EUTHANASIA AND PHYSICIAN-ASSISTED SUICIDE IN THE UNITED STATES AND THE NETHERLANDS: PARADIGMS COMPARED

I. INTRODUCTION

The Supreme Court recently held in *Washington v. Glucksberg*[1] that assistance in committing suicide is not a fundamental right protected by the Due Process Clause of the Constitution.[2] The Court distinguished assisted suicide from the withdrawal of lifesaving treatment, recognizing the difference between the two as a rational, if not always easily discernable, dividing line.[3] The Court's decision rested in part on a Due Process analysis of the nation's relevant history and traditions concluding that there is a "commitment to the protection and preservation of all human life."[4] Chief Justice Rehnquist also stated that the debate on assisted suicide in America should continue.[5]

Currently, physician assisted suicide (PAS) is legal in only one state, Oregon.[6] However, an act of Congress may soon overrule that law. On October 27, 1999, the House of Representatives approved legislation[7] that would outlaw physician-assisted suicide as well as alleviate barriers to physicians providing aggressive palliative care.[8] Palliative care involves allowing physicians to regularly administer pain control medication (such as narcotics) to prevent pain rather than waiting for pain to manifest before treating it.[9] The Pain Relief Promotion Act has broad bipartisan support.[10]

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1. Washington v. Glucksberg, 521 U.S. 702 (1997).

2. *See id.* at 706.

3. *See id.* at 725-26.

4. *Id.* at 710. *See also* THE DECLARATION OF INDEPENDENCE (U.S. 1776) ("We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain inalienable rights, that among these are life, liberty, and the pursuit of happiness.")

5. Washington v. Glucksberg, 521 U.S. 702, 735 (1997).

6. *See* OR. REV. STAT. §§ 127.800-127.897 (1998).

7. *See* Pain Relief Promotion Act of 1999, H.R. 2260, 106th Cong. § 1 (1999). The act is designed "[t]o amend the Controlled Substances Act to promote pain management and palliative care without permitting assisted suicide and euthanasia. . ." *Id.* The Bill is not expected to reach the Senate until sometime after the first of the year (2000) due to the rush to adjourn. *See* David Hess, *Assisted Suicide Targeted By House,* INDIANAPOLIS STAR, Oct. 28, 1999, at A1. President Clinton is opposed to PAS so it is likely that he will sign the Bill into law if it passes the Senate. *See* Steve Woodward, *Oregon Looks Again to Netherlands,* THE OREGONIAN, Mar. 6, 1998, at D1. *See also* Washington v. Glucksberg, 521 U.S. 702, 718 (1997) (noting that President Clinton signed the Federal Assisted Suicide Funding Restriction Act on April 30, 1997).

8. *See* Hess, *supra* note 7.

9. *See* ANNE MUNLEY, THE HOSPICE ALTERNATIVE 21 (1983).

10. *See* Wesley J. Smith, *Don't Kill the Pain Relief Bill,* WALL ST. J., Nov. 4, 1999, *available in* 1999 WL-WSJ 24920685. In the House, 71 Democrats voted for the bill. *See id.* In the Senate, the bill's sponsors include Joe Lieberman (D., Conn.), Chris Dodd (D., Conn.),

The Supreme Court distinguished aggressive palliative care with the intent to alleviate pain from the prescription of drugs with the primary intention of causing death in *Vacco v. Quill*.[11]

It is important to distinguish between withdrawal of lifesaving treatment and euthanasia. Dr. Herbert Hendin, a psychiatrist, cautions that those who fail to draw this distinction confuse causation (the physician directly causes the death) with culpability (the physician allows the patient to die).[12] Dr. Hendin also emphasizes that protecting physicians who prescribe pain medication to ensure their patients' comfort when nearing the end of life does not legitimize legalizing euthanasia.[13] There is a significant difference between gradually administering pain medication to ensure that a patient is as comfortable as possible and prescribing a drug overdose.[14]

This Note compares the development of the laws concerning euthanasia[15] and PAS in both the United States and the Netherlands. Part II focuses on the background of the ethical debate concerning euthanasia and PAS. Part III chronicles the history and tradition of euthanasia law in the United States, and Part IV provides background and analysis of euthanasia and the law in the Netherlands. Part V concludes that the arguments against euthanasia outweigh the arguments in favor. Legalizing either euthanasia or

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and Evan Bayh (D., Ind.). *See id.*

11. Vacco v. Quill, 521 U.S. 793, 802 (1997). *Quill* is the companion case to *Washington v. Glucksberg*. The Supreme Court held that a New York statute prohibiting assisted suicide did not violate the Equal Protection Clause. *Id.* at 797. The New York Court of Appeals equated withdrawal of life-sustaining treatment with assisted suicide and held that patients have a right to hasten death regardless of the means used. *See id.* at 800. The Supreme Court's rationale for reversing this decision was based in part on the difference between refusing treatment (patient dies from the "underlying fatal disease or pathology") and ingesting a lethal substance (patient dies from the medication). *Id.* at 801. The Court also relied on the American Medical Association's emphasis on the "fundamental difference between refusing life-sustaining treatment and demanding a life-ending treatment." *Id.* at 801 & n.6 (quoting *American Medical Association, Council on Ethical and Judicial Affairs, Physician-Assisted Suicide*, 10 ISSUES LAW & MED. 91, 93 (1994)).

12. *See* HERBERT HENDIN, M.D., SEDUCED BY DEATH 160-62 (1997).

13. *See id.*

14. Another physician, Dr. Kenneth Praeger, points out that the danger of "blurring the distinction between mercy killing and the merciful use of drugs that may unintentionally hasten death" is that it desensitizes society to the logical distinction between the two. *Id.* at 162.

15. Euthanasia is defined as: "The mercy-killing of another for the purpose of ending the other's intolerable and incurable suffering: euthanasia is [usually] regarded by the law as second-degree murder, manslaughter, or criminally negligent homicide." BLACK'S LAW DICTIONARY 234 (1996).

Involuntary euthanasia is defined as: "Euthanasia of a competent, nonconsenting person." *Id.*

Nonvoluntary euthanasia is defined as: "Euthanasia of an incompetent, thus nonconsenting person." *Id.*

PAS or both violates the Americans With Disabilities Act[16] as well as the Fourteenth Amendment to the U.S. Constitution.[17]

II. BACKGROUND: THE ETHICAL DEBATE ON EUTHANASIA

A. *Arguments in Favor of Euthanasia and PAS*

The argument in favor of euthanasia rests, in part, on the presumption that the individual's right to self-determination outweighs the state's interest in preserving life.[18] Advocates of euthanasia argue that individuals should be able to control the manner in which their lives end.[19] The right to privacy is thought to outweigh the state's interest in preserving life.[20] One problem with this argument is that proposals for legalizing euthanasia and PAS advocate allowing only those with physical afflictions to make a determination to end their lives.[21] If the issue is truly one of autonomy and privacy from governmental intrusion, then the right should be extended to individuals who suffer from extreme mental pain as well as those who suffer from physical pain.[22] For example, it is conceivable that individuals who lose their spouses and children to fatal car accidents suffer unbearable mental anguish. Therefore, according to the autonomy rationale, the state should extend the right to die to these individuals as well.[23]

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16. 42 U.S.C. § 12101(a)(7)(1999): "[I]ndividuals with disabilities are a discrete and insular minority who have been faced with restrictions and limitations, subjected to a history of purposeful unequal treatment, and relegated to a position of political powerlessness in our society, based on characteristics that are beyond the control of such individuals and resulting from stereotypic assumptions not truly indicative of the individual ability of such individuals to participate in, and contribute to, society. . . ." *Id.*

17. U.S. CONST. art. XIV, § 1.

18. *See* Julie A. DiCamillo, Note, *A Comparative Analysis of the Right to Die in the Netherlands and the United States after Cruzan: Reassessing the Right of Self-Determination*, 7 AM. U.J. INT'L L. & POL'Y 807, 838-39 (1992).

19. *See id.* Note, however, that the autonomy argument is problematic because it misconstrues the doctor-patient relationship. *See* HENDIN, *supra* note 12, at 163. A patient cannot insist that a doctor administer a treatment that "is not consistent with sound medical practice." *Id.* For example, if a patient adheres to the medieval practice of bleeding to purify the body, the patient does not have the right to insist that the doctor perform according to this belief.

20. *See* DiCamillo, *supra* note 18, at 839.

21. *See* OR. REV. STAT. §127.805 (1998). Section 127.805 reads: "An adult who is capable, is a resident of Oregon, and has been determined by the attending physician and consulting physician to be suffering from a *terminal disease*, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner in accordance with ORS 127.800 to 127.897." *Id.* (emphasis added).

22. *See* Not Dead Yet Homepage (visited Sept. 18, 1999) <http://acils.com/NotDeadYet/ndyscnr.html>.

23. *See id.*

Advocates of euthanasia also rely on the principle of beneficence.[24] Basically, the idea is that there is a merciful duty to prevent or alleviate pain and suffering.[25] This principle is used as an independent basis for legalizing euthanasia as well as a basis for supporting the aforementioned autonomy argument.[26] The issue of preventing unnecessary pain and suffering is addressed in part by the right[27] to refuse unwanted lifesaving medical treatment.[28] In addition, the Bill currently before Congress allows aggressive pain treatment "even if the use of (narcotics) to do so unintentionally hasten[s] death."[29] This aggressive treatment of pain is known as palliative care and is distinguishable from euthanasia because, although gradually increasing pain medication may accelerate death, the intent is not to cause death but rather to ease pain and ensure that the patient is as comfortable as possible during the process of dying.

Some advocates of PAS urge legitimizing the practice because they fear physicians will be exposed to liability for overmedicating narcotics and other pain relievers to ensure patients' comfort.[30] Dr. Timothy E. Quill points out that physicians receive inadequate education for effectively practicing palliative care and sometimes delay or discourage its use.[31] Because he

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24. *See* JOHN GRIFFITHS ET AL., EUTHANASIA AND LAW IN THE NETHERLANDS 172 (1998) [hereinafter GRIFFITHS ET AL.].

25. *See id.*

26. *See id.* The principle of beneficence is often used in response to the effects that recent medical developments have had, e.g. when continuing medical treatment may actually do more harm than good. *See id.* at 173. *But see* M. SCOTT PECK, M.D., DENIAL OF THE SOUL 7-10 (1997) (pointing out that determining whether or not continuing medical treatment is beneficial or harmful is often impracticable).

27. *See* Washington v. Glucksberg, 521 U.S. 702, 720 (1997). "We have also assumed, and strongly suggested that the Due Process Clause protects the traditional right to refuse unwanted lifesaving medical treatment." *Id.*

28. *See* Cruzan v. Director, Mo. Dept. of Health, 497 U.S. 261, 278-79 (1990).

29. Hess, *supra* note 7, at A2. (quoting Representative Tom Coburn, who is also a physician).

30. *See* Joe Rojas-Burke, *Oregon Residents, Groups Divided on House Suicide Vote Some See the Action as Meddling in the State's Affairs; Others Say It Protects Caregivers and Patients*, THE OREGONIAN, Oct. 28, 1999, *available in* 1999 WL 28270476. *See also* TIMOTHY E. QUILL, M.D., DEATH AND DIGNITY MAKING CHOICES AND TAKING CHARGE 90-91 (1993) (addressing colleagues' concerns about liability for prescribing high doses of pain medication). *But see* Rojas-Burke, *supra*. Dr. Greg Hamilton, president of Physicians for Compassionate Care disagrees and thinks the distinction is easily made: When you prescribe 90 barbiturate tablets and an anti-nausea medication, there is no other purpose than to kill the patient." *Id.*

31. *See* QUILL, *supra* note 30, at 99-101. Once patients begin receiving palliative (or comfort) care, medical students no longer see them. The rationale for this is that there is no longer anything the medical student can do for the patient. *See id.* at 99. This is problematic because it means medical students lack training in communicating with and relating to dying patients. *See id.* at 99. Also, many physicians under-medicate even dying patients because pharmacology training emphasizes the dangers of addiction more than the need to effectively combat pain. *See id.* at 100. Dr. Quill wrote of his experience of assisting a patient commit

believes patients have a right to help with ending their lives once they "reach a point where they would rather die than continue living under the conditions imposed by their illness," Dr. Quill advocates legalizing PAS.[32] Dr. Quill advocates legalizing PAS but not euthanasia because he thinks euthanasia gives the physician excessive power and potential for coercion.[33]

On the other hand, ethicist Peter Singer[34] advocates both voluntary and non-voluntary euthanasia.[35] In his book, *Practical Ethics*, Singer states his belief that killing a disabled infant[36] is not morally wrong.[37] The rationale for this argument is that there is no logical difference between allowing a parent to abort a disabled child and killing it after it is born.[38] Singer uses hemophilia as an example of the type of disability that he argues justifies infanticide.[39] Essentially, the argument is based on the utilitarian idea that the morality of human actions is derived solely from the consequences. Utilitarian bio-

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suicide in the *New England Journal of Medicine*. *See* Timothy E. Quill, *A Case of Individualized Decision Making*, 324 NEW ENG. J. MED. 691-694, March 7, 1991. Dr. Quill was also a plaintiff in a suit challenging the constitutionality of New York's prohibition of assisted suicide. *See* Vacco v. Quill, 521 U.S. 793 (1997).

32. QUILL, *supra* note 30, at 156.

33. *See id.* at 160. *But see* Erin Hoover Barnett, *Laws Separate Euthanasia and Assisted Suicide*, THE OREGONIAN, April 14, 1999, *available in* 1999 WL 5334292. The line between euthanasia and PAS is not easily drawn. *See id.* Some patients desiring death may be unable to self-administer the lethal overdose and may become catalysts for legalizing euthanasia. *See id.*

34. *See* Lori Hinnant, *Professor Says Euthanasia OK for Disabled Infants*, THE INDIANAPOLIS STAR, October 2, 1999 at A1. Singer was recently appointed as a tenured bio-ethics professor at Princeton University's Center for Human Values. His appointment sparked vigorous protests with as many as 250 protestors (many in wheelchairs) barricading the administration building and demanding Princeton rescind its offer. *See id.* Steve Forbes, Princeton alumnus, stated that he will no longer donate money to the school as long as Singer continues to teach there. *Id.* at A1-A2.

35. *See* PETER SINGER, PRACTICAL ETHICS 191 (1993).

36. Infanticide is defined as "[t]he act of killing a newborn child" or "the practice of killing newborn children". BLACK'S LAW DICTIONARY 313 (1996).

37. *See* SINGER, *supra* note 35.

38. *See id.*

39. *See id.* Singer states: "[T]he main point is clear: killing a disabled infant is not morally equivalent to killing a person. Very often it is not wrong at all." *Id.* Singer also believes that because a baby is not per se self-conscious its life has less value "than the life of a pig, a dog, or a chimpanzee." *Id.* at 169. The professor goes on to say that, "[t]he grounds for not killing persons do not apply to newborn infants." *Id.* at 171. Singer believes that because newborns are not autonomous, and, therefore, that killing them does not "violate the principle of autonomy," killing them is acceptable. *Id.* Further, he concurs with Jeremy Bentham's statement that infanticide is "of a nature not to give the slightest inquietude to the most timid imagination" because those who are old enough to understand infanticide are too old to be its victims. *Id.* (quoting Jeremy Bentham's *Theory of Legislation* 264). *Compare with* HENRY FRIEDLANDER, THE ORIGINS OF NAZI GENOCIDE: FROM EUTHANASIA TO THE FINAL SOLUTION 39 (1995) (describing how, prior to the Holocaust, Hitler initiated a program authorizing the killing of physically and mentally disabled children).

ethicists, such as Singer, believe that there is no distinction between allowing someone to die (withholding heroic measures) and actively killing them.[40] Applying this principle to the infant with hemophilia, Singer argues that the ends of allowing the parents to have another child that would possibly be healthier justifies the means of killing the first infant.[41]

B. *Arguments Against Euthanasia and PAS*

Legalizing euthanasia and PAS is problematic because it is difficult to determine whether an individual actually desires death because of intense pain and impending death or whether the person is suffering from treatable symptoms, such as depression.[42] Also, even with seriously ill patients, physicians cannot accurately predict how long a patient will live and whether or not the illness is actually terminal.[43] Legalizing assisted suicide would result in the deaths of many patients with mental disorders.[44] Many times these individuals cannot make a competent decision based on careful reflection.[45] One-third of physicians surveyed in Oregon said that they were unsure whether they could determine if a request to die was due to depression.[46] The causal connection between pain and euthanasia is extremely weak.[47] The two prevailing factors in a patient's choosing euthanasia or PAS were depression and fear of becoming a burden to loved ones.[48]

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40. *See* EUTHANASIA EXAMINED 128-29 (John Keown ed., Cambridge University Press 1st ed. 1995)[hereinafter EUTHANASIA EXAMINED].

41. *See* SINGER, *supra* note 35 at 191. However, arbitrarily determining that one life is of lesser value than another demeans the value of all lives. *See* Luke Gormally, *Walton, Davies, Boyd and the Legalization of Euthanasia, in* EUTHANASIA EXAMINED, *supra* note 40, at 113, 128. "Once it is accepted that one may justify the killing of a human being on the grounds that he lacks a worthwhile life, one has in effect repudiated recognition of the ineliminable dignity and worth of every human being. And with that repudiation goes repudiation of the indispensable foundation of justice in society." *Id.*

42. *See* David A. Pratt, *Too Many Physicians: Physician-Assisted Suicide After Glucksberg/Quill,* 9 ALB. L.J. SCI. & TECH. 161 (1999). The number of depressed elderly Americans not being treated is estimated at 90%. *See id.*

43. *See id.*

44. *See id.*

45. *See id.*

46. *See id.*

47. *See* Ezekiel J. Emanuel, *The Future of Euthanasia and Physician-Assisted Suicide: Beyond Rights Talk to Informed Public Policy,* 82 MINN. L. REV. 983, 997 (1998). The data from the Oregon Health Division's report on the first year of legalized PAS show that only 7% of the people (one out of fifteen patients) who chose PAS were concerned with inadequate pain control. *See* Oregon's Death With Dignity Act: The First Year's Experience (Dep't of Human Resources Oregon Health Division February 18, 1999)[hereinafter OHD Report].

48. *See* Emanuel, *supra* note 47, at 999. This article analyzes four studies, three from Holland and one from the United States, conducted by doctors who have performed PAS or euthanasia. *See id.*

Legalizing euthanasia also engenders discrimination against disabled people.[49] Because people with disabilities and poor physical health are singled out, a double standard is created for whether or not someone should be allowed to die.[50] The advocacy group, Not Dead Yet, points out that if the decision to die is merely an autonomy issue, then anyone who desires death should be able to choose it, not just the disabled or incurably ill.[51]

The danger of discrimination through singling out those who are disabled or otherwise physically afflicted is quite real.[52] Hitler stated:

> The völkisch state must see to it that only the healthy beget children. . . . Here the state must act as the guardian of a millennial future. . . . It must put the most modern medical means in the service of this knowledge. It must declare as unfit for propagation all who are in any way visibly sick or who have inherited a disease and can therefore pass it on.[53]

Under Hitler's reign, persons with retardation, brain damage, or psychiatric disorders were characterized as *Ballastexistenzen* (human ballast) and as "empty shells of human beings."[54] Alfred Hoche[55] said killing such people "is

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49. *See generally Not Dead Yet Homepage, supra* note 22 (explaining how legalized euthanasia and PAS discriminate against disabled individuals); Diane Coleman, J.D., *Withdrawing Life-Sustaining Treatment from People with Severe Disabilities Who Request It: Equal Protection Considerations,* 8 ISSUES IN LAW AND MEDICINE 55, 62-3 (1992) (determining that a disabled individual is not suicidal and therefore not entitled to suicide intervention based solely on physical limitations without addressing whether or not the individual is suffering from treatable depression is discrimination).

50. The Americans with Disabilities Act was enacted "to invoke the sweep of congressional authority, including the power to enforce the Fourteenth Amendment..., in order to address the major areas of discrimination faced day-to-day by people with disabilities." 42 U.S.C. §12101(a)(7)(1999).

51. Not Dead Yet is a national organization comprised of people with disabilities. *See Not Dead Yet Homepage, supra* note 22.

52. Hugh Gregory Gallagher, a historian and severely disabled polio quadriplegic, writes with the intention of enlightening the reader regarding the evil that can arise from discriminating against the disabled. The Nazi euthanasia killing program evolved from Western scientific theories such as Social Darwinism. Hitler used the application of these genetic principles regarding human evolution as justification for his euthanasia campaigns against the disabled, the diseased and the insane. *See* Hugh Gregory Gallagher, *"Slapping Up Spastics": The Persistence of Social Attitudes Toward People with Disabilities,* 10 ISSUES LAW & MED. 401 (Spring 1995).

53. ROBERT J. LIFTON, THE NAZI DOCTORS 22 (1986).

54. *Id.* at 47.

55. Hoche was a psychiatrist who along with lawyer Karl Binding wrote the book *The Destruction of Life Devoid of Value* which greatly influenced Hitler. *See* KARL BINDING & ALFRED HOCHE, DIE FREIGABE DER VERNICHTUNG LEBENSUNWERTEN LEBENS: IHR MASS UND IHRE FORM (1920). These men, regarded as reputable professors, advocated those who were retarded, deformed, terminally ill, and mentally sound but severely damaged by disease or

not to be equated with other types of killing . . . but [is] an *allowable, useful act.*"[56] In order to prevent abuse of human dignity and discrimination against the disabled in the United States, heeding the lessons of history is imperative.[57]

Another dimension of the problem is that allowing voluntary euthanasia inevitably leads to non-voluntary euthanasia.[58] Evidence of this derives from the Remmelink Commission Survey[59] which indicates that "cardinal safeguards—requiring a request which is free and voluntary; well-informed; and durable and persistent—have been widely disregarded. Doctors have killed with impunity."[60] However, the situation in the Netherlands differs from that in the United States because Holland's medical system is socialized to the extent that doctors are unable to profit from the practice of euthanasia.[61] With the current health care system in the United States and the emphasis on managed care, insurance companies and bureaucrats could easily encourage euthanasia as a cost-effective solution.[62] Thus, the slope could well prove even more slippery in the United States than in the Netherlands.[63]

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accident should be put to death. LIFTON, *supra* note 53, at 46.

56. LIFTON, *supra* note 53 at 47 (quoting Alfred Hoche, *Ärtzliche Bemerkungen*, 3 FREIGABE 46-47, 54-58).

57. President Theodore Roosevelt once said: "Someday we will realize that the prime duty, the inescapable duty, of the good citizen of the right type is to leave his or her blood behind him in the world; and that *we have no business to permit the perpetuation of the wrong type.*" Gallagher, *supra* note 52, at 406 (emphasis added) (quoting MARK A. HALLER, EUGENICS: HEREDITARIAN ATTITUDES IN AMERICAN THOUGHT 42 (1963)).

58. *See generally* John Keown, *Euthanasia in the Netherlands: Sliding Down the Slippery Slope?*, 9 NOTRE DAME J.L. ETHICS & PUB. POL'Y 407, 448 (1995) (analyzing euthanasia statistics from the Netherlands).

59. The Remmelink Commission Survey is a governmental study that was conducted in response to concerns that Dutch doctors were generally not reporting euthanasia. *See* HENDIN, *supra* note 12, at 49. The attorney general of the Dutch Supreme Court, Professor Jan Remmelink, supervised a study of the problem in conjunction with investigators at Erasmus University. *See id.* The attorney general granted participating physicians immunity from prosecution in exchange for candid information. *See id.* The study revealed that euthanasia was the cause of death in at least two percent of all deaths. *See id.* More than 50% of doctors reported performing euthanasia that year. *See id.* Just 60% kept a written record of these cases, and only 29% reported honestly filling out the death certificates in cases involving euthanasia. *See id.*

60. *See* Keown, *supra* note 58, at 437.

61. *See* PECK, *supra* note 26, at 228.

62. *See id.* at 227. The idea is that legalized euthanasia and PAS risk harm to those in poverty who lack access to good medical care, especially the elderly and stigmatized groups such as minorities. *See* HENDIN, *supra* note 12, at 179. This explains why, although a slight majority of whites favor PAS and euthanasia, African-Americans oppose the practices by more than two to one. *See id.* at 180.

63. Even Dutch advocates of euthanasia, such as Herbert Cohen and René Diekstra question the wisdom of implementing euthanasia and PAS in the United States. *See* HENDIN, *supra* note 12, at 180. The danger of legalizing euthanasia and PAS in the United States arises both from the profit motivations as well as "the litigious tendency of American patients" which "would make euthanasia a nightmare for physicians". *Id.* Proponents of euthanasia, such as

Finally, euthanasia endangers the practice and development of palliative care, also known as 'comfort care.'[64] Hospice[65] care involves both "controlling pain" and "creating supportive social environments."[66] The primary concern of hospice care is making the patient more comfortable and secure at the end of life.[67] "[L]egalization of euthanasia would be nothing more than a cheap, expedient solution to the problem of terminal care at the expense of the patient's best welfare."[68] Hospice advocates[69] argue that a request for euthanasia indicates that society or one of its members failed in some way to support the person making the request.[70]

In the Netherlands, the motivation to improve palliative care has all but evaporated.[71] The issue of caring for the terminally ill is dealt with by debating who will be eligible for euthanasia as the acceptance of death as a solution encompasses more groups of patients.[72] Euthanasia becomes a way to "ignore the genuine needs of terminally ill people."[73]

Derek Humphry, co-founder of the Hemlock Society, actually list cutting health care costs as a fringe benefit of legalizing euthanasia and PAS. *See International Anti-Euthanasia Task Force Update*, Vol. 13, No. 1 (January-March 1999)(visited November 16, 1999) <http://www.iaetf.org/iua16.htm.>[hereinafter *IAETF Update*]. Humphry believes that "a rational argument can be made for allowing [assisted suicide] in order to offset the amount society and family spend on the ill, as long as it is the voluntary wish of the mentally competent, terminally ill adult. . . . The hastened demise of people with only a short time left would free up resources for others. Hundreds of billions of dollars could benefit those patients who not only can be cured but who want to live." *Id.* at 11 (quoting DEREK HUMPHRY & MARY CLEMENT, FREEDOM TO DIE—PEOPLE, POLITICS, AND THE RIGHT-TO-DIE MOVEMENT).

64. *See* HENDIN *supra* note 12, at 214-15.

65. English physician Dame Cicely Saunders founded the hospice movement. *See IAETF Update, supra* note 63, at 9.

66. MUNLEY, *supra* note 9, at 275.

67. *See id.*

68. *Id.* D.J. Bakker, a Dutch surgeon, warns: "Euthanasia is then chosen as the wrong solution for a wrong development in medicine. A medical science that is in need of euthanasia has to be changed as soon as possible to a medicine that cares beyond cure." HENDIN *supra* note 12, at 163.

69. Some right-to-die advocates argue that hospice care may not be enough when patients linger in agony. *See* QUILL *supra* note 32, at 106. Dr. Quill argues that doctors should not turn their backs on these suffering patients. *See id.* at 108. However, he later points out that the possibility of successful prosecution in these cases is remote. *See id.* at 158.

70. *See* HENDIN, *supra* note 12, at 163.

71. *See id.* at 214-15.

72. *See id.*

73. *Id.* at 214.

III. EUTHANASIA AND PAS LAW IN THE UNITED STATES

A. *State Statutes and Recent Cases*

The law in the United States traditionally regards euthanasia and PAS as crimes.[74] Euthanasia is illegal throughout the United States,[75] and thirty-seven states criminalize assisted suicide by statute.[76] Assisted suicide is a common law crime in six states and the District of Columbia,[77] while in six states, the law is unclear.[78] Oregon's Death With Dignity Act[79] legalized PAS in that state.[80]

However, an act of Congress may soon overrule the Death With Dignity Act. On October 27, 1999, the House of Representatives passed legislation[81] that would make PAS and euthanasia federal crimes.[82] The Bill also appropriates five million dollars to medical schools and hospices for development of training programs for doctors on pain control for dying

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74. *See generally* Washington v. Glucksberg, 521 U.S. 702, 710 (1997) (regarding bans on assisted suicide as "expressions of the States' commitment to the protection and preservation of all human life").

75. *See* QUILL, *supra* note 32, at 158.

76. The thirty-seven states are Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Washington, and Wisconsin. *See The Hemlock Society Homepage* (visited Sept. 9, 1999) <http://www.hemlock.org//comm/states_12.html>.

77. The six states are Alabama, Idaho, Maryland, Massachusetts, Nevada, and West Virginia. *See id.*.

78. The six states are North Carolina, Ohio, Utah, Vermont, Virginia, and Wyoming. *See id.*.

79. OR. REV. STAT. §§ 127.800-127.897 (1998).

80. Since Oregon legalized assisted-suicide, many other states have, thus far, failed in attempts to legalize PAS. *See* Washington v. Glucksberg, 521 U.S. 702, 717 (1997). *See e.g.* Alaska H.B. 371 (1996); Ariz. S.B. 1007 (1996); Cal. A.B. 1080, A.B. 1310 (1995); Colo. H.B. 1185 (1996); Colo. H.B. 1308 (1995); Conn. H.B. 6298 (1995); Ill. H.B. 691, S.B. 948 (1997); Me. H.P. 663 (1997); Me. H.P. 552 (1995); Md. H.B. 474 (1996); Md. H.B. 933 (1995); Mass. H.B. 3173 (1995); Mich. H.B. 6205 (1996); Mich. S.B. 556 (1996); Mich. H.B. 4134 (1995); Miss. H.B. 1023 (1996); N.H.H.B. 339 (1995); N.M.S.B. 446 (1995); N.Y.S.B. 5024 (1995); N.Y.A.B. 6333 (1995); Neb. L.B. 406 (1997); Neb. L.B. 1259 (1996); R.I.S. 2985 (1996); Vt. H.B. 109 (1997); Vt. H.B. 335 (1995); Wash. S.B. 5596 (1995); Wis. A.B. 174, S.B. 90 (1995) *See* Washington v. Glucksberg, 521 U.S. 702 at n.15.

81. The legislation passed by a 271-156 vote. *See* Hess, *supra* note 7.

82. *See id.* Attorney General Janet Reno determined that Oregon was exempt from the Controlled Substances Act of 1970 and thus Oregon is not subject to the Drug Enforcement Agency's jurisdiction. *See id.* The attorney general made this determination after DEA Chief Thomas Constantine wrote to several congressmen that he believed the Controlled Substances Act forbids doctors from writing lethal prescriptions. *See* Woodward, *supra* note 7.

patients.[83] The American Medical Association endorses the Bill[84] as does Oregon's largest newspaper, *The Oregonian.*[85]

Other recent developments include the conviction of Dr. Jack Kevorkian in March, 1999.[86] A jury convicted Kevorkian of the second-degree murder of Thomas Youk.[87] The conviction related to a *60 Minutes* broadcast months earlier showing Kevorkian lethally injecting Thomas Youk.[88] In three previous trials, juries acquitted Kevorkian, and this time Kevorkian challenged prosecutors to charge him during the broadcast.[89] This time, the jury found him guilty on two counts, second-degree murder and delivery of a controlled substance without a license.[90]

In the *Glucksberg* case, the Supreme Court held that there is no constitutional right to assisted suicide.[91] The Court rejected Plaintiffs'

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83. *See* Hess, *supra* note 7, at A2.

84. *See id.*

85. *See* Congress (visited Nov. 3, 1999) < http://www.congress.gov>.

86. Kevorkian is a Michigan doctor who has participated in over 130 assisted suicides. *See* James A. McClear & Mark Truby, *Judge 'Stops' Kevorkian with Jail. He Gets 10 to 25 Years in Prison in Death of Thomas Youk, But Could Get Parole in Six*, THE DETROIT NEWS, April 14, 1999, at A1. Kevorkian first became known as Dr. Death in 1956 when he was completing his medical residency because of his fascination with photographing the eyes of patients at the moment of death. *See* Herbert Hendin, *Kevorkian on Trial* (January-March 1999) (visited November 16, 1999) <http://www.iaetf.org/iua16.htm>. Later, Kevorkian advocated that death row inmates be anesthetized rather than executed so that their living bodies could be utilized for medical experiments lasting up to several months then finally given a lethal overdose. *See id. See also* JACK KEVORKIAN, PRESCRIPTION: MEDICIDE THE GOODNESS OF PLANNED DEATH 28 (1991)(explaining the author's plan for submitting condemned criminals to medical experimentation with the use of anesthesia). Because of his unorthodox views, the medical community ostracized Kevorkian. *See* Hendin, *supra.* This cost Kevorkian an academic appointment at the University of Michigan. *See id.* He responded by accelerating his efforts to legitimize euthanasia. *See id.*

87. *See 60 Minutes* (CBS television broadcast, Nov. 27, 1998) (airing a videotape of Dr. Kevorkian administering a lethal injection to Thomas Youk, age 52, who had Lou Gehrig's disease). Prior to administering the lethal injection, Kevorkian asked only questions requiring one or two word answers. Youk's family and Kevorkian consistently spoke for him. *See* Hendin, *supra* note 86. Just as Kevorkian inserts the needle, Youk tried to speak, but Kevorkian apparently did not notice and continued the injection. Youk's hospice nurse, Marianne Potter, told television interviewers that she thinks she heard a "w" sound. *See IAETF Update, supra* note 63. Potter further laments, "I hope and pray that he wasn't saying 'wait'... My heart goes out because even if he wasn't saying 'wait', why wasn't he given the courtesy of figuring out what he was saying?" *Id.*

88. *See* McClear & Truby, *supra* note 86.

89. *See id.*

90. *See* Hendin, *supra* note 86. The Michigan Board of Medicine revoked Kevorkian's license to practice medicine in 1991. *See id.* Note also that Michigan voters rejected a ballot initiative to legalize PAS in November, 1998, by a 70% to 30% vote. *See* Pratt, *supra* note 42, at n.22.

91. Washington v. Glucksberg, 521 U.S. 702, 706 (1997). *But cf.* at 734, n. 24 (Stevens, J., concurring) (stating that plaintiffs' claim is a facial challenge to the constitutionality of Washington's prohibition of PAS and that the statute might not survive a more particular

argument that *Cruzan*[92] was premised upon concepts of personal autonomy, instead asserting that the decision in that case was based largely on the common law rule regarding forced medication as a battery.[93] Therefore, the Court in *Glucksberg* determined that the right to refuse medical treatment could not "be somehow transmuted into a right to assistance in committing suicide."[94] Thus, there is no fundamental Due Process right to assisted suicide. The Court determined that the Washington statute[95] prohibiting PAS did not violate the Fourteenth Amendment either facially or as applied.[96]

The focus now turns to Oregon, the only state in the Union in which PAS is currently legal.[97] Some right to die advocates see legalized PAS as the first step to legalizing euthanasia.[98] Oregon's Death With Dignity Act has been in effect for two years.[99] Whether or not that law will stand depends in part on whether or not the Pain Relief Promotion Act[100] becomes law.

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challenge).

92. *See* Cruzan v. Director, 497 U.S. 261 (1990).

93. Washington v. Glucksberg, 521 U.S. 702, 725 (1997).

94. *Id.* at 725-26.

95. *See* WASH. REV. CODE § 9A36.060(1)(1994).

96. *See* Washington v. Glucksberg, 521 U.S. 702, 735 (1997) (holding that the statute does not violate the Fourteenth Amendment "*as applied* to competent, terminally ill adults who wish to hasten their deaths by obtaining medication prescribed by their doctors.") (emphasis added).

97. *See* OHD Report, *supra* note 47. It is important to note that Oregon is the only place in the world where PAS is technically legal. *See id.* at 7. The Northern Territory of Australia legalized PAS for a short time (from July 1996 through March 1997). *See id.* In the Netherlands, PAS is often practiced without prosecution, although it is not technically legal. *See id.*

98. *See* Barnett, *supra* note 33, at A11. Derek Humphry, one of the founders of the Hemlock Society, sees PAS as the initial step to legalized euthanasia. *See id.* In Washington in 1991 and California in 1992, voters rejected initiatives that would have legalized euthanasia. *See id.* These rejections help explain why the Oregon initiative introduced PAS and not euthanasia. *See id.* Dr. Greg Hamilton, president of Physicians for Compassionate care (a group that opposes euthanasia and PAS) believes that "the line between assisted suicide and euthanasia is a false one, drawn for political purpose." *Id.*

99. *See* Hess, *supra* note 7, at A1-A2.

100. *See* Pain Relief Promotion Act H.R. 2260, 106th Cong. § 1 (1999). Note that some PAS advocates are already trying to find ways to circumvent the law should it become effective. *See* Erin Hoover Barnett, *Activists Turn Inventive to Aid Suicide Option,* THE OREGONIAN, November 12, 1999 at A1. Right-to-die activists convened at a Seattle hotel and presented suicide devices that do not involve the use of controlled substances. *See id.*

B. *Oregon's Death With Dignity Act*

1. *Background: Implementing the Act*

PAS became legal[101] in Oregon on October 27, 1997.[102] In 1998, at least fifteen people died[103] from taking lethal medications prescribed by their physicians.[104] The Death With Dignity Act has been and continues to be challenged.[105] In *Lee v. Oregon,* a coalition of terminally ill patients, their physicians, and several nursing homes challenged the constitutionality of the Act.[106] The Ninth Circuit Court of Appeals rejected Plaintiffs' claim that the Act violated the Equal Protection Clause of the Fourteenth Amendment on the grounds that the Plaintiffs did not have standing because there was no "injury in fact."[107] The court's rationale was that an injury could not be based on the *possibility* of patients taking their lives "against their true intent."[108]

Apparently, a patient would already have to be dead in order to have standing in the Ninth Circuit. Thus, the court did not decide the merits of the case; it merely ruled that the federal courts did not have jurisdiction because the plaintiffs did not have the proper standing.[109] Therefore, whether or not the Death With Dignity Act violates the Equal Protection Clause remains undecided.

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101. Although the Act was originally passed by Oregon voters (on a 51% to 49% vote) as a citizen's initiative, the Act was not immediately implemented due to a legal injunction. *See* OHD Report, *supra* note 47.

102. The statutes legalizing PAS are also known as the Death With Dignity Act. OR. REV. STAT. §§ 127.800-127.897 (1998).

103. *See* Arthur E. Chin, et al., *Legalized Physician-Assisted Suicide in Oregon—the First Year's Experience,* 340 THE NEW ENGLAND JOURNAL OF MEDICINE (February 18, 1999) <http://www.nejm.org/content/1999/0340/007/0577.asp>.

104. It is important to note that although fifteen people died from taking the lethal prescriptions, a reported total of twenty-three people received prescriptions for lethal medications. *See id.* This information was provided to the Oregon Health Division. *Id.* Of the twenty-three patients, fifteen died from the lethal medication, six from their actual illnesses, and two remained alive as of January 1, 1999. *See id.*

105. *See* Lee v. Oregon, 107 F.3d 1382 (1997).

106. *See id.* at 1392.

107. *Id.* at 1390. (overturning the ruling of the court below that granted summary judgment for Plaintiffs and permanently enjoined the Act's enforcement on August 3, 1995) *See id.* at 1386. *See also* Lee v. Oregon, 891 F.Supp. 1439 (1995) (issuing permanent injunction); Lee v. Oregon, 891 F.Supp. 1429 (holding that the Act violated the Equal Protection Clause because it did not adequately protect incompetent, or depressed, terminally-ill adults).

108. Lee v. Oregon, 107 F.3d 1382, 1388 (1997).

109. Note that the court also held that the doctors of these patients have no standing to bring suit on their behalf. *See id.* at 1390.

2. Death With Dignity Act violates Equal Protection and the ADA

An Equal Protection analysis of the Death With Dignity Act suggests that the Act violates the Fourteenth Amendment.[110] Of the fifteen people who legally committed suicide in 1998 with the assistance of their physicians, none of the choices resulted from "intractable pain or suffering".[111] The primary reason these patients chose to die was because they feared loss of independence.[112] Accepting worries about potential need for living assistance as a legitimate reason for doctors helping patients commit suicide places disabled and elderly people at lethal risk.[113] This insidious thinking engenders a patronizing attitude toward the disabled that is demoralizing and demeaning. "The dehumanizing message is that society regards such lives as undignified and not worth living."[114] This explains why nine disability-rights organizations oppose legalizing PAS, while none support it.[115]

The Death With Dignity Act gives terminally ill individuals a license to kill themselves.[116] By sanctioning death for these individuals while extending suicide protections to other individuals, Oregon denies the former individuals equal protection of the laws.[117] Because Oregon's law applies suicide policies in an unequal manner, it thereby implicates strict scrutiny analysis.[118] Further,

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110. *See* Wesley Smith, *Oregon Releases Information on Reported Assisted Suicide Death,* WALL ST. J., Feb. 25, 1999 (visited Oct. 8, 1999) < http://iaetf.org/orr299.htm>.

111. *Id.* Diagnosis of a terminal disease often leads to depression which may involve seeing things in black or white. *See* HENDIN *supra* note 12 at 24. "When a patient finds a doctor who shares the view that life is worth living only if certain conditions are met, the patient's rigidity is reinforced." *Id.*

112. *See* Smith, *supra* note 110. The fear of losing independence includes fears of needing help with going to the toilet, performing daily activities and bathing. *See id.* These concerns involve a much larger number of disabled people than terminally ill people. Also, the fear of dependency concerns people who are not yet dependent, and, similar to other difficulties in life, people adjust to it with time. *See id.*

113. *See id.*

114. *Id.*

115. *See id.* Diane Coleman, attorney and organizer of the advocacy group Not Dead Yet, as well as a wheelchair user since age eleven, points out that courts have relied on the liberty and equal protection clauses of the Fourteenth Amendment to support allowing assisted suicide for disabled people "while ignoring the possibility that such assistance may itself violate equal protection." Diane Coleman, *Withdrawing Life-Sustaining Treatment From People With Severe Disabilities Who Request It: Equal Protection Considerations,* 8 ISSUES LAW & MED. 55, 71-2, (1992).

116. *See* OR. REV. STAT. §§ 127.800-127.897 (1998).

117. *See* Coleman, *supra* note 115, at 57. Equal protection means "[n]o State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws." U.S. CONST. amend. XIV § 1.

118. *See* Coleman, *supra* note 115, at 76. *See generally* City of Cleburne v. Cleburne Living Center, 473 U.S. 432 (1985) (applying heightened scrutiny to discrimination against

recent federal legislation intimates that disabled individuals constitute a suspect class suggesting that heightened scrutiny applies.[119]

In addition to Fourteenth Amendment Equal Protection concerns, the Act also violates the Americans With Disabilities Act (ADA).[120] The ADA seeks, in part, "to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities".[121] The report on Oregon's Death With Dignity Act specifically states that ending life according to the Act is *"not suicide"* then goes on to state that it will nevertheless be referred to as physician-assisted suicide because that is the term commonly used by both the public and the medical community.[122] Arbitrarily renaming the act of intentionally swallowing a lethal overdose as "not suicide" is egregious doublespeak. The point is that an act of suicide does not transmute into an acceptable solution merely because the actor has a terminal illness or condition.[123] By applying a different standard to individuals

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class with immutable trait).

119. *See* 42 U.S.C. §12101 (a)(7). "[I]ndividuals with disabilities are a discrete and insular minority who have been faced with restrictions and limitations, subjected to a history of purposeful unequal treatment, and relegated to a position of political powerlessness in our society, based on characteristics that are beyond the control of such individuals and resulting from stereotypic assumptions not truly indicative of the individual ability of such individuals to participate in, and contribute to, society." *Id.*

120. 42 U.S.C. § 12101 (a)(5). "The Congress finds that . . . individuals with disabilities continually encounter various forms of discrimination, including *outright intentional exclusion . . . exclusionary qualification standards and criteria*, segregation, and relegation to lesser services, programs, activities, benefits, jobs, or other opportunities." *Id.* (emphasis added). By excluding disabled individuals from the protection of laws against suicide, the Death With Dignity Act unlawfully discriminates against them. *See* OHD Report, *supra* note 47, at 1 (stating that ending life in compliance with the Act does not constitute suicide).

121. 42 U.S.C. § 12101 (b)(1) (1999).

122. *See* OHD Report, *supra* note 47, at 1. It is important to note that the report is based only on data collected from doctors who prescribed lethal overdoses. The authors of the report did not collect data from family members of the decedents nor did they collect information from patients prior to their deaths. *See id.* at 3. Another interesting point is that of the twenty-three patients who requested lethal prescriptions, the report's authors collected data from only the fifteen who died from the overdoses, not from the six who died from their underlying illnesses or from the two who were still alive as of January 1, 1999. *See id.* at 3-4.

123. *See* Carol J. Gill, *Suicide Intervention For People With Disabilities: A Lesson in Inequality*, 8 ISSUES LAW & MED. 37, 49-51 (1992). "In a society that fears and rejects life with disability, people with disabilities need laws and the courts to safeguard their equal access to suicide prevention." *Id.* at 51. A suicide request from a disabled person should be "explored as rigorously and objectively as it would be for anyone else, including the specific reasons behind it and possible solutions." *Id.* at 50. Consider the case of Elizabeth Bouvia, a California woman with cerebral palsy who brought suit to procure a right to die in 1983. *See id.* at 42. Bouvia expressed a desire to die at age twenty-six after several traumatic events, including a miscarriage, a marital separation, and the loss of financial support. *See* Coleman, *supra* note 115, at 55-56. Despite these traumatic experiences, the court, the ACLU attorneys (who sued seeking a court-ordered right-to-die for Bouvia), the psychiatric professionals, and the media

with terminal conditions, the Death With Dignity Act unlawfully discriminates against them.[124]

America does not put discrimination up for a majority vote.[125] The Death With Dignity Act conflicts with the Americans With Disabilities Act, and federal law trumps state law.[126] Therefore, the former must fall. The Death With Dignity Act creates "the ultimate form of discrimination, legalizing lethal overdoses based on the health status of the victim."[127]

3. *Death with Dignity Act's Safeguards Failed*

The Death With Dignity Act addresses the problem of determining whether or not suicide requests are the result of underlying mental distress by suggesting that physicians who believe their patients are suffering from depression or a psychological disorder refer their patients to counseling.[128] However, it is important to note that referral is based on the physician's opinion and is not mandatory.[129] This provision may prove a rather poor prophylactic measure, especially in cases where the doctor and patient do not have a well-established relationship.[130] In addition, in cases where the patient is disabled to some extent, underlying and perhaps even subconscious

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simply assumed the rationality of Bouvia's death wish. *See id.* at 56. They never questioned whether depression was a factor. *See id.* By the time the judicial proceedings finished, Bouvia's crisis had passed and she no longer desired death. *See id.* at 56.

124. *See* Coleman, *supra* note 115, at 56.

125. *See Hearing on the Lethal Drug Abuse Prevention Act Before the House Judiciary Subcomm. on the Constitution* (1998)(statement of Diane Coleman, Attorney and Organizer, Not Dead Yet)[hereinafter Coleman's testimony].

126. *See id.*

127. *Id.*

128. *See* OR. REV. STAT. §127.825 § 3.03 (1998). The statute reads:

> If in the opinion of the attending physician or the consulting physician a patient may be suffering from a psychiatric or psychological disorder, or depression causing impaired judgment, either physician shall refer the patient for counseling. No medication to end a patient's life in a humane and dignified manner shall be prescribed until the person performing the counseling determines that the patient is not suffering from a psychiatric or psychological disorder, or depression causing impaired judgment.

Id.

129. *See id.*

130. The first woman to commit physician-assisted suicide under the Death With Dignity Act had a two-and-a-half week relationship with her doctor, to whom she was referred by an advocacy group after her own doctor refused to assist her, as did another doctor (who diagnosed her with depression). Six of the people who died from PAS tried to obtain lethal prescriptions from two or more doctors. *See* Wesley J. Smith, International Anti-Euthanasia Task Force Oregon Releases Information on Reported Assisted Suicide Deaths, (visited Oct. 8, 1999) <http://iaetf.org/orr299.htm>. *See also* QUILL, *supra* note 30, at 162-163 (admonishing the need for a well-established relationship not based solely on an assisted-suicide request).

prejudices may preclude the physician from looking further into the possible psychological motivations, such as depression, for the patient's request for suicide.[131]

As a means of policing the practice of PAS, the Death With Dignity Act requires that physicians file reports each time they write a prescription for lethal medication.[132] The documentation must include: (1) all requests for lethal prescriptions (both oral and written); (2) the physician's diagnosis and determination that the request is voluntary; (3) the verification of the consulting physician; (4) a report of the outcome of any [optional] counseling; (5) offer to rescind a second oral request; and (6) paperwork verifying that all the requirements of the statute were met.[133] Physicians who prescribed lethal medications submitted this data which was available to the Oregon Health Division when it published its first annual report.[134]

However, the authors of the report chose not to include the data from the six patients who received but did not take the lethal medication in their analysis.[135] The remarkably oblique reason for not doing so is stated in the report: "We did not [sic] conduct similar analyses of persons who received lethal medications, but chose not to use them, because of the small number of patients [six] in this group."[136]

This is a curious rationale because the six people make up roughly twenty-eight percent of the entire group, and therefore the data from the six patients is statistically significant.[137] Further, by disregarding data on subjects who differ from the norm, the scientific validity of the study is lost.[138] The

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131. Diane Coleman testified on Capitol Hill: "I wish that this civil rights violation were as obvious to everyone as it would be if assisted suicide were legalized based on gender or race. Policymakers have completely ignored the ADA violations inherent in assisted suicide laws." *See* Coleman's testimony, *supra* note 125, at 3.

132. OR. REV. STAT. 127.855 § 3.09 (1998).

133. *See id.*

134. *See* OHD Report, *supra* note 47, at 2.

135. *See id.* at 3.

136. *Id.*

137. *See* JEFFERSON HANE WEAVER, CONQUERING STATISTICS 41 (1997). The example the book gives is a sampling of 200 students who took shop class out of a total student population of 800 students. *See id.* Because the 200 students constitute 25% of the entire student body, the 200 student sampling is very significant. *See id.* Thus, it follows that a sample, such as the six patients who did not ingest the lethal medications, constituting nearly 28% of the total group, is even more statistically significant. *See id.*

138. *See id.* at 157. Conveniently discarding negative results suggests "a certain lack of scientific integrity to the entire . . . process." *See id.* Also, consider the statement of Dr. Kenneth R. Stevens, chairman of the department of radiation oncology at Oregon Health Sciences University: "They [the administrative rules on data collection] are analogous to doctors performing an experiment of giving instructions and instruments to patients for them to remove their own gallbladders at home, with the only monitoring being the number of gallbladders received by the Oregon Health Division." Patrick O'Neill, *Testimony Differs on How Much Information the Oregon Health Division Should Collect on Physician-Assisted*

data from these six patients, how it compares to the data from the other fifteen, and why these six people decided not to take the lethal medication are all relevant factors.[139] The authors claim to be neutral on the issue of assisted suicide.[140] Making the information collected available to the public is one of the Act's requirements.[141] But if only part of the information is made public, then an assertion of neutrality is misrepresentative. The authors go on to say that future reports may not contain as much detail as the 1998 report.[142]

In addition to concerns about complete and accurate data reporting, the Death With Dignity Act is problematic because it provides no punishment for doctors who do not comply with the reporting requirements.[143] However, according to the doctors[144] who drafted the 1998 report, the Act requires the Oregon Health Division report noncompliance to the Oregon Board of Medical Examiners.[145] But this requirement became inconsequential when state medical examiner Dr. Larry Newman announced in March, 1998, that his office will not investigate assisted suicide deaths.[146]

Suicide and What Then Should Be Done With the Data, THE OREGONIAN, March 21, 1998, *available in* 1998 WL 4191996.

139. *See id.* Dr. Kenneth R. Stevens, Jr. advised the Health Division to evaluate the data in a scientific way. *See id.* Health division officials said, "[I]t isn't the state's job to do research into the effectiveness of the suicide law. The main purpose of the record-gathering requirement is to make sure that the law's safeguards are working." *Id.* Barbara Coombs Lee, a key advocate of the Act, believes academic researchers, rather than the Health Division, should conduct research on how well the law works. *See id. Compare* Julie Belian, Note, *Deference to Doctors in Dutch Euthanasia Law,* 10 EMORY INT'L L. REV. 255, 257 (explaining how the Dutch judiciary gave oversight of euthanasia to the medical community, an extra-governmental body).

140. *See* OHD Report, *supra* note 47, at 10.

141. *See* OR. REV. STAT. 127.865 § 3.11 (3) (1998). "The Health Division shall generate and make available to the public an annual statistical report of information collected under subsection (2) of this section." *Id.*

142. *See* OHD Report, *supra* note 47, at 10.

143. *See* OR. REV. STAT. §§ 127.800-127.897 (1998).

144. The Act itself states only that "[t]he Health Division shall annually review a sample of records maintained pursuant to ORS 127.800 - 127.897." OR. REV. STAT. 127.865 § 3.11(1) (1998). Section 3.11(2) gives the Oregon Health Division rulemaking power over the collection of the data. *See* OR. REV. STAT. 127.865 §3.11(2) (1998).

145. *See* Arthur E. Chin, et al., *Legalized Physician-Assisted Suicide in Oregon—the First Year's Experience,* 340 NEW ENG. J. MED. 577-583, February 18, 1999. The authors of this article are the same doctors who drafted *Oregon's Death With Dignity Act—The First Year's Experience. See* OHD Report, *supra* note 47.

146. *See* O'Neill, *supra* note 138, at 162-63. Dr. Newman announced this in a newsletter. *See id.* The governor's office convened a panel consisting of public officials, the medical examiner, the state attorney general's office, the Oregon State Police, the Health Division, and various licensing boards. *See id.* The panel made the decision not to investigate the deaths. *Id. Compare* Belian, *supra* note 139, at 255-57 (explaining how the courts in Holland conceded control of euthanasia law to the medical community).

However, *The Oregonian* reported that the medical examiner's office investigated the March 10, 1999 death of Patrick Matheny[147] at the request of Paul Burgett, Coos County, Oregon district attorney. Because Matheny was almost completely paralyzed from his disease, his brother-in-law, who was alone with him in his trailer at the time, helped Matheny commit suicide.[148] The nurse who conducted the inquiry[149] did not question the brother-in-law, so exactly how the death took place remains unclear.[150] The district attorney concluded that the brother-in-law's assistance was a legal act and that "a person who is disabled should have the right to physician-assisted suicide, as long as they are otherwise qualified."[151] This case demonstrates that there is no bright line between PAS and euthanasia.[152]

Consider, as further evidence that the safeguards are inadequate, the case of Kate Cheney.[153] After doctors diagnosed Kate with inoperable stomach cancer at age eighty-five, she sought a lethal prescription.[154] The first doctor did not prescribe a lethal overdose, so Kate went to a second doctor, who recommended a psychiatric evaluation.[155] Upon evaluating the patient, the psychiatrist determined that she suffered from dementia and did not have the mental capacity required for making a voluntary decision, and, therefore, the doctors denied the request for a lethal prescription.[156] After three doctors

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147. *See* Erin Hoover Barnett, *Coos County Drops Assisted-Suicide Inquiry,* THE OREGONIAN, March 17, 1999, *available in* 1999 WL 5326260. Patrick Matheny, 43, had Lou Gehrig's disease. *See id.*

148. *See id.*

149. The examiner was Kris Kracher, R.N. and assistant to the Coos County chief deputy medical examiner. *See id.*

150. *See id.* The examiner did speak with the decedent's father who told her that the brother-in-law told him that he held a chocolate drink mixed with lethal medication so that his son could drink from a straw. *See id.*

151. *See id.*

152. *See* Barnett, *supra* note 33. Dr. Greg Hamilton, president of Physicians for Compassionate Care, said: "It's very clear to anyone who knows a lot about assisted suicide and euthanasia that the line between assisted suicide and euthanasia is a false one, drawn for political purpose." *Id.*

153. *See* Erin Hoover Barnett, *A Family Struggle: Is Mom Capable of Choosing to Die?,* THE OREGONIAN, October 17, 1999, *available in* 1999 WL 28267694. Kate Cheney and her family voluntarily shared their story so that they could assist people in better understanding Oregon's PAS law. *See id.* They initiated the contact with a letter to the editor opining that the legal safeguards of the Death With Dignity Act were "roadblocks to Kate's right to a lethal prescription." *Id.*

154. *See id.*

155. *See id.* Kate's daughter, Erika (who was caring for her at the time), thought the first doctor was "dismissive", and it was she who requested a second doctor. *Id.* at 5. Arranging a psychiatric evaluation is the standard operating procedure of Kaiser Permanente, Kate's HMO. *See id.*

156. *See id.* During the evaluation, which occurred in the patient's home, her daughter "coached her a few times, even after the psychiatrist asked her not to." *Id.* The psychiatrist also noted that Kate's daughter became angry at the assessment, whereas the patient herself accepted

declined approval of her assisted-suicide request, Kate sought another competency evaluation, this time with a clinical psychologist.[157] The psychologist concluded that "there was no severe impairment that would limit Kate's ability to make a medical decision."[158] Faced with contradicting competency evaluations, Dr. Robert Richardson, director of Kaiser Permanente's ethics department, met personally with Kate and determined that she was competent and her decision was voluntary.[159] Kate received her lethal prescription from Kaiser's pharmacy,[160] and she then killed herself on August 29, 1999.[161]

This case demonstrates the failure of the Death With Dignity Act's safeguards.[162] The first psychiatrist determined the patient was cognitively impaired and subject to coercion by family members, then "a single HMO official ended up making the decision and Kaiser Permanente is a fully capitated HMO with a profit-sharing plan for its doctors."[163] This case clearly indicates that "once assisted suicide is legalized, there is no way to protect the vulnerable and mentally ill."[164]

IV. EUTHANASIA AND PAS IN THE NETHERLANDS

A. *The History of Euthanasia and PAS in the Netherlands*

Euthanasia is not technically legal in the Netherlands.[165] Articles 293 and 294 of the Dutch Criminal Code prohibit euthanasia and PAS.[166] Killing a person upon request by that person is prohibited by Article 293.[167] However,

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it. *See id.* The psychiatrist also noted that the patient "does not seem to be explicitly pushing for this". *Id.* at 5-6.

157. *See id.* The psychologist noted that Kate's choices "*may be influenced by her family's wishes and her daughter, Erika, may be somewhat coercive.*" *Id.* at 7 (emphasis added). Erika herself stated,"I realize I sound real aggressive and assertive." *Id.*at 7. She also said, "I realize I've been standing up on the roof with a banner and Mom's been standing behind with a little flag." *Id.* at 7.

158. *See id.*

159. *See id.* Consider this question: "Would an HMO call for a second opinion if the first psychiatrist deemed a patient competent to request assisted suicide?" David Reinhard, *In the Dark Shadows of Measure 16,* THE OREGONIAN, Oct. 31, 1999, *available in* 1999 WL 28271446.

160. See Barnett, *supra* note 153, at 8.

161. *See* Steve Duin, *Kate Cheney Still Doesn't Rest in Peace,* THE OREGONIAN, Nov. 11, 1999, *available in* 1999 WL 28274623.

162. *See* Reinhard, *supra* note 159.

163. *Id.*

164. *Id.* (quoting Dr. Gregory Hamilton of Physicians for Compassionate Care).

165. *See* GRIFFITHS, *supra* note 24, at 18.

166. *See id.*

167. *See id.*

suicide itself is not illegal.[168] Over eighty percent of Dutch citizens favor legalized euthanasia as an available choice.[169] Although euthanasia and PAS are forbidden by law, the truth is that the exception has essentially swallowed the rule. The exception is Article 40, and it allows doctors charged under Articles 293 and 294 to make a *defense* of justification.[170] The defense of justification is that one who commits "an offense due to a force he could not be expected to resist [*overmacht*] is not criminally liable."[171]

The Dutch Penal Code has explicitly prohibited assisted suicide and euthanasia since 1886.[172] However, the Dutch courts began to tolerate PAS and euthanasia for competent terminally ill patients in the 1970s.[173] The judiciary in the Netherlands basically allowed the medical community to police itself.[174] The Royal Dutch Medical Society, the Koninklijke Nederlandsche Maatschappij tot beverdering der Geneeskunst (KNMG), was primarily responsible for crafting methods of prosecution and punishment regarding euthanasia.[175]

In 1984, the Dutch Supreme Court issued a landmark decision upholding the 1983 acquittal[176] of a doctor who argued the defense of justification.[177] The court determined that the defense of justification due to necessity could be

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168. *See id.*

169. *See* HENDIN, *supra* note 12, at 98. As an example of public opinion in the United States, consider an opinion poll done in California that showed that 68% of the population of that state favored medical aid in dying. *See* EUTHANASIA EXAMINED, *supra* note 40, at 87. When exposed to examples of the abuse that doctors would have discretion to impose, the poll numbers dropped to 49% in favor. *See id.*

170. *See* GRIFFITHS, *supra* note 24, at 326.

171. *Id.*

172. *See* CHARLES T. CANADY, PHYSICIAN-ASSISTED SUICIDE AND EUTHANASIA IN THE NETHERLANDS: A REPORT TO THE HOUSE JUDICIARY SUBCOMMITTEE ON THE CONSTITUTION (2d. Sess. 1996), *reprinted in* 14 ISSUES LAW & MED. 301 (1998).

173. *See id.* Public discussion of euthanasia and PAS in the Netherlands accelerated in 1973 when the criminal court at Leeuwarden sentenced a doctor to one week (suspended sentence) for lethally injecting her mother. This case is demonstrative of the legal tolerance for euthanasia in the Netherlands. *See id.* at 306-307. See also GRIFFITHS, *supra* note 24, at 52-53 (explaining how euthanasia began gaining acceptance in the Netherlands).

174. *See* Belian, *supra* note 139, at 257.

175. *See id.* "In its acceptance of the KNMG guidelines and the defense of "necessity" the judiciary has, for all practical purposes, deferred to a completely extra-governmental body: the medical community." *Id.*

176. *Schoonheim* was the first case where a physician was acquitted using the Article 40 defense of justification. *See* GRIFFITHS, *supra* note 24, at 19.

177. *See id.* at 18-19. *See also* CANADY, *supra* note 172, at 301 (explaining that the 1984 decision regarding the defense of justification expanded the acceptance of euthanasia and PAS to chronically ill elderly adults who were not terminal).

used even when the patient is not terminal.[178] Since the Dutch Supreme Court handed down this decision, euthanasia and PAS are very rarely prosecuted in the Netherlands.[179]

The implication of the Dutch Supreme Court's decision is that although technically illegal, euthanasia and PAS are routinely practiced with a virtual guarantee of immunity. In 1986, the Dutch medical association and the nurses association promulgated *Guidelines for Euthanasia*.[180] The current requirements that must be met before the Article 40 defense of justification can be used are as follows:

> 1. The request for euthanasia must come only from the patient and must be entirely free and voluntary.
> 2. The patient's request must be well considered, durable and persistent.
> 3. The patient must be experiencing intolerable (but not necessarily physical) suffering, with no prospect of improvement.
> 4. Euthanasia must be a last resort. Other alternatives to alleviate the person's situation must have been considered and found wanting.
> 5. Euthanasia must be performed by a physician.
> 6. The physician must consult with an independent physician colleague who has experience in this field.[181]

Despite these guidelines, the criteria remain vague and a great deal of discretion is given to physicians.[182]

In 1986, the Dutch Supreme Court held the necessity defense was available to doctors for necessity in the sense of "psychological compulsion" on the part of the doctor.[183] The Court's decision demonstrates its unwillingness to impose a request by the patient or unbearable suffering as prerequisites for the necessity defense since the defendant doctor's argument

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178. *See* GRIFFITHS, *supra* note 24.

179. *See id.* at 19.

180. *See* CANADY, *supra* note 172.

181. Facsimile from Clémence Ross-VanDorp, member of the Dutch Parliament, to Nico Foppen. (September 28, 1999) (copy on file with author).

182. *See* CANADY, *supra* note 172, at 301-02. It is important to note that the guidelines, while stating that patients' requests to end their lives must be voluntary, do not prevent the doctor from making a strong recommendation of euthanasia. *See* John Keown, *On Regulating Death; Dying Well? A Colloquy on Euthanasia and Assisted Suicide*, 22 HASTINGS CTR. REP. 39 (1992).

183. *Id.* (quoting Netherlandse jurisprudentie, 607 (1987): 2129).

was merely that he was overcome with psychological pressure [*psychische overmacht*].[184] The ramification of this is that doctors who experience an overwhelming desire to end the lives of their patients may very likely escape punishment and prosecution entirely. In 1990, the Minister of Justice informed prosecutors not to request police investigations of euthanasia unless they had reason to suspect noncompliance with the criteria.[185] Since it is unlikely that a physician would voluntarily report noncompliance with the guidelines in these situations, and the patient is no longer alive to convey the tale to the police, the probability that the police will have reason to suspect is practically nonexistent.

The Dutch Supreme Court broadened the defense of justification in June, 1994, when it convicted, *without punishment*, a psychiatrist, Dr. Doudewijn Chabot, for helping a patient,[186] who was physically healthy but suffered from a depressive disorder, commit suicide.[187] The Supreme Court rejected the prosecutor's argument that euthanasia and PAS are not justified without physical suffering or impending death.[188] However, the court found Dr. Chabot guilty because he did not get a valid second opinion since none of the physicians he consulted with actually saw the patient and there was "insufficient proof to support the defense of necessity" which is the normal mitigating factor in such cases.[189] This case is problematic because there is a question as to whether or not a person with a mental disorder can truly make a voluntary request.[190] Although the Court held the defense of justification did

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184. *See id.*

185. *See id.*

186. The patient was Hillie Hasscher, a fifty-year-old Dutch woman who was not terminally ill. However, she was suffering from the aftermath of a divorce, and had recently lost her two sons, one to cancer and the other to suicide. She was despondent and desired death as a solution. Her psychiatrist eventually provided her with twenty barbiturates dissolved in a glass of syrup which she consumed and then died listening to Bach. *See* William Drozdiak, *Dutch Seek Freer Mercy Killing; Court Could Ease Limits on Assisted Suicide,* THE WASH. POST, October 29, 1993 at A29. Ms. Hasscher was referred to Dr. Chabot by the Association for Voluntary Euthanasia. Dr. Chabot decided to grant her request upon determination that "her long-term psychic suffering. . .was unbearable and hopeless for her, and her request for assistance was well-considered." GRIFFITHS, *supra* note 24 at 81. Dr. Chabot also consulted with no fewer than seven of his colleagues, most of whom agreed with his decision, and none of whom thought it necessary to examine the patient. *See id.*

187. *See* Alan D. Ogilvie & S.G. Potts, *Assisted Suicide for Depression: The Slippery Slope in Action? Implications of a Case in the Netherlands in which a Physician Aided the Suicide of a Physically Healthy Patient with a Depressive Disorder,* 309 BRIT. MED. J. 492 (1994).

188. *See id.* The court said: "[A] doctor may be in a situation of necessity if he has to choose between the duty to preserve life and the duty as a doctor to do everything possible to relieve the unbearable and hopeless suffering of a patient committed to his care." *See* GRIFFITHS, *supra* note 24, at 81 (quoting Nederlandse Jurisprudentie 1994, no. 656:3154).

189. *See* GRIFFITHS, *supra* note 24, at 81.

190. This concern is voiced by one of the minority parties, the Christian Democrats, who

not apply in this particular case, it did state "that the wish to die of a person whose suffering is psychic can be based on an autonomous judgment."[191]

Thus, it seems that the court's decision violates the first of the six aforementioned criteria.[192] Essentially, the exceptions have swallowed the rule; therefore, it is no surprise that many people believe euthanasia is legal in the Netherlands.[193] Currently, the Dutch parliament is considering a proposal[194] that would not technically legalize euthanasia, but would further broaden its application and the exceptions for which it is allowed.[195]

B. *Preparations to Further Sanction Euthanasia in the Netherlands*

The proposed legislation set to come before Parliament states that euthanasia will remain technically illegal, but that doctors will not be prosecuted as long as they comply with the guidelines.[196] The proposal also states that cases where Article 40 (justification defense) is invoked will not have to be tried before a judge but may instead be tried before the commissions that monitor the procedures.[197] In addition, the proposal states that children as young as twelve will have the right to request euthanasia.[198] The proposal would not require parental consent.[199] The minister proposing this legislation plans to propose additional legislation allowing euthanasia on people who are unable to express their will sometime in the near future.[200]

The Royal Dutch Medical Association approves of the proposed legislation.[201] The expectation is that the legislation will pass smoothly through the Dutch Parliament, backed by the three government parties.[202] Otto

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are opposed to expanding the euthanasia laws. *See* Facsimile from Clémence Ross-VanDorp, *supra* note 181.

191. GRIFFITHS, *supra* note 24, at 81.

192. *See id.*

193. *See* GRIFFITHS, *supra* note 24.

194. De toetsing van levensbeëindiging op verzoek en hulp bij zelfdoding en tot wijziging van het Wetboek van Strafrecht en van de Wet op de lijkbezorging (Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding), Tweede Kamer, vergaderjaar 1998-1999, 26 691, nr. 3.

195. *See* Facsimile from Clémence Ross-VanDorp, *supra* note 181. The proposal is given by Minister Borst. *See id.*

196. *See id.*

197. *See id.*

198. *See id.*

199. *See id.*

200. *See id.*

201. *See* Charles Trueheart, *Holland Prepares Bill Legalizing Euthanasia,* THE WASH. POST, August 15, 1999, at A19.

202. *See Mercy Killing by Law; Holland Prepares to Approve Voluntary Euthanasia—Even for Children Aged 12,* LONDON DAILY MAIL, Aug. 11, 1999 at 24 [hereinafter *Mercy Killing by Law*]. *See also Dutch Move to Legalize Mercy Killing Parliamentary Approval Expected,* THE INDIANAPOLIS NEWS, Aug. 11, 1999, at A7.

P.G. Vos, Member of Parliament states, "There comes a moment when the jurisprudence has to be brought into the law."[203] Basically, Mr. Vos is saying everybody's doing it anyway so we may as well make it legal. This is not exactly a compelling argument for legalizing something as egregiously heinous as allowing children to be put to death without their parents' consent.

Opposition to the proposal comes from a rugged minority of Dutch, most of whom are practicing Christians.[204] The minority parties opposed to the legislation include the Christian Democrats and some small Calvinist parties.[205] Clémence Ross-VanDorp, Member of Parliament and a Christian Democrat, argues that "every single case of euthanasia must be judged by the court of law"[206] and that the proposal's provision for allowing euthanasia to be performed without parental consent is unconscionable.[207] The Christian Democrats also opposed the 1994 decision that allowed euthanasia and PAS for mental disorders. [208] Ross-VanDorp realizes that the minority parties have an uphill battle in parliament due to the majority parties'[209] backing of the expansion of the euthanasia laws.[210] However, she remains resolved to keep up the fight: "[A]s Churchill once said, 'Let them do their worst, we will do our best!'"[211]

C. *Statistics on Euthanasia and PAS in the Netherlands*

The first report on euthanasia was ordered by the Dutch government and was carried out by the Remmelink Committee in 1990 then published in 1991 (this study is commonly referred to as the Remmelink Report).[212] A second study was commissioned, again at the request of the government, in 1995 as a follow-up study and published on November 26, 1996.[213] The 1995 study

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203. Trueheart, *supra* note 201.

204. *See id.*

205. *See Mercy Killing by Law*, *supra* note 202, at 24.

206. Facsimile from Clémence Ross-VanDorp, *supra* note 181. In 1995, 1466 cases of euthanasia were reported. *See* Richard Fenigsen, *Dutch Euthanasia Revisited*, 13 ISSUES L. & MED. 301 (1997). The public prosecutors dismissed 1430 of these cases. *See id.* Only 36 cases were referred to the Attorney General's assembly. A mere five cases were tried in the courts. *See id.*

207. *See* Facsimile from Clémence Ross-VanDorp, *supra* note 181.

208. *See id.*

209. The majority government parties are Liberals and Social Democrats who form a coalition government. *See id.*

210. *See id.*

211. Letter from Clémence Ross-Van Dorp, member of the Dutch Parliament, to Cynthia Bumgardner, J.D. Candidate 2001 and member of the Indiana International & Comparative Law Review (October 5, 1999).

212. *See* Fenigsen, *supra* note 206, at 301.

213. *See id.* The study was published first in Dutch, and two days later *The New England Journal of Medicine* published the English summaries. *See also* 335 NEW ENG. J. MED. 1706

includes two groups that were mentioned in the 1990 study but not investigated, newborns and psychiatric patients.[214] The 1995 study is also distinguishable from the 1990 study because it places a greater emphasis on the "notification procedure."[215]

One particularly alarming statistic from the 1995 study is that forty-five percent of neo-natologists and thirty-one percent of general pediatricians reported that they "actively terminated a newborn's life" at some point in their careers.[216] The 1995 study shows that fifteen newborns died from their doctors' lethal injections that year.[217] An estimated 596 cases involved the withholding or termination of life-sustaining treatment.[218] In eighty-four of the 428 cases, the doctor administered drugs intended to hasten death.[219] Pediatricians cut off non-futile medical treatment "*without consulting the parents*" in twenty-three percent of the cases.[220]

Overall results from the comparison of the 1990 and 1995 studies illustrate an increase in euthanasia over time.[221] The 1990 study, the Remmelink Report, predicted this result.[222] The number of physician-assisted suicides was the same for both years: four hundred.[223] According to the studies, there were one thousand reported acts of involuntary euthanasia in 1990 and nine hundred in 1995.[224]

Scholars have found some significant discrepancies between the Dutch version of the Remmelink Report and the English-language synopsis of the report.[225] One notable omission from the English version of the Report was of the 0.8% of all euthanasia deaths (totaling one thousand) that were not the result of a voluntary decision by the patient.[226] The synopsis also omitted

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(1996).

214. *See* Fenigsen, *supra* note 206.

215. *Id.* The procedure, sanctioned by Parliament in 1994, requires that physicians who perform euthanasia upon or without the patient's request report their actions to the prosecutor who then has discretion to begin an investigation. *See id.*

216. *Id.*

217. *See id.*

218. *See id.*

219. *See id.*

220. *Id.* (emphasis added).

221. *See* GRIFFITHS, *supra* note 24, at 210.

222. *See id.* at 211.

223. *See id.* at 210. The significantly lower number of PASs may reflect a cultural difference between Dutch and American views on euthanasia and assisted suicide. Whereas the issue in the United States is framed largely as one of autonomy and self-determination, the push for euthanasia in the Netherlands came mainly from doctors insisting that it was a valid medical procedure. *See id.* at 111.

224. *See id.* at 210.

225. *See* EUTHANASIA EXAMINED, *supra* note 40, at 161.

226. *See id.* Note that although these numbers were not mentioned in the English-language synopsis, they were mentioned in subsequent commentaries on the subject such as the Griffiths book. *See, eg.* GRIFFITHS, *supra note* 24.

statistics regarding intentional drug overdoses with the intent to kill.[227] One implication of these omissions is that they are an attempt to hide the truth from the rest of the world.

The Remmelink Report[228] surveys posed no specific question regarding whether or not a patient's request for euthanasia or PAS was voluntary.[229] In sixty percent of the cases, the patient's request was purely oral.[230] Therefore, there is no way to determine the accuracy of doctors' statements regarding their patients' requests.[231] The Remmelink Report also shows that in a majority of the 10,558 cases (fifty-two percent) where a doctor intended to hasten death the patient made no explicit request.[232]

The Commission defends the one thousand cases of involuntary euthanasia on the assertion that the doctor's intervention was unavoidable because the patient suffered from "death agony."[233] This is the Commission's rationale for regarding these cases as physicians caring for the dying.[234] However, this line of reasoning is inherently problematic because the physicians "did not list 'agony' as a reason for killing these patients."[235] Rather, they listed no hope for improvement (60%), futility of medical treatment (39%), avoiding "needless prolongation" (33%), family coping difficulties (32%), "low quality of life" (31%), and least of all, pain or suffering (30%).[236] Regarding the last category, it seems curious that the deaths were not categorized under the category of alleviating pain rather than euthanasia without explicit request if the intent of the physician was truly to alleviate pain or agony.[237] The intent to promote merciful death is hardly served by extinguishing life without the patient's request because the doctor makes an arbitrary and inherently subjective decision regarding the illusive estimate of agony suffered.

Even cases where the physician claims the patient made a voluntary request become questionable when the patient has a psychiatric or mental disorder that very likely precludes a voluntary decision on the part of the patient. Five hundred and twenty-two psychiatrists responded to a questionnaire regarding assisted suicide in psychiatric practice.[238] Thirty-one percent believed that doctors should not grant requests for assisted suicide to

227. *See* EUTHANASIA EXAMINED, *supra* note 40, at 161.
228. The Report results were gleaned from surveys answered by physicians. *See id.* at 266.
229. *See id.* at 275.
230. *See id.*
231. *See id.*
232. *See id.*
233. *Id.* at 276.
234. *See id.*
235. *Id.*
236. *Id.*
237. *See id.*
238. *See* Fenigsen, *supra* note 206.

psychiatric patients.[239] Twelve psychiatrists reported that they assisted a psychiatric patient commit suicide within the past year.[240]

A comprehensive report on the 1990 and 1995 studies presents five conclusions:[241] (1) The majority of euthanasia and PAS cases and almost all non-voluntary euthanasia cases are not reported. Therefore, control by legal authorities is nearly impossible. (2) Euthanasia makes up about 3.4-6% of all deaths. The percentage increases to 4.9-8.6% of deaths occurring with a doctor in attendance. (3) Incompetent patients, usually severely handicapped newborns,[242] are intentionally killed with the acceptance of the courts. (4) The Netherlands has a shortage of palliative care facilities, i.e. hospice care. The report concludes that this is due to the use of euthanasia as a "substitute for palliative care."[243] (5) "The Dutch experiment of trying to regulate euthanasia while at the same time keeping it under control has failed."[244]

The finding that widespread acceptance of euthanasia proves detrimental to palliative care leads to the conclusion that euthanasia is "usually avoidable."[245] Dutch palliative care physician Dr. Ben Zylicz told the House of Lords that euthanasia is often unnecessary and is "proving detrimental to the practice of medicine."[246] Dr. Zylicz also warns that the practice of non-voluntary euthanasia is becoming prevalent in the Netherlands and that the 1984 guidelines are often breached.[247] Dr. Zylicz admonished the House of Lords, "If you accept euthanasia as a solution to difficult and unresolved problems in palliative care, you will never learn anything."[248] Professor Lord McColl of the House of Lords concluded that "[E]uthanasia is impossible to police and will be abused."[249]

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239. *See id.*

240. *See id.*

241. *See* Prepared Statement of H. Jochemsen, Ph.D., Director of the Lindeboom Institute, the Netherlands, Testimony Before the House Commerce Committee Health and Environment Subcommittee (March 6, 1997), *reprinted in* Federal News Service, *available in* LEXIS, News Library, Netherlands File. [hereinafter Prepared Statement of H. Jochemsen].

242. Note that public opinion polls show that 71% of the Dutch people believe it is acceptable for a doctor to lethally inject a "severely defective newborn baby" with the consent of the parents. Fourteen percent of the population opposes this. *See* GRIFFITHS, *supra* note 24, at 200. The term "severely defective newborn" seems inherently biased and may have affected the outcome of the poll. The label "defective" stigmatizes the disabled infant.

243. Prepared Statement of H. Jochemsen, supra note 241.

244. *Id.*

245. Hugh Matthews, *Better Palliative Care Could Cut Euthanasia*, 317 BRIT. MED. J. 1613 (1998).

246. *Id.*

247. *See id.*

248. *Id.*

249. *Id.*

Perhaps the most alarming statistic of all regards the opinion of elderly Dutch citizens. A survey of randomly selected elderly citizens[250] shows that 66% of those living independently were opposed to government-sanctioned euthanasia, and *95% of the nursing home residents were opposed.*[251] The obvious implication of these statistics is that nursing home residents fear for their lives.[252]

V. CONCLUSION AND PROPOSALS

Arguments against euthanasia and PAS far outweigh arguments in favor. Holland's current legal situation illustrates the dangers that result when the government sanctions euthanasia and PAS. Discrimination against the disabled, the elderly, and the mentally ill inevitably results from the practices of euthanasia and PAS. Therefore, any state law attempting to authorize PAS, euthanasia, or both, violates the Americans With Disabilities Act. The *Lee* decision does not preclude this determination because its holding was limited to the fact that Plaintiffs did not have standing. A plaintiff with proper standing could have the Death With Dignity Act overruled. The Act also violates the Equal Protection Clause of the Fourteenth Amendment. Alternatively, Congress should pass the Pain Relief Promotion Act, and the President should sign it. Future generations should recognize as self-evident truths that all Americans, not merely the strong and the healthy, are entitled to life, liberty, and the pursuit of happiness.

The Supreme Court correctly maintains the rational distinction between removal of life-saving treatment and the active termination of life. The Court should stand firm on this distinction and not carve out exceptions that would pave the way for a general right to die. The proverbial saying 'hard cases make bad law' rings especially true here.

Because the issues concerning PAS and its implementation involve matters of life and death, future reports should contain more rather than less

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250. The survey was based on interviews with 132 citizens living both independently and in nursing homes. Seventy-six of the respondents were living independently and 56 lived in various nursing homes. *See* EUTHANASIA EXAMINED, *supra* note 40, at 155.

251. *See id.* (emphasis added).

252. The comments given by those interviewed in response to the question, "Do you have anything further to say in connection with these question?" is indicative of the predicament. *See id.* (*quoted in* J.H. Segers, *Elderly Persons on the Subject of Euthanasia,* 3 ISSUES L. & MED. 407-424 (1988)). These comments include the following: "The unnecessary stretching of human life is inhumane."; "I hope that people will have a change of heart, the Netherlands is leading the way, that is frightening."; "When government officials get older, they will get their turn."; "If euthanasia is passed, then things can become difficult for believers."; "We still want to live long and happily."; "See to it that someone comes by once again."; "Older people are shoved into a corner, they certainly have a right to live."; "There is a great danger that euthanasia will be misused."; and "What are we up to?" *Id.* at 157. (Note that these statistics were reported in 1988).

information. In order to prevent potential abuses, understanding why some patients who received lethal medications did not take them is vital. So long as Oregon's assisted-suicide law remains in effect, future reports should analyze the complete set of data, including that of the patients who do not take the lethal prescriptions. The law requires that doctors record all requests for lethal medication as well as prognosis and competency determination; therefore this data is available. Scientifically valid conclusions require analysis of all the data.

There is no bright line between PAS and euthanasia, as the case of Patrick Matheny clearly illuminates. Therefore, if Oregon's law remains effective it will eventually result in an increasing number euthanasia cases. This further endangers many vulnerable individuals such as the disabled and the elderly who may be depressed and subject to coercive family members. Justice demands that the law protect these individuals.

Hospice care provides a viable alternative to legalized euthanasia or PAS. Medical schools should emphasize palliative care, as the Pain Relief Promotion Act indicates. This calls for reevaluation of existing policies. By denying contact with hospice patients, medical schools deprive future physicians of a valuable educational opportunity. Further, the practice of euthanasia undermines palliative care—the Dutch experience evidences this conclusion.

Finally, the Dutch Parliament should reject the proposal further expanding the boundaries of the already licentious euthanasia laws. Although the Parliament will not likely reject the legislation due to the majority coalition's support of the proposal, rejection is the best course of action. Further sanctioning euthanasia will ultimately result in an increase in the number of euthanasia cases, both voluntary and involuntary. The current policy already permits an alarming number of involuntary cases, including those where the doctor kills an infant without parental consent. There is no justification for infanticide. Finally, the proposed law allowing doctors to perform euthanasia on children as young as twelve without parental consent has no place in a civilized society.

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