The Ethics and Legality of Euthanasia and Physician Assisted Suicide

Julia Amanda Jackson

University of Tennessee - Knoxville

Follow this and additional works at: https://trace.tennessee.edu/utk_chanhonoproj

Recommended Citation
https://trace.tennessee.edu/utk_chanhonoproj/658
The Ethics and Legality of Euthanasia and Physician Assisted Suicide

A Senior Project by
Julia A. Jackson
5/10/2003
Mentor: Dr. Glenn Graber
The Ethics and Legality of Euthanasia/Physician Assisted Suicide

This senior project is a study of the ethics and legality of euthanasia and physician assisted suicide. It begins with a definition of these terms and then traces the changing perspectives on death and suicide in human societies. It outlines the gradual development of a “right to die” in American law and the court cases that played a significant role in shaping and limiting this right. Since the United States Supreme Court did not find state statutes banning physician assisted suicide unconstitutional, there follows an analysis of the states’ laws on the issue and a detailed analysis of the statistics from Oregon, the only state that currently allows physician assisted suicide. Ethical arguments for and against the legalization of physician assisted suicide are presented and weighed. Finally, the current state of affairs and the use of living wills are considered, as well as possible future legal developments.
The Ethics and Legality of Euthanasia/Physician Assisted Suicide (PAS)

I. Introduction
   A. Why Euthanasia and PAS are important issues
   B. Definitions of euthanasia and assisted suicide

II. Perspectives on Death
   A. Formerly seen as a metaphysical event
   B. Current brain-death standards

III. Perspectives on Suicide
   A. Ancient Greeks and Romans
   B. Christian views
      1. Bible
      2. St. Augustine
      3. Thomas Aquinas
   C. Philosophers
      1. Hume
      2. Kant
      3. Hobbes
      4. J.S. Mill

IV. The Development of American Law
   A. Natural Law
      1. Ancient Greeks - Antigone
      2. John Locke tied natural laws to man’s natural rights
      3. Declaration of Independence and the Bill of Rights grant “inalienable rights”
   B. Development of Right of Privacy
      1. based in “liberty” of Due Process Clause of 5 and 14 Amendments
      2. Griswold v. Connecticut
      3. Roe v. Wade

V. Important Court Decisions
   A. Quinlan (N.J. 1976)
      1. right to privacy expanded to “letting die”
   B. Bouvia v. Superior Court (Cal. 1986)
      1. privacy right extended to refusal of nutritional sustenance
   C. Cruzan v. Missouri Health Dept (Supreme Court 1990)
      1. recognized the Constitutional right of competent patients to refuse treatment
      2. Court decided withdrawal of feeding tubes is not legally different from removal of other kinds of sustaining devices
      3. states are allowed to pass statutes requiring clear and convincing evidence before termination of incompetent patients’ medical support
   D. Washington v. Glucksberg (Supreme Court 1997)
      1. based on the Due Process Clause of the 14th Amendment
      2. Court decided assisted suicide is not a fundamental liberty
      3. Washington statute banning PAS is Constitutional
   E. Vacco v. Quill (Supreme Court 1997)
      1. based on the Equal Protection Clause of the 14th Amendment
      2. Court drew distinctions between removing support and actively killing
      3. New York statute banning PAS is Constitutional
VI. States’ Laws on Assisted Suicide
   A. Supreme Court left laws up to the states’ discretion
   B. State by State Analysis

VII. The Oregon Experiment
   A. History of the Death with Dignity Act
   B. Legal challenges from within the state – *Lee v. State of Oregon*
   C. Statistics on how many people have utilized PAS
   D. Challenges from the state legislature
   E. Challenges from Congress
   F. Challenges from the Executive Branch
      1. Ashcroft’s Directive to the DEA to prosecute physicians that assist suicides
      2. Permanent injunction issued against him in US district court

VIII. Arguments Against the Legalization of PAS
   A. the traditional view of physicians as “healers” - AMA
   B. Unacceptable reasons that may lead a patient to PAS
      1. Elizabeth Bouvia – depression
      2. Larry McAfee – loss of independence due to lack of finances
   C. the slippery slope argument
      1. Nazi Germany
      2. the Netherlands
   D. Jack Kevorkian
   E. Double effect is allowed by the states

IX. Arguments For the Legalization of PAS
   A. As technology increases, so must our definition of “healing”
      1. suicide is often unsuccessful
      2. Analysis of the Hippocratic Oath
      3. while the AMA opposes PAS the Student AMA is in favor of
   B. Acceptable reasons that may lead a patient to PAS
      1. Suicide note from the Nobel Prize Winning physicist
   C. Arguments against the “slippery slope”
   D. Opinion Surveys
      1. public majority supports PAS when the word “suicide” is not used
      2. physicians are divided

X. The Current Situation
   A. Advance Initiatives
   B. Tennessee

XI. Conclusion
   A. The future of PAS in the Supreme Court
      1. if an “as applied” case is presented instead of a facial claim
   B. What a physician must consider
      1. Dr. Quill’s article
      2. physicians are left to deal with the issue
Introduction to Physician Assisted Suicide and Euthanasia

With the many advances made in medical technology during the past decades, physicians and patients are increasingly faced with life-altering decisions that would have been inconceivable only thirty years ago. With the development of life-prolonging devices such as ventilators and feeding tubes and treatments for infectious disease, people are more likely to suffer for an extended time before finally succumbing to a degenerative disease. A century ago, most people died in the comfort of home surrounded by family members, but today more than eighty percent of Americans die in hospitals.¹ This departure from deaths that were quickly and naturally resolved has introduced several issues into modern society including whether a suffering patient’s wish to die should be respected. If so, does that patient have the right to request help from others, perhaps even his physician? If the patient is unconscious, does his family have the right to determine whether or not he would want to die?

Two issues that have been widely debated in medical ethics in recent years are physician assisted suicide and euthanasia. While “euthanasia” has a negative connotation today, it originally comes from the Greek language for “good” or “merciful” death.² The term euthanasia is most often used to refer to what is known more specifically as active euthanasia. Active euthanasia is when a third party such as a physician or a family member commits the final act that results in a person’s death. For example, the third party gives a patient a lethal injection and/or places a plastic bag over a patient’s face to cause suffocation. Passive euthanasia describes instances in which death results from the underlying disease after the withdrawal of life-sustaining treatment or equipment.

Somewhere between active and passive euthanasia is physician assisted suicide. In this instance, it is the dying patient who performs the final death-inducing act such as swallowing an overdose of pills that have been prescribed by a physician or pushing a switch to trigger a fatal injection after the physician has inserted an intravenous needle.

**Perspectives on Death**

Physician assisted suicide and euthanasia generally tend to generate great controversy and powerful emotions within society. This is because they result in a person's death – an irreversible event that has been significant to societies throughout history regardless of culture or religion. For thousands of years, death was viewed as a metaphysical event that was the counterpart of birth and marked the departure of one's soul. While many people with religious beliefs still believe that a metaphysical event occurs at death, this cannot be scientifically proven. Instead, medical advances have moved the emphasis to the study of the physical events accompanying death.

The first physical factors that were recognized as contributors to death were the cessation of a person's breathing and heartbeat, which naturally occur within a couple of minutes of one another. However, with the invention of ventilators that are able to artificially maintain a person's breathing, a person whose brain is impaired and cannot breathe or survive on his own is able to live for an extended period of time. In such cases, a person is usually said to be dead when he is found to be brain dead. Brain death can be measured by different standards, which include among other factors loss of reflexes and bodily movement and flat electroencephalogram readings. It is loss of

---

3 Gregory E. Pence, 43.
function in the brain stem that leads to the inability to breathe. Difficult decisions arise when patients who are not completely brain dead survive for months or even years on breathing machines in a comatose state. While recovery after being comatose for one year or more is extremely rare, it is the accounts of those rare instances of recovery that make it difficult for family members to let go of hope.

**Perspectives on Suicide**

Many people feel that the greatest mercy family members can show to long-term comatose patients with little to no chance of recovery is to just let them go. What about terminally ill patients who consciously decide they are ready to let go of life? Even when a person's reason for wanting to end his or her life is as justifiable as a desire to end terrible pain and suffering and to hasten an inevitable end, suicide and attempted suicide, while not criminalized in any of the fifty states, are generally condemned by our society.

Many philosophers and theologians have debated the morality of "suicide" — a term that only recently developed in our language around 1662. However, evidence of self-killing can be found among the earliest known literature. One of the most famous philosophers, Socrates of ancient Greece, was condemned to death or exile by the Athenian government for his beliefs. He chose to self-administer a lethal dose of hemlock. Self-administering a poison while surrounded by family and friends was seen as a dignified form of execution for Greek citizens. The ancients Greeks' writings often portray Socrates' and others' acts of self-killing as heroic. Similarly, the ancient Romans

---

did not condemn self-killing. The emperor Marcus Aurelius praised suicide as being more courageous than a degrading life of pain.\(^5\)

With the growth of Christianity, many theologians denounced suicide as a sin. However, the Bible does not explicitly forbid suicide. Many conservative Christians believe that disapproval of suicide is implied in the Commandment “Thou shalt not kill.” And some read 1 Corinthians 3:17 which says, “If anyone defiles the temple of God, God will destroy him. For the temple of God is holy, which temple you are”\(^6\) to mean that the temple of God implies one’s body, created for God’s glory and not to be destroyed by anyone but Him. Critics of these arguments may point out the many instances of “just” killing and war in the Bible. Also, several of God’s chosen leaders such as Moses, Jonah, and Elijah asked God for death during trying times. Even Paul who is revered for playing a momentous role in shaping the early Christian church contemplated whether it is better to live or die. In Philippians 1:20-26, Paul questions whether he will continue to live in order to labor for God or die to be with Christ.

The Christian church did not officially denounce suicide until around the fourth century when St. Augustine argued that self-killing constituted self-murder. He expanded Plato’s belief that man is the property of God and said that except in cases of martyrdom where self-killing is to avoid an act of sin, self-killing is a wicked act.\(^7\) Thomas Aquinas further condemned acts of suicide in the thirteenth century by arguing that it violates natural law. He saw that all living creatures have a natural desire to preserve themselves and any act to destroy life is unnatural and therefore wrong.

---
\(^5\) Gregory E. Pence, 57.
\(^6\) New King James Version.
\(^7\) Raymond Whiting, 103.
Philosophers of the eighteenth century had opposing views on suicide. David Hume argued against St. Augustine's and Aquinas' immoral views of suicide by saying one person's death will not cause significant damage to society or the overall workings of the world. He found it presumptuous to believe that one human life could disrupt the course of nature. Immanuel Kant disagreed with this argument and claimed that suicide is immoral in that it treats oneself as a mere means to some end rather than the end itself. However, for this rationale to be valid in a case of a person's voluntary choice of suicide, human life must be regarded as an absolute value. Kant claimed a person would not be treating himself as an end if he were to destroy his rational autonomy.

Thomas Hobbes would have opposed suicide based on his belief that it is contrary to human nature to want to end one's life and therefore irrational. Hobbes had a very dark view of human nature and saw government as necessary to serve as a "mortal god" to maintain stability. This theory would allow government to prohibit suicide in order to protect society from itself. John Stuart Mill, the great British philosopher of the nineteenth century, developed an opposing theory based on individual liberty, which included the belief that each individual is guardian over his own body, and human nature allows a rational desire to end one's life. In On Liberty, Mill argued that government and the majority of society have no right to interfere with the liberty of any human being as long as he is doing no harm to others. Any conduct that concerns only that one person is protected as an absolute right. Mill's principles still affect American court decisions and popular thought today.

---

The Development of American Law

Many of these philosophers made reference to an overlying "natural law" that determines the morality of acts. It is this concept of natural law that shaped early American political thought. The theory of natural law can be traced back as far as the ancient Greeks. In Sophocles' *Antigone*, Antigone disobeys Creon's command that her brother be left unburied on the authority of an "unwritten and unshakable" law of the gods.\(^{10}\) It is from this belief that natural law guides the workings of the universe that the American theory of rights came. John Locke tied the theory of natural law to natural rights possessed by individuals, which need to be protected by government. Locke's influence can be found in the Declaration of Independence where Thomas Jefferson states, "that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty, and the pursuit of Happiness."

With the addition of the Bill of Rights to the Constitution, it is clear that the United States was founded with great reverence given to the protection of individuals' rights. As the country has developed, Americans' rights have been further defined and protected by the addition of amendments as well as rulings of the courts. In questioning the existence of rights not explicitly enumerated in the Constitution, the Supreme Court has given great deference to precedent and has expanded rights in an incremental fashion.

One right that has often been cited since the mid-1970's to refuse medical treatment is the right of privacy. While Supreme Court Justice Brandeis referred to "the right to be let alone" in *Olmstead v. Unites States* in 1928, the right of privacy did not fully develop until the growth of libertarianism in the late 1960's with the growing belief

\(^{10}\) Raymond Whiting, 72.
that individual freedom is the highest good and law should be interpreted to maximize this. As people began to question traditional morality and the right of the government to interfere in individuals’ private lives, the Court’s decisions began to reflect this change. The Supreme Court “discovered” the right of privacy in the guarantee of “liberty” found in the Due Process Clauses of the Fifth and Fourteenth Amendments. In 1965 in *Griswold v. Connecticut*, the Supreme Court struck down Connecticut’s statute prohibiting the use of contraceptives. In 1973, the Supreme Court made a highly controversial ruling in *Roe v. Wade* when it struck down a Texas statute criminalizing most abortions. The Court relied on a woman’s right of privacy to have control of her body until the fetus reaches the point of viability outside the womb. This expansion of the right of privacy has furthered the natural rights concept of an individual’s “self ownership” and opened the door to question the legality of a patient’s right to die. Before the establishment of a right to privacy, right to die claims and the notion of informed consent in medical care were based on the old English common law tradition that prohibited unwanted touching, seen as a form of battery.

**Important Court Decisions**

Within the past thirty years, state courts and the Supreme Court have made several rulings that have concretely established patients’ rights and also set limits on these rights. Because of the many developments in medical technology and the increasing tendency for people to suffer for prolonged periods of time from degenerative disease before dying, society’s definition of compassion must be reevaluated. As society

---

adjusts its views of traditional compassionate care and the morality of withholding care, it is up to the courts to ensure that legal rights evolve accordingly.

One of the first cases to shape patients’ right to die was that of Karen Quinlan. Karen was a healthy 21-year-old New Jersey woman. In April 1975 she was taken to the hospital after ingesting large quantities of drugs and alcohol. Karen was comatose and required a respirator for breathing. After many months of remaining in a “persistent vegetative state,” Karen’s doctors at St. Clare’s Hospital gave her only a one in a million chance of recovery, and her family accepted that she would never regain consciousness. Karen’s family felt she had already “died” and would have never wanted her body to continue in its vegetative condition. After consulting with their priest who assured them that “extraordinary means” such as a respirator were not required of Catholics, Karen’s family asked that her respirator be disconnected. However, her doctors refused because they feared it would be unethical and they could be charged with malpractice or even murder.\footnote{Howard Ball, \textit{The Supreme Court in the Intimate Lives of Americans} (New York: New York University Press, 2002) 172.}

Karen’s father took the issue to court. It was first heard in a New Jersey probate court where Judge Muir ruled in November 1975 that the respirator should not be disconnected. The New Jersey Supreme Court unanimously overturned this decision in January 1976 on “right to die” grounds. The court found this right in common law and the Supreme Court’s rulings in \textit{Griswold v. Connecticut} and \textit{Roe v. Wade}. The Court found the Constitution implied a right to privacy broad enough to permit the family of a comatose patient to let the patient die by disconnecting support. The Court stated that “an individual’s right to privacy grows as the degree of bodily invasion increases and the
prognosis dims,” and it can eventually override the State interest of preserving life.\textsuperscript{13} The New Jersey Supreme Court was the first to apply the right of privacy to a “letting die” case.

Karen was weaned from her respirator and lived for nine more years. Her parents never asked for permission to disconnect her nasogastric feeding tube. The question of whether a terminally ill patient has the right to refuse food and water delivered through a nasogastric tube was raised in the case of Elizabeth Bouvia. In September 1983, Elizabeth was admitted to Riverside General Hospital in California where she was diagnosed as suicidal after she asked to be left alone by everyone so she could starve to death.\textsuperscript{14} Elizabeth was almost totally paralyzed from cerebral palsy, with only slight control of one hand and facial muscles, and she also suffered from very painful degenerative arthritis.

Elizabeth's doctors refused to let her starve and force-fed her with feeding tubes. Many advocates for the disabled became involved in her case claiming that letting her die would depress other disabled persons. Elizabeth moved to several different hospitals, none of which honored her request to die. Elizabeth lost her case in probate and appeals courts on the grounds that the right to privacy did not apply to suicide by starvation. In 1985, Elizabeth began voluntarily eating again, but the hospital she was in reinstated her feeding tube because doctors found her weight to be low enough to constitute starvation.

Elizabeth again appealed to the courts to be allowed to starve, and the California Supreme Court heard her case in 1986. In Bouvia v. Superior Court, the court ruled in Elizabeth’s favor and found that the right to privacy included the right to terminate one’s

\textsuperscript{13} In re Quinlan, 70 New Jersey 10, 355 A. 2d. 647 (N.J. 1976).

\textsuperscript{14} Gregory E. Pence, 63.
life. The court dismissed the argument that Elizabeth could probably live for many more years and chose to emphasize the quality of life instead of the length of life.\textsuperscript{15} This case was the first clear declaration that competent adults have a constitutional right to refuse medical treatment for the purpose of death. It also expanded the right to privacy to refusal of treatment in the form of nutritional sustenance.

The first time the United States Supreme Court dealt with the issue of right to die was in the 1990 case \textit{Cruzan v. Missouri Health Department}. This case dealt with Nancy Cruzan, then age 24, who was in a car wreck January 11, 1983. Due to a lack of oxygen for approximately fifteen minutes, Nancy entered a persistent vegetative state. She remained so for the next seven years by receiving sustenance from a feeding tube until her parents asked hospital employees to terminate the artificial nutrition. The hospital refused unless the Cruzans could receive approval from a Missouri trial court. The Missouri court granted approval based on testimony from Nancy’s housemate who said Nancy once expressed that she would never want to live life if she could not live at least halfway normally.

The Missouri Supreme Court reversed this ruling. It rejected that a right to refuse medical treatment in all circumstances could be found in the Constitution and instead emphasized the state interest in preserving life embodied in the Missouri Living Will statute. The Missouri Supreme Court said that to withdraw support “clear and convincing” evidence of the patient’s wishes must be provided. The Court did not find the testimony of Nancy’s roommate to be adequate.

\textsuperscript{15} \textit{Bouvia v. Superior Court}, 179 Cal.App. 3d 1127, 225 Cal.Rptr. 297 (Cal.App. 2 Dist. 1986).
The United States Supreme Court heard the case and made a controversial 5-4 ruling that upheld the decision of the Missouri Supreme Court. Chief Justice Rehnquist ruled that competent patients have a right under the liberty interest of the Fourteenth Amendment to refuse treatment. He based this right on common law, which prohibited unwanted touching and guaranteed informed consent, as well as relevant state cases and prior Supreme Court rulings. The *Cruzan* ruling did not differentiate the withdrawal of feeding tubes from the removal of other kinds of life-sustaining devices such as respirators. However, since Nancy Cruzan was incompetent and unable to exercise any right to refuse treatment, the question the Court had to consider was whether Missouri's requirement of clear and convincing evidence was Constitutional.

In *Cruzan v Missouri Health Department*, the Court examined this question by balancing the patient's liberty interests against the interests of the state. The Court found Missouri could assert an unqualified interest in the preservation of human life without having to assess the "quality" of life. The Court also found that Missouri's required standard of proof was no higher that that of many civil cases in which much less is at stake. By requiring a stringent burden of proof, the Court felt Missouri was putting any possible error on the side of life with possible error being no more injurious than the maintenance of the status quo. Therefore the Court ruled that a state can, but need not, apply a clear and convincing evidence standard to discontinue nutrition of an incompetent patient.

---

In this case, the Court did not extend the right of privacy to an unfettered right to die but left it up to the states to serve as the surrogate decision makers for incompetent patients rather than the family.\(^\text{17}\) In his concurrence, Justice Scalia emphasized that neither the Constitution nor the Justices can determine when a life is "worthless" and when sustaining it would be considered "inappropriate."\(^\text{18}\)

The four more liberal Justices dissented. Justices Brennan, Marshall, Blackmun, and Stevens argued that family members are more competent to make life-and-death decisions and uphold a patient's choice to die with dignity than the state, which is concerned only with an abstract preservation of human life. Five months after the decision, Nancy's feeding tube was removed upon additional testimony from friends that fulfilled the "clear and convincing evidence" requirement.

The next time the Supreme Court was to decide a right to die issue was in 1997 in *Washington v. Glucksberg* and *Vacco v. Quill*. The *Washington v. Glucksberg* case began in January 1994 when a lawsuit was filed in Federal District Court in Seattle, Washington by three dying patients, four doctors and the group Compassion in Dying in order to challenge Washington's law banning assisted suicide. The District Court ruled that the ban on assisted suicide was unconstitutional based on the liberty interest found in the Due Process Clause of the Fourteenth Amendment and the Equal Protection Clause of the Fourteenth Amendment. In March 1996 a three-judge panel of the US Court of Appeals for the Ninth Circuit reversed this ruling saying that the federal judiciary does not have the right to establish a constitutional right to physician assisted suicide. In

\(^{17}\) Howard Ball, 179.
\(^{18}\) *Cruzan v. Missouri Health Department*, Scalia, A., concurring.
March 1996 an eleven-judge panel of the same court heard the appeal, reversed the decision and affirmed the original decision made by the District Court.

The Supreme Court ruled on this case June 26, 1997 and unanimously found Washington's law banning assistance in suicide was not unconstitutional. Before investigating the claim that the Washington law was in violation of the Due Process Clause, the Court examined the history and legal traditions of the Nation in dealing with suicide. Chief Justice Rehnquist, writing the opinion of the Court, pointed out that "for over 700 years, the Anglo American common law tradition has punished or otherwise disapproved of both suicide and assisting suicide". Rehnquist emphasized that the majority of states have deeply rooted laws banning assisted suicide, and while many states have recently reexamined them due to changing societal attitudes, the majority of states have reaffirmed these bans. Washington voters rejected a ballot initiative in 1991 that would have legalized a form of physician-assisted suicide.

The Court then looked directly at the Due Process claim. The Court stressed that when making substantive due process rulings (expanding the protections afforded by "liberty" of the Due Process Clause of the Fourteenth Amendment to areas such as marriage and abortion), protections may only be extended to rights and liberties so fundamental that "neither liberty nor justice would exist if they were sacrificed." While the Court granted it had assumed in the Cruzan case that the Due Process Clause protects the traditional right to refuse unwanted medical treatment, it decided that based on the Nation's history of not allowing assisted suicide, the "right to commit suicide with another's assistance" is not fundamental.

---

The Court then evaluated Washington's state interests, which included the preservation of human life, protection of depressed and suffering persons, protection of the medical profession's ethics, protection of vulnerable people who may be abused to reduce health care costs, the belief that every person's life is of the same value, and avoidance of a path towards involuntary euthanasia. The Court found these interests to be legitimate and the state ban on assisted suicide to be reasonably related to promoting these interests. Rehnquist's ruling held that the Washington law did not violate the Due Process Clause on its face as applied to competent, terminally ill adults who wish to hasten their deaths with drugs prescribed by their physicians.

Vacca v. Quill began in December 1994 when a US District Court upheld a New York state law banning assisted suicide after three New York physicians including Timothy Quill challenged it. In April 1996, the Second US Circuit Court of Appeals reversed and struck down the New York law on the basis that it violated the Equal Protection Clause of the Fourteenth Amendment. The court issued a stay order pending an appeal to the Supreme Court by New York's attorney general Dennis C. Vacco.

The Supreme Court issued a concise ruling for Vacca v. Quill on the same day as its Washington ruling. Quill and the other physicians claimed that New York's law against assisting suicide violated the Equal Protection Clause of the Fourteenth Amendment because patients in the final stages of terminal illness are able to hasten their deaths by directing the removal of life sustaining equipment, but patients who are in similar situations but lacking life sustaining equipment are not able to hasten their deaths by self administering prescribed drugs. Quill claimed that dying patients not being

sustained by medical equipment such as ventilators or feeding tubes were therefore discriminated against.

While the Second Circuit Court of Appeals had found that the ending of life by withdrawing life sustaining equipment was no more and no less than assisted suicide, the Supreme Court disagreed and reversed the ruling. Chief Justice Rehnquist delivered the opinion of the Court and began with an analysis of the Equal Protection Clause. Citing San Antonio Independent School Dist. v. Rodriguez, he emphasized that the Equal Protection Clause does not create substantive rights and only requires that states must treat "like cases alike but may treat unlike cases accordingly." The Court found a rational difference between turning off life-sustaining machines where the underlying disease leads to death and physician-assisted suicide where the lethal medication is the direct cause of death. Because of the difference between these situations, the Equal Protection Clause is not violated. Discrimination does not occur because every patient can refuse medical treatment while no patient can receive physician-assisted suicide.

The Court pointed out that most of the states have drawn a line between the withdrawal of life sustaining devices and physician assisted suicide. Rehnquist said this coincides with the Court's Cruzan ruling, which provided no support for the notion that refusing life sustaining medical treatment is "nothing more nor less than suicide." The right to refuse treatment is based on a right to freedom from unwanted touching and does not create a "right to hasten death" as the Appeals Court had asserted. Because the distinction between refusing treatment and assisted suicide was found to be neither arbitrary nor irrational, and the state of New York had several rational reasons similar to

\[22\] Vacco v. Quill.
those of Washington for its law opposing physician assisted suicide, New York’s law banning assisted suicide was not found unconstitutional.

States’ Laws on Assisted Suicide

The Supreme Court’s rulings in Washington v. Glucksberg and Vacco v. Quill undeniably leave decisions regarding physician assisted suicide to the states to decide. While the Court found state laws prohibiting assisted suicide Constitutional, it did not require that the states pass such laws. In her concurring Cruzan opinion, Justice O’Connor referred to the “laboratory of the States” as the appropriate place for liberty interests to be regulated and protected.²³ It seems that the Supreme Court wants the issue of physician assisted suicide to be solved legislatively within the states.

Currently, the majority of states do not allow assisted suicide. Thirty-six states have statutes explicitly criminalizing assisted suicide. Eight states criminalize assisted suicide through common law. Three states have abolished common law crimes and do not have statues criminalizing assisted suicide. Ohio’s supreme court ruled in 1996 that assisted suicide is not a crime. Virginia does not have a statute criminalizing the act but has a statute that imposes civil sanctions on a person who assists a suicide. Oregon is the only state that permits physician assisted suicide.

Several states have attempted to legalize physician assisted suicide with little success. “Aid in dying” voter initiatives, which would have permitted euthanasia and assisted suicide, failed in Washington in 1991 and California in 1992. An initiative in Michigan failed in 1998, as well as the “Maine Death with Dignity Act.” The only state

²³ Cruzan v. Missouri Health Department, O’Conner, S., concurring.
to successfully pass a voter initiative legalizing physician assisted suicide was Oregon with the passage of Measure 16, the “Oregon Death with Dignity Act” in 1994.

The Oregon Experiment

In 1994, Oregon voters passed Measure 16 by a narrow 51 percent vote to establish the nation’s first law legalizing physician assisted suicide. The Death With Dignity Act allows a “humane and dignified death” for adults who are able to self-administer a lethal drug prescription.²⁴ To be eligible, one must be a resident of Oregon, must have been determined by an attending physician as well as a consulting physician to be suffering from a terminal disease that will most likely produce death within six months, must have voluntarily expressed a wish to die, and made a written request to receive a lethal prescription. The Act includes safeguards such as requiring that two persons who are not related to or stand to gain anything from the patient witness the written request. The attending and consulting physicians must adhere to strict guidelines. The Act states that at least fifteen days must elapse between the patient’s first oral request for lethal medication and the writing of a prescription. At least 48 hours must pass between the official written request and the prescription. This is to ensure that life-ending decisions are well thought out and not hasty acts of desperation.

The Oregon Death With Dignity Act was soon challenged in federal district court in Lee v. State of Oregon in August 1995. Judge Hogan ruled that the law violated the Equal Protection Clause of the Fourteenth Amendment and enjoined its enforcement.²⁵ Due to Measure 16, terminally ill citizens are not under the protection of Oregon laws

that involuntarily commit persons considering suicide to receive psychiatric evaluation and counseling. Judge Hogan did not find sufficient enough safeguards to protect incompetent adults from irrationally ending their lives with physician assistance. Furthermore, he opined that there was no legitimate state interest underlying Measure 16 to justify the disparate treatment of the terminally ill because only two to four percent of these persons actually commit suicide.

A three-judge panel of the Court of Appeals for the Ninth Circuit ruled on this case in February 1997. This court vacated Hogan’s injunction on the grounds that the case was nonjusticiable. The Court found that the plaintiffs in Lee v. State of Oregon had originally lacked standing because their complaint was hypothetical and did not demonstrate an actual invasion of a right, which is necessary for standing in any case. The Supreme Court declined an appeal to review the case and the Oregon Death With Dignity Act officially went into effect on October 27, 1997.

The first physician assisted death in Oregon occurred on March 24, 1998 when “Helen,” a woman in her mid-eighties dying of breast cancer, self-administered a lethal dose of barbiturates and syrup followed by a glass of brandy and died within thirty minutes.26 After Helen’s personal physician refused to assist in her suicide, her family had contacted Compassion in Dying, which referred her to a willing physician. In 1998, twenty-three more patients received lethal prescriptions from their physicians and fifteen used them to commit suicide. Except in one case, all the prescriptions were for nine grams of a fast-acting barbiturate and an antiemetic agent. All patients were unconscious

---

within twenty minutes, and the majority died within an hour while the slowest death occurred 11.5 hours later.\textsuperscript{27}

The number of deaths from physician assisted suicide increased slightly over the next years with twenty-seven deaths in both 1999 and 2000. While the number of lethal prescriptions increased to forty-four in 2001, the number of patients who actually took them decreased to twenty-one. The numbers increased again in 2002 with thirty-eight deaths from physician assisted suicide. Fifty-eight prescriptions were written by thirty-three physicians, which was more than twice the number written during the first year of the Death With Dignity Act.\textsuperscript{28} The total number of deaths in Oregon from physician assisted suicide is 129.

Oregon's Death With Dignity Act has met much public opposition and several legal challenges. In 1997 Oregon's Republican controlled state legislature approved a bill that asked Oregonians to reconsider the Act. The legislature believed that the assisted suicide law was flawed and any legislative amendments to refine its provisions would be ineffective.\textsuperscript{29} The legislature's repeal referendum, Measure 51, appeared on the ballot in November 1997. The referendum was strongly defeated by a sixty percent vote.

In 1998, bills were presented to Congress that would have preempted the Oregon Death With Dignity Act through amendments to the Controlled Substances Act (CSA). Representative Harry Hyde introduced the Lethal Drug Use Prevention Act, which would have amended the CSA to authorize suspension of a practitioner's Drug Enforcement


\textsuperscript{28} Katrina Hedberg, David Hopkins and Melvin Kohn, "Five Years of Legal Physician-Assisted Suicide in Oregon," \textit{New England Journal of Medicine} 348: 961-964.

Agency registration if he intentionally dispensed a controlled substance for the purpose of
assisting a suicide. This bill failed to reach the floor of either the House or the Senate. A
second bill, The Pain Relief Promotion Act would have amended the CSA to clarify that
alleviation of pain is a legitimate medical purpose but the use of controlled substances to
cause death is not allowed. While this bill passed the House in 1999, it failed to reach the
Senate floor.

The Oregon Death With Dignity Act was next challenged by a directive issued by
the United States Attorney General John Ashcroft. In November 2001, he directed the
Drug Enforcement Agency to suspend the licenses of Oregon physicians prescribing
lethal medication to terminally ill patients pursuant to the Controlled Substances Act.
Ashcroft stated that assisting suicide is not a “legitimate medical purpose” within the
meaning set by the CSA and is therefore in direct violation of it. 30 Ashcroft stressed the
historical recognition of pain management as an acceptable medical practice.

Almost immediately, federal judge Robert Jones issued a temporary order
enjoining enforcement of the new policy so he could take evidence and hear arguments
about the policy. In April 2002, Judge Jones ruled that Congress did not enact the
Controlled Substances Act with intention to override a state’s decisions concerning what
constitutes a legitimate medical practice in the absence of an express federal law
prohibiting that practice, and Congress never intended to grant authority to the Attorney
General to define what constitutes the legitimate practice of medicine. 31 Judge Jones
emphasized that the Supreme Court had left the issue of physician assisted suicide up to

30 Attorney General John Ashcroft, “Dispensing of Controlled Substances to Assist Suicide,”
Memorandum for Asa Hutchinson, Administrator, The Drug Enforcement Administration. 66 Federal
Register 56,607 (November 9, 2001)
31 State of Oregon et al. v. Ashcroft et al., United States District Court for the District of Oregon,
Civil No. 01-1647-JO, April 17, 2002.
the states in *Washington v. Glucksberg* and that Congress had been unable to muster
enough support to legislatively invalidate its legalization by amending the CSA.
Therefore Oregon voters were acting within their rights in legalizing physician assisted
suicide, which they did by majority vote in two referendums.

**Arguments Against the Legalization of Physician Assisted Suicide**

Because physician assisted suicide is such a controversial issue, it has received
much criticism. Perhaps the most convincing argument is that it opposes physicians’
traditional roles and values. Many people feel that guiding physicians towards assisted
suicide by legalizing it would compromise their position as “healers.” The official
position of the American Medical Association (AMA) is that “physician assisted suicide
is fundamentally inconsistent with the physician’s professional role,” and patients’
requests for such action signal that more efforts need to be made to treat pain and
psychological discomfort.32 The AMA and forty-five other medical associations filed
briefs opposing the legalization of physician assisted suicide with the Supreme Court
concerning the *Washington v. Glucksberg* case. The AMA promotes the teaching of
advanced pain management techniques to physicians at both the graduate and
undergraduate level to combat any need for assisted suicide.

This leads to another argument against legalizing physician assisted suicide,
which is that it is often requested not because of inalterable suffering but due to
correctable circumstances. The American Medical Association asserts that inadequate
pain management contributes to patients’ requests for suicide. Another inappropriate

---

32 American Medical Association, H-140.952. Physician Assisted Suicide.
motive for suicide is depression. Many patients facing a terminal illness naturally feel isolated and depressed. Allowing and even helping such a person commit suicide would quite likely rob him of meaningful time that could be spent with family and friends. An example of this is the case of Elizabeth Bouvia. Even though the courts eventually ruled that she had the right to terminate her life by refusing nutritional sustenance, she chose to live. During her court battles and hospital stays, Elizabeth met several caring people who had come forward to aid her in her battle to die. These friends must have shown Elizabeth that her life was still worth living. Elizabeth’s case shows that not feeling connected to others often motivates the desire to die, not the disease itself.

Another factor that sometimes drives people toward suicide is the loss of independence caused by debilitation or disease. One such example is Larry McAfee who was made a quadriplegic at age 29 in a 1985 motorcycle wreck. After Larry exhausted his health insurance benefits on lengthy hospital stays and home nursing, he refused to be a financial burden on his family and was placed in a nursing home. This loss of independence made Larry very depressed, and he filed a suit in court to be allowed to disconnect his ventilator. Larry later said, "I couldn’t see past the institution, being locked up with the elderly, with no hope." While he won the right to disconnect his ventilator in Georgia courts, Larry qualified for additional benefits under Medicare disability and was transferred to an independent-living group home where he found life acceptable. This shows that suicide wishes can be influenced by an unacceptable quality of life often due to financial reasons. In other cases where patients are well cared for, patients may still consider suicide because they feel guilty they are causing an excessive

33 Gregory E. Pence, 69.
34 Gregory E. Pence, 70.
35 Raymond Whiting, 176.
financial or emotional burden on their family. While the Family and Medical Leave Act requires employers to grant up to twelve weeks of unpaid leave to employees to care for an immediate family member with a serious health problem, it seems that adjustments are still necessary in Medicaid and disability insurance to ensure that families can take advantage of respite care and are not overburdened with ensuring that their loved one is well cared for.

Another argument often made against physician assisted suicide is that it would create a “slippery slope” towards involuntary euthanasia. Once assisted suicide is found acceptable for reasons of “mercy,” then delivering people who have been dehumanized by illness or dependence may also become acceptable even though such people are not capable of requesting death.\(^{36}\) If society allows substituted judgments to be made to determine when a life is without value, “mercy” killings could increase especially among the elderly, poor, and disabled.

Some people believe that such “mercy” killings could lead to atrocities like those of the Nazi era. The Nazis’ euthanasia of people with disabilities and later the genocide of Jews has been traced back to the acceptance by German physicians of the idea that certain people with a poor quality of life were better off dead than alive.\(^{37}\) The Nazis used medical killing to terminate “life unworthy of life,” *lebensunwerten Lebens*. While it is difficult to imagine physician assisted suicide in the United States leading to such extremes, in the instance of a depressed economy with few medical allocations available to a growing population, difficult choices would have to be made.


\(^{37}\) Gregory E. Pence, 87.
Recently, reports from the Netherlands have strengthened the slippery slope argument. In the Netherlands, physician assisted suicide and euthanasia are legal with many fewer regulations than found in Oregon. In a 1990 survey conducted by the Dutch government, physicians reported over 1,000 cases of nonvoluntary euthanasia performed without the patients' knowledge or consent. While the Dutch later increased regulations, a 1995 survey still showed 948 patient deaths due to involuntary euthanasia. These statistics show that very strict regulations and reporting requirements are necessary to prevent the extension of assisted suicide to involuntary euthanasia.

The tendency for physicians to descend the “slippery slope” when assisted suicide is not regulated properly was demonstrated by Dr. Jack Kevorkian. Kevorkian became famous after assisting 131 deaths in Michigan in the 1990’s. Physician assisted suicide was not illegal in Michigan until September 1998 when Kevorkian’s actions prompted the state legislature to clarify the Penal Code to make all assisted suicide illegal. Many of Kevorkian’s assisted suicides occurred in his van using his “Thanatron” or death machine. The patient was connected intravenously to the machine, which delivered lethal drugs after the patient triggered a switch. Kevorkian was convicted of second-degree murder and delivery of a controlled substance in 1999 after he provided “60 Minutes” with a videotape of the death of Thomas Youk, a man with amyotrophic lateral sclerosis, also known as Lou Gehrig’s disease. Because the disease made Youk physically unable to operate the death machine, Kevorkian had himself injected potassium chloride into Youk’s hand to stop his heart.

Many people saw Kevorkian’s actions as compassionate acts for people debilitating by disease and lacking options. However, Kevorkian constantly violated the
standards he publicly claimed to follow. Kevorkian often failed to consult psychiatrists even when dealing with depressed people, failed to observe minimum-waiting periods before assisting suicides, did not consult pain specialists, and failed to discover financial or family problems that may have contributed to wishes to die. Because Kevorkian spent little time counseling his patients, he often did not discover their true motives for suicide. With the proper medication for pain or depression, perhaps these patients, several of whom did not have a terminal illness, would have wanted to continue living.

Kevorkian’s actions quite possibly stemmed not from compassion but from his obvious preoccupation with death. He has expressed interest in starting a new of medicine called “obitiatry” as well as approving of the medical killing of criminals. Legalized physician assisted suicide seems a frightening prospect when in the hands of a physician like Kevorkian.

Another argument against legalizing physician assisted suicide is that it is unnecessary because states allow “double effect,” which is administering massive doses of painkillers to relieve pain while simultaneously risking hastening death. In Vacco v. Quill the Supreme Court compared a physician’s withdrawal of life sustaining devices to respect the patient’s wishes to a physician providing aggressive palliative care where painkilling drugs risk hastening a patient’s death for the purpose of easing pain. The Court pointed out the law’s distinction between “actions taken ‘because of’ a given end from actions taken ‘in spite of’ their unintended but foreseen consequences.”38 In her Washington v. Glucksberg concurrence, Justice O’Conner emphasized that because terminally ill patients in Washington and New York face no legal barriers in obtaining

38Vacco v. Quill.
pain-relieving medication “even to the point of causing unconsciousness and hastening death” there is no need to even address the question of the constitutionality of physician assisted suicide.39

Arguments For the Legalization of Physician Assisted Suicide

While opponents of physician assisted suicide claim that it contradicts physicians’ roles as healers, others assert that as medical technology increases so must society’s definition of “healing.” The AMA’s Council on Ethical and Judicial Affairs declared that physicians’ commitments are to sustain life and relieve suffering, but when both cannot be achieved, patient autonomy requires the physician to respect a competent patient’s wish to forego life-sustaining treatment. An important characteristic of rights, including a patient’s right to life, is that the possessor of a right can choose to claim it or waive it.40 If a patient evaluates his quality of life and decides to waive his right to life, perhaps the only way left to “heal” the patient is to respect his decision and even provide aid in carrying it out. When a terminally ill patient decides to end his or her life, his “healer” could provide a prescription that would accomplish this goal in an efficient and painless manner. If the patient is left to his own devices, his suicide will quite possibly be a botched attempt resulting not in death but in pain, brain damage and/or a coma. Because the hand holding the gun can wobble, the carbon monoxide from a car may not be concentrated, and forty pills of Valium may not be sufficient, it is not easy to die, especially painlessly or aesthetically, without assistance.

40 Glenn C. Graber and David C. Thoma, 20.
Many opponents claim this assistance cannot be provided by physicians because they swore to not kill when they took the Hippocratic Oath. The original Oath prohibits euthanasia and physician assisted suicide as it states, “I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect.”\textsuperscript{41} However, the original Oath also prohibits medical practices that are uncontroversially recognized as legal such as surgery and charging medical students, as well as abortion, which has been recognized as legal by the Supreme Court.\textsuperscript{42} While the Hippocratic vows were written to ensure that physicians do no harm, the vows were also meant to solidify the membership of the Hippocratic School against competing healers who did perform surgery and were not opposed to mercy killing. Contemporary versions of the Oath, which are routinely adopted in medical-school graduations, omit these prohibitions.

Today’s medical students seem to be reevaluating the implications of the Hippocratic Oath in the context of current medical technology. The thirty-thousand-member American Medical Student Association (AMSA) filed a brief in favor of legalization of physician assisted suicide with the Supreme Court. The AMSA President Andrew Nowald said, “Students are simply being more progressive, I think, in reflecting the general societal understanding that there needs to be better training for physicians and more rights for patients.”\textsuperscript{43} As medical students prepare themselves to pledge to do no harm and take the Hippocratic Oath, they seem to be calculating that “harm” can be done to the terminally ill when their lives are prolonged by unwanted medical interventions.

\textsuperscript{41} Hippocrates, \textit{Oath of Hippocrates}, Edelstein translation.
\textsuperscript{42} Brief of Amicus Curiae Bioethicists Supporting Respondents for \textit{Vacco et al. v. Quill et al.} and \textit{Washington et al. v. Glucksberg et al.}
\textsuperscript{43} Howard Ball, 183.
While opponents of physician assisted suicide list unacceptable reasons such as depression or inadequate pain control that lead patients toward suicide, advocates for its legalization maintain that there exist many motives to justify suicide. Interviews with the physicians and family members of the Oregon patients who have utilized physician assisted suicide have shown that concern about pain control at the end of life and financial loss were not significant factors in the patients' choices. The three reasons cited most often by Oregon patients choosing physician assisted suicide have been concern over losing autonomy, a decreased ability to participate in activities that make life enjoyable, and losing control of body functions. Many of these patients also expressed concern about being in control of the manner and time of their deaths. Proponents for physician assisted suicide argue that it is reasonable and acceptable for a person to want to end his life before being rendered completely disabled and devoid of options. The Nobel Prize-winning physicist Percy Bridgman shot himself when he was nearly 80 years old and suffering from terminal cancer. His final note said, "It isn't decent for society to make a man do this thing himself. Probably this is the last day I will be able to do it myself." 44

Advocates for the legalization of physician assisted suicide are quick to point out weaknesses in the "slippery slope" argument. With adequate safeguards like those found in the Oregon Death With Dignity Act, it seems nearly impossible for involuntary or coerced deaths to occur. Abuses are no more likely to occur with physician assisted suicide than when treatment is withheld or withdrawn, when do-not-resuscitate orders are

---

written, or heavy doses of painkillers are given. Since “double effect” is allowed and left largely unregulated, legalizing a highly regulated practice of physician assisted suicide could actually increase assurance of total voluntariness by increasing the surveillance and reporting of all deaths related to heavy doses of painkillers.

Another challenge made in opposition to the “slippery slope” argument is the idea that opponents of assisted suicide are trading in one slippery slope for another. Forbidding any form of euthanasia could create a slippery slope toward a government that increasingly limits citizens’ decisions concerning their own bodies. Instead of physician assisted suicide being responsible for a Nazi-like loss of respect for human life, an American government that forces a person to live an unnatural life of decay in the name of societal good could be the true foundation for a loss of respect for life.

Advocates of physician assisted suicide often argue that the majority of the American public is in favor of its legalization. Yet the wording of the issue has a large impact on the outcome of opinion polls because of the negative connotation of the word “suicide” as an impulsive decision arising from depression or mental illness. When the practice is described as a “physician helping a patient end his or her life,” public support is in the sixty-nine to seventy-five percent range. Support for allowing a physician to end a life with a patient’s request has increased over twenty percent since 1973 with older Americans (particularly those over sixty-five) most likely to be opposed. These

---

46 Raymond Whiting. 58.
statistics show that American support for physician assisted suicide already constitutes a majority and will likely continue to increase.

In addition, despite the official position of the AMA, physicians are divided about the issue. Many physicians support the patient’s right to assistance in suicide and disapprove of state interference in how they practice medicine - in a way they see as compassionate and respectful of dying patient’s wishes.\(^49\) Sixty percent of doctors in Michigan and sixty-six percent of doctors in Oregon, where the issue has been thoroughly contemplated and discussed, support legalized assisted suicide for the terminally ill.\(^50\) Nationally, about fifty percent of physicians support legalization of assisted suicide, and one in five physicians have admitted to administering more pain medication than he considered optimal.\(^51\) However, a different ruling from the Supreme Court in *Glucksberg* or *Quill* would have never required a physician to fulfill a request for suicide if he felt it medically or morally wrong. Therefore, while physician support for legalized assisted suicide may increase as more physicians are forced to consider the issue, no physician would ever be forced to participate.

**The Current Situation**

In light of the many uncertainties that currently surround whether “extraordinary” measures should be taken to extend a person’s life, many people prepare advance directives to ensure that they will receive a level of care they find personally appropriate.

---

\(^49\) Brief of Amicus Curiae Bioethicists Supporting Respondents for *Vacco et al. v. Quill et al.* and *Washington et al. v. Glucksberg et al.*


if they are ever rendered incapable of making such decisions. Advance directives such as living wills and durable power of attorney, which are recognized by most states, provide a way for people to make their wishes known for the guidance of physicians at a later time. A durable power of attorney for health care allocates to someone else (usually a family member) the right to make life-and-death medical decisions if the patient becomes incompetent. A living will informs health care workers of the conditions under which a patient would or would not want to receive further medical support. The first living will was introduced by the Euthanasia Society of America in 1967, and living wills soon became popular in response to the Quinlan case. By 1990, forty-three states had statutes recognizing some version of advance directive. In 1991, the Health Care Financing Administration began requiring all American hospitals to ask incoming patients if they wanted to sign an advance directive. 52

Tennessee law gives patients the right to refuse medical treatment and recognizes living wills, durable power of attorney for health care, and physicians’ do-not-resuscitate orders to protect this right. While Tennessee law allows a physician to refuse to accept a patient’s living will, it would be very rare for that to happen today. Most Tennessee living wills designate that the patient does not wish to be kept alive using ventilators or other machines if he or she is about to die or if the physician believes he or she will never wake from a coma. A patient can designate whether or not he wants a feeding tube to be used to sustain his life and if he wants to donate all or part of his body after death. Tennessee law allows a patient to name anyone except his physician as his “attorney in

52 Gregory E. Pence, 52.
fact.” To be valid in Tennessee, living wills and durable power of attorney for health care must be witnessed by two non-family members.

Conclusion

The future of physician assisted suicide is unclear. Favorable reports from Oregon could lead other states to pass voter initiatives legalizing assisted suicide. There is also a possibility that future cases could come before the Supreme Court that would show state statutes banning physician assisted suicide to be unconstitutional. The Washington v. Glucksberg and Vacco v. Quill cases posed “facial” challenges to the state bans which are very difficult to sustain because a law must be shown to be unconstitutional in all its applications. The challenger would have to prove that no set of circumstances exist under which a ban on physician assisted suicide would be valid. If an “as applied” challenge came before the court, it would be judged according to a more easily met standard, as challengers would only have to prove the statute is invalid as applied specifically to them.

There were disagreements in the Supreme Court’s opinions in the Washington case as only four justices joined Chief Justice Rehnquist’s majority opinion. The concurring opinions of Justices Breyer, Souter, and Stevens can be read to suggest that given the right case they might find a particular law banning assisted suicide unconstitutional. Justices Ginsberg and O’Conner could also presumably accept the invalidity of state bans in certain situations. Justice Stevens wrote, “in a more particularized challenge to a general rule [prohibiting physician assisted suicide]” a

---

53 Susan M. Behuniak and Arthur G. Svenson, 134.
terminally ill and competent patient who sought to hasten death with the assistance of a physician "might prevail." 55 It seems that if a case with different legal circumstances and claims were brought before the court, a majority of the Court could find a state ban on physician assisted suicide unconstitutional.

At present, when treating the terminally ill, each physician must establish his or her own personal boundaries on what actions he feels are ethically acceptable. In 1991, Dr. Timothy Quill of New York published an article in the New England Journal of Medicine in which he described his decision to prescribe barbiturates for one of his patients suffering from acute myelomonocytic leukemia, knowing that she planned on using the prescription to end her life. Quill wrote, "I wonder how many families and physicians secretly help patients over the edge into death in the face of such severe suffering." 56 Dr. Quill’s admission led prosecutors to charge him with violation of New York’s law against assisting suicide. However, the grand jury refused to indict him.

It currently seems that the issue of physician assisted suicide is being left to physicians to solve. Physicians are giving excessive amounts of pain medication to keep terminally ill patients “comfortable” and free from pain. But what about the terminally ill patient who can only feel comfortable if he knows he can choose to die “with dignity” — before being rendered physically or mentally incapacitated? Some physicians may evaluate such a case and decide it warrants ending more than just the patient’s pain, and they may decide to overstep the boundaries of the law. Because physicians dedicate their lives to helping others and would possibly have to defend their actions in court, surely all physician who directly end a patient’s life or help a patient end his life are motivated

solely by compassion and concern, and the majority of society would sympathize with their actions. However, it is wrong to put physicians in the position where acting in accord with their personal and professional sense of morals and compassion is in conflict with the law. And what about the patients whose physicians cannot morally agree to quietly aid in terminating their lives? Surely these patients are entitled to as much dignity at their death as any other patient. These inconsistencies show that the issue of physician assisted suicide is far from being settled and will likely continue to frustrate patients and physicians for years to come.