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## Death with Dignity: AIDS and a Call for Legislation Securing the Right to Assisted Suicide, 29 J. Marshall L. Rev. 677 (1996)

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# NOTES

## DEATH WITH DIGNITY: AIDS AND A CALL FOR LEGISLATION SECURING THE RIGHT TO ASSISTED SUICIDE

### INTRODUCTION

Albert is a thirty-four year old white male who was diagnosed with AIDS<sup>1</sup> four years ago.<sup>2</sup> He is presently suffering severe wasting syndrome<sup>3</sup> and candidiasis<sup>4</sup> and is responding poorly to treatment of his third episode of *Pneumocystis carinii* pneumonia (PCP).<sup>5</sup> His T-cell<sup>6</sup> count is 120 and over the last six

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1. Acquired Immune Deficiency Syndrome (AIDS) refers to a specific set of diseases or conditions which indicate severe immunosuppression with Human Immunodeficiency Virus (HIV). AIDS AND THE LAW 1 (2d ed. Wiley Law Publications 1992). As of October 31, 1995, the cumulative number of AIDS cases in the United States reported to the Centers for Disease Control (CDC) was 501,310. Centers for Disease Control and Prevention, *First 500,000 AIDS Cases - United States, 1995*, 44 MORBIDITY & MORTALITY WEEKLY 849, 849 (Nov. 24, 1995).

2. Albert's story is fictional but is a realistic portrayal of a person living with AIDS.

3. Wasting syndrome is a condition which leaves the body drawn and weakened in skeleton-like condition. HUNG FAN ET AL., THE BIOLOGY OF AIDS 82 (Jones & Bartlett Publishers, Inc. 1991). Wasting Syndrome has two symptoms associated with it. *Id.* First is a loss in body weight. *Id.* at 82-83. It is usually progressive and leads to a wasting away of the infected person and may be accompanied by severe diarrhea. *Id.* at 83. The second symptom is night sweats. *Id.* The fevers involved with night sweats can involve dangerously high temperatures of 106 or 107 degrees Fahrenheit. *Id.*

4. Candidiasis is an infection of the esophagus which causes difficulty when Persons with AIDS (PWAs) swallow. FAN ET AL., *supra* note 3, at 87.

5. PCP is a rare form of pneumonia that is common among PWAs or other persons whose immune system has been weakened by chemotherapy, serious illness or drugs taken after organ transplants. ROSE WEITZ, LIFE WITH AIDS 11 (Rutgers University Press 1991). Symptoms of PCP include rapid, labored breathing, a nonproductive cough and extreme anxiety because of an inability to draw enough oxygen from the air into the bloodstream. Mary Cuff Plante, *Caring for the AIDS Patient*, in AIDS FACTS AND ISSUES 211, 219 (Victor M. Gong & Norman Rudnick eds., 1986).

6. See AIDS AND THE LAW, *supra* note 1, at 2-3 (discussing the role T-cells play in the human immune system). In 1993, the Centers for Disease Control revised its classification for HIV infection. CENTERS FOR DISEASE CONTROL, 1993 Revised Classification System for HIV Infection and Expanded Case Definitions for AIDS Among Adolescents and Adults, 41 MORBIDITY & MORTALITY WKLY. REP. NO. RR-17, at 1 (Dec. 18, 1992). The revised system is based on three ranges of T-cell counts and three clinical categories. *Id.* at 2. The three categories are as follows: category one, greater than 500 cells per microliter of blood; category two, 200-499

months he has lost T-cells at a very rapid rate. Albert shows no evidence of neurological impairment, and he is mentally competent. His mood is mildly depressed, but the depression is not pronounced given the seriousness of his medical condition. Albert wants nothing but comfort in the end. He also desires to maintain as much autonomy and dignity as possible. However, he is afraid that as his condition deteriorates, he will be unable to bear his pain and suffering with dignity. He has told his friends and family that "if you don't have quality of life, you don't have anything." He has informed his physician that he wishes to end his life before the suffering becomes unbearable. Albert's physician sympathizes with Albert, but fears that if he assists in any way in ending Albert's life, the doctor could be sanctioned by the medical licensing board, sued by Albert's family for Albert's death and criminally charged with Albert's homicide. Albert is also concerned that if he obtains the assistance of one of his friends in ending his life, the friend might be subject to similar difficulties. Yet, Albert has heard horror stories of unsuccessful suicide attempts among people living with AIDS (PWAs). He fears that should the suicide attempt fail, he could experience more pain and suffering than he endures with AIDS. Albert understands his physician's predicament, but still plans for someone to help him end his life.

Sadly, thousands of PWAs experience a similar situation as Albert. Every hour of every day more people become newly infected with HIV. Every day more people fall ill with symptoms of the myriad of disease conditions that can attend AIDS. Additionally, every day more people die of causes associated with AIDS. Indeed, as of October 31, 1995, the cumulative number of deaths of PWAs in the United States was 311,381.<sup>7</sup>

In some circumstances, the decision to commit suicide or to seek an assisted suicide is a rational choice.<sup>8</sup> When such a decision is made by a competent individual who has been informed by a physician of all of the available medical options, law and public policy should require that this decision be respected.

Although many courts have established uniform precedents allowing passive euthanasia<sup>9</sup> — the right of a patient to have life-

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cells per microliter of blood; and category three, less than 200 cells per microliter of blood. *Id.* at 3.

7. Centers for Disease Control and Prevention, *supra* note 1, at 849.

8. Suicide is the eighth leading cause of death in the United States. Centers For Disease Control and Prevention, *SUICIDE IN THE UNITED STATES 1980-1992* [hereinafter *SUICIDE*]. In 1992, there were 30,484 reported cases of suicide in the United States. *Id.* The national age adjusted suicide rate in 1992 was 11.09 per 100,000 population. *Id.* Almost 50% of these suicides occurred among the 20 to 44 age group. *Id.*

9. ALAN MEISEL, *THE RIGHT TO DIE* 63 (Wiley Law Publications 1989). Passive

prolonging treatment withheld or withdrawn — they steadfastly prohibit active euthanasia.<sup>10</sup> However, the purpose of passive and active euthanasia is precisely the same. Both serve to end the patient's life and release the patient from the painful, agonizing and dehumanizing loss of function.<sup>11</sup> As the New Jersey Supreme Court noted, "the line between active and passive conduct in the context of medical decisions is far too nebulous to constitute a principled basis for decisionmaking."<sup>12</sup>

As medical science extends life expectancy, more people who face the prospect of artificially prolonged, but painful and

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euthanasia is defined as "permitting a patient to die by withholding that treatment necessary to sustain life." *Id.*

10. *Id.* at 62. Meisel states that active euthanasia is "generally thought of as involving the administration of some agent or procedure to end a patient's life." *Id.* Assisted suicide refers to active, voluntary euthanasia where one or more persons participate in rational suicide at a patient's request. RUSSEL OGDEN, EUTHANASIA, ASSISTED SUICIDE AND AIDS 3 (Peroglyphics Press 1994). The courts distinguish between active and passive euthanasia in deciding whether a patient has the right to refuse treatment. *In re Quinlan* 355 A.2d 647, 650 (N.J. 1975), *cert. denied sub nom.*, *Garger v. New Jersey*, 429 U.S. 922 (1976). In *Quinlan*, the father of a girl in a persistent vegetative state sought court approval to disconnect his daughter's respirator. *Id.* at 651. The New Jersey Supreme Court granted relief and held that an individual has a right of privacy grounded in the U.S. Constitution to terminate treatment. *Id.* at 664. Similarly, in *Bouvia v. Superior Court*, petitioner was a bedridden quadriplegic who suffered with severe cerebral palsy. 225 Cal. Rptr. 297, 299-300 (Cal. Ct. App. 1986). Petitioner sought removal of a nasogastric feeding tube inserted and maintained against her will. *Id.* at 299. The court held that an individual has a right to refuse any medical treatment, even that which may prolong her life. *Id.* at 300.

However, in *Quill v. Koppell*, three physicians and three terminally ill patients brought an action to have a New York statute making it a crime to aid a person in committing suicide, or in attempting to commit suicide, declared unconstitutional. 870 F. Supp. 78, 80 (S.D.N.Y. 1994), *rev'd sub nom.*, *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996). In *Quill*, the district court held that the type of physician-assisted suicide at issue did not involve a fundamental liberty interest protected by the Due Process Clause of the Fourteenth Amendment. *Id.* at 84. The court held that the statute did not violate the Equal Protection Clause of the Fourteenth Amendment since the distinction drawn by the New York law had a reasonable and rational basis. *Id.* at 84-85. In *Compassion in Dying v. State of Washington*, the Ninth Circuit Court of Appeals held that there is no liberty interest protected by the Fourteenth Amendment in having a physician assist in terminating life. 49 F.3d 586, 590 (9th Cir. 1995), *rev'd*, 79 F.3d 790 (9th Cir. 1996) (en banc). In reversing the district court, the Ninth Circuit held that the distinction drawn by the legislature, in allowing a patient the right to refuse medical treatment but prohibiting physician-assisted suicide, did not violate the Equal Protection Clause. *Id.* at 593.

11. MEISEL, *supra* note 9, at 63. Meisel states that "[d]espite the plethora of judicial rulings permitting the forgoing [sic] of life sustaining treatment and thus approving passive euthanasia in all but name, there is still controversy over whether passive euthanasia is any different in principle from active euthanasia." *Id.*

12. *Matter of Conroy*, 486 A.2d 1209, 1234 (N.J. 1985).

unsatisfying experiences, may wish to end their lives.<sup>13</sup> This is a scenario that may be familiar to PWAs. For PWAs, the choice is not between life and death, but choosing whether to die now or to die later.<sup>14</sup> More precisely, it is not so much a choice of death as a choice to end irreversible emotional and physical suffering of grave dimensions. However, while euthanasia appears to be justified for terminally ill patients, such as PWAs, none of the legislative proposals permitting physician-assisted suicide have incorporated measures which cover PWAs to ensure that PWAs are included.

This Note argues that the decision to seek an assisted suicide is a rational choice when made by a PWA who no longer feels that he is enjoying a sufficient level of quality of life. Part I explores the relationship between suicide and AIDS, profiles the person who commits suicide and examines the incidence of suicide among PWAs. Part II discusses why the time has come to recognize a right to physician-assisted suicide, especially due to the attitudes of the legal system, the medical profession and the general public. Part III outlines the physician-assisted suicide experience in Oregon and shows how other states, most notably California, Massachusetts and Michigan, are attempting to legalize physician-assisted suicide in limited circumstances. Part IV identifies the flaws and shortcomings of the physician-assisted statutes in those four states. Finally, Part V proposes several urgent reforms that are needed in physician-assisted suicide proposals. These changes would ensure that the statute cover terminally ill patients, such as PWAs.

## I. THE RELATIONSHIP BETWEEN SUICIDE AND AIDS

In order to understand why suicide is a rational choice for PWAs, it is important for society, the legal system and the medical profession to explore the relationship between AIDS and suicide. Accordingly, Section A examines the profile of people who commit suicide and identifies the common motivating factors associated with suicide. Next, Section B discusses the incidence of suicide among PWAs, as well as the reasons why suicide is more common among PWAs than among the general population and even among people with other terminal illnesses. Finally, Section D considers why PWAs and the doctors who treat them generally approve of assisted suicide.

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13. Michael L. Closten & Joan E. Maloney, *The Health Care Surrogate Act in Illinois: Another Rejection of Domestic Partners' Rights*, 19 S. ILL. U. L.J. 479, 479-80 (1995).

14. OGDEN, *supra* note 10, at 38.

### A. *The Profile of People Who Commit Suicide*

Conventional wisdom has taught society that all people who commit suicide are abnormal and "sick."<sup>15</sup> However, while some people commit suicide for the wrong reasons, many suicides are rational and justified.<sup>16</sup> According to one medical ethicist: "[t]he ethical question is whether we may ever rightly take any rational human initiative in death and dying or are, instead, obliged in conscience to look upon life and death fatalistically, as something that just happens to us willy-nilly."<sup>17</sup> Understanding why people commit suicide is not an easy task. A suicide may be the result of situational stress or an imminent crisis.<sup>18</sup> However, suicides are more commonly due to identifiable motives on the part of each individual.

A person who commits suicide frequently has experienced social difficulties,<sup>19</sup> such as friction with a spouse or partner, a friend, a family member or a fellow worker.<sup>20</sup> Many individuals who commit suicide have recently suffered a significant social loss.<sup>21</sup> The common element in the profile of those who commit suicide is that they have feelings of guilt or shame,<sup>22</sup> which sometimes take the form of public humiliation.<sup>23</sup> They commonly feel fear caused by real or imagined threats to bodily integrity or to life itself.<sup>24</sup> Suicidal individuals frequently feel a loss of control over their environment.<sup>25</sup> Often the person who commits suicide is suffering great pain.<sup>26</sup> This pain may be in the form of real suffering without the possibility of relief, or even the threat of pain, such as the prospect of a chronic or terminal disease.<sup>27</sup>

Often, people who commit suicide exhibit altruistic sentiments. They see the option of their death as a benefit to others

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15. Joseph Fletcher, *In Defense of Suicide*, in SAMUEL E. WALLACE & ALBIN ESER EDS., *SUICIDE AND EUTHANASIA* 46 (1981).

16. Glenn C. Graber, *The Rationality of Suicide*, in SAMUEL E. WALLACE & ALBIN ESER EDS., *SUICIDE AND EUTHANASIA* 51 (1981). As an example of a rational suicide, Graber describes the story of Edgar, a wartime agent who is captured by the enemy. *Id.* at 53. Knowing that he will be tortured to death, he takes a cyanide capsule from a hidden compartment in his shoe, bites into it, and dies. *Id.*

17. Fletcher, *supra* note 15, at 38.

18. VICTOR M. VICTOROFF, *THE SUICIDAL PATIENT* 23 (Medical Economic Books 1983).

19. *Id.* at 26.

20. *Id.*

21. *Id.*

22. *Id.*

23. *Id.*

24. *Id.* at 27.

25. *Id.*

26. *Id.*

27. *Id.*

and believe they will be relieving their friends and family of further emotional and financial burdens.<sup>28</sup> Furthermore, suicidal persons often have feelings of overwhelming failure, which result in a loss of pride and making one's own death appealing.<sup>29</sup>

Studies suggest that imitative behavior and psychological identification are responsible for a higher incidence of suicide than biological or genetic factors.<sup>30</sup> A common psychological factor in nearly all suicides is depression and hopelessness.<sup>31</sup> Just as there are common motivating factors in suicides, there are also common characteristics of persons who commit suicide.

Males are at least four times more likely to commit suicide than females.<sup>32</sup> White males account for seventy-three percent of all suicides.<sup>33</sup> The likelihood of suicide tends to be higher among unmarried people.<sup>34</sup> Furthermore, the prospect of suicide attempts and successes is at least thirty times greater for depressed patients with a history of psychiatric hospitalization than for persons in the general population.<sup>35</sup> Upper, middle, professional and managerial classes, particularly artists, intellectuals and scientists (all of whom are less likely to express aggression) have the highest susceptibility to suicide.<sup>36</sup> Almost seventy-five percent of all people who committed suicide visited a physician within a year of their death.<sup>37</sup> One-third of these people had visited a doctor within three weeks prior to their suicides,<sup>38</sup> and about one-half had visited a psychiatrist as an outpatient within thirty days prior to their deaths.<sup>39</sup>

### B. *The Incidence of Suicide Among PWAs*

Studies on the relationship between medical illness and suicide have generally focused on mental disorders or cancers.<sup>40</sup> However, suicide is more common among PWAs than among the

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28. *Id.*

29. *Id.* at 28.

30. *Id.*

31. Aaron T. Beck et al., *Hopelessness and Suicidal Behavior*, 234 JAMA 1146, 1148 (1975). In their study of 384 people who attempted suicide, the researchers found that hopelessness accounts for 96% of the association between suicide and depression. *Id.*

32. SUICIDE, *supra* note 8, at 1.

33. *Id.*

34. See VICTOROFF, *supra* note 18, at 11. The rate of suicide attempts and successes for married people is one-half what it is for single people. *Id.*

35. *Id.* at 11-12.

36. *Id.* at 17.

37. *Id.* at 16.

38. *Id.*

39. *Id.*

40. OGDEN, *supra* note 10, at 34.

general population or even among people with other terminal illnesses.<sup>41</sup>

In 1985, Dr. Peter Marzuk and a team of researchers from Cornell University Medical College conducted the first study examining the relationship between AIDS and suicide.<sup>42</sup> Marzuk's study found the suicide rate among men in New York City with AIDS aged twenty to fifty-nine was thirty-six times higher than men in the same age group without the diagnosis and sixty-six times higher than the general population.<sup>43</sup> Since the time of Marzuk's study, others have examined the relationship between AIDS and suicide in California<sup>44</sup> and AIDS and suicide in the U.S. Air Force.<sup>45</sup> Dr. Timothy Coté conducted a national study of

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41. Stephen Mydans, *AIDS Patients' Silent Companion is Often Suicide, or Thoughts of it*, N.Y. TIMES, Feb. 25, 1990, at A1.

42. Peter Marzuk et al., *Increased Risk of Suicide in Persons with AIDS*, 259 JAMA 1333, 1333 (1988).

43. *Id.* at 1335. The New York City population for men aged 29 to 59 years old for the year January 1, 1985 to December 1, 1985 was 1,860,868. *Id.* Between January 1, 1985, and December 1, 1985, 668 New York City residents committed suicides. *Id.* During the same period, 3828 people were diagnosed with AIDS living in New York City. *Id.* Between January 1, 1985, and December 1, 1985, 12 PWAs committed suicide among PWAs. *Id.* The higher rate of suicide among PWAs was associated with various factors including: drugs causing delirium and depression, the subculture of grief that surrounds the epidemic and the tremendous psychological stressors associated with AIDS. *Id.* at 1336. The study suggests that there are several reasons to suspect that the true AIDS-related suicide rate may be higher than reported. *Id.* First, there may have been suicide victims in whom the diagnosis of AIDS was not reported to the medical examiner and who had no reason to suspect the person had AIDS. *Id.* Second, suicides may be hidden in other death classifications or may be classified as undetermined. *Id.* Third, it is difficult to estimate the number of patients who refused any form of treatment which is the equivalent to suicide. *Id.* at 1337. Part of the reason for the dramatic difference in rates between PWAs and the general population was certainly attributable to many factors such as the hysteria, stigma and uncertainty surrounding AIDS back in 1985.

44. Kenneth W. Kizer et al., *AIDS and Suicide in California*, 260 JAMA 1881, 1881 (1988). Kizer reports a higher incidence of suicide among PWAs than among the general population in the state of California. *Id.* In 1986, 3960 suicide deaths were reported in California, a total population rate of 14.68 suicide deaths per 100,000 person-years. *Id.* The California general population suicide rate for 1986 was 27.18 per 100,000 for males 10 years of age or older, while for men aged 20 to 59 the comparable rate was 27.12 per 100,000 person-years. *Id.* In 1986, 13 suicides identified AIDS as a significant condition contributing to the death. *Id.* Of these 13 suicides, all were male. *Id.* Eleven of the 13 PWAs who committed suicide were unmarried. *Id.* In 1986 the California AIDS registry listed 5616 males aged 10 years of age or older living with AIDS. *Id.* The number of person-years at risk for these men equals 2809.61, yielding a suicide rate of 462.69 per 100,000 person-years. *Id.* Thus, the suicide rate in California for male PWAs was 17.02 times higher than that of men without AIDS. *Id.*

45. J.R. Rundell et al., *Risk Factors for Suicide Attempts in a Human Immunodeficiency Screening Program*, 33 PSYCHOSOMATICS 24, 25 (1992). Rundell's study compared 15 HIV-positive individuals who attempted suicide with 15 HIV-positive



AIDS and suicide using National Center for Health Statistics Multiple-Cause Mortality Data from 1987 to 1989.<sup>46</sup> While the study found a lower suicide rate among PWAs than did previous studies,<sup>47</sup> the researchers warned that "[t]he use of multiple-cause death certificate data to determine the number of PWAs who commit suicide engenders biases that may have caused us to underestimate the association of these two causes of death."<sup>48</sup>

Whether it is because they are in pain, they no longer enjoy a sufficient quality of life or because they feel AIDS is a fate worse than death, many PWAs look upon suicide as a noble and ethical alternative.<sup>49</sup> Over the years, stories of individuals with AIDS who committed suicide appear in the news.<sup>50</sup> While the individuals may have chosen various methods of ending their lives, they all had one thing in common — they believed that committing suicide was a dignified option and a decision that was theirs to make.<sup>51</sup> According to one physician who treats PWAs: "[p]eople with AIDS and their advocates say that virtually everyone with the disease at least thinks about suicide when the end is near and wonders how it might be done."<sup>52</sup> Since suicide is a rational

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individuals who did not attempt suicide. *Id.* The risk factors for suicide attempts in the sample population were: social isolation, perceived lack of social support, adjustment disorder, personality disorder, alcohol abuse, HIV-related interpersonal or occupational problems and past history of depression. *Id.* at 27.

46. Timothy R. Coté et al., *Risk of Suicide Among Persons With AIDS*, 268 JAMA 2066, 2066 (1992). In their study of PWAs who committed suicide, the researchers found that 99% were male, 87% were Caucasian, 12% were African-American and 1% were other races. *Id.* at 2067. The median age was 35 years old, with a range from 20-69 years of age. *Id.*

47. *Id.* at 2068. Coté found the suicide rate among men with AIDS to be 7.4 times higher than among demographically similar men in the general population. *Id.* at 2068. The results from this study are significantly lower than previous studies. See Marzuk et al., *supra* note 42, at 1335 (finding the suicide rate among PWAs to be 36 times higher than among men in the same age group without the diagnosis). See also Kizer et al., *supra* note 44, at 1881 (finding the suicide rate for PWAs in California to be 17 times higher than among men in the same group without the AIDS diagnosis).

48. Coté et al., *supra* note 46, at 2068. In his study, Russel Ogden describes the suicide of "Daniel." OGDEN, *supra* note 10, at 74-76. Although Daniel left a note stating his intent was to commit suicide, his death was attributed to overdose. *Id.* at 76.

49. OGDEN, *supra* note 10, at 74-76.

50. See, e.g., Gina Kolata, *AIDS Patients Seek Solace in Suicide But Many Risk Added Pain in Failure*, N.Y. TIMES, June 14, 1994, at C4; Kay Longcope, *AIDS Related Suicide Up*, BOSTON GLOBE, Mar. 17, 1990, at A25 (describing the rise in AIDS related suicide in Massachusetts and around the country).

51. OGDEN, *supra* note 10, at 57. According to one PWA in Ogden's sample, "[suicide] brings back feelings of my independence, and my control of my life. It helps me alleviate fears of ending up comatose or on machines." *Id.* at 63.

52. Gina Kolata, *AIDS Patients Turning More Often to Suicide*, THE NEW ORLEANS TIMES-PICAYUNE, June 14, 1994, at A4.

choice for many of the PWAs who take their own lives, it is understandable that they share a similar profile and share many of the same motivating factors with people in the general population who commit suicide.

First, like people who commit suicide in the general population, PWAs who commit suicide are overwhelmingly male<sup>53</sup> and Caucasian.<sup>54</sup> The factors which motivate people in the general population to commit suicide are similarly present in PWAs who commit suicide. One common motivating factor in suicides is social difficulty.<sup>55</sup> While attitudes and perceptions have improved since the virus was first discovered, PWAs still face discrimination.<sup>56</sup> Both HIV and AIDS strains relationships with friends and with loved ones.<sup>57</sup> Often co-workers of PWAs make their fears and hostilities so obvious that PWAs can no longer tolerate the stress of working.<sup>58</sup>

People who commit suicide tend to have recently suffered a significant loss or trauma.<sup>59</sup> The losses associated with AIDS may pervade many of the facets of a PWAs life.<sup>60</sup> Because many people are infected with AIDS in the prime of their lives, many

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53. See *id.* See also Kizer, *supra* note 44, at 1881. In Kizer's study, all 13 PWAs who committed suicide in California in 1986 were male. *Id.*

54. Côté et al., *supra* note 46, at 2067. The study found that 87% of PWAs who commit suicide were Caucasian. *Id.*

55. VICTOROFF, *supra* note 18, at 26.

56. OGDEN, *supra* note 10, at 63. In his study on AIDS and suicide, Ogden reports that 27.7% of the PWAs in his sample identified experiences they perceived as discriminatory. *Id.*

57. Alexandra Teguis & Paul I. Ahmed, *Living With AIDS an Overview*, in PAUL I. AHMED, ED., *LIVING AND DYING WITH AIDS* 3, 16 (Plenum Press 1992). Unlike cancer patients whose families often rally and get reinolved in the patients' lives, PWAs do not enjoy a similar experience. *Id.* In fact, many PWAs lie and tell their families they have cancer. *Id.*

58. WEITZ, *supra* note 5, at 123.

59. VICTOROFF, *supra* note 18, at 26.

60. Teguis & Ahmed, *supra* note 57, at 14-16. According to Teguis and Ahmed, the major losses associated with AIDS include the following: loss of financial, job or health care security; stigmatization and social ostracism; loss of pride and self-esteem; loss of innocence; aborted continuum of recovery for those who finally conquered their addiction in treatment programs; loss of physical contact, such as touching, due to ill-informed fears regarding casual contagions; isolation by doctors, dentists and hospitals who transfer out PWAs or refuse to treat them so that "real" patients will not be driven away; loss of a sense of stability or correctness; loss of future hopes, dreams, or goals; loss of one's entire peer group; loss of youth or vigor, energy and physical appearance, particularly with Cytomegalovirus or Kaposi's sarcoma; multiple death losses and traumatic degenerative ones; loss of feeling of control, especially for groups like hemophiliacs, mothers of infants with AIDS and transfusion patients; loss of privacy entailed in having to reveal one's most private life, often visible by the disfiguring lesions produced by Kaposi's sarcoma; loss of mental competence associated with dementia; loss of "benefits" of the sick roles; loss of support of family origin; and loss of former lifestyle. *Id.*

PWAs are forced to confront death at an early age.<sup>61</sup>

The loss of friends or lovers to conditions associated with AIDS is a psychosocial factor that may serve as a precipitating factor to suicide.<sup>62</sup> The loss of the supportive relationship of family, friends and lovers due to the ostracism of the PWA is enormously unsettling. Without sufficient support sources, one feels isolated and alone. Hopelessness and despair can readily take over.

Guilt or shame is another factor that is present in many suicides.<sup>63</sup> PWAs frequently feel humiliated and guilty of contracting the disease.<sup>64</sup> This guilt is often the result of the public perception that PWAs have brought their ill health upon themselves. In fact, many PWAs share the same notion and often view their illness as God's retribution.<sup>65</sup> Also, public humiliation is associated with the various diseases and infections, as well as other social stigmatizations such as homophobia.

Fear is also a common motivating factor among people who commit suicide.<sup>66</sup> Similarly, fear permeates the lives of many PWAs. Depending upon the stage to which the virus has progressed, a PWA may fear that this is his last healthy day, or may fear this is the last day he can work at his job. If he is already ill, he may fear the onslaught of other more degenerative diseases, such as dementia,<sup>67</sup> cytomegalovirus<sup>68</sup> or even death.

People who commit suicide often feel as if they have lost

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61. *Id.* at 15. Except for natural disasters and wars, the multiple death losses experienced by PWAs do not typically occur until much later in life. *Id.*

62. Marzuk et al., *supra* note 42, at 1336.

63. VICTOROFF, *supra* note 18, at 26.

64. Teguis & Ahmed, *supra* note 57, at 16. Teguis and Ahmed explain that AIDS, unlike other terminal illnesses, involves shame as well as guilt. *Id.* Shame involves one's entire being, one's worth as an entity. *Id.* Guilt revolves around failures of doing or not doing. *Id.* Because of the stigma surrounding AIDS, PWAs suffer excessive shame, which leads not only to denial and nonrecognition of symptoms, but also to postponing help until the disease has progressed. *Id.*

65. MICHAEL L. CLOSEN ET AL., AIDS: CASES AND MATERIALS 60 (The John Marshall Publishing Co. 1989) (discussing various theories). God's retribution theory proposes that the "AIDS epidemic is punishment for the sins of gay men and drug users." *Id.*

66. VICTOROFF, *supra* note 18, at 27.

67. Leon D. Prockop, *AIDS Dementia Complex*, 9 J. LEGAL MED. 509, 510 (1988). Dementia is produced by central nervous system (CNS) syndromes associated with AIDS. *Id.* CNS syndromes may result from HIV infection or from opportunistic infections or neoplasms which may occur alone or as part of the systemic illness. *Id.*

68. Cytomegalovirus (CMV) is a member of the Herpes virus family. FAN ET AL., *supra* note 3, at 93. In PWAs, CMV tends to infect the retina of the eyes, which leads to blindness. *Id.* at 96. Pneumonia, fever, rashes and gastroenteritis due to CMV infection are also seen in PWAs. *Id.*

control of their environment.<sup>69</sup> Because many in society still hold a negative attitude towards AIDS and PWAs, many PWAs similarly feel like they have lost control of their environment. Furthermore, many of the conditions associated with AIDS makes many PWAs feel like they have lost control of their bodies and of their social setting. The stigmatization and fear surrounding AIDS may in some circumstances end relationships and prevent the person from enjoying life's ordinary activities.<sup>70</sup> AIDS can also take away sex, one's job, one's home and most important, one's dignity.<sup>71</sup>

### C. *The Incidence of Physician-Assisted Suicide Among PWAs*

Physician-assisted suicide is not legal in any jurisdiction.<sup>72</sup> As a consequence, PWAs are faced with turning to friends and loved ones for help in ending their lives.<sup>73</sup> Since the HIV-AIDS community is more closely knit than other communities, PWAs contemplating suicide often seek the advice and assistance of friends and doctors.<sup>74</sup>

While many PWAs secretly obtain the assistance of a physician in their suicide,<sup>75</sup> the majority of PWA assisted suicides are conducted outside of hospitals and in the hands of concerned, albeit, inexperienced people.<sup>76</sup> As a result, many of these suicides are improperly administered. Often, the person who has made a rational choice to die with dignity must accept his death in a totally undignified manner. Many times the people providing the assistance must turn to whatever means are available to end the person's life, whether it be hanging, suffocation or shooting.<sup>77</sup>

69. VICTOROFF, *supra* note 18, at 27.

70. Michael L. Closten, *HIV-AIDS in the 1990s*, 27 J. MARSHALL L. REV. 239, 239 (1994).

71. *Id.*

72. See *infra* notes 113-15 for a list of the legal status of assisted suicide in the various states.

73. Carol J. Castaneda, *Assisted Suicide Quietly Becoming More Common Among AIDS Patients*, MORNING NEWS TRIB. (TACOMA, WASH.), May 23, 1994, at A1.

74. See generally Kolata, *supra* note 52, at A4 (discussing how AIDS patients seek the advice of their doctors in ending their lives).

75. *Id.* According to one study, doctors in San Francisco who treat AIDS patients are more likely to agree to assist in suicide than doctors elsewhere. *Id.*

76. E.g., OGDEN, *supra* note 10, at 81. Ogden describes "Paul's" assistance in "James'" death. *Id.* James decided he wanted to die at home. *Id.* James asked Paul to help him ingest a large dose of morphine. *Id.* A few hours later, a horrible keening awakened Paul. *Id.* Paul discovered James huddled in the corner of the room. *Id.* James was still alive, but thought he had died and gone to hell. *Id.*

77. See, e.g., Clyde H. Farnsworth, *Vancouver AIDS Suicides Botched*, N.Y. TIMES, June 14, 1994, at C4. The author describes five assisted suicides where the people wishing to end their pain and suffering were unsuccessful. *Id.* In one case,

Thus, the assisted suicide may actually increase the suffering it was intended to alleviate. To avoid this horror, the AIDS epidemic is a driving force behind the efforts to legalize physician-assisted suicide.<sup>78</sup>

In his graduate thesis examining the incidence of euthanasia and assisted suicide among PWAs, Russel Ogden found that almost eighty-four percent of the PWAs sampled reported that they were considering euthanasia or assisted suicide as an alternative to the pain and suffering.<sup>79</sup> Those PWAs who had a euthanasia or assisted suicide plan had many similar identifiable characteristics.<sup>80</sup> They all possessed a strong desire to live well with AIDS.<sup>81</sup> They had a clear understanding of the HIV disease progression and the limits of the therapy.<sup>82</sup> Furthermore, they had all witnessed the loss of several friends to AIDS.<sup>83</sup> They all had the support of a partner, friend, physician or family member to provide assistance in their deaths.<sup>84</sup> Finally, all had a basic

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the person providing assistance resorted to slitting the other person's wrists with a razor blade. *Id.* In two cases, those aiding the person resorted to shooting the victim. *Id.* Many of the cases took several hours to complete. *Id.* One assisted suicide lasted four days. *Id.* In *People v. Cleaves*, the jury convicted Cleaves of second-degree murder for assisting an AIDS sufferer with a strangulation suicide. 280 Cal. Rptr. 146, 149 (Cal. Ct. App. 1991). According to Cleaves' account, victim Eaton tied a sash around his neck and had Cleaves tie his hands and feet with the sash. *Id.* Eaton put his face down on a pillow and had Cleaves put his hands on his back to steady him. *Id.* When the sash ripped, Eaton requested that Cleaves retie his hands. *Id.* Cleaves testified to the police that he helped Eaton by putting weight on his back until Eaton started to choke. *Id.*

Stephen Braun described the assisted suicide of Ron Weigart. Stephen Braun, *Deliver Them From AIDS*, L.A. TIMES, Aug. 28, 1988, at B1. Weigart suffered with AIDS for two years before obtaining assistance from two people in ending his life. *Id.* On December 31, 1984, Weigart drank a concoction of hypnotic medication and fruit juice. *Id.* However, by morning Weigart was still alive. *Id.* The people assisting him then tied a plastic bag over his head and suffocated him. *Id.* Weigart's assisted suicide may be due to the fact that in 1984 many of the medical treatments available today were not available.

78. See, e.g., Claudia Morain, *Out of the Closet on the Right To Die*, AM. MED. NEWS, Dec. 12, 1994, at 14. According to Ralph Mero, the Executive Director of Compassion in Dying, an organization which helps terminally ill patients find physicians who are willing to provide aid in dying, nearly half of the inquiries are from PWAs. *Id.* See also Castaneda, *supra* note 73, at A1 (citing Don Cox of the Hemlock Society who says that his office gets a call every other day of someone dying of AIDS).

79. OGDEN, *supra* note 10, at 57. Ogden reports that for many of the PWAs sampled, euthanasia was a potential solution that allowed them to set the terms and conditions on how they would complete their lives. *Id.* at 58.

80. *Id.* at 87-88.

81. *Id.* at 87. According to Ogden, the PWAs strong desire to live well with AIDS included careful monitoring and treatment of opportunistic infections. *Id.*

82. *Id.*

83. *Id.* at 88.

84. *Id.*

knowledge of lethal drug combinations and access to lethal doses of prescription medications.<sup>85</sup>

## II. THE GROWING ACCEPTANCE OF PHYSICIAN-ASSISTED SUICIDE IN LAW, MEDICINE AND THE GENERAL PUBLIC

In the United States, attempts to legislate physician-assisted suicide have either failed in their respective state legislatures<sup>86</sup> or the courts have struck down the legislation.<sup>87</sup> Nonetheless, the legal community and the public are moving toward the acceptance of the right of terminally ill patients to seek physician assistance in ending their lives. This expanding support for assisted suicide makes the present time appropriate for state legislatures to recognize such a right. This section outlines three principal reasons in support of recognizing the right to physician-assisted suicide.

First, while aiding a person in committing suicide remains illegal in a majority of states,<sup>88</sup> rarely is anyone found guilty.<sup>89</sup> Furthermore, those who are convicted receive little or no punishment.<sup>90</sup> Second, a shift in attitude among medical professionals regarding assisted suicide is apparent. An increasing number of physicians now support the right of terminally ill patients, such as PWAs, to seek assistance in ending their lives.<sup>91</sup> Third, a majority of the general public supports some form of physician-assisted suicide to help alleviate the pain and suffering of a terminally ill patient.

### A. Attitude of the Legal System

#### 1. Legal Sources of the Right to Die

##### a. The Right to Refuse Medical Treatment

The legal right to die refers to "an individual's right to refuse medical treatment, the refusal of which will cause death."<sup>92</sup> Given the inevitability of death, it may seem ironic that there would ever be the need to establish the legal right to die. However, the

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85. *Id.* Ogden reports that the prescription medications were usually sedative and hypnotic drugs. *Id.*

86. As of September 1995, physician-assisted suicide proposals were struck down in Connecticut, Maryland, Massachusetts, New Mexico and Oregon during the 1995 legislative session. CHOICE IN DYING, THIRD QUARTER LEGISLATION UPDATE 3 (Sept. 1995).

87. *E.g.*, *Lee v. Oregon*, 891 F. Supp. 1429, 1433 (D. Or. 1995).

88. See *infra* note 113 for a list of states that criminalize assisted suicide.

89. *California Doctor Won't be Prosecuted*, USA TODAY, May 23, 1994, at 8A.

90. ALAN MEISEL, 2 THE RIGHT TO DIE 474 (2d ed. Wiley Law Publications 1995).

91. See *infra* notes 160-67 for a discussion of the shift in physicians' attitudes.

92. ALAN MEISEL, 1 THE RIGHT TO DIE 4 (2d ed. Wiley Law Publications 1995).

unfortunate reality is that for many years, health care professionals viewed the patient's interests as irrelevant.<sup>93</sup> It was not until the 1976 case of *In re Quinlan*,<sup>94</sup> that a court finally tore down the barrier to patient autonomy in medical decision making.<sup>95</sup>

Although there is no absolute right to die, a growing consensus under both case law and statutory law indicates that such a right does exist.<sup>96</sup> While many state courts throughout the 1970s and 1980s held that a patient had the right to refuse unwanted medical treatment,<sup>97</sup> that concept did not find Supreme Court approval until the 1990 case of *Cruzan v. Director, Missouri Department of Health*.<sup>98</sup> In *Cruzan*, the Court upheld a determination by the Missouri Supreme Court that required proof by clear and convincing evidence of a patient's desire for the withdrawal of life-sustaining equipment.<sup>99</sup> In affirming the Missouri Supreme Court, the United States Supreme Court stated, "The principle that a competent person has the constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions."<sup>100</sup>

The legal right to die has been grounded in both constitutional and common law sources.<sup>101</sup> Some courts have drawn upon

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93. Robert J. Dzielak, Note, *Physicians Lose the Tug of War to Pull the Plug: The Debate About Continued Futile Medical Care*, 28 J. MARSHALL L. REV. 733, 737 (1995). Dzielak describes how historically, doctors made all definitive decisions for the patients, regardless of a patient's expressed or unexpressed wishes. *Id.*

94. 355 A.2d 647 (N.J. 1975), *cert. denied sub nom.*, Garger v. New Jersey, 429 U.S. 922 (1976). What distinguished *Quinlan* from the cases that preceded it was that even if the mechanical ventilator was to have been maintained, the patient's condition was such that she would never return to a "semblance of health." MEISEL, *supra* note 92, at 38.

95. *Developments in the Law — Medical Technology and the Law*, 103 HARV. L. REV. 1519, 1643 (1990). Prior to the New Jersey Supreme Court's decision in *Quinlan*, various courts had recognized the right of patient autonomy in minor medical decisions, but there had been a great reluctance to extend that right to the refusal of treatment that would lead to their death. MEISEL, *supra* note 92, at 38.

96. MEISEL, *supra* note 92, at 39.

97. *See id.* at 38-39 n.6 (listing the various state courts that had determined that a patient had the right to refuse unwanted life-sustaining treatment).

98. 497 U.S. 261 (1990). According to Meisel, the United States Supreme Court had denied certiorari in five previous cases dealing with a patient's right to die before granting an appeal in the *Cruzan* case. MEISEL, *supra* note 92, at 41. In *Cruzan*, Chief Justice Rehnquist, writing for the majority stated, this is the first case in which we have been squarely presented with the issue whether the United States Constitution grants . . . a right to die." 497 U.S. at 277.

99. *Cruzan*, 497 U.S. at 280.

100. *Id.* at 278.

101. Note, *Physician-Assisted Suicide and the Right to Die with Assistance*, 105 HARV. L. REV. 2021, 2025 (1992) [hereinafter *Physician-Assisted Suicide*]. According to Meisel, most courts have not provided any justification for the right to die because the courts have not made the scope of the right dependent on whether the

federal constitutional precedents dealing with reproductive rights,<sup>102</sup> and thus control of one's body, to find a constitutionally protected right to die grounded in the right of privacy.<sup>103</sup> Other courts, such as the *Cruzan* Court, have characterized the right to refuse medical treatment as a constitutionally protected due process liberty interest.<sup>104</sup> What these two positions have in common is the view that the right to die is rooted in an idea of personal autonomy.<sup>105</sup> However, the common-law doctrine of informed consent has been the most common basis for finding that a patient has the right to be free from unwanted medical treatment.<sup>106</sup> The right to refuse medical treatment has always been regarded as an implicit notion contained in the requirement of consent to medical treatment.<sup>107</sup>

#### b. Extending the Right to Refuse Medical Treatment to Physician-Assisted Suicide

Although courts have been careful to exclude assisted suicide from the scope of their decisions permitting the refusal or removal of life-sustaining medical treatment, many scholars argue that the

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right is grounded in the Constitution or in the common-law. MEISEL, *supra* note 92, at 55.

102. See *Roe v. Wade*, 410 U.S. 113, 153 (1973) (holding that the right of privacy, whether it is found in the Fourteenth Amendment concept of personal liberty, or in the Ninth Amendment reservation of rights to the people, is broad enough to encompass a woman's decision whether to terminate her pregnancy); *Griswold v. Connecticut*, 381 U.S. 479, 485 (1965) (recognizing that certain explicitly stated constitutional guarantees, such as the marital relationship, give rise to unstated zones of privacy).

103. In *Quinlan*, the New Jersey Supreme Court concluded:

Although the Constitution does not explicitly mention the right of privacy, Supreme Court decisions have recognized that a right of personal privacy exists and that certain areas of privacy are guaranteed under the Constitution. . . . Presumably this right is broad enough to encompass a patient's decision to decline medical treatment under certain circumstances.

355 A.2d at 663.

104. See, e.g., *Cruzan*, 479 U.S. at 279 (holding that the U.S. Constitution would grant a competent person a constitutionally protected right to refuse lifesaving nutrition and hydration). In *Cruzan*, the United States Supreme Court shifted away from the right of privacy to the Fourteenth Amendment's due process liberty interest as the basis for the right to refuse medical treatment. MEISEL, *supra* note 92, at 63. According to Meisel, this shift away from the right of privacy to a liberty interest under the Fourteenth Amendment has been followed by some states. *Id.* at 64.

105. *Physician-Assisted Suicide*, *supra* note 101, at 2025.

106. *Id.*; see also *Cruzan*, 497 U.S. at 269 (stating that the doctrine of informed consent has been firmly entrenched in American tort law).

107. MEISEL, *supra* note 92, at 58. In *Werth v. Taylor*, the Michigan Court of Appeals explained that the whole notion of informed consent leads to an inference of its converse, namely the informed refusal of medical treatment. 475 N.W.2d 426, 428 (Mich. Ct. App. 1991).



right to an assisted suicide is not fundamentally or morally different than the right to refuse unwanted medical treatment.<sup>108</sup> Advocates of the right to physician-assisted suicide assert that the court decisions recognizing the right to withhold or withdraw life-sustaining medical treatment serves as the basis for recognizing that right.<sup>109</sup> One rationale for recognizing assisted suicide is that patients with a terminal condition who no longer enjoy a sufficient quality of life should be given the uninterfered right to decide the time and manner of their death, whether or not their death involves a doctor's assistance. Another rationale relates to the regulation of the practice of assisted suicide which occurs regardless of its legal status.

Legalization of the practice of assisted suicide would act as a safeguard against abuses in many respects. First, by making the practice legal and establishing guidelines, it increases the probability that the procedure would be conducted properly in the hands of a qualified individual. Second, the practice may prevent the assisted suicide of those people who turn to friends and loved ones to assist because they feel they have no other choice. By legalizing the practice these patients could openly discuss with their physician the ramifications of all available options.<sup>110</sup>

## 2. Failure to Prosecute for the Crime of Assisted Suicide

Neither suicide nor attempted suicide has been a criminal offense in any state for at least ten years.<sup>111</sup> However, a majority of states still classify assisted suicide as a crime.<sup>112</sup> Thirty-four states explicitly classify assisted suicide as an independent offense in their criminal code.<sup>113</sup> In ten states and the District of

108. Julia Pugliese, Note, *Don't Ask, Don't Tell: The Secret Practice of Physician-Assisted Suicide*, 44 HASTINGS L.J. 1291, 1310 (1993). The author asserts the position that distinguishing between withdrawal of nutrition and hydration that results in death and administering a lethal injection which merely hastens the same result is an illusory distinction. *Id.*

109. Jody B. Gabel, *Release from Terminal Suffering? The Impact of AIDS on Medically Assisted Suicide Legislation*, 22 FLA. ST. U. L. REV. 369, 387 (1994).

110. Patients who are able to discuss sensitive issues such as physician-assisted suicide with their physician are more likely to trust their physician. Cheryl Smith, *Active Euthanasia*, 79 A.B.A. J. 42, 42 (1993).

111. Thomas J. Marzen et al., *Suicide: A Constitutional Right*, 24 DUQ. L. REV. 1, 25 (1985).

112. *Id.*

113. The following statutes criminalize assisted suicide as an independent criminal offense: ALASKA STAT. § 11.41.120 (1962); ARIZ. REV. STAT. ANN. § 13-1103(A)(3) (1956); ARK. CODE ANN. § 5-10-104(a)(2) (Michie 1987); CAL. PENAL CODE § 401 (Deering 1988); COLO. REV. STAT. ANN. § 18-3-104 (West 1973); CONN. GEN. STAT. ANN. § 53a-56 (West 1958); DEL. CODE ANN. tit. 11, § 645 (Supp. 1990); FLA. STAT. ANN. § 782.08 (West 1941); GA. CODE ANN. § 16-5-5(b) (Harrison 1971); HAW. REV. STAT. § 707-702 (1993); 720 ILCS 5/12-31 (West 1992); IND. CODE ANN.

Columbia, assisted suicide is criminalized through the common law.<sup>114</sup> In six states, the law is unclear concerning the legality of assisted suicide.<sup>115</sup> Yet despite the prohibition against assisted suicide there is a lack of enforcement.<sup>116</sup> Even when charges are brought, juries often sympathize with the defendant and refuse to convict.<sup>117</sup>

In 1991, Dr. Timothy Quill published an article in *The New England Journal of Medicine* detailing his experience and role in the death of a patient named "Diane."<sup>118</sup> The article provoked

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§ 35-42-1-2 (West 1971); KAN. STAT. ANN. § 21-3406 (1988); KY. REV. STAT. ANN. § 216.302 (Michie/Bobbs-Merrill 1994); ME. REV. STAT. ANN. tit. 17-A, § 204 (West 1964); MICH. COMP. LAWS § 752.1027 (1991); MINN. STAT. ANN. § 609.215 (West 1946); MISS. CODE ANN. § 97-3-49 (1972); MO. ANN. STAT. § 565.023 (Vernon 1979); MONT. CODE ANN. § 45-5-105 (1995); NEB. REV. STAT. § 28-307 (1989); N.H. REV. STAT. ANN. § 630:4 (1986); N.J. STAT. ANN. § 2C:11-6 (West 1995); N.M. STAT. ANN. § 30-2-4 (Michie 1978); N.Y. PENAL LAW § 125.15 (McKinney 1987); N.D. CENT. CODE § 12.1-16-04 (Supp. 1991); OKLA. STAT. ANN. tit. 21, §§ 813-818 (West 1983); OR. REV. STAT. § 163.12 (1)(b) (1953); PA. STAT. ANN. tit. 18, § 2505 (1983); S.D. CODIFIED LAWS ANN. §§ 22-16-37, -38 (1967); TENN. CODE ANN. § 39-13-216 (1956); TEX. PENAL CODE ANN. § 22.08 (West 1988); WASH. REV. CODE ANN. § 9A.36.060 (West 1961); WIS. STAT. ANN. § 940.12 (West 1982).

114. The following statutes criminalize assisted suicide through the common law of crimes: ALA. CODE § 1-3-1 (1975); D.C. CODE ANN. § 22-107 (1981); IDAHO CODE § 18-303 (1932); MD. CODE ANN., CONST. ART. 5 (1981); NEV. REV. STAT. § 192.050 (1986); R.I. GEN. LAWS § 11-1-1 (1989); S.C. CODE ANN. § 16-1-10 (Law. Co-op. 1976); VT. STAT. ANN. tit. 1, § 271 (1988); W. VA. CODE § 61-11-3 (1966).

115. In Iowa and Virginia, case law may criminalize assisted suicide. *See State v. Marti*, 290 N.W.2d 570, 581 (Iowa 1980) (holding that aiding and abetting in a suicide was not a defense to homicide); *Martin v. Commonwealth*, 37 S.E.2d 43, 47 (Va. 1946) (holding that invitation and consent to the perpetration of a crime did not constitute defenses, adequate excuses or provocations).

North Carolina, Utah and Wyoming have abolished the common law of crimes and therefore, assisted suicide is not explicitly prohibited. *E.g.*, N.C. GEN. STAT. § 14-17.1 (1986); UTAH CODE ANN. § 76-1-105 (1992); WYO. STAT. § 6-1-102 (1977). In Ohio, assisting in a suicide is not a crime. *See State v. Sage*, 510 N.E.2d 343, 346 (Ohio 1987) (holding that the "surviving participant of a mutual suicide pact, who provides the means of death to the decedent" was not guilty of a criminal offense).

116. Juliana Reno, *A Little Help from My Friends: The Legal Status of Assisted Suicide*, 25 CREIGHTON L. REV. 1151, 1160 (1992); Pugliese, *supra* note 108, at 1297. Pugliese describes the hesitancy on the part of prosecutors to prosecute assisted suicide cases if they believe the act was done out of compassion for an ailing loved one. *Id.* at 1297-98.

117. Pugliese, *supra* note 108, at 1298. According to Pugliese, even if the individual is convicted, the sentence tends to be light, with the person usually only receiving probation. *Id.* at 1299.

118. Timothy E. Quill, *Death and Dignity: A Case of Individualized Decision Making*, 324 NEW ENG. J. MED. 691, 691 (1991). In the article, Quill recounts the story of Diane's suicide. *Id.* Dr. Quill diagnosed Diane, his patient for many years, with leukemia. *Id.* While leukemia was an area of medicine where technological interventions were successful, Diane decided to live outside the hospital and forego all forms of treatment. *Id.* at 692. Diane also made the decision that when she was no longer able to maintain control of herself and her dignity, she wanted to end

immediate reaction in the media and in the New York District Attorney's Office (D.A.).<sup>119</sup> However, because the article gave only the patient's first name, Dr. Quill could not be charged with any criminal offense.<sup>120</sup> The media eventually revealed the patient's identity after several months of investigation.<sup>121</sup> The D.A.'s office presented Dr. Quill's case to the grand jury.<sup>122</sup> However, after hearing Dr. Quill's testimony concerning the case, the grand jury decided not to recommend prosecution.<sup>123</sup>

In 1990, Dr. Jack Kevorkian, a retired pathologist, began his second career as an advocate and practitioner of assisted suicides.<sup>124</sup> As an advocate for the practice, Dr. Kevorkian is opposed to shrouding his assisted suicides in secrecy. Since 1990, he has assisted at least twenty-seven people in ending their lives.<sup>125</sup> Dr. Kevorkian has stood trial twice for assisting in a suicide.<sup>126</sup> Both times he has been acquitted.<sup>127</sup>

As previously discussed, most people who assist in suicides are not medical professionals like Dr. Quill and Dr. Kevorkian. Often they are loved ones or people who just want to help others end their pain and suffering. One such person is Marty James. James, an AIDS activist, helped eight people suffering from AIDS end their lives.<sup>128</sup> Like Dr. Quill and Dr. Kevorkian, Marty James was not convicted in any of the deaths.<sup>129</sup>

her life. *Id.* at 693. Dr. Quill discussed the choices available to her and put her in touch with the Hemlock Society. *Id.* Diane requested a prescription for barbiturates from Dr. Quill, an essential ingredient in a Hemlock Society suicide. *Id.* Dr. Quill explained to her how to use the barbiturates for sleep and also the amount needed to commit suicide. *Id.* at 694. When Diane finally ended her life a few months later it was with the prescription of barbiturates prescribed to her by Dr. Quill. *Id.*

119. Timothy E. Quill, *Risk Taking by Physicians in Legally Gray Areas*, 57 ALB. L. REV. 693, 705 (1994).

120. *Id.*

121. *Id.*

122. *Id.*

123. Lawrence K. Altman, *Jury Declines to Indict Doctor who Said he Aided in a Suicide*, N.Y. TIMES, July 27, 1991, at A1.

124. Nancy J. Osgood, *Assisted Suicide and Older People — A Deadly Combination: Ethical Problems in Permitting Assisted Suicide*, 10 ISSUES L. & MED. 415, 416 (1995). In his first assisted suicide, Dr. Kevorkian helped Janet Adkins, a 54 year old Oregon woman who was diagnosed with Alzheimer's disease, end her life. *Id.* at 415. Even though she was not suffering from any pain, she made a deliberate decision to end her life "rather than face the mental decline associated with senile dementia." *Id.*

125. *Jury Acquits Kevorkian in Assisted Suicide Cases*, CHI. TRIB., Mar. 9, 1996, at A3.

126. *Id.*

127. *Id.*

128. Braun, *supra* note 77, at B1.

129. *Marty James, AIDS Activist, Counselor, Takes Own Life*, CHI. TRIB., Jan. 6, 1992, at C6. On December 25, 1991, Marty James who was himself suffering with

### 3. Striking Down Laws Criminalizing Assisted Suicide

This section discusses the two cases thus far that have successfully challenged state laws criminalizing physician-assisted suicide. Both cases challenged the state laws under the Due Process Clause and Equal Protection Clause of the Fourteenth Amendment. The message sent by the decisions of the Ninth and Second Circuits is twofold. First, it should send a message to the other thirty-two states which presently criminalize assisted suicide that their laws may be unconstitutional as well. Second, it should suggest to the state legislatures that the time has come to follow the lead of Oregon and enact a law permitting physician-assisted suicide.

#### a. *Compassion in Dying v. Washington*

In *Compassion in Dying v. Washington*,<sup>130</sup> an en banc panel of the Ninth Circuit Court of Appeals was faced with deciding whether a terminally ill person had a constitutionally protected liberty interest in the right to die.<sup>131</sup> The District Court of Western Washington held that the Fourteenth Amendment guaranteed such a right and as a result, competent, terminally ill adult patients could seek the assistance of a physician in ending their lives.<sup>132</sup> The district court concluded that the Washington statute, which made it a criminal offense to cause or aid another person to commit suicide, placed an undue burden on the exercise of that constitutionally protected liberty interest.<sup>133</sup>

The Ninth Circuit Court of Appeals reversed the holding of the district court.<sup>134</sup> The court held that there was no due process liberty interest in physician-assisted suicide.<sup>135</sup> Further-

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AIDS, took his own life. *Id.*

130. 79 F.3d 790 (9th Cir. 1996) (en banc).

131. The Ninth Circuit referred to the right to die as the right to determine the time and manner of one's own death. *Id.* at 793.

132. *Compassion in Dying v. Washington*, 850 F. Supp. 1454, 1462 (W.D. Wash. 1994).

133. *Id.* The District Court also held that the Washington law violated the Equal Protection Clause because it impermissibly treated similarly situated groups of terminally ill patients differently. *Id.* at 1467.

134. *Compassion in Dying v. Washington*, 49 F.3d 586, 588 (9th Cir. 1995), *rev'd*, 79 F.3d 790 (9th Cir. 1996) (en banc).

135. *Id.* at 590. The court held that the District Court had improperly taken the language of the United States Supreme Court's opinion in *Casey v. Planned Parenthood of Eastern Pa.* out of context. *Id.* The court also held that the opinion of the District Court had extrapolated from *Casey*, a case dealing with abortion jurisprudence, in order to hold the Washington statute invalid. *Id.* Finally, the court stated that the District Court failed to consider whether the state's interests outweighed any alleged liberty interest in suicide. *Id.* at 591.

more, the court concluded that the Washington statute did not violate the Equal Protection Clause.<sup>136</sup> The plaintiffs were granted a rehearing of the case.<sup>137</sup> Sitting en banc, the Ninth Circuit held that there is a constitutionally protected interest in determining the time and manner of one's own death.<sup>138</sup> Furthermore, insofar as the Washington statute prohibited physicians from prescribing life ending medication for use by mentally competent terminally ill patients, it violated the Due Process Clause of the Fourteenth Amendment.<sup>139</sup>

b. *Quill v. Vacco*

In *Quill v. Vacco*,<sup>140</sup> three physician and three terminally ill patients<sup>141</sup> brought an action challenging the constitutionality of a New York Penal Law making it a felony to assist another person in committing suicide.<sup>142</sup> The plaintiffs argued that the statute violated the Due Process and Equal Protection Clauses of the Fourteenth Amendment.<sup>143</sup> However, the court rejected both

136. *Id.* at 593. The court reasoned that because the distinction drawn by the legislature was not drawn on the basis of race, gender or religion or membership in any protected class and not infringing on any fundamental constitutional right, the plaintiffs were required to demonstrate that the legislature's actions were irrational. *Id.* The court held the plaintiffs had not sustained their burden. *Id.* at 594.

137. *Compassion in Dying v. Washington*, 62 F.3d 299 (9th Cir. 1995).

138. *Compassion in Dying*, 79 F.3d at 792. The court relied on the reasoning of *Cruzan* and *Casey* in deciding that the U.S. Constitution encompasses a due process liberty interest in the right to die. *Id.* at 810. The court further held that this right not only extends to mentally competent, terminally ill patients, but to other patients as well, such as those in a vegetative state or those in an irreversible state of unconsciousness. *Id.*

139. *Id.* The court examined the various state interests put forward by the State of Washington: the state's interest in preserving life; the state's interests in avoiding the involvement of third parties and in precluding the use of arbitrary, unfair or undue influence; the state's interest in protecting family members and loved ones; the state's interest in protecting the integrity of the medical profession; and, the state's interest in avoiding adverse consequences that might ensue if the statutory provision at issue was declared unconstitutional. *Id.* at 811.

140. 870 F. Supp. 78 (S.D.N.Y. 1994), *rev'd sub nom.*, *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996).

141. Two of the three terminally ill plaintiff-patients were suffering from AIDS. *Plaintiffs' Complaint and Motion for Declaratory Judgment*, July 12, 1994, available on DeathNet, [HTTP://WWW.islandnet.com/deathnet/lr.library.html#NYS](http://WWW.islandnet.com/deathnet/lr.library.html#NYS). Mr. Kingsley, age 48, and Mr. Barth, age 32, were both in the terminal phase of their illnesses and had no chance for recovery. *Id.* Both men were fully aware of the ravages wreaked by the disease and the progressive loss of bodily functions. *Id.*

142. The New York law provides that, "a person is guilty of manslaughter in the second degree when: . . . [h]e intentionally . . . aids another person to commit suicide." N.Y. PENAL LAW § 125.15(3) (McKinney 1987).

143. *Quill*, 870 F. Supp. at 80. The plaintiffs contended that the liberty interest guaranteed by the Due Process Clause of the Fourteenth Amendment was broad enough to establish a fundamental right on the part of the terminally ill patient to

claims and declined to hold the statute unconstitutional.<sup>144</sup> The court stated that there was a reasonable and rational basis for distinguishing between a patient's right to refuse medical treatment — even if that treatment will result in death — and a patient committing suicide with the advice of a physician.<sup>145</sup> As a result, the New York law did not violate the Equal Protection Clause of the Fourteenth Amendment.<sup>146</sup>

On appeal, the Second Circuit agreed with the district court that the right to assisted suicide was neither a fundamental right or liberty nor a right that is deeply rooted in the nation's tradition and history.<sup>147</sup> Accordingly, the court rejected the plaintiff's substantive due process claim.<sup>148</sup>

Turning to the Equal Protection claim, the Second Circuit held the New York statute criminalizing assisted suicide fell within the category of social welfare legislation and was therefore subject to rational basis review.<sup>149</sup> The court reasoned that because individuals in the final stages of a terminal illness are allowed to hasten their death by ordering the removal of life-sustaining equipment, but those who are similarly in a final stage, but not attached to life-sustaining equipment could not hasten death, New York did not treat individuals similarly situated alike.<sup>150</sup> The court then examined the possible state interests in

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decide to end his life with the assistance of a physician. *Id.* at 83. The plaintiff's second argument focused on the Equal Protection Clause of the Fourteenth Amendment. *Id.* at 84. Under New York law, a competent person may refuse medical treatment, even if the withdrawal of such treatment would result in death. *Id.* The plaintiffs argued that the right to refuse treatment is the same as committing suicide with the assistance of a physician. *Id.* The plaintiffs urged that for the state to sanction one course of action, and to criminalize the other, involves discrimination which violates the Equal Protection Clause. *Id.*

144. *Id.* at 84-85. The district court held that the source of substantive due process rights not expressly found in the U.S. Constitution must either "be implicit in the concept of ordered liberty so that neither liberty nor justice would exist if they were sacrificed," or must be among "those liberties that are deeply rooted in the nation's history and traditions." *Id.* at 83 (quoting *Bowers v. Hardwick*, 478 U.S. 186, 191-92 (1986)). According to the court, there is nothing in the historical record to indicate that assisted suicide was among the liberty interests protected by the Due Process Clause of the Fourteenth Amendment. *Id.* at 84. The court also held that the statute did not violate the Equal Protection Clause. *Id.* at 85.

145. *Id.* at 84. According to the court, there is a difference between allowing nature to take its course and intentionally using an artificial death producing device. *Id.*

146. *Id.* at 85.

147. *Quill v. Vacco*, 80 F.3d 716, 724 (2d Cir. 1996).

148. *Id.* The court stated that because the right of terminally ill patients to seek an assisted suicide finds no cognizable basis in the Constitution's language or design, it was not in a position to expand the limited rights guaranteed under substantive due process. *Id.*

149. *Id.* at 727.

150. *Id.* at 729. The court disagreed with the distinction drawn by the district

prolonging the suffering of a terminally ill patient.<sup>151</sup> The court concluded that the state interest in preserving life is greatly reduced when the individual is in agony and death is imminent and inevitable.<sup>152</sup> Accordingly, the state had no interest in interfering with the wishes of a mentally competent terminally ill patient who wished to have drugs prescribed to end his life.<sup>153</sup> As a result, the court concluded that the New York law criminalizing assisted suicide violated the Equal Protection Clause to the extent that it prohibited physicians from prescribing medication for the purpose of ending one's life.<sup>154</sup>

*B. The Shift in Physicians' Attitudes Toward Active Euthanasia and Assisted Suicide*

Active euthanasia and assisted suicide have been controversial topics throughout history.<sup>155</sup> The American Medical Association offers four primary reasons for opposing physician-assisted suicide. First, if physicians condone medically assisted suicides, the fact that death could be offered as a medical treatment might undermine public trust in medicine's dedication to preserving life and health.<sup>156</sup> Second, physicians fear that patients might not feel free to resist the suggestion that euthanasia may be appropriate for them.<sup>157</sup> Third, permitting assisted suicide might create an incentive for physicians to devote less energy and time to the treatment of difficult cases.<sup>158</sup> Finally, the pressure to decrease health care costs may serve as a motivation in favor of euthanasia over longer term care.<sup>159</sup>

Despite the opposition of the medical organization, attitudes of many physicians' concerning a patient's right to regain a level of dignity and humanity when faced with an incurable disease have changed.<sup>160</sup> While few physicians are willing to admit to

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court. *Id.* In its reasoning, the district court identified a distinction between allowing nature to take its course, and intentionally using an artificial death producing device. *Id.* (quoting *Quill*, 870 F. Supp. at 84). However, the Second Circuit held that death by the refusal of life-sustaining treatment is "nothing more nor less than assisted suicide." *Id.*

151. *Id.* at 730.

152. *Id.*

153. *Id.*

154. *Id.* at 731.

155. MEISEL, *supra* note 90, at 489. By the end of the nineteenth century physician-assisted suicide and active euthanasia "had become a topic of speeches at medical meetings and editorials in British and American medical journals." *Id.*

156. *Id.*

157. *Id.*

158. *Id.*

159. *Id.*

160. *Id.* at 490. See also *Doctors Offer Rules on Aiding Suicide*, CHI. TRIB., Dec. 5, 1995 at A3 (discussing a physician group which proposed a set of guidelines

the practice publicly, evidence suggests that a significant number of physicians support some form of physician-assisted suicide<sup>161</sup> and privately make assisted suicides part of their medical practice.<sup>162</sup> One example is that in recent years, it has become medically acceptable to prescribe relatively high levels of drugs to relieve pain even though it may risk death, a concept called "double effect."<sup>163</sup>

The AIDS epidemic has played a significant role in changing physicians' attitudes toward assisted suicide.<sup>164</sup> However, physicians who specialize in the treatment of PWAs and those physi-

which would allow mentally competent terminally ill patients to receive medical help in ending their lives).

161. See Jerald G. Bachman et al., *Assisted Suicide and Active Euthanasia in Michigan*, 331 NEW ENG. J. MED. 812, 812 (1994) (citing that 54% of physicians and 67% of the sample of the general population polled favored enactment of legislation to legalize physician-assisted suicide for terminally ill adult patients "suffering unacceptable pain"). According to a poll conducted by Jonathan Cohen, of 938 Washington state physicians polled, 54% believed euthanasia should be legal in some situations, but only 33% would be willing to perform it. Jonathan S. Cohen et al., *Attitudes Toward Assisted Suicide and Euthanasia Among Physicians in Washington State*, 331 NEW ENG. J. MED. 89, 91 (1994). In her study of physicians' attitudes regarding assisted suicide, Shapiro found that of 740 Wisconsin physicians polled, 42% agreed with the statement, "euthanasia should be limited to competent adults who request it as a result of their present situation and prognosis of recovery." Robyn S. Shapiro et al., *Willingness to Perform Euthanasia A Survey of Physician Attitudes*, 154 ARCHIVES INTERNAL MED. 575, 577 (1994). Almost 28% of the respondents reported they would be willing to perform the euthanasia if it were legalized. *Id.* See also Robert Ankeny, *20% of State Cancer Doctors Favor Physician-Assisted Death*, DET. NEWS, Apr. 26, 1995, at B4 (reporting on a survey of Michigan cancer doctors which found that more than 20% favor legislation allowing physician-assisted suicide).

162. B.D. Colen, *Doctors Who Help Patients Die*, LONG ISLAND NEWSDAY, Sept. 29, 1991, § 1, at 5; *Poll Shows that 1 in 5 Internists has Helped a Patient Die*, AM. MED. NEWS, Mar. 16, 1992, at 9.

163. MEISEL, *supra* note 90, at 478. The concept of double effect originated in Roman Catholic moral theology. *Id.* According to the concept, there are situations in which it is morally justifiable to cause evil in the pursuit of good. *Id.* In moral terms, the physician causes an evil, the death of the patient, in the pursuit of accomplishing a good, the amelioration of pain. *Id.*

164. Lee Slome et al., *Physicians' Attitudes Toward Assisted Suicide in AIDS*, 5 J. ACQUIRED IMMUNE DEFICIENCY SYNDROMES 712, 712 (1992). The authors conducted a comparative study of attitudes of two groups of physicians in San Francisco. *Id.* at 713. One group consisted of 69 members of the San Francisco County Community Consortium (CCC). *Id.* The other group comprised 86 randomly selected San Francisco physicians who were members of the California Medical Association (CMA). *Id.* Both groups responded to a case vignette of Tom, a 30-year old male diagnosed with AIDS who was suffering various illnesses. *Id.* at 715. During Tom's biweekly clinic visit, he asks the physician to prescribe a lethal dose of narcotics for possible use at some future date. *Id.* Twenty-four percent of physician participants responded they would be likely to grant Tom's initial request. *Id.* Twenty-seven percent responded they would grant Tom's request if he grew adamant. *Id.* There was no difference between the CCC and CMA groups. *Id.*



cians who specialize in other areas of medical practice may not exhibit a substantial difference of opinion on the subject.<sup>165</sup> As such, physicians with extensive contact with PWAs are not necessarily more compelled to assist in their patient's suicide.<sup>166</sup> Rather, a physician's belief that physician-assisted suicide is ethical is most predictive of a physician's decision to comply with a patient's request.<sup>167</sup>

There are numerous reasons why physicians now either support or participate in a patient's right to a medically assisted suicide. One reason for the shift in physicians' attitudes is the realization that technological innovations in medical science make it possible to keep patients alive in a terminal stage past the point where there is any quality of life.<sup>168</sup> A second reason may be the change in the public's perception of physician-assisted suicide.

### C. *The Shift in Attitude of the General Public*

Public opinion polls reveal that most Americans are now in favor of permitting physician-assisted suicide.<sup>169</sup> Within the last forty years, society has shifted toward a greater acceptance of allowing those suffering a terminal illness a release from life.<sup>170</sup> Polls also indicate that the public is opposed to prosecuting physicians who participate in helping their patients end their lives.<sup>171</sup>

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165. *Id.* at 715.

166. *Id.* at 717.

167. *Id.* at 716.

168. Closen & Maloney, *supra* note 13, at 479-80.

169. See Scott Boeck & Marcy E. Mullins, *Should a Doctor Aid Suicide*, USA TODAY, May 2, 1996, at 1A (citing a Gallup Poll conducted by CNN/USA Today which found that overall, 75% of Americans believe physician-assisted suicide should be legal if the patient and the family want it). See Also *Euthanasia Favored in Poll*, N.Y. TIMES (Nat'l Ed.), Nov. 4, 1991, at A9 (stating that 64% of those people surveyed favored physician-assisted suicide for terminally ill patients who request it).

170. Dee Lane, *Americans' Interest in Suicide Heightens*, PORTLAND OREGONIAN, Jan. 1, 1995, at B1. A poll conducted by the Journal of the American Medical Association in 1950 revealed that about one-third of Americans favored legalized euthanasia. *Id.* By 1991, almost two-thirds of those surveyed were in favor of legalized euthanasia. *Id.* In her work on criminal liability and assisted suicide, Catherine Schaffer cites to a survey conducted by the National Opinion Research Center. Catherine D. Schaffer, Note, *Criminal Liability for Assisting Suicide*, 86 COLUM. L. REV. 348, 367-68 n.114 (1986). The researchers asked, "[w]hen a person has a disease that cannot be cured, do you think doctors should be allowed by law to end the patient's life by some painless means if the patient and his family request it?" *Id.* The rate of those who answered in the affirmative rose from 37% in 1947, to 50% in 1973, to 63% in 1983. *Id.* See also Gary Heinlein, *Poll: Most Oppose Charging Kevorkian*, DET. NEWS, May 30, 1995, at D1 (citing a poll of 600 state adults which showed that 71% opposed prosecuting Dr. Kevorkian).

171. MEISEL, *supra* note 90, at 488.

Another example of the public's support for physician-assisted suicide is Oregon voters' approval of the "Death With Dignity Act" (Oregon Act).<sup>172</sup> The Act allows physicians to assist their terminal patients in ending their lives in a humane and dignified manner.<sup>173</sup> As Kathy Graham, a noted professor of law comments, "voters [in Oregon] are merely acknowledging that doctors have assisted the terminally ill in the process of dying for years."<sup>174</sup>

### III. ATTEMPTS TO LEGISLATE MEDICALLY ASSISTED SUICIDE

A number of states have unsuccessfully attempted to enact physician-assisted suicide statutes. However, when Oregon voters approved the Oregon Act in 1994, Oregon became the first state to recognize the right to a physician-assisted suicide. Accordingly, Part III of this Note first discusses the Oregon experience, from the passage of the Act through the ensuing legal challenge. Following the Oregon experience, Part III examines physician-assisted suicide proposals in various states, most notably California, Massachusetts and Michigan.

#### A. The Oregon Experience

##### 1. Oregon's "Death With Dignity Act"

The Oregon Act<sup>175</sup> was the first statute<sup>176</sup> in the United States to legalize physician-assisted suicide under limited circumstances. Even though a majority of Oregon voters voted in favor of the Act in a referendum, the federal district court in Oregon granted an injunction which prevented the State of Oregon from enacting the statute.<sup>177</sup>

Under the Oregon Act, a capable<sup>178</sup> adult<sup>179</sup> resident of

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172. See *infra* notes 178-99 for a discussion of the Oregon "Death With Dignity Act" (Oregon Act). Prior to the Oregon referendum on the Oregon Act, physician-assisted suicide referendums were narrowly defeated in California and Washington. See Alexander Morgan Capron, *Even in Defeat, Proposition 161 Sounds a Warning*, HASTINGS CENTER REP., Jan.-Feb. 1993 at 32, 32 (reporting that California voters rejected the proposal to legalize physician-assisted suicide by a 56% to 44% margin); Rob Carson, *Washington's I-119*, HASTINGS CENTER REP., Mar.-Apr. 1992, at 7, 7 (reporting that Washington voters rejected the initiative to legalize lethal injections by physicians to terminal patients by a 56% to 44% margin).

173. See *infra* notes 178-99 for a discussion of the Oregon Act.

174. Kathy T. Graham, *Tribute: Last Rights: Oregon's New Death with Dignity Act*, 31 WILLAMETTE L. REV. 601, 604 (1995).

175. 1995 OR. LAWS ch. 3, §§ 1-6 (I.M. 16).

176. Oregon voters approved Oregon Initiative Measure 16, the Oregon Act by a 51% to 49% margin. Joe Rojas-Burke, *Assisted Suicide Law Struck Down*, REGISTER GUARD, Aug. 4, 1995, at 1A.

177. *Lee v. Oregon*, 869 F. Supp. 1491, 1493 (D. Or. 1994). See *infra* notes 200-09 for a discussion of the court's opinion in *Lee*.

178. Capable is defined as not incapable. 1995 OR. LAWS ch. 3, § 1.01(6). Incapa-

the state,<sup>180</sup> who is suffering from a terminal disease<sup>181</sup> and who has voluntarily expressed his wish to die, may make a written request for medication for the purpose of ending his life in a humane and dignified manner.<sup>182</sup> The Oregon Act does not force physicians to comply with a patient's request.<sup>183</sup> However, if physicians choose to comply, the Act explicitly outlines the responsibilities of the attending physician.<sup>184</sup> First, the attending physician<sup>185</sup> must determine whether the patient has a terminal disease, whether the patient is capable of making health care decisions and whether the patient has made a voluntary request.<sup>186</sup> Next, the attending physician must inform the patient of his medical diagnosis,<sup>187</sup> prognosis,<sup>188</sup> the risks associated with taking the medication that is prescribed,<sup>189</sup> the probable results of taking the prescribed medication<sup>190</sup> and the feasible alternatives available, such as comfort care, hospice care and pain control.<sup>191</sup> The attending physician must then refer the patient to a consulting physician<sup>192</sup> for a medical confirmation of the diagnosis and for a determination that the patient is capable of acting voluntarily.<sup>193</sup>

The attending physician also has the responsibility of inform-

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ble is defined as:

[I]n the opinion of the court or in the opinion of the patient's attending physician or consulting physician, a patient lacks the ability to make and communicate health care decisions to health care providers, including communications through persons familiar with the patient's manner of communicating if those persons are available.

*Id.*

179. The Act defines an adult as an individual who is 18 years of age or older.

*Id.* § 1.01(1).

180. Only requests made by Oregon residents will be granted under the Act. *Id.* § 3.10.

181. The Oregon Act defines terminal disease as "an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six (6) months." *Id.* § 1.01(12).

182. *Id.* § 2.01.

183. *Id.* § 4.01(4).

184. *Id.* § 3.01(1)-(9).

185. The Act defines attending physician as "the physician who has primary responsibility for the care of the patient and treatment of the patient's terminal disease." *Id.* § 1.01(2).

186. *Id.* § 3.01.

187. *Id.* § 3.01(2)(a).

188. *Id.* § 3.01(2)(b).

189. *Id.* § 3.01(2)(c).

190. *Id.* § 3.01(2)(d).

191. *Id.* § 3.01(2)(e).

192. The Act defines consulting physician as "a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's disease." *Id.* § 1.01(3).

193. *Id.* § 3.01(3).

ing the patient that he may rescind the request at any time and in any manner.<sup>194</sup> Additionally, the physician must verify immediately prior to the writing of the prescription that the patient is making an informed decision.<sup>195</sup> If either the attending or consulting physician believes that the patient may be suffering from a psychiatric or psychological disorder, or depression causing impaired judgment, either physician must deny the request and refer the patient for counseling.<sup>196</sup>

Under the Oregon Act, a qualified patient must make an oral request, a written request and then reiterate the oral request no less than fifteen days after making the initial oral request.<sup>197</sup> The Act also requires that at least fifteen days elapse between the patient's initial oral request and the physician's written prescription.<sup>198</sup> Furthermore, at least forty-eight hours must elapse between the patient's written request and the physician's writing the prescription.<sup>199</sup>

## 2. *Lee v. Oregon: The Challenge to the "Death with Dignity Act"*

In *Lee v. Oregon*,<sup>200</sup> a coalition of two physicians, four terminally ill or potentially terminally ill patients, a residential care facility and individual operators of residential care facilities brought an action challenging the Oregon Act. The plaintiffs claimed that the Oregon Act violated the Equal Protection and the Due Process Clauses of the Fourteenth Amendment, the First Amendment rights of freedom to exercise religion and to associate and the Americans with Disabilities Act.<sup>201</sup> The district court held that the Act violated the Equal Protection Clause of the Fourteenth Amendment and, therefore, ruled that the Act was

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194. *Id.* § 3.01(6).

195. *Id.* § 3.01(7). The Act defines informed decision as:

[A] decision by a qualified patient, to request and obtain a prescription to end his or her life in a humane and dignified manner, that is based on an appreciation of the relevant facts and after being fully informed by the attending physician of: (a) his or her medical diagnosis; (b) his or her prognosis; (c) the potential associated with taking the medication to be prescribed; (d) the probable result of taking the medication to be prescribed; (e) the feasible alternatives, including, but not limited to, comfort care, hospice care and pain control.

*Id.* § 1.01(7).

196. *Id.* § 3.03.

197. *Id.* § 3.06.

198. *Id.* § 3.08.

199. *Id.*

200. 891 F. Supp. 1429 (D. Or. 1995).

201. *Id.* at 1431. Plaintiffs argued that the Act violated the Equal Protection Clause because non-terminally ill persons were entitled to certain statutory protections under Oregon law. *Id.* at 1433. Plaintiffs contended that these protections were arbitrarily and irrationally abrogated by the Act. *Id.*

unconstitutional.<sup>202</sup>

The court reasoned that statutory procedures in the Act were inadequate to distinguish the competent from the incompetent or the unduly influenced.<sup>203</sup> Thus, the court reasoned that the statute created an overinclusive class.<sup>204</sup> Furthermore, the court noted that under the Oregon Act, the physician making the patient's evaluation may not be appropriately qualified to decide whether the patient is suffering from impaired judgment or treatable depression that would preclude assisted suicide.<sup>205</sup> Additionally, the court was concerned that the statute was silent on the issue of how and when the fatal dose would be administered.<sup>206</sup> Finally, the court reasoned that the Act replaced the medical community standard of care normally required of Oregon physicians with a "good faith" standard of care.<sup>207</sup> The court concluded that all these deficiencies precluded any rational relationship between the statute and the state's interest of allowing competent terminally ill adults to choose suicide.<sup>208</sup> The State of Oregon has appealed the decision of the district court to the Ninth Circuit Court of Appeals.<sup>209</sup>

### *B. Legislative Attempts Following the Oregon "Death With Dignity Act"*

Following the passage of the Oregon Act in 1994, other states introduced physician-assisted suicide bills in their respective legislatures. Many of these proposed bills either duplicate or closely parallel the Oregon Act. This Section examines three of these legislative attempts.

#### *1. The Oregon Model States*

Over the past year, many state legislatures have introduced statutes permitting physician-assisted suicide.<sup>210</sup> Many of these

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202. *Id.* at 1437. Because the court found the Equal Protection Clause violation, the court did not reach the Due Process claim, the First Amendment claims or the American with Disabilities Act claim. *Id.*

203. *Id.* at 1434. The court held that there were insufficient safeguards in physician-assisted suicide. *Id.* Thus the court was able to distinguish physician-assisted suicide from the withdrawal or withholding of life support cases. *Id.* The court cited as an example in withdrawal cases a third party's ability to provide "substituted judgment" on behalf of an incompetent person. *Id.* The court found no similar feature present in the Oregon Act. *Id.*

204. *Id.* at 1437.

205. *Id.* at 1435.

206. *Id.* at 1437.

207. *Id.* at 1436.

208. *Id.* at 1438.

209. Rojas-Burke, *supra* note 176, at 1A.

210. In 1995, the following state legislatures proposed physician-assisted suicide

proposals duplicate the Oregon Act, while others closely parallel it. The California and Massachusetts proposals (Copycat Acts), for example, contain language that is identical to the Oregon Act.<sup>211</sup> Furthermore, the Copycat Acts use the same definitions<sup>212</sup> and contain the same safeguards<sup>213</sup> as the Oregon Act. Consequently, the future of these acts depends largely on the outcome of the appeal in *Lee v. Oregon*.<sup>214</sup>

However, not all assisted suicide legislative attempts are based on the Oregon Act. Other proposals, though containing many features which are similar to the Oregon model, use broader language and, therefore, appear more flexible to the needs of terminally ill patients, such as PWAs. One such proposal is the Michigan "Death With Dignity Act."<sup>215</sup>

## 2. The Michigan Model

The Michigan "Death With Dignity Act" (Michigan Act) authorizes a patient who is eighteen years of age or older and of

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bills: 1995 Cal. A.B. No. 1080, 1995-96 Reg. Sess. [hereinafter California Act]; 1995 Colo. H.B. No. 1308, 1st Reg. Sess., 60th Gen. Assem.; 1995 Me. H.P. No. 552, 117th Leg., 1st Reg. Sess.; 1995 Md. H.B. No. 933, 1995 Leg. Sess.; 1995 Mass. H.B. No. 3173, 179th Gen. Ct., 1st Ann. Sess. [hereinafter Massachusetts Act]; 1995 Mich. H.B. 4134, 88th Leg., 1995 Reg. Sess. [hereinafter Michigan Act]; 1995 N.H. H.B. No. 339, 1995 Reg. Sess.; 1995 Vt. H.B. No. 335, 1995 Bienn. Sess.; 1995 Wash. S.B. No. 5596, 1995 Reg. Sess., 55th Leg.; 1995 Wis. S.B. No. 90, 92d Leg.; 1995 Wis. A.B. No. 174, 92d Leg. Sess. [Because the California Act and the Massachusetts Act duplicate the Oregon Act, they are collectively referred to as the "Copycat Acts"].

211. All three acts state:

[A]n adult who is capable, is a resident of [state's name], has been determined by the attending physician and the consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner in accordance with this chapter.

1995 OR. LAWS, Ch. 3, § 2.01; California Act, *supra* note 210, § 7195.3; Massachusetts Act, *supra* note 210, § 2.

212. All three Acts define adult as an individual who is 18 years of age or older. 1995 OR. LAWS, Ch. 3, § 1.01(1); California Act, *supra* note 210, § 7195(a); Massachusetts Act, *supra* note 210, § 1(1). All three Acts define terminal disease as "an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death with six months." 1995 OR. LAWS, Ch. 3, § 1.01(12); California Act, *supra* note 210, § 7195(m); Massachusetts Act, *supra* note 210, § 1(12).

213. All three Acts require the attending physician to refer the patient for counseling if the physician believes the patient is suffering from a psychiatric or psychological disorder. 1995 OR. LAWS, Ch. 3, § 3.01(3); California Act, *supra* note 210, § 7196.2; Massachusetts Act, *supra* note 210, § 3(c).

214. 891 F. Supp. 1429 (D. Or. 1995).

215. Michigan Act, *supra* note 210, §§ 1-13.

sound mind to execute a directive to allow aid-in-dying.<sup>216</sup> The directive must be in writing, dated, executed voluntarily and signed by the patient.<sup>217</sup> Unlike the Oregon Act and the Copycat Acts where the patient must sign a written request, Michigan's Act allows another person to sign the directive in the presence of the patient if the patient is unable to sign the directive.<sup>218</sup> Furthermore, whereas the Copycat Acts only authorize a terminally ill patient to receive a prescription for medication, the Michigan Act allows the patient to specify the conditions under which aid-in-dying is authorized.<sup>219</sup> Thus, the Michigan Act is more flexible in serving the needs of terminally ill patients.

However, while the Michigan Act is an improvement over the Oregon Act and the Copycat Acts, it too can be improved to better address the needs of terminally ill patients, such as patients suffering with conditions associated with AIDS, who wish to end their lives.

#### IV. SHORTCOMINGS IN ASSISTED SUICIDE LEGISLATION

The attempts at legislating the right to a physician-assisted suicide demonstrates various states' concerns for easing the pain of terminally ill patients whose lives have become an unbearable burden. As a society, we have already made significant progress from the days when patients virtually had no say in their care. Today, with advance directives such as living wills, do-not-resuscitate orders and durable health care power of attorney, terminally ill patients can ease their suffering by not prolonging the dying process. Similar rights must be given to those patients who are also suffering from a painful, terminal condition, but who are not yet actually dying. The Oregon Act, the Copycat Acts and the Michigan Act are examples of the attempts to give individuals such rights. However, all of the legislative attempts contain various shortcomings that restrict the rights of these individuals.

The Oregon Act and the Copycat Acts allow a terminally ill patient to obtain a prescription for medication for the purpose of ending his life. However, all three of these acts prohibit third party administration of the medication.<sup>220</sup> As a result, a patient is required to take the lethal dose by himself.<sup>221</sup> This is a poten-

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216. *Id.* § 3(1).

217. *Id.* § 3(2).

218. *Id.*

219. *Id.* The Michigan proposal uses the term "lethal agent" instead of "medication." *Id.* § 4(f). Consequently, it appears to be more adaptable to the needs of terminally ill patients, such as PWAs.

220. 1995 OR. LAWS, Ch. 3, § 3.14; California Act, *supra* note 210, § 7197.7; Massachusetts Act, *supra* note 210, § 3(N).

221. The California, Massachusetts and Oregon Acts all prohibit the taking of a

tial obstacle for PWAs who wish to end their lives in a humane and dignified manner, but do not have the physical strength or ability to ingest the medication orally.

The Oregon Act and the Copycat Acts present a second problem because they are not broad enough to allow patients in great pain the option of assisted suicide. The three Acts limit the option of assisted suicide to those who are diagnosed with a terminal illness that will produce death within six months.<sup>222</sup> Many PWAs suffer from debilitating illnesses for months or years but may never meet this eligibility requirement, even though they may desire to end their lives.

A third problem with the Oregon Act and the Copycat Acts is that while explicitly prohibiting lethal injection by a physician,<sup>223</sup> they are silent on whether a patient has the right to self administer the lethal injection. Such a right is necessary for the patient who cannot orally ingest the dose and may need to end his life by lethal injection.

A final obstacle that prevents an individual from being included in the statutes is the lack of any maximum waiting period. The three proposals and the Oregon Act essentially leave the decision when to provide the assisted suicide up to the physician.<sup>224</sup> This creates a potential problem for competent PWAs who might develop dementia waiting for the physician to comply with the patient's request. In the United States, if a defendant receives a death penalty sentence but becomes incompetent while awaiting his sentence, the execution is stayed.<sup>225</sup> This is based on the notion that at no time will we condone the execution of an incompetent person. Therefore, it is unlikely that a court would ever grant a terminally ill patient's request for physician-assisted suicide if they are incompetent, even if the patient was competent when making the request. Therefore, reasonable maximum waiting periods must be included in the legislation to ensure that physicians comply patient's wishes.

To ensure that PWAs who wish to end their lives with the assistance of a physician are included in these statutes, future

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patient's life by lethal injection, mercy killing or active euthanasia. 1995 OR. LAWS ch. 3, § 3.14; California Act, *supra* note 210, § 7197.7; Massachusetts Act, *supra* note 210, § 3(N). The Michigan Act is unclear on this issue.

222. 1995 OR. LAWS ch. 3, § 1.01(12); California Act, *supra* note 210, § 7195(m); Massachusetts Act, *supra* note 210, § 1(12).

223. 1995 OR. LAWS ch. 3, § 3.14; California Act, *supra* note 210, § 7197.7; Massachusetts Act, *supra* note 210, § 3(N).

224. See *supra* notes 197-99 for a discussion of the minimum waiting periods required under the Oregon Act.

225. See *Ford v. Wainwright*, 477 U.S. 399, 409-10 (1986) (holding that the Eighth Amendment ban on cruel and unusual punishment prohibits a state from carrying out a sentence of death upon a prisoner who is insane).



acts need reform. With only minor adjustments and clearer definitions, physician-assisted suicide proposals would ensure the inclusion of terminally ill patients, such as PWAs.

## V. REFORMING PHYSICIAN-ASSISTED SUICIDE STATUTES

While this Note does not advocate that PWAs be explicitly named as a group in physician-assisted suicide statutes, attempts to legislate physician-assisted suicide need to be expanded to ensure that PWAs are included in the scope of the statute. This inclusion would promote a more dignified death. Accordingly, this Section proposes various reforms that are necessary in future physician-assisted suicide legislative proposals. Such reforms would ensure that PWAs receive the option of ending their lives in the most humane and dignified manner.

To qualify under current proposals, a person wishing to end his life must be suffering from a terminal disease. These proposals define a terminal disease as an incurable and irreversible condition that causes death within six months.<sup>226</sup> However, physicians might not be able to accurately diagnose when a PWA has six months to live.<sup>227</sup> Furthermore, because of the recurrent cycle of devastating illnesses and subsequent recoveries, physicians might be reluctant to diagnose a condition as one that will cause death in six months, even though that prognosis may be realistic. Finally, unlike other illnesses which are curable or which can go into remission, AIDS is presently a terminal condition. Therefore, the definition of terminal disease should be changed to an irreversible and incurable condition which reduces the quality of life of the patient.<sup>228</sup> This standard would remove the uncertainty on the part of physicians of having to determine when a terminally ill patient has six months to live, and leave the decision up to the patient to determine if they are no longer enjoying a sufficient quality of life.

Current proposals do not make it clear whether physician-assisted suicide can be provided outside of a clinical setting. However, terminally ill patients must be given the right to die with medical assistance at home, as well as in a hospice or other clinical setting.<sup>229</sup> Dr. Quill's account of Diane<sup>230</sup> and her adamant

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226. 1995 OR. LAWS Ch. 3, § 1.01(12).

227. Gabel, *supra* note 109, at 423.

228. In her article, Gabel proposes a "relatively short time" standard. *Id.* at 422. Gabel suggests that this standard respects considerations such as strength of diagnosis, the type of disorder and the judgment of the physician making the medical determination. *Id.* at 423. While this standard is an improvement over the rigid six month requirement, the physician still has the discretion of determining what qualifies as a relatively short period of time.

229. Gabel agrees that terminally ill patients should be given the option of dying

desire to end her life at home surrounded by her family demonstrates the need that legislation include this option.

Unlike physician-assisted suicide proposals that only provide for a prescription of oral medication, future proposals should follow the Michigan Act and allow patients the right to specify the conditions under which assistance is provided.<sup>231</sup> Allowing patients this option would permit lethal injection, and would serve the needs of those terminally ill patients who are unable to take the medication orally.<sup>232</sup>

Most proposals limit the physician's involvement to prescribing the medication.<sup>233</sup> However, a physician's absence may make the person's death more isolated and less dignified. Furthermore, the likelihood of improper administration of the medication or injection increases without physician supervision or participation. Therefore, physician-assisted suicide statutes must include the option of physician administration of the medication. If a patient solicits physician participation in ending his life but the physician is unwilling, the physician should have the responsibility of informing the patient that physician assistance is legal, but that the physician does not assist such a practice. Informing a terminally ill patient that physician-assisted suicide is legal is important because if a physician simply refuses, the patient may think that the physician's refusal is based on the legality of the practice and not on the physician's own personal preference.

Current legislative proposals mandate two minimum waiting periods before a physician may write a prescription for a lethal dose.<sup>234</sup> First, a minimum of fifteen days must elapse between the patient's first oral request and the time the physician writes the prescription. Second, a minimum of forty-eight hours must pass between the patient's written request and the physicians issuance of the prescription. While minimum waiting periods protect terminally ill patients from making impulsive decisions,

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at home. *Id.* at 426. Accordingly, she writes, "it makes little sense to provide the right to medically assisted death, yet mandate that the location for such assistance must be in the clinical setting of a hospital. The patient's right to seek medically assisted death must also include the right to decide where such assistance will occur." *Id.*

230. See Quill, *supra* note 118 for a discussion of Diane and her desire to die at home.

231. See Michigan Act, *supra* note 210, § 3(2) (detailing that the patient's directive may specify the conditions under which aid-in-dying is authorized).

232. Gabel, *supra* note 109, at 426. Gabel writes, "many patients suffering from AIDS or other terminal illnesses experience a collapse of the digestive system which necessitates an option of intravenous administration." *Id.*

233. See *supra* notes 183-96 for a discussion of the physician's role in the assisted suicide under the Oregon Act.

234. See *supra* notes 197-99 for a discussion of the minimum waiting period required under the Oregon Act.

current legislative proposals do not provide for a maximum waiting period before a patient receives his request. Since the risk of dementia is high among many PWAs, and because a court would not allow the assisted suicide of an incompetent person, a PWA who made a request for an assisted suicide would not receive the assisted suicide if dementia has set in. Thus, a maximum waiting period would limit the circumstances in which a competent PWA may make a request and then develop dementia waiting for his physician to comply. Accordingly, physician-assisted suicide statutes must contemplate such situations by including a maximum waiting period.

Finally, terminally ill patients may not have the ability to sign the written request for an assisted suicide. Accordingly, all future proposals should follow the lead of the Michigan Act and permit the signing of the written request by another in the presence of the terminally ill patient. While this may seem like a small point, it is a necessary reform that better serves the needs of a terminally ill patient.

#### CONCLUSION

The horrible and painful physical and emotional suffering associated with AIDS gives rise to some of the most compassionate and compelling arguments in favor of physician-assisted suicide. This Note maintains that the decision to seek a physician-assisted suicide is ultimately a rational choice when made by persons living with AIDS who feel like they are no longer enjoying sufficient quality of life due to conditions associated with AIDS. Opinion polls suggest that medical professionals and the general public increasingly support the right of terminally ill patients in seeking an assisted suicide. However, current legislative proposals do not adequately ensure that all terminally ill patients, most notably PWAs, are included in the statute. Significant drawbacks in these proposals may prevent a PWA from securing the right to a medically assisted suicide.

This Note has outlined certain reforms that would secure the right of terminally ill patients, such as PWAs, to receive a humane and dignified death when the time comes that they feel they no longer enjoy a sufficient quality of life.

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