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Rebecca C. Morgan

Thomas C. Marks Jr.

Barbara Harty-Golder

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The Issue of Personal Choice: The Competent Incurable Patient and the Right to Commit Suicide?

*Rebecca C. Morgan**
*Thomas C. Marks, Jr.***
*Barbara Harty-Golder****

I. INTRODUCTION

Medicine has made many advances in prolonging life artificially. As a result, people who in the past would have been sent home to die, can have life prolonged for months and years by artificial medical technology.¹ These people are in limbo, alive, but not having life. American society has great reverence for life including, apparently, the kind of life that may be given through artificial life-prolonging procedures. Consequently, the quality of a patient's life, many times is eclipsed by the medical profession's ability to sustain that patient's physical existence through artificial medical procedures.²

* Rebecca Morgan, Professor of Law and the Assistant Dean, Stetson College of Law, B.S. in Business Administration 1975 from Central Missouri State University, J.D. 1980 from Stetson College of Law.

** Thomas C. Marks, Jr., Professor of Law, Stetson College of Law. B.S. 1960 from Florida State University, LL.B. 1963 from Stetson College of Law, Ph.D. 1971 from University of Florida.

*** Barbara Harty-Golder, in private practice, B.S. 1972 from University of Arizona, M.D. 1977 from University of Florida, J.D. 1988 from Stetson College of Law.

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1. *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841, 2883 (1990).

2. *Id.* at 2859, 2883 (Scalia, J., concurring). Justice Scalia in his concurring opinion noted "the constantly increasing power of science to keep the human body

Indeed, in many cases, it seems that the length of time a person is alive has become more important than the satisfaction of that person with the quality of life.³ Government regulation over the medical profession and other health care providers, including hospitals and nursing homes, has grown over the past decade. That, coupled with the proliferation of lawsuits against health care providers, results in more frequent utilization of life-support measures. Additionally, this regulation and fear of liability, both from the providers and family, has resulted in courts being asked to decide when it is appropriate for a life-prolonging procedure to be halted and an individual to be allowed to die.⁴

There is no question that an individual who is competent generally has the right to consent to or refuse medical treatment.⁵ In fact, a health care professional who treats a person in a non-emergency situation without that person's consent is liable to that individual.⁶ Further, in the recent past, courts have made it quite clear that a once-competent individual also has the right to refuse medical treatment.⁷

Whether an incurably-ill⁸ competent individual who refuses medical treatment has a concomitant right to commit suicide⁹ is a question that the

alive for longer than any reasonable person would want to inhabit it." *Id.* at 2859.

3. *Bouvia v. Superior Court*, 225 Cal. Rptr. 297, 305 (Cal. Ct. App. 1986); *McKay v. Bergstedt*, 801 P.2d 617, 623 (Nev. 1990).

4. *In re Farrell*, 529 A.2d 404, 415 (N.J. 1987).

5. *Cruzan*, 110 S. Ct. at 2846-47.

6. *Id.* at 2846; see generally *Pratt v. Davis*, 79 N.E. 562 (Ill. 1906); *Mohr v. Williams*, 104 N.W. 12 (Minn. 1905), *overruled on other grounds sub nom.* *Genzel v. Halverson*, 80 N.W.2d 854 (Minn. 1957); *Schloendorff v. Society of New York Hosp.*, 105 N.E. 92 (N.Y. 1914).

7. *In re Guardianship of Browning*, 568 So. 2d 4, 12 (Fla. 1990) (citing *John F. Kennedy Hosp., Inc. v. Bludworth*, 452 So. 2d 921, 923 (Fla. 1984)); see also *Cruzan*, 110 S. Ct. at 2852.

8. Many states have right-to-die or living will statutes. A common condition triggering these statutes is a terminal illness and imminent death. However, a terminal condition or imminence of death cannot be defined legally, but is simply a question to be determined as best as possible by the medical profession. See, e.g., *McKay v. Bergstedt*, 801 P.2d 617, 630 (Nev. 1990) (a patient is terminally ill if the non-attending physicians certify that life expectancy with or without life support is less than six months). In this Article, the individual does not have to be "terminal" but must have a condition that is incurable and will be the ultimate cause of the person's death.

9. This does not encompass an individual who is depressed or suffering from a mental condition that results in the person's desire to commit suicide, or the case of mental illness per se. Neither does this Article encompass or address the question of whether a surrogate has the ability to implement a once-competent, now currently

judicial system and society must now face.¹⁰ This Article hypothesizes that an incurably-ill competent individual has the right to affirmatively act to end his life when, after appropriate medical treatment, his life no longer has quality to him. Additionally, this Article takes the position that the right of an incurably-ill competent individual to commit suicide is a reflection of the law of individual choice. Prior judicial opinions have laid substantial groundwork for the resolution of this issue.¹¹ This Article simply takes the

incompetent, individual's wish to commit suicide. Nor does this Article address physician participation.

Suicide is a word that is extremely inflammatory and perhaps is ill-suited to describe the hypothetical posed in this Article. It is important to remember that this Article addresses the right of an individual with an incurable condition to take affirmative steps to end his life when his life no longer has quality to him. By virtue of this hypothetical, it is presupposed that the individual is not in the initial stage of the condition. It is also presupposed that the individual has had what medical treatment is available, which is to no avail (i.e. the condition is now incurable).

10. It is important to note that courts routinely consider the issue of suicide in reviewing a right to terminate treatment cases. *See, e.g.*, *Superintendent of Belcher-town State Sch. v. Saikewicz*, 370 N.E.2d 417 (Mass. 1977) (one of the four state interests is prevention of suicide). Generally, courts determine that the individual does not want to commit suicide, but wants to live without the medical device, or wants to allow the natural progression of the disease to occur unimpeded by medical procedures. *See, e.g.*, *Bouvia v. Superior Court*, 225 Cal. Rptr. 297, 299 (Cal. Ct. App. 1986); *McKay*, 801 P.2d at 619-20; *In re Farrell*, 529 A.2d 404, 407-08 (N.J. 1987). For a partial listing of other cases, *see McKay*, 801 P.2d at 626.

Note that although prevention of suicide is one of the four state interests considered by the courts in deciding termination of treatment cases, the courts generally do not discuss the rationale for that interest. *See infra* note 166 and accompanying text. The courts do not define the state's interest in preventing suicide but usually find the interest not applicable in the facts of the case before the bench by finding that the patient does not have a wish to die, did not cause the underlying disease or condition and wishes to live, without the life-supporting procedure. *See, e.g.*, *McKay v. Bergstedt*, 801 P.2d 617, 627 (Nev. 1990); *In re Conroy*, 486 A.2d 1209, 1224 (N.J. 1985) where the court states:

[D]eclining life-sustaining medical treatment may not properly be viewed as an attempt to commit suicide. Refusing medical intervention merely allows the disease to take its natural course; if death were eventually to occur, it would be the result, primarily, of the underlying disease, and not the result of a self-inflicted injury.

See also In re Welfare of Colyer, 660 P.2d 738, 743 (Wash. 1983) ("Nor was prevention of suicide a pertinent consideration here. A death which occurs after the removal of life sustaining systems is from natural causes, neither set in motion nor intended by the patient.").

11. *See, e.g.*, *Bouvia*, 225 Cal. Rptr. at 304-05; *McKay*, 801 P.2d at 625-26; *see infra* notes 182-215 and accompanying text. Note that the *McKay* court states there

position that the courts may be on the threshold of recognizing that an incurably-ill person has a right to commit suicide,¹² based on either the common law or constitutional law. Further, it is time to recognize that the appropriate forum for decision making in these cases is generally not the courts, but is instead the religious and ethical community.¹³ The law does have a role in this issue, but it should be limited to enacting statutes to serve both as a guide and as a safety net to ensure that the appropriate decision is made.

This Article starts with a review of the history of an individual's right to make choices dealing with his body, including a history of suicide. It analyzes the impact that the *Cruzan* decision has on the decision-making process of the state courts, lays the foundation for the constitutional right to commit suicide, examines its impact on society, and concludes that the right to commit suicide is a question of personal choice best decided outside of the courts.

is no right to commit suicide. *McKay*, 801 P.2d at 626.

12. Recognition of this right is not done to encourage individuals to commit suicide nor to encourage physicians' participation. The right should be recognized only with appropriate guidelines to protect against abuses.

13. *See Bouvia*, 225 Cal. Rptr. at 304. The court in *Bouvia* stated that her decision to forego medical treatment or life-support . . . belongs to her. It is not a medical decision for her physicians to make. Neither is it a legal question whose soundness is to be resolved by lawyers or judges. It is not a conditional right subject to approval by ethics committees or courts of law. It is a moral and philosophical decision that, being a competent adult, is her's alone.

Id. at 305.

II. AN HISTORICAL OVERVIEW OF AN INDIVIDUAL'S RIGHT TO MAKE CHOICES DEALING WITH HIS BODY

A. *Historical Overview of the Issue of Suicide*

Suicide has long been viewed by English and American societies as inappropriate for a variety of reasons.¹⁴ Some societies, however, have both accepted and practiced suicide.¹⁵ Generally, Western arguments against suicide are based either upon religion¹⁶ or morals.¹⁷ Historically, the arguments used in England against suicide can be stated as: suicide is a crime against God; suicide is a crime against society; suicide is a crime against the King. In other words, it is either a religious wrong, a moral wrong, or a social wrong.¹⁸

Suicide was a social wrong—a bad example that was punished for deterrence.¹⁹ Various theologians set out arguments as to why suicide was a crime against God. One argument reasoned that life and the soul are received from God and to reject them is a crime against God.²⁰ Augustine has been attributed with saying that suicide is a sin based upon the sixth

14. The exact date when legal action began to be taken against a suicide is not known. NORMAN ST. JOHN-STEVAS, *LIFE, DEATH AND THE LAW: LAW AND CHRISTIAN MORALS IN ENGLAND AND THE UNITED STATES* 234 (1961). As early as 967 A.D., unless the suicide was due to a mental or physical illness, the suicide's property was forfeited to the lord. *Id.* Suicide was first viewed as wrong by Christianity. Suicide as a crime appears to be a Christian creation. ALFRED ALVAREZ, *THE SAVAGE GOD* 52 (1970). Early societies were afraid that a suicide's spirit was evil. GLANVILLE WILLIAMS, *THE SANCTITY OF LIFE AND THE CRIMINAL LAW* 249 (Alfred A. Knopf ed., 1st ed. 1957).

15. WILLIAMS, *supra* note 14, at 249; *see also McKay*, 801 P.2d at 636 (Springer, J., dissenting); LOUIS I. DUBLIN & BESSIE BUNZEL, *TO BE OR NOT TO BE* 139-46, 149-96 (1933); JOHN-STEVAS, *supra* note 14, at 245-52.

16. Certain religions have no stated prohibitions against suicide while others do have a stated prohibition against suicide. WILLIAMS, *supra* note 14, at 249. Hinduism and Buddhism do not have a stated prohibition. Contrast this with the Jewish, Christian and Islamic faiths, which do. *Id.*

17. Some commentators take the position that law and morals exist hand in hand while others take an opposing view. For a discussion of law and morals, see JOHN-STEVAS, *supra* note 14, at 13-49.

18. WILLIAMS, *supra* note 14, at 264 (citing SAINT THOMAS AQUINAS, 2 SUMMA THEOLOGICA, Q. 59, 64 art. 3, 5 (Joseph Rickaby trans., London, Burns & Oates 1896)).

19. By punishing suicide, others so inclined would be dissuaded from the "evil example" set by the suicide. JOHN-STEVAS, *supra* note 14, at 235.

20. WILLIAMS, *supra* note 14, at 250.

commandment.²¹ It could be argued that, under the Christian view, life on earth is simply an interlude for the moment when a person dies and achieves divine glory in heaven. If there were no prohibition through the Church against suicide, an individual would be tempted to commit suicide, and go to greater glory earlier.²² Blackstone wrote that suicide was an act of cowardice and a crime against God, as well as a crime against the King.²³ Because God gave life, life could end only when God chose. The individual who committed suicide committed a spiritual crime because the individual was, in effect, playing God.²⁴ Blackstone argued that it was a crime against the King because the King had a desire and a stake in the lives of all of his subjects.²⁵ Suicide deprived the King of this control.

The English arguments for why suicide was inappropriate were primarily views of Christian society. Historically, other cultures tolerated or even condoned suicide in certain circumstances.²⁶ Additionally there were commentators who wrote in favor of suicide.²⁷ Suicide has always been a

21. *Id.* at 255-56. The analysis goes that, under the sixth commandment, to kill oneself is to kill a man and therefore suicide is homicide and thus inexcusable. *Id.* at 256.

22. *Id.*

23. 4 WILLIAM BLACKSTONE, COMMENTARIES 189-90 (1771).

24. *Id.*

25. *Id.* Judge Brown took the position that suicide was a crime against the King because the King suffered the loss of one of his subjects. JOHN-STEVAS, *supra* note 14, at 235.

26. *Id.*

27. *Id.* at 251-52. Sir Thomas More in *Utopia* advocated suicide for people suffering from incurable conditions after consent from priests and magistrates. *Id.* at 251. More wrote

As I said before, the sick are carefully tended, and nothing is neglected in the way of medicine or diet which might cure them. Everything possible is done to mitigate the pain of those suffering from incurable diseases; and visitors do their best to console them by sitting and talking with them. But if the disease is not only incurable, but excruciatingly and unremittingly painful, then the priests and public officials come and urge the invalid not to endure further agony. They remind him that he is now unequal to any of life's duties, a burden to himself and others; he has really outlived his own death. They tell him he should not let the disease prey on him any longer, but now that life is simply torture and the world a mere prison cell, he should not hesitate to free himself, or let others free him, from the rack of living. This would be a wise act, they say, since for him death puts an end, not to pleasure, but to agony. In addition, he would be obeying the advice of priests, who are interpreters of God's will; thus it will be a pious and holy act.

problematic question for humankind and has throughout history experienced periodic support.²⁸

Once religion and King determined that suicide was wrong, deterrents had to be enacted to discourage people from committing suicide.²⁹ The deterrents were primarily religiously-based, ranging from a denial of funeral rites,³⁰ cutting off the hand that actually took the person's life and burying it separately from the rest of the body,³¹ hanging the body, to burying the body in such a manner as to discourage suicide.³² In England, it was common for a suicide's body to be buried in the road, generally at the crossroads, with either a stake through the body or a stone placed over the face.³³

Eventually, there developed legally-based deterrents as well.³⁴ In

Those who have been persuaded by these arguments either starve themselves to death or take a drug which frees them from life without any sensation of dying. But they never force this step on a man against his will; nor, if he decides against it, do they lessen their care of him. The man who yields to their arguments, they think, dies an honorable death; but the suicide, who takes his own life without approval of priests and senate, him they consider unworthy of either earth or fire, and they throw his body, unburied and disgraced, into the nearest bog.

SIR THOMAS MORE, *UTOPIA* 80-81 (Ralph Robinson, trans., Birmingham, Eng. 2d ed. 1869). *Utopia* has also been interpreted as a satirical work. See GEORGE M. LOGAN & ROBERT M. ADAMS, INTRODUCTION TO THOMAS MORE, *UTOPIA* XI-XIII (Logan & R. Adams eds., 1989).

28. JOHN-STEVAS, *supra* note 14, at 246-47, 251. The issue of suicide is currently experiencing revival, placed on the ballot in Washington State and possibly in New Hampshire. See *infra* note 250. Currently, there is a movement toward support of suicide in certain cases. See, e.g., DERECK HUMPHRY, *FINAL EXIT* (1991).

29. By punishing a suicide, suicide began to be viewed as a crime. In fact in early England, it was treated as a felony. JOHN-STEVAS, *supra* note 14, at 234-35.

30. In the Talmud, Mishnah, a suicide gets no funeral rites. *Id.* at 251 (citing DUBLIN & BUNZEL, *supra* note 15, at 186).

31. *Id.* at 246. In Athens, this was practiced and, in addition, the body would be denied the usual funeral rites. *Id.*

32. *Id.* at 233. In England, the body might be hanged and also denied funeral rites. *Id.*

33. *Id.* at 233 (citing 4 BLACKSTONE, *supra* note 23, at 190). The stone over the face or the stake through the body were generally thought to prevent the ghost or vampire from rising. Additionally, the crossroads contained a religious implication, in that the crossroads were laid out the same way as a cross. *Id.* Also, the crossroads had other significance. The frequent traffic was thought to keep the evil spirit trapped. If the spirit did escape, the spirit would be confused by the number of roads and be unable to find its way home. ALVAREZ, *supra* note 14, at 49.

34. ALVAREZ, *supra* note 14, at 51-53, 71. Suicide as a criminal act appears to

addition to punishment through burial rites, England also required that the suicide's property be forfeited to the King.³⁵ Judge Bracton wrote that an individual who committed suicide would have his goods confiscated. Bracton distinguished two types of individuals committing suicide: first, an incarcerated individual who killed himself because of fear of prosecution and punishment for a crime he was alleged to have committed; and second, from an individual who killed himself because he was either tired of living or could no longer endure physical pain. In the former case, all the goods would be forfeited, but in the latter case, only the movable goods would be forfeited.³⁶ As observed by Blackstone in his Commentaries, the forfeiture of the goods or the disreputable burial was intended to act as a deterrent. Theoretically, an individual would not commit suicide for fear of besmirching the family name or impoverishing the family.³⁷

Suicide was subsequently recognized as a criminal act,³⁸ and was generally viewed as a felony.³⁹ Yet, making suicide a crime was found not to be a deterrent.⁴⁰ In England a successful suicide was viewed as crazy and an unsuccessful suicide a felon.⁴¹

In America as the common law was adopted by the individual states,⁴² suicide was generally not recognized as a crime.⁴³ Denying a body burial rights or giving a body ignominious burial or seizing the suicide's property did not really deter the act. As a result, in many states a successful suicide is not a crime.⁴⁴ The states have generally recognized that suicide really

be a Christian creation. *Id.* at 52. Suicide originally was within the Ecclesiastical Court's jurisdiction. JOHN-STEVAS, *supra* note 14, at 233.

35. JOHN-STEVAS, *supra* note 14, at 233-34. This practice was abolished by the Forfeiture Act in 1870. *Id.* See also *Hales v. Petit*, 75 Eng. Rep. 387 (K.B. 1563).

36. 2 SAMUEL THORNE, *BRACTON ON THE LAWS AND CUSTOMS OF ENGLAND* 423-24 (1968).

37. 4 BLACKSTONE, *supra* note 23, at 190.

38. Suicide was recognized as a sin and a crime by the time of Thomas Aquinas. DUBLIN & BUNZEL, *supra* note 15, at 202. Attempted suicide was recognized in England as a criminal act in 1854. JOHN-STEVAS, *supra* note 14, at 236.

39. JOHN-STEVAS, *supra* note 14, at 234-35.

40. WILLIAMS, *supra* note 14, at 276 (citing HARRY ROBERTS, *EUTHANASIA, THE ASPECTS OF LIFE AND DEATH* (1936)). How can a successful suicide really be punished?

41. ALVAREZ, *supra* note 14, at 48.

42. See, e.g., *People v. Callopy*, 192 N.E. 634, 638 (Ill. 1934); *United States Fidelity v. Carter*, 170 S.E. 764, 769-70 (Va. Ct. App. 1933).

43. JOHN-STEVAS, *supra* note 14, at 241. The states generally eliminated penalties for suicide. *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841, 2860 (1990) (Scalia, J., concurring).

44. See, e.g., N.C. GEN. STAT. § 14-17.1 (1973) (suicide abolished as an offense);

cannot be effectively punished.⁴⁵ In many instances punishment may even be legally prohibited.⁴⁶

Currently, even though many states do not view suicide as a crime, it is still considered inappropriate, and there are actions taken to dissuade an individual from committing suicide.⁴⁷ Some states continue to recognize attempted suicide as a crime.⁴⁸ It is standard in life insurance policies to have a suicide clause that limits or nullifies coverage if the policy holder commits suicide.⁴⁹ Additionally, if an individual is considered to be a suicide risk, a danger to himself, many states have a statute that allows the individual to be taken into custody and either confined to a mental health facility or receive mental health treatment until the risk of suicide abates.⁵⁰

Burnett v. People, 68 N.E. 505, 510 (Ill. 1903); Hundert v. Commercial Travelers' Mut. Accident Ass'n of Am., 279 N.Y.S. 555, 556 (1935) (suicide not a crime but morally wrong); Wyckoff v. Mutual Life Ins. Co. of N.Y., 147 P.2d 227 (Or. 1944) (suicide not a statutory crime but is morally wrong); Grace v. State, 69 S.W. 529, 530 (Tex. Crim. App. 1902) (suicide not a violation of any law in Texas); *see also* KAN. STAT. ANN. § 21-3406 cmts. (1988) (suicide not now a crime in Kansas); MINN. STAT. ANN. § 609.215 (West 1986) (suicide not a crime). *But see* Hill v. Nicodemus, 755 F. Supp. 692, 693 (W.D. Va. 1991) (suicide is a crime in Virginia); McMahan v. State, 53 So. 89, 91 (Ala. 1910); State v. Willis, 121 S.E.2d 854, 856 (N.C. 1961) (suicide is a crime).

45. Hill, 755 F. Supp. at 693; *See* Willis, 121 S.E.2d at 856; *see also supra* note 43 and accompanying text.

46. Even though North Carolina found suicide to be a crime in *State v. Willis*, the court noted that suicide can not be punished in North Carolina. Willis, 121 S.E.2d at 856; *see, e.g.,* Hill, 755 F. Supp. at 693 (legislature repealed punishment for successful suicide); McMahan, 53 So. at 90-91 (a successful suicide cannot be punished); *see also* VT. CONST. ch II, § 65 (suicide doesn't cause forfeiture of property); VA. CODE ANN. § 55-4 (Michie 1950); W. VA. CODE § 61-11-4 (1966). North Carolina abolished suicide as a crime in 1973. N.C. GEN. STAT. § 14-17.1 (1973).

47. For example, suicide hotlines or counseling programs, such as crisis intervention exist in many cities.

48. For a discussion of attempted suicide as a crime, *see* Royal Circle v. Achterrath, 68 N.E. 492, 498 (Ill. 1903); Prudential Ins. Co. v. Rice, 52 N.E.2d 624, 626 (Ind. 1944); State v. Campbell, 251 N.W. 717, 718 (Iowa 1933); Darrow v. Family Fund Soc., 22 N.E. 1093, 1094 (N.Y. 1889). *See also* JOHN-STEVAS, *supra* note 14, at 242-43.

49. *See, e.g.,* Estate of Galloway v. Guaranty Income Life Ins. Co., 725 P.2d 827 (N.M. 1986); Turkett v. Gulf Life Ins. Co., 306 S.E.2d 602 (S.C. 1983).

50. *See, e.g.,* FLA. STAT. ANN. §§ 394.463, .467 (West 1986); MO. REV. STAT. § 632.300 (Supp. 1991); *see also* People v. Cleaves, 280 Cal. Rptr. 146, 151, (Cal. Ct. App. 1991) (quoting *In re Joseph G.*, 194 Cal. Rptr. 163 (1983) (under modern law, rather than a crime, committing or attempting suicide is a sign of mental illness)).

Perhaps a more effective prohibition against suicide is the one currently used in many states. Aiding and abetting a suicide is considered a crime.⁵¹

Other countries have a varied view of the appropriateness of suicide. In both Germany and France, suicide and assisting suicide are not criminal.⁵² Switzerland, however, punishes assisting suicide unless done for altruistic motives.⁵³ Italy as well holds that assisting suicide is a crime.⁵⁴ Suicide

51. See *State v. Willis*, 121 S.E.2d 854, 856-57 (N.C. 1961). Without a statute making aiding and abetting a crime, an argument can be made that aiding a suicide is not a crime if the suicide itself is not a crime. See, e.g., *Grace v. State*, 69 S.W. 529, 530 (Tex. 1902) (the suicide is not guilty and the person furnishing the means/method is also not guilty). Michigan has no law against assisted suicide. Nancy Gibbs, *Dr. Death Strikes Again*, TIME, Nov. 4, 1991, at 78. But see *McMahon v. State*, 53 So. 89, 91 (Ala. 1910) (guilty of a crime unless the suicide was incompetent); *Burnett v. People*, 68 N.E. 505, 510-11 (Ill. 1903); *People v. Duffy*, 566 N.Y.S.2d 768 (N.Y. App. Div. 1991) (intentionally causing or aiding another person to commit suicide violates N.Y. Penal Law § 125.15(3)); JOHN-STEVAS, *supra* note 14, at 244.

States that do have statutes making aiding/abetting suicide a crime include:

ALASKA STAT. §§ 11.41.120(a)(d) (1978); ARIZ. REV. STAT. ANN. § 13-1103 (1989); ARK. CODE ANN. § 5-10-104 (Michie 1987); CAL. PENAL CODE § 401 (1988); COLO. REV. STAT. ANN. § 18-3-104 (West 1986); CONN. GEN. STAT. ANN. § 53a-56 (West 1985); DEL. CODE ANN. tit. 11, § 645 (1987); FLA. STAT. ANN. § 782.08 (West 1976); ILL. ANN. STAT. ch. 38, para. 12-31 (Smith-Hurd 1991); IND. CODE ANN. § 35-42-1-2 (Burns 1985); KAN. STAT. ANN. § 21-3406 (1988); ME. REV. STAT. ANN. tit. 17-A, § 204 (1983); MINN. STAT. ANN. § 609.215 (West 1987); MISS. CODE ANN. § 97-3-49 (1973); NEB. REV. STAT. § 28-307 (1990); N.H. REV. STAT. ANN. § 630:4 (1986); N.J. STAT. ANN. § 2C:11-6 (West 1982); N.M. STAT. ANN. § 30-2-4 (Michie 1978); N.Y. PENAL LAW §§ 120.30, 120.35, 125.15 (McKinney 1987); N.D. CENT. CODE § 12.1-16-04 (1991); OKLA. STAT. ANN. tit. 21, §§ 813-15 (West 1983); OR. REV. STAT. § 163.125 (1989); 18 PA. CONS. STAT. ANN. § 2505 (1983); S.D. CODIFIED LAWS ANN. § 22-16-37 (1976); TEX. PENAL CODE ANN. § 22.08 (West 1989) (repealed effective 9/1/94); WASH. REV. CODE ANN. § 9A.36.060 (West 1988); WIS. STAT. ANN. § 940.12 (West 1982).

Although not explicitly providing suicide, ALA. CODE § 13A-25 (1982); MASS. GEN. LAWS ANN. ch. 265, § 1 (West 1990); and WYO. STAT. § 6-1-201 (1977) can be construed to apply. In Connecticut, if the accused forced one to commit suicide by force, duress or deception it is considered murder. CONN. GEN. STAT. ANN. § 53a-54a. (West 1985).

52. Alister Browne, *Assisted Suicide and Active Voluntary Euthanasia*, 2 CANADIAN J. OF L. & JURISPRUDENCE 35, 36 (1989).

53. *Id.* at n.7. The Swiss Penal Code provides that "Whoever, from selfish motives, induces another to commit suicide or assists him therein shall be punished, if the suicide was successful or attempted, by confinement in a penitentiary for not more than five years or by imprisonment." SWISS PENAL CODE, C.P. art. 115.

54. Browne, *supra* note 52, at n.8. Italy distinguishes the punishment by whether the suicide was successful:

is not a crime in Canada, but assisting a suicide is.⁵⁵ In Great Britain, suicide itself and attempted suicide are no longer criminal acts,⁵⁶ as a result of the Suicide Act of 1961.⁵⁷ In Japan, the judiciary has separated the offense of euthanasia from murder.⁵⁸ Like Great Britain and Canada, Japan does not criminalize suicide or attempting suicide; assisting suicide, however, is punishable.⁵⁹ In Korea, inciting or assisting a suicide is a crime;⁶⁰ in New Zealand, aiding or abetting a suicide is a crime.⁶¹ Sweden decriminalized attempted suicide.⁶² The issue of suicide and the right to commit suicide is extremely controversial and has been one of debate for the human race for hundreds of years.⁶³ The current debate on suicide becomes more difficult because of the interchange of the terms assisted suicide and euthanasia.⁶⁴

Whoever instigates another to commit suicide or reinforces his intention to do so or in any manner promotes the execution of suicide shall be punished, where the suicide is successful, by confinement from five to twelve years. Where the suicide is not successful, such person shall be punished by confinement from one year to five years, provided that the attempt at suicide results in a serious or very grave personal injury.

ITALIAN PENAL CODE, C.P. art. 580.

55. Browne, *supra* note 52, at 35-36. Canada legalized suicide in 1972. *Id.* at 35.

56. *Id.* at 35.

57. Allen C. Schlinsog, Jr., *The Suicidal Decedent and Tortfeasor Liability*, 24 J. MARSHALL L. REV. 463, 469 n.20 (1991).

58. Lynn Tracy Nerland, *A Cry For Help: A Comparison of Euthanasia Law*, 13 HASTINGS INT'L & COMP. L. REV. 115, 131-32 (1989). The guidelines include the victim has an incurable illness, is suffering unspeakable pain, the doctor's purpose is to relieve the pain, the patient is competent and has made an informed choice, the means of causing death are administered by the doctor when possible and are morally acceptable. *Id.*

59. *Id.* at 126 n.79.

60. KOREAN CRIM. CODE c. 24, arts. 252, 253 (1960).

61. Paul Key, *Euthanasia: Law & Morality*, 6 AUCKLAND U. L. REV. 224, 229 (1989).

62. Nerland, *supra* note 58, at 123 (citing Hadding, *Prevent or Aid Suicide?*, EUTHANASIA 151 (A. Carmi ed. 1984)).

63. See *supra* notes 14-46 and accompanying text.

64. As stated previously, a discussion of the issue of assisted suicide is beyond the scope of this Article. However, it is necessary to define euthanasia as it pertains to suicide. Euthanasia has been divided in the past by commentators into active or passive euthanasia. Passive euthanasia consists of acts of omission, such as the withholding or withdrawal of life support. Active euthanasia consists of acts of commission, such as injecting the patient with a drug for the sole purpose of causing the patient's death. Barry A. Bostrom, *Euthanasia in the Netherlands: A Model for*

The Netherlands is generally viewed as having the most progressive stance on the issue of suicide. The Netherlands' Penal Code contains no punishment for suicide or attempted suicide.⁶⁵ Despite perception to the contrary, assisting suicide is a crime in the Netherlands.⁶⁶ A state commission, however, wrote recommendations⁶⁷ for non-prosecution of a physician who assisted a patient in committing suicide.⁶⁸

The Royal Netherlands Society for the Promotion of Medicine issued *Guidelines for Euthanasia*⁶⁹ in 1984. For a request for euthanasia to be granted, these guidelines must be observed.⁷⁰ The guidelines require voluntariness, an informed request, a repeated request for death, severe pain and suffering, and a consultation by the attending physician with at least one other doctor.⁷¹

To meet the guidelines of voluntariness, the doctor needs to speak to the patient alone and, if possible, get the request in writing. The doctor needs to ascertain if the reason the patient wants to end his life is an appropriate one. A patient's feeling that he is a burden does not constitute an appropriate reason.⁷² If the reason is inappropriate, the request should be denied and

the United States, 4 ISSUES IN L. & MED. 467 (1989).

65. Marian H.N. Driesse et al., *Euthanasia and the Law in the Netherlands*, 3 ISSUES IN L. & MED. 385, 386 (1988).

66. The State Commission on Euthanasia in 1985 defined euthanasia as "the deliberate action to terminate life, by someone other than, and on request of, the patient concerned." Henk Rigter, *Euthanasia in the Netherlands: Distinguishing Facts From Fiction*, HASTINGS CTR. RPT. SPEC. SUPP. 31 (Jan./Feb. 1989). Assisted suicide is a criminal act only if the suicide was successful. B. Sluyters, *Euthanasia In The Netherlands*, 57 MEDICO-LEGAL J. 34, 35 (1989).

Article 294 provides that "He who deliberately incites another to suicide, assists him therein or provides him with the means, is punished, if the suicide follows, with a prison sentence of at most three years or a fine of the fourth category." (A fourth category maximum fine equals twenty-five thousand guilders.) Driesse et al., *supra* note 65, at 386.

67. The guidelines include the requirements of: the patient's condition is severe with no chance of improvement, the patient has voluntarily requested clearly and repeatedly that his life end, all other care options have been refused or used, and the doctor has consulted with another physician. Robert K. Landers, *Right to Die: Medical, Legal & Moral Issues*, EDITORIAL RES. REP., Sept. 28, 1990, at 554, 563 (citing Rigter, *supra* note 66, at 31).

68. Sluyters, *supra* note 66, at 38.

69. Driesse, *supra* note 65, at 429-42.

70. *Id.* at 431.

71. *Id.* at 431-33.

72. *Id.* at 431-32.

instead, the patient should be informed of alternatives.⁷³ If there is any other solution to the problem, the request for euthanasia should be denied.⁷⁴

To make sure the request is an informed one, the patient must be given sufficient information about his condition and the alternatives available to him. If there are other avenues to lessen his suffering, the request should be denied. The doctor should keep a record of the events and conversations.⁷⁵

The patient must make repeated requests for death. The guidelines do not set a minimum number required to be sufficient but do find that only one request is insufficient.⁷⁶

The patient must experience constant, unbearable, severe pain and suffering. The doctor can consider the patient's life-style, hobbies, activities, and the patient's view of his quality of life. This information would come from repeated, serious conversations with the patient. If there are possibilities of lessening the pain and suffering, this guideline would not be met.⁷⁷

The attending physician should consult with at least one other doctor. If the patient has several treating physicians, the consultation could be between the treating physicians or with a doctor who has no personal knowledge of the patient. Additionally, the doctor is encouraged to talk to the nursing staff, a minister, or counselor. In keeping with patient privacy, the guidelines stress limiting the consultation to only those absolutely necessary.⁷⁸

The Netherlands also allows doctors to give pain medication, even though the patient's life would, as a result, be shorter.⁷⁹ There is no exact data on the number of cases of euthanasia that occur each year in the Netherlands; a range of numbers has been used.⁸⁰ In addition to the guidelines, cases are generally not prosecuted until review by and approval for prosecution has been done by a committee of five senior prosecutors.⁸¹

73. *Id.* at 432.

74. *Id.*

75. *Id.*

76. *Id.*

77. *Id.* at 432-33.

78. *Id.* at 433.

79. Sluyters, *supra* note 66, at 38.

80. Although the range of 5000-8000 is most commonly used, this figure is too high. Rieger, *supra* note 66, at 32.

81. Sluyters, *supra* note 66, at 41. The committee considers a number of factors, including the patient's condition, the patient's desire, the patient's level of competency to decide, the hopelessness of the condition, others affected, and whether the doctor consulted with another doctor. *Id.*

B. *The Individual In a Society*

A predictable tension exists between society's perception that suicide is inappropriate and an individual's right to make choices dealing with his own body. John Stuart Mill in his essay, *On Liberty*,⁸² recognized that there is a potential for conflict between one's liberty and the authority that the government has over him to regulate the exercise of his liberty.⁸³ There is a zone of liberty possessed by each individual on which government cannot impinge.⁸⁴ Society has a tendency to try to impose on its members certain rules of conduct which may diminish or extinguish individuality. Society wants like-minded people in it.⁸⁵ There has to be a protection against and limits on society's imposition of its own will and ideas on an individual.⁸⁶ Certain individual decisions affect only the individual, and should not be regulated by government.⁸⁷ These include control over one's own body and mind.⁸⁸

82. JOHN STUART MILL, *ON LIBERTY* (1859) (Alburey Castell ed., 1947).

83. *Id.* at 1.

84. *Id.* at 2.

85. *Id.* at 4-5. Since suicide is wrong under current societal views, society exerts its influence to prohibit suicide.

86. *Id.* at 5.

87. *Id.* at 9.

88. *Id.* at 9-10.

The object of this Essay is to assert one very simple principle, as entitled to govern absolutely the dealings of society with the individual in the way of compulsion and control, whether the means used by physical force in the form of legal penalties, or the moral coercion of public opinion. That principle is, that the sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number, is self-protection. That the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because, in the opinion of others, to do so would be wise, or even right. These are good reasons for remonstrating with him or reasoning with him, or persuading him, or entreating him, but not for compelling him, or visiting him with any evil in case he do otherwise. To justify that, the conduct from which it is desired to deter him must be calculated to produce evil to some one else. The only part of the conduct of anyone, for which he is amenable to society, is that which concerns others. In the part which merely concerns himself, his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign.

Nonetheless, there is a limitation on an individual's ability to act.⁸⁹ Yet, in situations where the issue does not really concern anyone other than the individual, he should be free to act.⁹⁰ If he is not free to make his own decisions, then his value or worth as a person is diminished.⁹¹ Society is made up of individuals. What one individual believes is not necessarily the same as another. What one individual would choose to do is not necessarily the same as others. Each individual has his own level of tolerable pain,⁹² and a unique view of a happy life.⁹³ Society must allow a person his individuality if he is to be happy.⁹⁴ When his action affects only himself, then he should be absolutely allowed to act in that manner.⁹⁵

Still, by living in a society, one's existence can affect others' lives.⁹⁶ The fact that an individual's actions may affect another should be considered by him before acting.⁹⁷ It is unusual for a person to live an isolated life,⁹⁸ and if his actions injure others, then there must be limits on his ability to act.⁹⁹ If, however, there is really no impact on others, he should be allowed to act for "the greater good of human freedom."¹⁰⁰

Id.

89. *Id.* at 55. Mill recognized that one would have an absolute right to believe but not an absolute right to act. See, e.g., *Employment Div., Dep't of Human Resources v. Smith*, 494 U.S. 872 (1990); *Reynolds v. U.S.*, 98 U.S. 145 (1878).

90. MILL, *supra* note 82, at 56.

91. *Id.* at 58-59.

92. *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841, 2878 (1990) (Brennan, J., dissenting) (citing the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Deciding To Forego Life Sustaining Treatment* at 276 (1983)).

93. MILL, *supra* note 82, at 68; see also *Bouvia v. Superior Court*, 225 Cal. Rptr. 297, 305 (Cal. Ct. App. 1986); *McKay v. Bergstedt*, 801 P.2d 617, 624 (Nev. 1990).

94. MILL, *supra* note 82, at 68.

95. *Id.* at 75-76.

96. *Id.* at 76.

97. *Id.* at 76-77.

98. *Id.* at 80.

99. *Id.* at 80-82.

100. *Id.* at 82; see also *In re Gardner*, 534 A.2d 947, 950 (Me. 1987) (quoting Marjorie Maguire Schultz, *From Informed Consent to Patient Choice: A New Protected Interest*, 95 YALE L.J. 219, 220 (1985)) (the court recognized the great importance of personal autonomy and in this regard states: "In general, the more intense and personal the consequences of a choice and the less direct or significant the impact of that choice upon others, the more compelling the claim to autonomy in the making of a given decision." *Id.*).

C. Medical Treatment Cases

The idea of bodily integrity and the liberty to control one's body has long been recognized by the courts in considering the issue of medical treatment. The United States Supreme Court has held that "[n]o right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law."¹⁰¹ In fact, because an individual has such right of control over his body, a doctor must have the individual's express or implied consent before the doctor can treat the patient.¹⁰² The benefit to the patient is irrelevant if, absent an emergency, the doctor gives treatment without the patient's consent.¹⁰³ It has also long been recognized that every competent adult has the right to determine what will be done with his body; a doctor who treats such an individual without prior consent has assaulted the patient and is liable to the patient.¹⁰⁴

Government can regulate an individual's action or non-action where it is necessary for the health and welfare of society. This justification has been used, among other things, to require individuals to be compulsorily vaccinated against diseases that have epidemic proportions and that have, in the past, killed a great number of people.¹⁰⁵ The Supreme Court has recognized in such cases that a person, by living in a society, will be subjected to restraints on his liberty to the furtherance of the health, safety and welfare of society.¹⁰⁶ Liberty exists, but it is liberty that the law will regulate in appropriate circumstances.¹⁰⁷ Notwithstanding, there is a zone within which the individual may exercise his liberty free of any governmental restraint.¹⁰⁸

101. *Union Pac. Ry. Co. v. Botsford*, 141 U.S. 250 (1891). The court goes on to quote Judge Cooley, who states "[t]he right to one's person may be said to be a right of complete immunity; to be let alone." *Id.* at 251 (quoting THOMAS M. COOLEY, *TORTS* 29 (Chicago, Callaghan & Co. 1880)).

102. *Mohr v. Williams*, 104 N.W. 12 (Minn. 1905); *see also* *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841, 2866 (1990) (Brennan, J., dissenting) (the rule of general law is the patient, not the doctor, decides the treatment).

103. *Id.*; *accord* *Pratt v. Davis*, 79 N.E. 562 (Ill. 1906).

104. *Schloendorff v. Society of N.Y. Hosp.*, 105 N.E. 92 (N.Y. 1914).

105. *See, e.g., Jacobson v. Massachusetts*, 197 U.S. 11 (1905).

106. *Id.* at 26.

107. *Id.*

108. *Id.* at 29.

D. The "Right-To-Die"¹⁰⁹ Cases

The issue of the individual's right to consent to or refuse medical treatment, or to affirmatively act to end his life in certain circumstances,¹¹⁰ involves the liberty to do so free of governmental regulation. Over the passage of time, society has forgotten an important distinction in this issue. An individual's right to end his life or to refuse medical treatment is not a legal question. It is a moral, ethical, or religious question.¹¹¹ American society has lost sight of the fact that, for this issue, religion is separate from the law and that this is an issue for theologians and ethicists, not routinely the judiciary. Deciding when an individual will be allowed to die through the court-ordered termination of medical technology that merely prolongs a body's existence poses great problems for the courts, due in part to the inherent unsuitability of this forum to consider these issues.¹¹²

Modern cases began to deal with this issue of life and death, first with refusal of treatment cases that were primarily based upon religious grounds. Cases were brought to the court involving patients who refused blood transfusions because of their religion.¹¹³ Next, as medicine advanced and technology allowed health care professionals to prolong life, the courts began to see cases asking for the right, the court-ordered right, to cease treatment of the individual.

Previously, it was clear that individuals had the absolute right to control their bodies, that "[e]very human being of adult years and sound mind has a

109. Right-to-Die is a term of art used to describe the ability of an individual to have life-prolonging procedures withdrawn. These cases concern individuals for whom there is no hope or cure. They are to be distinguished from medical treatment cases where the individuals can be cured or restored to a normal, functioning life of quality.

110. Opponents of removal of life-prolonging procedures would argue that halting such procedures constitutes an affirmative act to end one's life. *See, e.g., Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841, 2861 (1990) (Scalia, J., concurring) (distinction is between refusing ordinary treatment and extraordinary treatment).

111. *Bouvia v. Superior Court*, 225 Cal. Rptr. 297, 305 (Cal. Ct. App. 1986) ("It is not a medical decision for her physicians to make. Neither is it a legal question whose soundness is to be resolved by lawyers or judges. . . . It is a moral and philosophical decision that, being a competent adult, is hers alone.").

112. It is common in the opinion for the court to observe that the courts are ill-equipped to handle these cases and call on the legislature to address the problem. *See, e.g., Satz v. Perlmutter*, 379 So. 2d 359, 360 (Fla. 1980), *aff'd*, 362 So. 2d 160 (Fla. Dist. Ct. App. 1978).

113. *See, e.g., "Application of the President & Directors of Georgetown College, Inc." ex rel. President & Directors of Georgetown College*, 331 F.2d 1000 (D.C. Cir. 1964); *Public Health Trust of Dade County v. Wons*, 541 So. 2d 96 (Fla. 1989); *St. Mary's Hosp. v. Ramsey*, 465 So. 2d 666 (Fla. Dist. Ct. App. 1985).

right to determine what shall be done with his own body"¹¹⁴ The state courts, in deciding right to die cases, turned to Supreme Court decisions for guidance in deciding right to terminate treatment cases. The two cases most frequently relied on were *Roe v. Wade*,¹¹⁵ and *Griswold v. Connecticut*.¹¹⁶ The *Roe* Court recognized that a right of privacy existed under the constitution.¹¹⁷ The *Roe* decision was significant precedent for right to terminate treatment cases because the Court recognized this right of privacy existed as far back as *Union Pacific Railway Co. v. Botsford*.¹¹⁸ The Court asserted that personal rights such as these are "fundamental" rights or rights that are "implicit in the concept of ordered liberty."¹¹⁹ The *Roe* Court found this right of privacy included the right of a woman to decide whether to have an abortion.¹²⁰ The Court also recognized that the privacy right is not an absolute right but is subject to regulation by the state because of the state's specific interests,¹²¹ when those state interests are compelling.¹²²

The *Griswold* case also recognized a zone of privacy that is based on, and initiated by, the constitutional guarantees that would be considered fundamental.¹²³ The *Griswold* opinion, like the *Roe* opinion, recognized that the government has the right to limit this fundamental interest, but the state interests or governmental interests which balance against the right must be narrowly drawn.¹²⁴ Fundamental rights are not defined in the Constitution and have to be defined by the court, and the Supreme Court has indicated a

114. *Canterbury v. Spence*, 464 F.2d 772, 780 (D.C. Cir. 1972) (citing *Schloendorff v. Society of N.Y. Hosp.*, 101 N.E. 92, 93 (N.Y. 1914)); see also *Natanson v. Kline*, 350 P.2d 1093, 1104 (Kan. 1960), *clarified*, 354 P.2d 670 (Kan. 1960).

115. 410 U.S. 113 (1973).

116. 381 U.S. 479 (1965).

117. The opinion noted that the right of privacy under the United States Constitution could be located in either the First Amendment, the Fourth and Fifth Amendments, in the penumbra of the Bill of Rights, in the Ninth Amendment, or in liberty guaranteed under the Fourteenth Amendment. *Roe*, 410 U.S. at 152.

118. *Id.* (citing *Union Pac. Ry. Co. v. Botsford*, 141 U.S. 250, 251 (1891)).

119. *Id.* at 152 (citing *Palko v. Connecticut*, 302 U.S. 319, 325 (1937)). *Palko* was overruled by *Benton v. Maryland*, 395 U.S. 784 (1969).

120. *Roe*, 410 U.S. at 153.

121. *Id.* at 154.

122. *Id.* at 155 (citing *Kramer v. Union Free Sch. Dist.*, 395 U.S. 621, 627 (1969); *Shapiro v. Thompson*, 394 U.S. 618, 634 (1969); *Sherbert v. Verner*, 374 U.S. 398, 406 (1963)).

123. *Griswold*, 381 U.S. at 485.

124. *Id.*

hesitance to redefine both fundamental rights and what rights are considered to be fundamental.¹²⁵

Within this framework of cases dealing with an individual's right to consent to medical treatment, and the right of privacy in one's own body, state courts began to decide an individual's right to terminate medical treatment.

E. The "Modern" Cases

The first and landmark case of an individual's right to terminate medical treatment is the 1976 case of *In re Quinlan*.¹²⁶ Although there have been numerous cases decided at the state court level since *Quinlan*, *Quinlan* was still considered the basis for state decisions on the right to terminate treatment up until the United States Supreme Court decision of *Cruzan v. Director, Mo. Dep't of Health*.¹²⁷ In *Quinlan*, the New Jersey Supreme Court held that Karen Ann Quinlan had a right of privacy to have a respirator that was maintaining her life¹²⁸ removed, terminating that treatment. The New Jersey Supreme Court considered several different bases for this right and concluded that it was based upon her Fourteenth Amendment right of privacy.¹²⁹ The court identified what it considered to be state interests that must be balanced against Karen Ann Quinlan's right to have the respirator terminated. Those state interests included the preservation of life and the maintenance of the integrity of the medical profession.¹³⁰

Quinlan dealt with a once-competent individual who was currently incompetent, and who had made prior expressions of her position on the use of life-prolonging procedures.¹³¹ The next significant case was decided in

125. *Bowers v. Hardwick*, 478 U.S. 186, 194 (1986). In his dissent in *Cruzan*, Justice Brennan found that the right to avoid unwanted medical treatment was fundamental. *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841, 2865 (1990) (Brennan, J., dissenting).

126. 355 A.2d 647 (N.J.), *cert. denied*, 429 U.S. 922 (1976).

127. 110 S. Ct. at 2847-51.

128. Note that after the respirator was removed, Karen Ann Quinlan lived for almost ten years, breathing on her own and her existence was maintained by a feeding tube. *Quinlan*, 355 A.2d at 664.

129. *Id.* at 662-63.

130. *Id.* at 663.

131. Note that in *Quinlan*, the court discredited Karen Ann's statements about her views on the use of life-prolonging procedures as not probative. *Id.* at 664. However, in a subsequent New Jersey Supreme Court opinion, the court reversed itself and indicated that it should have given weight to Karen Ann's statements. See *In re Conroy*, 486 A.2d 1209, 1230 (N.J. 1985).

1977 by the Supreme Judicial Court of Massachusetts.¹³² The Massachusetts court was not faced with the issue of removing a medical apparatus from an individual, but with whether an individual who had never been competent had the right to refuse medical treatment that would prolong life but not cure the individual.¹³³ The *Saikewicz* case is extremely significant in that it laid out what it considered to be the relevant state interests that would be balanced against an individual's right of privacy to refuse life-prolonging procedures.¹³⁴ The court determined that the appropriate state interests to be balanced against an individual's right of privacy were the preservation of life, the prevention of suicide, the protection of third parties, and the maintenance of the integrity of the medical profession.¹³⁵ Although these four state interests are the ones most utilized by courts, subsequent courts have determined that these are not necessarily the exclusive state interests.¹³⁶

The *Saikewicz* court, as have many subsequent state courts, recognized that the most significant of these articulated state interests is the preservation of life.¹³⁷ The court also recognized that there is a difference when the question before the court involves a curable condition as opposed to a situation where the only question is how long the individual's life would be maintained.¹³⁸ In other words, there is a distinction between cases where an individual is refusing treatment that would cure the individual, from cases where an individual refuses treatment for a condition from which there is no recovery.¹³⁹

The last of the key modern cases for subsequent decisions was the case of *Satz v. Perlmutter*.¹⁴⁰ This case differed from both *Quinlan* and *Saikewicz* in that the individual in question was competent and able to express his wish that the respirator be disconnected. The court, utilizing the four state interests of *Saikewicz*, found that none of the four state interests outweighed

132. See *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417 (Mass. 1977).

133. The individual was 67 years old with a mental status of 2 years and 8 months and was suffering from leukemia. The medical procedure was chemotherapy. *Id.* at 420.

134. *Id.* at 424-27.

135. *Id.* at 425.

136. See *In re Guardianship of Browning*, 543 So. 2d 266 n.11 (Fla. Dist. Ct. App. 1989) (other state interests applicable besides the four enumerated); *McKay v. Bergstedt*, 801 P.2d 617, 628 (Nev. 1990) (adding a fifth interest and encouraging charitable contributions for medical treatment of the poor).

137. *Saikewicz*, 370 N.E.2d at 425; See also *Browning*, 568 So. 2d at 14.

138. *Saikewicz*, 370 N.E.2d at 425-26.

139. *Id.*

140. 362 So. 2d 160 (Fla. Dist. Ct. App. 1978), *aff'd*, 379 So. 2d 359 (Fla. 1980).

Mr. Perlmutter's right to terminate his treatment. His right was founded on his constitutional right of privacy.¹⁴¹ The court recognized if an individual has the right to consent to treatment, then the individual also has a "concomitant right to discontinue it."¹⁴² If, once a competent adult has expressed that it is his wish that treatment be terminated, continuing treatment simply inflicts "never ending physical torture on his body until the inevitable, but artificially suspended, moment of death. Such a course of conduct invades the patient's constitutional right of privacy, removes his freedom of choice and invades his right to self-determine."¹⁴³ In cases like these, the patient needs comfort, not treatment.¹⁴⁴

III. THE EVOLUTION OF A CONSTITUTIONAL RIGHT OF A COMPETENT PERSON TO REFUSE MEDICAL TREATMENT ON OTHER THAN RELIGIOUS GROUNDS

A. *The United States Supreme Court's Decision in Cruzan v. Director, Missouri Department of Health*¹⁴⁵

The United States Supreme Court decision in *Cruzan* was anxiously awaited, but as will be seen, really had little impact on the way state courts decide right to terminate life support cases. The court substituted liberty for privacy, but essentially left unchanged the analysis to be used by the courts.¹⁴⁶ The Court found that the right to refuse treatment is based on a Fourteenth Amendment liberty interest rather than a constitutional privacy right used by numerous state courts before *Cruzan*.¹⁴⁷ The Court recognized the need to balance this "liberty interest against the relevant state interests."¹⁴⁸ Since *Cruzan* involved a person who was not then competent, the

141. *Satz*, 379 So. 2d at 360 (citing and adopting *Satz*, 362 So. 2d at 162).

142. *Satz*, 362 So. 2d at 163.

143. *Id.* at 164.

144. *Id.* at 163.

145. 110 S. Ct. 2841 (1990). The Supreme Court decided that due process was not violated when the Supreme Court of Missouri required "clear and convincing" proof that Nancy Cruzan had, prior to the automobile accident that left her in persistent vegetative state, expressed her desire not to be kept alive under those circumstances. *Id.* at 2852.

146. *Id.* at 2843.

147. *See id.* at 2851 n.7.

148. *Id.* at 2851-52. The Supreme Court here merely recognized that determining the effect of any non-absolute right required that the interests protected by that non-absolute right be balanced against the governmental interest that put that right in jeopardy in the first place. *Id.*

Court "assumed" for the "purposes of this case" that the Fourteenth Amendment "would grant to a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition."¹⁴⁹ The Court cautioned, however, that "[a]lthough we think the logic of the cases discussed¹⁵⁰ above would embrace such a liberty interest, the dramatic consequences involved in refusal of such treatment would inform the inquiry as to whether the deprivation of that interest is constitutionally permissible."¹⁵¹

Since the remainder of the majority opinion in *Cruzan* deals with the rights of a once competent person who was now incompetent,¹⁵² what the Court did say about the competent person's rights must be applied. Before doing so, the three groundbreaking cases¹⁵³ identified by the Supreme Court in *Cruzan* should be measured against what the Supreme Court said in *Cruzan*.

B. The Effect of *Cruzan* on the Early Precedent-Setting Cases—*Liberty v. Privacy*

As previously indicated, the first court to grapple with the issue of the right to refuse medical treatment outside of a religious reason appears to be the Supreme Court of New Jersey in the well-known case of Karen Ann

149. *Id.* at 2852.

150. *Id.* at 2846-50. These cases apparently include *Union Pac. Ry. Co. v. Botsford*, 141 U.S. 250 (1891); *Conservatorship of Drabick*, 245 Cal. Rptr. 840 (Cal. 1988); *McConnell v. Beverly Enters., Inc.*, 553 A.2d 596 (Conn. 1989); *In re Estate of Longeway*, 549 N.E.2d 292 (Ill. 1989); *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417 (Mass. 1977); *In re Conroy*, 486 A.2d 1209 (N.J. 1985); *In re Quinlan*, 355 A.2d 647 (N.J.), *cert. denied*, 429 U.S. 922 (1976); *In re Westchester County Medical Center*, 531 N.E.2d 607 (N.Y. 1988); *In re Storar*, 438 420 N.E.2d 64 (N.Y. 1981); *Schloendorff v. Society of N.Y. Hosp.*, 105 N.E. 92 (N.Y. 1914).

151. *Cruzan*, 110 S. Ct. at 2852. Presumably the Court, since it declined to find that privacy included the right to refuse nutrition and hydration, would treat the liberty interest in doing so to some test that is less rigorous than the compelling governmental interest that a deprivation of privacy entails. *See, e.g.*, *Regents of the Univ. of Cal. v. Bakke*, 438 U.S. 265 (1978); *Roe v. Wade*, 410 U.S. 113 (1973).

152. As noted above, the Supreme Court in *Cruzan* upheld the Missouri Supreme Court's use of the "clear and convincing" standard for determining Nancy Cruzan's wishes as stated by her before she was rendered incompetent. *Cruzan*, 110 S. Ct. at 2854.

153. "Many of the later cases build on the principles established in *Quinlan*, *Saikewicz* and *Storar/Eichner*." *Id.* at 2848; *see also In re Estate of Longeway*, 549 N.E.2d 292, 296 (Ill. 1989) (the Illinois Supreme Court described *Quinlan* as "seminal").

Quinlan.¹⁵⁴ That court found that she had a privacy right under the United States Constitution that was "[b]road enough to encompass a patient's decision to decline medical treatment under certain circumstances, in much the same way as it is broad enough to encompass a woman's decision to terminate pregnancy under certain conditions."¹⁵⁵ The New Jersey Supreme Court also relied on the state constitution.¹⁵⁶

The New Jersey Supreme Court did not suggest that the privacy it was discussing was necessarily a fundamental right which would trigger the compelling governmental interest test, although it did mention *Roe v. Wade*.¹⁵⁷ Thus, after *Cruzan*, the question must be: would the balance struck by the New Jersey Supreme Court under privacy be any different under Fourteenth Amendment liberty as espoused by the United States Supreme Court in *Cruzan*?

154. *In re Quinlan*, 355 A.2d 647 (N.J.), *cert. denied*, 429 U.S. 922 (1976). Ms. Quinlan, for unknown reasons, was in a "chronic persistent vegetative state" being kept alive by a respirator and a nasal-gastro tube. *Id.* at 654-55. The question with which the New Jersey Supreme Court had to deal was whether she had a constitutional right to refuse (through her father) further use of these extraordinary medical procedures and thus to let nature and her condition take their course leading to her death. *Id.* at 652. It is unclear whether such discontinuance of treatment included the nasal-gastro tube used for hydration and sustenance or was limited to the respirator. The better view probably is that the court decision contemplated only the respirator in that several times the court spoke of a singular life support system. *Id.* at 671.

155. *Id.* at 663 (citing *Roe*, 410 U.S. 113). It should, however, be noted that the "penumbra theory" was not unanimously accepted by the Supreme Court. Justice Goldberg, joined by Chief Justice Warren and Justice Brennan bolstered that theory through the use of the Ninth Amendment. *Griswold v. Connecticut*, 381 U.S. 479, 486-99 (1965) (Goldberg, J., joined by Warren, C.J., and Brennan, J., concurring). Justice Harlan, using a pure substantive due process argument, found that "[t]he due Process Clause of the Fourteenth Amendment stands, in my opinion, on its own bottom." *Id.* at 500 (Harlan, J., concurring in the judgment). The Supreme Court has apparently adopted the Harlan view. "This right of privacy, whether it be founded in the Fourteenth Amendment's concept of personal liberty and restrictions upon state action, as we feel it is . . ." *Roe*, 410 U.S. at 153.

156. "Nor is such a right of privacy forgotten in the New Jersey Constitution." *Quinlan*, 355 A.2d at 663 (citing N.J. CONST. art. I, para. 1 (1947)). The text of that provision reads "[a]ll persons are by nature free and independent, and have certain natural and unalienable rights, among which are those of enjoying and defending life and liberty, of acquiring possessing and protecting property, and of pursuing and obtaining safety and happiness." *Id.* (citing N.J. CONST. art. I, para. 1 (1947)).

157. *Id.* The New Jersey court did comment that it saw "no external compelling interest [which] could compel Karen to endure the unendurable, only to vegetate a few measurable months with no realistic possibility of returning to any semblance of cognitive or sapient life." *Id.*

The answer to this question would appear to be "no." The New Jersey Supreme Court identified two state interests, or at least "claimed" state interests: (1) "essentially the preservation and sanctity of human life"; and (2) "defense of the right of the physician to administer medical treatment according to his best judgment."¹⁵⁸

As to the first articulated state interest, rather than erect the compelling governmental interest test, the court merely found that as the treatment becomes more invasive while the prognosis for meaningful recovery decreases, the state's interest in the preservation of life will at some point give way to the individual's—whether it is described as "privacy" or "liberty."¹⁵⁹

After lengthy discussion as to the second state interest (the right of the physician to administer medical treatment according to his best judgment), the court determined the then prevailing medical guidelines were not binding on the court in ruling.¹⁶⁰

Apart from the one reference to the word "compelling," if *Cruzan's* refusal of a right to refuse medical treatment were categorized as privacy nothing would have changed in the *Quinlan* opinion. Using *Cruzan*, the New Jersey Supreme Court would merely have substituted the word "liberty" for the word "privacy." Put differently, there is nothing to suggest that the government interests in *Quinlan* were subject to the strict scrutiny of the compelling government interest test.

The second case referred to by the Supreme Court that also used constitutional privacy as a source of the right to refuse medical treatment was *Superintendent of Belchertown State School v. Saikewicz*.¹⁶¹ It also stressed

158. *Id.*

159. *Id.* at 664.

160. *Id.* at 669. The court then went on to conclude that no criminal liability would be involved in withdrawing Karen's life support system if the conditions it set out were followed. These conditions were:

Upon the concurrence of the guardian and family of Karen, should the responsible attending physicians conclude that there is no reasonable possibility of Karen's ever emerging from her present comatose condition to a cognitive, sapient state and that the life-support apparatus now being administered to Karen should be discontinued, they shall consult with the hospital "Ethics Committee" [sic] or like body of the institution in which Karen is hospitalized.

Id. at 671.

161. 370 N.E.2d 417 (Mass. 1977). The Supreme Judicial Court of Massachusetts also found the right to refuse medical treatment in the common law. *Id.* at 424. The court, however, recognized the constitutional right as being "[o]f even broader import." *Id.*

the importance of constitutional privacy as a basis for refusing life-prolonging procedures.¹⁶²

Of major importance is the court's "distilling" of four state concerns against which the privacy right to refuse treatment is to be measured. These are "(1) the preservation of life; (2) the protection of the interests of innocent third parties; (3) the prevention of suicide; and (4) maintaining the ethical integrity of the medical profession."¹⁶³

As was the case with *Quinlan*, it does not appear that the change from "privacy" to "liberty" would have made any difference in a case like *Saikewicz*. Although the Supreme Judicial Court of Massachusetts anchored the right to refuse medical treatment in the Federal Constitution, it never

162. *Id.* The court stated:

[A]rising from the same regard [as the common law] for human dignity and self-determination, is the unwritten constitutional right and privacy found in the penumbra of specific guarantees of the Bill of Rights . . . [T]his constitutional guaranty . . . encompasses the right of a patient to preserve his or her right to privacy against unwanted infringements of bodily integrity in appropriate circumstances.

Id.

163. *Id.* at 425. Balancing these state concerns against the privacy interests of a profoundly retarded senior citizen at a state institution, the Massachusetts court concluded that the privacy interest prevailed and thus Mr. Saikewicz would not receive chemotherapy treatment which he would not understand and which would be debilitating with small hope of any significant improvement in his condition. *Id.* at 435.

Although the case did not involve suicide the opinion does contain language which could have a bearing on that topic.

The interest of the State in prolonging a life must be reconciled with the interest of an individual to reject the traumatic cost of that prolongation. There is a substantial distinction in the State's insistence that human life be saved where the affliction is curable, as opposed to the State interest where, as here, the issue is not whether but when, for how long, and at what cost to the individual that life may be briefly extended The constitutional right to privacy, as we conceive it, is an expression of the sanctity of individual free choice and self-determination as fundamental constituents of life. The value of life as so perceived is lessened not by a decision to refuse treatment, but by the failure to allow a competent human being the right of choice.

Id. at 425-26 (footnote omitted).

The above quote could be read to sanction suicide under the conditions proposed. The court also discussed the question of the quality of life in a way that seems favorable to our argument. It pointed out that diminished quality of life caused by the side effects of chemotherapy would be a factor in deciding whether to authorize this treatment. *Id.*

applied the compelling government interest test that "privacy" should trigger. In other words, the state's interests were never put to the rigor of that test.

As to the first state purpose or interest found by the court, "the preservation of life," the *Saikewicz* opinion on why that interest loses out under a set of facts like those before the court certainly does not read like an application of the compelling governmental interest test:

It is clear that the most significant of the asserted State interests is that of the preservation of human life. Recognition of such an interest, however, does not necessarily resolve the problem where the affliction or disease clearly indicates that life will soon, and inevitably, be extinguished. The interest of the State in prolonging a life must be reconciled with the interest of an individual to reject the traumatic cost of that prolongation. There is a substantial distinction in the State's insistence that human life be saved where the affliction is curable, as opposed to the State interest where, as here, the issue is not whether, but when, for how long, and at what cost the individual life may be briefly extended. Even if we assume that the State has an additional interest in seeing to it that individual decisions on the prolongation of life do not in any way tend to "cheapen" the value which is placed in the concept of living we believe it is not inconsistent to recognize a right to decline medical treatment in a situation of incurable illness. The constitutional right to privacy, as we conceive it, is an expression of the sanctity of individual free choice and self-determination as fundamental constituents of life. The value of life as so perceived is lessened not by a decision to refuse treatment, but by the failure to allow a competent human being the right of choice.¹⁶⁴

There would not seem to be any reason to believe that the above holding would be any different under the Supreme Court's "liberty" standard. The court then considered the other three state interests, the effect of the patient's death on other people, the prevention of suicide and the integrity of the medical profession and found that they either did not apply or were satisfied.¹⁶⁵ Further, as is typical with the courts, passing consideration was given to the state interest in preventing suicide, without fully explaining the underlying justification for the interest.¹⁶⁶

164. *Id.* (citing *Roe v. Wade*, 410 U.S. 113 (1973)).

165. *Id.* at 426-27.

166. The court in *Saikewicz* gave the following explanation:

The interest in protecting against suicide seems to require little if any discussion. In the case of the competent adult's refusing medical treatment such an act does not necessarily constitute suicide since (1) in refusing treatment the patient may not have the specific intent to die, and (2) even if he did, to the extent that the cause of death was from natural causes the patient did not set the death producing agent in motion with the intent of

Looked at this way, it would appear that since those pre-*Cruzan* cases that relied on privacy as the source of the right to refuse medical treatment did not actually put the state to the rigorous compelling governmental interest test, the change from "privacy" to "liberty" is of no great moment, no matter what the Supreme Court thought when it made the change.

The third case mentioned by the Supreme Court, *Eichner v. Dillon*,¹⁶⁷ also located the right to refuse medical treatment in both the common law and the Fourteenth Amendment right to privacy.¹⁶⁸ The New York Court quoted *Roe v. Wade*.¹⁶⁹

The Constitution does not explicitly mention any right of privacy. In a line of decisions, however, going back to *Union Pacific R. Co. v. Botsford*. . . the Court has recognized that a right of personal privacy, or a guarantee of certain areas or zones of privacy, does exist under the Constitution.¹⁷⁰

The New York court went on to opine that,

this right has been discerned within the penumbras of the Bill of Rights, and from the language of the First, Fourth, Fifth, Ninth and Fourteenth Amendments to the Constitution. . . . However, "only personal rights that can be deemed 'fundamental' or 'implicit in the concept of ordered liberty,' are included in this guarantee of personal privacy". . . . Mr. Justice Douglas, speaking of the constitutional right of privacy, declared that "the freedom to care for one's health and person" falls within its purview, adding that the "right of privacy has no more conspicuous place than in the physician-patient relationship". We believe that the essence of this right is autonomy over matters of personal integrity, including control over one's body, and that such a right is fundamental within the meaning of the Fourteenth Amendment. . . ." By parity of reasoning, [with *Roe v. Wade*] the constitutional right to privacy, we believe, encompasses the freedom of

causing his own death. Furthermore, the underlying State interest in this area lies in the prevention of irrational self-destruction. What we consider here is a competent, rational decision to refuse treatment when death is inevitable and the treatment offers no hope of cure or preservation of life. There is no connection between the conduct here in issue and any State concern to prevent suicide.

Id. at 426 n.11 (citations omitted).

167. 426 N.Y.S.2d 517 (App. Div. 1980), *cert denied*, 454 U.S. 858 (1981).

168. "We believe, however, that [the patient's] right to refuse treatment when competent rests on a far more fundamental principle of law: the constitutional right to privacy." *Id.* at 537.

169. 410 U.S. 113 (1973).

170. *Eichner*, 426 N.Y.S.2d at 537-38 (citing *Roe*, 410 U.S. at 152) (citation omitted).

the terminally ill but competent individual to choose for himself whether or not to decline medical treatment where he reasonably believes that such treatment will only prolong his sufferings needlessly, and serve merely to denigrate his conception of the quality of life. The decision by the incurably-ill to forego medical treatment and allow the natural processes of death to follow their inevitable course is so manifestly a "fundamental" decision in their lives, that it is virtually inconceivable that the right of privacy would *not* apply to it. Individuals have an inherent right to prevent "pointless, even cruel prolongation of the act of dying". Stated in simpler and more fundamental terms, as a matter of constitutional law, a competent adult who is incurably-ill has the right, if he so chooses, not to resist death and to die with dignity. . . .¹⁷¹

The New York court then found that the "current state" of the then-prevailing ethical opinion of the medical profession for the most part affirmed that a terminally ill patient had the right to refuse treatment, allowing the disease to follow its natural progression to death.¹⁷² The court then balanced this interest against the four state interests discussed above¹⁷³ and concluded that the right to refuse medical treatment outweighed them all.¹⁷⁴

Although concerned with the right to refuse medical treatment, the rationale of some of the medical opinions cited by the *Eichner* court would also support the right of suicide for the hopelessly ill. For example, the court found that one authority states that recovery meant more than being alive, but meant "life without intolerable suffering."¹⁷⁵ The language in the court's discussion of the state interest in the preservation and sanctity of life supports the proposition to allow suicide in the case of certain medical conditions. Although used in the context of a patient in a permanent vegetative state, the words surely justify authorized suicide. The court speaks of a patient

171. *Id.* at 538-39 (quoting *Palko v. Connecticut*, 302 U.S. 319, 325 (1937); *Doe v. Bolton*, 410 U.S. 179, 214, 219 (1973); *In re Dinnerstein*, 380 N.E.2d 134, 137 (Mass. Ct. App. 1978) (footnote omitted).

172. *Id.* at 542.

173. *Id.* at 543.

It is not enough, however, simply to declare that the terminally ill patient in a chronic coma is entitled to refuse further medical treatment. We are bound by *Roe v. Wade* . . . to determine whether the exercise of that right contravenes some countervailing State interest . . . and we therefore measure the relief requested herein against the four major categories of relevant State interests.

Id. (citation omitted).

174. "We conclude, therefore, that there were no state interests sufficiently compelling in this proceeding. . . ." *Id.* at 544.

175. *Id.* at 541 (citing H.P. Lewis, *Machine, Medicine and Its Relation to the Fatally Ill*, 206 JAMA 387, 389 (1968)).

ensnared by medical technology while waiting for death, who having lived life, relies on machines to provide his existence.¹⁷⁶

Citing another case, the court recognized an "[i]ndividual['s] . . . inherent right to prevent pointless, even cruel, prolongation of the act of dying."¹⁷⁷ Even though the prevention of suicide is one of the four identified state goals, the discussion comes close to justifying suicide of the incurably-ill person:

The current Penal Law provides for criminal liability solely as to a third party who aids or promotes the suicide attempt; it does not impose liability against the *individual* himself. Hence, there seems to be no public policy against permitting a terminally ill patient to choose not to delay the inevitable and imminent termination of his life—at least insofar as public policy is reflected in the current Penal Law. Such decision, directed to terminating the artificial prolongation of life, cannot be deemed "irrational in the sense generally connoted by the term 'suicide'."¹⁷⁸

The court then went on to establish the substantive and procedural mechanism by which the interests of a person in a permanent vegetative state would be protected.¹⁷⁹ On review, the Court of Appeals of New York¹⁸⁰ declined to find that the right to refuse medical treatment was an aspect of constitutional privacy since principles of common law supported the decision.¹⁸¹

IV. FROM PERLMUTTER TO BERGSTEDT: ARE WE ALREADY AT THE JUDICIAL THRESHOLD OF A LIMITED RIGHT TO SUICIDE FOR COMPETENT, INCURABLE PATIENTS?

Some state court decisions have laid a foundation for finding a limited right to suicide for competent, incurably-ill adults. Since *Cruzan* would probably not change the results of those decided before *Cruzan*, these cases are precedent for finding the right to commit suicide.

The first case identified as authorizing a competent person to choose to discontinue a life sustaining treatment or device on non-religious grounds is

176. *Id.* at 543.

177. *Id.* at 538-39 (citing *In re Dinnerstein*, 380 N.E.2d 134, 137 (Mass. App. Ct. 1978)).

178. *Id.* at 544 (citation omitted).

179. *Id.* at 544-51.

180. *Eichner v. Dillon*, 420 N.E.2d 64 (N.Y. 1981).

181. *Id.* at 70-71. The court of appeals modified the opinion of the lower court by "deleting everything but the authorization to the petitioner to discontinue use of the respirator." *Id.* at 74.

Satz v. Perlmutter.¹⁸² Because of his illness, amyotrophic lateral sclerosis,¹⁸³ Mr. Perlmutter was being kept alive by a respirator.¹⁸⁴ Even on the respirator, Mr. Perlmutter had but a short time to live.¹⁸⁵ The respirator placed in his trachea made him "miserable" and he wanted it removed even though his life expectancy without it was no more than one hour.¹⁸⁶ The court, in reviewing the order of the trial judge which had ordered the respirator removed, relied heavily on *Superintendent of Belchertown State School v. Saikewicz*.¹⁸⁷

The Florida court went on to find that none of the four governmental interests announced in *Saikewicz* were controlling.¹⁸⁸ As to the interest in preserving life the court seemed to place great weight on Mr. Perlmutter's condition being terminal.¹⁸⁹ The protection of third parties as a government purpose was easily brushed aside because no one was dependent on Mr. Perlmutter.¹⁹⁰

The prevention of suicide proved to be more difficult. Nevertheless, the court concluded that

182. 362 So. 2d 160 (Fla. Dist. Ct. App. 1978). The Florida fourth district court of appeals approved the order of a trial judge that allowed a competent but terminally ill adult suffering from amyotrophic lateral sclerosis (Lou Gehrig's disease) to have his caregivers remove the respirator that was keeping him alive.

183. This malady is commonly known as Lou Gehrig's disease.

184. At times, courts refer to these devices as ventilators. For consistency, we will refer to them as "respirators."

185. *Satz*, 362 So. 2d at 161.

186. *Id.*

187. *Id.* The Florida district court of appeal recognized that the pros and cons are exhaustively discussed in [*Saikewicz*] and thus the court adopted "the view of the line of cases discussed in *Saikewicz* which would allow Abe Perlmutter the right to refuse or discontinue treatment based upon 'the constitutional right to privacy . . . an expression of the sanctity of individual free choice and self determination.'" *Id.* at 162 (quoting *Saikewicz*, 370 N.E.2d 417, 426 (Mass. 1977)).

188. The four are 1) interest in preserving life; 2) the need to protect innocent third parties; 3) duty to prevent suicide; and 4) the requirement that it help maintain the ethical integrity of the medical profession. *Saikewicz*, 370 N.E.2d at 425.

189. "In the case at bar the condition is terminal, the patient's situation wretched and the continuation of his life temporary and totally artificial" *Satz*, 362 So. 2d at 162. One is left to wonder what the court would have done had Mr. Perlmutter's condition been "wretched" but not terminal. The court, of course, limited its decision to the facts before it. *Id.* It should be noted that only on the question of preservation of life did the court suggest that it was using strict scrutiny. "We see no compelling state interest." *Id.* at 162.

190. "We point out that Abe Perlmutter is 73, his family adult and all in agreement with his wishes." *Id.*

[i]t is true that [being disconnected from the respirator] appears more drastic [than refusing the initiation of treatment] because affirmatively, a mechanical device must be disconnected, as distinct from mere inaction. Notwithstanding, the principle is the same, for in both instances the hapless, but mentally competent, victim is choosing not to avail himself of one of the expensive marvels of modern medical science.¹⁹¹

On the last issue, the integrity of the medical profession, the court adopted the exact language of *Saikewicz*.¹⁹²

The substantive concluding paragraph of the court's opinion would appear to go far towards providing a justification for suicide.

It is our conclusion, therefore, under the facts before us, that when these several public policy interests are weighed against the rights of Mr. Perlmutter, the latter must and should prevail. Abe Perlmutter should be allowed to make his choice to die with dignity, notwithstanding over a dozen legislative failures in this state to adopt suitable legislation in this field. It is all very convenient to insist on continuing Mr. Perlmutter's life so that there can be no question of foul play, no resulting civil liability and no possible trespass on medical ethics. However, it is quite another matter to do so at the patient's sole expense and against his competent will, thus inflicting never ending physical torture on his body until the inevitable, but artificially suspended, moment of death. Such a course of conduct invades

191. *Id.* at 163. As the court pointed out, with the respirator removed, Mr. Perlmutter would die of natural causes. *Id.* at 162.

192. *Id.* at 163-64.

The last State interest requiring discussion is that of the maintenance of the ethical integrity of the medical profession as well as allowing hospitals the full opportunity to care for people under their control. The force and impact of this interest is lessened by the prevailing medical ethical standards. Prevailing medical ethical practice does not, without exception, demand that all efforts toward life prolongation be made in all circumstances. Rather, as indicated in *Quinlan*, the prevailing ethical practice seems to be to recognize that the dying are more often in need of comfort than treatment. Recognition of the right to refuse necessary treatment in appropriate circumstances is consistent with existing medical mores; such a doctrine does not threaten either the integrity of the medical profession, the proper role of hospitals in caring for such patients or the State's interest in protecting the same. It is not necessary to deny a right of self-determination to a patient in order to recognize the interests of doctors, hospitals, and medical personnel in attendance on the patient. Also, if the doctrines of informed consent and right of privacy have as their foundations the right to bodily integrity, and control of one's own fate, then those rights are superior to the institutional considerations.

Id. (quoting *Saikewicz*, 370 N.E.2d at 426-27) (citations omitted).

the patient's constitutional right of privacy, removes his freedom of choice and invades his right to self-determine.¹⁹³

*Bartling v. Superior Court*¹⁹⁴ is similar in many ways to *Satz v. Perlmutter*. It involved a patient on a respirator, but the patient had "not been diagnosed as terminal."¹⁹⁵ This, of course, differs from Mr. Perlmutter who had been so diagnosed.¹⁹⁶ However, like Mr. Perlmutter, Mr. Bartling "wanted to live but . . . not . . . on the [respirator]."¹⁹⁷ And, like Mr. Perlmutter, he realized that if the respirator were removed he would likely die.¹⁹⁸ After determining that Mr. Bartling was competent,¹⁹⁹ the court weighed his right to refuse medical treatment against the four state interests first set out in detail in *Saikewicz*.²⁰⁰ Of prime importance were the state interests in preserving life and the prevention of suicide. As to the former, the court quoted from the opinion of the Florida court in *Satz v. Perlmutter*.²⁰¹

It is all very convenient to insist on continuing Mr. Perlmutter's life so that there can be no question of foul play, no resulting civil liability and no possible trespass on medical ethics. However, it is quite another matter to do so at the patient's sole expense and against his competent will, thus inflicting never ending physical torture on his body until the inevitable, but artificially suspended, moment of death. Such a course of conduct invades the patient's constitutional right of privacy, removes his freedom of choice and invades his right to self determination.²⁰²

As to suicide, the California court found that "[t]his is not a case, however, where real parties would have brought about Mr. Bartling's death by unnatural means by disconnecting the ventilator. Rather, they would merely have hastened his inevitable death by natural causes."²⁰³

193. *Id.* at 164.

194. 209 Cal. Rptr. 220 (Cal. Ct. App. 1984).

195. *Id.*

196. *Satz*, 362 So. 2d at 161.

197. *Bartling*, 209 Cal. Rptr. at 223.

198. *Id.*

199. *Id.*

200. *Id.* at 224. These are, it will be recalled, the preservation of life, the need to protect innocent third parties, the prevention of suicide, and maintaining the ethics of the medical profession. See *Saikewicz*, 370 N.E.2d at 417 (recognized as the source of these four interests by the California court).

201. 362 So. 2d 160.

202. *Bartling*, 209 Cal. Rptr. at 225 (quoting *Satz*, 362 So.2d at 164).

203. *Id.* at 225.

In *Bouvia v. Superior Court*,²⁰⁴ the California Court of Appeal ruled that a competent patient had the right to refuse the further use of a feeding tube even though she would in all likelihood starve without the nutrition and hydration received by way of the tube.²⁰⁵ During the course of reaching its decision the court came to several conclusions that are helpful to the case we wish to make. First, the court stated that in weighing the right to refuse medical treatment against the state interest in preserving life, the quality of that life was a consideration.²⁰⁶

The court in finding that the patient's wishes regarding the tube did not amount to an attempt to commit suicide, commented that the "desire to terminate one's life is probably the ultimate exercise of one's right to privacy. . . ."²⁰⁷

Although concurring in the court's opinion, Justice Compton would have gone further.

This state and the medical profession instead of frustrating [Bouvia's preference for death over her present circumstances] should be attempting to relieve her suffering by permitting and in fact assisting her to die with ease and dignity. The fact that she is forced to suffer the ordeal of self-starvation to achieve her object is in itself inhumane.

The right to die is an integral part of our right to control our own destinies so long as the rights of others are not affected. That right should, in my opinion, include the ability to enlist assistance from others, including the medical profession, in making death as painless and quick as possible.²⁰⁸

In the time that has passed since Justice Compton's concurring opinion, at least two state courts have gone part way down the path he suggested. In *State v. McAfee*,²⁰⁹ the Georgia Supreme Court found that McAfee was entitled to have the respirator keeping him alive removed.²¹⁰ The court, however, went further and held that "Mr. McAfee's right to be free from pain²¹¹ at the time the [respirator] is disconnected is inseparable from his

204. 225 Cal. Rptr. 297 (Cal. Ct. App. 1986).

205. *Id.* at 300.

206. "[T]he trial court mistakenly attached undue importance to the *amount of time* possibly available to the petitioner, and failed to give equal weight and consideration for the *quality* of that life; an equal, if not more significant consideration." *Id.* at 304.

207. *Id.* at 306.

208. *Id.* at 307 (Compton, J., concurring).

209. 385 S.E.2d 651 (Ga. 1989).

210. *Id.* at 652.

211. "The record shows that Mr. McAfee has attempted to disconnect his

right to refuse medical treatment."²¹² This led to the holding that "[h]is right to have a sedative (a medication that in no way causes or accelerates death) administered before the [respirator] is disconnected is a part of his right to control his medical treatment."²¹³

This humane addition to the right of a person like McAfee to refuse life sustaining treatment has been adopted by the Supreme Court of Nevada in *McKay v. Bergstedt*.²¹⁴

In all cases decided by a district court in favor of the patient, the court's order shall specify that any physician or health care provider who assists the patient in receiving the benefits of his or her decision with minimal pain, shall not be subject to civil or criminal liability. In the latter regard, we agree with the court in *State v. McAfee* that a patient's "right to be free from pain at the time the ventilator [or other life support system] is disconnected is inseparable from his right to refuse medical treatment."²¹⁵

V. THE IMPACT ON SOCIETY

Section IV laid the foundation for the right to commit suicide. Because this issue is not principally a legal question, it is necessary to examine the impact that such decision has on society.

Throughout history, it is clear, both through writing and through judicial opinions, that an individual has the right to control his body. This right includes the right to consent to and to refuse medical treatment,²¹⁶ and to make all relevant decisions concerning his health.²¹⁷ The decision in cases, such as these are decisions that affect only him.²¹⁸ It is well settled since *Cruzan* that one does have the right to refuse medical treatment when he has a condition from which there is no recovery.²¹⁹ For this right to be

[respirator] in the past, but has been unable to do so due to the severe pain he suffers when deprived of oxygen." *Id.*

212. *Id.*

213. *Id.*

214. 801 P.2d 617 (Nev. 1990) (quoting *McAfee*, 385 S.E.2d at 652).

215. *Id.* at 631 (quoting *McAfee*, 385 S.E.2d at 652).

216. *In re Guardianship of Browning*, 568 So. 2d 4 (Fla. 1990).

217. *Id.* at 11.

218. *See In re Gardner*, 534 A.2d 947 (Me. 1987) (decision is a personal one). Opponents would argue that more than just the individual would be affected. Like ripples from a stone dropped in a pond, the relatives would be greatly affected and society, slightly affected. *But see* *Public Health Trust v. Wons*, 541 So. 2d 96 (Fla. 1989); *St. Mary's Hosp. v. Ramsey*, 465 So. 2d 666 (Fla. Dist. Ct. App. 1985) (competent adult allowed to refuse life-saving blood transfusion on religious grounds).

219. *Cruzan v. Director, Mo. Dep't of Health*, 110 S.Ct. 2841, 2851-52 (1990).

meaningful, it now must be recognized that a person has a constitutional right to have total control, including the right to take affirmative action to end his life. If he is faced with a condition from which there can be no recovery, he has a right to refuse treatment. Without more, he may be sentenced, then, to an existence of suffering and pain, a life that only has duration, a life that has no quality or meaning to that individual.²²⁰ Quality of life is as important, if not more so, than length of life.²²¹

Who shall say what the minimum amount of available life must be? Does it matter if it be 15 to 20 years, 15 to 20 months, or 15 to 20 days, if such life has been physically destroyed and its quality, dignity and purpose gone? As in all matters lines must be drawn at some point, somewhere, but that decision must ultimately belong to the one whose life is in issue.²²²

If society does not recognize an individual's right to take affirmative action to end his life when he is suffering from a condition from which there can be no recovery, a condition that is incurable, his right to control his body is hollow, and he is sentenced to a "life" that is inhumane. These are cases that are concerned with morality.²²³

"Society" abhors suicide,²²⁴ it was a crime against society.²²⁵ If suicide were sanctioned, the very fiber of society would crumble and people would take their lives inappropriately.²²⁶ What is morality, then, if society allows an individual with an incurable condition to suffer endlessly, in great pain, and waste away in agony, wishing for death?²²⁷ Courts, in deciding the

220. See *McKay v. Bergstedt*, 801 P.2d 617, 624 (Nev. 1990) ("[W]here prospects for a life of quality are smothered by physical pain and suffering, only the sufferer can determine the value of continuing mortality.").

221. *Bouvia v. Superior Court*, 225 Cal. Rptr. 297, 304 (Cal. Ct. App. 1986); accord *McKay*, 801 P.2d at 623.

222. *Bouvia*, 225 Cal. Rptr. at 305.

223. *In re Quinlan*, 348 A.2d 801, 817 (N.J. Super. Ct. Ch. Div.), cert. granted, 354 A.2d 326 (N.J. 1975), modified and remanded, 355 A.2d 647 (N.J.), cert. denied, 429 U.S. 922 (1976).

224. There is no right to commit suicide. *McKay*, 801 P.2d at 626.

225. See *Brophy v. New England Sinai Hosp., Inc.*, 497 N.E.2d 626, 640 (Mass. 1986) (Nolan, J. dissenting) ("Suicide is direct self-destruction and is intrinsically evil.").

226. Suicide concerns "irrational self-destruction." *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 426 n.11 (Mass. 1977).

227. An example of such is a person in the end stages of AIDS or cancer. Is society more moral for allowing these individuals to suffer, waiting for a release from pain and suffering, or would society be more moral if it allowed such a person to end his own life? As the *Bouvia* court states:

right to die cases most usually discuss the state's interest in preventing suicide²²⁸ and find it not applicable to the facts of the case because either removal of life-prolonging procedures simply allows the disease to take its natural course,²²⁹ the condition was not self-inflicted²³⁰ or the individual wants to live, free of the medical device.²³¹ The state interest in preventing suicide stems from the view that suicide is "irrational self-destruction"²³² and the state "is 'motivated by, . . .' its interest in preserving life."²³³

Such is not the case here. The patient is incurably-ill and is making an informed decision, based on his physical condition. Society's concern is with physical existence, rather than quality of life. Society now focuses on how many days an individual can be maintained on a feeding tube²³⁴ instead of on the supportive services available to help the patient maximize the quality

Who shall say what the minimum amount of available life must be? Does it matter if it be 15 to 20 years, 15 to 20 months, or 15 to 20 days, if such life has been physically destroyed and its quality, dignity and purpose gone? As in all matters lines must be drawn at some point, somewhere, but that decision must ultimately belong to the one whose life is in issue.

Bouvia, 225 Cal. Rptr. at 305.

228. With the exception of the court in *Saikewicz*, the opinions just mention in passing the state interest in suicide without explaining the basis for the interest. See, e.g., *Brophy v. New England Sinai Hosp., Inc.*, 497 N.E.2d 626, 638 (Mass. 1986) ("Prevention of suicide is . . . an inapplicable consideration . . .") (citing *In re Colyer*, 660 P.2d 738, 743 (Wash. 1983)).

229. *In re Gardner*, 534 A.2d 947, 955 (Me. 1987).

230. *Rasmussen v. Fleming*, 741 P.2d 674, 685 (Ariz. 1987) (en banc); *In re Storar*, 420 N.E.2d 64, 71 n.6 (N.Y. 1981).

231. *Satz v. Perlmutter*, 362 So. 2d 160, 162-63 (Fla. Dist. Ct. App. 1978); *McKay v. Bergstedt*, 801 P.2d 617, 627 (Nev. 1990).

232. *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d at 426 n.11 (Mass. 1977).

233. *In re Farrell*, 529 A.2d 404, 411 (N.J. 1987) (quoting *In re Conroy*, 486 A.2d 1209, 1224 (N.J. 1985)). The *McKay* court noted that, for example, for individuals contemplating suicide because they were depressed "our societal regard for the value of an individual's life, as reflected in our Federal and State Constitutions would never countenance an assertion of liberty over life under such circumstances." *McKay*, 801 P.2d at 625.

234. In the *Cruzan* case, there was testimony that Nancy Cruzan could live approximately thirty years being maintained by this feeding tube. *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841, 2845 n.1 (1990).

of his life.²³⁵ Society has forgotten to ask or honor whether the individual wants this kind of life.²³⁶

Preserving life at all costs, that is, using extreme medical resources rather than usual medical treatment, is to turn a blind eye to the fact that death is a natural part of life.²³⁷ Death serves an important role in living. It ends "prolonged suffering . . . [.] the indignities associated with life bereft of self-determination and cognitive activit[ies]" ²³⁸ The patient is robbed of dignity; the family suffers longer, and final memories are of tubes, machines--a physical wasting away, rather than of the patient's true character.²³⁹

An individual has a liberty interest in his body.²⁴⁰ Because this is a liberty interest, his interest is not an absolute one and can be balanced against state interests.²⁴¹ When he has a condition from which there is no recovery, he has only the prospect of a worsening condition, pain, suffering, and ultimately death, then there is no possible state interest that can outweigh his interest in terminating his life when his life no longer has sufficient quality to him.²⁴² As pointed out by the court in *Saikewicz*

The interest in protecting against suicide seems to require little if any discussion. In the case of the competent adult's refusing medical treatment such an act does not necessarily constitute suicide since (1) in refusing treatment the patient may not have the specific intent to die, and (2) even if he did, to the extent that the cause of death was from natural causes the patient did not set the death producing agent in motion with the intent of causing his own death. Furthermore, the underlying State interest in this area lies in the prevention of irrational self-destruction. What we consider here is a competent, rational decision to refuse treatment when death is inevitable and the treatment offers no hope of cure or preservation of life.

235. The *Cruzan* opinion also contained testimony that the state was maintaining Nancy Beth Cruzan at the taxpayers' expense. *Id.* at 2846.

236. "[W]e attach great significance to the quality of Kenneth's life as he perceived it under the particular circumstances that were afflicting him." *McKay*, 801 P.2d at 625.

237. *Id.* at 622.

238. *Id.* at 622-23.

239. *Cruzan*, 110 S. Ct. at 2873 (Brennan, J., Marshall, J., & Blackmun, J., dissenting).

240. *Cruzan*, 110 S. Ct. at 2851 n.7.

241. *Id.* at 2852; *McKay v. Bergstedt*, 801 P.2d 617, 622 (Nev. 1990) (Rights not absolute and subject to balancing of relevant state interests).

242. The quality of life must be viewed from the individual's point of view. *McKay*, 801 P.2d at 624. Factors to consider include the amount of pain the individual is suffering, the physical limitations on the individual, the painfulness or invasiveness of the treatments that the individual must undergo, etc. For a discussion of criteria that could be considered, see *In re Conroy*, 486 A.2d 1209 (N.J. 1985).

There is no connection between the conduct here in issue and any State concern to prevent suicide.²⁴³

The number of people who have incurable conditions but who can be kept alive by extraordinary measures is ever increasing.²⁴⁴ Many times, such measures simply maintain a life without any quality.²⁴⁵ If the right to control one's life is significant, it must include, in conditions where there is no hope for recovery, the right to take affirmative steps to end one's life. "[A]t some point in the life of a competent adult patient, the present or prospective quality of life may be so dismal" that an individual's interest outweighs the state's.²⁴⁶ Where "a life of quality" is obliterated by "pain and suffering," only the individual can decide whether life is worth continued living.²⁴⁷ Nonetheless, the Supreme Court still noted that a state can ignore an individual's quality of life and assert an "unqualified interest" in preserving life that is to be balanced against the individual's interest.²⁴⁸ Yet, where the individual is competent, incurably-ill and dependent on life-prolonging procedures, and suffering physically and mentally, his "right to decide will generally outweigh the State's interest in preserving life."²⁴⁹

Society still views suicide as inappropriate.²⁵⁰ Although active

243. *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 426 n.11 (Mass. 1977) (citations omitted); *accord In re Gardner*, 534 A.2d 947, 955 (Me. 1987) ("[D]ecision to live without artificial life-sustaining procedures would not constitute suicide since the grievous injuries . . . were not self-inflicted.").

244. *McKay*, 801 P.2d at 628.

245. *Id.* at 628 ("[S]uch efforts . . . delay death in a bodily environment essentially bereft of quality").

246. *Id.* at 624.

247. *Id.*

248. *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841, 2853 (1990). Note that the dissent in the Missouri Supreme Court's *Cruzan* opinion found that "[i]t is unrealistic to say that the preservation of life is an absolute, without regard to the quality of life It is appropriate to consider the quality of life in making decisions about the extraordinary medical treatment." *Cruzan v. Harmon*, 760 S.W.2d 408, 429 (Mo. 1988) (en banc) (Blackmar, J., dissenting).

249. *McKay*, 801 P.2d at 624.

250. States would need to enact legislation that decriminalizes aiding and abetting a competent adult's suicide when that competent adult has a condition from which there can be no recovery and the condition has advanced to a point where the individual has determined that the ending of the individual's life is preferable to continued existence. For example, in *Satz*, Mr. Perlmuter had Lou Gehrig's disease and was unable to move. *Satz v. Perlmuter*, 379 So. 2d 160, 360-61 (Fla. Dist. Ct. App. 1978). The issue of aiding and abetting is an important one, but beyond the scope of this Article. That is not to say that an adult may be competent but physically

euthanasia²⁵¹ or aiding and abetting a suicide is considered a crime, it is clearly done. Sometimes society doesn't punish those individuals alleged to have aided or abetted a suicide.²⁵² Yet individuals who are in the best position to help a loved one take the steps necessary to end his suffering are reluctant to do so when it is "legally wrong."²⁵³

An incurably-ill, competent individual has an arguable right to commit suicide. Society and the courts must address this issue.²⁵⁴ Several courts have come to the brink of holding that an incurable patient has the right to commit suicide.²⁵⁵ Society must recognize its obligation to support such a

unable, for example, to put the pills in his mouth. Individuals in situations such as that will need help. Additionally, it needs to become beyond question for a doctor to prescribe the appropriate amount of medication necessary for the individual to take his own life.

251. For the purposes of this Article, the phrase active euthanasia means acting in some way to hasten death such as through the administration of a lethal dosage of drugs.

252. In fact, euthanasia or assisted suicide is not a recent idea. See Herbert Stephen, *Murder From the Best Motives*, 5 LAW Q. REV. 188-89 (1889) (concerning whether a doctor should practice euthanasia); Theodore Sachs, Recent Case, 48 MICH. L. REV. 1199-1201 (1950) (euthanasia or mercy-killing); Nancy Gibbs, *Dr. Death Strikes Again*, TIME, Nov. 4, 1991, at 78 (reporting that a Michigan judge last year decided not to prosecute Dr. Jack Kevorkian because the state has no law against assisted suicide); Jane Meinhart, *Helping Dying Along; Crime or Act of Love?*, ST. PETERSBURG TIMES, Aug. 19, 1991, § A, at 1-2; David J. Rothman, *Let Judges Weigh Patients' Request for 'Assisted Death'*, L.A. DAILY J., May 10, 1991, at 6; *Jury Won't Indict Doctor*, ST. PETERSBURG TIMES, July 27, 1991, § A, at 13. *But see* *People v. Cleaves*, 280 Cal. Rptr. 146 (Cal. Ct. App. 1991) (defendant convicted of second degree murder for assisting AIDS patient's suicide); *Griffith v. State*, 548 So. 2d 244 (Fla. Dist. Ct. App. 1989) *aff'd in part, quashed in part*, 561 So. 2d 528 (Fla. 1990), *on remand*, 571 So. 2d 484 (Fla. Dist. Ct. App. 1990) (convicted of first degree murder for "mercy killing" of daughter in vegetative state); *Gilbert v. State*, 487 So. 2d 1185 (Fla. Dist. Ct. App. 1986) (75 year old man convicted and sentenced to life imprisonment for "mercy killing" his wife).

253. The voters in the state of Washington voted down Initiative 119 that proposed legalization of doctor-assisted suicides. ST. PETERSBURG TIMES, Nov. 7, 1991, § A, at 16. Two legislators in New Hampshire have introduced a bill to allow terminally ill individuals to commit suicide, but not doctor assisted suicide. National Digest, ST. PETERSBURG TIMES, Nov. 13, 1991, § A, at 4.

254. In a survey conducted by the I.C.R. Survey Research Group for Maturity News Service, 51% of those surveyed responded that euthanasia (defined as painlessly putting to death a person with a incurable disease) was a personal choice. Roper Center for Public Op'n Research, U. of Conn. 1990. A suicide initiative has yet to be approved by voters. *See supra* note 253.

255. *See supra* notes 182-215 and accompanying text.

decision rather than to add to the patient's burden. Society must allocate money for dignity and comfort for the dying rather than money for the incurable patient.²⁵⁶ Rather than maintaining a terminally ill patient with a feeding tube, society should use those resources to help that individual die in dignity and comfort. Chronically-ill older people do commit suicide.²⁵⁷

Too many times resources are misdirected.²⁵⁸ It is time for society to look to the best stewardship of the resources and to permit individuals to have control over the quality of their own lives, as well as the quantity of days.

It is also important to realize that recognition of the right to commit suicide when irreversibly ill is not a basis to compel the deaths of those who do not desire to commit suicide, ill or not. Improved medical technology has changed the face of death. "Highly invasive treatment" maintain the rudiments of life by merging "body and machine that some might reasonably regard as a insult to life rather than" continuing it.²⁵⁹

It has also changed the environment in which people die, from at home surrounded by family to "relatively public places, such as hospital or nursing homes."²⁶⁰

256. See Carol Gentry, *More Care, Less Cure Suggested*, ST. PETERSBURG TIMES, Sept. 12, 1991, § B, at 1, 6.

257. Suicide rate for the elderly is increasing, study says. ST. PETERSBURG TIMES, Sept. 16, 1991, § A, at 5. Derek Humphrey's book, *FINAL EXIT* is a best seller. See also Peter Kent, *Final Exit offers solution to individuals, not society*, ATLANTA J., Aug. 19, 1991, § A, at 12. Older people have the highest rate of suicide of any age-based group. *Characteristics of Elderly Suicide*, 2 BROWN U. LONG-TERM CARE LETTER, July 23, 1990, at 7.

258. As a result, people may not be able to be treated unless they have the money to pay a significant deposit. Society needs to place its health care dollars where the most good will be accomplished. The dissent in the Missouri Supreme Court's *Cruzan* decision referred to a case of a judge who required extraordinary treatment which the hospital would not provide without a substantial deposit, and noted that many die for lack of available medical care. *Cruzan v. Harmon*, 760 S.W.2d 408, 429 (Mo. 1988) (en banc) (Blackmar, J., dissenting), *aff'd sub nom. Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841 (1990).

259. *Cruzan*, 110 S. Ct. at 2883 (Stevens, J., dissenting).

260. *Id.* In a footnote, Justice Stevens noted

"Until the latter part of this century, medicine had relatively little treatment to offer the dying and the vast majority of persons died at home rather than in the hospital." Brief for American Medical Association et. al. as *Amici Curiae* 6. "In 1985, 83% of deaths [of] Americans age 65 or over occurred in a hospital or nursing home. Sager, Easterling, et al., *Changes in the Location of Death After Passage of Medicare's Prospective Payment System: A National Study*, 320 New Eng.J.Med. 433, 435 (1989)" *Id.* at 6, n. 2.

Competent adults, who have managed their lives fully and completely, now suddenly find, at the end of their lives, a complete loss of control. Their final days can be a bewildering, dehumanizing mix of machines, tubes and specialists. What benefit is served an individual who is incurably-ill and who has decided that the time has come for him to die? When he no longer desires treatment and it can do more help for others, society needs to turn to other alternatives²⁶¹ to assist him.

But stopping treatment does not mean immediate death.²⁶² In some instances ceasing treatment means a quick death; other diseases dictate lingering and painful illness. Individuals with those diseases must be granted the right to a quick and peaceful death by giving them the right to act affirmatively to end their lives. Society must give the incurably-ill the right to decide to live or to die.²⁶³ In these cases, no state interest could outweigh the individual's. A state's opposition to such act is more symbolic than actual.²⁶⁴

VI. THE DANGERS OF SUICIDE

A variety of arguments can be put forward that permitting suicide is inappropriate. It is important to address a few of the most frequent concerns about the right to commit suicide.

The slippery slope or wedge argument²⁶⁵ is the most often used in

According to the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research:

"Just as recent years have seen alterations in the underlying causes of death, the places where people die change in where very ill patients are treated permits health care professionals to marshall the instruments of scientific medicine more effectively. But people who are dying may well find such a setting alienating and unsupportive." *Deciding to Forego Life-Sustaining Treatment* 17-18 (1983) (footnotes omitted), quoting Thomas, *Dying as Failure*, 447 *Annals Am.Acad.Pol. & Soc.Sci.* 1, 3 (1980).

Cruzan, 110 S. Ct. at 2883 n.11.

261. The court in *McKay* found that the patient should be informed of available support services. *McKay v. Bergstedt*, 801 P.2d 617, 628 (Nev. 1990).

262. *In re Guardianship of Browning*, 568 So. 2d 4, 17 (Fla. 1990) (death would occur 4-9 days after feeding tube's removal).

263. After Initiative 119 was defeated, Claude Pendell committed suicide with a shotgun blast to his head. Mr. Pendell had a variety of health problems, including leukemia and diabetes. His doctor had agreed to help him die if the initiative had passed. *Right To Die Fails; Rancher Kills Self*, AP, ST. PETERSBURG TIMES, Nov. 22, 1991, § A, at 8.

264. *Cruzan*, 110 S. Ct. at 2889 (Stevens, J., dissenting).

265. For a more extensive discussion of this, see JAMES RACHELS, *THE END OF*

opposition to termination of treatment or permitting suicide. Under that argument, society is heading down a "slippery slope" that will lead to selectively-enforced decisions about who lives and who dies based upon an individual's utility to society. Sanctioning suicide will lead society further down the slippery slope than is permitted. By permitting incurable individuals to commit suicide, it is feared society will encourage those who have no utility to society and who are burdens to society to end their lives.

The slippery slope argument fails to take into account that the current social state of affairs is such that the incurably-ill are often left unsupported and unassisted in the very life society wants them to continue.²⁶⁶ A more appropriate response for society is to recognize that the usual course of treatment is more correct for these individuals than an extreme course of treatment. This means that society, for these individuals, should direct its resources and attention toward true supportive care in order that an individual's life quality be maximized rather than denying the right of the individual to end his life when it becomes intolerable.²⁶⁷

Broader social prohibitions against suicide are invoked by the fear that to permit any taking of life is to devalue the human experience and would lead down the slippery slope to selective extermination. Our society currently condones the taking of life only in war, self-defense,²⁶⁸ and legal executions,²⁶⁹ situations which are designed to preserve social integrity and which do not address individual suffering. The inherent vagueness of any language that would permit suicide by the dying would perhaps open the door to abuses society cannot afford to condone at any level.²⁷⁰

The social injunctions against suicide by the terminally ill, however, have not been addressed in light of modern American culture, polyethnicity, and medical practice. It is not clear how the prevention of suffering by permitting suicide by the incurably-ill will be more damaging to the social fabric than permitting wholesale killing in a war, both of which are suspensions of the otherwise rigid prohibition against the intentional taking of life. To the contrary, some commentators argue that addressing the problem of relieving

LIFE 170-80 (1976).

266. See, e.g., *Bouvia v. Superior Court*, 225 Cal. Rptr. 297, 300 (Cal. Ct. App. 1986); *State v. McAfee*, 385 S.E.2d 651 (Ga. 1989).

267. *McAfee*, 385 S.E.2d at 652.

268. See, e.g., RACHELS, *supra* note 265, at 12.

269. *McKay v. Bergstedt*, 801 P.2d 617, 622 (Nev. 1990).

270. Peter Stalinsky, *Euthanasia and The American College of Physicians Ethics Manual*, 112 ANN. INT. MED. 312 (1990). An example of unacceptable abuse would be a doctor euthanizing a patient without the patient's request. See, e.g., Peter Steinfels, *Dutch Study Is Issue In Euthanasia Vote*, N.Y. TIMES, Nov. 2, 1991, § 1, at 11.

human suffering when it is intolerable and incurable by permitting the individual the choice of ending life elevates rather than diminishes the human experience; it focuses directly on the individual's values, pain, and right to determine when he has suffered enough.²⁷¹

A possibility of misdiagnosis is also raised as another reason to prohibit suicide. Misdiagnosis is a concern about the real possibility of factual error on which a decision may ultimately be based. Such concerns are better directed toward drafting appropriate statutory safeguards to insure an individual has complete medical information from which to act rather than being used as a basis to deny a constitutionally-based right. Further, as defined in the context of this Article, the incurably-ill are familiar both with diagnosis and prognosis, so that concerns for misdiagnosis, if not eliminated altogether, are necessarily quite limited.

Moral, political,²⁷² and religious arguments²⁷³ are also used but do not constitute legal arguments. These arguments have a place in the debate and in individual decision-making, but are insufficient grounds to deny this right.

The most persuasive argument against permitting suicide is the possibility that the individual might change his mind,²⁷⁴ which is undeniably true. Once again, our Constitution permits individuals to make irrevocable decisions that they later regret or wanted to change. Statutory safeguards will protect an individual who decides to commit suicide, but the mere prospect that an individual might change his mind is insufficient to deny the right altogether, particularly to those who do not.²⁷⁵

Any discussion about the permissibility of suicide by incurably-ill patients necessarily raises the question of the role of the medical profession in such cases and the impact on the medical profession of permitting suicide

271. Physician assistance in this case advances self-determination and diminishes human suffering. Marcia Angell, *Euthanasia*, 319 NEW ENG. J. MED. 1348 (1989).

272. See Hadley Arkes, et al., '*Always to Care, Never to Kill*', WALL ST. J., Nov. 27, 1991, § A, at 8 (excerpts from a declaration on euthanasia).

273. See *supra* notes 20-24 and accompanying text.

274. *State v. McAfee*, 385 S.E.2d 651, 652 (Ga. 1989); *Bouvia v. Superior Court*, 225 Cal. Rptr. 297, 306 (Cal. Ct. App. 1986). As of December 27, 1990, Elizabeth Bouvia is still alive. She had agreed to accept liquid nourishment. WASH. TIMES, Dec. 27, 1990, § A, at 1.

Mr. McAfee has received special computer equipment and entered a special employment program and was attempting to find a job. According to his mother, he had not changed his mind about ending his life. Duane Riner & Ben Smith III, *Quadriplegic Choosing Not to Pull Plug*, ATLANTA CONST., Jan. 18, 1990, § C, at 1.

275. Note that, in an interview with McAfee's mother, she stated he had not changed his mind. See *supra* note 274.

by the incurably-ill. Recent polls indicate that a majority of the American public supports the right to elect suicide in limited circumstances.²⁷⁶

Public perception is not a valid measure of the rights of any individual, but it must of necessity speak to both the arguments of policy and tradition opposing suicide. It is clear that monolithic and unquestioning opposition to voluntary suicide is rejected by a large proportion of the American public. Debate has begun and will continue with respect to the circumstances, if any, in which voluntary suicide is appropriate and should be permitted. Discussion will necessarily follow about the propriety of physician assistance in voluntary suicide. To what degree the medical profession participates in the discussion will determine the impact of this volatile subject on the medical profession.

It is as impossible to assign a single reaction to the prospect of permitting suicide for the incurably-ill among physicians as it is for any other group. The discussions of euthanasia, assisted suicide, and termination of life-supporting treatment, however, have long been linked in the medical literature.²⁷⁷ A brisk debate has already begun within the medical profession regarding the wisdom, morality, and practical effects of permitting and assisting voluntary suicide by the incurably-ill.²⁷⁸

No single organization represents a majority of American physicians. The American Medical Association, however, has long been considered the primary source of official positions by the profession on a wide variety of subjects. In 1989, the AMA issued a policy statement on euthanasia through the Council on Ethical and Judicial Affairs, which strongly condemned physician assistance in euthanasia, on grounds of public policy, moral values and medical tradition.²⁷⁹ Expounding the position of the American Medical

276. In the days leading up to the Washington state initiative on assisted suicide, the results of a number of independent polls were published. As many as 68% of the American public were reported to support assisted suicide by the terminally ill. Ellen Debenport, *Euthanasia Measure For Terminally Ill Is Defeated*, ST. PETERSBURG TIMES, Nov. 7, 1991, § A, at 16. A Gallup poll showed two-thirds of Americans support the right of a terminally ill patient to commit suicide. A Boston Globe poll showed 71% of Catholics favoring assisted suicide. David Von Drehle, *Suicide Initiative Defeated, Not Dead. Euthanasia Seen As Gaining Acceptance in U.S.*, WASH. POST, Nov. 7, 1991, § A, at 25.

277. Some commentators suggest that there is no moral difference between voluntary suicide and termination of life support. In both instances, the intent is a merciful death and cessation of suffering for the incurably ill patient. Angell, *supra* note 271, at 1350.

278. The New England Journal of Medicine, for example, has regularly received passionate letters, pro and con, following any publication of essays or articles on assisted suicide, termination of treatment and the role of physicians in death and dying. See, e.g., Jo Anne Lynn, *Euthanasia (letters)*, 321 NEW ENG. J. MED. 119-20 (1989).

279. REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS OF THE AMA:

Association, David Orentlicher, the Ethics and Health Policy Counsel, stated that the goal of the medical profession is to sustain life and relieve suffering.²⁸⁰ Physician participation in voluntary suicide, therefore, is wrong because physicians could not ethically choose a course of action, the primary purpose of which is to cause death rather than preserve life. Even discussion of the subject of suicide might convey the impression that the physician approves of suicide and unnecessarily sway patients into accepting this option over others.²⁸¹ Thus, the most conservative position endorsed by the American Medical Association not only would preclude physician participation in voluntary suicide, but any physician discussions of the matter with the patient.

Other objections to physician participation in patient suicide focus on traditional medical obligations outlined in the Hippocratic Oath, which specifically forbids the assistance of physicians in suicide.²⁸² Many commentators raise concerns that physicians who openly discuss assisted suicide with patients will erode public trust in the profession, because of the fear that a healer cannot also assist in procuring death.²⁸³ Less-frequently raised objections are that assisted suicide will have a disproportionate effect on the poor,²⁸⁴ or that it will frustrate medical research because the terminally ill will simply not be visible to stimulate interest and energies in discovering cures.²⁸⁵ These objections are based, again, on arguments of

EUTHANASIA, CHICAGO, ILL. (1989).

280. David Orentlicher, *Physician Participation In Assisted Suicide*, 262 JAMA 1844-45 (1989).

281. *Id.* at 1844.

282. The Hippocratic Oath clearly prohibits physician participation in suicide with its injunction: I will give no deadly medicine to anyone if asked nor suggest any such counsel. It is often assumed that all physicians swear the Hippocratic Oath upon graduation from medical school. In fact, the traditional oath, which also appeals to Apollo and all of the gods, and prohibits cutting for stone and abortion, as well as charging a fee for teaching students the art of medicine, is often abandoned in favor of a more modern version reflective of changed medical procedures and ethics. Alternatively, the Oath of Miamonides is also used for these same reasons. Despite the oath, there has been a practice of physician-assisted suicide. Darrell Amundsen, *Physician Obligation To Prolong Life: A Medical Duty Without Classical Roots*, HASTINGS CENTER REPORT, Aug. 1978, at 23.

283. See Matthew Conolly, *Euthanasia*, 321 NEW ENG. J. MED. 119-20 (1989); Samuel F. Hunter, *Active Euthanasia Violates Fundamental Principles*, 262 JAMA 3074 (1989); *The American College of Physicians Ethics Manual*, 111 ANN. INT. MED. 245-252, 327-35 (1989).

284. Conolly, *supra* note 283, at 119.

285. *Id.*

tradition, basic moral values or public policy, and are insufficient to overcome a constitutional right.

Recently, the willingness of commentators to challenge these objections which underlie traditional objections to suicide in the medical context increased as a result of medical and legal discussions surrounding the right of patients to refuse life prolonging treatment and from increasing public frustration with a perceived loss of control over the process of dying.²⁸⁶ There is a growing perception on the part of patients and physicians alike that the medical profession has strayed from a dedication to patient interests to a position of preserving life per se.²⁸⁷ Some commentators have gone so far as to suggest that the very sterility of modern medical practice is the basis for the increasing discussion of euthanasia. If there were more individualized caring for and relief of suffering, rather than concentration on extending life, the public demand for assistance in dying might diminish.²⁸⁸ Fear of suffering, rather than of death, appears to be a central factor in discussions of assisted suicide.²⁸⁹

Although it is commonly asserted that medical tradition has historically opposed suicide by the terminally ill, this does not appear to be entirely true. It is well established that Greek and Roman physicians, even those who were Hippocratic, often supplied their patients the means to commit suicide, despite the injunction against assistance in suicide embodied in the Hippocratic oath.²⁹⁰ This practice has continued, though not officially recognized, to the present.²⁹¹ Instances of physicians moved by their patients' pleas and

286. See, e.g., Debenport, *supra* note 276, at 16. An opinion poll conducted by the Times Mirror Center for the People and the Press reported a 6-1 majority support for the right of the patient to decide about life-prolonging procedures. Sara Ingram, *Letting Go Of Life*, ST. PETERSBURG TIMES, June 17, 1990, § D, at 4.

287. See Christine K. Cassel & Diane Meier, *Morals and Moralism in the Debate Over Euthanasia and Assisted Suicide*, 323 NEW ENG. J. MED. 750-52 (1990). This same thinking dominated termination of treatment cases for a number of years, until ethical debate forced a reassessment of the interest in preserving life per se. Courts and statutes which regulate termination of life-supporting treatment are beginning to shift from an emphasis on preserving life per se to the a patient-centered focus which allows incorporation of the patient's individual wishes, beliefs and medical condition as the basis for decision-making. See, e.g., Rebecca Morgan & Barbara Harty-Golder, *Constitutional Development of Judicial Criteria In Right-To-Die cases: From Brain Dead to Persistent Vegetative State*, 23 WAKE FOREST L. REV. 721 (1988).

288. *Id.* See also Angell, *supra* note 271, at 1349.

289. Cassel & Meier, *supra* note 287, at 752.

290. Steven Beeson, *Euthanasia and the American College of Physicians Ethics Manual*, (letter) 111 ANN. INT. MED. 952-53 (1989) (quoting S.B. NULAND, DOCTORS: THE BIOGRAPHY OF MEDICINE (Alfred Knopf ed. 1988)).

291. The publication of "It's Over, Debbie" 259 JAMA 272 (1988) provoked a

predicaments to assist them in dying have been regularly reported, and relatively infrequently punished.²⁹² Further, the practice of permitting patients, in concert with their physicians, to choose medical therapy which minimizes pain at the cost of shortening life has long been not only tolerated but encouraged.²⁹³ Finally, recent polls indicate that 60% of physicians favor assistance in dying by the terminally ill, although less than half would feel comfortable assisting a patient in committing suicide.²⁹⁴

The Dutch have the most experience in this forum although they have never legalized assisting suicide of the incurably-ill.²⁹⁵ Even so, assisting suicide is relatively more common than in the United States, and performed under well-defined guidelines.²⁹⁶ The Institute of Medical Ethics set up a "working party" to study the question of "whether and in what circumstances it is ethical to hasten their [incurably-ill patients'] death by administration of narcotic drugs."²⁹⁷ The majority view of that committee determined that

[a] doctor, acting in good conscience, is ethically justified in assisting death if the need to relieve intense and unceasing pain or distress caused by an

firestorm of controversy over the existence and propriety of physician-assisted suicide, but proved that, in fact, physicians continue to assist patients in ending their lives in some instances.

292. See Dennis Brodeur, *Is a Decision to Forego Tube Feeding For Another a Decision to Kill?*, 6 ISSUES IN LAW & MED. 385-94 (1991) (referencing "It's Over, Debbie"); see also *supra* note 252.

293. See Charles Culhane, *Ethicist: Helping Terminally Ill Commit Suicide Can Be Acceptable*, 34 AM. MED. NEWS, Oct. 14, 1991, at 8(1) (noting that the AMA as well as other medical organizations have generally agreed that "all appropriate means" should be used "to relieve a patient's pain, even when death might result."); see also *supra* note 79 and accompanying text.

294. Angell, *supra* note 271, at 1349.

295. See *supra* note 66 and accompanying text.

296. Dutch physicians impose these guidelines for assisted suicide:

- (1) The patient must be competent to make the decision.
- (2) The request for assistance in committing suicide must be voluntary, consistent and repeated over time, and must be well documented.
- (3) The patient must be suffering intolerably with no prospect of relief, though terminal illness is not a prerequisite.
- (4) Two physicians, one of them not connected with the case, must agree to perform the assistance, usually with the injection of curare after sleep induced by barbiturates.

Angell, *supra* note 271, at 1349.

297. *Institute of Medical Ethics Working Party on the Ethics of Prolonging Life and Assisting Death, Assisted Death*, 336 THE LANCET, Sept. 8, 1990, at 610.

incurable illness greatly outweighs the benefit to the patient of further prolonging his life.²⁹⁸

This standard applied when the patient had repeatedly stated his wish to die and would be given greater weight than an opposing position.²⁹⁹ Assisting suicide would be justified only when the doctor had verified that the patient's condition could not be relieved through other medical procedures or social services.³⁰⁰

Initiatives to permit assisting suicide in this country have generally included similar restrictions and safeguards.³⁰¹ In fact, the recent failure of the Washington state initiative has been attributed, in part, to insufficiently-clear restrictions and safeguards to prevent the abuses feared by those opposing the concept of permitting suicide by the terminally ill.³⁰²

It is clear that public discussion of the concept of permitting suicide by the terminally ill will continue for some time to come.³⁰³ The medical profession has historically given lip service in opposition to suicide by patients and assistance in suicide by their physicians, while continuing practices which are quite the contrary. The assertion of patient's rights to commit suicide when incurably-ill must challenge the medical profession to evaluate the basic nature of the physician-patient relationship, the goals of medical practice, the stewardship of medical resources and the role of the physician and patient in relieving suffering.³⁰⁴ The fact that the medical profession in this country

298. *Id.* at 613.

299. *Id.*

300. *Id.*

301. A 1988 initiative in California would have permitted the use of advance directives by incompetent patients to request assistance in suicide. The California initiative and the recent initiative in Washington state limited the right to request assistance in suicide to terminally ill patients with six months to live.

302. Derek Humphry, *Tactical Errors Defeated Proposed Suicide Law*, *NEWSDAY*, Nov. 13, 1991, at 99.

303. Public opinion seems to be moving toward accepting suicide in certain cases. Culhane, *supra* note 293, at 8(1). An aid-in-dying plan is under consideration for introduction in Florida. DEBENPORT, *supra* note 286. The General Synod of the United Church of Christ passed a resolution affirming individual freedom and responsibility to make a choice on euthanasia and suicide. The Methodist Church governing body will take up the appropriateness of suicide in limited circumstances in May, 1992. Peter Steinfels, *At Crossroads, U.S. Ponders Ethics of Helping Others Die*, *N.Y. TIMES*, Oct. 28, 1991, at A1, A15.

304. See Angell, *supra* note 271; Beeson, *supra* note 290; Cassel & Meier, *supra* note 287; David Schiedermayer, et al., *Euthanasia*, 321 *NEW ENG. J. MED.* 120 (1989). The latter authors raise the possibility that, if assisted suicide is appropriate and necessary, it may be better to designate a profession other than medicine to act to

controls access to humane methods of suicide means that physicians must be involved in the discussion of the issue and shaping of public understanding and response. Permitting the incurably-ill to choose death need not be a repudiation of either medical or social values. Participation by the medical profession in the assistance of suicide need not be required.³⁰⁵ Physicians, however, at the very least, will have to become involved in frank discussions of medical care, expectations of cure and palliation, and of management of pain and suffering whether the right of patients to commit suicide when terminally ill becomes formally recognized or remains tacitly acknowledged as it is at present.

VII. CONCLUSION

Choices about life, including decisions about death "touch the core of liberty."³⁰⁶ When an individual has an incurable condition and his quality of life has deteriorated, there must be the choice for him to affirmatively act to end his life according to personal morals, religious beliefs and conditions. The act of suicide is generally not illegal. Society, however, views it as impermissible. This is, therefore, not an issue for resolution by the courts. It is an issue for resolution by society. The obligation is on the religious community, and the ethicists, the fabric of society, the institutions which can convince or influence an individual's moral choice to see that true supportive care is provided to him.

The issue of suicide is one that has plagued the human race for centuries. It is time for the debate to continue: "[T]he merciful extinction of life, is morally permissible and indeed mandatory where it is performed upon a dying patient with his consent and is the only way of relieving his suffering."³⁰⁷

assist a patient in committing suicide.

305. See *supra* note 304.

306. *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841, 2885 (1990) (Stevens, J., dissenting).

307. WILLIAMS, *supra* note 14, at 311.