

# Voluntary Active Euthanasia for the Terminally Ill and the Constitutional Right to Privacy

Steven J. Wolhandler

Follow this and additional works at: <http://scholarship.law.cornell.edu/clr>

 Part of the [Law Commons](#)

## Recommended Citation

Steven J. Wolhandler, *Voluntary Active Euthanasia for the Terminally Ill and the Constitutional Right to Privacy*, 69 Cornell L. Rev. 363 (1984)

Available at: <http://scholarship.law.cornell.edu/clr/vol69/iss2/5>

This Note is brought to you for free and open access by the Journals at Scholarship@Cornell Law: A Digital Repository. It has been accepted for inclusion in Cornell Law Review by an authorized administrator of Scholarship@Cornell Law: A Digital Repository. For more information, please contact [jmp8@cornell.edu](mailto:jmp8@cornell.edu).

# VOLUNTARY ACTIVE EUTHANASIA FOR THE TERMINALLY ILL AND THE CONSTITUTIONAL RIGHT TO PRIVACY

Competent terminally ill persons have a right to choose the time and manner of their death. This choice is protected by the constitutional right to privacy. This Note contends that the protection afforded by the right to privacy extends to individuals whose assistance is necessary to help competent terminal patients end their lives. It proposes guidelines for both prosecutors and courts to ensure that a terminal patient's decision to end his life is made in a voluntary and competent manner.

## I

### BACKGROUND AND TERMINOLOGY

Euthanasia is defined as "the act or practice of painlessly putting to death persons suffering from incurable conditions or diseases."<sup>1</sup> It has been called a "merciful release from incurable suffering."<sup>2</sup> Euthanasia when performed with the consent of the terminally ill patient is an act of suicide.

Suicide by the terminally ill is not a recent phenomenon; its acceptance in western cultures dates back to the time of ancient Greece. Pythagoras, Plato, and Aristotle all accepted it in cases of incurable disease, and Epictetus advocated the right to die painlessly.<sup>3</sup> Lecky reports that the Roman Seneca asked, "If I can choose between a death of torture and one that is simple and easy, why should I not select the latter? . . . [W]hy should I endure the agonies of disease . . . when I can emancipate myself from all my torments?"<sup>4</sup> Several cultures and religions condone suicide under certain circumstances. Both Hinduism

---

<sup>1</sup> WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY OF THE ENGLISH LANGUAGE UNABRIDGED 786 (1976).

<sup>2</sup> J. FLETCHER, MORALS AND MEDICINE 172 (1954). Joseph Fletcher, a Protestant minister and a former professor of social ethics and moral theology at the Episcopal Theological School in Cambridge, Massachusetts, has written extensively on euthanasia.

<sup>3</sup> O. RUSSELL, FREEDOM TO DIE 53 (1975); Gillon, *Suicide and Voluntary Euthanasia: Historical Perspective*, in EUTHANASIA AND THE RIGHT TO DEATH 173-74 (A.B. Downing ed. 1969); cf. L. DUBLIN & B. BUNZEL, TO BE OR NOT TO BE 183-84 (1933) (finding confusion in ancient Greek view of morality of suicide generally).

<sup>4</sup> Gillon, *supra* note 3, at 174 (quoting W. LECKY, HISTORY OF EUROPEAN MORALS FROM AUGUSTUS TO CHARLEMAGNE (1869)); see also N. ST. JOHN-STEVAS, THE RIGHT TO LIFE 40-41 (1964). The medical historian Sigerist notes many recorded instances of doctors poisoning patients who were dying painfully. 2 H. SIGERIST, A HISTORY OF MEDICINE 302 (1951-1961).

and Confucianism accept suicide in incurable cases<sup>5</sup> and Japan's Shinto and Buddhist religions consider suicide an acceptable solution to problems such as physical pain and disease.<sup>6</sup> The Ancient Celts believed that an individual who dies of disease or senility goes to hell, but one faced with such a death who commits suicide goes to heaven.<sup>7</sup>

Although suicide itself is not illegal in the United States,<sup>8</sup> and an individual generally cannot be prosecuted for passively observing another's suicide, the vast majority of states impose criminal sanctions under either case law or statutory law for actively aiding and abetting suicide.<sup>9</sup> "Right to die"<sup>10</sup> legislation and judicial decisions allow "passive" euthanasia<sup>11</sup> but subject anyone actively assisting another in the

<sup>5</sup> Gillon, *supra* note 3, at 181-82.

<sup>6</sup> *Id.*

<sup>7</sup> *Id.* at 182.

<sup>8</sup> W. LAFAVE & A. SCOTT, HANDBOOK ON CRIMINAL LAW § 74, at 568-69 (1972). The authors note:

In America today the forfeiture-of-goods and ignominious-burial forms of punishment have been abolished, so that no penalty attaches to a successful suicide; but some states which retain common law crimes nevertheless speak of suicide as a "criminal" or "unlawful" act though, not being punishable, not strictly-speaking a crime . . . . In states which have abolished common law crimes . . . suicide can be no crime in the absence of a statute making it so. . . . No state has a statute making successful suicide a crime.

*Id.* § 74, at 568-69 & n.3; Litman, *Medical-Legal Aspects of Suicide*, 6 WASHBURN L.J. 395, 395 (1967). See generally D. HUMPHRY, LET ME DIE BEFORE I WAKE 87-88 (1982).

<sup>9</sup> Commonwealth v. Hicks, 118 Ky. 637, 82 S.W. 265 (1904); Commonwealth v. Mink, 123 Mass. 422 (1877); Blackburn v. State, 23 Ohio St. 146 (1872); State v. Jones, 86 S.C. 17, 67 S.E. 160 (1910); Turner v. State, 119 Tenn. 663, 108 S.W. 1139 (1908); ALASKA STAT. § 11.41.120 (1978); ARIZ. REV. STAT. ANN. § 13-1103 (1978); ARK. STAT. ANN. § 41-1504 (1977); CAL. PENAL CODE § 401 (West 1970); COLO. REV. STAT. § 18-3-104 (1978); CONN. GEN. STAT. § 53A-56 (1981); DEL. CODE ANN. tit. 11, § 645 (1979); FLA. STAT. ANN. § 782.08 (West 1976); HAWAII REV. STAT. §§ 707-702 (1976); KAN. STAT. ANN. § 21-3406 (1981); ME. REV. STAT. ANN. tit. 17-A, § 204 (1982); MINN. STAT. ANN. § 609.215 (West 1964); MISS. CODE ANN. § 979-3-49 (1972); MO. ANN. STAT. § 565.021 (Vernon 1979); MONT. CODE ANN. § 45-5-105 (1981); NEB. REV. STAT. § 28-307 (1979); N.J. STAT. ANN. § 2C:11-6 (West 1981); N.M. STAT. ANN. § 30-2-4 (1978); N.Y. PENAL LAW § 120.30 (McKinney 1975); OKLA. STAT. ANN. tit. 21, §§ 813-18 (West 1958 & Supp. 1981-82); OR. REV. STAT. § 163.125 (1981); 18 PA. CONS. STAT. ANN. § 2505 (Purdon 1973); P.R. LAWS ANN. tit. 33, § 1385 (1969); S.D. CODIFIED LAWS ANN. § 22-16-37 (1979); TEX. PENAL CODE ANN. § 22.08 (Vernon 1974); WASH. REV. CODE ANN. § 9A.36.060 (1977); WIS. STAT. ANN. § 940.12 (West 1982). *But see* People v. Campbell, 124 Mich. App. 333, 341 (1983) (refusing to recognize common law crime of incitement to suicide because crime "is vague and undefined and no reasonably ascertainable standard of guilt has been set forth").

<sup>10</sup> The phrase "right to die," as used by most legislatures, courts, and commentators refers only to a right to die *naturally*. See, e.g., Natural Death Act, ALA. CODE §§ 22-8A-1 to -10 (Cum. Supp. 1983) (permitting only "natural process of dying"); Death With Dignity, ARK. STAT. ANN. §§ 83-3801 to -3804 (Cum. Supp. 1983); Natural Death Act, CAL. HEALTH & SAFETY CODE §§ 7185-95 (West Cum. Supp. 1983) (permitting only "natural process of dying"); Natural Death Act, WASH. REV. CODE ANN. §§ 70.122.010-.122.905 (West Cum. Supp. 1983) (permitting only "natural process of dying"); *infra* notes 21-25 and accompanying text. See generally Freamon, *Death with Dignity Laws: A Plea for Uniform Legislation*, 5 SETON HALL LEG. J. 105, 119-21, 119-20 nn.78-79.

<sup>11</sup> For cases upholding the right of a competent adult patient to refuse treatment see *In*

act of euthanasia to criminal prosecution.

Both active and passive euthanasia may be either involuntary or voluntary.<sup>12</sup> Involuntary euthanasia occurs when a second party makes the decision to terminate an incompetent, or an unconsenting compe-

*re* Osborne, 294 A.2d 372 (D.C. Cir. 1972); *In re* Estate of Brooks, 32 Ill. 2d 361, 205 N.E.2d 435 (1965); *Belchertown v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977); *In re* Quinlan, 70 N.J. 10, 355 A.2d 647 (1976); *In re* Schiller, 148 N.J. Super. 168, 372 A.2d 360 (Ch. Div. 1977); *In re* Melideo, 88 Misc. 2d 974, 390 N.Y.S.2d 523 (Sup. Ct. 1976); *Erickson v. Dilgard*, 44 Misc. 2d 27, 252 N.Y.S.2d 705 (Sup. Ct. 1962).

<sup>12</sup> See J. FLETCHER, *supra* note 2, at 176. Involuntary euthanasia is the merciful killing of a person who does not request or consent to the act. The subject may or may not be capable of consent. See Gillon, *supra* note 3, at 173. Some advocate involuntary euthanasia for seriously defective infants and patients suffering from senile dementia. See, e.g., G. WILLIAMS, *THE SANCTITY OF LIFE* 347 (1957); Kamisar, *Euthanasia Legislation: Some Non-Religious Objections*, in *EUTHANASIA AND THE RIGHT TO DEATH*, *supra* note 3, at 112-13. The Nazis practiced involuntary euthanasia on many classes of persons not members of their "master race," including patients in mental institutions. See N. ST. JOHN-STEVAS, *supra* note 4, at 37-38; Kamisar, *supra* at 115.

American courts have allowed involuntary euthanasia in certain cases. Although the opinion suggests otherwise, *In re* Quinlan, 70 N.J. 10, 355 A.2d 647 (1976), is an example of involuntary euthanasia as defined in this Note. See *supra* notes 47-52 and accompanying text.

In *Quinlan*, parents sought and won the right to disconnect their comatose daughter Karen from a life-supporting respirator. The Quinlans' ultimate goal for their daughter is unclear. Had they sought her death, they also would have requested that the intravenous lines supplying high-calorie fluids and antibiotics to her blood be removed. These life-supporting techniques keep her alive today, comatose and curled in a tight fetal position. See ASSISTED SUICIDE: THE COMPASSIONATE CRIME 31 (D. Humphry ed. 1982) [hereinafter cited as COMPASSIONATE CRIME]; see also *In re* Eichner, 73 A.D.2d 431, 467, 426 N.Y.S.2d 517, 544 (App. Div. 1980) (concluding that absent any countervailing compelling state interest, terminally ill patient in comatose and vegetable state has right to have life-prolonging medical treatment discontinued). In reaching its decision, the *Quinlan* court relied on the fiction that the decision by Karen's guardian to remove the respirator was actually Karen's own decision. *Quinlan*, 70 N.J. at 41, 355 A.2d at 664. Such legal fictions inhibit clear analysis of the interests involved and invite the type of abuse that concerns euthanasia critics. See *infra* notes 79-84 and accompanying text. Karen, comatose throughout the proceedings, was incapable of making a choice concerning euthanasia. The court in effect sanctioned involuntary euthanasia. See *In re* Lydia E. Hall Hosp., 116 Misc. 2d 447, 455 N.Y.S.2d 706 (Sup. Ct. 1982) (permitting removal of dialysis equipment after patient slipped into coma because patient earlier had expressed desire to have equipment removed).

Voluntary euthanasia occurs when the suffering incurable makes the decision to die. See J. FLETCHER, *supra* note 2, at 176. Fletcher states:

Those who condemn euthanasia of both kinds would call the involuntary form murder and the voluntary form a compounded crime of murder and suicide if administered by the physician, and suicide alone if administered by the patient himself. As far as voluntary euthanasia goes, it is impossible to separate it from suicide as a moral category; it is, indeed, a form of suicide.

*Id.* Voluntary euthanasia may involve participation of second parties. See Silving, *Euthanasia: A Study in Comparative Criminal Law*, 103 U. PA. L. REV. 350, 359 (1954) ("Only where administered upon request, or at least with the consent of the deceased, can euthanasia be deemed comparable to assistance in suicide."). "[T]he time-honored rule that what one may lawfully do another may help him to do" underlies the right of a terminal patient to request assistance in the act of voluntary euthanasia. J. FLETCHER, *supra* note 2, at 176. See generally J. ROMAN, *EXIT HOUSE* (1980).

tent, person's life.<sup>13</sup> In voluntary euthanasia the incurable makes the decision to end his life; the distinction between the active and passive involvement of a second party is significant only to the extent that the patient is physically unable to implement that decision.<sup>14</sup> This Note argues that in cases of voluntary euthanasia the distinction between active and passive euthanasia is legally irrelevant.

### A. Voluntariness

Voluntary euthanasia is performed with the informed consent or at the informed request of a legally competent patient.<sup>15</sup> A terminal patient's rational decision to commit suicide is an exercise of free will.<sup>16</sup> In the related area of a patient's right to refuse treatment where the patient's life is at stake,<sup>17</sup> courts have defined legal competence as the

---

<sup>13</sup> See Sherlock, *For Everything There is a Season: The Right to Die in the United States*, 1982 B.Y.U. L. REV. 545, 548.

<sup>14</sup> When unassisted suicide is possible, there is no need to ask for help . . . . But when unaided suicide is impossible, various degrees of help may be asked for. The person may ask for the means of suicide to be made available: he may be too ill to go out and buy poison, or he may be in a hospital and unable to leave. He may ask for the act of killing to be performed by someone else: he may be unable to inject himself, or unable to pick up a pill and place it in his mouth.

J. GLOVER, *CAUSING DEATH AND SAVING LIVES* 183 (1977).

<sup>15</sup> Informed consent requires competence and disclosure.

True consent to what happens to one's self is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each. The average patient has little or no understanding of the medical arts, and ordinarily has only his physician to whom he can look for enlightenment with which to reach an intelligent decision.

*Canterbury v. Spence*, 464 F.2d 772, 780 (D.C. Cir.), cert. denied, 409 U.S. 1064 (1972) (footnotes omitted). In a footnote, the *Canterbury* court discussed the extent of the doctor's disclosure and the extent of the patient's knowledge in relationship to the doctor's tort liability: "Adequate disclosure and informed consent are, of course, two sides of the same coin—the former a *sine qua non* of the latter. But the vital inquiry [in establishing tort liability based on a] duty to disclose relates to the physician's performance of an obligation . . ." *Id.* at 780 n.15. Although *Canterbury* was a tort suit seeking damages for injuries sustained during surgery, the discussion of the degree of disclosure required for informed consent applies equally well as a minimum standard for physicians actively performing voluntary euthanasia at the request of a competent terminally ill patient. Voluntary active euthanasia should be viewed as a medical procedure to which the informed consent standards outlined in *Canterbury* can be applied. See also *In re Lydia E. Hall Hosp.*, 116 Misc. 2d 477, 455 N.Y.S.2d 706 (Sup. Ct. 1982) (court considered patient's alertness, mental orientation, coherence, awareness of consequences, clarity of purpose, and absence of medication in determining competence).

<sup>16</sup> Englehardt & Malloy, *Suicide and Assisting Suicide: A Critique of Legal Sanctions*, 36 Sw. L.J. 1003, 1010 (1982).

<sup>17</sup> In *Lane v. Candura*, 6 Mass. App. Ct. 377, 376 N.E.2d 1232 (1978), the court addressed the issue of the degree of legal competence required of a patient to decide to refuse medical treatment. In *Lane* a patient suffering from gangrene twice withdrew her consent to have her leg amputated even though the amputation was necessary to arrest the spread of the disease. The patient's daughter sought to have the patient declared incompetent and asked to be appointed her legal guardian for the purpose of consenting to the surgery. The trial court held the patient to be incompetent and ordered the daughter to act as her guardian. The

"mental ability to make a rational decision, which includes the ability to perceive, appreciate all relevant facts and to reach a rational judgment upon such facts."<sup>18</sup> In the euthanasia context, legal competence is the incurable's ability to understand that in requesting active euthanasia he is choosing death over life.<sup>19</sup> Only clear and convincing evidence should suffice for a finding of an incurable's competence.<sup>20</sup>

---

appellate court, however, finding insufficient evidence of Mrs. Candura's incompetence. *Id.* at 384, 376 N.E.2d at 1236.

The Tennessee Court of Appeals addressed a similar issue in *State Dep't of Human Servs. v. Northern*, 563 S.W.2d 197 (Tenn. Ct. App. 1978), *appeal dismissed as moot*, 436 U.S. 923 (1978). The court in *Northern* found the patient incompetent and appointed a guardian to authorize surgical amputation of the plaintiff's feet if necessary to save her life. *Id.* at 211-12. The *Northern* court concluded that the patient could not competently decide whether or not to consent to the amputation because she did not understand that her feet were damaged and that she was likely to die without the operation. This holding is consistent with the *Lane* case because the patient in *Lane* comprehended the choice she was making and its consequence. See Note, *The Right of Privacy and the Terminally-Ill Patient: Establishing the "Right-to-Die,"* 31 MERCER L. REV. 603, 609-10 (1980) (discussing *Northern* and *Lane* decisions). In *In re Lydia E. Hall Hosp.*, 116 Misc. 2d 477, 455 N.Y.S.2d 706 (Sup. Ct. 1982) the court relied on testimony describing the patient as "alert, oriented, not under medication and in a 'mentally capable state'" in concluding that the patient was legally competent. *Id.* at 483-84, 455 N.Y.S.2d at 710. This testimony was supported by psychiatric testimony that the patient was "coherent and relevant" and "'aware that [stopping dialysis would] result in his death.'" *Id.* at 484, 455 N.Y.S.2d at 710. The court concluded that it was "duty bound . . . to give effect to the clear, explicit and expressed wishes of [the patient] to terminate [his] treatment." *Id.* at 488, 455 N.Y.S.2d at 713.

Commentators have suggested similar tests for establishing competence. One commentator has noted that the Swiss require that a patient "be capable of grasping the import of the request and be aware of its consequences." Silving, *supra* note 12, at 384. Under this standard, "a patient in the initial state of general paresis [paralysis], who is aware of his condition and knows the consequences of a [positive] response to his request, may express a valid request." *Id.* Other commentators have defined competence as the ability to comprehend one's actions and to reason the consequences of those actions. T. BEAUCHAMP & J. CHILDRES, *PRINCIPLES OF BIOMEDICAL ETHICS* 66 (2d ed. 1983). Accord Sullivan, *A Constitutional Right to Suicide*, in *SUICIDE: THE PHILOSOPHICAL ISSUES* 245 (M. Batton & D. Mayo eds. 1980) (defining competence as mental capacity to comprehend one's predicament and to evaluate alternatives). There is a presumption in favor of competence, *id.*, used by courts in conjunction with the clear and convincing evidence standard of proof. See *infra* note 20 and accompanying text.

<sup>18</sup> *State Dep't of Human Servs. v. Northern*, 563 S.W.2d 197, 209 (Tenn. Ct. App. 1978), *appeal dismissed as moot*, 436 U.S. 923 (1978).

<sup>19</sup> *Lane v. Candura*, 6 Mass. App. Ct. 377, 384, 376 N.E.2d 1232, 1236 (1978).

<sup>20</sup> "Clear and convincing proof should . . . be required . . ." *In re Lydia E. Hall Hosp.*, 116 Misc. 2d 477, 487, 455 N.Y.S.2d 706, 712 (Sup. Ct. 1982) (quoting *In re Storar*, 52 N.Y.S.2d 363, 379, 420 N.E.2d 64, 72, 438 N.Y.S.2d 266, 274 (1981)); see Sherlock, *supra* note 13, at 593 (applauding use of clear and convincing evidence standard for determining whether to terminate treatment of obviously incompetent patient). A patient may have to be taken off painkillers to ensure that he can make a competent, rational decision. See *In re Lydia E. Hall Hosp.*, 116 Misc. 2d at 482, 455 N.Y.S.2d at 709 (patient "was taken off general medication so that his mind would be perfectly clear when the psychiatrists examined him so as to ascertain his competency to make this momentous decision.")

## B. Active versus Passive Means

The nature of a second party's acts distinguishes active euthanasia from passive euthanasia.<sup>21</sup> Passive euthanasia, caused by an act of omission, has been approved judicially in both voluntary and involuntary cases.<sup>22</sup> Although unplugging a respirator and switching off a dialysis machine are arguably acts of commission, an increasing number of judges and commentators have accepted these acts<sup>23</sup> as permissible passive euthanasia in both voluntary<sup>24</sup> and involuntary<sup>25</sup> settings. Although these authorities purport to respect the patient's "right to die," they limit that right to a patient's right to die naturally.<sup>26</sup>

Focusing on the distinction between a second party's active or passive involvement obscures the more important distinction between voluntary and involuntary euthanasia. The law should rest upon the decisionmaker's status and not upon the degree of second-party assistance.<sup>27</sup> In voluntary euthanasia cases, the only relevant legal concern

<sup>21</sup> See Sherlock, *supra* note 13, at 550.

<sup>22</sup> See *supra* notes 12-20 and accompanying text.

<sup>23</sup> See PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT: A REPORT ON THE ETHICAL, MEDICAL, AND LEGAL ISSUES IN TREATMENT DECISIONS 3 (1983) ("The voluntary choice of a competent and informed patient should determine whether or not life-sustaining therapy will be undertaken . . .") [hereinafter cited as REPORT OF PRESIDENT'S EUTHANASIA COMMISSION].

<sup>24</sup> See *infra* notes 41-46, 53-55 and accompanying text.

<sup>25</sup> See *infra* notes 47-52, 56-58 and accompanying text.

<sup>26</sup> [T]he use of legal technicalities in [the] acquittal [of mercy killers] tends to give laymen the impression that the law is a magic formula rather than an honest tool for meting out justice. Public confidence in the administration of criminal justice is hardly strengthened when moral issues are shifted instead of being solved, or when the law relegates to juries the function of correcting its inequities.

Silving, *supra* note 12, at 354. "[F]ailure [in the U.S.] to consider the ethical relevance of motive in criminal law results in circumvention of legal provisions, lack of uniformity of adjudication, and public dissatisfaction." *Id.* at 387.

<sup>27</sup> For a philosophical attack on the distinction between acts and omissions see J. GLOVER, *supra* note 14, at 92-112. "It is . . . hard to believe that the medical policy of refraining from killing in cases where 'not striving to keep alive' is thought morally right is a justifiable rule of thumb when the importance of what is at stake is fully appreciated." *Id.* at 106-07; see also G. WILLIAMS, *supra* note 12, at 309 (arguing that there is no valid distinction between supplying poison to patient, raising poison to patient's lips, pouring poison down patient's throat, or injecting air into patient's bloodstream; law should treat these acts equally). Although not abandoning the distinction between acts and omissions, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavior Research acknowledged that these categories are "inherently unclear" and that "their invocation is often so mechanical that it neither illuminates an actual case nor provides an ethically persuasive argument." REPORT OF PRESIDENT'S EUTHANASIA COMMISSION, *supra* note 23, at 61. The Commission concluded that such categories provide a "useful rule-of-thumb" for determining which cases require greater scrutiny, but added:

[T]he mere difference between acts and omissions—which is often hard to draw in any case—never by itself determines what is morally acceptable. Rather, the acceptability of particular actions or omissions turns on other morally significant considerations, such as the balance of harms and benefits

should be whether the terminally ill patient has made an informed and competent decision. It is legally inconsistent to honor a terminal patient's request that life support equipment be removed, but to deny a similarly situated patient's request for an immediate and painless end merely because a second party's active assistance is needed to implement the latter request. Prohibiting a second party from helping a patient commit self-euthanasia by imposing legal sanctions on that party is effectively equivalent to denying the patient the right to make that decision in the first place.

Although many doctors might be willing to assist a terminally ill patient commit self-euthanasia once the patient has made an informed and competent decision to do so, laws criminalizing active assistance in suicide deter them from providing such assistance. Furthermore, the potential for criminal prosecution inhibits doctors from engaging in a free and open exchange of information about euthanasia with their terminal patients.<sup>28</sup> The vast majority of terminal patients are inadequately informed about the euthanasia option<sup>29</sup> and are thus prevented from exercising their right of self-determination as protected by the constitutional right to privacy.<sup>30</sup>

## II

### THE RIGHT TO SELF-DETERMINATION

The constitutional right to privacy, as established by the Supreme Court in a series of cases<sup>31</sup> culminating in the 1973 decision on abortion,

---

likely to be achieved, the duties owed by others to a dying person, the risks imposed on others in acting or refraining, and the certainty of outcome.

*Id.*

The Commission ultimately takes an ambiguous stand on euthanasia. Although it concludes that the distinction between acts and omissions "fails to provide an adequate foundation for the moral and legal evaluation of events leading to death," *id.* at 64, it nonetheless states that "actions that lead to death are likely to be serious wrongs, while many omissions in the medical context are quite acceptable," *id.* at 68. The Commission rejects outright "the deliberate use of poisons or similar lethal agents" for patients who "wish that they [or someone acting at their request] could administer a poison to end their suffering more quickly." *Id.* at 62-63.

In rejecting active voluntary euthanasia the Commission fails to adequately consider the right of competent terminally ill patients to self-determination. Its preference for evaluating the particular considerations in each case as opposed to relying on rigid distinctions between acts and omissions belies its blanket condemnation of all acts leading to death. Indeed, the better solution is to allow voluntary active euthanasia in appropriate cases. *See infra* notes 95-109 and accompanying text.

<sup>28</sup> *Cf.* REPORT OF PRESIDENT'S EUTHANASIA COMMISSION, *supra* note 23, at 50 ("Since competent and informed patients ought to be made aware that they can forego medical interventions, the option of no effort at curative therapy should generally be explored with dying patients.").

<sup>29</sup> *Id.* at 46 ("[R]elevant treatment options must . . . be made available to the patient," to ensure free choice.).

<sup>30</sup> *See infra* notes 31-75 and accompanying text (discussing "right of self-determination").

<sup>31</sup> Supreme Court decisions prior to *Roe v. Wade*, 410 U.S. 113 (1973), established areas

*Roe v. Wade*,<sup>32</sup> protects the individual's fundamental right to self-determination.<sup>33</sup> This protection is particularly important in areas of moral controversy such as abortion, contraception, and euthanasia, where the right to privacy acts to protect private decisionmaking in personal matters.<sup>34</sup>

In *Roe*, the court considered the constitutionality of state criminal abortion legislation. The *Roe* Court balanced a mother's fundamental right to make personal decisions about private matters against a state's interest in forbidding abortions. It held that a mother's right to an abortion during the first trimester of pregnancy outweighs a state's interest in protecting both the mother's health and the "potentiality of human life" during these months.<sup>35</sup> Although the Constitution does not explicitly guarantee a right to privacy,<sup>36</sup> the Court stated:

This right of privacy, whether it be founded in the Fourteenth Amendment's concept of personal liberty and restrictions upon state action, as we feel it is, or . . . in the Ninth Amendment's reservation of rights to the people, is broad enough to encompass a woman's decision whether or not to terminate her pregnancy.

. . . .

---

of personal decisionmaking within the scope of the constitutional right to privacy. *E.g.*, *Eisenstadt v. Baird*, 405 U.S. 438, 453-54 (1972) (contraception); *Loving v. Virginia*, 388 U.S. 1, 12 (1967) (marriage); *Prince v. Massachusetts*, 321 U.S. 158, 166 (1944) (family relationships); *Skinner v. Oklahoma*, 316 U.S. 535, 541-42 (1942) (procreation); *Pierce v. Society of Sisters*, 268 U.S. 510, 535 (1925) (child rearing and education); *Meyer v. Nebraska*, 262 U.S. 390, 399 (1922) (same). The *Roe* Court cited and relied upon these cases. 410 U.S. at 152-53; *see also* Comment, *Justice Harry A. Blackmun: The Abortion Decisions*, 34 ARK. L. REV. 276, 283, 296 (1980) (arguing that right of "decisional privacy" protected in *Roe* is essential to ordered liberty and therefore extends to important personal decisions beyond abortion matters).

<sup>32</sup> 410 U.S. 113 (1973).

<sup>33</sup> Recognition of the right of self-determination is the condition for the concept of a community not based on force. Such a community can be termed an ethical community in that it is grounded on rationality and peaceful manipulation rather than force. Force used to impose on others, against their wishes, what one thinks is best for them is thus not allowed. This view undergirds a peaceable accommodation to the fact that there is a pluralism of moral beliefs: although one may not be able to agree about what constitutes good life, or good death, one can agree to let each make his own choices, as long as those choices do not involve direct and significant violence against others . . . . [Under this view i]ndividuals should be seen as not having delegated authority to the state to prevent them from making choices primarily concerning themselves. Examples of legal self-determination reflecting this libertarian view include *Roe v. Wade* . . . . There have as well been changes in the laws on sexual relations of consenting adults.

Englehardt & Malloy, *supra* note 16, at 1010-11 (footnotes omitted); *see* REPORT OF PRESIDENT'S EUTHANASIA COMMISSION, *supra* note 23, at 30-31, 1013-14.

<sup>34</sup> *See* Englehardt & Malloy, *supra* note 16, at 1011; Note, *supra* note 17, at 614-15 (reviewing right to privacy doctrine as applied to right-to-die cases and concluding that the right is more tenuous where patient is incompetent).

<sup>35</sup> 410 U.S. at 162.

<sup>36</sup> The *Roe* decision has been criticized for an alleged lack of constitutional authority. *See Doe v. Bolton*, 410 U.S. 179, 221 (1973) (White, J., dissenting) (companion case to *Roe*) ("I find nothing in the language or history of the Constitution to support the Court's judgment.").

. . . [But] this right is not unqualified and must be considered against important state interests in regulation.<sup>37</sup>

The Court concluded that after the first trimester a state may regulate abortions in order to protect maternal health<sup>38</sup> and that after the second trimester the compelling state interest in protecting a viable fetus permits a complete ban on abortions.<sup>39</sup>

Courts have extended the right to privacy to include the right of a terminally ill patient to refuse treatment, concluding that the individual patient's interests outweigh those of the state. These cases balance an individual's interest in self-determination and relief from the "traumatic cost"<sup>40</sup> of prolonged life against state interests which include protecting the sanctity of life.

In *Superintendent of Belchertown State School v. Saikewicz*,<sup>41</sup> the Supreme Judicial Court of Massachusetts upheld the right of a sixty-seven year old terminally ill leukemia victim to refuse chemotherapy treatments.<sup>42</sup> The court recognized that a state may have countervailing interests in preserving life, protecting the interests of innocent third parties, preventing suicide, and maintaining the medical profession's ethical integrity.<sup>43</sup> It concluded, however, that "the individual's interest in the freedom to choose to reject, or refuse to consent to, intrusions of his bodily integrity and privacy" outweighed those state interests.<sup>44</sup> The court stated that "[t]he constitutional right to privacy . . . is an expression of the sanctity of individual free choice and self-determination as fundamental constituents of life. The value of life as so perceived is lessened . . . by the failure to allow a competent human being the right of choice."<sup>45</sup> In rejecting state concerns about the ethical integrity of the medical profession, the court noted that the prevailing medical ethical practice recognizes that the dying more often need comfort than

<sup>37</sup> 410 U.S. at 153-54.

<sup>38</sup> *Id.* at 163.

<sup>39</sup> *Id.* at 163-64.

<sup>40</sup> *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 742, 370 N.E.2d 417, 425 (1977) (discussed *infra* notes 41-46 and accompanying text).

<sup>41</sup> 373 Mass. 728, 370 N.E.2d 417 (1977).

<sup>42</sup> *Id.* at 759, 370 N.E.2d at 435.

<sup>43</sup> *Id.* at 741, 370 N.E.2d at 425-26.

<sup>44</sup> *Id.* at 744-45, 370 N.E.2d at 427.

<sup>45</sup> *Id.* at 742, 370 N.E.2d at 426 (footnote omitted). The state's interest in preserving life may not always prevail over competing societal interests. Protecting society from certain heinous crimes, for example may be more important than protecting the life of the person committing those crimes.

Although the *Saikewicz* court mentioned the possible state interest in protecting minor dependents from the adverse consequences of a parent's decision to refuse treatment, it did not address this question because the plaintiff had no dependents. A child of a terminal patient might suffer less trauma if his parent dies quickly and painlessly rather than enduring a slow, degenerative, and painful death. In either case the child must face the consequent loss of the parent.

treatment.<sup>46</sup>

In *In re Quinlan*,<sup>47</sup> the New Jersey Supreme Court held that the constitutional right to privacy protects a patient's decision to disconnect her respirator.<sup>48</sup> Relying on *Roe v. Wade*, the court noted that the right to privacy "is broad enough to encompass a patient's decision to decline medical treatment under certain circumstances, in much the same way as it is broad enough to encompass a woman's decision to terminate pregnancy under certain conditions."<sup>49</sup> As in *Saikewicz*, the court balanced the competing state and individual interests and held that the state's interest in preserving and maintaining the sanctity of human life did not justify the bodily invasion that the treatment required, particularly in light of the extremely dim prognosis.<sup>50</sup> The court also rejected arguments that prevailing medical standards must govern the decision to remove life support systems<sup>51</sup> and that the patient's death would constitute criminal homicide.<sup>52</sup>

Since the *Quinlan* and *Saikewicz* decisions, other courts have recognized a patient's right to refuse treatment under the constitutional right to privacy. In *Satz v. Perlmutter*,<sup>53</sup> a Florida District Court of Appeal adopted the interest-balancing analysis developed in *Saikewicz* in holding that a competent patient suffering from amyotrophic lateral sclerosis<sup>54</sup> had the right to disconnect a mechanical respirator. The *Satz* court expressly limited its application of the right to privacy doctrine to cases

<sup>46</sup> *Id.* at 743, 370 N.E.2d at 426. In current medical practice, doctors not only comfort patients by administering pain killers but also by providing them with the final comfort of death. See COMPASSIONATE CRIME, *supra* note 12, at 18.

<sup>47</sup> 70 N.J. 10, 355 A.2d 647 (1976).

<sup>48</sup> *Id.* at 39-41, 355 A.2d at 663-64. The court further held that because the patient was comatose, her guardian could assert her constitutionally protected right to discontinue treatment on her behalf. *Id.* at 41, 355 A.2d at 664. In sanctioning involuntary euthanasia as an exercise of an incompetent patient's right to self-determination, the court resorted to the fiction that a guardian's decision is the patient's decision. This inadequate analysis presents the same dangers that have led some commentators to oppose all types of euthanasia. See *infra* notes 79-81 and accompanying text (discussion of wedge theory); see also Note, *supra* note 17, at 614-15 (arguing that extending right to privacy to protect involuntary euthanasia is inappropriate). For further discussion of the voluntary-involuntary distinction in the euthanasia context, see *supra* note 12.

<sup>49</sup> 70 N.J. at 40, 355 A.2d at 663.

<sup>50</sup> "We think that the State's interest *contra* weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims." *Id.* at 41, 355 A.2d at 664 (emphasis in original).

<sup>51</sup> *Id.* at 42-51, 355 A.2d at 664-69.

<sup>52</sup> *Id.* at 52, 355 A.2d at 670; see *infra* note 69 and accompanying text.

<sup>53</sup> 362 So. 2d 160 (Fla. Dist. Ct. App. 1978), *aff'd*, 379 So. 2d 359 (Fla. 1980).

<sup>54</sup> Amyotrophic lateral sclerosis is an incapacitating terminal disease commonly known as Lou Gehrig's disease. It involves degeneration of muscle and motor function, which results in death within two to five years after diagnosis. See 362 So. 2d at 161; see also BLACKISTON'S GOULD MEDICAL DICTIONARY 69 (4th ed. 1979) (defining the disease as a degenerative disorder of the upper and lower motor neurons, with onset chiefly in the middle age, characterized by motor weakness and spastic limbs).

involving competent adult patients.<sup>55</sup>

The Delaware Supreme Court in *Severns v. Wilmington Medical Center, Inc.*,<sup>56</sup> appointed the husband of a fifty-five year old comatose woman as her guardian with the authority to remove her respirator and withhold other treatment. The court, following the cases discussed above, held that Mrs. Severns had "a constitutional right to accept or reject medical assistance,"<sup>57</sup> and that her guardian could exercise that right.<sup>58</sup>

In at least one case, a patient's right to terminate treatment was upheld on grounds other than the constitutional right to privacy. In a New York case, *In re Eichner*,<sup>59</sup> the trial court rejected the right to privacy analysis yet permitted the cessation of treatment. The facts in *Eichner* were similar to those in *Quinlan*: for the purpose of disconnecting the patient's respirator, an individual sought guardianship of an incompetent eighty-three year old heart attack victim who had suffered massive brain damage. The trial court in declining to follow the *Quinlan* and *Saikewicz* decisions contended that basing a decision on the "insufficiently defined" right to privacy would "invite unrestrained applications" of the doctrine.<sup>60</sup> The court instead relied upon the common law principle of self-determination in holding that the state's interest in preserving human life was insufficient to bar removal of the respirator.<sup>61</sup> The appellate division affirmed the trial court's judgment but noted

<sup>55</sup> 362 So. 2d at 162. The court did not discuss the standards for determining legal competence because that standard was not an issue in the case; it did, however, note that Mr. Perlmutter was "fully aware of the inevitable result" of removing his respirator. *Id.* at 161. See *supra* notes 15-20 and accompanying text.

<sup>56</sup> 421 A.2d 1334 (Del. 1980). The patient, permanently comatose as a result of an automobile accident, required a respirator to keep her lungs clear. *Id.* at 1337.

<sup>57</sup> *Id.* at 1348.

<sup>58</sup> *Id.*

<sup>59</sup> 102 Misc. 2d 184, 423 N.Y.S.2d 580 (Sup. Ct. 1979), *aff'd sub nom.* *Eichner v. Dillon*, 73 A.D.2d 431, 426 N.Y.S.2d 517 (1980), *modified sub nom. In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981).

<sup>60</sup> 102 Misc. 2d at 199-200, 423 N.Y.S.2d at 591. The trial court's view reflects the fears behind the "wedge theory" discussed *infra* notes 79-81 and accompanying text.

<sup>61</sup> 102 Misc. 2d at 203-04, 423 N.Y.S.2d at 593-94. The supreme court stated that "[n]o right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others . . ." *Id.* at 200, 423 N.Y.S.2d at 591 (quoting *Union Pac. Ry. v. Botsford*, 141 U.S. 250, 251 (1891)). The court further declared that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body." *Eichner*, 102 Misc. 2d at 200, 423 N.Y.S.2d at 591 (quoting *Schloendorff v. Society of the New York Hosp.*, 211 N.Y. 125, 129 (1914) (Cardozo, J.)). For a review of the decisions upholding a common law right to self-determination see *Eichner*, 73 A.D.2d at 454-56, 426 N.Y.S.2d at 536-37. See also *In re Lydia E. Hall Hosp.*, 116 Misc. 2d 477, 455 N.Y.S.2d 706 (Sup. Ct. 1982) (citing *Eichner* and *Schloendorff* in ordering hospital to honor terminal patient's request to remove life-supporting dialysis equipment); Cantor, *A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity versus the Preservation of Life*, 26 RUTGERS L. REV. 228, 236-38 (1973); Sherlock, *supra* note 13, at 590.

that the constitutional right to privacy provides an alternative basis for the decision:

[T]he constitutional right to privacy, we believe, encompasses the freedom of the terminally ill but competent individual to choose for himself whether or not to decline medical treatment . . . . [I]t is virtually inconceivable that the right of privacy would *not* apply to [such a decision]. . . . [A]s a matter of constitutional law, a competent adult who is incurably and terminally ill has the right, if he so chooses, not to resist death and to die with dignity . . . .<sup>62</sup>

The New York Court of Appeals declined to reach the constitutional question, affirming on the basis of the common law right to self-determination.<sup>63</sup>

These decisions logically extend the *Roe* doctrine's protection of a competent individual's right to make his own decisions about personal and moral matters to that individual's decision to refuse treatment.<sup>64</sup>

<sup>62</sup> 73 A.D.2d at 458-59, 426 N.Y.S.2d at 539 (emphasis in original) (citing *Rutherford v. United States*, 438 F. Supp. 1287, 1299 (W.D. Okla. 1977)); *Satz v. Perlmutter*, 362 So. 2d 160, 162 (Fla. Dist. Ct. App. 1978); *Saitekewicz*, 373 Mass. at 742, 370 N.E.2d at 426; *Quinlan*, 70 N.J. at 39-40, 355 A.2d at 663; Cantor, *supra* note 50; Paris, *Compulsory Medical Treatment and Religious Freedom: Whose Law Shall Prevail?*, 10 U.S.F.L. REV. 1 (1975); Note, *The Tragic Choice: Termination of Care for Patients in a Permanent Vegetative State*, 51 N.Y.U. L. REV. 285, 294 (1976)).

<sup>63</sup> 52 N.Y.2d 363, 376-77, 420 N.E.2d 64, 70-71, 438 N.Y.S.2d 266, 272-73 (1981). The Court of Appeals noted that, because the Supreme Court has declined to address the question, it is unclear whether a constitutionally protected right to refuse treatment exists. *Id.* at 376, 420 N.E.2d at 70, 438 N.Y.S.2d at 272-73 (citing *Garger v. New Jersey*, 429 U.S. 922 (1976) (denying certiorari on *Quinlan* decision) and Byrn, *Compulsory Lifesaving Treatment for the Competent Adult*, 44 FORDHAM L. REV. 1, 5-9 (1975) (arguing that common law right of self-determination or right of free exercise of religion forms basis for right to refuse treatment)).

Byrn's refusal to apply the right to privacy to a patient's right to refuse treatment is not surprising in light of his view that the right to privacy as extended in *Roe* "is . . . a tragic judicial aberration that periodically wounds American jurisprudence." Byrn, *An American Tragedy: The Supreme Court on Abortion*, 41 FORDHAM L. REV. 807, 809 (1973).

Sherlock argues that the *Eichner* opinions are "hardly intelligible" and that they suffer from "woefully inadequate analysis." Sherlock, *supra* note 13, at 592, 594. Although he is correct in identifying confusion in these opinions, his own analysis is equally inadequate. His review of the case law in the right to die field concludes:

[T]he appellate decisions in the above cases are failures. . . . [T]hese courts have retreated to noble phrases and conventional platitudes. Wishing to avoid the awesome responsibility of deciding for death, they have tried to transfer that responsibility to the *incompetent patient*, purporting to discover what he or she would want, when in fact they have no basis for making such a decision. . . . The courts' efforts to give legal recognition to the right to die have led them to make decisions based on vague and arbitrary assertions that some lives are not worth living.

*Id.* at 597 (emphasis added).

Sherlock's skepticism regarding the legitimacy of allowing second parties to choose "death over life for an incompetent person," *id.* at 596, is appropriate. However, such skepticism is inappropriate in cases of voluntary euthanasia. Judicial recognition of constitutional protection for a competent terminal patient's decision to die does not require courts to authorize involuntary euthanasia as well.

<sup>64</sup> Note, *supra* note 17, at 614.

They reflect judicial recognition of "the value of human dignity."<sup>65</sup>

Similarly, courts can apply the *Roe* doctrine to protect a competent terminally ill patient's request for voluntary active euthanasia. If the right to privacy protects the right to die naturally, it should also protect the competent, terminal patient's right to choose a quick and painless death. The difference between a terminal patient's choosing to refuse treatment and choosing a faster means of dying does not offer a basis for legal distinction. When a competent terminal patient chooses to die, the state interests balanced against that patient's right to privacy are virtually the same regardless of the means chosen.<sup>66</sup> Indeed, applying the *Roe* doctrine to decisions made for incompetent patients by others, as in the *Quinlan* case, is far more difficult to justify and creates the risk of abuse. Self-determination by definition does not encompass decisions made for an individual by a third party.<sup>67</sup> In contrast, a competent terminal patient's right to choose the time and manner of his death fits squarely within the right to privacy doctrine and should be given effect "unless there exists a compelling state interest in preserving the patient's life."<sup>68</sup>

In cases in which the terminal patient is unable to end his life without another party's assistance, the other party's activities should also come within the constitutional penumbra of protection. Where the Constitution protects an individual's rights, it also protects from criminal sanction second parties whose assistance is necessary in exercising those rights.<sup>69</sup> In constitutional cases this question arises in the context of standing. A second party has standing to assert the constitutional rights of another when the second party's intervention is necessary to protect the other party's constitutional rights.

In *Griswold v. Connecticut*<sup>70</sup> the Supreme Court allowed suppliers of contraceptives to challenge, on behalf of contraceptive users,<sup>71</sup> the con-

<sup>65</sup> 373 Mass. at 745, 370 N.E.2d at 427.

<sup>66</sup> Some state interests might actually favor voluntary active euthanasia for the terminally ill. For example, this type of euthanasia fosters society's respect for individual free will. It also allows terminal patients to escape otherwise unavoidable suffering.

<sup>67</sup> Although the result in *Quinlan* is perhaps defensible, the court's reliance on the right to privacy is unfortunate. Applying the doctrine where an incompetent person incapable of making decisions regarding self-determination is involved only serves to discredit and dilute the doctrine.

<sup>68</sup> Note, *supra* note 17, at 609; *see Roe v. Wade*, 410 U.S. 113 (1973); *see also Sullivan, supra* note 17 (arguing for constitutionally protected right to self-determination in matter of suicide, subject to appropriate tests of competency).

<sup>69</sup> [T]he exercise of a constitutional right . . . is protected from criminal prosecution. . . . [This] constitutional protection extends to third parties whose action is necessary to effectuate the exercise of that right where the individuals themselves would not be subject to prosecution or the third parties are charged as accessories to an act which could not be a crime.

*In re Quinlan*, 70 N.J. at 52, 355 A.2d at 670 (citing *Eisenstadt v. Baird*, 405 U.S. 438, 455-46 (1972), and *Griswold v. Connecticut*, 381 U.S. 479, 481 (1965)).

<sup>70</sup> 381 U.S. 479 (1965).

<sup>71</sup> *Griswold v. Connecticut*, 381 U.S. 479 (1964); *see Eisenstadt v. Baird*, 405 U.S. 438 (1972).

stitutionality of a law banning contraceptive use. The Court stated that "the rights of husband and wife [first parties], pressed here [by the second party, Planned Parenthood, as defendant], are likely to be diluted or adversely affected unless those rights are considered in a suit involving those who have this kind of confidential relation to them."<sup>72</sup> In *Eisenstadt v. Baird*,<sup>73</sup> the Court was confronted with a constitutional challenge by a contraceptive distributor to a Massachusetts law prohibiting the distribution, but not the use, of contraceptives. The Court held that the distributor, "who is now in a position, and plainly has an adequate incentive, to assert the rights of unmarried persons denied access to contraceptives, has standing to do so."<sup>74</sup> In reaching this conclusion, the Court specifically noted the doctor-patient relationship as a "circumstance in which one person has been found to have standing to assert the rights of another."<sup>75</sup>

Based on this precedent, doctors assisting terminal patients in voluntary active euthanasia should be able to defend against prosecution by asserting the patient's constitutional right to self-determination. In many instances, without such assistance, voluntary active euthanasia for terminal patients would be impossible.

### III

#### VOLUNTARY ACTIVE EUTHANASIA: THE DEBATE

The "jaded debate"<sup>76</sup> over euthanasia is an old one. Objections to voluntary euthanasia are based on both religious<sup>77</sup> and nonreligious

<sup>72</sup> 381 U.S. at 481. The *Griswold* Court further stated:

This case [*Griswold*] is more akin to *Truax v. Raich*, 239 U.S. 33 [(1915)], where an employee was permitted to assert the right of his employer; to *Pierce v. Society of Sisters*, 268 U.S. 510 [(1925)], where the owners of private schools were entitled to assert the right of potential pupils and their parents; and to *Barrows v. Jackson*, 346 U.S. 249 [(1953)], where a white defendant, party to a racially restrictive covenant, who was being sued for damages by the covenantors because she had conveyed her property to Negroes, was allowed to raise the issue that enforcement of the covenant violated the rights of prospective Negro purchasers to equal protection, although no Negro was a party to the suit.

*Id.* (additional citations omitted).

<sup>73</sup> 405 U.S. 438 (1972).

<sup>74</sup> *Id.* at 446. The Court noted that to the extent the contraceptive users were not themselves subject to prosecution, they were "denied a forum in which to assert their own rights."

*Id.*

<sup>75</sup> *Id.* at 445.

<sup>76</sup> Williams, *Euthanasia Legislation: A Rejoinder to the Non-Religious Objections*, in EUTHANASIA AND THE RIGHT TO DEATH 143 (A. Downing ed. 1969).

<sup>77</sup> The religious objections may be summarized briefly: all life is from God; only God has the right to take life; and suffering, as a necessary part of living, is not to be avoided. Just as religious objections to abortion are irrelevant when discussing the legality of abortion, the religious objection to euthanasia is irrelevant when discussing the legality of voluntary active euthanasia. *In re Eichner*, 102 Misc. 2d 184, 189, 423 N.Y.S.2d 580, 584 (Sup. Ct. 1979) ("Parenthetically, the court notes that insofar as evidence concerning religious subjects has

grounds. Yale Kamisar has raised the major nonreligious objections to euthanasia.<sup>78</sup> He argues that the risks of abuse outweigh the benefits that would accrue to a small number of terminal patients. Kamisar identifies two major risks of euthanasia.

The first perceived risk is commonly known as the "wedge theory."<sup>79</sup> Its proponents contend that once society accepts that life can be terminated because of its diminished quality, there is no rational way to limit euthanasia and prevent its abuse. According to this theory, voluntary euthanasia is just the thin edge of a wedge that, once in place, will be driven deeply into our society. Kamisar concludes that legalized voluntary euthanasia inevitably would lead to legalized involuntary euthanasia because it is impossible to draw a rational distinction between those who seek to die because they are a burden to themselves and those whom society seeks to kill because they are a burden to others.<sup>80</sup> On this view the morality of the first step "rests in part on what the second step is likely to be."<sup>81</sup>

Glanville Williams believes that the wedge theory is not as persuasive as Kamisar and its other proponents suggest.<sup>82</sup> He contends that courts can establish workable guidelines that permit the free exercise of

been considered, it has been the court's consistent purpose solely to examine the evidence for the light it sheds on the secular concerns of the court.") (citing *In re Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976)), *aff'd sub nom. Eichner v. Dillon*, 73 A.D.2d 431, 426 N.Y.S.2d 517 (1980), *modified sub nom. In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981).

<sup>78</sup> See Kamisar, *supra* note 12. *But see* Williams, *supra* note 76 (responding to Kamisar's position with presentation of argument in favor of voluntary euthanasia).

<sup>79</sup> See Kamisar, *supra* note 12, at 114; Williams, *supra* note 76, at 143-45.

<sup>80</sup> Kamisar, *supra* note 12, at 87; *see* Williams, *supra* note 76, at 144 ("[The implication of the wedge theory] is that you must resist every proposal, however admirable in itself, because otherwise you will never be able to draw the line."). Actually, involuntary euthanasia is already accepted by some courts. *See supra* notes 40-63 and accompanying text. Kamisar apparently believes that these decisions allowing refusal of treatment are wrongly decided. Kamisar, *supra* note 12, at 109; *see also supra* note 67.

<sup>81</sup> Kamisar, *supra* note 12, at 115. Kamisar notes that many public advocates of legalized voluntary euthanasia privately advocate legalized involuntary euthanasia as well. *Id.* at 106-10. He quotes Lord Chorley upon the Lord's introduction of the 1950 Voluntary Euthanasia Bill in the House of Lords:

Another objection is that the bill does not go far enough, because it applies only to adults and does not apply to children who have come into the world deaf, dumb and crippled, and who have a much better cause than those for whom the Bill provides. That may be so, but we must go step by step.

*Id.* at 107 (footnotes omitted).

<sup>82</sup> G. WILLIAMS, *supra* note 12, at 316. For example, although the wedge theory strongly suggests that any legally sanctioned killing inevitably expands the scope of acceptable killing, Williams notes that soldiers may and do kill with legal impunity during wartime. *Id.* He also contends that American democratic processes provide adequate protection against the wedge theory. *See* Williams, *supra* note 76, at 144-45 (arguing that democratic processes brought end to compulsory sterilization programs in America).

In balancing the constitutional interests involved in voluntary active euthanasia, the terminal patient's right to privacy concerning the manner of his death usually outweighs the state's interest in preserving life and preventing abuse.

the right to self-determination and also protect against the abuses Kamisar fears.<sup>83</sup> Although establishing such guidelines may be difficult, the cases clearly justifying active voluntary euthanasia can be defined. Relief should not be denied in these clear cases merely because of difficulties in distinguishing between the less clear cases, which fall closer to the line separating justifiable from unjustifiable euthanasia.<sup>84</sup> Although courts and legislatures must proceed cautiously in euthanasia matters, this caution does not compel Kamisar's conclusion that no line can be drawn that will both protect the innocent and help the competent terminally ill.

Kamisar's second perceived risk is the potential for abuse or mistake in allowing euthanasia. Abuse can most easily occur in establishing voluntariness. Kamisar is concerned that unscrupulous doctors, nurses, or family members may coerce a weakened patient, for any number of improper reasons, into consenting to euthanasia that does not reflect the patient's true intent. Family members may not be entirely rational during the latter stages of the patient's illness, and may not keep the patient's best interests firmly in mind.<sup>85</sup> Kamisar would forbid all forms of euthanasia because of the inevitable uncertainty surrounding a patient's true desires. Kamisar fails to consider, however, that courts often make determinations about a person's state of mind or true intentions.<sup>86</sup>

Related to the problem of abuse is the problem of mistake. A doctor may incorrectly diagnose a patient as terminal.<sup>87</sup> A decision to administer euthanasia based on an incorrect prognosis would be a tragic error. In addition, even if a patient is correctly diagnosed as terminal, some relief or a full cure may become available before the patient's natural death. Such medical discoveries are usually foreseeable, however, and doctors working with terminal illnesses generally are apprised of developing or experimental treatments. An informed patient would have full notice of a potential cure.<sup>88</sup> The risk of an incorrect diagnosis

---

<sup>83</sup> Williams, *supra* note 76, at 144-45; *see infra* notes 95-109 and accompanying text.

<sup>84</sup> An example of a difficult case is that of James Haig, a 25-year old quadriplegic accident victim who could move only his head and one finger. He pleaded unsuccessfully with friends to shoot him. After failing in an attempt to drive his wheelchair into the Thames River, he finally succeeded in burning down his house while inside. *See* COMPASSIONATE CRIME, *supra* note 12, at 6.

<sup>85</sup> *See* Kamisar, *supra* note 12, at 97 (discussing pressures placed upon families of terminally ill patients).

<sup>86</sup> Intentions are determined circumstantially or inferentially in many areas of the law. For example, in the criminal area, courts often are asked to *infer* a defendant's mens rea. *See generally* W. LAFAVE & A. SCOTT, *supra* note 7, at 202-03. In contrast, a request for voluntary euthanasia is an *express* statement of intention. If criminal courts are willing to impose sanctions, including the death penalty, based on inferred determinations of intention, they should allow voluntary active euthanasia based on the patient's express desire.

<sup>87</sup> *See* Kamisar, *supra* note 12, at 99 (citing examples of incorrect diagnoses and prognoses).

<sup>88</sup> Williams recommends defining "a warning period when euthanasia in the particular

or the possibility of a relevant medical breakthrough are factors that an informed patient should consider when deciding on euthanasia.<sup>89</sup>

Kamisar finds that the risks of mistake and abuse in voluntary euthanasia outweigh the benefits of "easing pain" for a small group.<sup>90</sup> The balancing of these concerns against the benefits of a quick painless death, however, should properly be reserved for the individual patient.<sup>91</sup> The right to privacy demands no less; government should not interfere with a terminal patient's assessment of his personal situation and his subsequent decision concerning euthanasia absent overriding legitimate state interests.<sup>92</sup> The law should impose safeguards ensuring that terminal patients have access to adequate information with which to assess their alternatives and that they are free from coercion in making their decision. The legal system should minimize the risks and abuses associated with involuntary euthanasia. However, in cases involving a competent terminal patient, the right to privacy doctrine demands that the patient not be precluded from seeking and securing the assistance of others in committing self-euthanasia.<sup>93</sup> Only patients with access to the necessary information and assistance can make a meaningful choice.<sup>94</sup>

---

class of case [affected by the potential medical breakthrough] would probably be halted . . . ." Williams, *supra* note 76, at 142.

<sup>89</sup> Experimental medical treatments undertaken by some terminal patients actually may cause them more pain or bring about an even earlier death than no treatment at all.

<sup>90</sup> Kamisar, *supra* note 12, at 104. Kamisar argues that very few patients actually need euthanasia and those who claim to need it because of extreme pain can rely instead on pain-relieving drugs. *Id.* at 104-05. Williams responds by noting that "artificial, twilight existence, with nausea, giddiness, and extreme restlessness, as well as the long hours of consciousness [sic] of a hopeless condition" are not eliminated by drugs. Williams, *supra* note 76, at 142.

<sup>91</sup> See *supra* note 34 and accompanying text.

<sup>92</sup> Most patients make their decisions about the alternative courses available to them in light of such factors as how many days or months the treatment might add to their lives, the nature of that life (for example, whether treatment will allow or interfere with their pursuit of important goals, such as completing projects and taking leave of loved ones), the degree of suffering involved, and the costs (financial and otherwise) to themselves and others. *The relative weight, if any, to be given to each consideration must ultimately be determined by the competent patient.*

REPORT OF PRESIDENT'S EUTHANASIA COMMISSION, *supra* note 23, at 60 (emphasis added).

<sup>93</sup> Denial of such assistance would violate the patient's right to privacy in the choice of the time and manner of one of life's fundamentally private events, death. See *supra* notes 40-75 and accompanying text.

<sup>94</sup> Finally, Kamisar advocates a "laissez-faire" approach of permitting a patient to take his own life if he chooses. Kamisar, *supra* note 12, at 105. This, however, is inconsistent with his arguments about preserving the sanctity of life. *Id.* at 88. A true laissez-faire approach would remove legal restrictions from those whose suicide Kamisar finds morally acceptable whether assisted or unassisted.

IV  
VOLUNTARY ACTIVE EUTHANASIA: SOME PRACTICAL  
GUIDELINES

In certain circumstances, assisting a competent terminally ill patient in implementing his voluntary, informed decision to commit suicide<sup>95</sup> should not be subject to criminal sanctions. Exempting those who assist the suicide of a terminally ill patient from sanctions will often be necessary to protect the patient's right to privacy in making this very personal decision. The following are suggested legal guidelines for dealing with voluntary active euthanasia. To avoid criminal liability, those assisting a competent terminally ill patient commit suicide should be required to demonstrate satisfactory compliance with these guidelines.

1. The patient must be terminally ill. For a patient to be deemed terminal, two independent corroborative medical opinions must agree that the patient has less than six months to live.<sup>96</sup> In termination of treatment cases, courts and hospitals successfully use the standard safeguard of verifying prognoses through two independent medical opinions.<sup>97</sup>

2. The decision must be voluntary. A patient's decision in favor of euthanasia is only voluntary if made free of coercion. The patient's motive for making his decision is irrelevant. Many factors including pain, debilitation, emotional and financial burdens on loved ones, and the quality of his remaining life may affect a terminal patient's euthanasia decision. For example, a patient may choose to die in order to spare his family the trauma of watching him reduced to a suffering vegetable.<sup>98</sup> Although the euthanasia decision may be made for the benefit of others,

<sup>95</sup> Suicide is defined for purposes of this Note as any termination of life desired and requested by the patient.

<sup>96</sup> See Hemlock Society, Hemlock Manifesto 1 (1982) (available from the Hemlock Society, Los Angeles, Cal.) (defining terminal patient as one "likely, in the judgment of two examining physicians, to die of that condition within six months").

<sup>97</sup> See, e.g., *Severns v. Wilmington Medical Center, Inc.*, 421 A.2d 1334, 1337 (Del. 1980) ("highly skilled and respected neurosurgeon" and "highly skilled and respected neurologist" testified about patient's comatose state); *In re Quinlan*, 137 N.J. Super. 227, 245-47, 348 A.2d 801, 811-12 (1975) (court received testimony from seven doctors on patient's physical and mental state), *modified on other grounds*, 70 N.J. 10, 355 A.2d 647 (1976); *In re Lydia E. Hall Hosp.*, 116 Misc. 2d 477, 480-83, 455 N.Y.S.2d 706, 708-10 (Sup. Ct. 1982) (court heard testimony about patient's physical condition from two physicians); *State Dep't of Human Servs. v. Northern*, 563 S.W.2d 197, 203, 205 (Tenn. Ct. App.) (chancellor below relied on statement of two physicians and appeals court heard testimony of three doctors), *appeal dismissed*, 436 U.S. 923 (1978). The British Voluntary Euthanasia Bill of 1969 defines a "qualified patient" as one "whom two physicians have certified in writing . . . appears to them to be suffering from an irremediable condition"; see also J. FLETCHER, *supra* note 2, at 187, 199; *infra* note 103.

<sup>98</sup> Jo Roman, a proponent of voluntary active euthanasia, discussed the effect of her terminal illness and suicide with her loved ones. See J. ROMAN, *supra* note 12.

it is nevertheless the patient's own choice.<sup>99</sup>

The patient should request voluntary euthanasia by signing a request form in the presence of two witnesses not otherwise involved with the patient.<sup>100</sup> Second parties may discuss the euthanasia alternative with a terminal patient but if they request that the patient consent to euthanasia a presumption of involuntariness should arise.<sup>101</sup> A candid exchange of information about alternative means of dying, particularly between a doctor and the terminal patient, will ensure that the patient's decision is fully informed as well as voluntary.<sup>102</sup> Doctors should carefully document all information exchanges as evidence of voluntariness.

3. The patient must be legally competent. Two independent psychiatric opinions must confirm the patient's competence.<sup>103</sup> Euthanasia involving an incompetent patient is involuntary and in such cases the state interests in avoiding abuses weigh more heavily against the patient's right to privacy than they do in the case of a legally competent patient. Individuals fearful of being left incapacitated and without legal competence to terminate their lives may prepare living wills.<sup>104</sup>

---

<sup>99</sup> Decisions about the length of life are not necessarily more demanding of a patient's capabilities than other important decisions. And decisions that might shorten life are not always regarded by patients as difficult ones: a patient who even with treatment has a very short time to live may find a few additional hours rather unimportant, especially if the person has had a chance to take leave of loved ones and is reconciled to his or her situation.

REPORT OF PRESIDENT'S EUTHANASIA COMMISSION, *supra* note 23, at 45.

<sup>100</sup> Other ambulatory patients might be asked to witness these requests. The Hemlock Society suggests that a witness may not be:

(1) one who signed declaration at behest of declarant; (2) related to declarant by blood or marriage; (3) entitled to any part of estate of declarant, whether by statute or will; directly, financially responsible for declarant's medical care; or (4) the attending physician, an employee of the attending physician, or an employee of a health care facility in which declarant is a patient.

Hemlock Manifesto, *supra* note 96, at 4. For an example of an adequate expression of a patient's intention, see *In re Lydia E. Hall Hosp.*, 116 Misc. 2d 477, 483, 455 N.Y.S.2d 706, 710 (Sup. Ct. 1982).

<sup>101</sup> It is unlikely that a cost-conscious relative could pressure a terminal patient to commit euthanasia to save money on hospital expenses. The patient's consideration of the financial burden on family and loved ones does not in itself indicate coercion. See *supra* note 98 and accompanying text.

<sup>102</sup> See *infra* notes 105-06 and accompanying text.

<sup>103</sup> See *Lane v. Candura*, 6 Mass. App. Ct. 377, 382 n.5, 376 N.E.2d 1232, 1235 n.5 (1978) (testimony from two psychiatrists); *In re Lydia E. Hall Hosp.*, 116 Misc. 2d 477, 482, 455 N.Y.S.2d 706, 709 (Sup. Ct. 1982) (court accepted "comprehensive and detailed" testimony of several family members and hospital procedures requiring competency examinations by more than one psychiatrist). *But see* *State Dep't of Human Servs. v. Northern*, 563 S.W.2d 197, 208 (Tenn. Ct. App.) (court satisfied with testimony of one psychiatrist and its own examination of patient), *appeal dismissed*, 436 U.S. 923 (1978).

<sup>104</sup> The Hemlock Society suggests appointing a proxy and using the following language: In the absence of my ability to give further directions regarding the termination of my life, it is my intention that this request shall be honored by my family and physicians on [sic] this final expression of my legal right to terminate my life, and accept the consequences of the carrying out of this request.

Hemlock Manifesto, *supra* note 96, at 3.

4. The patient's decision must be informed. A patient should be aware of the stages of degeneration accompanying his illness, the likelihood of temporary or permanent remission, the possibility of recovery, and any other medically relevant information.<sup>105</sup> Full disclosure is essential to the unfettered exercise of the right to self-determination. Early disclosure provides a terminal patient more time to carefully consider his limited options before his thought process becomes inhibited by pain-relieving drugs.<sup>106</sup> During this time period, the patient may want to participate in support-group discussions with other patients who have suffered serious illness and contemplated euthanasia but have since recovered.

5. To further evidence voluntariness, the doctor must prescribe the least active means to effectuate death. Because a fully informed request by a competent terminal patient for assistance in the act of self-euthanasia is presumptively acceptable,<sup>107</sup> the burden should normally rest on a prosecutor to demonstrate that the euthanasia choice was improperly honored by a physician. A person more capable of causing his own painless death needs less active second party participation.<sup>108</sup> Thus, the use of a more active method when less active means are available suggests improper conduct by the doctor.<sup>109</sup>

If these five conditions are satisfied, doctors and the judicial system should honor a terminal patient's decision regarding the time and manner of his death.

#### CONCLUSION

Although terminal patients do not desire death<sup>110</sup> they nevertheless

<sup>105</sup> See generally J. ROMAN, *supra* note 12.

<sup>106</sup> If the terminal patient is already receiving painkillers, it may be necessary to stop such treatment for a short time to ensure that the patient has a clear mind when making his decision. See *supra* note 20 and accompanying text. This determination should be made on a case-by-case basis.

<sup>107</sup> See *supra* note 20 and accompanying text.

<sup>108</sup> Although an unconfined terminally ill pharmacist needs no assistance in committing euthanasia, a victim of total paralysis may need to have pills brought to his lips and a paralytic with advanced throat cancer may be unable to swallow pills and thus may need to be injected.

If assisted suicide [where the final act is performed by the subject] is possible, it is always to be preferred to voluntary euthanasia [where the final act is performed by someone else]. If we know that a person himself knowingly took a lethal pill, there is by comparison with euthanasia little ambiguity about the nature of his decision . . . . But where the person does not perform the final act himself, there is always more room for doubt about the extent to which he desired death.

J. GLOVER, *supra* note 14, at 184.

<sup>109</sup> For example, injecting a patient who can swallow pills might be cause for closer scrutiny.

<sup>110</sup> In *Satz v. Perlmutter*, 362 So. 2d 160 (Fla. Dist. Ct. App. 1978), *aff'd*, 379 So. 2d 359 (Fla. 1980), where Mr. Perlmutter sought an order permitting removal of his respirator, the

must confront it. They should be free to choose between a slow, debilitating, painful death and a quick, painless one. The constitutional right to privacy protects a competent terminal patient's right to determine for himself the time and manner of his death. It is inconsistent to recognize a terminal patient's legally protected right to make a decision in favor of self-euthanasia but deny that patient the means of implementing that decision. This Note provides well-defined guidelines for individuals assisting in voluntary active euthanasia, as well as for prosecutors, judges, and juries who must consider the legal implications of voluntary euthanasia. If a case falls within these guidelines, the law should impose no criminal sanctions on the individual assisting the terminal patient in committing suicide.

The law should protect those who do not choose euthanasia of their own volition or who are incapable of making such decisions for themselves. This is necessary to protect society from the dangers inherent in allowing euthanasia decisions to be made by anyone other than the patient. Nevertheless, a voluntary request by a legally competent terminal patient for a gentle passing should be honored. In addition, second parties whose assistance is needed to effect such requests should be protected from legal sanctions. The constitutional right to privacy compels no less.

*Steven J. Wolhandler\**

---

court noted that "the testimony of Mr. Perlmutter . . . is that he really wants to live . . . ." *Id.* at 162.

\* The author thanks David Lyons, Professor of Law and Philosophy, Cornell University, and Derek Humphry, Director of Hemlock, for their helpful criticisms and suggestions.