PHYSICIAN-ASSISTED SUICIDE FOR THE TERMINALLY ILL: THE ULTIMATE CURE?

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*Dogs do not have many advantages over people, but one of them is extremely important: euthanasia is not forbidden by law in their case; animals have the right to a merciful death.***

INTRODUCTION

Faced with an incurable disease and the prospect of imminent death in a sterile hospital environment, terminally ill people seek ways to end their misery. Their choices range from passively waiting for a cure to assertively taking steps to end their suffering. If those choosing suicide find themselves unable to obtain the means of suicide alone, or are unwilling to risk failure, they may turn to friends and relatives,[1] or even physicians for help.[2] Among the most difficult and complex issues physicians face is whether to assist patients in committing suicide. Physicians must contemplate not only the ethical implications of this decision,[3] but also the legal ones.[4] They debate morality and legality while lives hang in the balance — lives they have vowed to preserve.[5]

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** M. KUNDERA, THE UNBEARABLE LIGHTNESS OF BEING 299 (1987).

1. *See, e.g.*, People v. Roberts, 211 Mich. 187, 178 N.W. 690 (1920) (ailing woman's husband set poison within her reach, she committed suicide, and he was found guilty of murder).

2. Quill, *Death and Dignity: A Case of Individualized Decision Making*, 324 NEW ENG. J. MED. 691 (1991) (physician admits to assisting patient's suicide); *See also Euthanasia Bid in Washington State: 'Aid in dying,' or giving doctors a license to kill?*, N.Y. Times, July 6, 1990, at A9, col. 1 [hereinafter *Euthanasia Bid*] (physician's suicide machine aids woman in taking her own life).

3. *American Medical Association Principles of Medical Ethics*, in CURRENT OPINIONS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS OF THE AMERICAN MEDICAL ASSOCIATION ix, 1 (1989) [hereinafter CURRENT OPINIONS].

4. *See, e.g., id.* at 1. *See also* ARIZ. REV. STAT. ANN. § 13-1103 (1989); 10 CAL. PENAL CODE § 401 (West 1990); NY PENAL LAW § 120.35 (McKinney 1990) criminalizing assisted suicide.

5. As they begin their professional careers, physicians take an oath vowing, *inter alia*, to protect their patients to the best of their abilities. *See* Clarke, *Euthanasia and the Law*, in MEDICAL ETHICS: A GUIDE FOR HEALTH PROFESSIONALS 217 (J. Monagle & D. Thomasma

The early Greeks and Romans saw euthanasia as a common-place method of easing the strains of old age and avoiding the indignities of terminal illness.[6] As Christianity developed, physicians and laypeople began to view euthanasia as unacceptable and uncivilized.[7] In recent years, however, a growing acknowledgement of the right to die has elevated physician-assisted suicide to the forefront of debate in medical and legal ethics.[8] The recent Supreme Court ruling in *Cruzan v. Director, Missouri Department of Health*[9] and the work of the Hemlock Society[10] have brought public awareness to the issue of rational assisted suicide. Physicians, legislators, and laypeople alike have begun debating an individual's right to choose the time and manner of her own death and the obligation of physicians to respect and perhaps even contribute to the outcome of that decision.[11]

This Note examines the legal and moral issues arising from a physician's involvement in a competent, yet terminally ill patient's suicide.[12] Beginning with a study of judicial opinions from *In re Karen Quinlan*[13] — the first reported right to die case — to the recent *Cruzan v. Director, Missouri Department of Health*[14] decision, the first section discusses judicial views on

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ed. 1988). *See also infra* notes 177-182 and accompanying text (discussing Hippocratic and other medical oaths).

6. *See* Clarke, *supra* note 5, at 219. Euthanasia is a Greek word meaning "a painless and happy death." WEBSTER'S NEW 20TH CENTURY UNABRIDGED DICTIONARY (2d ed. 1979).

7. *See* Clarke, *supra* note 5, at 219. Christianity taught "that human life belonged to the deity alone." *Id.* at 219. Discussing suicide at common law, Blackstone asked:

> [W]hat punishment can human laws inflict on one who has withdrawn himself from their reach? They can only act upon what he has left behind him, his reputation and fortune; on the former, by an ignominious burial in the highway, with a stake driven through his body; on the latter by a forfeiture of all his goods and chattels to the king; hoping that his care for either his own reputation or the welfare of his family would be some motive to restrain him from so desperate and wicked an act.

4 W. BLACKSTONE, COMMENTARIES *190.

8. *See, e.g., Model Aid-in-Dying Act*, 75 IOWA L. REV. 133 (1989) [hereinafter Model Act]; Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986); Lewin, *Doctor Cleared of Murdering Woman With Suicide Machine*, N.Y. Times, Dec. 14, 1990, at B8, col. 1 (Michigan judge dismisses murder charges against physician who assisted woman in committing suicide). *But see* Gross, *Voters Turn Down Legal Euthanasia*, N.Y. Times, Nov. 7, 1991, at A10, col. 1 (Washington voters reject Initiative proposing legalization of physician-assisted suicide).

9. 110 S. Ct. 2841 (1990).

10. The Hemlock Society is an organization dedicated to what its founders see as "the ultimate civil liberty: the right to choose how and when to die." *Q. and A. on the Hemlock Society*, HEMLOCK Q. (Jan. 1990). *See also* D. HUMPHRY, LET ME DIE BEFORE I WAKE (1983); Wanzer, Federman, Adelstein, Cassel, Cassem, Cranford, Hook, Lo, Moertel, Safar, Stone & Van Eys, *The Physician's Responsibility Toward Hopelessly Ill Patients*, 320 NEW ENG. J. MED. 844, 848 (1989).

11. *See, e.g.*, HUMPHRY, *supra* note 10, at 6; Initiative on the Washington State November, 1991 Ballot (incorporating H.B. 3005, 51st Leg., Reg. Sess. (1990)) [hereinafter Washington Initiative] (initiative proposing legalization of physician-assisted suicide); Model Act, *supra* note 8; *Euthanasia Bid*, *supra* note 2.

12. To certify that a patient is terminally ill, the physician must determine that such patient has a life expectancy of six months or less. 42 C.F.R. § 418.22(b)(1) (1988).

13. 70 N.J. 10, 355 A.2d 647 (1976), *cert. denied*, 429 U.S. 922 (1976).

14. 110 S. Ct. 2841 (1990).

the issue of a right to die, focusing primarily on how that relates to assisted suicide. The second section concentrates on physicians' ethical responsibilities, as well as their potential criminal and civil liability. The final section demonstrates a growing trend toward social and judicial acceptance of physician-assisted suicide by studying proposed legislation which would, to some extent, legalize rational suicide and legitimate the philosophies of those organizations supporting it.

THE RIGHT TO DIE

The common law treated suicide as a felonious offense.[15] In 1961, however, legislative reform led most states to repeal laws criminalizing suicide.[16] Since then, individuals and legislatures alike have increasingly accepted the right to a dignified death. Public interest in this topic has led some state legislatures to enact living will legislation.[17] These statutes allow individuals to express whether or not they consent to the use of extreme life-sustaining measures in the event they become comatose or are otherwise rendered incompetent.[18] Most states condone the use of living wills,[19] but retain legislation criminalizing assisted suicide.[20]

The issue of rational assisted suicide has arisen by inference in cases focusing on the right to withhold or withdraw life-sustaining treatment.[21] The most notable opinion favoring the right to rational assisted suicide is Justice Compton's concurring opinion in *Bouvia v. Superior Court.*[22] *Cruzan v.*

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> [T]he law of England wisely and religiously considers, that no man hath a power to destroy life, but by commission from God, the author of it: and, as the suicide is guilty of a double offence: one spiritual, in invading the prerogative of the Almighty, and rushing into his immediate presence uncalled for; the other temporal, against the king, who hath an interest in the preservation of all his subjects; the law has therefore ranked this among the highest crimes, making it a peculiar species of felony, a felony committed on oneself.

W. BLACKSTONE, *supra* note 7, at *190.

16. Williams, *Euthanasia and the Physician*, in BENEFICENT EUTHANASIA 145, 164 (M. Kohl ed. 1975).

17. *See, e.g.*, ARIZ. REV. STAT. ANN. §§ 36-3201 to -3210; CAL. HEALTH & SAFETY CODE § 7188 (West 1991).

18. Living wills or advanced directives are instruments signed by the patient or individual stating her preferred mode of medical treatment. These directives generally do not take effect unless the individual is rendered incompetent and is thus unable to communicate an opinion on the subject of life-sustaining treatment. *See* J. DUKEMINIER & S.M. JOHANSON, WILLS, TRUSTS, AND ESTATES 283-85 (3d ed. 1984).

19. Currently, only eleven states have not enacted living will legislation. *A.M.A. Pushing Living Wills, Guide to Life-Support Use*, MED. WORLD NEWS, July 24, 1989, at 27, col. 3. Consequently, the overwhelming majority of states recognize a statutory right to refuse treatment. The states which do not recognize such a right are: Kentucky, Massachusetts, Michigan, Nebraska, New Jersey, New York, North and South Dakota, Ohio, Pennsylvania, and Rhode Island. SOCIETY FOR THE RIGHT TO DIE, HANDBOOK OF LIVING WILL LAWS 12 (1987).

20. *See* Clarke, *supra* note 5, at 217.

21. *See, e.g.*, Superintendent of Belchertown Schools v. Saikewicz, 373 Mass. 728, 737 n.11, 370 N.E.2d 417, 426 n.11 (1977); *In re* Colyer, 99 Wash. 2d 114, 119, 660 P.2d 738, 743 (1983).

22. 179 Cal. App. 3d 1127, 1146-48, 225 Cal. Rptr. 297, 307-08 (1986) (Compton, J., concurring). *See also infra* notes 143-46 and accompanying text.

Director, Missouri Department of Health[23] is the only United States Supreme Court decision addressing the withholding of medical treatment. These opinions shed some light on the direction which courts and legislatures are likely to take regarding rational assisted suicide.[24]

Until the New Jersey Supreme Court decided *Quinlan* in 1976, American courts declined to recognize a right to die.[25] The *Quinlan* court premised its opinion primarily on the constitutional right to privacy.[26] Other courts have used the right of self-determination as a basis for finding a right to refuse treatment.[27] Since *Quinlan*, most American courts, including the United States Supreme Court, have accepted the proposition that a competent individual may choose to decline life-sustaining treatment.[28]

The right to refuse life-sustaining treatment stems from the constitutional right to privacy.[29] Courts have arrived at the right to refuse treatment through a balancing test, whereby courts weigh the state's interests in preserving life against the individual's interest in freedom from pain and suffering.[30] Common law tort principles support the right to die arguments.[31] Courts have held that physicians who treat such patients against their will may face tort liability for battery or bodily invasion.[32]

A. Rejecting an Individual's Right to Withdraw Life-Sustaining Treatment

In *John F. Kennedy Memorial Hospital v. Heston*,[33] the New Jersey Supreme Court rejected the right to withdraw life-sustaining treatment. In *Heston*, the mother of an unconscious twenty-two-year-old woman refused, for religious reasons, to allow the hospital to give her daughter a needed blood

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23. 110 S. Ct. 2841 (1990). *Cruzan* primarily dealt with a state's right to require a high standard of proof before allowing the withdrawal of life-sustaining treatment.

24. Several state courts have dealt with suicide and assisted suicide simply by distinguishing them from withdrawal of treatment cases. *See, e.g., Saikewicz*, 373 Mass. 728, 743 n.11, 370 N.E.2d 417, 426 n.11; *Colyer*, 799 Wash. 2d 114, 122-23, 660 P.2d 738, 743.

25. *Cruzan*, 110 S. Ct. at 2847.

26. 70 N.J. 10, 39, 355 A.2d 647, 663. The U.S. Supreme Court, in *Griswold v. Connecticut*, determined that a right to privacy exists in the "penumbra" of the Bill of Rights. 381 U.S. 474, 484 (1965).

27. *See, e.g., Colyer*, 99 Wash. 2d at 120, 660 P.2d at 742 ("an adult who is incurably and terminally ill has a constitutional right of privacy that encompasses the right to refuse treatment that serves only to prolong the dying process, given the absence of countervailing state interests"). *See also Quinlan*, 70 N.J. 10, 355 A.2d 64; *Bouvia*, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297.

28. *Cruzan*, 110 S. Ct. at 2843. The Supreme Court determined that "[a] competent person has a liberty interest under the Due Process Clause in refusing unwanted medical treatment."

29. *See, e.g., Bouvia*, 179 Cal. App. 3d at 1131, 225 Cal. Rptr. at 301.

30. *See, e.g., Cruzan*, 110 S. Ct. at 2847-48.

31. A. MEISEL, THE RIGHT TO DIE 50 (1989).

32. *See, e.g.*, Bartling v. Glendale Adventist Medical Center, 184 Cal. App. 3d 961, 229 Cal. Rptr. 360 (1986); Spring v. Geriatric Auth., 394 Mass. 274, 475 N.E.2d 727 (1985); Estate of Leach v. Shapiro, 13 Ohio App. 3d 393, 469 N.E.2d 1047 (1984).

An actor is liable if he intended to cause offensive or harmful conduct and such conduct results. RESTATEMENT (SECOND) OF TORTS § 13 (1965). "Another possible remedy [for unwanted treatment] is an action for intentional infliction of emotional distress, and an action in tort for invasion of privacy may also exist." A. MEISEL, *supra* note 31, at 51 (citations omitted).

33. 58 N.J. 576, 279 A.2d 670 (1971).

transfusion.[34] Dolores Heston ruptured her spleen in a car accident. Physicians determined that she would die without surgery.[35] As a Jehovah's Witness, Heston's religion forbade blood transfusions.[36] Heston was unable to consent to any treatment, so physicians sought a release from her mother who refused to consent on her daughter's behalf.[37] The hospital then applied to a Superior Court judge for appointment of a guardian who would consent to Heston's transfusion.[38] Upon appointment and consent of a guardian, physicians proceeded with the transfusion and Miss Heston survived.[39] The New Jersey Supreme Court upheld the lower court's order appointing a guardian who could consent to the transfusion on Miss Heston's behalf.[40] A unanimous court held that the state's interest in life outweighed Heston's religious beliefs regarding transfusions.[41]

The *Heston* court decided the state's interests, as well as those of the hospital and attending physicians, vastly outweighed the interests of a woman whose religion forbade blood transfusions.[42] The court reasoned that there is no constitutional right to choose to die.[43] The court further remarked that because the state may outlaw suicide, it may likewise disallow the rejection of life-sustaining treatment.[44]

At the time of the *Heston* decision, the New Jersey Supreme Court favored very strict rules against the refusal of treatment. The court, however, only addressed the issue in a case involving a patient whose illness could be cured by the procedure. The court suggested that a determination that the life-saving procedure was itself laden with life-threatening risks might outweigh the state's interest in saving a life.[45] In its opinion, the court chose to promote the preservation of life and allowed the hospital and medical staff to continue treatment based on professional standards of conduct.[46] *Heston* established the New Jersey Supreme Court's early position on the right to refuse medical treatment. However, the court's position has changed. *In re Conroy*[47] expressly overruled *Heston* regarding a patient's right to withdraw treatment.

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34. *Id.* at 577, 279 A.2d at 670.
35. *Id.*, 279 A.2d at 671.
36. *Id.*
37. *Id.*
38. *Id.*
39. *Id.* Upon Miss Heston's recovery, her family moved to vacate the order. Failing in their motion, they appealed to the New Jersey Supreme Court. Determining that public interest required a resolution, the court ruled on their motion despite its mootness.
40. *Id.*
41. *Id.* at 579, 279 A.2d at 673. The court rejected the individual's rights saying that "[t]he solution sides with life, the conservation of which is, we think, a matter of State interest."
42. *Id.* at 580, 279 A.2d at 674.
43. *Id.*, 279 A.2d at 672. "It seems correct to say there is no constitutional right to choose to die." Although suicide is no longer a crime, it has been prosecuted in New Jersey. *See, e.g., State v. Carney*, 69 N.J.L. 478 (1903).
44. *Heston*, 58 N.J. at 582, 279 A.2d at 673. The court noted "[i]f the State may interrupt one mode of self-destruction, it may with equal authority interfere with the other.... [U]nless the medical option itself is laden with the risk of death or of serious infirmity, the State's interest in sustaining life in such circumstances is hardly distinguishable from its interest in the case of suicide." *Id.*
45. *Id.*
46. *Id.* at 583, 279 A.2d at 673.
47. 98 N.J. 321, 351, 486 A.2d 1209, 1224 (1985).

B. Recognizing an Individual's Right to Withdraw Life-Sustaining Treatment

Heston was the first case to consider the right to die.[48] Subsequent cases, however, have given right to die proponents hope,[49] and several state courts have since recognized a right to refuse medical treatment.[50]

The New Jersey Supreme Court was the first to finally recognize a right to die.[51] *In re Karen Quinlan* involved a woman in a persistent vegetative state with no possibility of recovery.[52] When physicians determined that Quinlan would never recover, her father sought to withdraw life-sustaining treatment.[53] The New Jersey Superior Court refused to authorize termination of Quinlan's treatment.[54]

Relying on the implied right to privacy found in the penumbra of the Bill of Rights,[55] the New Jersey Supreme Court determined that an individual's right to privacy gives a patient in a chronic vegetative state the right to refuse life-sustaining treatment despite the state interest in the preservation of life.[56] A unanimous court held that Karen's guardian and family, in consultation with Karen's physicians, could decide to disconnect life-support apparatus as Karen had "no reasonable possibility of ... emerging from her present comatose condition."[57] The decision to terminate is subject to review by the hospital ethics committee, and if the committee concurs with the treating physicians that Karen has no reasonable chance of recovery, then life-support apparatus may be withdrawn.[58]

The court determined that if Karen Quinlan were capable of one cognizant moment, she could consent to a withdrawal of treatment.[59] The court further found that because suicide is no longer illegal in New Jersey, Ms.

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48. 58 N.J. 576, 279 A.2d 670.

49. *See Cruzan*, 110 S. Ct. 2841; *Bouvia*, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297.

50. *See, e.g., Quinlan*, 70 N.J. 10, 355 A.2d 64; *Colyer*, 99 Wash. 2d 114, 660 P.2d 738; *Saikewicz*, 373 Mass. 728, 370 N.E.2d 417. Although these cases deal only with the right to reject life-sustaining treatment, they recognize an individual's interest in self-determination.

51. *Quinlan*, 70 N.J. 10, 355 A.2d 647.

52. *Id.* at 23, 355 A.2d at 654. One day, for undetermined reasons, Ms. Quinlan stopped breathing and fell into a coma.

53. *Id.* at 18, 355 A.2d at 651. Mr. Quinlan sought a judicial determination of his daughter's incompetence. He further asked to be appointed her guardian with authority to consent to termination of treatment.

54. *Id.* at 20, 355 A.2d at 652. The court denied Mr. Quinlan's request and the judge filed a Pretrial Order stating his finding that "[u]nder any legal standard recognized by the State of New Jersey and also under the standard medical practice, Karen Ann Quinlan is presently alive."

55. *See Griswold*, 381 U.S. 479, 484 (1965).

56. 70 N.J. at 39, 355 A.2d at 663.

57. *Id.* at 55, 355 A.2d at 672

58. 70 N.J. at 39, 355 A.2d at 663.

59. The court reasoned:

> [I]f Karen were herself miraculously lucid for an interval (not altering the existing prognosis of the condition to which she would soon return) and perceptive of her irreversible condition, she could effectively decide upon discontinuance of the life-support apparatus, even if it meant the prospect of a natural death.

Id.

Quinlan could have withdrawn her own treatment without any liability.[60] Because she would not, herself, be subject to prosecution for withdrawal of treatment,[61] the court held that a third party acting on Quinlan's behalf, when she could not act herself, would similarly be immune from prosecution.[62] The court reasoned that, for all practical purposes, Karen Quinlan was already dead.[63] Because Quinlan was in an unrecoverable vegetative state, the court stated that withdrawal of treatment would not constitute assisting a suicide.[64]

The court determined that an ethics committee, consisting of physicians and members of several other professional communities, should determine a patient's curability.[65] The court believed that a "regular forum" could better make determinations of this nature, rather than a court with no medical expertise.[66] Responsibility should lie with the physician and committee members. Such a committee would base its decision on the standards and practices of the profession itself.[67] If the committee agreed with the treating physician that a reasonable possibility of recovery does not exist, the physician could withdraw life-sustaining apparatus without fear of liability.[68]

The *Quinlan* court also recognized a distinction between curing the ill and easing the pain of the dying.[69] In an effort to comfort, rather than continue prolonged suffering, physicians often refuse to consider the hopelessly ill and dying as being curable, and are, therefore, much more willing to withhold

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60. *Id.*

61. *Id.* at 51, 355 A.2d at 669-70.

62. *Id.* at 52, 355 A.2d at 670. The court found: "[t]he constitutional protection extends to third parties whose action is necessary to effectuate the exercise of that right where the individuals themselves would not be subject to prosecution or the third parties are charged as accessories to an act which could not be a crime."

63. *Id.* at 26, 355 A.2d at 655 ("she can *never* be restored to cognitive or sapient life") (emphasis in original).

64. *Id.* at 52 n.9, 355 A.2d at 670 n.9. The court further pointed out an "unwritten and unspoken standard" in the medical profession not to resuscitate terminally ill patients. *Id.* at 29, 355 A.2d at 657. The symbol DNR, "do not resuscitate," is often cited on a terminally ill patient's chart when the physician knows that any attempts to prolong life would only lead to a few moments of agony and pain. The *Quinlan* court found that the imperative to sustain life at any cost no longer exists. *Id.*

65. One physician suggested "it would be more appropriate to provide a regular forum for more input and dialogue in individual situations and to allow the responsibility of these judgments to be shared. Many hospitals have established an Ethics Committee composed of physicians, social workers, attorneys, and theologians." *Id.* at 49-50, 355 A.2d at 668 (quoting Teel, *The Physician's Dilemma: A Doctor's View: What The Law Should Be*, 27 BAYLOR L. REV. 6, 8-9 (1975)).

The court agreed: "If there could be created not necessarily this particular system but some reasonable counterpart, [the court] would have no doubt that such decisions, thus determined to be in accordance with medical practice and prevailing standards, would be accepted by society and by the courts, at least in cases comparable to that of Karen Quinlan." *Id.* at 50-51, 355 A.2d at 669.

66. *Id.* at 50, 355 A.2d at 669. The court stated that "applying to a court to confirm such decisions would generally be inappropriate, not only because that would be a gratuitous encroachment upon the medical profession's field of competence, but because it would be impossibly cumbersome."

67. *See id.* at 44-45, 355 A.2d at 666.

68. *Id.* at 55, 355 A.2d at 672.

69. *Id.* at 47, 355 A.2d at 667. The court noted that physicians often "refuse to treat the curable as if they were dying or ought to die, and that they have sometimes refused to treat the hopeless and dying as if they were curable."

extraordinary treatment.[70] While recognizing this practice in the medical community, the court indicated an unwillingness to give physicians complete immunity from prosecution comparable to judicial immunity because it felt there must be some check on the power of medical professionals.[71] The court suggested, however, that to achieve objective maximization of the medical arts, physicians should be free from inhibiting factors like the fear of prosecution for murder.[72]

In *Heston*,[73] the New Jersey Supreme Court rejected the right to refuse treatment. *Quinlan*, however, is distinguishable from *Heston* as Ms. Quinlan existed in a permanent vegetative state from which she would never recover,[74] while Ms. Heston had an excellent chance of full recovery provided she received the needed transfusion.[75] Consequently, in *Quinlan*, withdrawing treatment would only confirm death, not cause it. The *Quinlan* court gave comatose individuals with no possibility of recovery the right, through their physicians, to reject continued life-sustaining treatment. The withdrawal of treatment hastens death which is, in the case of a hopelessly comatose individual, imminent. *Quinlan* paved the way for other state courts to explore an individual's right to withdraw life-sustaining, but futile, treatment.

In *In re Colyer*, the Washington Supreme Court specifically dealt with the issue of the right to withdraw treatment.[76] Mr. Colyer sought to withdraw life-sustaining treatment from his comatose wife. Bertha Colyer's heart had stopped beating and her respiration ceased for approximately ten minutes, but paramedics managed to revive her. However, ten minutes without oxygen left Mrs. Colyer with massive brain damage, and she survived only with artificial support.[77] Knowing that his wife existed in a persistent vegetative state with no prospect of a meaningful existence, Mr. Colyer petitioned the superior court to authorize removal of life-support systems.[78]

The Washington Supreme Court, affirming the trial court order authorizing withdrawal of treatment, held that the physicians would not be criminally liable for terminating Mrs. Colyer's treatment.[79] The court stated that physicians could follow "living wills" or "directives" in determining

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70. *Id.* Physicians who gave testimony at the *Quinlan* superior court hearing indicated that many physicians "have refused to inflict an undesired prolongation of the process of dying on a patient in irreversible condition when it is clear that such 'therapy' offers neither human nor humane benefit."

71. *Id.* at 48, 355 A.2d at 668. The court announced: "We would hesitate, in this imperfect world, to propose as to physicians that type of immunity which from the early common law has surrounded judges and grand jurors." (citations omitted).

72. *Id.* at 49, 355 A.2d at 668. "[T]here must be a way to free physicians, in the pursuit of their healing vocation, from possible contamination by self-interest or self-protection concerns which would inhibit their independent medical judgments for the well-being of their dying patients."

73. 58 N.J. 576, 279 A.2d 670.

74. The fact that Ms. Quinlan could "*never* be restored to life" was critical to the court's determination. 70 N.J. at 26, 355 A.2d at 655 (emphasis in original).

75. *Heston*, 58 N.J. at 577, 279 A.2d at 674.

76. 99 Wash. 2d 114, 660 P.2d 738.

77. *Id.* at 116, 660 P.2d at 740.

78. *Id.*

79. *Id.* at 138, 660 P.2d at 751.

whether to continue life-sustaining treatment.[80] The court recognized the state's interest in preventing suicide, but pointed out that the withdrawal of treatment is not suicide within the traditional definition because the withdrawal would lead to death from natural causes.[81] The court explained that nothing in the opinion authorized or condoned euthanasia.[82] Furthermore, the court recognized a state interest in maintaining the ethical integrity of the medical profession.[83] However, this interest in integrity is tempered by a strong showing that those who are dying need more comfort than they do treatment.[84] The court determined that the integrity of the physicians involved remains intact despite the withdrawal of treatment.[85] It further found the state interest in integrity no longer compelling when weighed against the interests of a patient in an incurable condition.[86]

The *Colyer* court stated that a *Quinlan*-type administrative body is not the best way to determine curability because of the bureaucratic backlog the procedure would necessarily entail.[87] Rather than involve nonmedical personnel in a necessarily medical decision, the court suggested that a "prognosis board," including at least two competent physicians plus the attending physician, make the determination.[88] Such a safeguard would severely limit the chances of misdiagnosis.[89] Finally, and contrary to the *Quinlan* view, the courts would remain as the final safeguard.[90] A court determination, however, should serve only as a last resort if the three-member panel cannot unanimously concur on diagnosis or treatment.[91]

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80. The court found that where a directive, signed by either a competent patient or a surrogate exists, (otherwise known as a "living will"), the withdrawal of life-sustaining treatment will not constitute murder because the privacy right embodied in the fifth and fourteenth amendments extends to the decision to decline such treatment. *Id.* at 117-18, 660 P.2d at 741 (citing the Washington Natural Death Act, WASH. REV. CODE ANN. § 70.122.060 (1979)).

81. *Id.* at 122-23, 660 P.2d at 743. The court explained that "[a] death which occurs after the removal of life sustaining systems is from natural causes, neither set in motion nor intended by the patient."

82. *Id.* at 139, 660 P.2d at 751-52. The court's reasoning lies in its definition of euthanasia as "the unnatural termination of a patient's life."

83. *Id.* at 123, 660 P.2d at 743-44.

84. *Id.* at 123, 660 P.2d at 744 (citing *Saikewicz*, 373 Mass. 728, 743-44, 370 N.E. 2d 417, 426-27).

85. *Id.* at 123, 660 P.2d at 743-44.

86. *Id.* at 122, 660 P.2d at 743. The court stated: "This interest weakens ... in situations where continued treatment serves only to prolong a life inflicted with an incurable condition."

87. *Id.* at 134, 660 P.2d at 749. The court recognized that critics deride the *Quinlan*-type committee for "its amorphous character, for its use of nonmedical personnel to reach a medical decision, and for its bureaucratic intermeddling."

88. *Id.* at 134-35, 660 P.2d at 749.

89. *Id.* at 134, 660 P.2d at 749.

90. *Id.* at 137, 660 P.2d at 751. The court provided for "a court determination of the rights and wishes of the incompetent, with a guardian ad litem appointed to represent the incompetent patient and to present all relevant facts to the court."

91. *Id.* at 136, 660 P.2d at 750. Despite this determination, the court nevertheless encouraged judicial intervention as a means by which to gain the benefit of a detached and neutral opinion. It seems likely, however, that such intervention can do no more good than a neutral and detached board or committee could in the way of forming an independent opinion. Neither the physicians nor the ethical advisors on such committees would have a stake in the outcome of their decisions. Clearly, an informed board, including some members of the medical commu-

The *Colyer* court also discussed the physician's potential criminal liability resulting from his involvement in another's death.[92] The court determined that withdrawing treatment is not a criminal act so long as it is done in good faith by a physician or other licensed health care personnel.[93] The court held that the patient has a constitutional right to discontinue treatment. Since the patient could face no criminal liability for withdrawing his own treatment, the physician would be similarly immune when exercising the constitutional right of the incompetent patient.[94]

Yet another court faced the question of treatment withdrawal in *Superintendent of Belchertown Schools v. Saikewicz*.[95] In this case, a mentally retarded patient in a mental health facility needed leukemia treatment.[96] The patient was incapable of giving informed consent.[97] Upon a determination that Mr. Saikewicz's illness was incurable and that the adverse side effects of chemotherapy would outweigh any benefits, his physician decided that treatment would not be in the patient's best interests.[98] The trial judge appointed a guardian who agreed with the physician's determination.[99]

The Massachusetts Supreme Court unanimously held that individuals possess a general right to refuse medical treatment.[100] The court accepted the guardian *ad litem*'s reasoning that the fear, pain, and other side effects resulting from the suggested treatment would outweigh any possible benefits the patient could receive from a few more moments of life.[101] In addition, this court differentiated between curing the ill and caring for the dying.[102] The court distinguished this case from one where the patient suffers from a curable illness, reasoning that the state's interest in life is not as significant if the patient is already close to death.[103]

The court also addressed the issue of ethical integrity in the medical profession and determined that withdrawing a hopelessly ill patient's treatment

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nity, could make a neutral determination without the judicial backlog caused by the involvement of the court system.

92. *Id.* at 138, 660 P.2d at 751.

93. *Id.* (citing the Washington Natural Death Act, WASH. REV. CODE ANN. § 70.122.060 (1979)).

94. *Id.* Again the court determined that statutory law indicated "acts in accordance with a directive are not deemed suicide...." *See* WASH. REV. CODE ANN. § 70.122.070 (1979).

95. 373 Mass. 728, 370 N.E.2d 417.

96. Mr. Saikewicz suffered from acute myeloblastic monocytic leukemia, an incurable and fatal disease, which required chemotherapy treatment to impede its progress. *Id.* at 729-30, 370 N.E.2d at 419.

97. *Id.* at 731, 370 N.E.2d at 420.

98. *Id.* at 730, 370 N.E.2d at 419.

99. *Id.* at 729-30, 370 N.E.2d at 419.

100. *Id.* at 759, 370 N.E.2d at 435. The court stated: "[f]inding no State interest sufficient to counterbalance a patient's decision to decline life-prolonging medical treatment in the circumstances of this case, we conclude that the patient's right to privacy and self-determination is entitled to enforcement."

101. *Id.* at 730, 370 N.E.2d at 419.

102. *Id.* at 738, 370 N.E.2d at 423.

103. *Id.* at 742, 370 N.E.2d at 425-26. The court reasoned: "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."

would not damage a physician's integrity.[104] The court stated that physicians do not need to implement extreme life-saving procedures in every circumstance.[105] Weighing the state's interest in life against an individual's interest in comfort, the court held that the balance must swing in favor of comfort and individual choice when there is no chance of a meaningful existence with the life-prolonging treatment.[106]

In *Saikewicz*, the court directly discussed suicide, distinguishing rejection of treatment cases from those involving suicide or assisted suicide.[107] The court determined that suicide involves an intent to die, while mere rejection of treatment does not constitute the requisite intent.[108] The patient's death would ultimately result from natural causes, as opposed to the actions of the patient or his physician.[109]

In *Rasmussen v. Fleming*,[110] the Arizona Supreme Court held that physicians could withdraw life-sustaining treatment from terminally ill or comatose patients without incurring criminal liability.[111] Mildred Rasmussen suffered three strokes while living in a nursing home.[112] Her condition deteriorated to the point where she required a nasogastric tube for sustenance.[113] Her physicians determined that she existed in a chronic vegetative state and doubted that she would ever return to cognitive life.[114] The trial court allowed her guardian to use his substituted judgment to determine the patient's best interests.[115]

The Arizona Supreme Court affirmed the trial court ruling.[116] The court pointed out that "medical technology has effectively created a twilight zone of suspended animation where death commences while life, in some form, continues."[117] The court held that the zone of privacy created by both the federal and state constitutions encompasses an individual's right to refuse treatment.[118] The court recognized that an individual maintains a common law

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104. *Id.* at 743, 370 N.E.2d at 426.
105. *Id.* "Prevailing medical practice does not, without exception, demand that all efforts toward life prolongation be made in all circumstances."
106. *Id.* at 742, 370 N.E.2d at 426. The court stated that "[t]he 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."
107. *Id.* at 743 n.11, 370 N.E.2d at 426 n.11. "[R]efusing medical treatment ... does not necessarily constitute suicide.... There is no connection between the conduct here in issue [refusal of life-sustaining treatment] and any State concern to prevent suicide."
108. *Id.*
109. The court reasoned: "in refusing treatment the patient may not have the specific intent to die, and ... 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." *Id.*, 370 N.E.2d at 426 n.11.
110. 154 Ariz. 207, 741 P.2d 674 (1987).
111. *Id.* at 215, 741 P.2d at 682.
112. *Id.* at 212, 741 P.2d at 679.
113. *Id.*
114. *Id.* at 212-13, 741 P.2d at 679-80.
115. *Id.* at 213, 741 P.2d at 680. The trial court found that "a guardian of an incapacitated person has the authority to exercise the ward's right to refuse care."
116. *Id.* at 225, 741 P.2d at 692.
117. *Id.* at 211, 741 P.2d at 678.
118. *Id.* at 215, 741 P.2d at 682.

right to possession and control of his person.[119] The Arizona Supreme Court distinguished between mere postponement of death and actual improvement of life.[120]

The *Rasmussen* court justified its holding on the basis of the American Medical Association's (AMA) conclusion that the withholding of life-prolonging treatment does not violate standards of medical ethics.[121] The AMA Council on Ethical and Judicial Affairs determined that it is the social commitment of physicians to both sustain life and relieve suffering.[122] Where a conflict arises between those two goals, the physician must resolve it in accordance with the best interests of the patient.[123] This may ethically include the discontinuation of life-prolonging methods of treatment.[124] Although the Council advocated withdrawal of treatment, it did not support physician involvement in intentionally causing death.[125] The Council's position clearly rejects the principle of physician-assisted suicide.

The *Rasmussen* court held that since the AMA condoned the withdrawal of treatment in severe cases, there could be no dispute regarding the ethical integrity of the medical profession when a physician discontinues life-prolonging, but futile, treatment.[126] The court reasoned that a withdrawal could not constitute suicide where the death results from the natural process of the illness or coma, and not from some newly inflicted injury.[127] The court explained that, under Arizona law, assisted suicide is a form of manslaughter.[128] However, because the withdrawal of treatment is not suicide, there can be no charge of manslaughter.[129]

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119. *Id. at 215*, 741 P.2d at 682-83 (citing Union Pac. Ry. v. Botsford, 141 U.S. 250, 251 (1891)).

120. *Id.* at 217, 741 P.2d at 684. "Hospitalization or resuscitation would have only postponed Rasmussen's death rather than have improved her life."

121. *Id. See* § 2.18 CURRENT OPINIONS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS OF THE AMERICAN MEDICAL ASSOCIATION (Mar. 15, 1986) [hereinafter AMA COUNCIL OPINION]:

> The social commitment of the physician is to sustain life and relieve suffering. Where the performance of one duty conflicts with the other, the choice of the patient, or his family or legal representative if the patient is incompetent to act in his own behalf, should prevail. In the absence of the patient's choice, or an authorized proxy, the physician must act in the best interest of the patient.
>
> For humane reasons, with informed consent, a physician may do what is medically necessary to alleviate severe pain, or cease or omit treatment to permit a terminally ill patient whose death is imminent to die.

Id.

122. AMA COUNCIL OPINION, *supra* note 121, at § 2.18.

123. *Id.* "[T]he physician should determine whether the benefits of treatment outweigh its burdens. At all times, the dignity of the patient should be maintained."

124. *Id.*

125. *Id.* "However, [the physician] should not intentionally cause death."

126. *Rasmussen*, at 218, 741 P.2d at 685.

127. *Id.* (quoting *In re* Conroy, 98 N.J. 321, 351, 486 A.2d 1209, 1224 (1985)). This reasoning is also embodied in ARIZ. REV. STAT. ANN. § 36-3208 (1986) (sanctioning withdrawing or withholding of medical treatment).

128. *Rasmussen*, 154 Ariz. at 218 n.16, 741 P.2d at 685 n.16.

129. *Id. See also* Medical Treatment Decision Act, ARIZ. REV. STAT. ANN. §§ 36-3208 to -3210 (1986). The withdrawal or withholding of medical treatment is not tantamount to suicide. The statute clearly states that it does not condone mercy killing and euthanasia, but rather it permits the natural process of dying to occur. *Id.* § 36-3208.

While New Jersey, Washington, and Arizona are not the only states to confront the right to refuse treatment,[130] *Quinlan*, *Saikewicz*, and *Rasmussen* provide insight on the factors at work when courts confront this issue. *Quinlan* recognized the right of a comatose patient's guardian to refuse treatment on the patient's behalf.[131] *Saikewicz* applied that right to a cognizant patient in need of life-sustaining treatment.[132] Finally, *Rasmussen* recognized the American Medical Association's growing acceptance of the right to refuse treatment.[133]

C. Recognizing a Right to Die

Although several state courts have recognized a right to refuse life-sustaining treatment, courts have been reluctant to address whether a right to assisted suicide exists. The California Court of Appeals side-stepped the issue in *Bouvia v. Superior Court*.[134] However, Justice Compton, in a concurring opinion, advocated a right to assisted suicide.[135] Elizabeth Bouvia, a quadriplegic afflicted with cerebral palsy, resided in a state hospital. Bedridden and unable to care for herself, she was utterly dependent on others and required periodic doses of morphine to ease her continual physical pain.[136] She asked to be let alone and allowed to die by starvation, but the hospital kept her alive through forced feeding.[137]

Holding that she had the right to refuse medical treatment, the California Court of Appeals stated that such a right is "basic and fundamental."[138] The court explained that one should not look solely to the fact that she could tolerate the medical procedures, but should rather consider her state of mind and subjective feelings to determine the course that treatment should take.[139] The majority also stated that the decision to live or die is ultimately the patient's, not the state's.[140] The court determined that the motivation behind Elizabeth Bouvia's decision had no bearing on her right to make that decision.[141] This court, like the courts in *Quinlan*, *Fleming*, and *Saikewicz*, distinguished refusing medical service from actually committing suicide.[142]

Associate Justice Compton wrote an opinion concurring in the court's result, but deviating from the court's assumptions about suicide.[143] Justice Compton considered Ms. Bouvia's decision to die a decision to commit sui-

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130. *See supra* note 19.
131. *See supra* notes 61-64 and accompanying text.
132. *See supra* notes 100-03 and accompanying text.
133. *See supra* notes 121-25 and accompanying text.
134. 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297.
135. *Id.* at 1146, 225 Cal. Rptr. at 307-08 (Compton, J., concurring).
136. *Id.* at 1136, 225 Cal. Rptr. at 300.
137. *Id.*
138. *Id.* at 1137, 225 Cal. Rptr. at 301.
139. *Id.* at 1134, 225 Cal. Rptr. at 299. The court stated that the "ability to tolerate physical discomfort does not diminish [Elizabeth Bouvia's] right to immediate relief. Her mental and emotional feelings are equally entitled to respect."
140. *Id.* at 1143, 225 Cal. Rptr. at 305.
141. *Id.* at 1145, 225 Cal. Rptr. at 306.
142. The *Bouvia* court defined assisted suicide as: "affirmative, assertive, proximate, direct conduct such as furnishing a gun, poison, knife, or other instrumentality or usable means by which another could physically and immediately inflict some death producing injury upon himself." *Id.*
143. *Id.* at 1146-48, 225 Cal. Rptr. at 307-08 (Compton, J., concurring).

cide.[144] He believed that she had "an absolute right to effectuate that decision."[145] He would include in this right the ability to seek assistance of others, including physicians:

> 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.[146]

The courts in *Quinlan*, *Colyer*, *Saikewicz*, and *Rasmussen* drew distinctions between curable and terminally ill patients.[147] The *Bouvia* court expanded these decisions by holding that Elizabeth Bouvia had the right to reject medical treatment despite the fact that she was not terminally ill.[148] In a concurring opinion, Justice Compton supported a patient's right to choose the manner of her own death.[149] These cases suggest a judicial willingness to recognize that prolonging life may not always be an ideal solution. State courts have acknowledged a right to refuse treatment and have recognized that, in some instances, death may be preferable to a life of agony.[150] This supports the proposition that those courts may be willing to accept the next step and allow those patients whose illnesses are indeed terminal to determine the time and manner of their own deaths. The American Medical Association Council has determined that a physician may administer a drug to a terminally ill patient "even though the effect of the drug may shorten life."[151] Where a competent patient in excruciating pain asks a physician for aid-in-dying, that physician should be allowed to assist.

D. Cruzan v. Director, Missouri Department of Health (1990)

In June 1990, the United States Supreme Court announced its first "right to die" decision, *Cruzan v. Director, Missouri Department of Health*,[152] which centers on a woman in a persistent vegetative state with no hope of recovery. Nancy Beth Cruzan suffered severe injuries in an automobile accident which rendered her incompetent.[153] Artificial nutrition and hydration kept her alive.[154] Her parents sought to terminate her artificial feeding after it became

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144. Justice Compton observed, "Elizabeth Bouvia wants to die; and if she had the full use of even one hand, could probably find a way to end her life — in a word — commit suicide." *Id.* at 1146-47, 225 Cal. Rptr. at 307.

145. *Id.* at 1147, 225 Cal. Rptr. at 307.

146. *Id.*

147. *Quinlan*, 70 N.J. 10, 355 A.2d 670; *Colyer*, 799 Wash. 2d 114, 660 P.2d 738; *Saikewicz*, 373 Mass. 728, 370 N.E.2d 417; *Rasmussen*, 154 Ariz. 207, 741 P.2d 674.

148. *Bouvia*, 179 Cal. App. 3d at 1138, 225 Cal. Rptr. at 302.

149. *Id.* at 1147, 225 Cal. Rptr. at 307.

150. *See, e.g.*, *Quinlan*, 70 N.J. 10, 355 A.2d 670; *Colyer*, 799 Wash. 2d 114, 660 P.2d 738; *Saikewicz*, 373 Mass. 728, 370 N.E.2d 417; *Rasmussen*, 154 Ariz. 207, 741 P.2d 674.

151. *See Euthanasia*, in REPORTS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS OF THE AMERICAN MEDICAL ASSOCIATION § 12 (June 1988) [hereinafter COUNCIL REPORTS].

152. 110 S. Ct. 2841, 2846.

153. *Id.* at 2845.

154. *Id.*

apparent that Nancy would never recover.[155] The trial court granted them the authority to withdraw the treatment even though withdrawal would inevitably lead to Nancy's death.[156] Upon appeal by the Missouri Department of Health, the Supreme Court of Missouri reversed the trial court decision.[157] Nancy's parents appealed to the United States Supreme Court. The Court granted certiorari to determine whether a patient has a constitutional right to require a hospital to withdraw treatment under these circumstances.[158] The Court upheld the Missouri Supreme Court ruling refusing to recognize a privacy right broad enough to authorize termination of treatment without clear and convincing evidence as to the patient's wishes.[159]

The Court recognized the privacy right outlined in *Quinlan*,[160] allowing the guardian of a patient in a persistent vegetative state to withdraw life-sustaining treatment.[161] However, the Court explained that a state may require a patient to consent to the withdrawal.[162] If the patient is unable to consent, the state may require the patient's guardian to provide "clear and convincing" evidence of what the patient would wish were she cognizant of her situation.[163] The Court recognized that the state's interest in life is balanced against a competing interest — the deeply personal choice between life and death.[164] The Supreme Court determined, however, that states retain an interest in the preservation of human life.[165]

Justice Brennan, in dissent, stated his belief in the importance of a quiet, proud death.[166] Justice Brennan rejected the idea that there could exist a legitimate state interest which would outweigh an individual's choice to refuse treatment.[167] He based this opinion on notions of bodily integrity and the importance of its protection.[168] Justice Brennan recognized that modern tech-

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155. *Id.* at 2846.
156. *Id.*
157. The Missouri Supreme Court "recognized a right to refuse treatment embodied in the common-law doctrine of informed consent, but expressed skepticism about the application of that doctrine in the circumstances of this case." The Missouri court further refused to read a right to refuse treatment into the right of privacy as reflected in the State Constitution and "expressed doubt as to whether such a right existed under the United States Constitution." *Id.* (quoting Cruzan v. Harmon, 760 S.W.2d 408, 416-17 (Mo. 1988)).
158. *Id.*
159. *Id.* at 2854.
160. *Id.* at 2847 (citing *Quinlan*, 70 N.J. 10, 355 A.2d 647).
161. *Id.*
162. *Id.*
163. *Id.* at 2854. The Court held that "a State may apply a clear and convincing evidence standard in proceedings where a guardian seeks to discontinue nutrition and hydration of a person diagnosed to be in a persistent vegetative state."
164. *Id.* at 2852.
165. *Id.* at 2853. In a concurring opinion, Justice Scalia adamantly rejected a right to commit suicide, pointing out that it is not a right "implicit in the concept of ordered liberty." *Id.* at 2860 (Scalia, J., concurring) (quoting Marzen, O'Dowd, Crone & Balch, *Suicide: A Constitutional Right?*, 24 DUQ. L. REV. 1, 100 (1985)). Justice Scalia asserted that "[s]tarving oneself to death is no different from putting a gun to one's temple as far as the common law definition of suicide is concerned; the cause of death in both cases is the suicide's conscious decision." *Id.* at 2861.
166. *Id.* at 2868 (Brennan, J., dissenting).
167. *Id.*
168. Justice Brennan stated, "no State interest could outweigh the rights of an individual in Nancy Cruzan's position." *Id.* at 2869.

nology enables physicians and hospitals to keep people "metabolically alive."[169] An incompetent and incurably ill patient must, therefore, have some recourse to avoid a fate similar to Nancy Cruzan's.[170] The dissent concludes that while new medical technology can save the lives of some patients, it fails in the case of others who are incurable, like Nancy Cruzan.[171]

While courts across the country have recognized some right to refuse or withdraw life-sustaining treatment,[172] they have yet to recognize a patient's right to assistance in committing suicide. Courts have distinguished suicide, the active taking of life, from withdrawal of treatment, which allows a terminal illness to take its natural course.[173] Although courts may try to distinguish withdrawal of treatment from suicide, the same interests support both a right to refuse treatment and a right to assistance in rational suicide.[174] Both withdrawal of treatment and suicide require recognition of a fundamental or basic human right to a dignified death.[175] Courts have legitimized the withdrawal of treatment, allowing a terminal illness to take its natural course. Assisting suicide merely hastens the inevitable — at the request of the patient. The move from withdrawal of treatment to assisted suicide is but one step.[176] It may be a step the courts are unwilling to take, but in the interest of human dignity and self-determination, it is one which they must take.

A PHYSICIAN'S DUTY

A. The Hippocratic Oath

While lawyers debate the issues of assisted suicide in legal terms, physicians must deal with these issues in a much more personal way. For two thousand years, physicians have taken some form of an oath at the onset of their professional careers.[177] This oath symbolizes a physician's obligation to her

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169. *Id.* at 2877. Justice Brennan further stated that eighty percent of Americans, usually sedated or comatose, die in hospitals. Beyond that, one-fifth of the adults reaching the age of eighty will suffer some sort of progressive dementing disorder. *Id. See also* Cohen & Eisdorfer, *Dementing Disorders*, in THE PRACTICE OF GERIATRICS 194 (E. Calkins, P. Davis & A. Ford eds. 1986).

170. *Cruzan*, 110 S. Ct. at 2878 (Brennan, J., dissenting).

171. *Id.*

172. *See, e.g., Cruzan*, 110 S. Ct. 2841; *Quinlan*, 70 N.J. 10, 355 A.2d 670; *Colyer*, 99 Wash. 2d 114, 660 P.2d 738; *Saikewicz*, 373 Mass. 728, 370 N.E.2d 417; *Rasmussen*, 154 Ariz. 207, 741 P.2d 674.

173. *See Saikewicz*, 373 Mass. 728, 743 n.11, 370 N.E.2d 417, 426 n.11; *Colyer*, 99 Wash. 2d 114, 122-23, 660 P.2d 738, 743.

174. Rosenblum & Forsythe, *The Right to Assisted Suicide: Protection of Autonomy or an Open Door to Social Killing?*, 6 ISSUES L. & MED. 3, 20 (1990) ("By both depreciating society's compelling interest in the sanctity of human life and in adopting substituted judgment, recent court decisions have laid the groundwork for the ultimate approval of suicide and assisted suicide.").

175. *Id.* at 21.

176.

> The law will be seen to be hypocritical if it allows action — the withdrawal of nutrition and hydration — that will purposely and certainly bring about the death of the patient but prohibits "humane" actions, such as lethal injections, that merely hasten the direct, certain result that has been purposely set in motion.

Id. at 25.

177. *See* Clarke, *supra* note 5, at 223.

patients as well as a dedication to society.[178] In the original Hippocratic oath, physicians in part swore they would "neither give a deadly drug to anybody if asked for it, nor [would they] make a suggestion to this effect. Similarly [they would] not give to a woman an abortive remedy. In purity and holiness [they would] guard life and [their] art."[179]

Alternatives to the Hippocratic oath exist, including the Prayer of Moses Maimonides[180] and the Declaration of Geneva.[181] Each of these oaths promulgates a different philosophy of medicine. The preservation of life, however, remains the ultimate objective.[182]

Because they must answer to the patient's family and to a profession which exists to preserve life, physicians who facilitate a patient's suicide face social and professional stigma for their actions.[183] Individual physicians, however, may differ in their attitudes about the preservation of life.[184] For example, the New Jersey Supreme Court in *Quinlan* pointed out an "unwritten and unspoken standard" in the medical profession not to resuscitate terminally ill patients.[185] The court concluded that the imperative to sustain life at any cost no longer exists.[186]

The American Medical Association determined that its standards of conduct involve compassion, respect for human dignity, and above all, the best interests of the patient.[187] While no law condones easing a patient's suffering by prescribing death, many physicians do condone such action.[188] The AMA

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178. *Id.*

179. 4 ENCYCLOPEDIA OF BIOETHICS 1731 (1978). The medical community has modified this portion of the oath to allow for changes such as the legalization of abortion. *See generally* Roe v. Wade, 410 U.S. 313 (1973).

180. The Prayer of Moses Maimonides is a prayer rather than an oath. It makes no reference to any prohibition on medical treatment beyond statements deriding profiteering, arrogance, or lack of concentration. Primarily, it calls for the physician to benefit mankind. M.B. ETZIONY, THE PHYSICIAN'S CREED 28 (1973).

181. The Declaration of Geneva, modified in 1976, states that the "health of [the physician's] patient will be [his] first consideration." It calls for the "utmost respect for human life" and prohibits the physician from using "medical knowledge contrary to the laws of humanity." *Id* at 89.

182. *See* CURRENT OPINIONS, *supra* note 3, at 13.

183. Quill, *supra* note 2, at 694.

184. *Id.* In his article, Dr. Timothy Quill wrote of his patient "Diane." Diane suffered from leukemia and faced years of pain and suffering from what would ultimately be useless treatment. Dr. Quill prescribed sleeping pills for Diane, telling her the recommended dosage to aid sleep as well as the lethal dose. Diane used these pills in committing suicide.

185. 70 N.J. at 29, 355 A.2d at 657.

186. *Id.*

187. *See supra* note 123.

188. *See* Quill, *supra* note 2, at 693. *See also* BENEFICENT EUTHANASIA, *supra* note 16, at 146. A 1936 debate in the British House of Lords dealt with Britain's first euthanasia bill. The bill revealed a practice among physicians of "shortening the gap" between illness and death by prescribing a humane overdose of some drug, usually morphine. *Id. See also* Nagler, *Uremia — A Way Out?*, in HUMAN AND ETHICAL ISSUES IN THE SURGICAL CARE OF PATIENTS WITH LIFE-THREATENING DISEASE 155, 156 (F. Herter, K. Forde, L. Mark, R. DeBellis, A. Kutscher & F. Selder eds. 1986) (suggesting that allowing death by renal failure is preferable to allowing the patient to die slowly and painfully by the progression of urinary cancer).

Council determined that it may be unconscionable, in certain cases, to cherish life at all costs.[189]

While the Hippocratic oath and others like it endorse medicine for the purpose of preserving life, modern scientific advances necessitate an examination of the reasons behind that philosophy. The philosophies of medicine must take into account the wishes of the rational patient. In cases of catastrophic illness and incurable disease, where a rational patient asks for help in committing suicide, perhaps medicine is better suited to easing death than it is to prolonging life.

B. Failing to Preserve Life: A Physician's Potential for Liability

Although suicide and attempted suicide are no longer criminal acts,[190] assisting suicide remains a criminal offense in most states.[191] In many of these states, aiding and abetting a suicide is a felony punishable by imprisonment.[192] Studies have shown, however, that a growing number of people support the legalization of some dignified alternative to a slow, painful death.[193] There is a

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189. *See* AMA COUNCIL OPINION, *supra* note 121, at 12 (discussing withdrawal of life-support systems from terminally ill or hopelessly unconscious patients).

190. *See* Note, *Criminal Liability for Assisting Suicide*, 86 COLUM. L. REV. 348.

191. *See* ALASKA STAT. § 11.41.100(a) (1989) ("A person commits the crime of murder in the first degree if with intent to cause the death of another person, the person compels or induces any person to commit suicide."); ARIZ. REV. STAT. ANN. § 13-1103(a) (1989) ("A person commits manslaughter by ... intentionally aiding another to commit suicide."); ARK. STAT. ANN. § 5-10-104 (1987) ("A person commits manslaughter if ... he purposely causes or aids another person to commit suicide."); CAL. PENAL CODE § 401 (West 1988) ("Every person who deliberately aids, or advises, or encourages another to commit suicide, is guilty of a felony."); COLO. REV. STAT. ANN. § 18-3-104(1) (1990) ("A person commits the crime of manslaughter if ... he intentionally causes or aids another person to commit suicide."); CONN. GEN. STAT. ANN. § 53a-56(a) (West 1985) ("A person is guilty of manslaughter in the second degree when ... he intentionally causes or aids another person, other than by force, duress or deception, to commit suicide."); DEL. CODE ANN. tit. 11, § 645 (Supp. 1990) ("Promoting suicide is a class F felony."); FLA. STAT. ANN. § 782.08 (West 1976) ("Every person deliberately assisting another in the commission of self-murder shall be guilty of manslaughter, a felony of the second degree."); ME. REV. STAT. ANN. tit. 17-A, § 204(1) (1983) ("A person is guilty of aiding or soliciting suicide if he intentionally aids or solicits another to commit suicide, and the other commits or attempts suicide."); MINN. STAT. ANN. § 609.215 (West 1987) ("Whoever intentionally advises, encourages, or assists another in taking the other's own life may be sentenced to imprisonment ... or to payment of a fine ... or both."); N.J. STAT. ANN. § 2C:11-6 (West 1982) ("A person who purposely aids another to commit suicide is guilty of a crime of the second degree if his conduct causes such suicide or an attempted suicide."); N.M. STAT ANN. § 30-2-4 (1978) ("Whoever commits assisting suicide is guilty of a fourth degree felony."); OKLA. STAT. ANN. tit. 21, § 813 (West 1983) ("Every person who willfully, in any manner, advises, encourages, abets, or assists another person in taking his own life, is guilty of aiding suicide."); 18 PA. CONS. STAT. ANN. § 2505(B) (Purdon 1983) ("A person ... is guilty of a felony of the second degree if his conduct causes such suicide or an attempted suicide."); TEX. PENAL CODE ANN. § 22.08(a) (Vernon 1989) ("A person commits an offense if, with intent to promote or assist the commission of suicide by another, he aids or attempts to aid the other to commit or attempt to commit suicide.").

192. *See, e.g.*, ARIZ. REV. STAT. ANN. § 13-1103 (equating assisted-suicide with manslaughter); ARIZ. REV. STAT. ANN. § 13-1103(B) (1989) ("Manslaughter is a class 3 felony."). In Arizona, class 3 felonies are punishable by five years in jail for a first offense. *Id.* § 13-701. *See also* FLA. STAT. ANN. § 782.08 (West 1976); ME. REV. STAT. ANN. tit. 17-A, § 204(2) (1983).

193. *See* Clarke, *supra* note 5, at 217. *But see* Gross, *supra* note 8 (Washington voters reject initiative proposing legalization of physician-assisted suicide).

need to legalize assisted suicide in order to guarantee individuals freedom from the pain and uncertainty involved in unassisted methods of suicide.[194] Society should enable physicians to prescribe drugs to help ailing patients achieve a painless, quick, and certain death. As the law stands, however, physicians who seek to assist their patients in committing rational suicide may experience both civil and criminal repercussions for their actions.[195]

As with murderers, those who assist suicides may have various levels of culpability depending on the nature of their acts and the closeness of connection to the actual deed.[196] Although assisted suicide remains a crime, there are few reported cases imposing criminal sanctions on a physician for assisting in a patient's suicide.[197]

A physician's oath at graduation as well as the criminal codes of many states recognize the sanctity of life as a vital interest. Civil and criminal sanctions exist to guarantee that physicians uphold their oaths and protect that interest. Faced with a patient whose illness defies all treatment, physicians may feel obligated to fulfill their oaths by respecting their patients' express wishes and upholding the sanctity of life through the dignity of death. Of course, existing laws do not condone assisted suicide. As society's views on rational suicide evolve, however, states must pass legislation allowing competent individuals to choose a dignified death.

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194. For example, an overdose of sleeping pills may lead to a drug-induced coma. A bullet wound or slit wrists may cause severe damage short of death. Likewise, attempting suicide by hanging or asphyxiation (for example, inhaling car exhaust fumes) may lead only to more severe trauma and pain and an even less dignified death.

195. *See supra* notes 191-92 (statutes criminalizing assisted suicide). *See also* Fuller v. Preis, 35 N.Y.2d 425, 322 N.E.2d 263, 363 N.Y.S.2d 568 (1974). In *Fuller*, a 43-year old surgeon suffered severe trauma resulting from an auto accident. Following the accident, he experienced seizures and was finally diagnosed as having a concussion. Hospitalization and rehabilitation caused pressures which began to affect his personal and professional activities. When this pressure grew too intense, he committed suicide. The court held that a jury could find the accident to have been the proximate cause of Dr. Lewis's suicide. Furthermore, the court pointed out that the defendant in the accident suit could then be liable for wrongful death. *Id.* at 427, 322 N.E.2d at 264, 363 N.Y.S.2d at 570.

Fuller seems to indicate a possible theory by which a court may hold a physician liable when she assists her patient in committing suicide. However, while the potential for civil liability is a significant issue in the debate over assisted suicide, a complete discussion of this issue is beyond the scope of this Note.

196. *See* Clarke, *supra* note 5, at 228-29. Most criminal statutes divide homicide into two main categories: manslaughter and murder (a third category may be negligent homicide, requiring a lower mental state requirement). Particularly now that most statutes impose minimum penalties, the difference between a conviction for murder or manslaughter can be as much as ten to twenty years of mandatory prison time. W. LAFAVE & A. SCOTT, CRIMINAL LAW 605 (2d ed. 1986).

197. In December 1990, a Michigan judge dismissed murder charges against Dr. Kevorkian upon a finding that Mrs. Adkins' use of his suicide machine did not make the physician criminally liable for her death. Lewin, *supra* note 8. *See also* Barber v. Superior Court, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983) (physician prosecuted for helping a patient to forgo treatment, but the indictment was ultimately dismissed); Engelhardt & Malloy, *Suicide and Assisting Suicide: A Critique of Legal Sanctions*, 36 SW. L.J. 1003, 1029 (1982) ("No published American opinions have reported convictions of physicians for aiding, abetting, or assisting suicide. This lack of reported cases is perhaps due to prosecutorial decisions not to pursue potential violators, thereby leaving no avenue for judicial comment.").

RECOGNIZING AN INDIVIDUAL'S RIGHT TO ASSISTED SUICIDE

Several organizations currently focus their efforts on the legalization of assisted suicide. Among them is the Hemlock Society,[198] which promotes legislation allowing physicians to assist competent patients in securing humane and painless means to end their lives.[199] The Hemlock Society has gained much notoriety in recent years, particularly through its work on aid-in-dying initiatives. Furthermore, *Cruzan*[200] and related cases have helped to inform the public of existing rights. Society may now be more willing to accept a broadening of these rights, including a right to physician-assisted suicide. Several states, with the assistance of the Hemlock Society and the Society for the Right to Die, have drafted initiatives hoping to bring existing law more in line with their philosophies.[201]

In November 1991, voters in the State of Washington rejected an initiative which would have legitimized the request of a competent individual to receive life-ending drugs, and legalize the decision of an attending physician to comply with such a request.[202] This initiative would have countered public pressures against legalization of suicide by focusing on human dignity and placing rational assisted suicide in a category of its own.[203] For example, the Washington initiative clearly states that a physician's aid to a terminally ill patient will not constitute homicide.[204] The initiative sought to legalize a physician's aid in the death of a competent, qualified patient who actually requests such assistance.[205]

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198. Derek Humphry founded the Hemlock Society in 1980 to promote rational, assisted suicide. *See* Humphry, *General Principals*, in LET ME DIE BEFORE I WAKE, *supra* note 10 (unnumbered preface). The Hemlock Society "does not encourage suicide for any primary emotional, traumatic, or financial reasons in the absence of terminal illness. It approves of the work of those involved in suicide prevention." *Id.* Writing about his book, Mr. Humphry states that "it addresses only the option of rational suicide for a person in advanced terminal illness or serious incurable physical illness." Humphry, *Alternatives*, in LET ME DIE BEFORE I WAKE, *supra* note 10. The Hemlock Society believes that

> active voluntary euthanasia for the terminally ill should be tackled on two levels: raising public consciousness so that the old taboos drop away and ethical standards are modernized; and ensuring that appropriate guides and information are available to ordinary people who face a terminal illness — either of their own or within the family.

D. HUMPHREY, *supra* note 10, at 6.

199. *Id.*

200. 110 S. Ct. 2841.

201. *See, e.g.*, Washington Initiative, *supra* note 11; Gross, *supra* note 8.

202. Washington Initiative, *supra* note 11. *The New York Times* reported that 54% of the voters opposed the initiative, while 46% voted in its favor. Gross, *supra* note 8, at A10. *See also* Model Act, *supra* note 8 (model act proposing the legalization of physician-assisted suicide).

203. Washington Initiative, *supra* note 11, at § 1.

204. *Id.* § 4.

205. *Id.* § 1

Certainly, there are compelling reasons for maintaining laws against assisted suicide, the most important of which is a real fear of abuse.[206] The Washington Initiative counters this fear by requiring a written directive signed by two unrelated and disinterested witnesses.[207] The directive would instruct the attending physician to provide aid-in-dying, or withdrawal of life-sustaining treatment.[208]

The Netherlands, one of the few countries to condone rational assisted suicide, deals with the potential for abuse through stringent procedural requirements. In that country, physicians and legislators have outlined several conditions which must be fulfilled before authorities will condone euthanasia in a particular case.[209] The patient must first experience lasting and unbearable physical and mental suffering.[210] She must have a clear understanding of her options and must have made a voluntary decision.[211] Moreover, there must be no other reasonable alternative and the procedure must involve a physician.[212] Finally, the time and manner of the death must not cause avoidable misery to others.[213] Following these guidelines, the Netherlands allows several thousand people to undergo euthanasic treatment each year.[214]

In a recent Iowa Law School seminar, law and graduate students formulated a Model Aid-in-Dying Act.[215] This Act legalizes assisted suicide only

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206. One reason is the fear that condoning assisted suicide might lead some physicians to use consent as their excuse when a patient dies of unnatural causes. No doubt some basis exists for these fears. They may, however, be countered by strong procedural safeguards.

Such a procedure already exists in the law of wills, trusts and estates. With strict requirements of formality and technicality, the possibilities for abuse in estate planning are severely limited. Laws requiring formality in wills exist to counteract the danger that "witnesses might either misremember or deliberately lie about what the testator said he wanted done with his property after death." W. MCGOVERN, JR., J. REIN & S. KURTZ, WILLS, TRUSTS AND ESTATES § 4.1 (1988).

207. The Initiative requires that the directive:

> be signed by the declarer in the presence of two witnesses not related to the declarer by blood or marriage and who would not be entitled to any portion of the estate of the declarer upon declarer's decease under any will of the declarer or codicil thereto then existing or, at the time of the directive, by operation of law then existing.

Washington Initiative, *supra* note 11, at § 3. The Initiative further requires that the witness cannot be the attending physician or any person associated with the health care facility. *Id.*

208. *Id. See also* Model Act, *supra* note 8 (laying out a model act for assisted suicide including several safeguards and checks on the attending or assisting physician); Williams, *supra* note 16, at 165 (indicating that legislatures could implement safeguards to guard against such abuse); Clarke, *supra* note 5 (addressing the "slippery slope" argument followed by other opponents of assisted-suicide).

209. Clarke, *supra* note 5, at 230 (citing Address by Pieter V. Admiraal, *Euthanasia in the Netherlands: A Dutch Perspective*, Third National Voluntary Euthanasia Conference, Washington, D.C. (Sept. 25-27, 1986)).

210. *Id.*

211. *Id.*

212. *Id.*

213. *Id.*

214. *Id.* "5,000 persons annually request and are granted voluntary euthanasia under these guidelines."

215. Students and faculty developed this Act through a year-long seminar on euthanasia and assisted suicide. *See* Model Act, *supra* note 8.

in cases of terminally ill or intolerably ailing patients.[216] Under the Model Act, attending medical professionals would not be liable for the patient's death.[217]

The Model Act distinguishes passive and active assistance of suicide. A passive assistant merely provides the means, while an active assistant actually helps the patient to die.[218] The Act specifically speaks to the issue of physician aid-in-dying and outlines several subjective differences between directly causing a patient's death and simply allowing the illness to take its natural course without active intervention.[219] An objective distinction between withholding and administering treatment is impractical to make.[220] A physician who merely sets sleeping pills on the bedside table assists in the resulting suicide in much the same way as does the physician who administers a lethal dose of morphine.[221]

The physician's personal feelings and beliefs may pose problems when she actually assists a patient's suicide.[222] Merely pulling the plug of a life-support system will lead to the patient's death, but the actor remains innocent of other involvement. By contrast, the physician who administers a lethal dose to a dying patient may feel responsible for his patient's death.[223] Such feelings may prevent a physician from acting in the patient's best interest.[224] The Act, however, weighs the physician's discomfort against the patient's intent.[225] Under the proposed Act, the patient's interests prevail.[226]

Finally, the drafters of the Model Act discussed society's fears that some physicians may abuse the right to assist a patient's suicide.[227] The drafters pointed out that safeguards, many of which are implemented in the Model Act

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216. *Id.* at 133. "This [Act] authorizes the termination of life both through the administration of a life-terminating drug ... as well as the withholding, withdrawal, or abatement of life-sustaining treatment."

217. Section 13-101 of the Model Act would immunize the assistant from civil or criminal liability or loss of professional license so long as her act was committed in good faith compliance with another's request for aid-in-dying. *Id.* at 196.

218. *Id.* at 134-35. The differences between passive and active assistance include: the intent of the actor or omitter, causation, subjective feelings of the actor, and the potentials for abuse.

219. *Id.* at 135. "The administration of a lethal drug is a different kind of cause of the patient's death than the withholding of oxygen or water. This also reflects the difference between acts of omission and commission."

220. *Id.* "Many do not regard the difference as meaningful, and certainly not in the context of a patient completely in the care of others."

221. *Id.* The Act suggests that "the difference is more illusory than real, at least in this context."

222. *Id.* "Those who inject a lethal drug may feel more clearly that they are 'killing' the patient than those who merely turn off a respirator and wait to see what course nature takes."

223. *Id.*

224. *Id.*

225. *Id.* "The discomfort the psychological difference causes the caregiver should not be ignored, but it must be weighed against the comfort and intent of the patient."

226. *Id.*

227.

> Two forms of abuse are feared. The first is that patients who only are moderately ill could be given a lethal drug and die.... The second risk ... is that a regime limited to passive aid-in-dying encourages abuse for all the reasons offered to distinguish active aid-in-dying. Enabling caregivers to end someone's life while pretending they are not really causal agents in the patient's death promotes more, not less, abuse.

Id.

itself,[228] could curb this fear just as they have in other areas of the law. Drafters of the Model Act suggest that openly facing the issue of physician-assisted suicide is the best deterrent to potential abuse.[229] They would weigh any potential for abuse against the desires of terminally ill patients who seek to benefit from this type of legislation.[230] The authors adamantly believe that individual autonomy is the primary consideration in determining whether rational assisted suicide is appropriate in a particular case.[231] The high value which the Act places on autonomy corresponds to the medical community's heightened respect for individual self-determination.[232] A standard may exist within the medical profession to gear care towards comfort rather than a life-at-all-costs philosophy.[233]

The Washington Initiative and the Iowa Model Act are two examples of current legislative proposals designed to deal with the issue of rational assisted suicide. Both proposals focus on the prevention of fraud and seek to alleviate fears of misuse. Despite the defeat of the Washington Initiative, the Hemlock Society and its compatriots will continue their struggle to convince society to legitimize rational assisted suicide.

CONCLUSION

Clearly, compelling arguments exist for the legalization of rational, physician-assisted suicide. Physicians can now keep comatose patients alive long after normal bodily functions cease. Terminal diseases create even more difficulties. Physicians must tell these patients that they have contracted an incurable terminal illness and yet offer them no opportunity to choose a dignified death. Before modern medicine gave rise to new hopes for combatting otherwise fatal diseases, physicians often prescribed morphine and other similarly potent drugs to their patients in an effort both to ease their pain and hasten their inevitable deaths.[234] As modern medicine evolves, so must society's views on self-determination and personal dignity. Choosing death over painful life should never be an easy decision. The individual should make that decision for herself, with the counsel of a caring physician and after careful deliberation. Courts and legislatures should not interfere in this most private decision.

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228. Article two of the Act discusses the requirements for a valid directive, including formal requirements much like those required for the creation of valid testamentary instruments. First, the declarant must be competent. *Id.* (§ 2-101). In addition, the signature of the declarant must be accompanied by that of two witnesses, one of whom must be a patient advocate if the declarant is a patient in a health care facility. *Id.* (§ 2-102). These requirements preserve the interests of the declarant while checking the potentials for abuse which may otherwise arise. *Id.*

229. *Id.*

230. *Id.* at 136.

231. *Id.* "[T]he interests of the patient and the minimization of the patient's suffering are paramount."

232. *Id.* at 137. *See also* COUNCIL REPORTS, *supra* note 151.

233. Model Act, *supra* note 8. *See also* Clarke, *supra* note 5, at 657. The AMA Council on Ethical and Judicial Affairs supports the proposition that when the illness is clearly terminal or permanent, the preference of the individual should prevail. Unless and until such a determination is made, physicians must continue to treat the illness aggressively, with the object of sustaining life and curing the illness. AMA COUNCIL OPINION, *supra* note 121.

234. Clarke, *supra* note 5, at 219.

Legalization of rational physician-assisted suicide would give suffering individuals a right to self-determination and a right to a dignified and painless death. Although courts have not yet spoken directly on the issue, organizations and individuals dedicated to creating a right to obtain assistance in suicide will compel legislatures to consider the question. As with any such topic, public opinion will play a crucial role in the course of the assisted suicide debate. Although abortion, animal rights, and other similarly explosive topics tend to generate passionate responses, none hit as closely to home as do the issues of death and dying. While not every member of society faces decisions regarding abortion, every living being must ultimately face death.

Debating the issues involved in suicide and assisted suicide brings the reality of death to the forefront and forces individuals to face their own mortality — something very few are willing to do. Furthermore, they must accept the real likelihood that assisted suicide, particularly physician-assisted suicide, will actually result in death. In the case of unassisted suicide, there is still some chance of failure — of recovery. Already unwilling to face the concept of mortality, individuals are even more hesitant to confront the certain success of physician-assisted suicide. Soliciting assistance in committing suicide eliminates the potential for failure. This reality may make the topic nearly unbearable, but, nevertheless, intensely critical.

In light of *Cruzan*,[235] *Bouvia*,[236] *Quinlan*,[237] and other recent court decisions, as well as the positions of the American Medical Association, the Hemlock Society and the Society for the Right to Die, it seems clear that physician-assisted suicide is not an issue to be dealt with lightly. Terminally ill patients and their physicians must deal with that issue every day. Trying to act in their patients' best interests, physicians find themselves in a Tantalus[238] cycle: reaching up for the life they have sworn to save, they find themselves clutching nothing but death.

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235. 110 S. Ct. 2841.
236. 179 Cal. App. 3d 227, 225 Cal. Rptr. 297.
237. 70 N.J. 10, 355 A.2d 647.
238. In the mythical story of Tantalus, a man punished by eternal torment must stand forever in a lake of water. Overhead hangs a branch laden with fruit. If he reaches for the fruit, a gust of wind blows the branch out of reach. If he stoops to drink, the water recedes. *See* 2 R. GRAVES, THE GREEK MYTHS 25-26 (1988).