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I. INTRODUCTION

In a village nursing home in Holland, a ninety-four year-old woman, bedridden and unable to feed herself, refused to allow her broken hip to be repaired. As a result, she experienced extreme pain. In response to that pain she pleaded with her doctor to end her life. After several interviews which convinced the doctor and a colleague that she did not want to go on any longer and that there was nothing more they could do to ease her pain, they agreed to her request. She bid an emotional farewell to her son and daughter-in-law and then received one injection to put her to sleep, another to assure unconsciousness, and a third injection of curare which brought about respiratory arrest.[1] Although prosecuted, the doctors involved were finally acquitted.[2]

Roswell Gilbert described himself as a professional scientist and his wife as a fine lady.[3] Nevertheless, he walked up to her, pointed a loaded revolver at her head, and killed her. He took these actions because his wife of fifty-one years, Emily, suffered from Alzheimer's disease. She

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1. Wall St. J., Aug. 21, 1987, at 1, col. 1.
2. *Id.* at 6, col. 2.
3. *Dying With Dignity* (KTLA television broadcast, Apr. 4, 1987).

was incontinent and was mentally aware for only brief moments.[4] In those moments she begged to die. Gilbert saw the termination of her suffering as his mission. He was prosecuted for murder in the first degree and sentenced to twenty-five years in prison by a Florida jury in 1985.

These are only two cases out of many which reflect the varying responses of different governments to active euthanasia: the active intervention to cause the painless death of a hopelessly sick or terminally ill person. A number of state court opinions and living will statutes which accept passive euthanasia, the disconnection of life-sustaining equipment, suggest that the United States is in a posture to accept and legalize active euthanasia.

Although the battle lines became clearly drawn in the 1980's when debate over active euthanasia reached a fever pitch, the issue of the benevolent taking of a life has stretched across the history of the human race. From the common law treatment of suicide, through the changing attitudes toward compassionate crimes in which disease prompts the taking of life by loved ones, this nation and western society as a whole have moved toward the condonation of active euthanasia.

The American public has come to realize that the real issue is individual choice and that realization has been reflected in various court decisions, most particularly those of the New Jersey Supreme Court.[5] The rights of the individual must prevail over the less compelling state interests in sustaining life. This recognition by the people of the United States must result in statutes which, although containing broad safeguards, will permit supervised aid in dying.

II. SUICIDE AND THE COMMON LAW

Plato saw active euthanasia as a remedy for unbearable pain. In ancient India and Sardinia, it was viewed as custom for the aged and infirm.[6] With the ascendancy of religion, however, the taking of a life, no matter what the motive, was condemned: life and death were the domain of God and not his creations.[7]

The common law mirrored religion's view of the taking of life, even

4. *Mercy Or Murder* (NBC television broadcast, Jan. 11, 1987).

5. In 1987 the New Jersey Supreme Court decided a trilogy of cases addressing passive euthanasia: *In re* Farrell, 108 N.J. 335, 529 A.2d 404 (1987); *In re* Peter, 108 N.J. 365, 529 A.2d 419 (1987); and *In re* Jobes, 108 N.J. 394, 529 A.2d 434 (1987). *See infra* notes 65-86 and accompanying text.

6. Note, *The Right of the Terminally Ill To Die, With Assistance If Necessary,* 8 CRIM. JUST. J. 403, 404 (1986).

7. *Id.*

by oneself. Suicide was considered a felony, a crime against God and state, as was assisting suicide.[8] So heinous was suicide that the penalties included surrender of all personal property [9] and ignominious burial.[10]

The common law was, of course, applied in the United States, but with varying penalties. In Connecticut, although property was not forfeited, ignominious burials took place.[11] Massachusetts law spoke of burying a suicide's corpse on a highway with a cart-load of stones laid on the grave as a "brand of infamy" and warning to others.[12] In an 1816 decision a Massachusetts court addressed the issue of assisting suicide in a case where one prisoner persuaded the occupant of an adjoining cell to take his own life.[13] There the court concluded that the murder of one's self is a felony, and one who counsels, advises, or assists another to commit suicide is guilty of murder as a principal.[14]

The Field Penal Code defined suicide as the intentional taking of one's life.[15] Although the Code eliminated property forfeiture, it found aiding suicide, attempting suicide, and aiding the attempt to be criminal.[16] In 1903 an Illinois court concluded that suicide was not a felony, but assisting suicide was murder.[17]

Texas courts took a far different point of view. In *Sanders v. State*, a 1908 decision, the court held that neither suicide nor furnishing the means for it was a crime.[18] However, the person assisting could not shoot the gun or put the poison in the mouth of another.[19] Several decades later, in 1973, Texas passed a statute criminalizing the assistance of suicide.[20]

Recently the California Supreme Court considered a suicide pact where two teenagers vowed to drive off a cliff.[21] One survived. The

8. *Id.* at 418.

9. Marzen, O'Dowd, Crone & Balch, *Suicide: A Constitutional Right?*, 24 DUQ. L. REV. 1, 63 (1985) [hereinafter Marzen].

10. *Id.* An ignominious burial included being laid to rest on the highway with a stake driven through the body. *Id.* (citing 4 W. BLACKSTONE COMMENTARIES *189).

11. *Id.* at 65.

12. *Id.*

13. Commonwealth v. Bowen, 13 Mass. 356 (1816).

14. *Id.* at 360-61.

15. Marzen, *supra* note 9, at 76-77. The Field Code was adopted in the Dakota Territory in 1877 and Oklahoma Territory in 1890, among others. *Id.*

16. *Id.*

17. Burnett v. People, 204 Ill. 208, 68 N.E. 505 (1903).

18. Sanders v. State, 54 Tex. Crim. 101, 112 S.W. 68 (1908), *overruled on other grounds*, Aven v. State, 102 Tex. Crim. 478, 277 S.W. 1080 (1925).

19. *Id.* at 105, 112 S.W. at 70.

20. TEX. PENAL CODE ANN. § 22.08 (Vernon 1974).

21. *In re* Joseph G., 34 Cal. 3d 429, 667 P.2d 1176, 194 Cal. Rptr. 163 (1983).

court noted that suicide is an expression of mental illness and that psychiatrists currently view attempted suicide as a symptom of mental illness.[22] However, the court distinguished aiding suicide on the grounds that it could be done for personal motives of the abettor, threatened the sanctity of life, and is not accompanied by the ameliorating factor of mental illness.[23]

The American Law Institute's 1962 Model Penal Code proposed to make causing suicide by force, duress, or deception a criminal homicide, and to make aiding another's suicide a felony of the second degree.[24] The Institute proposed that penalties for assisting suicide should be mitigated where unselfish motive was involved, but thought that decision best left to the court at the time of sentencing.[25] A wide majority of states currently prohibit assisting suicide.[26]

III. COMPASSIONATE CRIMES

Although the vast majority of states currently prohibit assisting suicide, statutory provisions will not always deter the actions of otherwise peaceful citizens. There has been a continuing saga of tragedies in this country in which one person has taken the life of another for reasons other than force, duress, or deception. Usually, each occasion has been followed by invasive accounts of the personal lives of the participants in headline grabbing fashion.

In 1938 Harry Johnson asphyxiated his wife who was dying from cancer.[27] A grand jury refused to indict him after a psychiatrist described him as temporarily insane.[28]

Otto Werner pled guilty to a murder charge after suffocating his

22. *Id.* at 434, 667 P.2d at 1179, 194 Cal. Rptr. at 166 (citing Comment, *The Punishment of Suicide — A Need for Change,* 14 VILL. L. REV. 463, 469 (1969)).

23. *Id.* at 437, 667 P.2d at 1181, 194 Cal. Rptr. at 168.

24. MODEL PENAL CODE § 210.5 (Official Draft and Revised Comments 1980).

25. Marzen, *supra* note 9, at 95.

26. *Id.* at 97. Twenty-six states plus Puerto Rico have statutes outlawing assisting suicide: Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Kansas, Maine, Minnesota, Mississippi, Montana, Nebraska, New Hampshire, New Jersey, New Mexico, New York, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Texas, Washington, and Wisconsin. Three states hold assistors guilty of murder as a principal: Illinois, Michigan, and Ohio. Seven jurisdictions could penalize assisting suicide under the common law: Alabama, West Virginia, Virginia, Tennessee, Maryland, Massachusetts, and the District of Columbia. The remaining states have not prohibited suicide and therefore would probably not penalize it. *Id.* at 97-98 & n.643.

27. Note, *supra* note 6, at 414 n.74 (citing N.Y. Times, Oct. 19, 1938, at 46, col. 1).

28. *Id.*

sixty-three year-old crippled, bedridden wife.[29] He was allowed to withdraw the plea after his family testified to the devotion and care he had given his wife, as well as the request to die made by his wife.[30] In consideration of these facts, the judge stated: "I can't find it in my heart to find you guilty."[31]

In 1967 Robert Waskin shot and killed his mother. Suffering from terminal leukemia, she had begged her twenty-three year-old son to end her life. Waskin was found not guilty of murder by reason of insanity and released upon a finding that he was no longer insane.[32]

In 1984 Wallace Cooper killed his terminally ill uncle who had been suffering from coronary heart disease, anemia, an aneurysm, and Crohn's disease.[33] He had told Cooper that he wanted help in being put out of his misery.[34] Cooper, a nurse at Los Angeles County U.S.C. Medical Center, injected his uncle with a lethal dose of morphine and Lanoxin. Cooper was eventually placed on five years' probation and fined $100 after being found guilty of involuntary manslaughter.[35]

Unlike the scenarios described above, not every situation in which suffering was brought to an end through the assistance of another was heard in the courtroom, or even aired in the newspaper, at least initially. On June 1, 1983, Lolly and Gronky Martin shared a bottle of Jack Daniels with a single glass.[36] In addition to the whiskey, they each swallowed enough white powder made from crushed tranquilizer tablets to cause certain death.[37] Four months shy of their fiftieth wedding anniversary, Lolly and Gronky Martin chose to "terminate their terminal illnesses."[38]

Lois "Lolly" Martin, a retired psychologist and counselor for Los Angeles public schools, suffered from emphysema. She was unable to walk, talk, or stand up straight without severe breathing difficulties, and was attached to an oxygen machine twenty-four hours a day. Paul

29. *Id.* at 415 n.74 (citing People v. Werner (Crim. Ct., Cook County, Ill., 1958). A transcript of the case was presented in Williams, *Euthanasia and Abortion*, 38 U. COLO. L. REV. 178, 184-87 n.15 (1966)).

30. *Id.*

31. *Id.*

32. *Id.* (citing Chicago Tribune, Aug. 9, 1967, at 1, col. 8; Chicago Tribune, Aug. 10, 1967, at 1, col. 2).

33. *Id* at 415-16 n.74. (citing L.A. Daily J., Jan. 8, 1986, at 5, col. 3). *See also* Wickett, *Law Rejects 'Euthanasia' Defense*, HEMLOCK Q., July, 1985, at 1.

34. *Id.*

35. Note, *supra* note 6, at 415-16 n.74 (citing L.A. DAILY J., Jan. 8, 1986, at 5, col.3).

36. Fadiman, *The Liberation of Lolly and Gronky*, LIFE, Dec., 1986, at 71.

37. *Id.*

38. *Id.*

"Gronky" Martin, the former president of Compton Community College, was in the final stages of congestive heart disease, subject to hallucinations, and unable to control his bladder. Their children and grandchildren noted that the two seemed to have a purpose to their lives as well as a greater awareness of their surroundings once they made their decision.[39]

Lolly and Gronky are a case study of an American societal dilemma of major proportions. Although traditional societies revere their elders for their wisdom, in the United States their knowledge is often considered to be obsolete.[40] In addition, the sense of family that once existed in the United States has eroded. Twenty-five years ago Americans over sixty-five years of age were twice as likely to live with their children as they are today.[41] In 1987 the overwhelming majority of older citizens lived alone, with their spouses, or in nursing homes where they were more often than not drugged into a sedated state, afforded little respect, and treated with condescension.[42]

Rather than face the "nightmare" of growing old in America, the Martins sought a final respectable solution.[43] Lolly initially tried to slit her wrists, but the attempt failed. After seeing a television talk show discussion featuring Derek Humphry, director of the Hemlock Society, she wrote to Humphry. Three months later she received the Society's handbook on how to commit suicide.[44] Meticulously following the suggestions of the book, Lolly prepared the appropriate amount of tranquilizer, poured the whiskey, and brought a peaceful end to the misery she and Gronky faced.[45]

The Hemlock Society, an organization which assists people like the Martins in reaching their goal, was founded in 1980 by Derek Humphry. It currently consists of more than 19,000 members throughout the United States.[46] The Society is a leading proponent of "self-deliverance" and "death with dignity": autonomy in ending one's own life when confronted with the pain and misery of disease. Its general principles include a belief that the final decision to terminate life is ultimately an

39. *Id.* at 90.
40. *Id.* at 72.
41. *Id.*
42. *Id.*
43. *Id.* at 72.
44. *Id.* at 80.
45. *Id.* at 71.
46. HEMLOCK Q., Oct. 1987, at 1.

individual one. The action, and most importantly its timing, is considered a very personal decision. The Society believes that whenever possible the decision should be made with family and friends.[47]

The Society publishes books and a quarterly newsletter, conducts panel discussions, and holds regular meetings among its twenty-three chapters throughout the United States. Its political action wing, Americans Against Human Suffering (AAHS), was established on July 18, 1986, with the goal of changing state laws "to permit physician aid-in-dying for the terminally ill."[48] The group attempted to gather sufficient signatures to place its proposed assistance-in-dying statute on the California ballot via initiative in November, 1988.[49] Although the effort failed, the group will attempt to put the question on the ballot in 1990.[50]

IV. JUDICIAL OPINIONS AND LEGISLATIVE OPTIONS

If there is a logical pathway to legislation authorizing the administration of drugs to terminate human life, it follows the strong precedent of recent court decisions and legislative action addressing living wills.

The courts of several states have come to recognize the right to be free of artificial support systems. In the Karen Ann Quinlan case,[51] a New Jersey court held that the constitutional right of privacy extends to the decision to disconnect life-prolonging equipment when there is no reasonable possibility that the patient can return to a cognitive, sapient state.[52] A Massachusetts court found in 1977 that the right to decline chemotherapy extends to a mentally incompetent person if the court determines that the patient would have refused treatment when competent.[53] In a similar case, a New York court balanced compelling state

47. Membership Application Form, The National Hemlock Society, *inserted in* HEMLOCK Q, Oct. 1987.

48. R. RISLEY, A HUMANE AND DIGNIFIED DEATH, xii (1987).

49. Derek Humphry, Address to the Oklahoma Chapter Meeting of the Hemlock Society (Sept. 16, 1987). Four hundred fifty thousand signatures are required in California, 5% of the last gubernatorial vote. *Id.*

50. Telephone interview with Derek Humphry, Executive Director of the Hemlock Society (Aug. 30, 1988).

51. *In re* Quinlan, 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976). Karen Ann Quinlan was in a drug/alcohol-induced coma, suffering from irreversible brain damage, and apparently sustained by a respirator. When her father signed a release allowing for the respirator to be disconnected, litigation ensued. The family prevailed, but Quinlan lived 10 years without the respirator, fed through tubes until her body finally gave out in July, 1985. D. HUMPHRY & A. WICKETT, THE RIGHT TO DIE 107-08 (1986).

52. *Quinlan*, 70 N.J. at 39, 355 A.2d at 663.

53. Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977).

interests against the individual's constitutional right of privacy and concluded that when there is clear and convincing evidence of a comatose, terminally ill patient's intent to refuse treatment, and certain medical criteria are satisfied, the individual's rights will prevail.[54]

A Florida court went a step further by affirming the right of a husband to authorize the discontinuance of nasogastric nutrition for his wife who was irreversibly comatose.[55] Similar decisions have been rendered in California,[56] Arizona,[57] and Massachusetts.[58] As those cases underscore, the courts have come to see no distinction between removing life-sustaining equipment and halting artificial hydration and nutrition.[59]

A California court has found that even when a competent, adult patient is not comatose, there is a constitutional right to refuse medical treatment.[60] In *Bartling v. Superior Court* the court noted that the patient's right was found in the penumbra of rights guaranteed by the fifth and ninth amendments.[61] The court did, however, concede that the right was to be balanced against interests of the state in preserving life, preventing suicide, maintaining ethical integrity of the medical profession, and protecting innocent third parties.[62]

The *Bartling* court found the patient's rights prevailed because he had made oral and written statements of his desire. Moreover, in addressing the question of suicide, the court held that disconnecting a ventilator did not cause death by unnatural means, but rather merely served to hasten an inevitable death by natural causes.[63] Unfortunately, the court's decision came too late for Bartling, who succumbed while still attached to the equipment.[64]

To date the most dramatic judicial opinions have been handed down by the New Jersey Supreme Court. That court's 1976 decision in *In re Quinlan* signalled a new era in the right to die debate. Moreover, the

54. *In re* Storar, 52 N.Y.2d 363, 420 N.E.2d 64, *cert. denied*, 454 U.S. 858 (1981).

55. Corbett v. D'Alessandro, 487 So. 2d 368 (Fla. Dist. Ct. App.), *rev. denied*, 492 So. 2d 1331 (Fla. 1986).

56. Barber v. Superior Court, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983).

57. Areen, *The Legal Status of Consent Obtained From Families of Adult Patients to Withhold or Withdraw Treatment*, 258 J. A.M.A. 229, 231 n.44 (1987) (citing Rasmussen v. Fleming, No. 2 CA-CIV 5622 (Ariz. Ct. App., June 1986)).

58. Brophy v. New Eng. Sinai Hosp., 398 Mass. 417, 497 N.E.2d 626 (1986) (patient in persistent vegetative state who could have lived decades if nutrition maintained).

59. Areen, *supra* note 57, at 232.

60. Bartling v. Superior Court, 163 Cal. App.3d 186, 209 Cal. Rptr. 220 (1984).

61. *Id.* at 195, 209 Cal. Rptr. 225.

62. *Id.*

63. *Id.* at 196-97, 209 Cal. Rptr. 226.

64. *Dying with Dignity* (KTLA television broadcast, Apr. 4, 1987).

1987 ruling in the monumental *Farrell-Peter-Jobes*[65] trilogy marked the clearest recognition of the patient's rights thus far.

The trilogy of 1987 New Jersey cases addressed the rights of three women suffering from irreversible and incurable medical conditions. Kathleen Farrell, thirty-seven, suffered from amyotrophic lateral sclerosis (Lou Gehrig's disease). Because the incurable affliction left her mind intact while her body shut down, Mrs. Farrell was able to request removal of a respirator as a competent patient.[66] Hilda Peter, a sixty-five year-old nursing home resident in a persistent vegetative state, had been sustained by a nasogastric tube for over two years.[67] A close friend and guardian requested that the tube be removed. Nancy Jobes was a thirty-one year-old nursing home resident also in a persistent vegetative state. Her husband requested removal of the J-tube which sustained her.[68] Neither Ms. Peter nor Mrs. Jobes was expected to die within a year.[69]

In *In re Farrell* the court noted a well-recognized common law right of self-determination, but also identified countervailing state interests in sustaining a person's life.[70] The court found that Mrs. Farrell's right outweighed the state's interests and set out the criteria to be applied when patients living at home request the discontinuance of life-sustaining medical treatment.[71] The patient must be competent, as determined by two non-attending physicians. The physicians must also inform the patient of the prognosis, alternative treatments available, and the risk involved in withdrawing treatment. Moreover, the patient's decision must be voluntary and without coercion.[72] The *Farrell* court also held that judicial review of the competent patient's refusal of treatment was appropriate only under unusual circumstances[73] and that there would be no civil or criminal penalties imposed on persons who withdrew life-sustaining equipment in good faith reliance on the established procedures.[74]

65. *In re* Farrell, 108 N.J. 335, 529 A.2d 404 (1987); *In re* Peter, 108 N.J. 365, 529 A.2d 419 (1987); *In re* Jobes, 108 N.J. 394, 529 A.2d 434 (1987).

66. *Farrell*, 108 N.J. at 344, 529 A.2d at 408.

67. *Peter*, 108 N.J. at 370, 529 A.2d at 422.

68. *Jobes*, 108 N.J. at 400, 529 A.2d at 437. A jejunostomy tube, or J-tube, is a tube inserted through a hole cut into the abdomen by which hydration and nutrition are maintained.

69. *Farrell*, 108 N.J. at 341, 529 A.2d at 407.

70. *Id.* at 349, 529 A.2d at 411. The state interests noted by the court were similar to those identified in *Bartling*: preserving life, preventing suicide, safeguarding the integrity of the medical profession, and protecting innocent third parties. *Id.*

71. *Id.* at 353-54, 529 A.2d at 413.

72. *Id.* at 354, 529 A.2d at 413.

73. *Id.* at 357, 529 A.2d at 415. Conflict among physicians, or among family members, or between physicians and family members or other health care professionals, would constitute unusual circumstances. *Id.*

74. *Id.* at 358, 529 A.2d at 415-16.

In *In re Peter*[75] the court addressed the rights of a patient who had left a power of attorney authorizing a friend to make health care decisions for her. The court recognized that the medical preferences of the patient were paramount and rejected objective tests that had previously been applied to support surrogate decisions.[76] The real issue, in the opinion of the court, was whether there was clear and convincing evidence that, if competent, the patient would reject the treatment.[77]

Procedurally, the *Peter* court required ombudsman oversight, two independent medical opinions,[78] and appointment of a guardian in the absence of a close family member or a specifically designated surrogate decisionmaker.[79] Significantly, the court noted that "[i]f there is clear and convincing evidence that a patient has designated a family member or close friend to make surrogate medical decisions, upon receipt of the two medical confirmations the Ombudsman should defer any decisions concerning life-support to the designated decisionmaker."[80] According to the court, deference should be given to a close family member in the absence of a designated decisionmaker.

Finally, in *In re Jobes*,[81] the court laid down procedures for dealing with a patient in a persistent vegetative state who had failed to express an attitude toward life-sustaining treatment prior to becoming incompetent.[82] The court held that the "substituted judgment" standard established in *Quinlan* provided the best resolution.[83] By that standard, a surrogate, typically a family member, considers the patient's prior statements regarding medical issues as well as "all the facets of the patient's personality."[84] From those considerations the surrogate determines what treatment the patient would have wanted. The surrogate then secures

75. *In re* Peter, 108 N.J. 365, 529 A.2d 419 (1987).

76. *Id.* at 373, 529 A.2d at 423. *See In re* Conroy, 98 N.J. 321, 486 A.2d 1209 (1985). *Conroy* held that an ombudsman could approve a surrogate's decision to disconnect or withhold treatment when an elderly, incompetent nursing home patient was involved and a subjective, limited objective, or objective test was met, depending on the circumstances. *Id. See infra* note 131 and accompanying text.

77. *Peter*, 108 N.J. at 377, 529 A.2d at 425.

78. *Id.* at 384, 529 A.2d at 429. The medical opinions are to confirm the patient's condition, alternatives available, risks involved, likely outcome of discontinued treatment, and possibility of the patient's recovery to a cognitive, sapient state. *Id.*

79. *Id.*

80. *Id.*

81. *In re* Jobes, 108 N.J. 394, 529 A.2d 434 (1987).

82. *Id.* at 399, 529 A.2d at 436.

83. *Id.* at 414-15, 529 A.2d at 444-45.

84. *Id.*

statements from two independent physicians "knowledgeable in neurology" to the effect that the patient has no chance of recovering to a cognitive, sapient state.[85] The statement of the attending physician, if there is one, is also required. Once again, neither civil nor criminal liability is imposed on the surrogate, and judicial review is necessary only when there is disagreement.[86]

Throughout the trilogy, the court spoke in terms of respecting the will of the patient, whether stated by a competent patient, or through a surrogate. Moreover, the court was most cognizant of the patient's right to self-determination and the role of the family. These factors outweigh the state's interests in the vast majority of situations.

The earlier New Jersey Supreme Court decision in *In re Quinlan*[87] not only established the trend in the courts that recognized the rights of the patient, but also seemed to usher in statutory reform. In 1977 fifty bills providing for living will statutes were introduced in thirty-eight states.[88] By 1987 thirty-eight states and the District of Columbia had passed the statutes which, in essence, provide competent adults a means to give directions for health care if they become terminally ill and unable to direct their own care.[89]

With this impetus the Hemlock Society, and its political wing, AAHS, proposed legislation which carried living will statutes and court decisions one step further. Brushing aside the courts' concerns about suicide, the Society proposes a Directive to Physicians.[90] This instrument would make the patient's physician an attorney-in-fact with the power to decide the time of death so long as the physician acts in accordance with the desires of the patient. The proposal would allow the patient to indicate a desire to reject artificial life sustaining systems and to have a physician administer aid-in-dying in a "humane and dignified manner."[91]

The proposal contains a number of substantive and procedural safeguards. It requires the opinion of two physicians that the illness is terminal. The instrument is valid for seven years if the patient is competent, but can be revoked orally. If the patient is incompetent, the instrument remains in effect as long as the incompetency continues. The proposal

85. *Id.* at 422, 529 A.2d at 448.
86. *Id.* at n.15.
87. *In re* Quinlan, 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976).
88. D. HUMPHRY & A. WICKETT, *supra* note 57, at 108.
89. Areen, *supra* note 57, at 230.
90. RISLEY, *supra* note 48, at 30-33.
91. *Id.*

requires that the instrument be signed by two present and uninterested witnesses and places limitations on the attorney-in-fact allowing the court to take away the power should the agent act contrary to the known desires of the patient.[92] Moreover, the directive is to have no force and effect during the term of a pregnancy.[93] The proposed statute closely follows standard terms of accepted living wills and durable powers of attorney with one important distinction: it permits assistance in dying.

V. RELIGIOUS OPPOSITION AND NON-RELIGIOUS OBJECTIONS

The concept of aid-in-dying raised heated argument long before the existence of the Hemlock Society. No opponent of the practice has been more effective than the Roman Catholic Church.

The leaders of the Catholic Church have condemned euthanasia for centuries. Augustine wrote that there was no divine precept or permission to take one's life.[94] He taught that the Sixth Commandment forbade suicide unless it was necessary to avoid dishonor, or was requested by God or State, such as in war or capital punishment.[95] Aquinas viewed suicide as sinful and cited three reasons to condemn it. First, it was contrary to natural inclinations toward self-preservation and charity; second, it injured the community of which all persons are members; third, it violated God's rights over his creation, man.[96]

Pope Pius XII drew some distinctions relevant to the modern debate. In a 1957 speech he stated that respirators were extraordinary measure which were not required.[97] Thus, prolonging life by mechanical equipment was not necessary.[98] Pope Paul VI, however, stated that the right to life is inalienable and grievously violated by abortion and euthanasia.[99] The Declaration on Euthanasia,[100] authorized by Pope John Paul II in 1980, reiterated the Church's view that life is a gift of God's love and stated that no one can permit the killing of one suffering from an incurable disease or consent to it, explicitly or implicitly.

A recent California decision, *Bouvia v. Superior Court*,[101] prompted

92. *Id.*
93. *Id.*
94. Marzen, *supra* note 9, at 27.
95. *Id.*
96. *Id.* at 29.
97. G. LARUE, EUTHANASIA AND RELIGION 27 (1985).
98. *Id.*
99. *Id.* at 28.
100. *Id.*
101. Bouvia v. Superior Court, 179 Cal. App.3d 1127, 225 Cal. Rptr. 297 (1986).

a debate with the Catholic Church on the subject of euthanasia.[102] In a logical extension of the *Bartling* decision, the court held that the state could not force a nasogastric tube into a patient's body. Archbishop Roger Mahony of the Archdiocese of Los Angeles found the decision to be an open invitation to euthanasia and "perhaps eventually [to] the elimination even of those who do not want to die."[103] Mahony argued that a physician has a commitment to relieve pain, but not by every possible means. Moreover, he asserted that society should rule out efforts aimed at shortening life.

The key to Mahony's position is that a moral balance must be achieved that clearly distinguishes between eliminating the burdens inherent in the patient's condition and avoiding the additional burdens that a particular procedure will impose.[104] Mahony takes no exception to the denial of additional medical treatment that would cause "significant pain, discomfort, risk or even dehumanization."[105] He interprets the court's decision, however, to be based on its determination that Bouvia's situation was hopeless and her life unenjoyable and, therefore, meaningless because it had lost quality, dignity, and purpose.[106] Mahony strongly believes that the decision to tolerate life's passing away belongs to the patient, not the court, and should be based on the burden caused by life sustaining treatment.[107]

Opposition to aid-in-dying also finds secular support.[108] In Mahony's opinion, decisions such as those in *Bouvia* set the stage for a Nazi-like disregard of human life.[109] That same concern was voiced by Leo Alexander, psychiatrist and consultant to the Secretary of War on duty at the Nuremberg war trials.[110] Alexander wrote from the unparalleled vantage point of a witness to the atrocities exacted upon the human

102. Mahony, *Elizabeth Bouvia Versus Superior Court,* L.A. LAW., Dec. 1986, at 30. The feature also included the opposing view of Fred Okrand, legal director emeritus of the ACLU Foundation of Southern California.

103. *Id.* at 33.

104. *Id.*

105. *Id.* at 32.

106. *Id.* at 33.

107. *Id.* at 32, 33.

108. *See generally* G. LARUE, *supra* note 97. Larue's survey of attitudes disclosed that spokesmen for the world's religions generally oppose active euthanasia. There are, however, some exceptions. Unitarians take no position on the issue. *Id.* at 118. The Hindu sect of Jainism demand euthanasia in certain circumstances. *Id.* at 134.

109. Mahony, *supra* note 102, at 30.

110. Alexander, *Medical Science Under Dictatorship,* 241 NEW. ENG. J. MED., July 14, 1949, at 39.

race by the Third Reich. He noted that a starting point for Hitler's medical programs was a directive for euthanasia issued on September 1, 1939. That directive quickly grew into a practice of annihilation in which the useless were exterminated.[111]

Alexander queried whether such practices could develop in the United States. He questioned if a utilitarian society, in which doctors who have acquired a sense of omnipotence were threatened by people who could not be cured, might be the stage for a return to "killing centers."[112]

Alexander, who warned against "small beginnings," was followed a decade later by Yale Kamisar. Kamisar espoused a non-religious opposition to euthanasia relying heavily on the "wedge" theory.[113] He contended that the euthanasia movement is based on the belief "that there is such a thing as life not worthy to be lived."[114] The centerpiece of his theory is that once a wedge opens the door by allowing the death of the non-rehabilitative ill, an entire state of mind is triggered which could allow the elimination of the socially unproductive and ideologically unwanted.[115]

Kamisar set forth certain practical concerns that lead him to question whether someone who is terminally ill could be relied upon to state true opinions on anything, let alone an opinion on being put to death. He illustrated this point with the example of a person so ravaged with pain that judgment is distorted.[116] He worried that even if a person's choice is clear and uneffected by disease or pain the decision may be based on the wrong criteria. He also feared that the euthanasia process could become dangerously over-inclusive by sweeping up some individuals who have the desire to live, but feel that they should die. Such feelings often arise when the chronically ill believe that they have become emotional and economic burdens to their families.[117]

Thirty years later, in response to the Hemlock Society's announced plans for a proposed aid-in-dying statute, C. Everett Koop, Surgeon General of the United States, followed the path travelled by Alexander and

111. *Id.*

112. *Id.* at 45. The analogy to the current AIDS epidemic leaves a chilling inference.

113. Kamisar, *Some Non-Religious Views Against Proposed "Mercy-Killing" Legislation*, 42 MINN. L. REV. 969 (1958).

114. *Id.* at 1031-32 (citing Alexander, *Medical Science Under Dictatorship*, 241 NEW ENG. J. MED., July 14, 1949, at 39, 44).

115. *Id.*

116. *Id.* at 987.

117. *Id.* at 990.

Kamisar.[118] Writing from the perspective of a later generation, and in the wake of court decisions and living will statutes, Koop and co-author Edward R. Grant found a legal climate that encouraged the legalization of euthanasia. They support this finding by pointing to living will statutes. They found the statutes to be unidirectional because they do not permit the patient to request medical treatment. They allow patients only to refuse treatment.[119]

Koop and Grant posit that the emphasis on the right to die in living wills establishes a public policy in favor of that right rather than the right to request continuing medical treatment.[120] Living wills, in conjunction with cost containment strategies of profit-motivated sectors of the health care market, may, they caution, change the "right to die" to the "duty to die."[121] Moreover, they contend that the euthanasia movement has seized upon this atmosphere to press for acceptance of living wills.[122] In lock step with Kamisar, they maintain that, although it is difficult to oppose the prevention of prolonged, painful death, acceptance of that approach creates the risk of compromising other fundamental principles of our notion of justice.[123] Specifically, the price of maintaining the rights of all citizens against the ethic of mercy killing may require that, temporarily, others will have to continue living in pain, wanting to die.[124]

Koop and Grant are troubled by the approval of the Uniform Rights of the Terminally Ill Act (URTIA) by the National Conference of Commissioners on Uniform State Laws in 1985. They view the approval as an endorsement of the march toward legalizing euthanasia led by the living will acts.[125] As they see it, URTIA's treatment of hydration and nutrition as devices that can be withdrawn pursuant to a living will is difficult to reconcile with its stated intent "to err on the side of preserving life."[126]

They see further support for the euthanasia movement in the *Bouvia*

118. Koop & Grant, *The "Small Beginnings" of Euthanasia: Examining The Erosion In Legal Prohibitions Against Mercy-Killing,* 2 J. LAW, ETHICS & PUB. POL'Y 585 (1986).

119. *Id.* at 600. Indiana and Arkansas are exceptions. The statutes of those states permit patients to request medical treatment. *Id.* at n.39.

120. *Id.* at 604-05.

121. *Id.* at 605.

122. *Id.* at 606-07.

123. *Id.*

124. *Id.*

125. *Id.* at 599.

126. *Id.* at 612-13.

decision.[127] Like Mahony, they are distressed by the *Bouvia* court's consideration of the individual's ignominy and humiliation caused by the compromised state. Moreover, they interpret the concurring opinion of Justice Compton to find "a fundamental and absolute right to commit suicide, and to demand the assistance of others, including the medical profession, if one is unable to perform the act."[128]

The New Jersey Supreme Court decision in *In re Conroy*[129] gave Koop and Grant some hope.[130] In *Conroy* the court found that adequate proof of the patient's wishes was required in order to determine what life-sustaining measures could be withdrawn and set forth three tests for determining the wishes of the patient.[131] Koop and Grant view those standards as draconian and limiting the circumstances for euthanasia.[132] They see the trial court opinion in *In re Jobes*[133] as expanding *Conroy* (and *Quinlan*) to cover a patient who was not terminal even though profoundly impaired.[134]

Koop and Grant propose that legislation is the answer to the control of euthanasia and that certain categories of patients should be addressed by the legislatures.[135] They contend that protecting vulnerable adults, establishing minimal care guidelines, and protecting the right to consent to treatment should be afforded citizens.[136] They suggest that offices for the protection of nursing home patients and others should be provided

127. *Id.* at 629.

128. *Id.* at 631.

129. *In re* Conroy, 98 N.J. 321, 486 A.2d 1209 (1985).

130. Koop & Grant, *supra* note 118, at 631. *See supra* note 76 and accompanying text.

131. Koop & Grant, *supra* note 118, at 623-25. The tests to be applied depend on whether the patient has made a prior statement on the issue, and the precise content and circumstances of that statement. Under the subjective test life-sustaining treatment would be withheld or withdrawn from an incompetent patient when it was clear that the patient would have refused treatment. Under the limited objective test there must be some trustworthy evidence that the patient would have refused the treatment and the burdens of the patient's life markedly outweigh any physical pleasure, emotional enjoyment or intellectual satisfaction. The pure objective test applies when the burdens of life outweigh the benefits and further provisions of life sustaining treatment would be inhumane. *Id.* (citing *Conroy*, 98 N.J. at 360-66, 486 A.2d at 1229-32).

132. *Id.* at 622.

133. *In re* Jobes, 108 N.J. 394, 529 A.2d 434 (1987). *See supra* notes 81-86 and accompanying text.

134. Koop & Grant, *supra* note 118, at 628-29 n.139. The Surgeon General and Mr. Grant wrote that the New Jersey Supreme Court would have a number of issues to resolve. *Id.* That Court ultimately applied *Quinlan's* "substituted judgment" approach holding that Mrs. Jobes' husband could decide to withdraw artificial feeding from the 31-year old patient. The court found that loved ones "who support and care for the patient . . . best understand the patient's personal values and beliefs." *Jobes*, 108 N.J. at 427, 529 A.2d at 451.

135. The New Jersey Supreme Court would agree. *See In re* Farrell, 108 N.J. 335, 529 A.2d 404 (1987); *In re* Peter, 108 N.J. 365, 529 A.2d 419 (1987); and *In re* Jobes, 108 N.J. 394, 529 A.2d 434 (1987).

136. Koop & Grant, *supra* note 118, at 616-20.

with ombudsmen who could investigate abuse of patients and withdrawal of life-prolonging medical treatment. With respect to minimal care, Koop and Grant insist that foregoing nutrition and hydration must be strictly justifiable by medical criteria such as impossibility, imminent death, and "futility due to inability to metabolize."[137] Finally, they urge informed consent and a right to request all appropriate medical attention to accompany a right to refuse. A physician would be granted immunity, under Koop and Grant's approach, only when good faith is shown and medically appropriate decisions are made under a patient's directive.[138]

Numerous other arguments against the euthanasia movement have been raised. One author contends that support of "rational suicides" would lead to clusters of suicides, epidemics, and repetitions of the Jonestown, Guiana tragedy.[139] Others argue that statutes should retain elements of deterrence so that citizens would risk prosecution for the taking of the life of a loved one in only "the most sincerely desperate cases."[140] A patient's rational choice may be drawn into question because decisions made in advance may be rejected when the time comes. Medical error is always possible, and safeguards against error may draw out the process so that it is self-defeating. Terminal illness may be curable tomorrow. There could be a negative impact on research, hospitals might kill those who could not pay, and patient recovery rates would suffer if patients gave up.[141]

VI. ARGUMENTS IN FAVOR OF EUTHANASIA AND THE HOLLAND EXPERIENCE

Those in support of euthanasia essentially occupy three camps. Some rely on the Constitution and find a right to die. Others find support in the decriminalization of aid for the dying found in other Western countries. Still others rely simply on logic and human compassion.

The argument for active euthanasia anchored in the contention that there is a Constitutional right to die is based upon the Supreme Court's reasoning in *Roe v. Wade*.[142] In that case the Court found that, in the presence of psychological harm, the impairment of mental and physical

137. *Id.* at 618.
138. *Id.*
139. Marzen, *supra* note 9, at 139, 145. *See also* Gelfand, *Euthanasia and the Terminally Ill Patient*, 63 NEB. L. REV. 741 (1984) (outlining twelve basic components in support of the preservation of life).
140. *Id.* at 757.
141. *Id.* at 766-69.
142. 410 U.S. 113, *reh'g denied*, 410 U.S. 959 (1973).

health, and distress for all concerned, a right to an abortion springs from the Constitutional right of privacy. It would seem to follow that individuals would have the right to terminate their own lives for the same considerations.[143]

This position is usually coupled with practical guidelines for the regulation of voluntary active euthanasia. One author[144] would require that two doctors determine that the patient is terminally ill with less than six months to live, that the decision of the patient be voluntary, that the patient be legally competent and making an informed decision, and that the least active means of effectuating death be used. Under those circumstances, the "judicial system" should honor a patient's decision on when and how to die. Moreover, no criminal penalties should be imposed on the individual helping the terminal patient to commit suicide.[145]

Another approach looks to the statutes of other nations in the West as support for a revision of the criminal code in the United States. Both the German and Swiss penal codes consider the motive of the actor in grading the offense and sentencing the offender.[146] Thus, when compassion or the request of the person suffering motivates the act, a mitigated sentence results. Moreover, a motive which is completely benevolent or honorable results in total exculpation. On this basis, supporters of this approach posit that motive could become an exculpatory element of our criminal code. Similar arguments have been offered by authors reviewing Canadian law. They contend that Canadian authorities have the power to decline prosecution depending on the circumstances.[147]

Finally, there are those who assert that reason and human decency should permit active, voluntary euthanasia. One theologian asserts that it strains logic to permit the administration of morphine to a suffering patient in quantities which eventually pyramid to fatal levels, but to prosecute the single, massive dose of the same drug.[148] The theologian suggests that there may be circumstances when it would be acutely

143. Note, *supra* note 6, at 403.

144. Note, *Voluntary Active Euthanasia for the Terminally Ill and the Constitutional Right to Privacy*, 69 CORNELL L. REV. 363 (1984).

145. *Id.* at 383.

146. Note, *Euthanasia: A Comparison of the Criminal Laws of Germany, Switzerland and the United States*, 6 B.C. INT'L & COMP. L. REV. 533, 547 (1983).

147. Schiffer, *Euthanasia and The Criminal Law*, 42 U.T. FAC. L. REV. 93, 108 (1986) (citing Law Reform Comm'n of Canada, *Medical Treatment and Criminal Law*, working paper No. 28, at 51 (Ottawa 1982)). *See also*, Carnerie, *Euthanasia and Self-Determinism: Is There a Charter Right to Die in Canada*, 32 MCGILL L.J. 299-335 (1987) (finding a Canadian Constitutional right to die).

148. Lucyk, *Theological Reflections on Euthanasia*, 21 LAW SOC'Y OF UPPER CANADA GAZETTE, Mar. 1987, at 34-40.

reasonable and therefore ethical to terminate a patient's life through either affirmative action or designed neglect, rather than wait for disease to run its natural course.[149]

The passive euthanasia, or termination of life-sustaining treatment, permitted in the United States may also result in a painful death.[150] When dialysis equipment is disconnected a patient remains conscious and experiences nausea, vomiting, gastrointestinal hemorrhage, inability to concentrate, neuromuscular twitching, and convulsions. Death may take weeks. Even the disconnection of a respirator may result in conscious air hunger lasting hours.[151] Once again, the position that administering drugs to cause a painless death is illegal while disconnecting life-support machinery is permitted, seems to defy logic.

Ironically, the nation of singular importance to the euthanasia movement world-wide is the same nation that was extolled by Leo Alexander in his condemnation of the Nazi's use of "mercy killing": the Netherlands.[152] Although the Dutch contend that euthanasia is no more common in Holland than anywhere else,[153] Holland is universally looked upon as the one bastion of assisted dying.

Dr. Pieter V. Admiraal has indicated that a 1985 poll showed 67% of the Dutch population supported active euthanasia.[154] He describes "passive" euthanasia as merely a description of the attending physician's attitude, noting that disconnecting equipment or discontinuing life-lengthening drugs may cause the patient to suffer for weeks in the course of dying.

Admiraal contends that there is no role for passive euthanasia alone.[155] Rather, he believes death assisted by drugs is necessary when euthanasia is considered. Admiraal defines euthanasia as an act in the interests of an incurable patient which is done so that quick, peaceful death ensues. He believes that future generations will question why "it

149. Maguire, *The Freedom to Die,* NEW THEOLOGY, No. 10, at 189 (1973).

150. Kuhse, *The Case for Active Voluntary Euthanasia,* 14 LAW, MED. & HEALTH CARE 145, 147 (1986).

151. *Id.*

152. Alexander, *supra* note 110, at 44. "It is to the everlasting honor of the medical profession of Holland that they recognized the earliest and most subtle phases of this attempt and rejected it." *Id.*

153. Telephone interview with Robert Haslach, Information Officer, Embassy of the Netherlands (Oct. 20, 1987). Haslach reports that the abortion rate in Holland is one-fourth that of the United States and suggests that the rate of euthanasia in Holland is also actually lower than the rate in this country. *Id.*

154. Pieter V. Admiraal, Address at the Anniversary Meeting of the Voluntary Euthanasia Society of England and Wales, Apr. 14, 1985, *reprinted in* HEMLOCK Q., Oct., 1985, at 3-6.

155. *Id.* at 5.

took so long for our generation to accept euthanasia unconditionally and recognize it as a natural human right."[156]

Despite Admiraal's admission that active euthanasia is practiced in Holland, it remains illegal even there. The Dutch Council of State, however, has proposals for a bill on euthanasia under consideration. Under the proposed legislation the act would remain a criminal offense, but a doctor could be exempted from prosecution or punishment under defined conditions.[157] One effect of the legislation would be to legitimize the practices described by Admiraal which are responsible for an estimated 8,000 to 10,000 deaths per year in Holland.[158]

Euthanasia has been an open secret among the Dutch and the rest of Europe for many years. Dutch doctors have prescribed for themselves a de facto procedure which has been supported and supplemented by court decisions.[159] The patient must be fully conscious, with time to think about this final decision. Medical and spiritual advisers who are "prepared to disagree" must support the decision.[160] The patient must sign an authorization. There is constant consultation with family members and a last meeting with the patient, relatives, and doctor at which all are counseled. Finally, the patient is given an injection which consists of one drug to induce sleep and another to bring death.[161]

The Dutch procedure insists that the patient and doctor have contact over many months, even years, and that the patient ask repeatedly over time for the procedure. Terminal illness is not required, but the patient must have physical and mental suffering judged to be unbearable, with no prospect for improvement. In situations where a patient is incompetent, however, there is no chance for this form of deliverance because it can be requested only by the patient. The patient's only option would be a living will which can contain a provision for being put to death.

In light of the fact that euthanasia remains illegal, Dutch doctors are reluctant to acknowledge when it has occurred.[162] In one case a doctor who listed "unnatural death" on the death certificate of a forty year-

156. *Id.* at 6.
157. United Press International, Sept. 2, 1987 (available on LEXIS, Nexis library, Wires file).
158. *Id.*
159. Tulsa World, Sept. 6, 1987, at D2, col. 1-6.
160. *Id.*
161. *Id.*
162. It is estimated that a family doctor in Holland receives a request for euthanasia once every two or three years, although it may be two or three times a year if the doctor has an elderly practice. Haslach, *supra* note 153.

old cancer victim underwent four separate police interrogations and was forced to wait thirteen months before being told he would not be prosecuted.[163]

There is concern that AIDS patients from other countries might flood into Holland. The Dutch emphasis on long term contact with the patient, however, would seem to make that unlikely.[164]

VII. ANALYSIS

A number of factors indicate that euthanasia is no longer a topic to be relegated to theoretical debates. The United States has a population which is becoming dominated by senior citizens. Those citizens are at times being kept alive by mechanical-medical achievements. Nursing homes provide no answers, but merely add to the nightmare of those languishing in a twilight zone of sedated near-death in an environment more likely hostile than not, and civil at best.

It is no longer the elderly or a relatively small number of accident victims who experience a grim existence. The spectre of AIDS has created the population Alexander warned of: a group, ever-increasing in size, for whom there is no cure, who defy the doctor's sense of omnipotence. With this terrible plague the process of dying is ignominious, and its potential victims well-informed of exactly what they will face. With estimates that AIDS will soon afflict millions, a very real demand for an answer to the euthanasia debate can be expected.

As discussed, those in opposition to euthanasia have presented their case forcefully for generations. Fears of a return of Nazi regimes is an argument that should not be lightly brushed aside. However, it should be remembered that traditionally this country has been remarkable in its adherence to the principles of our Constitution. The guarantees of our system, with its checks and balances to protect the cherished rights of citizens, provide a safeguard against the trampling of the individual by the state. The Nazi atrocities were the actions of the state forced upon individuals, not the actions of individuals making their own choices.

This slippery slope can be avoided by following the Holland approach: the individual's choice is determinative and the safeguards have proven successful. The flaw in Holland's system, if there is one, is that doctors still proceed at their own risk. Even when the most beneficent

163. Wall St. J., Aug. 21, 1987, at 1, col. 3.
164. *Id.* at 6, col. 2.

motive is involved, the physician may have to bear the anxiety of awaiting a decision by local prosecutors.

The legislation proposed by the Americans Against Human Suffering presents a well-reasoned approach which overcomes the flaw of Holland's system. The choice of the individual is cherished above all others. Safeguards are included to guarantee that the patient gives an informed consent with desires clearly stated. Under such a statute, which protects a physician from criminal or civil liability for putting into effect the desires of a competent patient, multiple tragedies would be compassionately avoided.[165]

As Surgeon General Koop acknowledged, court decisions and legislative action have brought the country a step away from accepting aid-in-dying. The cases discussed above, among others, have shown that the courts appreciate the rights of the individuals to be their own masters, even when their wishes are presented by family, those who know and love the patient. Based on those decisions, both competent and incompetent patients can be freed from indignities and afforded deserved compassion. Legislatures have also recognized that right in the individual in most jurisdictions. Even the conservative voices of organized religion have agreed that maintaining life beyond a certain point is not necessary.[166] It is simply in going that last step that segments of society hesitate.

Unfortunately, the most recent court decisions reflect a trend away from acceptance of active euthanasia. In its exhaustive, superbly reasoned 1987 trilogy of opinions, the New Jersey Supreme Court was careful to note that the withdrawal or withholding of life-sustaining treatment is not suicide and that the patient does not die from the withdrawal or withholding, but rather from the underlying medical problem.[167] Further, a dissenting opinion noted: "Thirteen new living will statutes enacted . . . last year included a prohibition against withholding or withdrawing of artificial nutrition and hydration from terminally-ill patients."[168] These statutes were enacted in spite of the fact that a majority of Americans believe their physician should be able to help them die if they are terminally ill.[169] Thus, it does not appear that courts or

165. Caplan, *It's Time We Helped Patients Die,* MED. ECON., June 8, 1987, at 214.

166. *See supra* notes 97-107 and accompanying text.

167. *In re* Peter, 108 N.J. 365, 382, 529 A.2d 404, 428 (1987).

168. *Id.* at 390, 529 A.2d at 432.

169. Humphry, HEMLOCK Q., July, 1986, at 1. Sixty-two percent of those polled favored help in dying according to the Roper Poll, April 26-May 3, 1986. *Id.*

legislatures can be expected to readily endorse active euthanasia absent active public support.

Nevertheless, there is a most compelling argument in support of aid-in-dying, whether under the format proposed by Americans Against Human Suffering or a hybrid version, and that argument is the fact that the alternative has caused so much agony.

Joseph M. Hassman was a well-respected member of his community in Berlin, New Jersey. He was a general practitioner who made house calls and "forgot" to collect the bills of poor patients.[170] In early 1986 he visited his mother-in-law in a nursing home. She was incontinent, unable to eat, and suffering from cerebral atrophy. "Dr. Joe" injected a lethal dose of an analgesic into her nasogastric tube, and she died. Hassman was charged with manslaughter, pled guilty, and was sentenced to two years probation, a $10,000 fine, and 400 hours community service. His medical license was revoked.

Cecil and Julia Saunders were devoted to each other. They were always seen together until one day she fell, and he was too weak to lift her. Julia was taken to a nursing home, and Cecil visited every day, twelve hours a day. He became upset about the care she had been given and brought her home to care for her and tend to her broken body. When the stress, pain, and suffering came to be too much, Cecil and Julia drove to a peaceful setting alongside oak trees. He fired two bullets into her heart and one into his own. Death was instantaneous.[171]

These are just two more examples of a mounting list of individuals attempting to bring a peaceful end to their lives or to do the same for someone they love. These are people who must risk reputations or savage themselves because we have yet to achieve an understanding, legislative compassion.

VIII. CONCLUSION

In spite of the fact that a majority of the American public favors physician's assistance in dying when the patient is faced with unbearable suffering,[172] the courts and legislatures are not prepared to endorse a system of active euthanasia. If that majority believes that they should have the *choice* to end pain that they cannot tolerate rather than allow it to savage themselves and their loved ones, an endorsement of an initiative

170. Caplan, *supra* note 165, at 224.
171. N.Y. Times, Sept. 24, 1984, at B6, col. 6.
172. Humphry, *supra* note 169.

like the proposal of the Americans Against Human Suffering appears to be the best chance at speaking that will.

Any plan that endorses active euthanasia must include the broadest safeguards against abuse. Those safeguards should include the requirements of a written directive by a competent individual, and a terminal condition without any reasonable hope for recovery. Medical and, if the patient desires, spiritual advisors should consult with the patient and be prepared to disagree. Furthermore, the directive should include the appointment of a surrogate for carrying out the will of the patient, including the use of all possible life-sustaining procedures if the individual so desires. Finally, a physician should be the only one authorized to perform the act. Although the physician's conduct should be closely scrutinized, there should be freedom from all civil or criminal liability if the doctor acts in absolute good faith. In this way the right of the individual, as provided by common law and guaranteed by the Constitution, will prevail over the less compelling interests of the state in sustaining a life that is condemned to an agonizing finale.

Government's compelling interests in sustaining life must give way to the rights of the individual. An individual's natural acceptance of pending death, especially when enveloped in unbearable suffering, is not cause for the administration of anti-depressants. Rather it is the occasion to show the individual respect by honoring a final request.[173] The time to die is not necessarily at the end of horrid suffering. Only by accepting this fact will our society reach a peaceful resolution of the current debate. Once that level of respect is given the rights of the individual, with all due procedural safeguards, we will have achieved the highest moral order.

173. Caplan, *supra* note 145, at 216.