were involuntary. *See* HUMPHRY & WICKETT, *supra* note 2, at 22. Some dispute exists over whether Hitler's secret order was backdated. *See* Yale Kamisar, *Some Non-Religious Views Against Proposed "Mercy-Killing" Legislation*, 42 MINN. L. REV. 969, 1034 n.219 (1958).

Reports of Nazi practices did make their way to the rest of the world, however. In 1941, William Shirer's *Berlin Diary* was published, which contained accounts of the Gestapo's mur-

addition to the millions of other "undesirables."[188]

The German medical profession, seeking readmission to the World Medical Association, admitted its guilt and pledged to "exact from our members a standard of conduct that recognizes the sanctity, moral liberty, and personal dignity of every human being."[189] After heated discussion at the same meeting of the General Assembly, approval was given to a resolution to "condemn the practice of euthanasia under any circumstances."[190]

Interestingly, the German debacle appeared to have little effect on American public opinion regarding voluntary euthanasia.[191] In 1945, the Euthanasia Society of America started a new campaign in New York to legalize voluntary euthanasia.[192] In 1946, a committee of 1776 physicians and 54 Protestant ministers publicly supported the movement.[193] The clergymen announced that, in their view, voluntary euthanasia was not contrary to the principles of Christianity.[194] In 1949, additional Protestant and Jewish spokesmen supported the bill, but it was never introduced into the New York legislature.[195]

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derous practices. Other accounts surfaced intermittently throughout the war. HUMPHRY & WICKETT, *supra* note 2, at 37.

188. Dr. Leo Alexander, an investigator for the War Crimes Tribunal, attributed much of Germany's moral decline to the attitudes of the physicians. In what is often incorporated as a major argument for anti-euthanasia and "pro-life" forces, Dr. Alexander described a "wedge," or slippery slope effect of the German programs:

> The beginnings at first were merely a subtle shifting in emphasis in the basic attitude of the physicians. It started with the acceptance of the attitude, basic in the euthanasia movement, that there is such a thing as life not worthy to be lived. This attitude in its early stages concerned itself merely with the severely and chronically sick. Gradually the sphere of those to be included in this category was enlarged to encompass the socially unproductive, the ideologically unwanted, the racially unwanted and finally all non-Germans. But it is important to realize that the infinitely small wedged-in lever from which this entire trend of mind received its impetus was the attitude toward the nonrehabilitable sick.

HUMPHRY & WICKETT, *supra* note 2, at 27. *But cf. infra* note 374 (explaining why the wedge or slippery slope argument may be ruled out).

189. RUSSELL, *supra* note 2, at 93-94. The German request for readmission was thus palatable to the General Assembly, which admitted German doctors by a vote of 33 to 3, with Israel, Great Britain, and Czechoslovakia strongly protesting. *Id.* at 94.

190. *Id.* The United States was among those supporting the resolution. This is likely a result of the influence of a U.S. representative and former American Medical Association president, Dr. Morris Fishbein, who held strong anti-euthanasia beliefs. *Id.*

Assuming the use of the term "euthanasia" is illegitimate when describing the actions of the Nazi Germans, the confusion of the term after the war to prevent "real" euthanasia is logically improper. *See supra* note 183. The effect is the bar of rational considerations of euthanasia policy because of Nazi co-optation of the term and strong, if incorrect, association with the atrocities of Nazi Germany. Perhaps for this reason alone a new term is preferable.

191. WILSON, *supra* note 2, at 35. *But see* SPRING & LARSON, *supra* note 2, at 89.

192. WILSON, *supra* note 2, at 36. The proposed bill, presented to the New York legislature in 1947, was similar to previous voluntary euthanasia model bills. *Id.*; *see supra* text accompanying note 162.

193. *See* RUSSELL, *supra* note 2, at 95.

194. *Id.* This brought forth strong religious opposition. Monsignor R.E. McCormick, the presiding judge of the ecclesiastical tribunal in New York's Catholic Archdiocese, denounced both the statement by the ministers, and the ministers themselves. He further announced that the proposed bill was "Anti-God, un-American, and a menace." *Id.*

195. *See* WILSON, *supra* note 2, at 37. Further efforts were suspended until 1952, when a final attempt was made. HUMPHRY & WICKETT, *supra* note 2, at 38. In a dramatic attempt to capture attention, representatives from the Euthanasia Society in New York presented to the

Cases of euthanasia continued, but rarely publicly. In one well-publicized 1943 case, John Noxon, a forty-six-year-old Harvard-educated attorney crippled for twenty years by polio, was charged with first-degree murder in the death of his six-month-old mongoloid child.[196] The evidence was substantial but not conclusive.[197] After five hours of deliberations, the jury found Noxon guilty; death via electric chair was mandatory.[198] Eight days before his scheduled execution, the Massachusetts governor cited "extenuating circumstances" and commuted his sentence to life.[199] The governor carefully explained that mercy killing, so-called, could not be considered extenuating circumstances and was not a factor in his decision; he never specified the basis for his decision.[200]

In another case, New Hampshire physician Hermann Sander was charged with first-degree murder after ordering the injection of forty cubic centimeters of air into an incurably ill patient.[201] The patient's husband pled with the doctor to end her suffering; she was within a week of death and could neither eat nor sleep.[202] Dr. Sander was acquitted due to problems with proof of causation, thereby avoiding the broader question of mercy-killing.[203] The case polarized the local community.[204] While supporters gathered money to defray his legal expenses, the Reverend Napoleon Gilbert declared that "suffering on earth is useful in the sight of God,"[205] and the Reverend Dr. Franklin Frye condemned all mercy killing, although he hoped that Dr. Sander could be restored to practice without condoning euthanasia.[206]

In 1958, an Illinois defendant pleaded guilty to manslaughter for suffocating his wife, a rheumatoid arthritis sufferer, who begged to be killed.[207] Following testimony concerning her pain and his devotion to

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president of the Senate a nine-foot petition signed by two thousand voters. *Id.* at 47. The bill was not introduced into the legislature. *Id.*

196. HUMPHRY & WICKETT, *supra* note 2, at 40.

197. *Id.* The child was found on a metal tray in wet diapers with a radio wire around his arm. He died by electrocution, suffering acute heart failure caused by electric current passing through the chest from forearm to forearm. *Id.* Noxon maintained his innocence throughout the trial and appeals. *See id.*

198. *Id.*

199. *Id.*

200. *See id.* at 40-41.

201. *Id.* at 42-43. This is a rather painful way to go. Scuba divers (good ones, anyway) are obsessed with avoiding overly rapid decompression as they ascend. If the diver ascends too rapidly, the result can be fatal. The medical results, in increasing order of severity, include decompression sickness (the "bends") and air embolisms. The latter arefatal, while the bends are the excruciatingly painful result of nitrogen gas bubbles formed within the blood vessels and body cells. See OWEN LEE, THE SKIN DIVER'S BIBLE 162 (3d ed. 1986).

202. HUMPHRY & WICKETT, *supra* note 2, at 43.

203. *Id.* at 43.

204. *Id.*

205. *Id.* at 44.

206. *Id.* Evangelist Billy Graham told a Boston audience of six thousand that Dr. Sander should be punished as "an example. . . . Anyone who voluntarily, knowingly or premeditatively takes the life of another, even one minute prior to death, is a killer. I don't say that Dr. Sander deserves death, but if we let this pass, who is to say who is to die and who is to live." RUSSELL, *supra* note 2, at 108.

207. WILSON, *supra* note 2, at 39-40.

her, he was allowed to change his plea to not guilty and was acquitted.[208] Similarly tragic cases arose over the years but with inconsistent legal results; much depended on the circumstances and the characters surrounding the "crime."[209] The difficult moral and legal questions regarding euthanasia were never addressed in these cases.[210]

In 1950, the Euthanasia Society in England submitted a petition to the United Nations that called for universal human enjoyment of "freedom from fear." The petition was signed by 356 prominent Britons and more than two thousand Americans,[211] but was not submitted to Eleanor Roosevelt, the chairperson of the Commission on Human Rights, for two years.[212] She sympathized but was concerned about possible conflicts with the Genocide Convention and felt it inappropriate to submit the proposal at that time.[213]

In 1956, Pope Pius XII declared:[214] "Medical jurisprudence is subordinate to medical ethics which expresses the moral order willed by God. Medical jurisprudence cannot, therefore, in any circumstances permit doctor or patient to carry out euthanasia directly, nor may a doctor ever perform it either upon himself or upon anyone else."[215] In 1957, at a convention of Catholic physicians, the Pope softened his stance when he responded to three questions presented for edification of euthanasia-re-

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208. *Id.* at 40. Otto Werner, the defendant, was resuscitated after taking an overdose of drugs following the euthanizing of his wife. HUMPHRY & WICKETT, *supra* note 2, at 61. Her physician had described the severity of her illness in a letter to the Court. *Id.* The trial court's comments are worth noting:

> Well, folks, how would the family and neighbors feel if I permitted the defendant to withdraw his plea of guilty and I found him not guilty?
>
> Here is a man sixty-nine years old, in the twilight of his life, and he has been so devoted and attentive to his wife. . . .
>
> I would rather send him home to his daughter and son without the stigma of a finding of guilty, and I am not reluctant to do it if the family feels they wouldn't have any objection.
>
> I won't ask the state's attorney for his consent to [the change of plea]. I know him well enough to know he would be inclined to do the same thing . . . .
>
> Mr. Werner, this is a time in one's life where good reputation and decency over a span of years pay off. I can't find it in my heart to find you guilty. I am going to permit you to go home with your daughter and live out the rest of your life in as much peace as you can find it in your heart to have.

Id. at 62 (alterations in original).

209. *See, e.g.*, HUMPHRY & WICKETT, *supra* note 2, at 60-62; RUSSELL, *supra* note 2, at 135-36; WILSON, *supra* note 2, at 38-40. The fact that uncertainty is the rule of law in this area is itself cause for concern. Individuals who disclose their actions or consult with medical or legal professionals are at risk of prosecution, providing a strong incentive for clandestine euthanasia. This results in even less societal control over the safeguards which even devout proponents generally agree are necessary to protect those who either do not wish to, or should not, end their lives.

210. *See* WILSON, *supra* note 2, at 40.

211. RUSSELL, *supra* note 2, at 110.

212. *Id.*

213. *Id.*

214. The Pope's declaration was given in an allocution to the Seventh International Congress of Catholic Doctors in the Hague. RUSSELL, *supra* note 2, at 128.

215. *Id.*

lated issues.[216] While addressing a later international audience of physicians, the Pope gave instructions to Catholic doctors on the use of extraordinary means for prolonging life. Although he admired the instances of resurrecting a seemingly dead person, he made it clear that when life was ebbing irrevocably, physicians might abandon further efforts to prolong life.[217] Indeed, relatives may ask doctors to desist "in order to permit the patient already *virtually dead*, to pass on in peace."[218]

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216. *See* LIFE ETHICS CENTRE, EUTHANASIA: RECENT DECLARATIONS OF POPES AND BISHOPS (1983). The questions were:

1. Is there a general moral obligation to refuse analgesia and to accept physical pain in a spirit of faith?
2. Is it in accord with the spirit of the Gospel to bring about by means of narcotics the loss of consciousness and the use of a man's higher faculties?
3. Is it lawful for the dying or the sick who are in danger of death to make use of narcotics when there are medical reasons for their use? Can narcotics be used even if the lessening of pain will probably be accomplished by a shortening of life?

RUSSELL, *supra* note 2, at 128-29.

Before answering specifically, the Pope spoke to the spiritual value of suffering and the justification for seeking relief from it if one so desired, because: "[I]n the long run, pain prevents the achievement of higher goals and interests." *Id.* at 129. In answer to the first question, the Pope responded: "The patient desiring to avoid or relieve pain can in good conscience use those means discovered by science which, in themselves, are not immoral." *Id.*

Regarding the suppression of consciousness, the Pope had no moral objection to the use of narcotics, providing "they do not prevent the patient from fulfilling his duties." *Id.* The Pope warned, in response to question three, that:

> every form of direct euthanasia, that is to say, the administration of a narcotic, in order to procure or to hasten death, is unlawful because it is a claim to dispose directly of life. It is one of the fundamental principles of natural and Christian morality that man is not the master and possessor, but has only the usufruct of his body and of his existence. One lays claim to a right of direct disposition, whenever one wills the shortening of a life, whether as an end or as a means. In the hypothesis you envisage, it is merely a question of saving the patient from insupportable sufferings, as for example, in the case of inoperable cancers or of incurable diseases.
>
> If between the narcosis and the abridgment of life there exists no direct chain of causality due to the will of the interested parties, or from the nature of the circumstances, (this would be the case if the suppression of pain was obtainable only by a shortening of life), and if, on the contrary, the administration of narcotics, itself lead to two distinct effects, one the relief of pain and the other the shortening of life, it is lawful; one is still bound to ascertain that between these two effects there exists a reasonable proportion and that the advantages of the one compensate the disadvantages of the other. It is also important, in the first place, to determine whether, in the actual state of science, the same result might be obtained by employing other means, and then in the administration of the narcotic not to exceed the limits of what is practically necessary.

LIFE ETHICS CENTRE, *supra*, at 8-9.

217. *See* RUSSELL, *supra* note 2, at 131; *cf. infra* note 245 (advancing medical technology as a possible threat to human dignity due to prolonging life for too long). *See also* Kevin O'Rourke, *Catholic Teaching in Regard to Two Prominent "Right to Life Issues": A Historical Theological Study*, 11 ST. LOUIS U. PUB. L. REV. 425 (1992).

218. RUSSELL, *supra* note 2, at 131 (emphasis added). Curiously, this is in opposition to the Hippocratic Oath requiring of doctors "to strive at all costs to keep a patient alive as long as possible." *Id.*; *infra* part IV.A.4.

The use of the word "virtually" belies the crux of the issue. In effect, the Pope is begging the question by leaving open the possibility of some Twilight Zone of human existence. "Virtually" is susceptible of shades of meaning—particularly in the context of modern medicine and death. Even if by "virtually" the Pope meant merely "just a matter of a very short time," he is sanctioning behavior which contradicts the ethos of sacrosanct life. *Cf. infra* note 216 (comments about the sanctity of life).

The Sanctity of Life and the Criminal Law, written in 1957 by Glanville Williams,[219] sparked debate among both supporters and opponents of euthanasia. Williams, in response to what he saw as the counterproductive effect of legal safeguards in euthanasia legislation,[220] recommended that future euthanasia legislation provide only that physicians would not be criminally liable for helping a patient to die—providing the physician "acted in good faith, with the consent of the patient, and to save [the patient from] severe pain in an illness both incurable and fatal."[221] Williams' recommendation did not recognize a patient's right to choose euthanasia, leaving the issue to the discretion of the physician.[222] Consequently, many euthanasia supporters while appreciating Williams' efforts, were unenthusiastic about his recommendation.[223]

5. The 1960s

a. Legislative Attempts

Efforts to enact legislation in England continued with the attempted passage of a new Voluntary Euthanasia Bill.[224] Controversy in this area was already high due to a controversial Neasden Hospital policy on the resucitation of patients brought to public attention in 1967.[225] The policy had been posted in the hospital for over a year before being reported to authorities by a patient. The policy provided: "The following patients are not to be resuscitated: very elderly, over sixty-five; malignant disease. Chronic chest disease. Chronic renal disease. Top of yellow treatment card to be marked NTBR [not to be resuscitated]."[226] The Bill, passed

219. A Fellow of Jesus College, Rouse Ball Professor of Laws at Cambridge University, and member of the Standing Committee on Criminal Law Revision. HUMPHRY & WICKETT, *supra* note 2, at 57. He also wrote the treatise CRIMINAL LAW: THE GENERAL PART (1953).

220. HUMPHRY & WICKETT, *supra* note 2, at 58-59. He noted that, rather than drawing support, they provided additional areas for attack by anti-euthanasia groups: "Did the opposition like these elaborate safeguards? On the contrary, they made them a matter of complaint. The safeguards would, it was said, bring too much formality into the sickroom, and destroy the relationship between doctor and patient." *Id.*

221. *Id.* Similar to the Pope's pronouncements, Williams' proposals focused on decisions and actions instigated by the physician. *Id.*

222. RUSSELL, *supra* note 2, at 127. He likely continued to believe that legislation recognizing a right to choose euthanasia, with legal safeguards, was the best alternative; in 1969, he assisted in the drafting of a new British Voluntary Euthanasia bill. *Id.* at 127-28.

223. *See* HUMPHRY & WICKETT, *supra* note 2, at 59.

224. HUMPHRY & WICKETT, *supra* note 2, at 89. The 1969 version of the Bill contained fewer safeguards than the 1936 version. *See supra* text accompanying note 162.

225. *Id.* at 88.

226. *Id.* Do-not-resuscitate orders, previously non-existent, are now commonplace. Sydney H. Wanzer et al., *The Physician's Responsibility Toward Hopelessly Ill Patients: A Second Look, in* EUTHANASIA: THE MORAL ISSUES 163, 163-64 (Robert M. Baird & Stuart E. Rosenbaum eds., 1989); *see also* Lieutenant Colonel William A. Woodruff, *Letting Life Run its Course: Do-Not-Resuscitate Orders and Withdrawal of Life-Sustaining Treatment,* ARMY LAW., April 1989, at 6, 6-18 (discussing the history, substance, and potential problems with both do-not-resuscitate orders and withdrawal of life-sustaining policies in the United States Army).

For an interesting discussion of this issue in the tentatively developing area of law that is the reciprocal of the "wrongful death" tort, see William C. Knapp & Fred Hamilton, *Wrongful Living: Resuscitation as Tortious Interference with a Patient's Right to Give Informed Refusal,* 19 N. KY. L. REV., 253, 255-76 (1992).

without debate on its first reading in the House of Lords,[227] subsequently met opposition on several fronts. St. John-Stevas[228] launched the "Human Rights Society" to fight the bill, while the British Medical Association continued its opposition to euthanasia.[229] A rabbi and a bishop similarly expressed their opposition.[230] The Bill was rejected by a vote of sixty-one to forty on its second reading.[231]

In 1967, the Euthanasia Society in New York established the Euthanasia Education Fund[232] with the goal of distributing information concerning the dying. Some isolated attempts at promoting legislation were made by others not affiliated with the New York group.[233] In Florida, Dr. Walter Sackett[234] sought to amend the state constitution to include the concept of "death with dignity."[235] The attempt failed.[236] In 1969, the Health and Welfare Committee of the Idaho House of Representatives introduced a Voluntary Euthanasia Bill to legalize voluntary euthanasia "when the patient is suffering from an irremediable condition."[237] Although safeguards to prevent abuse were included, this Bill also failed.[238] Bills similar to the Florida measure were introduced in several states, including Idaho, Montana, Oregon, West Virginia, and Wisconsin.[239] Nevertheless, no significant progress was made in addressing the difficult issues faced by these proposals.[240]

b. Technological Change

The subject of death, which underwent a process of repression in the cultural psyche throughout the advancement of medical technology,[241]

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227. HUMPHRY & WICKETT, *supra* note 2, at 89.

228. A conservative member of Parliament. *Id.*

229. *Id.*

230. *Id.* The bishop viewed euthanasia as a violation of the commandment "[t]hou shalt not kill." *Id.* The rabbi explained his position as:

> We cannot agree to purchasing the relief from pain at the cost of life itself . . . . One of the reasons for our position is that we consider human life to have infinite value and therefore every fraction of human life, even only one hour of it, has precisely the same infinite value as the whole of life.

Id. See generally IMMANUEL JAKOBOVITS, JEWISH MEDICAL ETHICS 123, 123-25, 276 (1959) (positing that Jewish law sanctions passive euthanasia while condemning active euthanasia); Baruch A. Brody, *A Historical Introduction to Jewish Casuistry on Suicide and Euthanasia, in* SUICIDE AND EUTHANASIA, *supra* note 2, at 39-75 (arguing that Jewish law consists of more than a blind reverence for mere physical existence).

231. HUMPHRY & WICKETT, *supra* note 2, at 89.

232. *Id.* at 87-88. To preserve its tax-exempt status, the fund abstained from further efforts to promote euthanasia legislation. *Id.*

233. *Id.* at 88.

234. Dr. Sackett was a Catholic physician and member of the Florida House of Representatives. *Id.*

235. *Id.*

236. *See id.*

237. RUSSELL, *supra* note 2, at 192.

238. HUMPHRY & WICKETT, *supra* note 2, at 88.

239. WILSON, *supra* note 2, at 42.

240. *See id.* at 43.

241. *See* HUMPHRY & WICKETT, *supra* note 2, at 63-64; RUSSELL, *supra* note 2, at 168; Alastair MacIntyre, *The Right to Die Garrulously, in* DEATH AND DECISION 75, 77-79 (Ernan McMullin ed., 1978).

underwent a new period of examination in the 1960s and later.[242] This was, simultaneously, a period of rapid advances in medical technology, especially in the areas of life-saving and life-prolonging techniques.[243] Various physicians publicly supported revised legal guidelines for dealing with critically ill or incurable patients.[244] Among them were Dr. Perrin Long,[245] Dr. Arthur Levisohn,[246] Dr. William Williamson,[247] Dr. Frank Ayd, Jr.,[248] Dr. Robert Williams,[249] and Dr. Arthur Schiff.[250]

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242. *See* HUMPHRY & WICKETT, *supra* note 2, at 63-90.

243. *See* RUSSELL, *supra* note 2, at 15-16, 140.

244. *See id.* at 140-52.

245. Dr. Long, editor of the *Medical Times*, published an article in 1960 entitled *On the Quality and Quantity of Life*, which described numerous examples of human suffering. *See id.* at 140-41. Dr. Long asked:

> Has not the medical profession missed the point in certain of its endeavors? Are we not piling up one Pyrrhic victory after another, while gradually losing the war? Are we not causing . . . untold anguish to the patient and his friends, insupportable financial burdens for the family and community, the diversion of resources from those who could use them more effectively, and a great increase in the cost of hospitalization for the average patient, just because we are more interested in increasing the "quantity" of life no matter at what painful cost to the individual or his community?

Id. at 142 (alteration in original).

246. Professor of medical jurisprudence at the Chicago Medical School. *Id.* He viewed the advancement of medical technology as a possible threat to human dignity, forcing sometimes tortured and hideous deaths, which would be a disgrace to our civilization if no legal remedy were devised. *Id.* at 142-43. He cited inadequate public awareness as the result of relatively uncommon tragic occurrences, but warned that all faced the possibility of a painful and lingering death. *Id.* at 143. He criticized the forced circumvention of the law by judges and juries in cases where "mercy killing" is at issue. *Id.* He further illustrated the fallacies of religious arguments against euthanasia: "They would have come to some other very startling different conclusions had their reasoning preceded their conclusions instead of succeeding them in order to bolster a conclusion already established." *Id.* Regarding Pope Pius XII's 1957 statements, Levisohn commented that while euthanasia was condemned in name, "the most essential contention of the euthanasists is conceded." *Id.* at 144.

He conducted a poll of 250 internists and surgeons. Of the 156 who responded, sixty-one percent agreed that doctors did practice euthanasia, by either accelerating death or omitting life-saving measures. *Id.* Still, seventy-two percent disapproved of proposed legislation to legalize euthanasia. *Id.* In a poll of 146 non-doctors, eighty percent of the 116 respondents would welcome euthanasia if they were incurably ill and were suffering unendurable pain. HUMPHRY & WICKETT, *supra* note 2, at 71. Seventy-six percent favored legalization of euthanasia for incurable adult sufferers at their own request. *Id.* In both instances, affirmative responses were received by seventy-four percent of Protestants, seventy percent of Jewish respondents, one-hundred percent of those with no religious affiliation, and twenty to twenty-five percent of the Catholics. *Id.*

247. Professor of surgery at the University of Kansas Medical School. RUSSELL, *supra* note 2, at 144. He emphasized a team approach involving consultations among the patient, the family, and the physicians, to reassure all that the medical profession is deeply concerned about the welfare of the patient. *Id.* at 145. While supporting the medical responsibility to prolong life, he believed there were times for the doctor to ask: "Should [I] lengthen a man's life a few months at the cost of leaving the man's wife and children penniless?" *Id.*; *cf. infra* part V.C.

248. Catholic psychiatrist who opposed any deliberate hastening of death, but said that a physician must recognize a person's right to live and die peacefully. RUSSELL, *supra* note 2, at 146. Although he objected to calling it such, he advocated passive euthanasia where the patient is clearly dying. *Id.* He further deplored the intrusion of gadgets and medical personnel, which deprived the family and the patient of the chance to share his last moments. *See id.* He surprisingly called for what could be seen as advocating *surreptitious* administration of active ("positive") euthanasia:

> Also there should be no need or demand for positive euthanasia if physicians unhesitatingly administer whatever amount of pain relieving drugs a dying patient

In opposition, Dr. Laurence Foye[251] insisted that it is the duty of doctors to prolong life as long as possible in every case.[252] Physicians remain divided over what appropriate role, if any, euthanasia should play in both their practices and in society.[253] Medical associations have not escaped the controversy.[254] Interestingly, nurses—especially those who care for

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needs. The medical profession has the power to erase any demand for legalized euthanasia. All doctors have to do is apply their skills prudently as they are morally and legally [sic] empowered to do.

Id. at 147.

249. Professor of medicine at the University of Washington Medical School. *Id.* He criticized the law's inability to differentiate between murder and the merciful act of euthanasia. *Id.* He commented on the vast sufferings which are forced on many and urged that euthanasia was preferable to suicide in dealing with intolerable cases. *Id.* at 148. He further noted the irony of a society that refused to permit a suffering, dying person for whom life has no further value to terminate his life, while simultaneously condoning wars, in which millions are killed. *See id.* at 147; *cf. infra* part IV.C (discussing the inability of the criminal law to distinguish between active euthanasia and murder).

250. A general practitioner in Florida, Dr. Schiff appealed to doctors and society to face honestly and realistically the problems associated with euthanasia. RUSSELL, *supra* note 2, at 148.

251. Formerly associated with the National Cancer Institute and with the Veterans Administration at the time of his testimony before the U.S. Senate Special Committee on Aging in 1972. *Id.* at 149.

He defended his position on the grounds that mistakes in prognosis can sometimes be made and the outcome of any given case can never be known with certainty. *Id.* He noted instances where patients had been misdiagnosed, leading to unforeseen recoveries or remissions. *Id.* He also rejected the notion that people were being kept alive needlessly. *Id.* "Neither I nor anyone else knows how to decide when being alive becomes useless." *Id.* He did not differentiate, however, between those who are still young and want to live, and those who are aged, truly incapacitated, or already damaged irreparably by their illnesses and who want to die. *Id.*

252. *Id.*

253. A poll conducted by the medical journal *New Medica Materia* in 1962 indicated that more than thirty percent of American physicians approved of euthanasia in some cases. RUSSELL, *supra* note 2, at 153. Almost forty percent approved in cases of severely defective infants, while forty-one percent favored legislation to permit euthanasia, with legal safeguards. *Id.*

A questionnaire by Dr. Robert Williams, sent to members of the Association of Professors of Medicine and of the Association of American Physicians, found that eighty percent admitted practicing negative euthanasia and eighteen percent favored positive voluntary euthanasia, provided legal safeguards existed. *Id.* Dr. Williams defined negative euthanasia as planned omission of therapies that would probably prolong life and positive euthanasia as therapy that is hoped will promote death sooner than otherwise. *Id.*

A National Opinion Poll taken in 1964 and 1965 of 2000 general practitioners in England—selected at random from the Medical Register—found that 48.6 percent reported being asked by a dying patient to give final relief from suffering, while 53.9 percent saw a conflict between the request and the law. *Id.* at 155. 35.8 percent would be willing to administer voluntary euthanasia if it became legally permissible, while 75.5 percent thought some doctors already performed such treatments. *Id.* They were equally divided when asked whether adequate legal safeguards could be devised. *Id.*

254. The World Medical Association, meeting in Sydney in 1968, adopted a declaration stating that it was not their role to be the deliberate agents of euthanasia. RUSSELL, *supra* note 2, at 156.

The British Medical Association has remained firmly opposed to euthanasia, and in 1969 passed a resolution condemning it. *Id.* at 156-57. Many British doctors dissented, however, pointing out that the influential members who had devised the condemnation were elderly, and thus overly conservative and out of touch with the misery of dying patients. *Id.* at 157. Conversely, they might have been more thoughtful regarding death.

elderly and dying patients—tend to favor euthanasia.[255]

The field of bioethics developed rapidly after the invention of a kidney dialysis procedure[256] that proved to be a mixed blessing. In 1960, Dr. Belding Scribner developed a new shunt which permitted repeated blood

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In 1970, the General Council of the Canadian Medical Association approved a change in the code of ethics: "An ethical physician will allow death to occur with dignity and comfort, when death of the body appears inevitable." *Id.* It further stated that unusual or heroic means to prolong life were unnecessary when clinical death of the mind has occurred. *Id.*

In 1973, the American Hospital Association made public its new "Bill of Rights" for patients: "The patient has the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of his action." *Id.*

Also in 1973, the governing board of the Medical Society of the state of New York announced the following adoption by its Committee on Ethics:

> The use of euthanasia is not in the province of the physician. The right to die with dignity, or the cessation of the employment of extraordinary means to prolong the life of the body when there is irrefutable evidence that biological death is inevitable, is the decision of the patient and/or the immediate family, with the approval of the family physician.

Id. at 158.

The American Medical Association had not taken an official position on euthanasia, although the subject has been the source of considerable discussion. *See id.* at 159. In 1973, despite suggestions that the AMA develop a euthanasia policy rather than force doctors to make decisions for themselves, the Association officially condemned mercy killing, although simultaneously adopting a report advising doctors that they should respect a dying person's wishes. *See* HUMPHRY & WICKETT, *supra* note 2, at 101.

255. *See* RUSSELL, *supra* note 2, at 165; *but cf.* Irene P. Loftus, Note, *I Have a Conscience, Too: The Plight of Medical Personnel Confronting the Right to Die*, 65 NOTRE DAME L. REV. 699 (1990) (discussing the medical professional's right to refrain from participating in euthanasia for ethical reasons); *Nurses Question* Cruzan *Decision*, AUSTIN AMERICAN-STATESMAN, Dec. 16, 1990, at A13. (noting that the nurses responsible for the care of Nancy Cruzan were attempting to deal with the anger they felt toward those whose decision prompted the termination of a feeding tube from Nancy, whom they had come to love). As with most of life's situations, it is the "person in the trench" who should be heeded when questions with which they are the most connected arise. Nurses have the greatest contact with patients and should at least be heard in this debate, if not above the voices of other groups.

Barbara Davis, a geriatric nurse, criticized the role of doctors in the debate, when nurses are likely to be more closely involved with the patient. RUSSELL, *supra* note 2, at 165. She further commented that passive euthanasia is unsatisfactory, as it will often increase the patient's suffering. *Id.*

Eileen Strauss, a nursing supervisor, protested the distance between doctors and patients in reality; doctors often disobey their own orders not to resuscitate if they are on the ward at the time. *Id.*

Jennifer MacPherson, a pediatric intensive care nurse, doubts that heroic efforts made to save severely defective infants are well advised. *See id.* at 166. Even parents who ask for such efforts may not consider the effects decades hence, when they may not be able to care for the severely disabled adult. *See id.*

Sharon Curtin related her nursing experiences in her book *Nobody Ever Died of Old Age.* She recounts the dread many elderly have, not of dying, but of losing all pretense of independence. *Id.* She castigates our society for its deplorable neglect of the elderly and their potential. *See id.* She's right, but that's for another article.

At a convention of the Colorado Nurses Association in 1970, an unofficial vote revealed roughly sixty-one percent favored active euthanasia. *Id.* at 166-67.

Nurses are further at risk by becoming involved in efforts to covertly end life. *See id.* at 167. This, however, carries the same moral and legal dilemmas, with none of the possible safeguards against abuse.

256. Kidney dialysis is needed when the kidneys fail and impurities build up in the bloodstream. *See* SPRING & LARSON, *supra* note 2, at 29.

dialysis.[257] Physicians soon realized that too few machines existed for too many patients.[258] Between 1962 and 1972, hospital selection committees performed the gruesome task of choosing, in effect, which patients lived and which died.[259] Due to the explosive issues involved, Congress extended Medicare to cover every patient under sixty-five who needed kidney dialysis.[260]

The dilemma of euthanasia is particularly acute when confronting the problem of severely deformed infants who are otherwise not in threat of imminent death. Perhaps one of the greatest medical tragedies in this regard was the result of the use of thalidomide, a tranquilizer that, if used during pregnancy, caused serious fetal malformations.[261] The case that attracted the greatest attention was that of Madame van de Put, of Belgium.[262] On May 22, 1962, her child Corinne was born severely deformed as a result of thalidomide use.[263] The family was shocked and decided that Corinne should not live.[264] The mother pleaded with both her gynecologist and midwife to do away with the baby.[265] Both refused.[266] The nun replied: "It is God who gives life and God who takes life away."[267] The family doctor[268] gave to Corinne's grandmother a prescription for a dosage of barbiturates sufficient to kill an infant.[269] Madame

257. Previously, direct access to the veins was required, resulting eventually in collapsed veins. *Id.* at 30. With no further means to access the blood for cleansing, the patient died. *See id.*

258. *See id.* The expense of treatment was also often an obstacle. *See id.*

259. *See id.*

260. *See id.* As of 1980, the costs have risen to $1.2 billion annually. *See id.* This effectively avoids the issue by government largess. The underlying problems of valuation of life in situations of limited resources are so repugnant that virtually any option, regardless of cost, is accepted. As is increasingly apparent given fiscal constraints, this may no longer be continuously feasible.

Interestingly, only where the lives in question are visible is the dilemma so clear. The more impersonal the life involved, the easier the choice to terminate, or disfavor, that life. A commander's choice of battle plans by necessity involves a choice of some lives over others. Even less dramatic situations require similar choices, as with problems commonly faced by decision makers, high and low politicians in social programs (although the solution is usually the same—largess, particularly when politicians become involved, as they invariably do when controversies arise). This proves only that what is espoused generally is often unsustainable in practice. A euthanasia policy at either extreme is unlikely to be popular when individual cases of need or abuse arise.

261. *See* RUSSELL, *supra* note 2, at 175.

262. She was 24, and had taken eleven thalidomide pills prescribed by her family doctor, Dr. Casters, during her pregnancy with her first child. *Id.* at 176.

263. Corinne had no arms or shoulder structure and flipper-like embryos of hands protruding from the end of each shoulder. *Id.* Her feet were deformed, her face was disfigured, and her anal canal emptied into her vagina. Her chances of survival, however, seemed good. *Id.* Her family doctor later testified, however, that there would have been no possibility of fitting her with artificial limbs because there was no shoulder bone structure, only cartilage. *Id.* at 177. Other experts gave her a one in ten chance of living. *Id.*

264. *Id.* at 176. "The grandmother told the doctor 'Don't condemn the child to live.'" *Id.*

265. *Id.*

266. *Id.*

267. *Id.* It could be argued, however, that it was not God who was responsible for the tragically deformed thalidomide babies.

268. Testimony at the trial described him as "'the doctor of the poor' and beloved by his patients." *Id.* at 177.

269. Considering the baby's future, Dr. Casters later expressed no regrets. *Id.* at 176.

van de Put insisted on performing the euthanasia herself, and alone.[270] She rocked Corinne gently, and fed her a bottle of milk, honey, and the barbiturates.[271] She was indicted on a charge of murder, and her husband, mother, sister, and family doctor were arraigned as aiders and abettors.[272] At the trial, she stated that she could not put the baby in a home, as suggested by the gynecologist, because: "[I]t wouldn't have given her her arms."[273] She further stated that Corinne's normal mental state only made things worse: "If she had grown up to realize the state she was in, she would never have forgiven me in her whole life for letting her live."[274] The prosecutor demanded a verdict of guilty while indicating that he would support a recommendation from the jury for a royal pardon.[275] He warned that an acquittal would set a "terrible precedent" and possibly lead to "great abuse."[276] The defense attorney broke down and sobbed: "For this terribly deformed child there was no possible place of happiness on this earth."[277] The courtroom burst into applause when the "not guilty" verdict was read.[278]

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270. *Id.*

271. *Id.*

272. *Id.* at 176-77.

273. *Id.* at 177.

274. *Id.*

275. *Id.*

276. *Id.* He continued: "You must affirm that the principle of respect for life is sacred. Thousands of thalidomide mothers who kept their children alive in spite of malformations have their eyes on your verdict." *Id.* This illegitimately presumes that because other mothers chose to raise their children under such circumstances, or could not personally choose otherwise, Ms. van de Put had a legal obligation to raise Corinne—which was precisely the question at issue.

277. *Id.* at 177. His were not the only tears in the courtroom. *Newsweek* reported: "Even the lawyers, reporters, and gendarmes felt tears welling up as the story of the final hours of Corinne was told . . . ." *Id.* at 178. A public opinion poll by Radio Luxembourg showed popular opinion to be ten to one in the defendants' favor. *Id.*

278. *Id.* Dr. St. John-Stevas, a Catholic and strong opponent of euthanasia, described the reaction:

> The verdict was greeted with frenzied joy by the thousand people who had crowded into the court for the last day of the trial. Their rejoicing was taken up by the crowds outside the court when the news became known . . . . Undoubtedly popular sympathy in Belgium and elsewhere was on the side of the mother and her family doctor. This is hardly surprising. Both had suffered intensely. They had been five months in custody, and had experienced the harrowing public ordeal of the trail [sic]. Whether misguided or not, both had acted from what they imagined to be unselfish motives, and the element of malice present in ordinary murders was totally lacking. The mother was a pathetic figure; the doctor, a revered one, regarded as a saint by the poor of Liege. No one wanted further punishment inflicted on them.

Id. St. John-Stevas continued in his opposition to euthanasia. In his book *The Right to Life*, he wrote that, "if there is a right to life, Corinne van de Put possessed it as much as anyone else." *Id.* Even if this is assumed, however, it does not address the questions of parental discretion where Corinne is in a situation susceptible to euthanasia, but cannot decide for herself. As incapacity is not a question here, this would be about as far into the grey as any euthanasia issue could be. Given that more basic questions of euthanasia remain undecided, the right of a parent to decide for a malformed but mentally normal child will likely remain an open question, decided by judges or juries—as is perhaps best.

Not until 1973 did the Distillers Corporation, which manufactured and marketed thalidomide in England under the trade name Distaval, agree, under public pressure, to compensate the thalidomide victims. Each child would be paid an average of $126,000. *See id.* at 179.

6. The 1970s to Present

In 1972, an elderly Seattle couple were found side-by-side on their bed with plastic bags wrapped around their heads,[279] reportedly despondent over the fact that one needed to move to a nursing home.[280] The following year, a San Francisco couple also insisted on controlling their own fates,[281] deciding years earlier that if one became terminally ill they would go together.[282] They first sent a telegram to their son and then committed suicide.[283]

In the summer of 1973, Donald "Dax" Cowart was critically injured in a freak natural gas explosion.[284] His wish to discontinue excruciating burn treatments was ignored despite his constant requests; throughout his ordeal he maintained his demand to die.[285] He lives in Henderson, Texas, where he practices law and continues in his belief that his wish should have been granted.[286]

A 1973 Gallup poll reported that public approval of active euthanasia had increased dramatically since an identical poll was taken in 1950.[287] In 1975, eighty-seven percent of Californians surveyed favored passive euthanasia.[288] Another majority—sixty-three percent—supported active eutha-

279. HUMPHRY AND WICKETT, *supra* note 2, at 105. Both were in their eighties and in failing health.

280. *Id.*

281. *Id.*

282. *Id.*

283. *Id.* Their son, after receiving the telegram, flew to San Francisco, where he found them in their bedroom, dead from cyanide. He related: "I was relieved and I was proud of them." *Id.*

For an interesting examination of double suicides, usually committed by aged couples, see generally ANN WICKETT, DOUBLE EXIT: WHEN AGING COUPLES COMMIT SUICIDE TOGETHER (1989). Parenthetically, Ms. Wickett is believed to have committed suicide. *Advocate for Suicide Group Found Dead*, N.Y. TIMES, Oct. 10, 1991, at A8. It is unclear whether breast cancer, which had been surgically removed, or depression caused her action; her former husband, Derek Humphry, disavowed her action if caused by the latter. *Id.*

284. His story is detailed in DAX'S CASE: ESSAYS IN MEDICAL ETHICS AND HUMAN MEANING (L. Kliever ed., 1989). The explosion, which occurred as he was attempting to start his truck, killed his father and left him blind, permanently disfigured, and severely maimed. *Id.* at xi, 3-4.

285. *See id.* at 5-9, 15. His attorney, who, as counselor and family friend, represented him and his mother in their personal injury actions, not only refused to help Dax obtain a court order for the termination of treatment, but—in good faith—apparently circumvented Dax's desires. *See id.* at 99-101.

286. *See id.* at xi; *see also* Gary Taylor, *Reluctant Survivor Turns to Law*, 10 NAT'L L.J. at 6 (Sept. 21, 1987).

287. *See* RUSSELL, *supra* note 2, at 198. Fifty-three percent of respondents answered "yes" to the following question, which had also been used in the 1950 poll: "When a person has a disease that cannot be cured, doctors should be allowed by law to end the patient's life by some painless means if the patient and his family request it." *Id.* Safeguards were not mentioned in the question.

Men and women held similar views, while Protestants and Catholics were not greatly dissimilar (fifty-three percent to forty-eight percent, respectively). *Id.* at 198-99. Educational level was positively correlated, with support of euthanasia increasing with formal educational level; six in ten of the college-educated respondents favored active euthanasia. *Id.* at 199. The young also were more in favor of active euthanasia, with sixty-seven percent of people under thirty approving. *Id.*

288. *See* HUMPHRY & WICKETT, *supra* note 2, at 94. Seventy-seven percent of Catholics agreed. *Id.*

nasia.[289] The Euthanasia Society of America[290] was reactivated in 1974 with the goal of legalizing the Living Will through state legislatures.[291] By the end of 1975, bills legalizing the Living Will had been introduced in fifteen states.[292] Only in California did such a measure pass.[293]

On the night of April 15, 1975, a pretty, bright twenty-one-year old was rushed to a New Jersey hospital.[294] Karen Ann Quinlan was in a coma caused by a combination of drugs and alcohol consumed on an empty stomach during a birthday party.[295] She had stopped breathing, and thus suffered irreparable brain damage, although she was not brain-dead.[296] Three months later her father signed a release to discontinue her use of the respirator.[297] Her physicians, however, refused to remove the respirator, arguing that to do so would be homicide.[298] The Quinlans, both Catholics, had been advised by priests about the Catholic Church doctrine distinguishing between acting to take a life and removing devices that artificially sustain life in hopeless cases.[299] Consequently, Joseph Quinlan filed for appointment as Karen's guardian with the express power to authorize discontinuance of all extraordinary means of sustaining vital processes.[300] Noting that she did not meet the Harvard criteria for brain death,[301] the judge ruled for the hospital.[302] The New Jersey Supreme Court reversed, citing Karen's right to privacy.[303] The respirator was removed but Karen did not die as expected.[304] She was transferred to a nursing home where she remained in a coma until her death in July 1985,

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289. *Id.*

290. After 1975, the name was changed to the Society for the Right to Die. *Id.* at 100.

291. *Id.*

292. *Id.* at 99.

293. HUMPHRY & WICKETT, *supra* note 2, at 99. In 1976, Governor Brown signed into law the Natural Death Act, which recognized the legitimacy of the Living Will. He commented: "For too long, people have been unwilling to talk about death. This bill gives recognition to the human right that people have to let their life come to its natural conclusion." *Id.*

294. *Id.* at 107.

295. *Id.*

296. *Id. See also supra* note 53 and accompanying text. Some movement was recorded on the electroencephalogram (EEG, which monitors electrical brain activity), she exhibited some involuntary muscle activity, and responded to pain, light, sound, and smell. HUMPHRY & WICKETT, *supra* note 2, at 107. *But cf. infra* note 325 (findings of trial courts regarding Nancy Cruzan's unconsciousness).

297. *See* HUMPHRY & WICKETT, *supra* note 2, at 107.

298. *Id.* at 108.

299. *Id.*

300. *Id.* Both testified that only weeks before Karen went into a coma, she had told her sister and mother that she would not want to be kept alive by extraordinary means if she ever became ill beyond hope. *Id.*

301. *See* BLACK'S LAW DICTIONARY, *supra* note 53, at 400.

302. *See* HUMPHRY & WICKETT, *supra* note 2, at 108. The judge held: "There is a duty to continue life-assisting apparatus.... There is no constitutional right that can be asserted by a parent for his incompetent adult child." *Id.*

303. The court held:

> We think the State's interest... weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims.... It is for that reason that we determine that Karen's right of privacy may be asserted on her behalf, in this respect, by her guardian and family....

In re Quinlan, 355 A.2d 647, 664 (N.J.), *cert. denied sub nom.*, Garger v. New Jersey, 429 U.S. 922 (1976).

304. HUMPHRY & WICKETT, *supra* note 2, at 108.

ten years later.[305]

The *Quinlan* case had a profound effect on both public opinion and legislative efforts, while also establishing legal precedent.[306] As of 1992, thirty-eight states have recognized Living Wills.[307]

The Living Will has been devised to enable competent adults to make their wish known for an end to extraordinary treatment.[308] The Living Will has promoted discussion of the various issues surrounding euthana-

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305. *Id.* For a complete discussion of her case, see generally IN THE MATTER OF KAREN QUINLAN (2d ed. 1982).

306. Karen's situation led to a series of decisions regarding a patient's right to terminate life-sustaining measures. *See* Cruzan v. Harmon, 760 S.W.2d 408, 412 n.4 (Mo. 1988) (en banc) (listing 54 state court decisions), *cert. granted*, 492 U.S. 917 (1989); Lyon, *infra* note 454, at 1367 n.2.

307. *See* ALA. CODE §§ 22-8A-1 to -10 (1975); ARIZ. REV. STAT. ANN. §§ 36-3201 to -3210 (Supp. 1992); ARK. CODE ANN. §§ 20-17-210 to -217 (Michie 1991); CAL. HEALTH & SAFETY CODE §§ 7185-7194.5 (West Supp. 1992); COLO. REV. STAT. §§ 15-18-101 to -113 (1987 & Supp. 1992); CONN. GEN. STAT. §§ 19a-570 to -580c (Supp. 1993); DEL. CODE ANN. tit. 16, §§ 2501-2508 (1983); D.C. CODE ANN. §§ 6-2401 to -2403 (1989); FLA. STAT. ANN. §§ 765.101-.401 (West Supp. 1993); GA. CODE ANN. §§ 31-32-1 to -12 (1991 & Supp. 1993); IDAHO CODE §§ 39-4501 to -4509 (1993); ILL. ANN. STAT. ch. 755, para. 35/1-35/10 (Smith-Hurd 1992); IND. CODE ANN. §§ 16-8-11-1 to -22 (Burns 1990); IOWA CODE ANN. §§ 144A.1 -.12 (1989 & Supp. 1993); KAN. STAT. ANN. §§ 65-28,101-28,109 (1992); LA. REV. STAT. ANN. §§ 40:1299.58.1-.58.10 (West Supp. 1992); MD. CODE ANN. HEALTH-GEN. §§ 5-601 to -614 (1990); MISS. CODE ANN. §§ 44-41-101 to -121 (Supp. 1992); MO. ANN. STAT. §§ 459.010-.055 (Vernon 1992); MONT. CODE ANN. §§ 50-9-102 to -206 (1991); NEV. REV. STAT. ANN. §§ 449.535-.690 (Michie 1991); N.H. REV. STAT. ANN. §§ 137H:1-16 (1990 & Supp. 1991); N.M. STAT. ANN. §§ 24-7-1 to -10 (Michie 1991); N.C. GEN. STAT. §§ 90-320 to -323 (1990 & Supp. 1992); OKLA. STAT. ANN. tit. 63 §§ 3101.1-.6; OR. REV. STAT. §§ 127.605-.650 (1990); TENN. CODE ANN. §§ 32-11-101 to -112 (1992); UTAH CODE ANN. §§ 75-2-1101 to -1119 (1993 & Supp. 1993); VT. STAT. ANN. tit. 18, §§ 5251-5262 (1987); VA. CODE ANN. §§ 54.1-2981 to -2992 (1988 & Supp. 1989); WASH. REV. CODE ANN. §§ 70.122.010-.920 (West 1992 & Supp. 1993); W.V. CODE 16-30-1 to -13 (1985 & Supp. 1993); WIS. STAT. ANN. §§ 154.01-.15 (West 1989 & Supp. 1992); WYO. STAT. §§ 35-22-101 to -208 (1988 & Supp. 1993); *Introductory Letter from the National Hemlock Society*, *supra* note 65, at 2.

308. *See, e.g.*, Anthony J. Burgalassi, *Living Wills—The Right to Die: A Selective Bibliography with Statutory Appendix* 45, THE RECORD OF THE ASS'N OF THE BAR OF THE CITY OF N.Y. 816 (1990). *See generally* Norman L. Cantor, *Prospective Autonomy: On the Limits of Shaping One's Postcompetence Medical Fate*, 8 J. CONTEMP. HEALTH L. & POL'Y. 13 (1992). A sample living will:

> TO MY FAMILY, PHYSICIAN, MY CLERGYMAN, MY LAWYER—If the time comes when I can no longer take part in decisions for my own future, let this statement stand as the testament of my wishes: If there is no reasonable expectation of my recovery from physical or mental disability, I, _____, request that I be allowed to die and not be kept alive by artificial means or heroic measures. Death is as much a reality as birth, growth, maturity, and old age—it is the one certainty. I do not fear death as much as I fear the indignity of deterioration, dependence and hopeless pain. I ask that drugs be mercifully administered to me for terminal suffering even if they hasten the moment of death. This request is made after careful consideration. Although this document is not legally binding, you who care for me will, I hope, feel morally bound to follow its mandate. I recognize that it places a heavy burden of responsibility on you, and it is with the intention of sharing that responsibility and of mitigating any feeling of guilt that this statement is made.
>
> Signed _____
> Date _____
>
> Witnessed by:
>
> _____
>
> _____

RUSSELL, *supra* note 2, at 296-97 (distributed by the Euthanasia Educational Council, 1972). The Council reported that, as of 1973, it had distributed a quarter of a million copies of the Living Will. *Id.* at 181.

sia, but may also provide a false confidence to those who believe it carries the force of law.[309] Indeed, doctors hesitate in following Living Wills absent clear legal guidelines.[310] Further, the Living Will is a positive action that must be taken. Many are not unaware of the Living Will or its problems, but nonetheless do not complete one, or assume nothing tragic will ever befall them.[311] Finally, the Living Will provides no guidance for the treatment of congenitally defective minors or incapacitated individuals.[312]

Also available to authorize others to act on one's behalf are Durable[313] Powers of Attorney.[314] Originally intended to simplify commercial transactions for relatives after the death or disability of the principal, they are now often recognized by state statute, and are valid for health-care decisions.[315] A Durable Power of Attorney may be drafted to the specifications of the principal, within legal limits, granting either broad or narrow powers in all or specified areas.[316] One drawback, however, is the possibility of a change in heart of the designated attorney-in-fact, or a change in circumstances, without a corresponding change in the Durable Power of Attorney.

As a converse to the emphasis on the death-inducing consequences of Living Wills and Durable Powers of Attorney, a person can request in advance that maximum treatment be given in case of disabling illness or injury.[317] The problem of incompetent persons who have not, for whatever

309. *See id.* at 182. Moreover, in cases where the provisions of the statute are not followed properly, the existence of a Living Will statute might be construed as positive evidence of legislative intent strongly favoring the preservation of life. *See infra* part IV.A. For an interesting examination of the law concerning living wills, see Craig K. Van Ess, Note, *Living Wills and Alternatives to Living Wills: A Proposal—The Supreme Trust*, 26 VAL. U. L. REV. 567 (1992).

310. RUSSELL, *supra* note 2, at 182.

311. *See id.* Judge Teel, who presided over the controversial case involving Nancy Cruzan and who recently suffered a heart attack, has not executed a Living Will. *See* Andrew H. Malcolm, *Paying a Personal Price in a Big Right-to-Die Case*, N.Y. TIMES, Nov. 4, 1990, at 14; *see also infra* notes 319-38, 438-44. Neither has Mr. McCanse, who is Nancy's court-appointed guardian: "I suppose I should, though, shouldn't I?" Malcolm, *supra*, at 14.

312. RUSSELL, *supra* note 2, at 182.

313. They are "durable" because they remain effective even after the principal becomes disabled or incompetent, if the document so provides. *See* BLACK'S LAW DICTIONARY 611 (5th ed. 1979).

314. As of June 1990, thirteen states and the District of Columbia have durable power of attorney statutes expressly authorizing the appointment of proxies for making health care decisions. *See* Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261, 290 n.2 (1990) (O'Connor, J., concurring). All fifty states and the District of Columbia have general durable power of attorney statutes. *Id.* at n.3. Missouri has had a particularly public debate in this arena. *See, e.g.*, Catherine J. Barrie, *Legislative History of Missouri Senate Bill 148, Durable Power of Attorney for Health Care*, 11 ST. LOUIS U. PUB. L. REV. 453, 454-76 (1992); *cf.* Michael A. Refolo, *The Patient Self-Determination Act of 1990: Health Care's Own Miranda*, 8 J. CONTEMP. L. HEALTH & POL'Y 455 (1992) (discussing various advance directives concerning a patient's desire for or against certain types of medical care).

315. *See* Barrie, *supra* note 314, at 461.

316. *See* SPRING & LARSON, *supra* note 2, at 141.

317. *See id.* at 141-42. A model form:

LIFE-SUSTAINING PROCEDURES DECLARATION:

I, _____, being at least eighteen (18) years old and of sound mind, willfully and voluntarily make known my desire that if at any time I have an incurable injury, disease, or illness determined to be a terminal condition I request the use of

reasons, used a Living Will remains, and they become candidates for the drastic action of life-support withdrawal, with only hearsay as evidence of their unknowable—indeed, nonexistent—intent.

On January 11, 1983, Nancy Cruzan lost control of her car as she travelled down Elm Road in Jasper County, Missouri.[318] She was revived by paramedics after being found lying face down in a ditch with her car overturned.[319] She was taken unconscious to a hospital, where an attending neurosurgeon diagnosed her as having sustained probable cerebral contusions[320] compounded by significant anoxia.[321] Nancy's brain had probably been deprived of oxygen more than twice as long as is necessary for permanent brain damage to occur.[322] She remained comatose for approximately three weeks and then improved somewhat to an unconscious state in which she could orally ingest some nutrition.[323] Surgeons implanted a gastrostomy feeding and hydration tube with the consent of her then husband.[324] Nancy's condition did not improve, and she lay in a Missouri state hospital in a persistent vegetative state.[325] The State of Mis-

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all medical procedures, treatments, and interventions that would extend my life [or delay my death, without regard to my physical or mental diagnosis, condition, or prognosis, and without regard to financial cost]. This includes appropriate nutrition and hydration, the administration of medication, and the performance of all other medical procedures necessary to extend my life, to provide comfort[,] care, or to alleviate pain.

In the absence of my ability to give directions regarding the use of life-sustaining procedures, it is my intention that this declaration be honored by my family and physician as the final expression of my legal right to request medical or surgical treatment and accept the consequences of the request.

I understand the full import of this declaration.

Id. at 169. Indiana has enacted a statute recognizing, with minor alterations, this form. *Id.* at 168.

This ignores, however, the issue of cost. Even where the incapacitated person is wealthy, the use of capital to maintain life with no reasonable chance of future benefit to the individual or to society is economically unjustified and ethically questionable as related to the depletion of resources for surviving relatives. Where the incapacitated person is impecunious (not an unusual hypothetical in this age of rapidly escalating medical costs), the economic issue is easy—society should not waste its limited resources. The economic condemnation is even sharper where the cost must be borne by individual physicians or hospitals. The ethical issue is reversed: can society deny sustaining treatment, albeit at great cost, with some chance of patient recovery remaining? Even if no chance of recovery exists, the act of denying medical treatment involves questions of appropriate state policy, with corresponding questions of the safeguards available to ensure against abuse and broader issues of a slippery slope of state valuation of individual life. *Cf. infra* part V.C (discussion of economic considerations of euthanasia).

318. Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261, 266 (1990).

319. *Id.*

320. Internal head injuries. *See* WEBSTER'S NEW WORLD DICTIONARY 229, 304 (1988).

321. Lack of oxygen. *Cruzan*, 497 U.S. at 266.

322. *See id.*

323. *Id.*

324. *Id.*

325. A "persistently vegetative state" is a condition in which a person exhibits motor reflexes, but evinces no indications of significant cognitive function. *See Cruzan*, 497 U.S. at 266. The Supreme Court of Missouri adopted much of the trial court's findings, which described Nancy's condition:

(1) [H]er respiration and circulation are not artificially maintained and are within the normal limits of a thirty-year-old female; (2) she is oblivious to her environment except for reflexive responses to sound and perhaps to painful stimuli; (3) she suffered anoxia of the brain resulting in a massive enlargement of the ventricles filling

souri bore the cost of her care.[326] When the permanence of her condition became apparent, Nancy's parents requested that her artificial nutrition and hydration procedures be terminated, which would have caused her death.[327] The hospital employees refused in the absence of court approval,[328] whereupon her parents sought and received authorization from the state trial court. The court found that Nancy had a fundamental right under the state and federal constitutions to refuse or direct the withdrawal of "death prolonging procedures."[329] The divided Supreme Court of Missouri reversed, based on either the applicability of the common-law doctrine of informed consent[330] to Nancy's case[331] or on the broader questions of a state constitutional right.[332] It further found that Nancy's parents did not have the power to order withdrawal of life-sustaining treatment in the absence of a valid Living Will.[333] The United States Supreme Court granted certiorari to consider whether or not Nancy had a right under the Federal Constitution to require the hospital to withdraw life-sustaining measures.[334] In sharply divided opinions, the Court affirmed the Supreme Court of Missouri, based on questions of the appropriate standard of proof required for Nancy to have evidenced her feelings regarding life-sustaining treatment,[335] and the interests of the State in preserving life in such cases.[336]

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with cerebrospinal fluid in the area where the brain has degenerated and [her] cerebral cortical atrophy is irreversible, permanent, progressive, and ongoing; (4) her highest cognitive brain function is exhibited by her grimacing perhaps in recognition of ordinarily painful stimuli, indicating the experience of pain and apparent response to sound; (5) she is a spastic quadriplegic; (6) her four extremities are contracted with irreversible muscular and tendon damage . . . (7) she has no cognitive or reflexive ability to swallow food or water to maintain her daily essential needs and . . . she will never recover her ability to swallow sufficient [sic] to satisfy her needs.

Id. at 266 n.1. "She is not dead. She is not terminally ill. Medical experts testified that she could live another thirty years." *Id.*

Persons in a persistent vegetative state "may *react reflexively* to sounds, movements, and normally painful stimuli, but they do not *feel* any pain or *sense* anybody or anything. Vegetative state patients may appear awake but are completely unaware." *Id.* at 301 (Brennan, J. dissenting). *See generally* Lawrence J. Schneiderman, *Exile and PVS*, 20 HASTINGS CENTER REP., May-June 1990, at 5 (discussion of ethical issues relating to persons who are in a persistent vegetative state).

326. *Cruzan*, 497 U.S. at 266.

327. *Id.* at 267-68.

328. *Id.* at 268.

329. *See id.* The court further found evidence that Nancy had:

[E]xpressed thoughts at age twenty-five in somewhat serious conversation with a housemate friend that if sick or injured she would not wish to continue her life unless she could live at least halfway normally . . . given her present condition she would not wish to continue on with her nutrition and hydration.

Id.

330. *Id.* This doctrine was used as a basis for the trial court's decision. *See id.*

331. *Cruzan*, 497 U.S. at 268.

332. *See id.*

333. *See id. See also supra* notes 309-13 and accompanying text.

334. *See id.* For a criticism of the judicial role played in this debate, see generally Terrence A. Kline, *Suicide, Liberty, and Our Imperfect Constitution: An Analysis of the Legitimacy of the Supreme Court's Entanglement in Decisions to Terminate Life-Sustaining Medical Treatment*, 14 CAMPBELL L. REV. 69 (1991).

335. *See Cruzan*, 497 U.S. at 284-87. *See also infra* notes 438-55 and accompanying text.

336. *See Cruzan*, 497 U.S. at 284-86. *See also infra* notes 446-49 and accompanying text.

"Do carrots cry?"[337]

On March 4, 1985, Roswell Gilbert shot his wife of 51 years, who suffered from Alzheimer's disease[338] and osteoporosis.[339] The retired electrical engineer was convicted and sent to prison with a life term that carried a minimum twenty-five-year sentence.[340] On August 2, 1990, Florida Governor Bob Martinez pardoned Mr. Gilbert, who was then eighty-one and in failing health,[341] after previously opposing clemency.[342] After being freed, a frail Gilbert admitted that he was wrong to commit a "mercy killing" of his wife: "I tried to help her as much as I could. The best word to use is desperation. It was a state of desperation, in my mind."[343]

In 1987, Janet Adkins began to notice slips in her memory; she became frustrated when she lost her concentration while playing the piano, one of her great loves in life.[344] In 1989, she was diagnosed as having Alzheimer's disease, and immediately began planning her death.[345] She had always led an unusually active life and continued to do so up to the time she committed suicide.[346] She contacted Dr. Jack Kevorkian,[347] who

337. *Nurses Question* Cruzan *Decision*, AUSTIN AMERICAN-STATESMAN, Dec. 16, 1990, at A13 (comment of a nurse concerning the persistent vegetative state of Nancy Cruzan).

338. *See Freed Man Says He Regrets "Mercy Killing" of His Wife*, AUSTIN AMERICAN-STATESMAN, Aug. 3, 1990. Alzheimer's is a degenerative disease with no known cure or treatment. *See generally* RONALD C. HAMDY ET AL., ALZHEIMER'S DISEASE: A HANDBOOK FOR CAREGIVERS (1990); LENORE S. POWELL & KATIE COURTICE, ALZHEIMER'S DISEASE: A GUIDE FOR FAMILIES (1983).

339. *See Man Who Shot Wife Is Granted Clemency*, N.Y. TIMES, Aug. 2, 1990, at A9.

340. *Id.*

341. *Id.*

342. *See Man Freed After Five Years in Jail for Mercy Killing*, AUSTIN AMERICAN-STATESMAN, Aug. 2, 1990, at A4.

343. *See Freed Man Says He Regrets "Mercy Killing" of His Wife*, *supra* note 338.

344. *See Whose Right to Die?*, AUSTIN AMERICAN-STATESMAN, June 10, 1990, at D1.

345. *See id.* She had previously been a member of the Hemlock Society. *See id.*

346. *See id.* She remained an avid mountain climber had recently climbed Mount Hood and hiked in the Himalayas. *See id.*

347. A 62-year-old semi-retired pathologist, Dr. Kevorkian considers himself on the frontlines of a movement to legalize and legitimatize assisted suicide. *See id.* at D4. Indeed, he is now considered by others, for good or evil, to be on the frontline. As of March 1993, Dr. Kevorkian has helped 15 terminally ill people commit suicide. *See, e.g.*, Tom Morganthau et al., *Dr. Kevorkian's Death Wish: The 'Suicide Doctor' Plans to Carry On, Despite a Murder Investigation and a Law Aimed to Stop Him*, NEWSWEEK, Mar. 8, 1993, at 46-48. He has been charged with committing three murders, in 1990 and 1991, but each time the cases were thrown out for the simple reason that Dr. Kevorkian had been careful not to do the deed himself. *Id.* at 46. Until 1992, Michigan had no law making assisted suicide a crime. *Id.* In December of that year and in clear response to Kevorkian's actions and public comments, Michigan enacted such a law. Again in response to Kevorkian, Michigan moved the effective date from March 30 to February 26 of 1993 to combat the quickened pace of assisted suicides; six took place in February 1993. *Id.* at 46-47.

Nevertheless, Kevorkian has vowed to continue to aid in the suicide of the terminally ill. *Id.* at 46. Indeed, having since lost his license to practice medicine, Dr. Kevorkian defied a Michigan law that proscribed assisted suicide. Isabel Wilkerson, *Suicide Doctor Tests Law, Stays with Man Who Dies*, N.Y. TIMES, May 17, 1993, at A1. Kevorkian was arrested after allegedly assisting in the suicide of Ron Mansur, a 54-year-old man who suffered from both bone and lung cancers. *Id.* The extent of Kevorkian's involvement was unclear, and prosecution against him under the law which makes assisted suicide a felony punishable by four years in prison and a two-thousand-dollar fine was equally uncertain, according to the prosecutor's office. *Id.*

assisted her by connecting her to a device of his invention, which induced death in three stages.[348] Their actions produced much public commentary.[349]

On July 26, 1990, Maxim Menendez, a twenty-five-year-old pet-store worker, lapsed into a coma after drinking a cocaine-laced soft drink that was accidentally missorted by a cocaine smuggler.[350] He is brain-dead and is kept alive by machine.[351]

In a rare public admission, Dr. Timothy E. Quill disclosed that in 1990 he had prescribed barbiturates sufficient for one of his long-time patients, suffering from acute myelomonocytic leukemia, to commit suicide.[352] The fact he knew his patient well distinguishes his case from cases involving Dr. Kevorkian and the anonymous resident who did not.[353] The prosecutor decided against bringing charges against Dr. Quill because of a lack of evidence.[354]

IV. THE CURRENT DEBATE

A. *Arguments Against Euthanasia*

Two primary arguments are made in opposition to euthanasia.[355] The first, rooted in Judeo-Christian heritage, concerns an intrinsic immorality of "premature" death.[356] The second relates to the unacceptable consequences which, it is believed, inevitably follow any loosening of legal proscriptions or social mores.[357] Additional arguments contest the scope of the problem, question the effect on the medical community and society, and reject the psychological consequences faced by potential euthanasia candidates and their families under any legalized active euthanasia scheme.[358]

Kevorkian's actions remain highly controversial. *See generally, e.g.*, Nancy Gibbs, *Rx for Death*, TIME, May 31, 1993, at 35-39 (comprising the lead and cover article for the issue).

348. *See Whose Right to Die?*, AUSTIN AMERICAN-STATESMEN, June 10, 1990, at D1.

349. A poll conducted by the Times Mirror Center of 1213 adults showed that fifty-nine percent would want to terminate life-sustaining treatment if they suffered from a painful, terminal disease. *See id.* Religion was a strong factor, and a distinction was made between withholding treatment from adults and from severely disabled children. *See id.* Interestingly, one-third could imagine assisting in the suicide of a loved one suffering from a terminal illness. *See id.* Eight in ten polled approve of state laws allowing the withdrawal of life-sustaining treatment where the terminally ill patient's wishes are known. *See id.* at D4. Fifty-five percent support active euthanasia, compared with only forty-one percent in 1975. *See id.* Fundamentalist Christians are generally strongly opposed to active euthanasia, but, paradoxically, a majority of "born-again" Christians and the very religious support mercy killings by spouses in some instances. *See id.*

350. *See* Sydney P. Freedburg, AUSTIN AMERICAN-STATESMAN, Aug. 16, 1990, at A23.

351. *Id.*

352. Lawrence K. Altman, *Doctor Says He Agonized, But Gave Drug for Suicide*, N.Y. TIMES, Mar. 7, 1991, at A1.

353. *See infra* text accompanying note 514.

354. *See Doctor Won't Be Charged in Suicide Case*, AUSTIN AMERICAN-STATESMAN, April 13, 1991, at A23.

355. Susan M. Wolf, *Holding the Line on Euthanasia*, 19 HASTINGS CENTER REP. 13 (Spec. Supp., Jan.-Feb. 1989).

356. *See id.*

357. *See id.*

358. *See infra* parts III.A.3-5.

1. Theological Objections

"His Death concerns the gods, not those men, no!"[359]

"Thou shalt not kill."[360] From no less an authority than God, the proscription against any form of killing seems clear.[361]

There are two fundamental theological premises for the conclusion that all *active* forms of euthanasia are forbidden: the sanctity of human life, and the merits of human suffering.[362] The concept of the inviolability of human life[363] is derived from divine revelation and natural law. Through the *Bible*, God's will is expressed in numerous commands against the taking of life.[364] According to natural law, God has sovereign dominion over all life[365] and thus man has no right to usurp God's domain.[366] To dis-

359. SOPHOCLES, AJAX 970, *reprinted in* THE OXFORD DICTIONARY OF QUOTATIONS para. 6 at 513 (3d ed. 1979).

360. *Exodus* 20:13. Some biblical scholars believe the proper interpretation is: "Thou shalt not murder." *See* RUSSELL, *supra* note 2, at 217-18.

361. This may pose interesting questions regarding the religious justifications for war, but that is a topic for another millennium.

362. *See* WILSON, *supra* note 2, at 82. Many religions do not see passive euthanasia, or the withholding of medical care, as euthanasia at all; indeed, many refuse the nomenclature. *See supra* notes 41-43 and accompanying text. Passive euthanasia can be considered, however, either the withholding of *all* medical care, or of only *extraordinary* medical efforts. The difference can be crucial to approval or condemnation in practice. *See supra* note 46 and accompanying text. *See generally* Joseph V. Sullivan, *The Immorality of Euthanasia, in* BENEFICENT EUTHANASIA 12 (Marvin Kohl ed., 1975); SPRING & LARSON, *supra* note 2, at 96 (discussing the euthanasia debate among theologians).

363. One argument not raised by proponents of euthanasia, but a general presupposition nonetheless, involves the definition of "human." A religious view assumes that all persons are human, *see generally supra* note 214, and accompanying text (Pope Pius XII discussing euthanasia); *supra* part II.B. (life is *per se* valuable, regardless of circumstances), but this is arguable where a person is in a persistent vegetative state. The lack of cognitive capacity can at least be considered the absence of an essential element of being human, leading to the unanswerable question of whether the body, without sentience, is sufficient to be "human."

This should not be confused with the Nazi assumptions of sub-humanity; Gypsies, Jewish people, and persons with physical disabilities do not, as groups, suffer from persistently vegetative states. In Nazi Germany the defining characteristics were wholly unrelated to the quality, if possible, of being less than fully "human." *See generally supra* notes 176-89 and accompanying text discussing Nazi Germany.

According to a religious perspective, it might not be incompatible to distinguish physical existence from being "human"; the concept of the soul as a separate entity is common to religions, and it is there that salvation will occur, if at all. The issue would then be one of deciding whether a soul inhabits a person in a persistently vegetative state. Presumably it does, but the question has not been posed so specifically; previously no need for such edification existed.

364. *See, e.g., Exodus* 23:7; Darrel W. Amundsen, *Suicide and Early Christian Values: The Nature of the Problem and the Scope of this Essay, in* SUICIDE AND EUTHANASIA, *supra* note 2, at 81-96; BAILEY, *supra* note 2, at 22-23.

365. *See* BAILEY, *supra* note 2, at 20-22. *But cf. id.* at 113 (suggestion by theologian Daniel Maguire that humans have underestimated their dominion over life and death with regard to difficult medical situations). *See generally* SPRING & LARSON, *supra* note 2, at 122-25 (explaining God's sovereign power over all creation).

366. *See* WILSON, *supra* note 2, at 83. It is further argued that any action to take life goes against a basic instinct in humans of self-preservation and is thus inherently *unnatural. See* Gay-Williams, *supra* note 43, at 98-99; William F. May, *The Right to Die and the Obligation to Care: Allowing to Die, Killing for Mercy, and Suicide, in* DEATH AND DECISION 111, 111 (Ernan McMullin ed., 1978). This presupposes that such an instinct, while generally accurate, cannot in certain instances be overwhelmed by suffering, or overridden by conscious decision. Even given the instinct of survival, its existence is not its justification; its origins are (presuma-

obey this divine order is to reject God's will and suffer the consequences; obedience to God takes primacy over considerations of human suffering. Such considerations can be irrelevant in any event as Christian dogma places a spiritual significance on suffering.[367]

2. The Slippery Slope Objection

Even assuming that moral obstacles are not controlling, the possibility of mistake or malevolent abuse presents the common slippery slope objection.[368] Even where euthanasia is seen as beneficial in certain circumstances, the potential for misdiagnoses and the threat of non-mercy killings are seen as too great to justify any exceptions to an absolute bar against euthanasia.[369] Further, counterbalancing the needs of a particular individual are the considerations for society as a whole. The slippery slope objection is particularly relevant here because euthanasia involves such a serious and complicated subject and because we have an example of a contemporary, similar society, run amok.

Anti-euthanasia forces often point to the Nazi atrocities as an example of the dangerousness of euthanasia.[370] This argument is flawed for several

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bly) biological and cannot be juxtaposed against the complex ethical questions surrounding the value and meaning of life filled with suffering. Indeed, in nature, no such creature that suffered to the extent normally envisaged in the euthanasia debate would long survive.

367. *See* HUMPHRY & WICKETT, *supra* note 2, at 165; WENNBERG, *supra* note 2, at 82-88; SACRED CONGREGATION FOR THE DOCTRINE OF THE FAITH, DECLARATION ON EUTHANASIA III (May 5, 1980) (*reprinted in* LIFE ETHICS CENTRE, *supra* note 216; full text in *L'Osservatore Romano*, June 30, 1980). Monsignor Middleton, while condemning the proposed New York euthanasia bill, *see supra* note 193 and accompanying text, "extolled 'the mystical beauty of pain.'" HUMPHRY & WICKETT, *supra* note 2, at 38. *See generally* SPRING & LARSON, *supra* note 2, at 130-31. Suffering is seen as providing an opportunity to draw closer to, and become more dependent on, Jesus Christ. *Id.* at 131. Further, some view as repugnant any attempt by moralists to decide how much suffering is too much. *Id.*; *see also id.* at 56 (rejection of the belief that man should be free to control his own life and death). A pastoral letter from Dutch Catholic Bishops refuted the "secular philosophy that equates good health with the 'value' of a person's life," stating that personalities can grow despite deteriorating bodies. *Id.*

Original-sin beliefs notwithstanding, Dr. James Walsh's argument extolling suffering as virtuous disregards the possibility of innocent suffering, as with infant AIDS sufferers today. *See supra* note 163.

368. For an interesting discussion on slippery slope arguments, *see generally* Frederick Schauer, *Slippery Slopes*, 99 HARV. L. REV. 361 (1985) (explaining that slippery slope arguments focus on the possibility of future damages).

369. Additionally, opponents fear that a "right to die" would rapidly deteriorate into a "duty to die," as those who are burdens would feel pressure to succumb to euthanasia. *See* SPRING & LARSON, *supra* note 2, at 49; *see also infra* note 540 (former Governor of Colorado stating that the elderly have a "duty to die"). This, coupled with the demographically aging U.S. population, is seen as a serious genocidal possibility. *See* SPRING & LARSON, *supra* note 2, at 22. Some see efforts by euthanasia proponents as a thinly veiled attempt to, step by step, "establish the death penalty for those whose lives *they* consider unworthy to be lived." Rita Marker, *Don't Let Doctors Turn into Killers*, USA TODAY, Apr. 6, 1989, at 8A (photocopy distributed by the International Anti-Euthanasia Task Force) (emphasis added).

370. *See* RUSSELL, *supra* note 2, at 90. Anti-euthanasia forces, which tend as well to correlate positively with those who hold strongly religious beliefs, have little answer to the criticism that the Holocaust occurred through deafening Church silence in an overwhelmingly Christian country (a 1940 census indicated that ninety-five percent of Germans were affiliated with a church). *See* HUMPHRY & WICKETT, *supra* note 2, at 29. Further, many who were directly responsible for the heinous acts were church oriented and continued to think of themselves as such, despite their actions. *Id.* Franz Stangl, commandant of the Treblinka concentration

reasons. The motives behind the Nazi programs are at the opposite end of the moral spectrum from legislation with the goal of meeting the desires of the suffering individual.[371] The Nazi emphasis was not on the suffering *individual*, but rather on the *society's* right to exterminate unwanted individuals regardless of the individual's feelings on the matter.[372] Killing for the convenience of the State has never been a goal of mainstream euthanasia proponents.[373] Further, the Nazi euthanasia program was directed secretly and in an extra-legal manner.[374] If anything, this argument might support openly discussed and legislated policies in order to lessen the likelihood of a possible reoccurrence of the Nazi debacle.

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camp, where 700,000 people died, was a devout Roman Catholic. *Id.* Indeed, he found it difficult to sign a statement that he was a *Gottglaubiger* (a believer in God without a religious affiliation); Germans were loyal to their churches and church rituals. *Id.* Hermann Goering, at the Nuremberg court, proclaimed: "[I] always considered I belonged to the church." *Id.* He further noted that the party represented a "'positive Christianity... [fighting] the spirit of Jewish materialism.'" *Id.*

Historian William Allen argues essentially that it would have been futile for the churches to oppose the Nazi regime. *Id.* He further explains that a lack of focus on moral fundamentalism and concern for the church's survival, even in the face of blatant violations of religious dogma, in effect supported the Nazi regime, except where government policies were directly opposed to church self-interest. *Id.*

371. One wonders how many Charles Proteus Steinmetzs were slaughtered for the morally obscene and intellectually idiotic "euthanistic" justifications of the National Socialists. Then again we do know, give or take a few hundred thousand, how many ordinary John and Jane Q. Europeans were exterminated. After all, one need not be a genius to validate existence. The question that follows is not, however, what *does* one need to validate one's existence; that presupposes that the State has the right to terminate existence based on intelligence or physiological (or other, state-defined) factors. *See supra* notes 176-89 and accompanying text. Rather, the question is more appropriately: when does one have the right to legitimately conclude that his own life no longer desires existence? The difference in emphasis is critical. No remotely mainstream advocates propose active *involuntary* euthanasia in any form even approaching what occurred in Nazi Germany; to do so would be antithetical to the foundations of our culture and legal system. *See also supra* notes 186-88 (outlining the Nazi's secret and involuntary euthanistic programs).

The U.S. Supreme Court grappled with an analogous issue concerning the execution of retarded defendants convicted of capital crimes. *See, e.g.*, Al Kamen, *Executing the Insane Forbidden: High Court Rules Punishment Unconstitutionally Cruel and Unusual*, WASH. POST, June 27, 1986, at A4.

372. Or the feelings of the individual's family, where the individual was incapacitated. An article by Michael Straight published in the *New Republic* detailed German practices:

> In September, October, and November, 1940, 85,000 blind, incurably ill or aged Germans were put to death by the Gestapo. They were put to death as casually as the SPCA chloroforms old and helpless dogs. They were not killed for mercy. They were killed because they could no longer manufacture guns in return for the food which they consumed; because the German hospitals were needed for wounded soldiers; because their death was the ultimate logic of the national socialist doctrine of racial superiority and the survival of the physically fit.

RUSSELL, *supra* note 2, at 91.

373. Further, according to Marvin Kohl:

> There is simply no evidence that killing per se is contagious, but there is overwhelming evidence to show that it is not. It is true that people who believe that it is right to kill Gypsies, Jews, or anyone else, provided their deaths may profit the state, will probably continue to kill if they have the power to do so. But this is not evidence of the seductiveness of killing. Rather it is evidence that when men have almost unlimited power their actions will be consistent with their beliefs, and if their beliefs entail needless cruelty, so will their actions.

Kohl, *supra* note 180, at 137.

374. According to generally accepted Western legal principles. *See supra* notes 186-89 and accompanying text.

3. Objections as to the True Extent of the Problem

Some writers opposed to euthanasia stress that the need for euthanasia is often exaggerated with extreme examples of patient suffering.[375] This is a specious argument, implying that because euthanasia is truly needed so rarely it is thus wrong. That a single person must endure extreme and/or hopeless suffering validates the arguments both for and against euthanasia.

4. The Effect on the Medical Community

> *I swear by Apollo the physician, by Aesculapius, Hygeia, and Panacea, and I take to witness all the gods, all the goddesses, to keep according to my ability and my judgment the following Oath:*
>
> *To consider dear to me as my parents him who taught me this art; to live in common with him and if necessary to share my goods with him; to look upon his children as my own brothers, to teach them this art if they so desire without fee or written promise; to impart to my sons and the sons of the master who taught me and the disciples who have enrolled themselves and have agreed to the rules of the profession, but to these alone, the precepts and the instruction. I will prescribe regimen for the good of my patients according to my ability and my judgment and never do harm to anyone. To please no one will I prescribe a deadly drug, nor give advice which may cause his death. Nor will I give a woman a pessary to procure abortion. But I will preserve the purity of my life and my art. I will not cut for stone, even for patients in whom the disease is manifest; I will leave this operation to be performed by practitioners (specialists in this art). In every house where I come I will enter only for the good of my patients, keeping myself far from all intentional ill-doing and all seduction, and especially from the pleasures of love with women or with men, be they free or slaves. All that may come to my knowledge in the exercise of my profession or outside of my profession or in daily commerce with men, which ought not to be spread abroad, I will keep secret and will never reveal. If I keep this oath faithfully, may I enjoy my life and practice my art, respected by all men and in all time; but if I swerve from it or violate it, may the reverse be my lot.*[376]

Euthanasia stands against all that modern medicine stands for; "to kill" is, after all, antonymic of "to cure." Blurring the lines of the function of medicine would arguably harm an essential element of trust among pa-

375. *See, e.g.*, MARX, *supra* note 33, at 25.

376. The Hippocratic Oath, *reprinted in* DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 767-68 (27th ed. 1988). Although the Hippocratic Oath has for generations been a revered tradition at medical school graduation ceremonies, it has undergone changes, sometimes severe. *See* BARNARD, *supra* note 31, at 29. Some schools have made word changes, while others have abandoned it altogether, or substituted the Declaration of Geneva, which was adopted in 1914 by the World Medical Association. *Id.* at 28. Few Canadian schools use the Hippocratic Oath. *Id.*

In fairness to Hippocrates, he could not have foreseen the progress of two thousand years of medical advancements. Indeed, he avoided the use of drugs even in his own time; he preferred instead a homeopathic healing process. *See* DORLAND'S ILLUSTRATED MEDICAL DICTIONARY, *supra*, at 767. In addition, Ms. Russell proposed that, if man can promulgate such an oath, he can also revise it. RUSSELL, *supra* note 2, at 221.

tients, physicians, nurses, and society.[377] In addition to a fundamental moral unacceptability, many are concerned that if active euthanasia becomes a prevalent practice, a stigma would be attached to those doctors willing to perform euthanasia.[378] Others point to the demoralizing effect of a condoned and systematic "abandonment" of scores of patients.[379]

Another argument against euthanasia involves the progress that medical technology makes against diseases. Euthanizing patients might deprive them of potential cures developed after it is too late, but before they would otherwise have died.[380] This might occasionally prove true, but is also a function of the time before "natural" death when euthanasia would be allowed.[381] It is doubtful a breakthrough would be made and be available to the dying patient in a matter of a few months or even years. Restrictions on medical experimentation might significantly restrict the benefits of new discoveries to any who suffered from the affliction too near to the time of the discovery. Even if a discovery is made and is available, the issue then requires a proper balancing of the demands of the patient[382] with the probabilities of an effective, available cure.[383] Also of concern is the possibility of misdiagnoses which might result in euthanizing non-terminal patients.[384] These remain valid concerns, but the risks

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377. *See* Willard Gaylin et al., *Doctors Must Not Kill, in* EUTHANASIA: THE MORAL ISSUES, *supra* note 31, at 25, 27; *see also* THOMASMA & GRABER, *supra* note 2, at 146-49. *See generally* HELGA KUHSE, THE SANCTITY-OF-LIFE DOCTRINE IN MEDICINE: A CRITIQUE (1987).

378. RUSSELL, *supra* note 2, at 79. Dr. Abraham Wolbarst, a distinguished New York physician, argued that—analogous to the situation of abortion operations—legalization would remove the stigma attached to what has been a criminal act. *Id.* Many opposed to euthanasia see the issues of abortion and euthanasia as inextricably related, both involving a question of the right to life. *See, e.g.*, MARX, *supra* note 33, at 17; SPRING & LARSON, *supra* note 2, at 47-48.

379. *See* Gay-Williams, *supra* note 43, at 100-01 (arguing that the practice of euthanasia would eventually affect the attitudes of all health professionals, diminishing the quality of medical care for everyone).

380. *See* WEISS, *supra* note 53, at 87.

381. "Natural" is now a difficult concept, as life can often be extended "artificially" via extraordinary medical care. Moreover, our life spans are historically much longer now than previously, due to both better nutrition and living conditions, and improvements in medical care. Distinctions of when "natural" ends and "artificial" begins become an academic argument, with little basis in medical realities. *See generally* MEDICAL INNOVATION AND BAD OUTCOMES: LEGAL, SOCIAL, AND ETHICAL RESPONSES (Mark Siegler et al. eds., 1987).

382. At the time euthanasia is considered.

383. Quantifying probabilities may not be as difficult as it first appears. Most medical progress now occurs as the result of organized, even bureaucratic, experimentation. Knowledge of programs in development, with educated guesses as to rates of progress, would give a nearly complete picture of new cures "in the pipeline." These considerations should, however, be a part of the physician's analysis of the patient's condition and recommended treatments as a matter of course.

384. Gay-Williams, *supra* note 43, at 100.

Best while you have it use your breath,

There is no drinking after death.

JOHN FLETCHER, THE BLOODY BROTHER, *reprinted in* THE OXFORD DICTIONARY OF QUOTATIONS para. 7 at 215 (3d ed. 1979).

Death, for all its presumed beneficence against suffering, is final. Any mistake, whether honest or otherwise, cannot be reversed. Even honest mistakes can take several forms: improper medical diagnosis by either incompetence or the state of medical knowledge, or the unpredictability of the progression of an illness. The finality of euthanasia requires at the very least a high degree of certainty that only those persons who meet the requisite criteria of x amount of human suffering and y amount of hopelessness will be given the option of

can be reduced in accordance with intelligent practice in any case by "getting a second opinion." In a terminal case where euthanasia is under consideration, third or fourth opinions would be well warranted.

Many who oppose euthanasia reject the implication that it is the only option available to a dying person. They propose instead alternatives such as hospice care.[385] Others emphasize the Christian responsibility to minister to the needs of those who might otherwise consider euthanasia.[386] While these are legitimate criticisms and honorable suggestions,[387] they do not avoid the underlying question of the right of an individual to choose death, even with the option of alternative health care, in the face of continuing pain.

Yet another objection relates to the ability of physicians to alleviate most pain with drugs, obviating the need for euthanasia.[388] This again does not address the underlying question of the patient's right, or lack thereof, to choose death, and further disregards the question posed by those favoring euthanasia: "What will be the resulting *quality* of life?"[389] While drugs certainly do much to alleviate pain, at some point, the quantity and type of drugs needed increases to the point that this question becomes particularly relevant.

5. Effect on Society

Mary Senander, of the International Anti-Euthanasia Task Force, presents an interesting argument. She reverses a standard refrain by those favoring euthanasia of a legislated morality imposed by those in opposition:

> If you want to commit suicide, you can do that. It's not illegal. If you want to hang yourself with a velvet cord from the rafters of your garage—I'm not recommending it and I wish you wouldn't—you *can* do that. If you want to blow your brains out

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euthanasia. Where the risks are so lopsided, it seems reasonable to err on the side of caution and thus against euthanasia.

Even if we could be certain as to the honor of those who might euthanize improperly, more fundamental questions remain. Who decides what those circumstances are and whether the patient meets them? Further, what controls are needed to ensure faithful compliance with a presumption against euthanasia? And what of the instances where the patient is unable to make known his or her wishes? These questions bode ill for the very real problems facing any implementation of a euthanasia policy.

385. *See, e.g.*, Robert J. Miller, *Hospice Care as an Alternative to Euthanasia*, 20 LAW, MED. & HEALTH CARE 127 (1992); MARX, *supra* note 33, at 81. Hospitals, it is noted, are oriented toward the treatment of those who can be treated, while nursing homes are oriented toward non-terminal elderly; neither are designed for the needs of the dying. *See id.*; *see also* THOMASMA & GRABER, *supra* note 2, at 113-15; DAVID CUNDIFF, M.D., EUTHANASIA IS NOT THE ANSWER: A HOSPICE PHYSICIAN'S VIEW (1992).

386. *See generally* SPRING & LARSON, *supra* note 2, at 173-75 (discussing the rationale behind hospice care).

387. *See generally* ELIZABETH CALLARI, A GENTLE DEATH: PERSONAL CAREGIVING TO THE TERMINALLY ILL (1986) (registered nurse's advice on coping with and caring for a terminally ill loved one).

388. *See* SPRING & LARSON, *supra* note 2, at 176-77.

389. A patient, bed-ridden and racked with drug-masked pain, may well ask: "Is this life?" — a question that, sadly, begs to not be answered.

> with a diamond-studded pistol—I hope you won't, for your sake and for your family's—you can *do* that. If you want to save up pills and poison yourself—I'd try to talk you out of it—but you *could* do it. But what you're asking for—what proponents of euthanasia are demanding,[sic]—is *my approval* and *acceptance* of your actions. What's more, you expect—and proponents of "aid in dying" demand—someone *else* to help.[390]

She continues:

> When you ask for social and legal approval of killing, you're asking ME to participate in YOUR death, to share a communal responsibility and burden. And guilt. And blame. And *I won't do it!* Now you're meddling with MY choices and MY conscience. Don't expect me to be silent when these issues of public policy are debated; I have MY rights too.[391]

This presents a unique perspective of two opposing forces, each saying: by your actions and beliefs, you are forcing me to do or to countenance something that is reprehensible to me. Who's rights are being infringed by whom's? It is further notable that this position posits a moral objection that is not necessarily religious, thus distinguishing theological from strictly moral objections.

Here, Ms. Senander relies on the premise that assistance of suicide (not euthanasia per se)[392] violates a right of all citizens to be free from immoral infringements (according to the complaining individual's sense of moral correctness). This is, at once, both a powerful emotional argument and a difficult one to refute on any but a strictly logical basis. The fallacy here is that Ms. Senander's use of the term "participate" is susceptible to different meanings in different contexts. Her "participation" is limited to her existence in a society that may condone a practice that is reprehensible to her. Her argument, however, should not be so simply dismissed. She validly exposes a base objection to the effect on non-participants of the difficult decisions that must be faced by those considering euthanasia. To those who feel strongly about the importance of maintaining a bar on any takings of life, euthanasia is an affront to humanity and a diminution of society's claim to civilization. This does, however, disregard the fact that the argument is disassociated from the situation of any particular individual. This leaves the argument in the untenable position of requiring compliance to the moral dogma of society—an impossible task in this society and probably an undesirable goal even if feasible. In effect, this would necessarily lead to a lowest common denominator of moral jurisprudence.

Should society condone euthanasia, there is recourse available to those who object to the practice. As a member of society, each person has the right to participate in the process of legislating both morals and public policies, via whatever reasonable means is available—in our case via demo-

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390. MARY C. SENANDER, INTERNATIONAL ANTI-EUTHANASIA TASK FORCE, DEATH ON DEMAND: "DON'T COUNT ME IN!" (1988).

391. *Id.*

392. See *supra* note 34 and accompanying text.

cratic governance. Whether the victor will be able to gather the greatest political power to force the issue remains an open and troubling question with such a basic issue at stake; neither side can live easily, if at all, with the other's demands.[393]

Another objection, closely related to the slippery slope objection,[394] is the change in attitudes toward the terminally ill and others who are medically vulnerable, which is viewed as necessarily leading to an eroded value of life in general.[395] After it becomes possible to think of some as deserving death, it will consequently become less improbable that the general revulsion against killing will decline.[396]

6. An Admission of Defeat: Creating an Atmosphere of Despair

> *I do not want to die—no; I neither want to die nor do I want to want to die;*
>
> *I want to live for ever and ever and ever. I want this "I" to live—this poor "I"*
>
> *that I am and that I feel myself to be here and now, and therefore the problem of the duration of my soul, of my own soul, tortures me.*[397]

The option of euthanasia might be seen by patients as a shortcut, perhaps leading many to give up too easily.[398] The very possibility of euthanasia might keep some from surviving when they otherwise might.[399] Medical recoveries can occur based not on medical care, but rather on a simple yet powerful desire to live.[400] To give up the fight[401] is to close off the incentive to live, thus resulting for some in a needless death.[402]

Furthermore, some might choose euthanasia out of concern for their

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393. This raises interesting philosophical questions of democracy in that a presumption of consent to the process is required of any minority; in losing, the loser must accede to the legitimacy of the contest. This is less certain in areas where some believe strongly that issues beyond mere governance are involved. The power of any citizen or group of citizens to veto a practice based on its discontinuity with their sense of morality is itself both undefined and worthy of further exploration.

394. *See supra* part III.A.2.

395. *See, e.g.*, C. Everett Koop & Edward R. Grant, *The "Small Beginnings" of Euthanasia: Examining the Erosion in Legal Prohibitions Against Mercy Killing, reprinted in* STUDIES IN L. MED. & SOC'Y 19 (1986) (published by Americans United for Life, which opposes euthanasia).

396. *See id.* at 42-43.

397. MIGUEL DE UNAMUNO, THE TRAGIC SENSE OF LIFE IN MEN AND IN PEOPLES 45 (J.E. Crawford Flitch trans. 1926).

398. Gay-Williams, *supra* note 43, at 100; *see also* David C. Clark, *"'Rational' Suicide and People with Terminal Conditions or Disabilities,* 8 ISSUES IN L. & MED. 147 (1992); Harry M. Hoberman, *The Impact of Sanctioned Assisted Suicide on Adolescents,* 4 ISSUES IN L. & MED. 191 (1988).

399. Gay-Williams, *supra* note 43, at 100.

400. *See, e.g.*, BARNARD, *supra* note 31, at 79-82 (relating a personal experience while on a "farm call").

401. *See supra* note 367 (discussing human instinct to survive).

402. This argument may have merit in cases where the diagnosis is uncertain, but in cases of terminal or incurable illnesses, the value of "willing the illness away" is unproved and not a legitimate argument against euthanasia generally, particularly considering the restrictions that would accompany any acceptable euthanasia policy.

families or others, rather than from a true desire to die.[403] This is a strong argument for anti-euthanasia forces in that it combines elements of (non-religious) moral and slippery slope objections. The argument is further strengthened by the inability to guarantee that any decision favoring euthanasia will be based strictly on the needs and desires of the individual who will die and not on the influence of others who may be affected, but who will not themselves suffer the consequences. This is particularly troublesome considering that any influence will likely come not from any conscious encouragement, but from a sense of obligation on the part of the euthanasia candidate to cease or prevent being a burden on loved ones.

These concerns are not easily assuaged by an emphasis on the judicial safeguards present to prevent undue influence. First, whether any influence can be *due* is not certain; the "correctness" of an individual's decision to die to prevent emotional or financial burdens on loved ones is as justifiable on grounds that it is within a person's autonomy to sacrifice for love as it is condemnable on grounds of its terrible import. Second, assuming such influence is condemnable, few cases of serious medical decisionmaking would survive such an influenceless standard—life decisions are not made in an emotional vacuum. Finally, the courts might indeed be the best available arena to ensure that any influence is not undue.

"No life that breathes with human breath
Has ever truly long'd for death."[404]

B. *Arguments for Euthanasia*

1. A Need

Darkling I listen; and, for many a time
I have been half in love with easeful Death,
Call'd him soft names in many a mused rhyme,
To take into the air my quiet breath;
Now more than ever seems it rich to die,
To cease upon the midnight with
no pain . . . . [405]

Compassion. In a word, *compassion* embodies all that insists on the practice of euthanasia.[406] To effectively understand arguments favoring

403. Gay-Williams, *supra* note 43, at 100: *see also* Joseph Richman, *Sanctioned Assisted Suicide: Impact on Family Relations*, 3 ISSUES IN L. & MED. 53, 54-62 (1987). Even more objectionable is the possibility of subtle or not-so-subtle pressure to force elderly patients to commit euthanasia. David G. Bjornstrom, *Elderly Will Be Pressured to Die Early*, 105 L.A. DAILY J., Oct. 28, 1992, at 6.

404. Lord Alfred Tennyson, *reprinted in* THE OXFORD DICTIONARY OF QUOTATIONS para. 20 at 543 (3d ed. 1979).

405. John Keats, *reprinted in* THE OXFORD DICTIONARY OF QUOTATIONS para. 22 at 291 (3d ed. 1979).

406. *See* William A. Squires, *A Call for Compassion: Removing Obstacles from the Right to Die*, 19 BARRISTER Winter 1993 at 3; *see also* Paul Kurtz, *The Case for Euthanasia: A Humanistic Perspective*, 8 ISSUES IN L. & MED. 309, 309-16 (1992). Euthanasia has evolved into so many forms, particularly due to the ever-expanding capabilities of medical professionals, it would be simplistic to attempt to advocate all in blanket arguments. Compassion, though, does describe the motive behind beneficent forms under serious consideration.

euthanasia, it is necessary to distinguish the various forms; different arguments, on either side, apply differently depending on the nature of the action or non-action to end life, the state of the suffering individual, and his or her say in the matter.

"Death is perhaps nothing, dying everything."[407]

The primary argument for euthanasia is not so much *for* euthanasia—no one[408] enjoys the contemplation of misery—as it is *against* the arguably absurd propositions that deny a remedy for that which exists—insufferable and unending pain. Assuming that needless suffering is to be neither tolerated nor glorified, we either act or do nothing, to relieve such pain.

"Naught broken save this body, lost but breath;
Nothing to shake the laughing heart's long peace there
But only agony, and that has ending;
And the worst friend and enemy
is but Death."[409]

Some of the early commentators on euthanasia based their ideas on a religious theme. In one of the first articles on euthanasia to appear in a Protestant Church periodical, E.N. Jackson cited the infinite regard of Jesus for every distressed human soul.[410] He continued by proposing that, based on the Christian concept of soul, what a physician might do to the physical body would not injure the soul itself.[411] He further believed that adequate safeguards could exist to prevent unwise or unscrupulous actions.[412] In an address in 1954, Dr. Claude E. Forkner[413] proclaimed: "It is not death that people fear . . . it is ceaseless pain, endless suffering, excessive use of the family financial resources, lifelong incompetence, hopeless dependency."[414] Euthanasia, he continued, embodies one of the strongest Commandments of the Bible: "Do unto others as thou wouldst have them do unto you."[415] Eighty-four-year-old Dr. Heinrich Wolfe[416] deplored the zeal of many doctors in prolonging life cruelly and futilely,

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407. E. du Perron, *in* 19 HASTINGS CENTER REP. 31 (Special Supp. Jan.-Feb. 1989).

Another of many horror stories involved a 94-year-old woman who entered a hospital after experiencing severe internal bleeding. A large, malignant tumor was found in her colon. With reservations about the wisdom of surgery, the tumor was removed. Resuscitation was expressly rejected, in writing, before the surgery. After the operation, a respirator was placed in her mouth and would remain there until her death, weeks later. Sedation was minimal so as to not interfere with diagnoses. Her hands swelled to three times their normal size and were tied to the bed to prevent her from removing the irritating tubes. The onset of pneumonia was treated with antibiotics, and was revealed only inadvertently to family members two days hence. Her kidney malfunction worsened. Her face was swollen beyond recognition. Her lips were raw from the respirator. Finally, she died. *See* Fred M. Hechinger, *They Tortured My Mother*, N.Y. TIMES, Jan. 24, 1991, at A14.

408. Sadists and masochists notwithstanding.

409. Rupert Brooke, *reprinted in* THE OXFORD DICTIONARY OF QUOTATIONS para. 28 at 94 (3d ed. 1979).

410. RUSSELL, *supra* note 2, at 113.

411. *Id.*

412. *Id.*

413. Professor of Clinical Medicine at Cornell Medical College. *Id.* at 112.

414. *Id. See also* HUMPHRY & WICKETT, *supra* note 2, at 65 (noting that, according to studies, *prolonged* dying was most feared).

415. RUSSELL, *supra* note 2, at 112.

416. A consultant at Mount Sinai Hospital. *Id.*

eager to demonstrate technical skills at the expense of their dying patients.[417]

Dr. Harry E. Fosdick[418] countered the basic religious contention that only God has the right to determine when life should end by pointing out that man had been responsible for increasing the average lifespan from approximately 30 years during early colonial days to well over 70 years today.[419] In so doing, man may inadvertently have increased suffering for those who otherwise would not have survived, leading to the dilemma society now faces in dealing with euthanasia.[420]

> *"It is silliness to live when to live is torment; and then have we a prescription to die when death is our physician."*[421]

The situation where the patient is incapable of requesting euthanasia raises a more difficult question.[422] Where a Living Will, Durable Power of Attorney, or other extant evidence provides a clue as to the person's prior wishes, physicians and the courts are not faced with the problems of involuntary[423] euthanasia. Where a person faces continued existence in a form quite different from cognitive human existence, however, the capacity of family or relatives to make the decision to end life is far more ethically and legally attenuated.

> *"To live a life half dead, a living death."*[424]

2. Questions Concerning the Meaning of Life

> *"Please . . . kill me."*[425]

A difficult question that is rarely raised concerns the reasons for wanting to die. After all, even for those who are unhappy or in ill health, life is "good."[426] It is not enough to say merely that death provides a release from suffering. If this were so, any love-spurned soul would provide a sufficient rationale for death. For death to be appealing, its alternative, life, must be far worse. People view "life," however, as either sacrosanct, in which case any infinitesimally minute portion always has positive value, or as relative, in which case life can become negative at some variable point in the future, the only question being when. Ordinarily, death makes the

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417. *Id.*

418. Then minister of the Riverside Church in New York. *Id.*

419. *Id.*

420. *Id.*

421. WILLIAM SHAKESPEARE, OTHELLO, THE MOOR OF VENICE act 1, sc. 3.

422. *See, e.g.*, THOMASMA & GRABER, *supra* note 2, at 43-46.

423. *See supra* note 49 and accompanying text.

424. John Milton, *reprinted in* THE OXFORD DICTIONARY OF QUOTATIONS para. 17 at 350 (3d ed. 1979).

425. Plea of a female planet colonist, immobilized in a fibrous cocoon, who begs rescuing Marines to kill her before an alien, which was implanted via alien embryo carrier through the colonist's mouth to her abdomen, is about to hatch. ALIENS (Twentieth Century/Fox 1986).

426. *See* Foot, *supra* note 38, at 87. Here, "good" probably is best defined in the context of an expectation of better or improving health. The fundamental issue underlying euthanasia is the inevitability of death faced continuously, rather than abstractly as is usual until serious illness strikes or old age creeps up. *See also* JOHN HARRIS, THE VALUE OF LIFE 1-110, 192-213, 238-42 (1985).

determination for us. In cases of terminal illness, the central issue becomes: *Which* death is preferable? Either way, the person will die. Will the preferred death be (1) painful, according to verified diagnoses, or (2) controlled? No one would ordinarily choose controlled death,[427] but where pain becomes unbearable, a controlled death is no longer unthinkable. The equation, therefore, is the relationship between what will happen in the absence of death versus death.[428] Where only pain or incapacitation awaits, the question then enters the standard euthanasia realm of whether or not the person has a right to choose a controlled death.

> *Apocryphal dinner-party guest to female acquaintance: "Would you have sex with me for one million dollars?" The woman replies, after consideration: "Yes, I think I would." "Well then, would you have sex with me for one hundred dollars?" To which she exclaims in disgust: "What do you think I am—a prostitute?" "We have already established that, madam; we are now merely haggling."*[429]

Opponents' assertions of sacrosanct life are seriously challenged by prima facie valuations of life made continuously in the criminal law. For instance, persons convicted of murdering police officers face more severe punishments.[430] Whether those increased punishments are desirable is not at issue; that police officers as a group are afforded stricter enforcement of differentiated laws is a value judgement that society has made—determined not by the act, or even the actor, but rather by the person who dies. Conversely, the life of someone who attempts to commit a felony but is killed by the victim as a matter of self-defense is per se less "valuable" in

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427. Much less a painful death.

428. A fundamental chasm exists between opposing and favoring forces, which can be reduced to a mathematical construct. Those opposing generally espouse a view of life as sacrosanct. As such, logically there can be no such thing as a life with a *negative* value. The whole reason for euthanasia is a belief that life sometimes does indeed have a negative value; suffering with no reasonable possibility for relief is negative.

The question underlying all discussions of euthanasia is: Is life, per se, always good? Following theological doctrines, and normal experience, the answer is: Yes. But "always" is such an absolute beast, so easily defeated in logic and on exams. To disprove the hypothesis, we simply have to find one example where life is not good. Assuming a reasonable interpretation of "good," examples both hypothetical and real abound.

Suppose a person were to be executed—let's say a notorious spy to liven the Article—and had a choice of being shot directly through the cerebral cortex, with the monotonously predicable outcome of death, or of first being tortured over a generous time by various lovingly cared for medieval instruments. The first question is whether the torture preceding and including death is worse than death sans agony. The next question is whether our spy has the right to decide (which might, of course, depend on the honor of the captors). For an interesting discussion of this dilemma, *see also* SUICIDE AND EUTHANASIA, *supra* note 2, at 251-76 (concluding that a coercive state force should not be available to prevent suicide or euthanasia).

Nancy Cruzan's pseudo-ghost will attest to the experience that the above debate is anything but fictitious. Accordingly, is her experience sufficient to qualify as "negative?" Or perhaps: "neutral?" If neutral, the arguments for euthanasia are even muddier.

429. Source blessedly forgotten; a preemptory apology for the implied sexism.

430. *See, e.g.*, Tex. Penal Code Ann. § 19.03(1)(West 1974). Firemen are also covered; the homicide must occur when the officer or fireman is acting in the lawful discharge of an official duty. *Id.*

the eyes of the law; no punishment is meted.[431] Valuations *are* made regarding human life. It is for civilization to justify those distinctions.

Whose Life Is It Anyway?[432]

Some people object to the effect of intensive medical care on the process of dying. Although the goal may be admirable, the effect is one of degradation of the patient to the status of a research specimen.[433] The patient sometimes becomes little more than an experimental mass, subjected to treatment after treatment in the hopeless quest for a continued heartbeat.[434]

Death (to a woman in pain, about to die): Do not fear me, my child. Come, climb into my arms, and I shall take away all your pain.[435]

V. CONTEMPORARY LEGAL ISSUES

A. *Euthanasia and the Courts*

I know not what course others may take; but as for me, give me liberty, or give me death![436]

As if to mimic society's uncertainty regarding euthanasia, a deeply divided[437] U.S. Supreme Court, in a decision affecting Nancy Cruzan,[438] upheld the right of the State of Missouri to maintain Nancy's artificial nutrition and hydration.[439] The Court's opinion focused on technical

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431. *See, e.g., id.* at § 9.32.

432. WHOSE LIFE IS IT ANYWAY? (Metro-Goldwyn-Mayer 1981).

433. *See, e.g.*, COLEN, *supra* note 53, at 229-42; HUMPHRY & WICKETT, *supra* note 2, at 96 (describing the experience of a cancer patient).

434. *See, e.g.*, HUMPHRY & WICKETT, *supra* note 2, at 96; THOMASMA & GRABER, *supra* note 2, at 158-64; *supra* note 16.

435. Franz Schubert, *Der Tod und das Madchen* (1821).

436. Patrick Henry, *reprinted in* THE OXFORD DICTIONARY OF QUOTATIONS 245-46 (3d ed. 1979). The question at hand appears to be: can we demand both?

437. *Five* opinions were written for a 5-4 majority. *See* Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 269 (1990); *infra* note 440.

438. *See supra* notes 319-38 and accompanying text.

439. *See Cruzan*, 497 U.S. at 265.

Justice Rehnquist's opinion focused on narrow legal issues. *See infra* text accompanying notes 442-45.

Justice O'Connor emphasized personal interests in refusing medical treatment. *See id.* at 287; *infra* note 442.

Justice Scalia, rejecting any federal judicial role in the debate, commented on the Court's divisions:

> The various opinions in this case portray quite clearly the difficult, indeed agonizing, questions that are presented by the constantly increasing power of science to keep the human body alive for longer than any reasonable person would want to inhabit it.

Id. at 292 (Scalia, J., concurring). He argues that any decision regarding appropriate public policy is the sole domain of the legislature of the separate States; to rule otherwise violates our original principle of federalism. *See id* at 293. He further rejects Nancy's petition on three points: (1) the relevance of Nancy's suffering, (2) the passive/active distinction, and (3) prevention of withholding of artificial nutrition and hydration violates her bodily integrity. *See id* at 295. He does not seem to accept the legal distinction between suicide and euthanasia. *See id.* at 296.

Justices Brennan, Marshall, and Blackmun, dissenting, reject as procedural obstacles the evidentiary standard of Missouri, which they argue impermissibly burden Nancy's right to terminate artificial nutrition and hydration. *See id.* at 302.

points, concluding that Missouri had a sufficient interest, and a right, to impose a clear and convincing standard of proof, in the evidence required, to show that Nancy would have chosen withdrawal of her artificial food and water.[440] Further, the Court ruled that the Missouri Supreme Court did not err constitutionally in overturning[441] the trial court, which had found that the evidence "suggested" Nancy would not have wanted the continuation of life-preserving measures in her situation.[442] Finally, the Court concluded that Missouri was not required to accept the "substituted judgment" of Nancy's close family.[443]

Justice Stevens, dissenting separately, objects to the primacy of general State interests when in conflict with Nancy's personal interests, and criticizes the majority for its decision in the face of principles guaranteeing Nancy the fulfillment of her interests. *See id.* at 331. He does not dispute the importance of a clear and convincing standard of proof, but disagrees that the facts proved here should be controlling. *See id.* at 344-45. He further criticizes judicial interpretations that set Nancy's life and liberty interests in opposition, and decides her fate for her—the ultimate denial of her interests. *See id.* at 347.

440. *See id.* at 281. Because of the necessarily invasive nature of artificial nutrition and hydration, it is considered medical treatment. In 1989, the Supreme Court of Illinois adopted the "consensus opinion [that] treats artificial nutrition and hydration as a medical treatment." *In re* Estate of Longeway, 549 N.E.2d 292, 296 (Ill. 1989):

> Feeding a patient by means of a nasogastric tube requires a physician to pass a long flexible tube through the patient's nose, throat and esophagus and into the stomach. Because of the discomfort such a tube causes, "[m]any patients need to be restrained forcibly and their hands put into large mittens to prevent them from removing the tube.

Cruzan, 497 U.S. at 288-89 (O'Connor, J., concurring). Alternately, a jejunostomy tube must be surgically implanted into the stomach or small intestine. *Id.*

Justice O'Connor wrote separately to emphasize the invasive nature of artificial nutrition and hydration, and to stress the due process protection of an individual's "deeply personal decision to reject medical treatment, including the artificial delivery of food and water." *See id.* at 289. She further emphasized that the Court did not decide whether a State must give effect to the decisions of a surrogate who has been chosen by the individual undergoing treatment; it ruled only on an evidentiary standard of one State. *See id.* at 289. She warned that, because evidence of the patient's intent is often not conclusive, current evidentiary standards might often result in actions inconsistent with the patient's wishes. *See id.* at 289-90. She recommends State recognition of Durable Powers of Attorney to effectuate the individual's intent. *See id* at 290.

441. By a divided vote. *See id.* at 263-64.

442. *See id.* at 285. The independent guardian ad litem appeared to have only reluctantly appealed the trial court's decision to the Missouri Supreme Court as a matter of duty; he advised the court in the appeal that he did not disagree with the trial court's decision. *See id.* at 334 (Stevens, J., dissenting). Specifically, he cited the undisputed finding that: "it was in Nancy Cruzan's best interests to have the tube feeding discontinued." *See id.* Further, the trial court had found no adverse impact on third parties and no economic motivations. *See id.* at 333.

443. *See id* at 334. The Court has upheld the constitutionality of favored legal treatment of traditional family relationships, but refused to turn into a constitutional *requirement* that the states recognize family decisionmaking in cases such as this. *See id* at 275. The Court emphasized that the Cruzans were worthy of such a substituted judgment standard, but the criteria were a function of state, but not federal due process, powers. *See id.* at 281; *see also* Michele Yuen, *Letting Daddy Die: Adopting New Standards for Surrogate Decisionmaking*, 39 UCLA L. REV. 581 (1992).

Nancy's parents, emotionally exhausted from their legal battles, continued in their struggle to end her life, such as it was, citing new evidence of her desire to not live under such circumstances. *See* Andrew H. Malcolm, *Case Testing Right to Die "Aged Us All,"* N.Y. TIMES, Nov. 4, 1990, at L24.

Ensuring that a person in Nancy's position[444] benefits from the full protection of the law poses another dilemma. The State has the right, if not the obligation, to demand solid evidence of the incapacitated person's beliefs and intentions, *as if they were not incapacitated.*[445] Parol evidence[446] is normally forbidden in transactions not involving life-or-death questions; why then should it be allowed where the consequences are all the more important?[447] Essentially, no other option exists. In order to fulfill the State's presupposed duty to preserve life, some standard of evidence must be maintained, with the State acting automatically as adversary, even where the guardian *ad litem* has a good faith belief that the best interest of the patient is to terminate artificial support.[448]

The Court has never considered whether a State evidentiary standard higher or lower than "clear and convincing" would be constitutionally acceptable. The Court has relied on balancing tests to weigh the compelling State interests in preserving life against the wishes and rights of the individual and the family.[449] A lower standard might run the risk of unconstitutionality by failing to properly safeguard the interests of the patient, and a higher standard might sway some of the Justices against a deferent view

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444. "Nancy will never interact meaningfully with her environment again. She will remain in a persistent vegetative state until her death." *Cruzan*, 497 U.S. at 287 (Brennan, J., dissenting) (quoting Cruzan v. Harmon, 760 S.W.2d 408, 411 (Mo. 1988)).

445. This assumes, moreover, that the State has the authority to recognize the authority of an individual to terminate life-supporting measures.

446. Which, in the absence of a Living Will or Durable Power of Attorney, is the only available indication of the incapacitated person's view on life and death. The Court specifically did not address the question of what result would have followed if a Durable Power of Attorney had been made. *See Cruzan*, 497 U.S. at 287 n.12.

447. *See id.* at 284.

448. *See id.* at 281 n.9; *see also* Carl Hernandez III, Note, *Legitimate Exercise of Parens Patriae Doctrine: State Power to Determine an Incompetent Individual's "Right to Die" After* Cruzan ex rel. Cruzan v. Director, Missouri Department of Health, 6 B.Y.U. J. PUB. L. 167 (1992); Dr. G. Steven Neeley, *Patient Autonomy and State Intervention: Re-examining the State's Purported Interest*, 19 N. KY. L. REV. 235 (1992).

Of increasing importance in the debate over constitutional protections for euthanasia decisions is the emergence of state constitutional reliance. *See generally* Thomas C. Marks, Jr. & Rebecca C. Morgan, *The Right of the Dying to Refuse Life Prolonging Medical Procedures: The Evolving Importance of State Constitutions*, 18 OHIO N.U. L. REV. 467 (1992) (suggesting that the explicit privacy provisions in state constitutions represent the best guarantees against the artificial prolongation of life against one's wishes).

449. *See* Youngberg v. Romeo, 457 U.S. 307, 321 (1982). "[W]hether respondent's constitutional rights have been violated must be determined by balancing his liberty interests against the relevant state interests." *Id.*; *In re* Conroy, 486 A.2d 1209, 1225 (N.J. 1985); *In re* Quinlan, 355 A.2d 647, 664 (N.J.), *cert. denied sub nom.*, Garger v. New Jersey, 429 U.S. 922 (1976) (the New Jersey Supreme Court noted that the State's interest weakens and the individual's right to privacy correspondingly grows as the prognosis dims and the degree of bodily invasion increases). *See generally* Glenn W. Peterson, Comment, *Balancing the Right to Die with Competing Interests: A Socio-Legal Enigma*, 13 PEPP. L. REV. 109 (1985) (highlighting the difficulty in formulating adequate balancing equations and suggesting an overhaul of the laws governing the right to refuse medical treatment). *But cf. In re* Westchester County Medical Center, 531 N.E.2d 607 (N.Y. 1988) (the Court of Appeals of New York, over objections of her family, granted an order for artificial feeding of a 77-year-old woman who was incompetent as a result of several strokes). "[N]o person or court should substitute its judgment as to . . . the life [of] another." *Id.* at 613.

of the State's duties and powers.[450] It remains an open question to what extent *Cruzan* will act to continue the formation of a common-law consensus regarding passive euthanasia;[451] the number and content of the opinions give little comfort to those looking for solid answers.[452]

Implicit in the *Cruzan* opinion is the fact that, had Nancy completed a Living Will,[453] the case would not have arisen because Missouri presumably would have had clear and convincing evidence of her intentions. Nevertheless, a Living Will remains in most instances merely evidence of a person's views; it does not have the force of law and may prove ineffective unless recognized by the State.[454]

The *Cruzan* decision is remarkable in that it neither accepts nor rejects either the sanctity of life or the "right to die." The majority opinion is narrowly technical, purposefully ignoring broader issues, while the concurring and dissenting opinions illustrate the dependence of the "answer" on one's own perspectives of life—an arguably non-judicial function.

B. *A Constitutional Right to Euthanasia?*

The presupposition that government has plenary authority over the ending of life is pervasive in both judicial decisions and general literature. This presupposition has been made, however, with little reference to underlying concepts of personal autonomy or extenuating mortal circumstances.

One possible means of asserting a legal "right" to euthanasia rests on the principle of personal autonomy via a right of privacy.[455] Because the right to privacy is itself increasingly controversial and belies an uneven,

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450. Compare Justice Scalia's concurrence, 497 U.S. at 292 (arguing impliedly that a State can set any evidentiary standard), with Justice Brennan's dissent, *id.* at 301 (arguing that any evidentiary standard must be designed to effectuate the intent of the individual, and any contrary effect is illegitimate; the clear and convincing standard, coupled with Missouri's exclusionary rules, are thus nearly prima facie illegitimate). *See generally* David F. Forte, *The Role of the Clear and Convincing Standard of Proof in Right to Die Cases*, 8 ISSUES IN L. & MED. 183 (1992).

451. Active euthanasia was not at issue in *Cruzan*.

452. *See supra* note 441; *see also* Holly C. Gieszl & Peggy A. Velasco, Comment, *The* Cruzan *Legacy: Legislative and Judicial Responses and Insights for the Future*, 24 ARIZ. ST. L.J. 719 (1992); Philip G. Peters, Jr. et al., *Physician Willingness to Withhold Tube Feeding After* Cruzan*: An Empirical Study*, 57 MO. L. REV. 831, 833-48 (1992).

453. *See supra* note 309 and accompanying text.

454. *See supra* notes 310-13 and accompanying text.

455. *See infra* notes 478-82 and accompanying text. A California appellate court regarded a right to terminate one's life as probably the "ultimate exercise of one's right to privacy[.]" Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 1144, 225 Cal. Rptr. 297, 306 (1986); *see also* Martin B. Berman, *Whose Rite Is It Anyway? The Search for a Constitutional Permit to Die*, 22 SW. U. L. REV. 105 (1992) (proposing that in those cases which involve a persistently vegetative patient, courts adopt a presumption that, absent evidence to the contrary, the patient chooses to have his or her life terminated). *But cf.* Edward A. Lyon, Comment, *The Right to Die: An Exercise of Informed Consent, Not an Extension of the Constitutional Right to Privacy*, 58 U. CIN. L. REV. 1367 (1990). Lyon criticizes extensions of constitutional protections beyond marriage, procreation, and family for reasons similar to the slippery slope objection (part III.A.2, *supra*), and on grounds of appropriate judicial authority. Lyon discusses the legal foundation for refusal of life-sustaining measures only, and is thus more limited in scope than this Article; unfortunately, informed consent is not helpful in cases of incapacitated persons. Further, the bases for a right to privacy are not mutually exclusive; reliance on

poorly expressed development,[456] an investigation of alternative grounds for supporting such a right—particularly as it relates to euthanasia—is warranted.

The legal principle of a right to privacy developed relatively recently in common law, having often been appended as a parasite to property, tort, and contract law.[457] This development contrasts sharply with that of other legal systems, which often have long histories of protected privacy rights.[458] Samuel Warren and Louis Brandeis, in their watershed 1890 article, argued that the common law *had* developed a right of privacy, which nevertheless went unnoticed because of mislabeling as a "property" or "contract" right or "breach of trust."[459] They advocated instead a protection based on the law of tort.[460] Although the two did not consider the issue of government intrusion into the "inviolate personality" of the individual, they helped establish the notion in American jurisprudence of a cognizable legal interest in privacy.[461]

Griswold v. Connecticut,[462] which laid the foundation for modern constitutional privacy protections, was decided on arguably irrelevant grounds.[463] An ill-defined "right to privacy," along with the Fourteenth

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informed consent does not preclude the applicability of a constitutional right of privacy, or vice versa.

456. This implies that a well-defined right to privacy is possible, built on common core values of bodily integrity. This may be unrealistic or even undesirable given our constitutional framework and uniquely vague concepts of socially appropriate mores. *Cf.* Jed Rubenfeld, *The Right of Privacy*, 102 HARV. L. REV. 737 (1989) (arguing that traditional constitutional privacy analysis, which looks to the prima facie effect of the law, misses the point; instead, we should look to the affirmative powers of the law in question).

457. *See* SAMUEL H. HOFSTADTER & GEORGE HOROWITZ, THE RIGHT OF PRIVACY 1, 5, 11-24 (1964). Blackstone records no recognition of an enforceable right of privacy. The writings of renowned political philosophers such as Hobbes, Locke, Montesquieu, Paine, Rousseau, and Spencer, which preceded the Industrial Revolution, concerned only interference with life and property, not with the less tangible aspects of invasions of privacy. *See id.* at 11. *But cf.* 1 WILLIAM BLACKSTONE, COMMENTARIES 125-26 (discussion of natural liberties as "the power of acting as one sees fit, without any restraint or control, unless by the law of nature" and "inherent in us by birth," restrained only by "human laws (and no farther) as is necessary and expedient for the general advantage of the public"—thus defining *civil* liberties).

The right of privacy is still not recognized in British common law. *See* PETER CANE, TORT LAW AND ECONOMIC INTERESTS 15, 87 (1991); RAYMOND WACKS, PERSONAL INFORMATION: PRIVACY AND THE LAW 39-40 (1989).

458. *See* Hofstadter & Horowitz, *supra* note 457, at 1. The earliest record of a right to privacy is contained in the *Mishnah*, a compilation of ancient Israeli Oral Law collected circa 200 A.D., which constitutes the core of the *Talmud*. *See id.* at 9. In Roman law any "willful disregard of another's personality" was *injuria*, and Greek law similarly recognized *Contumelia*, or "every infringement of the personality of another." *See id.* French, Swiss, and German laws, which have been influential throughout Europe, followed the Roman and Greek example in recognizing actionable rights against invasions of privacy. *See id.* at 10-11.

459. *See* Samuel D. Warren & Louis D. Brandeis, *The Right to Privacy*, 4 HARV. L. REV. 193, 200-12 (1890).

460. *See id.* at 219-20.

461. Interestingly, but not too surprisingly, Warren and Brandeis addressed only *non*-governmental intrusions. *Id.*

462. 381 U.S. 479 (1965).

463. The Court was deeply split. Three concurring opinions were written, with Justices Black and Stewart dissenting seperately. Central to Justice Douglas' opinion, disregarding the questionable treatment of standing, was the importance of the marriage relationship in the right to use contraceptives. *See id.* at 480, 486; *see also id.* at 502-07 (White, J., concurring).

Amendment, formed the basis for a right of bodily autonomy,[464] from which a right of procreation emerged.[465] A right of marriage was established in *Loving v. Virginia*,[466] which held unconstitutional a statute that made interracial marriage a punishable offense.[467] Further expansion of the right to privacy occurred in *Stanley v. Georgia*,[468] where the Court relied on the First Amendment to strike a Georgia statute that made illegal

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This is hardly arguable with a straight face given today's radically different (if perhaps more honest) treatment of sexual mores; the right to use contraceptives more likely inheres, if at all, in individual freedom—not in marital units. *See also* Eisenstadt v. Baird, 405 U.S. 438 (1972). In fairness to Justice Douglas, he likely felt constrained to justify his decision with specific textual references to avoid broader questions of the role of the Court. *See* JOHN E. NOWAK ET AL., CONSTITUTIONAL LAW 686-87 (3d ed. 1986). The right to use contraceptives is analogous to the issues of euthanasia because both depend on who or what has authority over the physical being of the individual.

Justice White presumed that "the State's policy against all forms of promiscuous or illicit sexual relationships, be they premarital or extramarital, [is] concededly a permissible and legitimate legislative goal." 381 U.S. at 505 (White, J., concurring). This begs the question: *is* it permissible for the State to impose, by force of law, its demands into private consensual adult relationships? To enforce the majority concept of "proper" sexual mores is to violate one of the purposes of our system of government: the protection of (non-destructive) minority interests. To further assume that socially undesirable sexual liaisons are inherently destructive may be proper, but the justification of the statute prohibiting the use of contraceptives requires a quantum leap in faith. The statute was indeed an "uncommonly silly law" because it illegitimately presupposed that banning contraceptive use would necessarily decrease the incidence of socially undesirable sexual relationships. *Id.* at 527 (Stewart, J., dissenting). This is a patently spurious argument; such illicit contacts would most likely continue with roughly the same frequency regardless of official sanction. Even if they do become less frequent, far more damage will be caused by the *non*-use of contraception. Additionally, the burden of this statute falls biologically on only fifty percent of the sexual participants—women—creating a prima facie equal protection violation. The poor effectiveness of child support laws negate any counterarguments of equality of legal effect.

The Court demonstrated its uneasiness with its decision based on what was essentially a value judgment of the control over one's sexual actions as an individual. The issue as it relates to euthanasia is even sharper, where the exercise of control, if at all, is final.

The Court, in Eisenstadt v. Baird, extended the right of privacy to single persons as related to procreation and contraception on equal protection grounds. *See* 405 U.S. at 446-56. The Court suggested that the freedom to decide to have children is so fundamental it is protected by a right to privacy. *See id.* at 453. This circular precedent thus based the right to use contraceptives on a right between married persons, extended to those unmarried via the fourteenth amendment.

464. *See* Tom Gerety, *Redefining Privacy*, 12 HARV. C.R.-C.L. L. REV. 233, 266 (1977).

465. The Supreme Court first recognized procreative rights in Skinner v. Oklahoma. *See* 316 U.S. 535, 536-43 (1942). Justice Douglas, writing for the Court, held that the right to procreate is "one of the basic civil rights of man[,]" because "[m]arriage and procreation are fundamental to the very existence and survival of the race." *Id.* at 541. Are not thought and the power to control our destinies similarly important? Would we regard mere existence with the same philosophical respect as we afford the assumptions of free will? These debates have burdened philosophers throughout history; we must merely acknowledge them as casting doubt on any dogmatic position.

In Roe v. Wade, the Court held the right to privacy to extend to the decision to not have children, subject to the state's interest in the protections of fetal life. *See* 410 U.S. 113, 153-56, 163-65 (1973). This doctrine is currently the focus of intense societal and jurisprudential debate—113 files are produced by the phrase "Roe v. Wade" on Nexis; 513 for "abortion."

466. 388 U.S. 1 (1967).

467. The Court later poorly expressed this right to marriage and the standard of judicial review in Zablocki v. Redhail, 434 U.S. 374 (1978).

468. 394 U.S. 557 (1969).

the possession of pornography in any individual's home.[469]

In *Bowers v. Hardwick*,[470] the Court severely curtailed the right to bodily autonomy in deciding that state sodomy laws do not interfere with an individual's right to privacy.[471] Given the dependence of previous findings of a right to privacy on a right to marriage and procreation, no prece-

469. *See id* at 558-68. Georgia argued that forbidding the possession of pornography, even within the confines of one's home, was necessary for the protection of the moral health of the community. *See id.* at 559-60, 565. The Court disagreed, finding little evidence to indicate that possession of pornography incited illegal action. *See id.* at 566-67. The correlation between viewing (non-violent) pornography and criminal sexual behavior remains uncertain, at best, and very possibly is negative, counter to the assumptions of many who are vocal in that debate. *Compare* EDWARD DONNERSTEIN ET AL., THE QUESTION OF PORNOGRAPHY: RESEARCH FINDINGS AND POLICY IMPLICATIONS (1987) *and* PORNOGRAPHY AND SEXUAL AGRRESSION (Neil M. Malamuth & E. Donnerstein eds., 1984) *and* WILLIAM H. MASTERS ET AL., MASTERS AND JOHNSON ON SEX AND HUMAN LOVING 301 (3d ed. 1986) *with* U.S. DEPARTMENT OF JUSTICE, ATTORNEY GENERAL'S COMMISSION ON PORNOGRAPHY (Final Report July 1986). Care must be taken to distinguish the effects of violent pornography from pornography per se; many studies confuse these distinctions within pornography. The Court found finally that the restriction was a form of thought control "wholly inconsistent with the philosophy of the First Amendment." 394 U.S. at 566.

This issue is similar to euthanasia in that it raises the question of public authority over consensual actions outside of the public domain. This is raised in cases of voluntary euthanasia, where the public interest is expressed only tangentially by an assumed desire to live; any damage to society in the form of decreased productive capacity has already occurred. The slippery slope objection to euthanasia similarly relates to the moral decline of the community. While the right of the state to regulate behavior in public spheres is well established, the opposite is true of activity within the home. The adage that a person's home is his castle did not develop lightly; serious implications regarding the state's authority of intervention are involved. *See, e.g.* U.S. CONST. amend. III. This alone casts serious doubt as to the propriety of Georgia's assertion of authority.

470. 478 U.S. 186 (1986).

471. The Court reasoned that the right to privacy protects only those rights "implicit in the ordered concept of liberty" or "deeply rooted in this nation's history and tradition." *Id.* at 191-92, 194. This contradicts one of the primary purposes of the Constitution itself: to protect minority interests against potential tyranny of the majority. Because popular majorities are transient, an essential function of the Constitution must be effective structural frustrations against present majorities that attempt to prevent the formation of future majorities. We are each members of numerous minorities. If constitutional protections were valid only to the extent that they were "implicit in the ordered concept of liberty" or "deeply rooted in this nation's history and traditions," our Constitution would have little meaning indeed. The Court assumes that acts of sodomy—not limited to acts between persons of the same sex or unmarried heterosexuals—somehow violate an ordered sense of liberty, with little reasoning to support such a claim. The Court further relies on history to mandate social mores. Given the repressed and culturally heterogeneous traditions of our ancestors, this seems both logically unsubstantiated and a slavish dependence on a history not nearly as clear as the Court would have us believe.

In a statement to law students on October 18, 1990, former Justice Powell, whose swing vote decided the case, admitted that "[w]hen I had the opportunity to reread the opinions a few months later, I thought the dissent had the better of the arguments." Anand Agneshwar, *Ex-Justice Says He May Have Been Wrong: Powell on Sodomy*, NAT'L L.J., Nov. 5, 1990, at 3. Powell considered Bowers v. Hardwick "of little or no importance" because no one had been prosecuted for sodomy. Aaron Epstein, *Ex-Justice Admits 'Mistake' in Gay Ruling*, AUSTIN-AMERICAN STATESMAN, Oct. 26, 1990, at A2. The case remains the law of the land, however, and thus carries precedential effect in both judicial and legislative arenas. It has been cited regularly, for example, to deny to gay persons the choice of becoming foster parents, custody of their own children, and service in the military. *See id.*

Twenty-five states outlaw sodomy. *See* 38 Playboy 46 (Jan. 1991). Five of these only outlaw homosexual sodomy. *See id.* Several individuals have been indicted or sentenced for violations involving oral sex performed by married or unmarried heterosexual couples. *See id.*

dent was available to support a right to private anal sex.[472] This raises the question whether a right to sexual privacy is or should be based on a right of procreation, or an inherent authority over one's own person. Human rights, which are so often self-proclaimed by the United States as yardsticks for judging other societies, presuppose governmental respect for individuals' authority to make choices relating to their own lives where their behavior is not destructive to others or to society.[473]

The right to privacy, even if somewhat strained in construction,[474] is far too important to destroy.[475] The contemporary interpretation that infers broad privacy protections in the penumbrae of specific constitutional guarantees has been important, but it is increasingly subject to attack, and deflects legal analysis from the true source of the right of privacy and all that follows. The right of privacy can be logically supplemented and substantiated regardless of the *Griswoldian* constructs by drawing on the most basic of legal precepts.

What is ignored in discussions of a right to privacy is the possibility that the Constitution did not *create* a right of privacy, but instead reflected an *assumption* in the New World of then-unknown personal autonomy—what would now be labeled a right of privacy. A right of privacy is not enumerated because *it is a precondition to the Constitution itself.*[476] "We the

472. *Bowers v. Hardwick* should not be read in an exclusively homosexual context; heterosexuals, whether married or not, were equally subject to criminal sanction. *See* 478 U.S. at 187; *see also id.* at 200 (Blackmun, J., dissenting). *But see id.* at 188 n.2. Even if criminal prosecutions are less likely—or nonexistent—for heterosexual couples, the objections remain valid; laws cannot be justified on the grounds of non-enforcement against particular groups. Indeed, such non-enforcement, selective or otherwise, brings into question the legitimacy of a statute, particularly if it deals with issues of morality.

473. The question is then legitimately posed whether or not sodomy is per se destructive to society. Judicial balancing is often relied on in difficult value issues, and the degree of destruction is thus logically relevant in determining the legitimacy of the government's actions. For example, treason is expressly provided for in the Constitution and is perhaps the best example of a true threat to the continued operation of the People's government. Were government to assert itself in all areas of potential damage, the concept of limited government would be empty. Even if repulsive to many, the damage private sodomy poses to the continued functioning of society is uncertain and cannot reasonably be said to be severe enough for the positive intrusion required for enforcement against it. It must be conceded that the true nature of the Georgia statute is a desire to control the sexual behaviors of its citizens. This drains any remaining legitimacy to the causal argument of sodomy's destructive societal effect.

474. *See* JOHN E. NOWAK ET AL., *supra* note 463, at §§ 11.5-11.7, 14.26-14.30.

475. Indeed, any attempts to emasculate it severely (i.e., so as to affect personally a large enough contingent of citizens) would likely be averted by whatever other judicial grounds were available to avoid nearly inevitable popular confrontations. Alternatively, legislative action would likely reassert many of these underlying rights of privacy.

476. Ours is not the first generation to debate the constitutional sources of liberty interests. In 1875 Chief Justice Waite noted:

> The right of the people peaceably to assemble for lawful purposes existed long before the adoption of the Constitution of the United States. In fact, it is, and always has been, one of the attributes of citizenship under a free government. It "derives its source," to use the language of Chief Justice Marshall, in *Gibbons v. Ogden*, 9 Wheat. 211, "from those laws whose authority is acknowledged by civilized man throughout the world." It is found wherever civilization exists. It was not, therefore, a right granted to the people by the Constitution. The government of the United States when established found it in existence, with the obligation on the part of the States to afford it protection.

People" cannot legitimately form a more perfect Union unless we first have dominion over ourselves.[477] Given that We the People created a limited government to protect our survival against the real evils of external threats and internal economic protectionism, the value of privacy rights intrinsic to the individual appears clear.[478] This leads, however, to an additional question that asks where this self-authorized power originates.

The building block of the Constitution is: People. The smallest indivisible unit of People is: Person. It is mathematically intuitive to attach some significance to the importance of the Person in this constitutional equation, quite apart from our strong cultural bias of individuality. Still, asserting a basis for individual authority demands further investigation.

The right to privacy should be based fundamentally in property law. Indeed, dominion over one's own physical and mental personalty is arguably the purest example of a property interest.[479] Any defense of property

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United States v. Cruikshank, 92 U.S. 542, 551 (1875).

477. The then-radical notion of non-monarchial government was probably best attempted in the unique environment of the New World, where ancient interdependencies and close autocratic supervision were attenuated to the extent that the citizenry felt less and less beholden to the European powers. Additionally, the sparse populations and relative isolation even among colonies added to the sense of social and cultural isolation. This, coupled with the generally negative experiences with colonial powers, led to a general distrust of governmental authority. *See, e.g.*, ARTHUR M. SCHLESINGER, THE BIRTH OF THE NATION 3-16, 33-54, 113-27 (1968).

478. This analysis is strengthened by the debate between the Federalists and Anti-Federalists preceding constitutional ratification, which centered around the need for a bill of rights in the Constitution. The Federalists, avidly pro-Constitution, argued against a bill of rights. *See* ROBERT A. RUTLAND, THE BIRTH OF THE BILL OF RIGHTS 118-19, 132-33 (1955). The Anti-Federalists, who were against the proposed Constitution, insisted on a bill of rights to protect the States and people. *See id.* at 117-25. Alexander Hamilton's reply to the Anti-Federalists, in a famous *Federalist* opinion, viewed with alarm the concept of a bill of rights, because such enumeration of rights would imply that the federal government had residuary power, where it supposedly had none. *See* THE FEDERALIST No. 84 (Alexander Hamilton). A bill of rights would thus be not only superfluous, but would dangerously limit rights to only those in the bill. With hindsight we can commend or criticize these views, but their existence does illustrate unique assumptions of autonomy that render present commentary about the source of a contemporary right of privacy as proof of the Federalists' fears of implied governmental powers, and Anti-Federalists' demands for constitutional protections. *See generally* ANTI-FEDERALISTS VERSUS FEDERALISTS: SELECTED DOCUMENTS (John D. Lewis ed., 1967).

479. The standard justifications for property interests remain weak; they are often justified by power and primacy. *See, e.g.*, SHELDON F. KURTZ & HERBERT HOVENKAMP, AMERICAN PROPERTY LAW 1-29, 45, 62-63, 84, 101, 116 (1987); Michelle B. Bray, Note, *Personalizing Personalty: Toward a Property Right in Human Bodies*, 69 TEX. L. REV. 209, 211 (1990); *see also* EDWARD S. CORWIN, THE "HIGHER LAW" BACKGROUND OF AMERICAN CONSTITUTIONAL LAW 21 (1928) (citing von Gierke: "Property had its roots . . . in Law which flowed out of the pure Law of Nature . . ."). Locke early recognized the connection between personal existence and ownership, beginning with the premise that "every Man has a *Property* in his own *Person*." JOHN LOCKE, TWO TREATISES OF GOVERNMENT § 27, at 305 (Peter Laslett 2d ed., student ed. 1967) (3d ed. 1698); Bray, *supra*, at 212.

Defining the body as property is not only not foreign to legal property constructs, but strongly analogous to common property laws. The general rule relating to the enjoyment of property assumes a right of use, with government limitations only with cause. Further, the government has a duty, and stake, in ensuring the peaceful use of property. Thus, tort law has been applied early to property interests. *See* W. PAGE KEETON ET AL., PROSSER AND KEETON ON TORTS § 13 (5th ed. 1984). *See generally* RUSSELL SCOTT, THE BODY AS PROPERTY (1981) (discussion of developing medical technologies and resultant social and legal problems).

The California Supreme Court recently decided a case involving the use of a patient's spleen, for commercial purposes, without the patient's consent or knowledge. Despite facts

rights beyond the human being—what property law now encompasses—in reality requires a legal structure that merely defines proximate relationships to individuals.[480] Neither common property nor tort law was sufficiently developed to fully incorporate the impact of a right of privacy. Given nearly a century of legal introspection, however, the contemporary concept of property rights is sufficiently expanded and flexible to accompany complex new legal challenges. It is more than sufficient to encompass the basic question presented: defining the ownership of personalty for purposes of defining a privacy interest.

Do we own ourselves?[481] The answer is far from historically certain. Slavery was constitutionally justified.[482] So too was the virtual ownership

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quite unfavorable to the defendants, the court decided finally that the patient did not have a cause of action for conversion of the spleen. *See* Moore v. Regents of the Univ. of Cal., 793 P.2d 479 (Cal. 1990). This opinion has been a source for much legal debate. *See, e.g.*, Jennifer Lavoie, Note, *Ownership of Human Tissue: Life After* Moore v. Regents of the University of California, 75 VA. L. REV. 1363 (1989); Patricia A. Martin & Martin L. Lagod, *Biotechnology and the Commercial Use of Human Cells: Toward an Organic View of Life and Technology*, 5 SANTA CLARA COMPUTER & HIGH TECH. L.J. 211 (1989); Catherine A. Tallerico, Comment, *The Autonomy of the Human Body in the Age of Biotechnology*, 61 U. COLO. L. REV. 659 (1990); *see also* Bray, *supra* (discussion of property rights applied to personalty).

The suggestion of body-as-property is neither logically unsound nor immoral. We each depend strongly on others for identity, and consider others to be strongly connected to us. Referring to "*my* child" or "*my* mother" is not insignificant; the possessive grammatical form necessarily connotes—possession. Each descriptive term invariably involves a deep sense of emotional bonding and belonging. This does not imply any sense of fee simple ownership, but it does illustrate analogous privacy concepts. Privacy extends spherically not only beyond individuals, but also pairs and groups of individuals who are bonded by family or other relationships. In this sense, any uninvited intrusion into a sphere is a violation of an interest in the sphere's integrity. For a discussion of personhood as a basis for defining property, see generally Margaret J. Radin, *Property and Personhood*, 34 STAN. L. REV. 957 (1982). The question for the law remains to define how far an interest extends beyond physical being.

A natural resistance to the concept of body-as-property is reinforced by the history of slavery. *See infra* notes 484, 486-87 and accompanying text. Societies that accept slavery promulgate codes to regulate it. *See* SCOTT, *supra*, at 27. The Law has no virgin slate from which to castigate ownership of human beings, however; historical ownership of humans merely strengthens the analogy. What was (viewed contemporaneously) morally despicable was the ownership of *others*—not the concept of ownership itself; slavery is antithetical to the concept of self-ownership. It is for society to recognize the illegitimate basis for human ownership beyond one's own person. This inalienability is crucial to recognition of self-ownership, and is explored in depth in Margaret J. Radin, *Market-Inalienability*, 100 HARV. L. REV. 1849 (1987).

For an excellent discussion of property rights applied to personalty, see generally Bray, *supra*.

480. *See* 1 AMERICAN LAW OF PROPERTY § 1.7 (1952). Business organizations are the legal equivalent of fictional (human) beings, enabling economic prosperity via the most basic demand of capitalism: private ownership. *See* Trustees of Dartmouth College v. Woodward, 17 U.S. (4 Wheat.) 518, 636 (1819) (discussion by Chief Justice Marshall of the nature of a corporation as a being); ALAN R. BROMBERG, CRANE AND BROMBERG ON PARTNERSHIP § 3C (1968); HARRY G. HENN & JOHN R. ALEXANDER, LAWS OF CORPORATIONS § 80 (1983).

481. An individual who is fundamentally religious (if within the Judeo-Christian tradition) will answer this negatively. There, the religious entity is the owner, with the resident human merely enjoying (or not, as the case may be) usufructory rights. Notwithstanding the religious perspective, if we do not own ourselves, who does? This rhetorically poses no legitimate alternative, leading to the assumed answer that each individual "owns" himself.

482. *See* Dred Scott v. Sandford, 60 U.S. (19 How.) 393 (1856); DANIEL J. FLANIGAN, THE CRIMINAL LAW OF SLAVERY AND FREEDOM 1800-1868, at 191-92 (1987).

of women, whose legal identities merged into that of their husbands[483]—what is ownership if not legal recognition of identity? In addition to their status as property of others, slaves were denied legal recognition as individuals.[484] The law proved logically inconsistent, however, in the treatment of their personalty when they were either the perpetrators or victims of crime.[485]

In sharp contrast with the dearth of common law on a right of privacy,[486] the common law early recognized a presumption of bodily integrity, drawing on John Stuart Mill's oft-cited assertion that a state may not exercise power over members of a civilized community except to prevent harm to others.[487] Interestingly, recent decisions have emphasized common law principles at the expense of constitutional doctrines, suggesting that courts are approaching the limits of a privacy-protected right to die.[488]

Raising self-ownership to a constitutionally protected right is difficult, if not impossible, given the continuing debate over proper textual interpretation. Recognizing this more intellectually honest basis for a right to privacy does, however, change the relative positions of the interested parties in the euthanasia debate. Proceeding from the assumption of per-

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483. *See* 1 AMERICAN LAW OF PROPERTY §§ 5.50-5.52 (1952). Interestingly, the term "woman" (much to feminists' dismay, no doubt) is derived from the German "wifmann" (variously spelled), meaning essentially "property of a man." VII OXFORD ENGLISH DICTIONARY, *supra* note 35; at 325, 484; OXFORD DICTIONARY OF ENGLISH ETYMOLOGY 523, 1011 (C.T. Onions ed., 1969) (cf. also leman—mistress of man).

484. The Constitution, in providing for a census, considered slaves as three-fifths of a person. U.S. CONST. art. I, § 2, cl. 3.

485. The status of slaves as people was uncertain at best. While they are obliquely referred to twice in the Constitution, courts had difficulty reconciling Justice Taney's decision (one of *eight*) in *Dred Scott*, which declared that slaves were not persons under the Constitution. 60 U.S. (19 How.) 393 (1856). *Compare* U.S. CONST. art. I, § 2, cl. 3 *and* art. IV, § 2, cl. 3 *with* 60 U.S. (19 How.) at 404-26. Slaves, however, could not logically be prosecuted for criminal violations; could a criminal statute apply to a non-person? Moreover, even if slaves were persons for purposes of prosecution under criminal statutes, to incarcerate or capitally punish them would deprive their owners of property in violation of the Constitution.

In United States v. Amy, Chief Justice Taney considered a point reserved at trial that contested the application of a federal criminal statute to Amy—a slave and thus a non-person. 24 F. Cas. 792 (C.C.D. Va. 1859). The statute forbade "any person" to steal a letter from the United States mail. *See id.* at 793-809. The motion for a new trial was overruled, with little legal reasoning. *See id.* at 809-11. Justice Taney could have cited THE FEDERALIST No. 54 (James Madison), which argued that slaves were both property and persons in differing respects.

In the final analysis, slaves were most equal—most human—under the law when they committed crimes; the logical inconsistencies of the law were better left unchallenged. For an excellent discussion of this issue, see generally DANIEL J. FLANIGAN, THE CRIMINAL LAW OF SLAVERY AND FREEDOM 1800-1868 (1987). Where a slave was the victim and the perpetrator was white, prosecution was unlikely, and serious punishment rare. *See id.* at 145-50, 414. Where, however, a black even remotely threatened a white, the punishment tended to be capital. *See id.* at 26.

Interestingly, *Dred Scott* was the only decision other than Marbury v. Madison, 5 U.S. (1 Cranch) 137 (1803), to hold a federal statute unconstitutional prior to the Civil War. *See* NOWAK et al., *supra* note 463, at § 3.1, n.11.

486. *See supra* note 459 and accompanying text.

487. J.S. MILL, *On Liberty*, *in* 43 GREAT BOOKS OF THE WESTERN WORLD 267, 271 (Robert Hutchens ed., 1952); Lyon, *supra* note 455, at 1384 n.111.

488. *See* LAURENCE H. TRIBE, AMERICAN CONSTITUTIONAL LAW 1370 (2d ed. 1988).

sonal autonomy, the question for the government is: Under what circumstances may an individual's right to determine the nature and time of his death be overridden by state and societal interests? This does not provide an easy answer to the euthanasia dilemma—that would be neither possible nor desirable. Rather, the debate is placed in a different context. The issue is essentially one of who must bear the burden of approving or prohibiting euthanasia. The "right" of the individual to a peaceful death should be balanced with the government's duty to ensure that that individual's death is indeed peaceful. The burden should not be on the individual; rather, the government should show cause for invading a property interest in a person's autonomy and reasonable extensions thereof.

C. *Active Euthanasia and Legal Proscriptions Against Taking Life*

Passive euthanasia has posed difficult issues for judicial resolution, resulting slowly in a compromise of legal recognition of some personal authority to decide for oneself to terminate one's own health care in severe health care situations. This presents two problems. First, the distinction between active and passive euthanasia is becoming an increasingly academic exercise.[489] Advances in medicine afford increasingly sophisticated life-saving and -prolonging options previously unavailable.[490] This blurs the bright line that divides the previously clear legal and ethical distinctions of euthanasia actions. Second, even with clearly passive euthanasia, such as the withholding of food and water, the reality is that even "non-action" is torment to those who are necessarily involved. The process of starvation[491] is hardly compatible with a civilized ethos. It entails, by design, progressive deterioration in the functioning of the body, increasing levels of pain,[492] and complication of other medical conditions.[493] This, in any other context, we would label torture.

To justify any actions beyond passive euthanasia requires a quantum leap in both faith and precedent; the criminal law is generally incapable of distinguishing active euthanasia from murder.[494] Given this, why is one even possibly acceptable when the other is an assumed evil? To attempt escape from this dilemma's horns, we must first know: Why is murder wrong?

As a matter of human history, murder has been condemned because it presents a destructive force in civilized society. Further, murder violates a person's interest in continuing to live. When applied to the situation where active euthanasia is being considered, the reasons behind the proscription against homicide are absent. Any disruption for society has al-

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489. *See* Fletcher, *supra* note 47.

490. *See, e.g., supra* notes 247, 420 and accompanying text.

491. *See infra* notes 534-35 and accompanying text.

492. Big Mac attacks are the closest most will ever come to the physiological distress of food deprivation.

493. *See infra* notes 533-35. One need only look to instances of famine to verify the physiologically violent nature of starvation.

494. *See* WILSON, *supra* note 2, at 143; *see also* Donald G. Casswell, *Rejecting Criminal Liability for Life-Shortening Palliative Care*, 6 J. CONTEMP. HEALTH L. & POL'Y 127, 128-40 (1990).

ready occurred, via the loss of the productive capabilities of the individual.[495] Indeed, disruption on a smaller scale—for family and friends—would continue after the individual becomes a candidate for euthanasia, but would diminish after a euthanic death. Violating a person's interest to live is, by definition, absent as an objection where active voluntary euthanasia is concerned.[496]

Active euthanasia involves some action causing death.[497] Although this definition could also be used for murder,[498] three crucial differences serve to distinguish the two. Homicide is not defined by the motives of the person who kills, by the circumstances and motives of the person who dies, or by the circumstances of his death, but such distinctions are unofficially relevant in prosecutorial discretion, grand jury indictments, jury verdicts, and sentencing.[499] These distinctions have been the only means to differentiate "real" murderers from "good"—or at least sympathetic—ones. Reliance on the graces of individual prosecutors, jurors, and judges is anathema to the rule of law, however, and counter to advocates' interests in answering the criticism of those opposed to euthanasia, who rightly point to the threat of unchecked abuses. These three considerations are thus crucial in reliably distinguishing euthanasia from murder.

First, humanitarian motives are not recognized as legitimate justifications for homicide.[500] Positive motives could legitimately be incorporated, under very limited circumstances,[501] into the legal definition of homicide, where humanitarian considerations were present, without jeop-

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495. An opponent of euthanasia could point to the slippery slope argument as a disruptive factor in itself. *See supra* part III.A.2.

496. Active *in*voluntary euthanasia presents a more difficult question, as it remains an open question whether such an interest can be transferred via "substituted judgment" to relatives. *See supra* notes 445-50 and accompanying text. It is presumed that the state has a legitimate interest in advocating on behalf of the incapacitated and assuming in the individual's stead a desire to live. *See supra* notes 450-52.

497. *See supra* note 45.

498. *See, e.g.*, TEX. PENAL CODE ANN. §§ 19.01-19.05, 19.07 (West 1989 & Supp. 1993). Indeed, active euthanasia fits the definition of pre-meditated murder perhaps perfectly—often better than prosecutors could normally hope for. What is normally contested definitionally is the meaning of malice aforethought. *See* WAYNE R. LAFAVE & AUSTIN W. SCOTT, CRIMINAL LAW § 7.1 (2d ed. 1986). In common law and statutory definitions of felonious homicide, "malice" is equivalent to "intent," serving to distinguish intentional homicide from manslaughter. *Id.* This is problematic for proponents of active euthanasia, as a person who assists another in suicide, for whatever noble purposes, does *intend* his actions.

499. This poses a related risk. Euthanasia as currently practiced occurs with virtual ignorance of the law. Coroners might falsify reports, prosecutors might decline to prosecute, grand juries might decline to indict, juries might acquit, and judges might compensate in sentencing. The one consistent thread is uncertainty. This, if not breeding disrespect for the law, brings into question the legitimacy of legal sanctions on an issue as central to civilized government—and as legally amorphous—as euthanasia. Even the *Cruzan* opinions either avoided the issue or framed it in one-sided contexts.

A recent opinion concerning capital punishment poses an interesting tangential argument, in that consideration of subjective factors may arguably violate equal protection guarantees, and subject minorities to disfavorable results (or majorities to unfairly favorable leniency). *See* Graham v. Collins, 113 S. Ct. 892, 912-15 (1993) (Thomas, J., concurring).

500. *See* WILSON, *supra* note 2, at 143.

501. Verification of humanitarian motives would necessarily be a question of fact for the state and courts.

ardizing the integrity of the criminal justice system.[502] Second, the circumstances and motives of the person who dies are, according to criminal law precepts, irrelevant to the guilt of the person who kills.[503] Yet a clear medical tragedy, coupled with a sincere desire to die, properly substantiated, clearly distinguishes the act of euthanasia from homicide. Third, the circumstances of the death provide substantial evidence regarding the authenticity of both the motives behind the killing and the reasons for wanting to die.

Looking officially to humanitarian motives of the person who kills, the circumstances of the death, and the circumstances of the person who dies provides a clear means to distinguish euthanasia from homicide. Critics of euthanasia will likely point to the importance of an absolute criminal proscription against assisting suicide to prevent the possibility of true murder under the guise of a requested death. This, however, is a question of fact. The criminal law could be as specific as the most ardent euthanasia supporter would accept in demanding evidence of the authentic need for death to safeguard against such possible abuse. Rather than skirting the issues, with a result worse for everyone, the criminal law could distinguish euthanistic from homicidal death, and make allowances accordingly.

VI. Policy Considerations

It is dangerous to go out into this hellish world but it is still more dangerous to hide in the bushes.[504]

Complex moral, medical, and social considerations enter into any discussion of when, if ever, euthanasia should be condoned or regulated. Moral objections are present on two levels: a rejection of the philosophy which sees the possibility of life having negative value, and objections to the effects of purposeful taking of life.[505] The medical community remains divided, while further advances in medical technology increase the likelihood of situations arising where euthanasia might be considered.[506] Social considerations interweave with religious and moral values, as well as more dispassionate economic and political consequences.[507] Still, objections to euthanasia fall into two major categories: concern for the sanctity of life and of the consequences of non-sacrosanct life, which some fear would result in an inexorable slide into barbarism.

A. *Moral Implications*

For many, the topic of euthanasia touches chords that cannot be retuned by logic.[508] Judeo-Christian presuppositions reject human self-de-

502. *See infra* part VI.C.

503. Although the status of the person who dies can—inconsistently with sanctity-of-life views—affect the level of punishment. *See supra* notes 431-31 and accompanying text.

504. Yevtushenko, *in* Kohl, *supra* note 180 at 140.

505. *See infra* part VI.A.

506. *See infra* part VI.B.

507. *See infra* part VI.C.

508. An opponent of euthanasia comments:

termination with regard to ending suffering by ending life.[509] Against these faiths, no logic can prevail. Yet we, as a society, are faced with conflicts and painful choices that cannot, and must not, be resolved by reference to any one system of beliefs.[510] This, unfortunately, disrespects a view of life as sacrosanct.[511]

There is little room to argue logically against (or for) theological arguments.[512] One either accepts divine revelation—and all that follows—on faith, or one does not. Similarly, strictly moral arguments are constrained by their necessary reference to contested bases of analysis. Where the state is involved, however, the question becomes more difficult. Whether to form public policy based, at least in part, on assumptions of the inviolability of life necessarily affects the direction of the debate, and involves broader questions of the role of government and its constitutional limitations.[513]

B. *Medical Implications*

> *The call came in the middle of the night. As a gynecology resident rotating through a large, private hospital, I had come to detest telephone calls, because invariably I would be up for several hours and would not feel good the next day. However, duty called, so I answered the phone. A nurse informed me that a patient was having difficulty getting rest, could I please see her. She was on 3 North. That was the gynecologic-oncology unit, not my usual duty station. As I trudged along, bumping sleepily against walls and corners and not believing I was up again, I tried to imagine what I might find at the end of my walk. Maybe an elderly woman with an anxiety reaction, or perhaps something particularly horrible.*
>
> *I grabbed the chart from the nurses* [sic] *station on my way to the patient's room, and the nurse gave me some hurried details: a 20-year-old*

> It is very illogical of us to make this distinction between active and passive. Well, so it is. Logically there is little or no difference. But our gut instinct tells us that there is. And, like it or not, we are not going to be browbeaten into changing our minds by mere logic; nor even by the remarkable fact that, whereas in the case of human beings passive euthanasia is widely regarded as a civilized and humane compromise, in the case of animals the same thing is considered an inexcusable cruelty.

Thurston Brewin, *Voluntary Euthanasia*, 1986 LANCET 1085, *reprinted in* Robert Campbell & Diane Collinson, *Passive and Active Euthanasia Are Not Equally Acceptable*, *in* EUTHANASIA: OPPOSING VIEWPOINTS, *supra* note 31, at 52.

In the final analysis, one's views of the euthanasia debate are inextricably dependent upon one's perspective of other ethical issues. This is unfortunate in attempts to deal with the problem, because logic, by itself, is all but powerless to alter prejudices; dispassionate logic is unwelcome in arenas of morality.

509. *See, e.g.*, SPRING & LARSON, *supra* note 2, at 124.

510. Interestingly, nearly all books on euthanasia, of either persuasion, give an accurate and reasonable account of opposing beliefs. This unfortunately reinforces the appearance that a fundamental chasm of values between the opposing forces renders the development of any mutually acceptable social policy improbable.

511. Few would argue with the proposition that human life is, ordinarily, worthy of such absolute protections. But, as with most absolutes, reality rears its Hydraic heads, forcing qualifications where they are not wanted.

512. *See supra* part III.A.1. Western religions are, by definition, self-referential. They are justified internally, premised on the assumptions of faith.

513. *See supra* note 394 and accompanying text.

girl named Debbie was dying of ovarian cancer. She was having unrelenting vomiting apparently as the result of an alcohol drip administered for sedation. Hmmm, I thought. Very sad. As I approached the room I could hear loud, labored breathing. I entered and saw an emaciated, dark-haired woman who appeared much older than 20. She was receiving nasal oxygen, had an IV, and was sitting in bed suffering from what was obviously severe air hunger. The chart noted her weight at 80 pounds. A second woman, also dark-haired but of middle age, stood at her right, holding her hand. Both looked up as I entered. The room seem filled with the patient's desperate effort to survive. Her eyes were hollow, and she had suprasternal and intercostal retractions with her rapid inspirations. She had not eaten or slept in two days. She had not responded to chemotherapy and was being given supportive care only. It was a gallows scene, a cruel mockery of her youth and unfulfilled potential. Her only words to me were, "Let's get this over with."

I retreated with my thoughts to the nurses [sic] *station. The patient was tired and needed rest. I could not give her health, but I could give her rest. I asked the nurse to draw 20 mg. of morphine sulfate into a syringe. Enough, I thought, to do the job. I took the syringe into the room and told the two women I was going to give Debbie something that would let her rest and to say good-bye. Debbie looked at the syringe, then laid her head on the pillow with her eyes open, watching what was left of the world. I injected the morphine intravenously and watched to see if my calculations on its effects would be correct. Within seconds her breathing slowed to a normal rate, her eyes closed, and her features softened as she seemed restful at last. The older woman stroked the hair of the now-sleeping patient. I waited for the inevitable next effect of depressing the respiratory drive. With clocklike certainty, within four minutes the breathing rate slowed even more, then became irregular, then ceased. The dark-haired woman stood erect and seemed relieved.*

It's over, Debbie.[514]

1. Debbie

This letter touched off a firestorm of criticism, both within the medical community and without. Some medical professionals called for a strengthening of fundamental moral principles of medicine.[515] Others argued for a reassessment of medicine's role.[516] The resident's actions should, however, be distinguished from the purpose behind them. Few would commend the unplanned and unsupervised euthanization by a bone-tired resident outside his normal duty rounds, but the underlying dilemma remains: should Debbie have had her wish[517] of death fulfilled? Assuming the laws of that state recognized her choice, she could have cho-

514. *It's Over, Debbie,* 259 JAMA 272 (1988).

515. *See* Willard Gaylin et al., *Doctors Must Not Kill, in* EUTHANASIA: THE MORAL ISSUES, *supra* note 31, at 25, 27. In addition to objecting to the resident's methods, they condemned any doctor who would kill a patient, and further insisted on disciplinary actions against any physician who kills. *Id.* at 28.

516. *See, e.g.*, Kenneth L. Vaux, *Debbie's Dying: Mercy Killing and the Good Death, in* EUTHANASIA: THE MORAL ISSUES, *supra* note 31, at 29.

517. Assuming that was clearly what she meant by: "Let's get this over with."

sen to refuse medical treatment[518] and would have died eventually via passive euthanasia. The medical staff would have had no choice but to watch. The question of whether she would have been better off refusing medical treatment,[519] rather than dying from an injection of morphine, leads to a basic problem with the medical community's approach.

> *The words of one of my teachers flashed through my mind: "If no cure is available, the doctor is required to alleviate pain and suffering as much as possible." For the supreme relief of supreme suffering, there is only one answer.*[520]
>
> *I am a doctor. I cannot kill. I must let live.*[521]

2. The Medical Community's Schizophrenia

The primary function of medicine has never been defined.[522] Is it to preserve life, or to reduce suffering?[523] Based primarily on this conflict, the medical community has had a difficult time dealing with the issue of euthanasia.[524] The American Medical Association supports the patient's

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518. It could well be argued that the problem with what happened to Debbie was not that she wanted euthanasia (how can anyone not sympathize), or that she got it. Rather, the method of her death was, at least, grossly inappropriate. Particularly objectionable was the resident's complete lack of familiarity with the patient, her family, her situation beyond the chart, and his failure to consult with any medical professional—least of all Debbie's personal physician or anyone else who may have provided some safeguards for a person in Debbie's position.

519. Assuming she had the willpower.

520. BARNARD, *supra* note 31, at 71 (thoughts before preparing a morphine solution for Maria, who had terminal cervical cancer, and was in great pain). He didn't inject her, however, and she later went into temporary remission. He criticizes not his initial decision, as her later temporary remission was a medical exception, but the lack of any professional direction for a physician resident. *Id.* at 73.

521. RUSSELL, *supra* note 2, at 177 (gynecologist for Madame van de Put).

522. It has, rather, been assumed. Previously, medicine was busy learning the methods of fighting disease and other agents of misery, with few negative side effects. Thus, preserving life and reducing suffering were synonymous—until the technologies advanced to the point of, arguably, forcing some to outlive their own deaths. *See* SCULLY & SCULLY, *supra* note 42, at 16; *see also* THOMASMA & GRABER, *supra* note 2, at 118-20, 193-97 (discussing the goal of medicine and the obligations to relieve pain and suffering).

523. Alternatively: "curing" patients, or "improving" their lives (and deaths). Either way, the underlying dilemma remains the same.

524. *See, e.g.*, Dennis Brodeur, *Assisted Suicide: The Limits of Personal Choice in a Social Society*, 11 ST. LOUIS U. PUB. L. REV. 439 (1992) (Right to Life/Right to Die Symposium issue); Stephanie B. Goldberg, *Assisted Suicide Resolution Defeated: Opponents Say Measure Crosses Line Between Suicide and Passive Euthanasia*, 78 A.B.A. J. 107 (April 1992); Sanford H. Kadish, *Letting Patients Die: Legal and Moral Reflections*, 80 CAL. L. REV. 857, 860-86 (1992); Aida A. Koury, *Physician-Assisted Suicide for the Terminally Ill: The Ultimate Cure?*, 33 ARIZ. L. REV. 677 (1991); Juliana Reno, *A Little Help from My Friends: The Legal Status of Assisted Suicide*, 25 CREIGHTON L. REV. 1151 (1992); Thomas Rivosecchi, Comment, *Medical Self-Determination: A Call for Uniformity*, 31 DUQ. L. REV. 87 (1992); George P. Smith II, *All's Well That Ends Well: Toward a Policy of Assisted Rational Suicide or Merely Enlightened Self-Determination?*, 22 U.C. DAVIS L. REV. 275 (1989); Lynn D. Wardle, *Sanctioned Assisted Suicide: "Separate but Equal" Treatment for the "New Illegitimates,"* 3 ISSUES IN L. & MED. 245 (1987); Robert F. Weir, *The Morality of Physician-Assisted Suicide*, 20 LAW, MED. & HEALTH CARE 116 (1992); Note, *Physician-Assisted Suicide and the Right to Die with Assistance*, 105 HARV. L. REV. 2021 (1992).

The issue is hardly academic: an estimated 10,000 patients are being maintained in persistent vegetative states in the United States alone. The number is expected to increase significantly. *See* Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261, 328 (1990) (Brennan, J., dissenting). A fifth of all adults surviving to age 80 will likely suffer from a progres-

right to choose the withholding or withdrawal of treatment, while firmly condemning active euthanasia.[525] The dilemma is the refusal to face reality—somewhat like the child who cannot fathom the reason for the euthanizing of its beloved pet.[526] Debbie's death, when it came, would have been far worse than by morphine. The fact that it came somewhat sooner, and by the hand of a doctor,[527] is a further question of ethics that has not been well addressed.[528] The dilemma will likely become worse, especially with respect to the acquired immuno-deficiency syndrome epidemic.[529]

> *For I was hungry and you gave me something to eat, I was thirsty and you gave me something to drink.*[530]

Similarly, physicians are deeply troubled by the implications of withholding food and water from patients. The physiological effects of withdrawal of nutrition and hydration, which are considered medical treatment,[531] provide a harrowing lesson in dying.[532] Witnessing death

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sive, demential disorder prior to death. *Id.* at 329. The eighty percent of Americans who die in hospitals are likely to die in sedated or comatose, and certainly manipulated, states. *Id.*

The issue of legal liability for physicians who assist in euthanasia is another dimension to the medical community's dilemma. *See, e.g.*, Hilary H. Young, *Assisted Suicide and Physician Liability*, 11 REV. LITIG. 623, 641-50 (1992).

525. *See* AMERICAN MEDICAL ASS'N, COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, REPORT 12: EUTHANASIA 3 (June 1988).

526. The Council on Ethical and Judicial Affairs of the American Medical Association sees the withholding or withdrawing of life-prolonging treatment as acceptable, with the intention not to kill the patient but rather to relieve the patient of the burden of treatment or suffering. *Id.* at 4. This ignores, however, the reality that withdrawal of life-prolonging measures, such as oxygen, food, water, will increase, not relieve, suffering—at least until death.

527. *Cf. supra* notes 348-50 and accompanying text (description of Dr. Kevorkian and his invention to assist suicide).

528. *Compare* Rachels, *supra* note 31, at 43 (arguing that there is no difference between letting die and killing) *and* Howard Caplan, *Doctors Should Support Euthanasia Decisions in* EUTHANASIA: OPPOSING VIEWPOINTS, *supra* note 31, at 49 (recounting of a patient's miserable death, and the court order needed for withdrawal of nutrition and hydration), *with* Robert Campbell & Diane Collinson, *Passive and Active Euthanasia Are Not Equally Acceptable, id.* at 51 (arguing a prima facie difference exists). The best defense of the position against active euthanasia appears to be Thurston Brewin's comment. *See supra* note 508 (pointing out that passive euthanasia is considered "inexcusable cruelty" in the case of animals.

Compounding the problem is the relative secrecy of the instances where passive euthanasia occurs; most are well hidden even within the hospitals that are already isolated from society.

529. *See* SPRING & LARSON, *supra* note 2, at 31.

530. *Matthew* 25:35 (Revised American).

531. *See supra* note 440.

532. Progressive effects of withholding food and water:

a. The mouth dries out and becomes caked or coated with thick material.
b. The lips become parched and cracked or fissured.
c. The tongue becomes swollen and might crack.
d. The eyes sink back into their orbits.
e. The cheeks become hollow.
f. The lining of the nose might crack and bleed.
g. The skin hangs loosely on the body and becomes scaly.
h. The urine becomes highly concentrated, burning the bladder.
i. The lining of the stomach dries out, causing dry heaves and vomiting.
j. Hyperthermia develops.
k. The brain cells begin drying out, causing convulsions.
l. The respiratory tract dries out, causing very thick secretions which can plug the lungs and cause death.

via starvation and thirst is against *both* functions of medicine; health care professionals are forced to watch as they fail to *either* preserve life or reduce suffering.[533] Passive euthanasia is thus arguably more against the traditions of medicine than either active euthanasia or organized palliative care. Even more problematic for the medical profession is the dilemma posed by children who are born with, or develop, serious deformities or mental incapacities.[534] As legal incompetents, they must rely on the decisions of their parents or guardians, which can sometimes present confused conflicts as the parents face terrible options in situations where objective decisionmaking is difficult, at best, and heart-rending always.[535] This presents an additional burden for the physician, and the courts, in balancing the needs of the child with the intentions of the parents.[536] After all, children must rely on others for everything, including wisdom.

C. *Economic Considerations*

> *People talk about the right to die as if they have the right to refuse to die.*[537]

Persons who are dying often worry about the effect of their illness on their family's financial situation.[538] The increasing reliance on hospitals

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m. Eventually, the major organs fail, resulting in death.

See Rita Marker, *Euthanasia Part III: Starvation and Dehydration as Treatment*, STEUBENVILLE REGISTER, Nov. 13, 1987, at 12 (description by Judge David H. Kopelman of Massachusetts). *Compare* Fred Rosner, *Food and Water Must Always Be Provided*, *in* EUTHANASIA: OPPOSING VIEWPOINTS, *supra* note 31, at 77, *with* Dan W. Brock, *Food and Water Must Not Always Be Provided*, *id.* at 83.

One recent book that has caused considerable controversy discussed alternative methods of euthanasia, criticized the effects of many such methods, and provided advice for recommended methods. *See* DEREK HUMPHRY, FINAL EXIT: THE PRACTICALITIES OF SELF-DELIVERENCE AND ASSISTED SUICIDE FOR THE DYING (1991).

533. Withholding of food and water provides an interesting contrast to the withholding or withdrawal of other, less basic medical treatments. Similar to the kidney dialysis story (*see supra* notes 256-60 and accompanying text), starvation is something that physicians and nurses can (easily) *do* something about. Resources are not a problem (indeed, even if they were, congressional reaction would probably be the same as with kidney dialysis: since we don't like the problem of a pie cut unevenly, let's legislate a bigger pie), yet a vegetative or terminal life cannot be fixed, whatever the commitment.

534. Some children have congenital defects that will result inevitably in their deaths, normally after much suffering. Others, such as Down's syndrome children, are in no immediate threat of death, and can live their lives in reasonably normal ways, remaining as children and capable of emotional relationships and simple tasks. *See* Foot, *supra* note 38, at 106. *See also* THOMASMA & GRABER, *supra* note 2, at 37-40 (discussing euthanasia when the patient is not terminal).

535. *Cf. supra* notes 262-78 and accompanying text (story of Corinne van de Put). Of course Corinne was not consulted; infants must rely on others for everything, including wisdom. The pertinent question is: Does she have a right to a peaceful death? If so, does that right outweigh reliance on an assumed desire of a right to live?

536. "If we say we are *unable* to look after children with handicaps we are no more telling the truth than was the S.S. man who said that the Jews could not be fed." Foot, *supra* note 38, at 106-07 (emphasis in original).

537. Richard Lamm, *Euthanasia Should Be Based on Economic Factors*, *in* EUTHANASIA: OPPOSING VIEWPOINTS, *supra* note 31, at 135.

538. *See* HARRY VAN BOMMEL, CHOICES: FOR PEOPLE WHO HAVE A TERMINAL ILLNESS, THEIR FAMILIES, AND THEIR CAREGIVERS 118 (1987); *see also* M. Rose Gasner, *Financial Penalties for Failing to Honor Patient Wishes to Refuse Treatment*, 11 ST. LOUIS U. PUB. L. REV. 499, 499-520 (1992).

and medical professionals has greatly increased the cost of dying in the United States.[539] According to basic societal values, personal financial considerations must not be controlling, but, realistically, cannot be considered illegitimate, either.

The macroeconomic impact of euthanasia, or its prohibition, is an increasingly troublesome issue, particularly since it disrespects the moral and social implications of its findings.[540] Nevertheless, health care costs continue to escalate, and many who need health care are forced to survive, or not, without adequate care. The wisdom of allocating larger portions of our already insufficient health care resources on the maintenance of terminally ill, or persistently vegetative, patients is not clear.[541] This element of the euthanasia debate is generally ignored, and will likely continue to be so, as a decision based on economic considerations would be seen as perilously close to the illegitimate considerations of the Nazi Germans.[542]

VII. COMPARATIVE LEGAL SCHEMES

Perhaps the Netherlands provide the best example of officially ac-

539. *Cf.* VAN BOMMEL, *supra* note 538, at 118.

540. With some macroeconomic qualifiers, ours is substantially a "zero-sum" society (particularly with respect to the short- and medium-term allocations); where we allocate resources (money) on one thing, we have roughly that same amount less for whatever else we want or need. *See, e.g.*, ABRAHAM L. GITLOW, ECONOMICS 7-12 (1962).

Further, the demographic aging of our society will eventually force these issues more into focus; by the year 2040, the elderly will likely constitute twenty-one percent of the population and consume forty-five percent of all health care resources. Daniel Callahan, *Euthanasia Should Be Based on Age, in* EUTHANASIA: OPPOSING VIEWPOINTS, *supra* note 31, at 120. *But cf.* Roy A. Fox, *Euthanasia Should Not Be Based on Age, id.* at 126 (supporting medical decisions based solely on individual cases and rejecting economic considerations as contrary to public policy). A particularly troubling aspect of this debate is discussed in Robert L. Risky, *Voluntary Active Euthanasia: The Next Frontier: Impact on the Indigent*, 8 ISSUES IN L. & MED. 361 (1992).

An estimated *eighty* percent of the average American's medical costs are spent in the last year of life. VAN BOMMEL, *supra* note 538, at 118.

541. Richard Lamm, who served as governor of Colorado from 1974 to 1986, caused an uproar when he declared that the elderly had a "duty to die," rather than waste precious medical resources in the last months of life. *See* Lamm, *supra* note 537, at 132. He further lambastes public policy which favors treatment of the terminally ill while ignoring education, prenatal care, and our infrastructure. *See id.* at 133, 137. He asserts that we, as a nation, are not wealthy enough to base our health care on the assumption that we can provide everything medically possible to everyone who needs it. He thus supports rationing, and points out that medical rationing already exists. *See id.* at 134. He also disapproves of the favoritism bestowed on his (older) generation. *See id.* at 136; *see also* Margaret P. Battin, *Age Rationing and the Just Distribution of Health Care: Is There a Duty to Die?*, 97 ETHICS 317, 319-40 (1987); Subrata N. Chakravarty & Katherine Weisman, *Consuming Our Children?*, FORBES Nov. 14, 1988, at 222, 222-32 (cover story title: Cry Baby: The Intergenerational Transfer of Wealth). *But cf.* Dana E. Johnson, *Euthanasia Should Not Be Based on Economic Factors, in* EUTHANASIA: OPPOSING VIEWPOINTS, *supra* note 31, at 139 (arguing that the medical relationship should not be disturbed by economic interference); THOMASMA & GRABER, *supra* note 2, at 190-91 (noting the potential danger of "technofix" medical solutions).

Not considered relevant by the drafters of the Life-Sustaining Procedures Declaration, *supra* note 317, is the tremendous cost associated with continued vegetative care that often cannot be covered by family resources. Also, should the family not wish impoverishment, the ability to abandon the patient poses a difficult problem, if not a cruel dilemma, for the family.

542. *See supra* notes 178-82 and accompanying text.

knowledged euthanasia.[543] Although active euthanasia remains illegal in the Netherlands, as many as several thousand are still performed annually.[544] Dutch opinions have changed dramatically over the past two decades, and a solid majority now favor active euthanasia.[545] The action to

543. *See, e.g.*, Pieter V. Admiraal, *Justifiable Euthanasia*, 3 ISSUES IN L. & MED. 361 (1988); Margaret Battin, *Voluntary Euthanasia and the Risks of Abuse: Can We Learn Anything from the Netherlands?*, 20 LAW, MED. & HEALTH CARE 133 (1992); Catharina I. Dessaur & Chris J.C. Rutenfrans, *The Present Day Practice of Euthanasia*, 3 ISSUES IN L. & MED. 399 (1988); Dana E. Hirsch, Comment, *Euthanasia: Is It Murder or Mercy Killing? A Comparison of the Criminal Laws in the United States, the Netherlands, and Switzerland*, 12 LOY. L.A. INT'L & COMP. L.J. 821, 835-38(1990); Henk Jochemsen, *Life-Prolonging and Life-Terminating Treatment of Severely Handicapped Newborn Babies: A Discussion of the Report of the Royal Dutch Society of Medicine on "Life-Terminating Actions with Incompetent Patients: Part I, Severely Handicapped Newborns"*, 8 ISSUES IN L. & MED. 167 (1992); John Keown, *The Law and Practice of Euthanasia in the Netherlands*, 108 LAW Q. REV. 51 (1992); M.T. Meulders-Klein, *The Right Over One's Own Body: Its Scope and Limits in Comparative Law*, 6 B.C. INT'L & COMP. L. REV. 29 (1983); J.H. Segers, *Elderly Persons on the Subject of Euthanasia*, 3 ISSUES IN L. & MED. 407 (1988); Helen Silving, *Euthanasia: A Study in Comparative Criminal Law*, 103 U. PA. L. REV. 350 (1954); Peter Zisser, *Euthanasia and the Right to Die: Holland and the United States Face the Dilemma*, 9 N.Y.L. SCH. J. INT'L & COMP. L. 361 (1988).

In February of 1993, "[t]he Dutch parliament adopted the most liberal euthanasia guidelines in Europe after years of keeping the widely accepted practice in legal limbo." WALL ST. J., Feb. 10, 1993, at A1. The measure stopped short of legalization, but guarantees physicians immunity from prosecution provided they follow strict rules. Euthanasia remains punishable by up to 12 years in prison, however. *Id.*

Other societies are slowly, if begrudgingly, becoming exposed to this dilemma. In Japan, where life expectancies are among the highest anywhere, the high rate of suicide has pushed euthanasia into the headlines. *See* Catharine Rosair, *Long-Living Japanese Debate Right to Die with Dignity*, HONOLULU STAR-BULLETIN, Nov. 4, 1992, at A-28. The circumstances surrounding Emperor Hirohito's death, in which he received more than ten times his blood capacity in transfusions after being diagnosed with pancreatic cancer, brought euthanasia issues to the forefront. His weight dwindled to a mere 66 pounds. During his agonizing illness, neither he nor the Japanese people were told the truth about his condition. *Id.*

For discussions of legal policy in Canada, see Daryl-Lynn Carlson, *Euthanasia: The Controversy of Mercy*, 16 CAN. LAW. 26 (Dec.-Jan. 1992-93); Fran Carnerie, *Euthanasia and Self-Determinism: Is There a Charter Right in Canada?*, 32 MCGILL L.J. 299 (1987). For a discussion of euthanasia policy in England, see Albert W. Alschuler, *The Right to Die*, 141 NEW L.J. 1637 (1991).

For an interesting corollary in a non-Western social context, see Isam Ghanem, *The Response of Islamic Jurisprudence to Ectopic Pregnancies, Frozen Embryo Implantation, and Euthanasia*, 27 MED., SCI. & L. 187 (1987).

544. *See* Pieter V. Admiraal, *Justifiable Active Euthanasia in the Netherlands*, *in* EUTHANASIA THE MORAL ISSUES, *supra* note 31, at 125; Marlise Simons, *Dutch Survey Sheds Light on Euthanasia, Suicide*, AUSTIN AMERICAN-STATESMAN, Sept. 22, 1991, at C2. Every doctor who performs active euthanasia is technically liable to prosecution, but so long as certain clearly circumscribed guidelines are followed, prosecutions have not been pursued. *See* Admiraal, *supra*. Under these guidelines, (1) the patient must have been informed of his situation, (2) he must have requested euthanasia freely and after careful consideration, (3) the doctor must believe that death is justified and no alternatives are available, (4) an independent physician must have been consulted, and (5) a report must be filed. After the death, the case must be reported to the coroner, and the police must investigate and report to the prosecutor, who, in consultation with the Attorney General, will decide whether to prosecute. *Id.* at 125-26.

On December 11, 1987, a bill was introduced, after considerable debate, into the Dutch legislature to legalize active euthanasia. *See* H.J.J. Leenen, *Euthanasia in the Netherlands*, *in* MEDICINE, MEDICAL ETHICS AND THE VALUE OF LIFE 1 (Peter Byrne ed., 1990).

545. *See* Leenen, *supra* note 544, at 2. The percentages below illustrate this change:

1966	39.9 percent
1975	52.6 percent
1979	51.4 percent
1986	67.0 percent

end life must be voluntary, thus excluding incompetent persons.[546] Many opposed to active euthanasia in the United States accuse the medical profession of atrocities in the Netherlands,[547] although no independent evidence has verified this.[548]

VIII. CONCLUSIONS

Euthanasia is controversial because it can be viewed from either the eyes of God or the hearts of humans. Alternatively, opponents object from a position disassociated with individuals who must face euthanasia directly, while those individuals must go against the accumulated wisdom of their society to meet life as it meets them. Fundamental moral values are pitted against the exigencies of suffering patients who demand—and deserve—relief. Active euthanasia has been practiced sporadically throughout history, but is contrary to the sanctity of life, a tenet of Christian belief. The frequency of persons who suffer with no reasonable possibility of recovery continues to increase, further intensifying the debate.

In addition to violating the sanctity of life, euthanasia can be seen as the first step down a road of self-destructive barbarism. Moreover, the medical community, and patients themselves, are apprehensive about taking their own life before Death does. On the other side of the debate is essentially one argument with two dimensions: we must allow euthanasia because we must not allow needless suffering. Beyond that—even accepting the arguments of euthanasia opponents—to continue as we do now is to ignore reality and insist on forcing euthanasia underground, where no legal safeguards are available. The answer, if one exists, will deny one side its fundamental beliefs.

Euthanasia can be either voluntary or involuntary. Voluntary euthanasia is the least problematic ethically, since the person suffering can justify his decision intelligently. Involuntary euthanasia has not been further categorized, but should be. It can be either beneficent or malevolent. Beneficent involuntary euthanasia is accomplished on behalf, and in the best interests, of an incapacitated person, and is currently the topic of much legal action, as *Cruzan* illustrated.[549] Provided adequate legal safeguards

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Id.; *see also* VAN BOMMEL, *supra* note 538, at 124.

546. Unless they have expressly so provided previously. *See* Leenen, *supra* note 544, at 3.

547. The International Anti-Euthanasia Task Force is particularly critical:

> Eight Dutch hospitals are performing involuntary euthanasia. Families of patients who will die by euthanasia need not be consulted.
>
> Some Dutch doctors have been advised to kill their elderly patients rather than admit them to hospitals, and elderly people report they fear being "assisted to die" because they are burdensome to others.
>
> And the Royal Dutch Medical Association has endorsed euthanasia for children without parental consent.

Mary Senander, *Medical Murder Is Given a Forum*, MINNEAPOLIS STAR TRIB., June 8, 1989, at 27A.

548. We can reasonably assume that atrocities *à la* Nazi Germany would be well reported.

549. In the process of molding a new common law, many have suffered beyond their already pitiful situations, yet that remains the price of our system of justice. *See, e.g.*, *supra* part II.C.

are in place, the use of Durable Powers of Attorney or Living Wills in an evidentiary capacity militates against extended litigation, while absence of evidence of the incapacitated person's intent forms the core of the current legal debate. Malevolent involuntary euthanasia, as occurred in Nazi Germany, is not euthanasia at all—it is murder. In any event, it is neither espoused nor seriously considered as appropriate public policy.

Euthanasia can be either active or passive. Active euthanasia involves some positive action causing death and is thus equated with murder. Passive euthanasia is increasingly a poorly defined area extending from simple withholding to active withdrawal of medical treatment, including food and water, until death occurs. The effort to distinguish these forms creates a false dichotomy given current medical technology, because active and passive are no longer distinct categories. Rather, they form a spectrum of possibilities that blend into each other. This makes many arguments against active euthanasia less persuasive when presented with the medical realities of (barely) live patients.

Assuming we, as a society, recognize situations where euthanasia is acceptable, then our current attitudes toward death and its ways are worse than dilemmic; they are hypocritical. Passive euthanasia can be not only worse than active euthanasia, it is often barbaric. The process of starvation cannot reasonably be said to be preferable to death itself; there is no logical answer to the question of how starving a comatose person is better than a lethal narcotic injection. Denying positive relief, while condoning the systematic, if hidden, near-torture of those near—in time or physiology—death is the height of ethical hypocrisy. Hippocrates may indeed have opposed the Greek tradition of suicide, but he could not have imagined the advances medical technology would provide. Such advances have proved a double-edged sword, however. All the physicians we can produce cannot change this reality. In prolonging life, medicine sometimes prolongs suffering. There is no escape from the horns of this dilemma—as with war, it will be with us for a very long time indeed. The medical community is singularly unable to cope with this dilemma, and needs guidance from the law, which must in turn honestly appraise the issues involved.

We insist more fervently on humane treatment for animals than for those who are dying and need all the compassion we can find in ourselves to give them.[550] Sometimes that means, in the real world, doing that which we don't want to do, but must. What is wrong is not that we must aid in their deaths, but the tragedy—of whatever making—that they must die so ignominiously.

We as a species are probably not yet mature enough to deal with the explosive issues surrounding euthanasia, yet we have little choice. Not dealing with the issues directly has brought unnecessary misery into the lives of many. Society too must learn better to deal with death. Death is certainly not a joyful occasion, but it needn't be so maudlin. In our efforts

550. Humane is not insignificantly derived from Latin *humanus*, or human. *See* VII OXFORD ENGLISH DICTIONARY 473-74 (2d ed. 1989).

to outmaneuver Death, we have stopped accepting it when it calls and have often been our own worst enemy in denying it its due. Death is not always the enemy to be feared and fought to the last.

Mechanisms for killing are, to put it mildly, problematic. Opponents of active euthanasia are rightly concerned about the potential for social disaster. We can either proscribe all active euthanasia, with the resultant misery, or confront the problem and provide for adequate, even obsessive, legal safeguards. The common slippery slope objection is specious. Life is a slippery slope. So too, now, is Death. We have no choice but to deal with these issues in a reasoned, balanced way. We must stop fighting against the slope and instead define acceptable and unacceptable policies. To attempt to define precisely the distinctions of euthanasia is to dichotomize falsely what are in reality categories that blend into each other. At some point passive is no longer so passive, and guidelines to ensure the patient's rights are needed to ensure civilization's continued presence. This is not to suggest that judicial standards should be loose—quite the opposite. But the courts must acknowledge the reality of the diverse circumstances possible in this arena, and, with polished safeguards in their sheaths, do justice.[551] Legal safeguards are particularly important when concerning incapacitated patients, but, as *Cruzan* has shown, our legal system is capable of handling such delicate issues. That is, after all, its function.

To accept the religious perspective is to wholly accept the assumptions underlying the beliefs of some, but not all, which is as directly opposed to the Constitution and our special social leniencies as is likely to be found. The law cannot accept on faith—to assume that which cannot be proved—a basic assumption of religious belief. With most issues, religious beliefs do form a common background for public policy, but with euthanasia, the answer is binary. We must accept either all or nothing—there is no middle ground to the sanctity of human life. Yet reality indicates otherwise. So long as some are forced to live, and suffer through, that reality, it is arrogant, at least, for some to insist on the meaning of life to those already half in hell.

Society cannot avoid the complex controversies surrounding euthanasia and must at least attempt to provide for adequate guidelines and legal safeguards for those who tragically must face such a decision. Passive euthanasia is rarely painless. Active euthanasia is not only painless, but if properly administered it should be a positive experience. Drugs that produce pleasurable sensations given before a fatal injection, coupled with a dignified ceremony, are far preferable to an ignominious starvation as an end to life. This is not maniacal; the horror of suffering *exists*—it is for society to be honorable in aiding those who would otherwise needlessly suffer by providing a legally safeguarded exit.

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551. Notwithstanding Justice Holmes' admonition that a judge's duty is to apply the law, and not to "do justice." IRVING DILLARD, THE SPIRIT OF LIBERTY 306-07 (3d ed. 1960) (quoting Judge Learned Hand), *reprinted in* EUGENE C. GERHART, QUOTE IT! MEMORABLE LEGAL QUOTATIONS 314 (1969).

A right to privacy—possibly the ultimate refuge for a right to die—is more legitimately based in a person's property interest in his own being. This redefinition does not resolve the debate surrounding euthanasia. It does, however, frame it differently, placing the burden more squarely on society to show cause for interrupting a person's actions to end his own life. Such a showing is not onerous where the individual's demands are unsubstantiated. Reliance on a constitutional right to privacy is worrisome, however, because it defies what the law craves—ready definition and concrete rules.[552] Recognizing this more intellectually honest basis for a right to privacy changes the relative positions of the interested parties in the euthanasia debate. Proceeding from the assumption of personal autonomy, the question for the government is under what circumstances an individual's right to determine the nature and time of his death can be overridden by state and societal interests. This does not provide an easy answer to the euthanasia dilemma—that would be neither possible nor desirable. Rather, the debate is placed in a more appropriate context. The legal system must bear the burden in balancing the "right" of the individual to a peaceful death with the government's duty to ensure that that individual's death is indeed peaceful. The burden should not rest on the individual; government must show cause for invading a property interest in a person's reasoned desire for death.

The criminal law must come to terms with the issues surrounding euthanasia. Three means of distinguishing active euthanasia from murder are available: the humanitarian motives of the person who kills, the circumstances and motives of the person who dies, and the circumstances surrounding the death. In so distinguishing, two badly needed functions are served. First, safeguards against abuse are available to all parties involved. Second, criminal sanctions against actions not in keeping with the benefit of the suffering individual are legitimized. The criminal justice system, however, is not solely to blame; the criminal law is merely a reflection of societal values.

Society as well must face the issue and develop consistent rules. Where the person is legally competent and suffers from a terminal illness with no reasonable expectation of recovery or remission, euthanasia must be voluntary—evidenced by persistent, conscious, and free requests. Where the person is a minor, the parent's wishes must be balanced by the medical profession and the courts against any possible abuse. Where the adult person is incapacitated and has not completed a societally encouraged document stating his wishes, the family members should be given limited discretion, again under court supervision, to authorize active euthanasia. Any reports of abuse must be investigated thoroughly, and, if substantiated, punishment to the full extent the law allows must be meted.

552. This illustrates the difficulty in defining too closely an issue—privacy—so basic we assume its general authenticity. Attempts to make discrete that which is inherently vague inevitably result in poor articulation of created fictions, which then run the risk of eventual exposure as the superstructure of stare decisis overwhelms the fluid foundation. It is far better to recognize a public policy as existing broadly while resisting efforts to define it precisely, insisting instead on flexible, equitable decisions with structural safeguards.

With authorized means available, no excuse would exist for unsupervised or inappropriate euthanasia. Regardless of the course the courts or society takes, euthanasia will remain a controversial issue. We must recognize this and accept the need for balancing the contradictory interests, and get on with our deaths.

The debate should not center around a "right to life"; does anyone question that? Rather, it involves a right to non-life; a right, legitimately circumscribed, to abstain from that which is needlessly painful. As Hamlet's soliloquy attests, the debate is intensely personal. Yet we cannot deny to those who are suffering beyond our comprehension the alternative of a gentle and easy death.

> *I've never heard of anyone dying from laughing. Wouldn't that be nice?*[553]

553. DAD (Universal 1990) (spoken by Jake Tremont (actor Jack Lemmon) to his wife, Bette, after his near-fatal hospitalization, following which he rebounds with uncharacteristic *joie de vivre*).