NOTES

PHYSICIAN RESPONSIBILITY AND THE RIGHT TO "DEATH CARE": THE CALL FOR PHYSICIAN-ASSISTED SUICIDE

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I. INTRODUCTION

Debbie, a twenty year old patient, believed the young resident who visited her in the middle of the night was a man "[who] would let her rest."[1] Debbie was dying of ovarian cancer and was unresponsive to chemotherapy treatments.[2] She suffered from severe oxygen hunger and struggled for every breath.[3] The resident noted she weighed less than 80 pounds, experienced "unrelenting vomiting," and had not slept or eaten in two days.[4] Debbie's simple plea "[l]et's get this over with" motivated the resident to inject Debbie

1. Anonymous, *It's Over Debbie*, 259 JAMA 272, 272 (1988).
2. *Id.*
3. *Id.*
4. *Id.*

intravenously with 20 milligrams of morphine sulfate.[5] Debbie's breathing slowed immediately and within four minutes she ceased breathing completely, receiving the rest for which she had pleaded.[6]

An anonymous author submitted Debbie's story to the *Journal of the American Medical Association*.[7] Presumably, the account is true and for that reason, the resident requested his name be withheld for fear of legal and ethical repercussions. Clearly, Debbie's doctor provided the one aspect of health care evading most other patients in situations similar to Debbie's—"death care."

Current common law and statutory law does not allow the use of physician aid-in-dying, also known as physician-assisted suicide.[8] Consequently, the terminally ill, as well as individuals suffering from severe pain and long-term illness, have chosen to end their lives without the help of doctors, but often with the assistance of others. The response of both the courts and the legislatures to these actions are inconsistent and inconclusive. In Part II, this Note explores the current foundations in the law for physician-assisted suicide, particularly the judicial and legislative responses to requests to withdraw life-sustaining treatment. Part III discusses the courts' treatment of individual "mercy killings" and the legislatures' views regarding the responsibility of physicians' death care. This Note concludes that the legalization of assisted-suicide would be in the best interests of all concerned, including patients, their loved ones, and physicians.

II. CURRENT FOUNDATIONS IN THE LAW

A. *Withholding and Withdrawing Life-Sustaining Treatment*[9]

1. *Terminally Ill Patients*

It is easier for terminally ill patients to refuse or request removal of life-sustaining treatment than it is for nonterminally ill patients to do the same. In the early case of *Satz v. Perlmutter*,[10] the court examined the right of a competent, terminally ill patient to discontinue medical treatment.[11] Mr. Perlmutter suffered from Lou Gehrig's disease and was kept alive

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5. *Id.*
6. *Id.*
7. *Id.*
8. *See infra* text accompanying notes 119-74.
9. The impetus for the growth of law in this area was the tragic case of *In re* Quinlan, 355 A.2d 647 (N.J.), *cert. denied*, 429 U.S. 922 (1976).
10. Satz v. Perlmutter, 362 So. 2d 160 (Fla. Dist. Ct. App. 1978), *aff'd*, 379 So. 2d 359 (Fla. 1980).
11. *Id.* at 163.

through the use of a respirator.[12] Mr. Perlmutter made several attempts to disconnect the respirator, expressing his wish to die, but the hospital staff reconnected it against his wishes.[13] Mr. Perlmutter petitioned the court for removal of the respirator.[14]

The State argued removal of the respirator constituted an unlawful killing and fell within either the state murder statute or the state manslaughter statute.[15] Despite this argument, the court found Mr. Perlmutter had the right to refuse medical treatment under the constitutional guarantee of a right to privacy.[16] It reasoned that despite the State's interests of preservation of life, protection of innocent parties, suicide prevention, and maintenance of the medical profession's ethical integrity, no basis existed to force a "competent, but otherwise mortally sick, patient [to] undergo the surgery or treatment which constitutes the only hope for temporary prolongation of his life."[17] The court further recognized requests for withdrawing life-support from terminally ill patients had resulted in a "prevailing ethical practice seem[ing] to . . . recognize that the dying are more often in need of comfort than treatment."[18] The court analogized the right of a dying man to discontinue treatment to that of a cancer patient declining to undergo life-prolonging treatment, and recognized the similarity in both instances–the right of a competent, terminally ill patient to choose to forego available medical technology.[19] Thus, the court concluded the hospital's attempt to keep Mr. Perlmutter alive through "never ending physical torture on his body" was an invasion of Mr. Perlmutter's right to privacy and could not be continued against his will.[20]

The issue of a terminally ill patient's right to discontinue medical treatment appeared again in the companion cases of *In re Storar*[21] and *Eichner v. Dillon*.[22] Decided together, these two cases focused on the right of a third party to make decisions on behalf of an incompetent, terminally ill patient. In *In re Storar*, a fifty-two year old man with the mental competency of eighteen months was diagnosed with bladder cancer.[23] The man required blood transfusions to counteract the blood loss the cancer caused and to prevent him from bleeding to death.[24] The patient's mother requested

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12. *Id.* at 161.
13. *Id.*
14. *Id.*
15. *Id.* at 162.
16. *Id.*
17. *Id.*
18. *Id.* at 163.
19. *Id.*
20. *Id.* at 164.
21. *In re* Storar, 420 N.E.2d 64 (N.Y.), *cert. denied*, 454 U.S. 858 (1981).
22. Eichner v. Dillon, 420 N.E.2d 64 (N.Y. 1981).
23. *In re* Storar, 420 N.E.2d at 68.
24. *Id.* at 69.

discontinuance of the transfusions, and the hospital petitioned the court to allow the transfusions to continue in order to sustain the patient's life.[25]

The court recognized the right of a patient to participate in determining what medical treatment will be administered, as well as the authority of a physician to carry out a patient's wishes to discontinue medical treatment.[26] The sticking point for the court was, however, this patient had never experienced an instance of competency in his life.[27] The patient's lack of even momentary competency made it impossible for the court to determine if the patient had possessed a specific desire, or had ever expressed such a desire, to discontinue medical treatment in the event of incompetency.[28] As a result, the court alternatively examined the ability of a parent to consent to medical treatment for a child,[29] and concluded a parent did not have the authority to withhold life-sustaining treatment from a child.[30] Thus, the court held the patient's mother could not refuse the use of the blood transfusions her son needed to prolong his life until the eventual stages of cancer took a terminal course.[31]

The court distinguished *Eichner* from *In re Storar*, stating these cases resembled one another only superficially.[32] In *Eichner*, Brother Joseph Fox suffered cardiac arrest and deprivation of oxygen to his brain during surgery for a hernia.[33] He suffered severe brain damage and was placed on a respirator for maintenance in a chronic vegetative state.[34] Father Eichner, the president of the Catholic high school where Brother Fox worked, determined Brother Fox would prefer the discontinuation of life-support.[35] The hospital refused to disconnect the respirator and Father Eichner petitioned the court to be named administrator of Brother Fox's property with the authority to disconnect the respirator.[36] The New York Supreme Court focused on Brother Fox's prior declarations stating he wished to have a respirator removed in the event of incompetency, and granted Father Eichner's petition.[37] The court reasoned Brother Fox possessed the right to refuse treatment as a competent patient, and these wishes were known be-

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25. *Id.*
26. *Id.* at 71.
27. *Id.* at 72.
28. *Id.*
29. *Id.* at 73.
30. *Id.*
31. *Id.*
32. *Id.*
33. Eichner v. Dillon, 420 N.E.2d 64, 67 (N.Y. 1981).
34. *Id.*
35. *Id.*
36. *Id.*
37. *Id.* at 68.

fore he became incompetent thus, it logically followed that Brother Fox's wishes should be carried out despite his incompetency.[38]

The New York Court of Appeals agreed with the supreme court's determination to grant Father Eichner's petition.[39] The court of appeals employed the same reasoning as in *In re Storar*, recognizing the right of the patient to participate in determining what medical care he will receive.[40] The district attorney argued, however, the right to discontinue treatment could not vest in a third party when the patient becomes incompetent.[41] He further argued if such a right does vest, the overriding State's interest in preventing a third party from causing the death of another should apply to prevent the exercise of that right.[42]

The court rejected these arguments, focusing instead on Brother Fox's wishes prior to his incompetency in which he expressed a desire to discontinue such treatment if he should ever become incompetent.[43] The court found Father Eichner had satisfied his burden of proving by clear and convincing evidence Brother Fox desired to have life-support equipment removed in the event of incompetency.[44] Finding no ulterior motives for disconnection of the respirator, the court affirmed the granting of the petition allowing Father Eichner to disconnect Brother Fox's respirator.[45]

In *Eichner*, the court relied on Brother Fox's prior expressions of his wish not to have his life sustained by means of medical treatment as a basis for allowing a third party to discontinue medical treatment on Brother Fox's behalf.[46] This expression by the patient of his wish to discontinue life-support treatment made when he was competent distinguishes *Eichner* from *In re Storar*. The mental incompetency of the patient in *In re Storar*, which existed from birth, prevented the court from allowing a third party to make the decision to discontinue treatment for the patient.[47] If the patient in *In re Storar* had at some point made a competent decision to discontinue life-sustaining treatment, the court probably would have permitted the patient's mother to discontinue treatment for her son during his incompetency.

These cases are only a sample of those in which the courts demonstrated a willingness to protect the rights of the terminally ill to forego life-supporting treatment, regardless of whether it is a competent patient, as in *Perlmutter*, or an incompetent patient who previously expressed his wishes

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38. *Id.*
39. *Id.* at 70.
40. *Id.* at 71.
41. *Id.*
42. *Id.*
43. *Id.* at 72.
44. *Id.*
45. *Id.* at 74.
46. *Id.* at 68.
47. *In re* Storar, 420 N.E.2d 64, 72-73 (N.Y.), *cert. denied* 454 U.S. 858 (1981).

to discontinue treatment, as in *Eichner*. The judicial system's willingness to recognize a patient's right to make a choice foregoing medical treatment extended singularly, however, to terminally ill patients until the decisions of several courts in the early 1980s.

2. *Nonterminally Ill Patients*

As an initial inquiry, the courts in *In re Storar, Eichner,* and *Perlmutter* considered the person's status as a terminally ill patient in deciding whether to continue life-sustaining treatment. In the early 1980s, courts shifted their focus to whether the patient, regardless of the duration of his life, would want to be sustained by medical means. For example, in *Bartling v. Superior Court,*[48] the court held the "right to have life-support equipment disconnected was [not] limited to comatose, terminally ill patients, or representatives acting on their behalf."[49] Mr. Bartling, a seventy year old man, entered the hospital for a physical examination, and when an x-ray revealed a tumor on his lung, a biopsy was performed.[50] Mr. Bartling's lung was perforated during the biopsy and did not heal properly, requiring him to be connected to a ventilator.[51] Mr. Bartling and his wife brought suit against the hospital for its refusal to disconnect Mr. Bartling's ventilator at his request.[52]

Evidence was presented in two important areas: (1) Mr. Bartling needed to be placed in restraints because on several occasions he had tried to remove the ventilator tubes,[53] and (2) Mr. Bartling had executed a living will and "Durable Power of Attorney for Health Care" appointing his wife as his attorney-in-fact.[54] Relying on the lower court's findings that Mr. Bartling was competent to make a decision to refuse medical treatment and he was not terminally ill,[55] the court stated "[t]he right of a competent adult patient to refuse medical treatment has its origins in the constitutional right of privacy."[56] Balancing this constitutional right against the State's interests of "preservation of life, the need to protect innocent third parties, the prevention of suicide, and maintaining the ethics of the medical profession,"[57] the court

48. Bartling v. Superior Court, 209 Cal. Rptr. 220 (Ct. App. 1984). Mr. Bartling died prior to the hearing on his petition to the court. *Id.* at 221. Despite the mootness of the case, the court rendered a decision because of the medical and legal issues involved. *Id.*

49. *Id.* at 223.

50. *Id.* at 221.

51. *Id.*

52. *Id.*

53. *Id.*

54. *Id.* at 222.

55. *Id.* at 223.

56. *Id.* at 225.

57. *Id.* at 224 (citing Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417 (Mass. 1977)).

concluded the "right of a competent adult patient to refuse medical treatment is a constitutionally guaranteed right which must not be abridged."[58]

Interestingly, the court rejected any connection between the disconnection of the ventilator and an act of aiding suicide, stating removal of the ventilator "would merely . . . haste[n] his inevitable death by *natural causes*."[59] In distinguishing the act of removing the ventilator from any overt act on the part of the physician, and by choosing to treat the withdrawal of treatment as merely the hastening of death by natural causes, the court successfully removed the physician from any "active" role in Mr. Bartling's request for death.

In a similar vein, *Brophy v. New England Sinai Hospital,*[60] involved the request of family members to remove the gastrostomy tube ("G-tube") providing nutrition and hydration to a patient in a persistent vegetative state.[61] Mrs. Brophy brought suit in the Probate and Family Court when Mr. Brophy's attending physician and the hospital refused to disconnect the G-tube.[62] The doctors believed removal of the G-tube would constitute a willful, "harmful act which would deliberately produce death."[63] Although Mr. Brophy was not considered terminally ill, or in danger of imminent death, his cognitive functioning had ceased and the doctors determined he possessed less than a one percent chance of ever regaining his cognitive functions.[64] Prior to the rupture of the aneurysm that incapacitated Mr. Brophy, he was a healthy, active man, and it was his wife's belief Mr. Brophy would choose to resist the present medical treatment if he were competent.[65]

The court found the right to refuse treatment "arises both from the common law and the unwritten and penumbral constitutional right to privacy."[66] Focusing on the patient's right to refuse treatment, the court noted a movement away from the "paternalistic view of what is *'best'* for a patient" toward ascertaining "what decision will comport with the *will* of the person involved" regardless of the competency of the patient.[67] Because Mr. Brophy was incompetent and unable to make this individual autonomous decision, the court recognized the doctrine of substituted judgment was the most

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58. *Id.* at 225.
59. *Id.* (emphasis added).
60. Brophy v. New England Sinai Hosp., 497 N.E.2d 626 (Mass. 1986).
61. *Id.* at 628.
62. *Id.*
63. *Id.* at 632.
64. *Id.* at 630.
65. *Id.* at 632. The probate judge to whom Mrs. Brophy initially petitioned found Mr. Brophy, if competent, would refuse the use of the G-tube; however, he ordered the continuation of nutrition and hydration despite recognizing this was contrary to the patient's wishes. *Id.* at 629.
66. *Id.* at 633.
67. *Id.* (emphasis added).

effective means of preserving individual autonomy,[68] as well as protecting "the right to be free of nonconsensual invasion of one's bodily integrity."[69] The doctrine of substituted judgment allows another party to act on behalf of an incompetent patient to make medical choices compatible with the patient's desires.[70] Thus, the exercise of substituted judgment provides the means to allow incompetent patients, such as Mr. Brophy, the same right to refuse unwanted treatment and prolongation of life belonging to competent patients, such as Mr. Bartling.

The court's decision balanced four State interests: "(1) the preservation of life; (2) the protection of interests of innocent third parties; (3) the prevention of suicide; and (4) the maintenance of the ethical integrity of the medical profession."[71] The court focused primarily on the interest in preservation of life, stating it was contrary to the "scheme of ordered liberty and to our respect for the autonomy of the individual for the State to make decisions regarding the individual's quality of life."[72] Additionally, the court concluded the interest in preventing suicide was not implicated in this case because removal of the G-tube "'merely allows the disease to take its natural course.'"[73] As in *Bartling*,[74] the court's characterization of the removal of the G-tube as only allowing nature to take its course, and, as less than active physician participation in the resulting death, avoided any questions of euthanasia or physician-assisted death.[75]

The decisions of the courts in both *Bartling* and *Brophy* are best brought to bear in *Bouvia v. Superior Court*,[76] the tragic case of a twenty-eight year old victim of severe cerebral palsy.[77] Elizabeth Bouvia, completely confined to her bed and unable to take care of herself in any manner, sought removal of the nasogastric tube that kept her alive against her wish.[78] Ms. Bouvia was mentally competent, in severe pain, and had previously indicated her desire to die.[79] The nasogastric tube was inserted, against Ms.

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68. *Id.*
69. *Id.* at 634.
70. *Id.* at 634-35.
71. *Id.* at 634.
72. *Id.* at 635.
73. *Id.* at 638 (quoting *In re* Conroy, 486 A.2d 1209, 1224 (N.J. 1985)).
74. *See supra* text accompanying note 58.
75. A dissenting opinion stated: "Euthanasia is the termination of another's life by act or omission, with the specific intention to do so, in order to eliminate suffering. The court must consider whether on the facts of this case legal rights to commit suicide should be recognized. Such rights should never be recognized." Brophy v. New England Sinai Hosp., 497 N.E.2d 626, 644 (Mass. 1986) (O'Connor, J., dissenting).
76. Bouvia v. Superior Court, 225 Cal. Rptr. 297 (Ct. App. 1986).
77. *Id.* at 299.
78. *Id.* at 300.
79. *Id.* In order to relieve some of the pain, Ms. Bouvia was permanently connected to a device that periodically injected morphine into her chest. *Id.*

Bouvia's will, when the hospital staff concluded she was not receiving sufficient sustenance through manual feeding.[80] The court likened Ms. Bouvia's case to that of Mr. Bartling, who also was not terminally ill, and held "[t]he right to refuse medical treatment is basic and fundamental. It is recognized as a part of the right of privacy protected by both the state and federal constitutions."[81] Citing California Health and Safety Code section 7185,[82] the court defined a state policy allowing adult individuals the right to participate in and control their own medical care.[83] Furthermore, the court, as in *Brophy*, refused to limit this right to patients who were terminally ill, stating "[t]he right to refuse treatment does not need the sanction or approval by any legislative act, directing how and when it shall be exercised."[84]

As in *Brophy* and *Bartling*, the court addressed the State's countervailing interests in "(1) preserving life, (2) preventing suicide, (3) protecting innocent third parties, and (4) maintaining ethical standards" and concluded "they are insufficient to deny [Ms. Bouvia] the right to refuse medical treatment."[85] Particularly, the court stated:

> We do not believe it is the policy of this State that all and every life must be preserved against the will of the sufferer. It is incongruous, if not monstrous, for medical practitioners to assert their right to preserve a life that someone else must live, or, more accurately, endure . . . .[86]

The court also rejected the notion Ms. Bouvia was committing an act of suicide by starvation.[87] Instead, it chose to characterize her refusal to use the nasogastric tube as merely a choice to "allow nature to take its course."[88] Finally, the court nullified the fear of the doctors and the hospital by indicating removal of the nasogastric tube would not result in criminal or civil liability.[89] Subsequently, the court ordered removal of the nasogastric tube in

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80. *Id.* Ms. Bouvia consistently weighed approximately 65 to 70 pounds, a condition the hospital considered potentially life-threatening. *Id.*

81. *Id.* at 301 (citations omitted).

82. CAL. HEALTH & SAFETY CODE § 7185 (West 1991).

83. Bouvia v. Superior Court, 225 Cal. Rptr. 297, 302 (Ct. App. 1986).

84. *Id.*

85. *Id.* at 304.

86. *Id.* at 305.

87. *Id.* at 306.

88. *Id.* This characterization of a physician's removal of life support devices at the patient's request as less than active participation by a physician was also apparent in *Bartling* and *Brophy*. *See supra* text accompanying notes 48-75. The courts' characterization of the resulting death as "natural" allows the judiciary to remove the act from the illegal realm of physician-assisted suicide. *See supra* text accompanying notes 57-60, 73-75.

89. Bouvia v. Superior Court, 225 Cal. Rptr. 297, 306 (Ct. App. 1986). The court relied on the position the judiciary took in Barber v. Superior Court, 195 Cal. Rptr. 484 (Ct. App. 1983), in

accordance with Ms. Bouvia's wishes and prohibited the replacement of the tube without her consent.[90]

These three cases most dramatically illustrate the progression of the law in the area of withdrawal of unwanted medical treatment.[91] They demonstrate a steady acceptance of a personal autonomy that is no longer limited to patients who are terminally ill. *Bouvia* and *Bartling* are perhaps the most significant because they gave *competent*, nonterminally ill patients the right to choose death, with the help of a physician's removal of life-sustaining treatment.[92] This is possibly the closest courts have come to stating assisted suicide is lawful.[93] Additionally, these cases have abrogated the physicians' fear of criminal and civil liability for carrying out these requests, and have given judicial recognition to the right of individuals to participate in and control the medical decisions affecting them.

B. *Legislative Response*

1. *State Legislative Action*

In response to judicial action regarding the termination of medical treatment, state legislatures hastened to develop guidelines for the withholding or termination of life-sustaining medical treatments. Currently, at least forty-four states and the District of Columbia have statutory provisions

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which two doctors removed life-support machines from a patient at his wife's request. *Id.* at 486. Both physicians were charged with murder and conspiracy to commit murder, but the court found no criminal liability although the doctors' actions were intentional and done with the knowledge the patient would die. *Id.* at 493.

In Bartling v. Superior Court, 209 Cal. Rptr. 220, 226 (Ct. App. 1984), the court noted if Mr. Bartling had survived until the conclusion of the proceedings, and had he chosen to have the ventilator removed, the doctors would not have been civilly or criminally liable for carrying out his request.

90. Bouvia v. Superior Court, 225 Cal. Rptr. at 307.

91. *See also In re* Spring, 405 N.E.2d 115 (Mass. 1980); Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417 (Mass. 1977); Lane v. Candura, 376 N.E.2d 1232 (Mass. App. Ct. 1978); *In re* Westchester County Medical Ctr., 532 N.Y.S.2d 133 (App. Div.), *rev'd*, 531 N.E.2d 607 (N.Y. 1988).

92. *See supra* text accompanying notes 48-59, 76-84.

93. In a concurring opinion, Judge Compton expressed the view:

> Elizabeth apparently has made a conscious and informed choice that she prefers death to continued existence in her helpless, and to her, intolerable condition. I believe she has an absolute right to effectuate that decision. This state and the medical profession instead of frustrating her desire, should be attempting to relieve her suffering by permitting and in fact assisting her to die with ease and dignity. The fact that she is forced to suffer the ordeal of self-starvation to achieve her objective is in itself inhumane.

Bouvia v. Superior Court, 225 Cal. Rptr. at 307 (Compton, J., concurring).

for living wills.[94] These documents clarify patients' desires regarding the withholding and termination of medical treatment.

Additionally, legislatures have created statutory provisions allowing an individual to designate a surrogate or proxy to make medical decisions for that individual if incompetency results in the individual's inability to make the decisions regarding health care.[95] In particular, the Michigan Patient's Rights Act,[96] effective December 19, 1990, permits the designation of a "patient advocate" to carry out the wishes of a patient once the patient is incapacitated.[97] The Act presumes all decisions the patient made while competent, such as the execution of a living will or an advance directive, are in the patient's best interests.[98] Those states not employing surrogate decision-making legislation provide other statutory methods, such as advance directives and living wills, for a third party to make decisions on behalf of the incompetent patient.

An advance directive or advance directive for health care becomes effective when a physician determines a patient is incompetent.[99] The advance directive itself is a written agreement the patient executes desig-

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94. *See* ALA. CODE §§ 22-8A-1 to -10 (1990); ALASKA STAT. §§ 18.12.010 to .100 (1991); ARIZ. REV. STAT. ANN. §§ 36-3201 to -3210 (1986); ARK. CODE ANN. §§ 20-17-201 to -218 (Michie Supp. 1991); CAL. HEALTH & SAFETY CODE §§ 7185-7195 (West Supp. 1993); COLO. REV. STAT. ANN. §§ 15-18-101 to -113 (West 1987); CONN. GEN. STAT. ANN. §§ 19A-570 to -580 (West Supp. 1993); DEL. CODE ANN. tit. 16, §§ 2501-2508 (1983); D.C. CODE ANN. §§ 6-2421 to -2430 (1989); FLA. STAT. ANN. §§ 765.301 to .310 (West Supp. 1993); GA. CODE ANN. §§ 31-32-1 to -12 (Harrison 1988); HAW. REV. STAT. §§ 327D-1 to -27 (Supp. 1992); IDAHO CODE §§ 39-4501 to -4509 (1992); ILL. ANN. STAT. ch. 755, paras. 35/1 to /10 (Smith-Hurd 1993); IND. CODE ANN. §§ 16-36-4-1 to -21 (Burns 1993); IOWA CODE §§ 144A.1 to .11 (1989); KAN. STAT. ANN. §§ 65-28,101 to -28,109 (1992); KY. REV. STAT. ANN. §§ 311.622 to .644 (Michie/Bobbs-Merrill Supp. 1992); LA. REV. STAT. ANN. §§ 40:1299.58.1 to .10 (West Supp. 1993); ME. REV. STAT. ANN. tit. 18-A, §§ 5-701 to -714 (West Supp. 1992); MD. HEALTH-GEN. CODE ANN. §§ 5-601 to -614 (1990); MINN. STAT. ANN. §§ 145B.01 to .17 (West Supp. 1993); MISS. CODE ANN. §§ 41-41-101 to -121 (Supp. 1992); MO. ANN. STAT. §§ 459.010 to .055 (Vernon 1992); MONT. CODE ANN. §§ 50-9-101 to -104, 50-9-201 to -206 (1992); NEV. REV. STAT. §§ 449.540 to .690 (1992); N.H. REV. STAT. ANN. §§ 137H:1 to :16 (1990); N.J. STAT. ANN. § 26:2H-54(c) (West Supp. 1993); N.M. STAT. ANN. §§ 24-7-1 to -10 (Michie 1992); N.Y. PUB. HEALTH LAW §§ 2960-2978 (Consol. Supp. 1993); N.C. GEN. STAT. §§ 90-320 to -322 (1992); N.D. CENT. CODE §§ 23-06.4-03 to -14 (Supp. 1993); OKLA. STAT. tit. 63, §§ 3101.1 to .16 (West Supp. 1992); OR. REV. STAT. §§ 127.605 to .650 (1991); S.C. CODE ANN. §§ 44-77-10 to -160 (Law. Co-op. Supp. 1992); S.D. CODIFIED LAWS ANN. §§ 34-12D-1 to -22 (Supp. 1993); TENN. CODE ANN. §§ 32-11-101 to -112 (Supp. 1992); TEX. HEALTH & SAFETY CODE ANN. §§ 672.001 to .021 (West 1992); UTAH CODE ANN. §§ 75-2-1101 to -1118 (Supp. 1993); VT. STAT. ANN. tit. 18, §§ 5251-5262 (1988); VA. CODE ANN. §§ 54.1-2981 to -2992 (Michie 1991); WASH. REV. CODE ANN. §§ 70.122.010 to .905 (West 1992); W. VA. CODE §§ 16-30-1 to -10 (1991); WIS. STAT. ANN. §§ 154.01 to .15 (West 1989); WYO. STAT. §§ 35-22-101 to -109 (1988).

95. *See infra* text accompanying notes 96-106.

96. MICH. COMP. LAWS ANN. § 700.496 (West Supp. 1992).

97. *Id.* § 700.496(1)-(2).

98. *Id.* § 700.496(7)(f).

99. N.J. STAT. ANN. § 26:2H-59(a) (West Supp. 1992).

nating what medical treatment is desired in the event of incapacitation.[100] Typically, such statutes require: (1) the patient be terminally ill or suffering from an irreversible illness; (2) treatment will only lengthen the dying process; and (3) the patient is an adult of eighteen years of age or more.[101] Any additional requirements are state-specific and can be located in the advance directive legislation of each state.

An extension of a durable power of attorney is another method state legislatures have adopted to provide for medical treatment decisions made on behalf of an incompetent patient. Termed a durable power of attorney for health care, it is created, in Ohio for example, specifically for health care decision-making and creates an attorney-in-fact, or proxy, who typically can "make health care decisions for the principal at any time that the attending physician of the principal determines that he has lost the capacity to make informed health care decisions for himself."[102] Unlike a power of attorney, which ceases to exist on the death or incapacity of the principal,[103] the durable power of attorney for health care is effective at the time of incapacitation or incompetence of the patient.[104] Thus, the patient's wishes for medical treatment are able to be carried out despite the patient's inability to communicate directly with the physician.

Essentially, the statutes governing instances in which a surrogate or proxy will be executing decisions for an incompetent patient are similar to an advance directive and require: (1) the principal be an adult of eighteen years or more; (2) a physician deem the principal incompetent and unable to make health care decisions; and (3) two witnesses, who were present at the execution of the document,[105] affirm the principal was of sound mind and entered into the document voluntarily.[106]

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100. *Id.* § 26:2H-55.

101. *See, e.g., id.*

102. OHIO REV. CODE ANN. § 1337.12(A)(1) (Anderson 1991); *see, e.g.*, IOWA CODE § 144B (1993); N.H. REV. STAT. ANN. § 137-2 (Supp. 1992).

103. BARRY R. FURROW ET AL., BIOETHICS: HEALTHCARE LAW AND ETHICS 275 (1991).

104. *See, e.g.*, IOWA CODE § 144B (1993) (adopting a Durable Power of Attorney for Health Care).

105. Each statute bars relatives or individuals who will benefit from the death of the principal from serving as witnesses. *See, e.g.*, IOWA CODE § 144B.3 (1993); N.H. REV. STAT. ANN. § 137-2:14 (Supp. 1992).

106. *See, e.g.*, MICH. COMP. LAWS ANN. §§ 700.496(1)-(8) (West Supp. 1992); N.H. REV. STAT. ANN. §§ 137J:16 to :6 (Supp. 1992); S.C. CODE ANN. §§ 44-77-10 to -40 (Law. Co-op. Supp. 1992).

2. *Federal Legislative Action*

The enactment of the Patient Self-Determination Act ("PSDA") has increased the awareness of patients' rights.[107] Amending 42 U.S.C. § 1395cc, the PSDA requires all Medicare or Medicaid funded health care facilities to comply with the statute or risk losing federal government funding.[108] In particular, it requires health care organizations[109] to maintain a written policy for providing information to each individual with respect to: (1) an individual's statutory and common law rights under state law regarding the right to accept or reject medical treatment and to execute advance directives,[110] and (2) the health care provider's individualized written policies regarding how it respects and implements such rights.[111] The PSDA requires this information to be dispensed to a patient at the time of admission or enrollment in the health care provider's program.[112] Additionally, the PSDA requires the execution of an advance directive to be recorded in the patient's medical record and forbids the type and quality of care to be conditioned on the existence of an advance directive.[113] The effect of recording the existence of an advance directive is to leave little doubt as to the patient's wishes for medical treatment at the time of incompetency. Thus, recordation reduces the likelihood of an incapacitated patient receiving unwanted medical treatment. Also, the health care provider must comply with all state laws regarding advance directives as well as educate its staff on advance directives and related concerns.[114]

The PSDA affirmatively strengthens the power of individuals to participate actively in the health care decisions affecting them.[115] The enactment of the PSDA promotes an awareness on a federal level of the importance of

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107. Medicare Provider Agreements Assuring the Implementation of a Patient's Right to Participate in and Direct Health Care Decisions Affecting the Patient, sec. 4206, § 1866(a)(1), 104 Stat. 1388-115 to -117 (1990) (codified as amended at 42 U.S.C.A. § 1395cc(a)(1) (West 1992)).

108. *Id.* sec. 4206, § 1866(a)(1), para. (b)(8)(r), 104 Stat. at 1388-116 (codified as amended at 42 U.S.C.A. § 1395cc(a)(1) (West 1992)).

109. The organizations to which the act applies include "hospitals, skilled nursing facilities, home health agencies, and hospice programs." *Id.* sec. 4206, § 1866(a)(1), para. (a)(1)(Q), 104 Stat. at 1388-115 (codified as amended at 42 U.S.C.A. § 1395cc(a)(1) (West 1992)).

110. *Id.* sec. 4206, § 1866(a)(1), para. (f)(1)(A)(i), 104 Stat. at 1388-115 (codified as amended at 42 U.S.C.A. § 1395cc(a)(1) (West 1992)).

111. *Id.* sec. 4206, § 1866(a)(1), para. (f)(1)(A)(ii), 104 Stat. at 1388-115 (codified as amended at 42 U.S.C.A. § 1395cc(a)(1) (West 1992)).

112. *Id.* sec. 4206, § 1866(a)(1), paras. (f)(2)(A)-(f)(2)(E), 104 Stat. at 1388-116 (codified as amended at 42 U.S.C.A. § 1395cc(a)(1) (West 1992)).

113. *Id.* sec. 4206, § 1866(a)(1), paras. (f)(1)(B)-(f)(1)(C), 104 Stat. at 1388-115 (codified as amended at 42 U.S.C.A. § 1395cc(a)(1) (West 1992)).

114. *Id.* sec. 4206, § 1866(a)(1), paras. (f)(1)(D)-(f)(1)(E), 104 Stat. at 1388-115 to -116 (codified as amended at 42 U.S.C.A. § 1395cc(a)(1) (West 1992)).

115. *Federal Law Boosts Patients' Rights*, NEWSL. (Concern for Dying/Society for the Right to Die, New York, N.Y.), Spring 1991.

the patients' rights to decide end-of-life issues. This congressional action fills the persistent gap, to some degree, between a patient's choice and a health care provider's reluctance to honor that choice.

III. ASSISTED SUICIDE: A LOGICAL EXTENSION OF PATIENTS' RIGHTS?

It would appear from the foregoing discussion patients currently have sufficient rights in the ending phases of their lives to make choices determining how much, if any, medical care they are willing to accept. Although this is true, patients are limited in exactly what they are able to request of their physician. For those patients who are not kept alive by nutrition tubes, hydration devices, or ventilators, it is illegal for a physician actively to assist in helping the patient to die.[116] The American Medical Association in a Statement of the Council on Ethical and Judicial Affairs has adopted a position in opposition to physician-assisted suicide, stating "[f]or 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. *However, he should not intentionally cause death.*"[117] Active physician participation in assisting a nonterminally ill patient to die, therefore, is expressly forbidden by the American Medical Association. Further, the current status of the law forbids a physician or any other individual from actively assisting another individual to commit suicide.[118] Thus, the question arises: How close to death must patients be before medical ethics and the law allows a third party to relieve their suffering?

A. *Current State of the Law*

1. *Statutory Dimensions*

Suicide and attempted suicide are not statutory crimes in any state.[119] At least thirty-two states plus the Virgin Islands and Puerto Rico, however, prohibit assisting, encouraging, or aiding another to commit suicide.[120]

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116. *See infra* text accompanying note 119.

117. *Withholding or Withdrawing Life Prolonging Medical Treatment*, NEWSL. (American Medical Ass'n/Society for the Right to Die, New York, N.Y.), Mar. 15, 1986 (emphasis added).

118. *See infra* note 119 and accompanying text.

119. *Assistance in Compassionate Suicide: Still No Legal Right*, HEMLOCK Q. (National Hemlock Society, Eugene, Or.), Oct. 1990, at 6.

120. ALASKA STAT. § 11.41.120(A)(2) (1992); ARIZ. REV. STAT. ANN. § 13-1103(A)(3) (1989); ARK. CODE ANN. § 5-10-104(a)(2) (Michie 1987); CAL. PENAL CODE § 401 (West 1988); COLO. REV. STAT. ANN. § 18-3-104(1)(b) (West 1986 & Supp. 1993); CONN. GEN. STAT. ANN. § 53a-56(a)(2)

Merely providing the means for another individual to commit suicide is sufficient under some statutes for the individual offering assistance to incur criminal liability.[121]

In an effort to prevent the sting of criminal homicide befalling an individual helping another to commit suicide, supporters of physician-assisted suicide have pushed to pass legislation allowing physicians to render "aid-in-dying" to qualified patients.[122] In a November 1991 ballot voters defeated, by fifty-four percent to forty-six percent, a recent effort in Washington State to pass Initiative 119.[123] The proposal, which was to be known as the Natural Death With Dignity Act ("Act"), would have allowed a physician to provide "aid-in-dying" to a qualified patient.[124]

(West 1985); DEL. CODE ANN. tit. 11, § 645 (1987 & Supp. 1992); FLA. STAT. ANN. § 782.08 (West 1992); HAW. REV. STAT. § 707-702(1)(b) (1985); 1993 Ill. Legis. Serv. 88-392 (West); IND. CODE ANN. § 35-42-1-2 to -1-2.5 (Burns 1985 & Supp. 1993); KAN. STAT. ANN. § 21-3406 (1988); ME. REV. STAT. ANN. tit. 17-A, § 204 (West 1983); MICH. COMP. LAWS ANN. § 752.1027(7)(1)-(5) (West Supp. 1993); MINN. STAT. ANN. § 609.215 (West 1987 & Supp. 1993); MISS. CODE ANN. § 97-3-49 (1972); MO. ANN. STAT. § 565.023 (Vernon Supp. 1993); MONT. CODE ANN. § 45-5-105 (1991); NEB. REV. STAT. § 28-307 (1989); N.H. REV. STAT. ANN. § 630:4 (1986); N.J. STAT. ANN. § 2C:11-6 (West 1982); N.M. STAT. ANN. § 30-2-4 (Michie 1984 & Supp. 1991); N.Y. PENAL LAW § 120.30 (McKinney 1987); N.D. CENT. CODE § 12.1-16-04 (Supp. 1993); OKLA. STAT. ANN. tit. 21, § 813 (West 1983); OR. REV. STAT. § 163.125(1)(b) (1991); PA. STAT. ANN. tit. 18, § 2505(b) (1983); S.D. CODIFIED LAWS ANN. § 22-16-37 (1988); TENN. CODE ANN. § 39-13-216 (Supp. 1993); TEX. PENAL CODE ANN. § 22.08 (West 1989); WASH. REV. CODE ANN. § 9A.36.060 (West 1988); WIS. STAT. ANN. § 940.12 (West 1982); P.R. LAWS ANN. tit. 33, § 4009 (1992); V.I. CODE ANN. tit. 14, § 2141 (1992).

121. *See* IND. CODE ANN. § 35-42-1-2.5(b) (Burns Supp. 1993); *see also* People v. Cleaves, 280 Cal. Rptr. 146, 150-51 (Ct. App. 1991) (stating defendant is guilty of assisting a suicide under § 401 of the California Penal Code when he merely provides the means).

122. In 1988, California unsuccessfully attempted to present a Humane and Dignified Death Act on the ballot. Edmund D. Pellegrino, *Ethics*, 265 JAMA 3118, 3118 (1991). The initiative paralleled, with two exceptions, the Dutch practice, which tolerates physician involvement "under certain specified conditions: the patient's consent must be free, conscious, explicit, and persistent; patient and physician must agree that suffering is intolerable; other measures for relief must have been exhausted; a second physician must concur; these facts must be recorded; and, in the case of children, parental consent must be obtained." *Id.* The California initiative exceptions to the Dutch practice were: (1) it accepted advance directives; and (2) it required the patients to be terminally ill. *Id.* Holland is the only country practicing active euthanasia. *Id.*

123. Steve Taravella, *California Movement Seeking Physician-Assisted Suicide*, MOD. HEALTHCARE, Dec. 9, 1991, at 14. The Washington State Medical Association opposed the initiative. Pellegrino, *supra* note 121, at 3118.

124. 1991 Wash. Legis. Serv. 112, at 70.122.020, § 2(9) (West). The proposed Act defined "aid-in-dying" as a:

> form of medical service provided in person by a physician that will end the life of a conscious and mentally competent qualified patient in a dignified, painless and humane manner, when requested voluntarily by the patient through a written directive in accordance with this chapter at the time the medical service is to be provided.

Id.

The Act would have required the patient to voluntarily execute a written directive,[125] witnessed by two people who would not benefit by the patient's death,[126] and the patient to be a terminally ill,[127] mentally competent adult. The Act expressly stated its enactment would not condone mercy killing or any other affirmative act intended to end life.[128] Instead, it stressed pursuant to the provisions in the Act *only* a physician was permitted to fulfill a request for aid-in-dying.[129]

Despite the failure of Washington Initiative 119, other states are currently attempting to pass similar aid-in-dying legislation. Iowa Senator Al Sturgeon filed a bill in the January 1992 state legislative session proposing an Assistance-in-Dying Act.[130] The proposal would "recognize the right of an adult person to prepare a written declaration instructing the person's physician to withhold or withdraw life-sustaining procedures in the event of a terminal condition as well as to request and receive assistance-in-dying."[131] It incorporates much of the same language found in the Washington Initiative, requiring a terminally ill, mentally competent adult to execute a written declaration[132] witnessed by two individuals who cannot benefit by the patient's death.[133] Additionally, the proposal expressly limits assistance-in-dying to performance by a physician in accordance with the provisions of the proposal, and repudiates the notion the proposal in any way condones mercy killing or affirmative acts by an individual other than a physician.[134]

Iowa is not alone in current proposals for aid-in-dying legislation. Despite its 1988 failure to pass a Humane and Dignified Death Act,[135] California succeeded in placing a Terminal Illness Assistance in Dying Initiative Statute on the November 1992 ballot. Known to voters as Proposition 161, it was to appear as the California Death With Dignity Act under title 10.5 of the California Civil Code upon enactment.[136] In order to

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125. 1991 Wash. Legis. Serv. 112, at 70.122.020, § 3(1) (West).

126. *Id.* at 70.122.030, § 3(1).

127. *Id.* at 70.122.020, § 2(7). The proposed Act defined terminal condition as an incurable or irreversible condition, which in the judgment of two physicians would result in death in six months, or a situation in which two physicians have made a written determination that the patient is in an irreversible coma or persistent vegetative state from which there is no chance of recovery. *Id.*

128. *Id.* at 70.122.100, § 10.

129. *Id.*

130. The proposal would be incorporated as a new section in IOWA CODE 144C.1 to .7.

131. S. 2066, 74th Leg., 1992 Sess. § 1(6).

132. *Id.* § 3(8).

133. *Id.* § 4(2). The definitions of each of these qualifications paralleled those in found in the Washington Initiative 119. *See supra* text accompanying notes 124-29.

134. S. 2066, 74th Leg., 1992 Sess. § 8(6).

135. *See supra* note 122.

136. California Terminal Illness Assistance in Dying Initiative Statute § 2525 (to have been codified at CAL. CIV. CODE § 2525).

place the initiative on the ballot 385,000 valid signatures were required, and as of December 1, 1991, proponents had collected 150,000 signatures.[137] The initiative was defeated, however, in a November 3, 1992 election, despite its apparent support.[138]

As with the Iowa proposal, the California initiative contained substantially the same qualifications as the Washington initiative.[139] Unlike the Iowa proposal, however, the California initiative prevented fulfillment of an advance directive in a skilled nursing facility unless one of the attending witnesses was a patient advocate or an ombudsman the Department of Aging designated expressly for this purpose.[140] There was also an express provision making it a misdemeanor, or a felony in the event death resulted, for any person who induced or coerced a patient to execute an aid-in-dying directive.[141] Additionally, the initiative did not require a physician, another licensed health care provider, or a private hospital to fulfill a patient's request for aid-in-dying if there was moral, ethical, or religious opposition to it.[142] As with the Iowa proposal and the defeated Washington initiative, the California initiative also expressly prohibited designating aid-in-dying as suicide and repudiated any authorization of mercy killing.[143]

Despite these safeguards, which are lacking in both the Iowa proposal and the 1988 California proposal, the Los Angeles County Medical Association and the California Association of Catholic Hospitals strongly opposed the 1992 California initiative.[144] Furthermore, opposition by the medical community as a whole was strongly evident in the physician response to the publishing of the anonymous article about Debbie in the

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137. Taravella, *supra* note 123, at 14.

138. *Doctors Urge Policy on Suicide Help*, CHI. TRIB., Nov. 5, 1992, at C3. Californians Against Human Suffering placed the initiative on the ballot despite strong opposition from various religious and medical organizations. Ben MacIntyre, *Voters Hold Sway on Life and Death*, THE TIMES (London), Nov. 3, 1992, at Overseas News Section.

139. *See supra* notes 124-29. The California initiative required a voluntary written directive made by a mentally competent terminally ill patient, in the presence of two witnesses, whose request must be communicated directly to the physician. California Terminal Illness Assistance in Dying Initiative Statute § 2525.1. A significant difference between the California proposal and both the Iowa and Washington proposals is the California proposal did not prohibit pregnant women from seeking assistance-in-dying. *Id.* The Iowa assistance-in-dying request is voided if the patient is a pregnant woman. S. 2066, 74th Leg., 1992 Sess. § 4. The Washington proposal contains an identical provision. 1991 Wash. Legis. Serv. 112, at 70.122.030(1) (West).

140. California Terminal Illness Assistance in Dying Initiative Statute § 2525.4.

141. *Id.* § 2525.18.

142. *Id.* § 2525.8.

143. *Id.* §§ 2525.16, .23.

144. *Washington State Voters Reject Euthanasia, Term Limits*, REUTERS, Nov. 6, 1991, *available on LEXIS*, Nexis Library, Reuter File. Derek Humphry, founder of the Hemlock Society, noted the failure of the Washington initiative was due to the lack of safeguards from abuse that are component parts of the California initiative. *Id.*

January 8, 1988 issue of the *Journal of the American Medical Association*—a four to one ratio against the action taken by the physician/author.[145] Additionally, the official American Medical Association ("AMA") policy does not permit a physician to end life deliberately through physician assisted suicide; however, it does allow the withholding or withdrawal of nutrition, hydration, and ventilation.[146] Not only are doctors ethically bound by the AMA's policy, but they are also compelled to follow the tenet of the Hippocratic Oath, which states: "I will give no deadly drug to any, though it be asked of me, nor will I counsel such."[147] Physician-assisted suicide legislation not only lacks the support of the AMA, but also that of the American Bar Association ("ABA").[148] On February 3, 1992, the ABA, perhaps the most influential group in the legal profession, refused to support any legislation advocating physician-assisted suicide.[149]

Thus, there is little support from both professional spheres for the passage of currently proposed assistance-in-dying legislation. The lack of professional support, however, may carry little weight in trying to pass the current aid-in-dying proposals. A May 1991 Roper Poll of 1500 people in California, Oregon, and Washington reported sixty percent of the respondents believed a physician should be able to fulfill an aid-in-dying request. Only thirty-two percent stated that the law should not change to include physician-assisted suicide, and eight percent did not adhere to either position.[150]

2. *Common Law Dimensions*

The progression of the judiciary from permitting a terminally ill patient to refuse nutrition, hydration, and ventilation[151] to permitting a competent, nonterminally ill patient to refuse nutrition and hydration,[152] thereby

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145. George D. Lundberg, *It's Over, Debbie and the Euthanasia Debate*, 259 JAMA 2142, 2142 (1988). More than 150 letters expressing views on the physician's action were submitted to the editors. *Id.* In a recent Physician's Management journal survey of 498 doctors, however, 88% of the physicians stated they would fulfill a patient's request to remove life support. *Medical Support for Euthanasia*, HEMLOCK Q. (National Hemlock Society, Eugene, Or.), July 1991, at 9.

146. *Supra* text accompanying note 117.

147. Lundberg, *supra* note 145, at 2142.

148. Gail Appleson, *Kevorkian Case Will Hurt Euthanasia Legislation Efforts*, REUTERS, Feb. 6, 1992, *available on LEXIS*, Nexis Library, Reuter File.

149. *Id.*

150. *1991 Roper Poll of the West Coast*, HEMLOCK Q. (National Hemlock Society, Eugene, Or.), July 1991, at 9. The Hemlock Society commissioned the Roper Organization to conduct the poll. *Id.*

151. *See* Satz v. Perlmutter, 362 So. 2d 160 (Fla. Dist. Ct. App. 1978), *aff'd*, 379 So. 2d 359 (Fla. 1980); *In re* Storar, 420 N.E.2d 64 (N.Y.), *cert. denied*, 454 U.S. 858 (1981); Eichner v. Dillon, 420 N.E.2d 64 (N.Y. 1981).

152. *See* Bouvia v. Superior Court, 225 Cal. Rptr. 297 (Ct. App. 1986).

bringing about her own death, indicates the judiciary may be one step ahead of legislative acceptance of an individual's right to make "death care" choices. Authors have commented this transmutation of "a right to refuse medical treatment into a 'right to die,' however, switches the focus from the burden of nonbeneficial medical treatment to the desire for death itself."[153] The transmutation has resulted from a judicial trend refusing to distinguish between ordinary and extraordinary care.[154] The judiciary has not focused on the burden of nonbeneficial treatment for the patient, but rather on an evaluation of quality of life and the "allegedly autonomous desire for death."[155] The result of this judicial trend may be an acceptance in practice of what the legislature has not achieved statutorily.

The abyss existing between the technological advances allowing the indefinite perpetuation of life and the failure of the current law to evolve concomitantly with these advances has created difficulties not only for the patient in making end-of-life decisions, but also for the physician. For instance, the failure of the law to enunciate clearly whether or not physicians who discontinue life-support are liable for their actions has played an important role in many physicians' decisions of whether to carry out their patients' requests.[156] At least one act of discontinuing life-support has resulted in a criminal prosecution for murder against the attending physicians. In *Barber v. Superior Court*,[157] Clarence Herbert suffered cardiorespiratory arrest after a successful surgery and fell into a deep coma and permanent vegetative state.[158] Mr. Herbert's family requested the removal of all life-support and the physicians complied.[159] The physicians were subsequently charged with murder and conspiracy to commit murder.[160] Addressing the defendants' criminal liability, the court bemoaned:

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153. Victor Rosenblum & Clarke Forsythe, *The Right to Assisted Suicide: Protection of Autonomy or An Open Door to Social Killing?*, 6 ISSUES IN LAW & MED. 3, 7 (1990).

154. *In re* Conroy, 486 A.2d 1209, 1234-35 (N.J. 1985) (stating the distinction between ordinary treatment and extraordinary treatment is unpersuasive); Brophy v. New England Sinai Hosp., 497 N.E.2d 626, 637 (Mass. 1986) ("[T]he use of such a distinction [between ordinary and extraordinary care] as the sole, or major, factor of decision tends, . . . to create a distinction without meaning."); Barber v. Superior Court, 195 Cal. Rptr. 484, 491 (Ct. App. 1985) (stating the use of extraordinary and ordinary "begs the question. A more rational approach involves the determination of whether the proposed treatment is proportionate or disproportionate in terms of the benefits to be gained versus the burdens caused.").

155. Rosenblum & Forsythe, *supra* note 153, at 13.

156. *See, e.g.*, Bouvia v. Superior Court, 225 Cal. Rptr. at 306; Bartling v. Superior Court, 209 Cal. Rptr. 220, 226 (Ct. App. 1984); Brophy v. New England Sinai Hosp., 497 N.E.2d at 632.

157. Barber v. Superior Court, 195 Cal. Rptr. 484 (Ct. App. 1983).

158. *Id.* at 486.

159. *Id.* Mr. Herbert continued to live after his respirator was removed. *Id.* Two days after removing the respirator, the defendants removed all nutrition and hydration tubes, and Mr. Herbert subsequently died. *Id.*

160. *Id.*

> This gap between the statutory law and recent medical developments has resulted in the instant prosecution and its attendant legal dispute. That dispute in order to be resolved within the framework of existing criminal law must be narrowed to a determination of whether petitioners' conduct was unlawful. That determination . . . must be made on the basis of principles other than those limited ones set forth in [the] Penal Code . . . .[161]

The court resigned itself to assessing the defendants' conduct "within the context of the woefully inadequate framework of the criminal law"[162] and recognized the right of an individual to control medical treatment in a manner not limited by the express terms of the Natural Death Act.[163] Examining the legislative history of the Act, the court determined the law's requirement of an execution of an advance directive was not the only manner in which medical treatment decisions could be made.[164] The court reasoned the "lack of generalized public awareness of the statutory scheme and the typically human characteristics of procrastination" made it highly unlikely more than a small population would be motivated to prepare a medical directive in advance.[165] Thus, the court concluded the Act's language was not to be construed as limiting a patient's right to refuse medical treatment because the overriding right to refuse medical treatment was evident in the Act's legislative history.[166]

After recognizing an individual possesses a right to refuse medical treatment, the court addressed the criminal liability of the physicians who carried out Mr. Herbert's request. In order to avoid a thorough examination of the physicians' "unlawful killing" of Mr. Herbert caused by removal of the life-support systems, the court chose to redefine the removal as a "withdrawal or omission of further treatment" rather than as an affirmative act.[167] Thus, criminal liability turned on whether the physician had a duty to continue essentially ineffective treatment[168] and not on the act of removing the life-support systems. The court reasoned that generally treatment becomes ineffective when the burdens of the treatment are disproportionate

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161. *Id.* at 487-88. The court stated this case was the "first instance in which the issue has been presented in the context of a criminal prosecution." *Id.* at 488.

162. *Id.* at 489.

163. *Id.* (citing CAL. HEALTH & SAFETY CODE § 7185 (West Supp. 1983) (citations omitted)).

164. *Id.*

165. *Id.*

166. *Id.*

167. *Id.* at 490.

168. *Id.* at 490-91. It is well recognized the crime of homicide cannot be committed by omitting to act unless there first exists a duty to act. Leonard H. Glantz, *Withholding and Withdrawing Treatment: The Role of the Criminal Law*, 15 LAW, MED. & HEALTHCARE 231, 232 (1987).

to the benefits the patient receives.[169] Thus, even the most burdensome treatments must be continued if the patient experiences considerable improvement, although the most minuscule treatments must be discontinued if prognosis is poor.

The only question remaining, given these guidelines indicating when a duty to provide care exists, was who possessed the authority to express the patient's wishes.[170] The court stated a surrogate knowledgeable about the patient's interests, or who was willing to act in the patient's best interests if the requisite knowledge was lacking, was the proper person to carry out an incompetent patient's request to refuse medical treatment.[171] The court then applied this analysis to the facts of Mr. Herbert's medical condition and concluded Mr. Herbert's family was the proper group of persons to act as surrogate, and further concluded the physicians' removal of life-support systems based on the request of the family was an omission of treatment that did not constitute an "unlawful failure to perform a legal duty."[172]

Thus, *Barber* paved the way for a common law abrogation of criminal repercussions for physicians who either remove or fail to provide care in the form of hydration, nutrition, or ventilation.[173] Despite this fact, physicians are still reluctant to remove care from competent patients, believing removal is too similar to physician-assisted suicide.[174] What recourse is left to these patients, then? Unfortunately, many try to accomplish alone what neither the courts nor the legislatures have expressly authorized.

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169. Barber v. Superior Court, 195 Cal. Rptr. 484, 491 (Ct. App. 1983).

170. *Id.* at 492.

171. *Id.* at 493. The court noted a judicial proceeding to appoint a guardian to make decisions for Mr. Herbert was not required by statute. *Id.* at 492.

172. *Id.* at 493.

173. Additionally, the current aid-in-dying legislative proposals expressly prohibit holding physicians or health care providers criminally liable for assisting in the death of a patient. *See* California Terminal Illness Assistance in Dying Initiative Statute § 2525.9; S. 2066, 74th Leg., 1992 Sess. § 6(2)-(3); 1991 Wash. Legis. Serv. 112, at 70.122.050, § 5 (West).

174. *See* Bouvia v. Superior Court, 225 Cal. Rptr. 297, 305 (Ct. App. 1986). The physician refused to remove Ms. Bouvia's nasogastric tube because of her previous attempt to starve herself to death. *Id.* The physician feared removal would aid Ms. Bouvia in the illegal act of committing suicide. *Id.*; *see* Rosenblum & Forsythe, *supra* note 153, at 13 (stating the action of the court in *Bouvia* constitutes judicial permission to commit suicide). The courts in *Bouvia* and Barber v. Superior Court, 195 Cal. Rptr. 484, 493 (Ct. App. 1983), placed significant reliance on the decision of the *Barber* court stating criminal liability did not attach to a physician fulfilling the patient's request to refuse medical treatment.

B. *Mercy Killings: The Consequences of Not Legalizing Physician-Assisted Suicide*

1. *The "Mercy Killing" Cases and the Law*

Every year individuals suffering from terminal illness or severe pain decide to take their own lives to relieve the suffering and to avoid the indignity of end-of-life health care treatment. For many of these individuals, the actual act ending their lives is done by a loved one at the individual's request.[175] These "mercy killings" do not go unadjudicated; however, few of the "killers" are ever sentenced to prison.[176]

One of the rare cases in which a prison sentence was actually meted out and partially served occurred in the Florida case of *Gilbert v. State*.[177] In 1985, seventy-five year old Roswell Gilbert was found guilty of the premeditated murder of his wife and was sentenced to life imprisonment under Florida law.[178] Gilbert's wife of fifty-one years, Emily, suffered from Alzheimer's disease and osteoporosis.[179] Often in pain, Emily had on occasion told her husband her illness made her want to die.[180] On March 4, 1985, Mr. Gilbert took his wife out to lunch and later that afternoon shot her in the head.[181]

At Mr. Gilbert's trial, doctors testified Emily had a life expectancy of five to ten years and her illness was not so debilitating so as to leave her completely bedridden.[182] The jury convicted Mr. Gilbert of first degree murder, and the court of appeals affirmed the trial court's refusal to instruct the jury on euthanasia.[183] The appellate court stated that "[e]uthanasia is not a defense to first degree murder in Florida."[184] As a result, Mr. Gilbert was not relieved of criminal liability by acting in good faith on the belief that his wife's statement, "'I'm so sick I want to die,'" constituted a "constructive mercy will."[185] Mr. Gilbert was sentenced to the minimum mandatory sentence of twenty-five years.[186] The court declared the sentencing guidelines allowed no room for distinguishing between a hired killer and a person "however misguided, who kills for love or mercy."[187] Despite the professed

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175. *See infra* text accompanying notes 177-216.
176. *See infra* text accompanying notes 190-217.
177. Gilbert v. State, 487 So. 2d 1185 (Fla. Dist. Ct. App. 1986).
178. *Id.* at 1186-87.
179. *Id.* at 1187.
180. *Id.*
181. *Id.* at 1187-88.
182. *Id.* at 1189.
183. *Id.* at 1190.
184. *Id.*
185. *Id.* at 1191.
186. *Id.* at 1187.
187. *Id.* at 1192.

inflexibility of the mandatory sentence, Mr. Gilbert was released from prison in 1990 after serving only five years of his sentence.[188] Citing Mr. Gilbert's poor health, Florida Governor Bob Martinez granted an early release.[189]

Mr. Gilbert's serving of an actual, although unfulfilled prison sentence, seems to be an anomaly in "mercy killing" cases.[190] For instance, in *State v. Rosier*,[191] a Fort Meyers doctor was acquitted in 1988 on first degree murder charges for administering an overdose of morphine to his terminally ill wife.[192] Mrs. Rosier was diagnosed with lung cancer in April 1985, and in November of that same year, she was also diagnosed with brain tumors.[193] Mrs. Rosier chose her day to die, January 14, 1986, and went to bed that night after ingesting twenty sleeping pills.[194] When the sleeping pills had not killed her within twelve hours, Dr. Rosier injected her with six milligrams of morphine and administered eighty milligrams of morphine suppositories.[195] Ten months after Mrs. Rosier's death, Dr. Rosier admitted in an interview he was the cause of his wife's death, not cancer.[196] Dr. Rosier was brought to trial in Pinellas Circuit Court for the first degree murder of his wife, and was subsequently acquitted of the charges.[197]

A similar instance of "mercy killing" resulted in the second degree murder charges brought in the case of *People v. Edwards*.[198] Mr. Edwards, an eighty-one year old retiree, was the sole caretaker of his bedridden wife, Muriel.[199] Muriel was paralyzed by a stroke and was unable to care for

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188. *81-Year Old Mercy Killer Says He Wouldn't Do It Again*, REUTERS, Aug. 2, 1990, *available on LEXIS*, Nexis Library, Reuter File.

189. *Id.* Mr. Gilbert suffered from heart and lung disease and experienced a weight loss of 40 pounds in five years of imprisonment. *Id.*

190. One commentator believes "most cases of mercy killing have been excused by virtue of the spirit rather than the letter of the law." Kenneth L. Vaux, *Debbie's Dying: Mercy Killing and the Good Death*, 259 JAMA 2140, 2142 (1988).

191. State v. Rosier, No. 87-1547CF, 88-2095CF (Fla. Cir. Ct., Lee County, Dec. 1, 1988). The unavailability of the court's opinion has resulted in all citations to this case referring to a secondary source.

192. Deborah M. Levy, *Legal Remedies as Bad Medicine*, LEGAL TIMES, Oct. 9, 1989, at 54.

193. Todd Woody, *Was His Act of Mercy Also Murder?*, N.Y. TIMES, Nov. 7, 1988, at A12.

194. *Id.*

195. *Id.* It was later revealed the injection of morphine was not the final act causing Mrs. Rosier's death. *Id.* Vincent Delman, Mrs. Rosier's stepfather, suffocated her when the dosage of morphine did not kill her. *Id.* Prior to this act being revealed, however, the State Attorney's office granted immunity to Mr. Delman in exchange for his participation. *Id.*

196. *Doctor Freed in Wife's Death*, N.Y. TIMES, Dec. 2, 1988, at A20.

197. *Id.*

198. People v. Edwards, CR 7853 (Cal. Criminal Sup. Ct., Napa County, May 1, 1991). The unavailability of the court's opinion has resulted in all citations to this case referring to a secondary source.

199. Barbara Mahan, *Till Death Do Us Part*, 11 CAL. LAW. 42, 43 (Sept. 1991). Mr. Edwards had to feed and bathe Muriel, as well as change her catheter bag. *Id.* Every two hours, both day and night, he turned her in her bed to prevent her from developing bed sores. *Id.*

herself in any manner.[200] On May 26, 1989, remembering a promise to Muriel to never "let [her] end up like that," Mr. Edwards wrapped cellophane around Muriel's head, suffocated her, and turned himself in to the police.[201]

As in all other states, California does not have a defense based on mercy killing or euthanasia.[202] Thus, finding a foundation on which to base a defense in a "mercy killing" case is difficult. In Mr. Edwards' case, however, the defense developed a sleep deprivation theory.[203] In order to persuade the court to find Mr. Edwards not guilty of second degree murder, but guilty to the lesser charge of voluntary manslaughter, the defense attempted to show Mr. Edwards' state of mind at the time of Muriel's death by arguing Mr. Edwards was consistently suffering from sleep deprivation.[204] Essentially, the defense argued Mr. Edwards was sleeping at irregular one hour intervals in order to care for his wife, and was thereby suffering from a lack of Rapid Eye Movement ("REM") sleep, which results in delusions and hallucinations.[205] Overwhelmed by exhaustion, Mr. Edwards fluctuated in and out of reality and even "watched himself" kill Muriel as if he was watching another person commit the act.[206]

The judge ruled Mr. Edwards was guilty of the lesser charge of voluntary manslaughter.[207] He stated Mr. Edwards' case was about

> the unique facts surrounding the lives of Muriel and Robert Edwards culminating in these sad events and, more centrally, about the state of mind of Robert Edwards when he killed his wife. . . . Edwards' state of mind . . . when he wrapped Saran Wrap around the face of his wife was one of two conflicting passions: love for his wife and a delusional fear that he himself was fatally ill and unable to care for her.[208]

Mr. Edwards was sentenced to only three years probation and community service.[209] Additionally, he was required to contribute one academic year toward teaching Napa County jail inmates how to read.[210]

Recently, another California resident was found innocent of second degree murder in the "mercy killing" of his sixty-nine year old wife, Virginia,

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200. *Id.*
201. *Id.*
202. *Id.* at 45.
203. *Id.*
204. *Id.* at 46.
205. *Id.*
206. *Id.* at 47.
207. *Id.* at 48.
208. *Id.*
209. *Id.*
210. *Id.* Mr. Edwards died of cancer on July 12, 1991. *Id.*

in *Bertram R. Harper*.[211] Bertram Harper, seventy-three, traveled to Michigan with his wife and stepdaughter under the belief Michigan permitted assisted suicide.[212] Mrs. Harper was diagnosed with terminal liver cancer and had expressed a wish to die.[213] She had tried to commit suicide by herself in 1989, but the drugs she ingested put her to sleep before she could place a plastic bag over her head.[214] In order to achieve success in the second attempt, the family traveled to a hotel room in Michigan where Virginia ingested sleeping pills and alcohol, and her husband helped her place a plastic bag over her head.[215] After Virginia died, Mr. Harper and his stepdaughter turned themselves into the police believing they had done nothing in violation of the law.[216] Mr. Harper was charged with murder and later acquitted by a Detroit Recorders Court jury.[217]

These "mercy killing" cases, with the exception of *Gilbert*, have resulted in either an acquittal or conviction without the imposition of a prison sentence. In each instance, the "mercy killer," usually a family member, acted at the request of the deceased who was faced with a terminal illness and unbearable pain. Although each case involved a blatant violation of the statutory prohibition against assisted suicide,[218] the courts failed, despite the evidence in each case, to convict or impose a prison sentence. Instead, the courts grounded their conclusions on the questionable state of mind of the defendant, as in *Roberts*, rather than the letter of the law.[219] Thus, the strength of the prosecution's evidence was undermined by each court's perception of the defendant's good intentions and motives.

2. *The Backlash of Physician-Assisted Suicide in Practice*

Dr. Jack Kevorkian, a retired pathologist, has become the figure-head of physician-assisted suicide. His invention, the Mercitron,[220] was first used in 1990 by Janet Adkins, an Oregon resident diagnosed with Alzheimer's

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211. Bertram R. Harper, 90-010081 (Detroit Recorders Court, May 10, 1991). The unavailability of the court's opinion has resulted in all citations to the case referring to a secondary source.

212. Nicholas Platt, Jr., *Man Found Not Guilty in Michigan Suicide Case*, REUTERS, May 10, 1991, *available on LEXIS*, Nexis Library, Reuter File.

213. *Id.*

214. *Helping to Die is Murder–DA*, HEMLOCK Q. (National Hemlock Society, Eugene, Or.), Oct., 1990, at 1, 2.

215. *Id.* at 2.

216. *Id.*

217. Platt, *supra* note 212.

218. *See supra* text accompanying note 120.

219. *See supra* text accompanying notes 201-208.

220. James Bowman, *Best-sellers in a Fight to the Death: Why Are Two Authors, Whose Books Both Advocate the Individual's Right to Commit Suicide, in Bitter Dispute?, Asks James Bowman*, DAILY TELEGRAPH, Oct. 13, 1991, at 112.

disease.[221] The Mercitron is activated by the person to whom it is connected and it injects a lethal combination of drugs into the user's bloodstream.[222] Mrs. Adkins traveled to Michigan to use the device because, at the time, Michigan did not have a law prohibiting assisted suicide.[223] Following Mrs. Adkins' death, Dr. Kevorkian was charged with murder, but the charges were subsequently dropped.[224] A court order barred him from using the device again, however.[225]

Despite the court order, on October 23, 1991, in a cabin in Michigan, police found the bodies of two women connected to a device similar to the one Janet Adkins previously used.[226] Although neither woman was terminally ill, one suffered from multiple sclerosis and the other from an extremely painful pelvic disease.[227] The police found the women after receiving a phone call from Dr. Kevorkian.[228] The deaths were treated as homicides and Dr. Kevorkian was arrested and indicted for the two deaths in February 1992.[229] In reaction to Dr. Kevorkian's actions, the Michigan Board of Medicine suspended his license.[230] In July 1992, an Oakland County Circuit judge dismissed the first degree murder charges in both deaths.[231]

Dr. Kevorkian has continued to add to his "death count," assisting two more women in their deaths. In May 1992, Dr. Kevorkian was present at the suicide of multiple sclerosis patient Susan Williams.[232] In September 1992, he assisted Lois Hawes, a terminal cancer sufferer, in committing suicide using carbon monoxide.[233] In light of the dismissal of the three prior charges and the absence, at the time, of a statute in Michigan making assisted suicide illegal, no charges were filed against Dr. Kevorkian in relation to these suicides.[234]

Michigan has become the "dying ground" for individuals wanting to end their lives with the aid of a physician rather than a plastic bag or sleeping pills. The absence of common-law prohibition of either assisted or physician-

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221. *"Dr. Death" Assists Suicides of Two Michigan Women*, REUTERS, Oct. 24, 1991, *available on LEXIS*, Nexis Library, Reuter File.

222. *Id.*

223. *Id.* Michigan has since enacted a temporary statute prohibiting assisted suicide. *See infra* note 237 and accompanying text.

224. *"Dr. Death" Assists Suicides of Two Michigan Women*, *supra* note 221.

225. *Id.*

226. *Id.*

227. *Id.*

228. *Id.*

229. *Death Charges*, THE TIMES (London), Feb. 7, 1992, at 13.

230. *License Suspended*, FIN. TIMES, Nov. 21, 1991, at I1.

231. *Kevorkian Cleared of Murder Charge*, CHI. TRIB., July 22, 1992, at C3.

232. *Another Suicide Aided by Controversial Doctor*, CHI. TRIB., Sept. 27, 1992, at C4.

233. *Id.*

234. Andrea Stone, *'Dr. Death': No Law Is Needed on Euthanasia*, USA TODAY, Oct. 28, 1992, at 6A.

assisted suicide has led to confusion in this area of the law.[235] Even in the face of obvious court disapproval, Dr. Kevorkian affirmed his intent to continue his "death care" practices.[236]

In February 1993, the Michigan legislature finally spoke out against Dr. Kevorkian's practices when it passed a highly controversial, temporary statute forbidding assisted suicide.[237] The statute, however, has not settled

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235. In People v. Roberts, 178 N.W. 690, 693 (Mich. 1920), the defendant was convicted of first degree murder for assisting his wife's suicide. The defendant's wife was bedridden and suffering from multiple sclerosis when she requested her husband's help. *Id.* at 691. The court found the defendant's mere preparation of a poisonous solution, which he placed within his wife's reach at her request, constituted a taking of a life by poison within the meaning of the state murder statute. *Id.* at 693. Although the defendant did not actively assist his wife in taking the poison, his assistance in making his wife's death possible was sufficient for the court to convict him of murder. *Id.* at 693-94.

In contrast, the appeals court in People v. Campbell, 335 N.W.2d 27, 30-31 (Mich. Ct. App. 1983), held incitement to suicide was not a crime. The defendant provided the deceased with a loaded weapon and encouraged him to use it. *Id.* at 28. The court stated murder and manslaughter, not homicide, were crimes in Michigan. *Id.* at 29. It then defined homicide as the killing of one human being by another, and concluded, by definition, homicide excluded suicide. *Id.* at 30. Because the defendant's provision of the weapon to the deceased was only assisting the deceased and not a killing of another person, the court held it was not homicide. *Id.* at 31.

These two cases create confusion about the current status of Michigan's common law with respect to assisted suicide. In People v. Campbell, 335 N.W.2d at 29, the Michigan Court of Appeals stated *Roberts* was no longer representative of Michigan law, but the Michigan Supreme Court has not reversed *Roberts*. The Michigan Supreme Court has indicated its unwillingness to settle the confusion as to what the Michigan common law represents in this area through its refusal to hear an appeal of the court of appeals decision in *Campbell*. People v. Campbell, 342 N.W.2d 519, 519 (Mich. 1984).

236. Dr. Kevorkian "vowed to the Michigan State Medical Society to continue assisted suicides" on October 6, 1992, just ten days after assisting Lois Hawes in her suicide attempt. *Another Suicide Aided By Controversial Doctor*, *supra* note 232, at C4. The Hemlock Society, the nation's largest advocate of assisted suicide and physician-assisted suicide, believes physician aid-in-dying should occur only when the following elements are met:

> 1. There must be adequate legal documentation that the euthanasia was requested by the patient well in advance of its occurring,
> 2. The physician who aids the patient in dying must know the patient and must have been fully aware of his/her medical history and desire for aid-in-dying in the event of terminal illness,
> 3. The physician must have a second opinion from another qualified physician that affirms that the patient's condition is indeed terminal, and
> 4. The rights of physicians who cannot in good conscience perform aid-in-dying are to be fully respected, providing they in no way obstruct the practice of physicians who in good conscience give such aid.

Don C. Shaw, *It's Over Debbie*, 259 JAMA 2094, 2096 (1988).

237. *See* MICH. COMP. LAWS ANN. § 752.1027(7)(1)-(5) (West Supp. 1993). The statute is self-repealing, effective six months after a commission on death and dying makes recommendations to the Michigan legislature. *Id.* § 752.102(7)(5). The commission has until May 25, 1994, at the latest, to make recommendations "concerning the voluntary self-termination of life." *Id.* § 752.1027(4)(1),(2).

the law in Michigan.[238] More importantly, it has not stopped Dr. Kevorkian from assisting suicides, and likely will not stop him.[239] Clearly, Dr. Kevorkian has brought the assisted-suicide debate to the forefront. The law in this area is continuously evolving as courts and legislatures deal with this issue.

IV. CONCLUSION

The "mercy killing" cases represent individuals who would not stand idly by and wait for the suffering to end, but who sought the help of people they trusted to help them end their lives with dignity. Most of the individuals were forced to choose less than quick, dignified deaths, using implements such as plastic bags, guns, morphine overdoses, and cellophane. If physician-assisted suicide were available to these people, death may have been easier, if not more dignified, and their loved ones would not have experienced the ensuing accusations and trials. These cases also demonstrate "when the victim is related to the killer, the killer performs his deed openly at great personal risk, the killer has reason to believe that the victim is greatly suffering or will suffer, and the evidence indicates no self-serving motive—jurors tend not to convict."[240] If they do convict, the defendant does not serve a prison term.[241] Thus, the letter of the law does not allow euthanasia and "mercy killing" as a defense or mitigating factor in these types of murders; however, courts often take this motivation behind the crimes into account.[242]

The current state of the law in all fifty states does not permit a physician to administer aid-in-dying to a patient who requests it; yet the law does permit physicians to *allow* patients to die. Commentators have recognized

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238. On May 20, 1993, a Michigan circuit court voided the statute on technical grounds. *See* Hobbins v. Attorney General, No. 93-306-178CZ, 1993 WL 276833 (Mich. Cir. Ct. May 20, 1993). On June 22, 1993, however, the Michigan Court of Appeals stayed the Circuit Court's ruling while it reviews the case, essentially making the statute legal once again. Edward Walsh, *Kevorkian Charged in Assisted Suicide. Michigan Prosecuter Says He Intends to Force Resolution of Issue*, WASH. POST, Aug. 18, 1993, at A1, A18. The unavailability of the court's opinion has resulted in a citation referring to a secondary source.

239. On October 11, 1993, a Michigan court ordered Dr. Kevorkian to stand trial for assisting a 73 year old man in committing suicide in September 1993. *Kevorkian Faces 2nd Suicide Trial*, WASH. POST, Oct. 12, 1993, at A10. "The decision marked the second time that the retired pathologist has been ordered to stand trial on charges that he ignored the state's controversial ban on assisted suicide." *Id.*

240. Glantz, *supra* note 168, at 234.

241. An exception is Mr. Roswell Gilbert who was convicted and sentenced to twenty-five years in prison. Gilbert v. State, 487 So. 2d 1185, 1187 (Fla. Dist. Ct. App. 1986). However, Mr. Gilbert was released after serving only five years of his sentence. *81-Year Old Mercy Killer Says He Wouldn't Do It Again*, *supra* note 188.

242. *See supra* text accompanying notes 201-208.

this dichotomy, particularly when it becomes evident that *permitting* a patient to die will result in more suffering than the patient is able to withstand.[243] The result is essentially an empty distinction because, in either case, the doctor is taking an initial action that sets into motion a chain of events with a singular result—death.

Medical technology has advanced life-prolonging devices to the degree "we have transformed death; we have taken it out of the acute, natural, and noninterventional mode and made it more into a chronic, contrived, and manipulated phenomenon."[244] Thus, patients are forced to live with their diseases until medical technology, and the law, permit them to choose to end their lives. Even though physician-assisted suicide or assisted suicide by any other person is not yet legal, people with painful, incurable diseases still seek to find individuals like Dr. Kevorkian, husbands, wives, children, and friends who are willing to take the personal risk to relieve the suffering of the individuals about whom they care. The legalization of suicide would be the most preferable means to an end.

Jennifer L. Hoehne

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243. Helge Khuse, *The Case for Active Voluntary Euthanasia*, 14 LAW, MED. & HEALTHCARE 145, 146 (1986).

244. Vaux, *supra* note 190, at 2141.