BUT, WHY Do WE SHOOT HORSES?: AN ANALYSIS OF THE RIGHT TO DIE AND EUTHANASIA

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Scenario 1: Imagine you are a healthy adult, living life to its fullest. You have a successful career and a loving family—the American dream. One cool autumn afternoon, you start experiencing some weakness in your hands while playing with your seven-year-old daughter. It is not too painful, so you dismiss it as mere fatigue from the hectic week before. Throughout the next several weeks, however, you start experiencing more and more weakness, accompanied by cramping and stiffness. Finally, after a couple of months you consult your family physician, and after a battery of tests, you are diagnosed with Amyotrophic Lateral Sclerosis, more commonly as Lou Gehrig's Disease.\textsuperscript{1} How is this possible? You have always taken care of yourself. This is not fair. You have just begun to live your life.

After consulting literature on this deadly disease, you realize that your future is not as bright as you once thought. The disease starts with the wasting of the muscles, and gradually overtakes virtually all normal functions.\textsuperscript{2} You see yourself losing the ability to walk, eat, and to hold your only daughter. Eventually, you will not be able to speak, swallow, or move.\textsuperscript{3} However, this is not the worst of it. This heartless disease spares your awareness and intellect; there is no loss of sensation.\textsuperscript{4} This disease usually leads to death in two to four years, but some victims live more than twenty years after diagnosis, often with constant physical and emotional pain.\textsuperscript{5}

The disease is progressing now. The physical pain is excruciating, but you can handle that. The most distressing part is watching your family watch you degenerate into a shell of existence. You decide that you want to spare your family and yourself the

\textsuperscript{1} AM\textit{A}, ENCYCLOPEDIA OF MEDICINE 696 (Charles B. Clayman ed., 1989).
\textsuperscript{2} Id.
\textsuperscript{3} Id.
\textsuperscript{4} Id.
\textsuperscript{5} Id.
emotional heartbreak accompanying your deterioration. You have a long talk with your family, and you all agree that the suffering is not worth the seemingly endless pain. As a family, you decide you want a dignified death, but due to the debilitating effects of this disease you are powerless to end the suffering. Your family enlists the help of your physician. Can he help you?

Scenario 2: Imagine the same facts as before. However, now you are at the point where you need feeding tubes and a ventilator to keep you alive. Again, as a family, you reach the same conclusion as in Scenario 1, that it is not worth the suffering and you enlist your physician’s help. Can he help you?

Unfortunately, the answer to only one of these scenarios is yes.6

I. Introduction

This Note is not about the law, medicine, or ethics, although each plays a vital role in the true understanding of the subject. It is about life, and death, and individuals that are faced with a "deeply personal decision of obvious and overwhelming finality."7 This deeply personal decision has been termed the "right to die," which, for the time being, will encompass the right to die and the right to die with assistance, or "voluntary active euthanasia." However, in order to fully understand and discuss this subject, you must experience the emotions and hardships of being a terminally ill individual in constant physical and emotional pain. Otherwise, the best one can do is explain the current basic understandings prevalent in today’s society.

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6 An individual does have a right to refuse lifesaving treatment, as in Scenario 2. See infra part II.A. However, the answer to Scenario 1 is not so clear. See Compassion in Dying v. Washington, 850 F. Supp. 1454 (W.D. Wash. 1994) (holding that "a competent, terminally ill adult has a constitutionally guaranteed right under the Fourteenth Amendment to commit physician-assisted suicide"), rev’d, 1995 WL 94679 (9th Cir. 1995). Although the Compassion in Dying case has been reversed, the plaintiffs are seeking a rehearing. See Assisted Suicide—Rehearing Sought in Ninth Circuit on Panel’s Assisted Suicide Ruling, BNA HEALTH CARE DAILY, Mar. 29, 1995, available in LEXIS, News Library, Curnws File.

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This Note attempts to do that, and only that. To truly understand the right to die, you must live it—a fact that escapes the majority of scholars that discuss such a right.8

Before discussing voluntary active euthanasia, Part II will first analyze the right-to-die movement, and will give a brief history of what recognition this right has received under the Constitution and under the common law. Part II will also discuss how the right is exercised, what its limits are, and who receives the benefit of such a right.

Part III will analyze the landmark Supreme Court decision, Cruzan v. Director, Missouri Department of Health,9 and how the Court has interpreted the right to die. This discussion will focus on the individual’s interests versus the State’s interest, and the reasoning behind the "clear and convincing" standard, as viewed by the majority and two of the dissenters in Cruzan. This section will close with post-Cruzan developments in the right-to-die movement.

Part IV will then focus on the jump from the narrow interpretation of the right to die under Cruzan to a more broad interpretation that encompasses the right to die with assistance, if necessary, or voluntary active euthanasia. This Part will analyze the unjust terms used in today’s society, and will offer a more compassionate way to view this area. Next, this Part will discuss the limitations, as well as the arguments for and against the right to die. This Note will then conclude with some closing thoughts on this highly controversial and deeply personal subject.

II. The Right-To-Die Background

The right to die has evolved over time into a legal, moral, and ethical issue. This evolution began when doctors and lawmakers

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8 "'They don't realize how bad the pain is, of course, they would never realize it, unless they were going through it themselves, but their job is to keep their patients alive for as long as they can.'" Primetime Live: Benny’s Choice—Children and the Right to Decide (ABC television broadcast, July 7, 1994) (quoting Benito "Benny" Agrelo, a courageous fifteen-year-old Florida teenager who refused lifesaving medical treatment after years of constant pain and suffering).

started the debate about withholding extraordinary life support in critical situations. The debate then shifted to withholding versus withdrawing extraordinary life support when medical conditions looked hopeless. As in withholding extraordinary life support, withdrawing extraordinary life support was seen as "letting nature take its course," or accepting that the patient is "really dying from the disease."

Withdrawing life support originally started with the withdrawal of an artificial ventilator from terminal, comatose, and incompetent patients. But the legal and medical community began to realize that these were not the only patients who had rights. Some "patients in really bad condition were not dependent on any extraordinary medical support that could be withdrawn so as to enable them to die." Thereafter, non-extraordinary life support therapy was being withdrawn. Finally, it became acceptable to withdraw life saving hydration and nourishment in order to let nature take its course. Although the Supreme Court found this right to be constitutionally protected, other courts have found the right to die under the common law.

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11 Id.
12 Id. at 307.
13 Id.
14 Id.
15 See Clouser, supra note 10, at 307 (listing cardiopulmonary resuscitation, antihypertensives, and antibiotics as some of the non-extraordinary life support that was being withdrawn).
16 Id.
17 Cruzan, 497 U.S. at 265.
18 See Cruzan v. Harmon, 760 S.W.2d 408, 416-17 (Mo. 1988) (en banc) (explaining that under common law, there is an individual liberty right to protect ones bodily integrity), aff'd sub nom. Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261 (1990); In re Storar, 420 N.E.2d 64 (N.Y.) (holding that the right to refuse medical treatment stems from the doctrine of informed consent), cert denied, 454 U.S. 858 (1981); see also Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417 (Mass. 1977) (finding that the right to refuse treatment stems from the doctrine of informed consent as well as the constitutional right to privacy).
A. The Constitutional and Common Law Basis
For the Right to Die

The Constitution does not explicitly mention a right to die. However, this right has been found to be encompassed in the constitutional right to privacy.\footnote{See Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417 (Mass. 1977); In re Quinlan, 355 A.2d 647 (N.J.), \textit{cert. denied sub nom.} Garger v. N.J., 429 U.S. 922 (1976). However, the Supreme Court found that the constitutional right to die should, more appropriately, be evaluated under the liberty interest of the Fourteenth Amendment. \textit{See Cruzan}, 497 U.S. at 279 n.7. "Although many state courts have held that a right to refuse treatment is encompassed by a generalized constitutional right of privacy, we have never so held. We believe this issue is more properly analyzed in terms of the Fourteenth Amendment liberty interest." \textit{Id.}; \textit{see U.S. CONST. amend. XIV, \textsection 1, cl. 3} ("nor shall any State deprive any person of life, liberty or property, without due process of law"). For a constitutional analysis of the right to die under the liberty interest, \textit{see infra} part III. A-B.} The constitutional right to personal privacy has been recognized by the Supreme Court in situations dealing with abortion, contraception, and marriage.\footnote{See generally \textit{Roe} v. \textit{Wade}, 410 U.S. 113 (1973) (holding that the right to privacy is broad enough to encompass a woman's decision to terminate a pregnancy under certain conditions); Eisenstadt v. Baird, 405 U.S. 438 (1972) (holding the right to privacy encompasses the right of the individual "to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child"); Stanley v. \textit{Georgia}, 394 U.S. 557 (1969) (holding the right to privacy extends to the private possession of obscene material in one's home); Griswold v. \textit{Conn.}, 381 U.S. 479 (1965) (finding the unwritten right to privacy exists in the penumbra of specific guarantees of the Bill of Rights).} This right mandates that "[w]e have a right simply to be private, which depends on the power to exclude unwarranted and uninvited intrusions or disclosures."\footnote{\textit{Roe}, 410 U.S. at 152.} The right to privacy has its roots in the First, Fourth, Fifth, Ninth, and Fourteenth Amendments,\footnote{\textit{Griswold}, supra note 21, at 281-82 (stating further that privacy "allows us to be with ourselves, and thereby to be ourselves").} and is "the inseparable guarantor of our constitutional way of life." Without it, there is no way of life, just a mandatory way to live.

The right to privacy was originally the right relied on by most
courts when they found a constitutional right to die.24 The New Jersey Supreme Court relied on the right to privacy when it decided In re Quinlan.25 Karen Ann Quinlan sustained extensive physical injuries which rendered her incompetent.26 Thereafter, Karen’s father wished to be appointed her guardian, and further sought express authorization to discontinue all extraordinary life support.27 Mr. Quinlan was opposed by a court appointed guardian ad litem, the treating physicians, the hospital, the county prosecutor, and the state attorney general.28 The Quinlan court ultimately held that "[p]resumably [the right to privacy] is broad enough to encompass a patient’s decision to decline medical treatment under certain circumstances, in much the same way as it is broad enough to encompass a woman’s decision to terminate pregnancy under certain conditions."29 The court permitted the withdrawal of life support as long as there was a consensus that Karen would never recover.30

After the Quinlan decision, other courts have held that the right to privacy encompasses the right to forego life sustaining treatment.31 For example, the Massachusetts Supreme Judicial Court held that "[t]he constitutional right to privacy . . . is an expression of the sanctity of . . . life . . . . The value of life as so perceived is lessened not by a decision to refuse treatment, but by the failure to

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24 These courts drew "upon federal constitutional precedents dealing with reproductive rights and . . . with [the] control of one's body." ALAN MEISEL, THE RIGHT TO DIE § 3.4, at 52 (1989).
26 Id. at 651.
27 Id.
28 Id.
29 Id. at 663 (citing Roe, 410 U.S. at 153).
30 Quinlan, 355 A.2d at 672. The court also held that no civil or criminal liability would attach to such a procedure. Id.
allow a competent human being the right of choice."\(^{32}\) Therefore, an individual has a constitutionally protected right to privately choose a course of treatment without interference.\(^{33}\)

However, after *Quinlan*, courts were reluctant to base their decisions solely on the right to privacy, and increasingly relied upon the common law right to autonomy, or self-determination, when deciding if a right to die existed.\(^{34}\) The common law basis for the right to die has been defined as the right to control one’s own body.\(^{35}\) This definition’s roots stretch back over a century to when the Supreme Court declared: "No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others . . . ."\(^{36}\) Therefore, the Constitution is not the only foundation upon which this right is based.

At common law, it was considered an assault and a trespass to be touched without lawful consent.\(^{37}\) This lawful consent doctrine developed into what is commonly referred to as the doctrine of informed consent, and encompasses the right of every human being, of adult years and sound mind, to determine what shall be done with

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\(^{32}\) *Saikewicz*, 370 N.E.2d at 426. The individual at issue in *Saikewicz* was a profoundly retarded elderly man who had an IQ of 10, and a mental age of two years and eight months. *Id.* at 419. Mr. Saikewicz was diagnosed with myeloblastic monocytic leukemia, which is fatal and for which treatment causes serious and painful side effects. *Id.* at 420. The trial judge carefully weighed all the evidence and decided the negative factors outweighed the positive ones, and ordered that no treatment be administered. *Id.* at 422. The Massachusetts Supreme Judicial Court upheld the trial court’s ruling. *Id.* at 435.

\(^{33}\) *Id.* at 427.

\(^{34}\) See *Meisel*, supra note 24, § 3.4, at 52; *In re Eichner*, 423 N.Y.S.2d 580 (Sup. Ct. 1979) (finding that an individual’s right to self determination, as opposed to a right to privacy, permitted him to withdraw unwanted medical treatment), modified, 426 N.Y.S.2d 517 (App. Div. 1980).

\(^{35}\) *Meisel*, supra note 24, at 50-51.

\(^{36}\) Union Pac. Ry. Co. v. Botsford, 141 U.S. 250, 251 (1891). The *Botsford* Court, quoting Judge Cooley, stated that "[t]he right to one’s person may be said to be a right of complete immunity: to be let alone." *Id.*

\(^{37}\) *Id.* at 252.
his or her body. The doctrine of informed consent "envisions that if patients are to 'chart their own course understandably,' there must be a collaborative, mutual, or shared decision-making between physician and patient." The physician is schooled and experienced in the art of medicine, but is not intimately familiar with an individual's beliefs, values, hopes and aspirations. However, the converse is also true. The patient is intimately familiar with his or her own person, but ordinarily is not experienced in medicine. Therefore, both the physician and the patient have "an essential role to play" when deciding on the course of treatment to pursue. The basic goal of informed consent is to enable patients to make rational and intelligent decisions so as to fully exercise their right to self-determination.

Whether the right to die is grounded in the constitutional right to privacy or the common-law right to self-determination, this right is not absolute. The right to die only exists when the benefit of life-sustaining treatment is outweighed by the burden it imposes on the individual, and when the state cannot show any compelling interest against removal of such treatment.

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38 See Schloendorff v. N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914). A general definition of informed consent includes the duty of a physician to disclose to his patient all risks of injury that the patient may incur from a proposed course of treatment so that the patient may make an intelligent decision when facing the choice of undergoing the proposed treatment, or deciding on an alternative treatment, or no treatment at all. BLACK'S LAW DICTIONARY 537 (Abridged 6th ed. 1991).


40 Id. at 20.

41 Id.

42 Id. at 19-20.

43 Id. at 20-21. "[The] right to self determination has been described as an individual's 'strong . . . personal interest in directing the course of his own life, an individual's right to behave and act as he deems fit, provided that such behavior and activity do not conflict with the precepts of society.'" In re Jobes, 529 A.2d 434, 453 (N.J. 1987) (Handler, J., concurring) (quoting In re Conroy, 486 A.2d 1209, 1228 (N.J. 1985)).


45 Id.
B. Limitations on the Right to Die

1. The Benefit-Burden Approach

The benefit-burden approach essentially weighs the positive factors an individual would experience from the life prolonging treatment against the negative factors such treatment would inflict. When analyzing the benefit and the burden of life sustaining treatment, the courts have generally looked at the patient's ability to cooperate, the adverse side effects of treatment, the probability of recovery, if and to what extent the treatment will cause immediate suffering, and the quality of life if the treatment brings about recovery. If the benefit outweighs the burden, the life sustaining treatment should be continued. Unfortunately, in many situations the burden is just too great, and the "negative factors of treatment exceed the benefit." In such situations, it would be better to forego any further treatment because letting the disease run its course will usually result in less pain and suffering.

This benefit-burden analysis describes the proportionate treatment as one that "has at least a reasonable chance of providing benefits to the patient, which benefits outweigh the burdens attendant

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46 Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 422 (Mass. 1977) (discussing the probate judge's conclusion that "the negative factors of treatment exceed the benefits," and, therefore, that no treatment should be administered).

47 See id. This benefit-burden analysis has been rejected by some courts when it is applied in cases where the individual is comatose. See In re Severns, 425 A.2d 156, 157 (Del. Ch. 1980) (finding that patient in a coma suffering from severe brain damage "does not suffer discomfort and does not feel pain"); In re Torres, 357 N.W.2d 332, 338 (Minn. 1984) (finding that for patients that are permanently unconscious, "[d]isability is total and no return to an even minimal level of social or human functioning is possible").

48 See Cruzan v. Harmon, 760 S.W.2d 408, 419, 424 (Mo. 1988) (en banc) (holding that, because the patient was not terminally ill, would have a life of relatively normal duration and the burdens of treatment were not excessive, the state's interest in preserving life outweighed the patient's right to refuse treatment), aff'd sub nom. Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261 (1990).

49 Saikewicz, 370 N.E.2d at 422.

50 Id. at 420-21 (finding that as a result of the decedent's age, he would have more difficulty tolerating chemotherapy treatment; moreover, the treatment would be less successful for people over 60 than for younger people).
to the treatment."\(^{51}\) If the proposed treatment is only minimally painful or intrusive but the prognosis is virtually hopeless, the procedure may be considered disproportionate to the potential benefits the patient would receive.\(^{52}\) Such a determination can only be made by looking at the specific facts of a particular case because burdens and benefits are unique to each patient.\(^{53}\)

The indignity which mentally competent, as well as incompetent, patients must suffer by not allowing nature to take its course can also constitute a substantial burden. Furthermore, the embarrassment, humiliation, and helplessness accompanying terminal illnesses are personal and unique to each individual. "It is incongruous, if not, monstrous, for medical practitioners to assert their right to preserve a life that someone else must live, or, more accurately, endure, for 15 to 20 years."\(^{54}\) Such an intrusion is a direct violation of a patient's constitutional right to privacy, right to self-determination, and right to freedom of choice.\(^{55}\)

Perhaps the most controversial term used when discussing the benefit-burden approach is "quality of life."\(^{56}\) Quality of life includes concerns regarding human dignity, physical fitness, autonomy, and

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\(^{51}\) Barber v. Superior Court, 195 Cal. Rptr. 484, 491 (Ct. App. 1983).

\(^{52}\) Id.

\(^{53}\) See id. at 492. "[T]he determination as to whether the burdens of treatment are worth enduring for any individual patient depends on the facts unique to each case, namely, how long the treatment is likely to extend life and under what conditions." Id.

\(^{54}\) Bouvia v. Superior Court, 225 Cal. Rptr. 297, 305 (Ct. App. 1986). The Bouvia court went further, and stated that it "cannot conceive it to be the policy of this state to inflict such an ordeal upon anyone." Id.


\(^{56}\) See MEISEL, supra note 24, § 9.31, at 296. Quality of life has been interpreted in two distinct ways:

1. the quality of life to one's self, which is viewed as a legitimate factor when deciding right to die cases; and 2. the quality of life to others or to society, which is uniformly rejected by courts because they believe this would be a "step towards active voluntary euthanasia."
other areas of personal well being. This term often compares the individual's present condition with what he or she had before life prolonging treatment was required. However, courts are ill-equipped to handle such determinations, and they will often not permit "anyone to decide when another should die on any basis other than clear and convincing evidence." Moreover, the quality of life one individual chooses does not mandate that all individuals, similarly situated, must live the same way. The only person who can decide if a life is worth living is the individual who has to live that life or the people that know the individual best—his or her family and/or close friends.

The benefit-burden analysis helps put the life prolonging treatment in perspective with regard to individual patients. However, after concluding that the burdens of treatment outweigh the benefits, the decision-making process generally is not at an end. Usually, the court will weigh the individual's interests against those of the state and, depending on the findings, either permit the removal or direct the continuation of the life prolonging treatment.

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59 See Stephen A. Newman, Treatment Refusals for the Critically and Terminally Ill: Proposed Rules for the Family, the Physician, and the State, 3 N.Y.L. SCH. HUM. RTS. ANN. 35, 47-48 (1985) (stating that "[c]ourts are too inaccessible and slow . . . to spend time inquiring into the patient's life, philosophy, and value preferences").
60 DeGrella v. Elston, 858 S.W.2d 698, 702 (Ky. 1993).
61 See Newman, supra note 59, at 47 (noting that "[i]nvolved family members are both readily accessible and possessed of enough knowledge about the patient to make the necessary decisions").
62 See In re Eichner, 423 N.Y.S.2d 580, 588 (Sup. Ct. 1979) ("[I]n appropriate circumstances, an individual other than a relative may be appointed to the committee even though surviving relatives can be located. The factor of paramount importance is what the best interest and welfare of the incompetent require."), modified, 426 N.Y.S.2d 517 (App. Div. 1980).
64 See In re Conroy, 486 A.2d 1209, 1223 (N.J. 1985).
2. The Individual-State Interest Approach

The individual-state balancing test assumes there are competing interests at stake when deciding whether to forego life sustaining treatment. The individual’s interests lie in autonomy, self-determination, privacy, and bodily integrity, while the state’s interests lie in the preservation of life, the prevention of suicide, the protection of third parties, and the ethical integrity of the medical profession. There is a presumption in the individual’s favor, and the state can only override this presumption by demonstrating a compelling countervailing interest. Therefore, the individual’s choice must prevail where a compelling state interest is not established.

The most important state interest countervailing the removal of lifesaving treatment is the interest in the preservation of life. The state’s argument for preserving the individual patient’s life is that withdrawing treatment will "cheapen" the value placed on the concept of living. However, life is not "cheapened" when the decision is made to withdraw a medical treatment. Life is cheapened when an individual’s right to choose is abridged. This interest will rarely override a patient’s right to die when the patient is suffering from an incurable condition and is near death. The state confers little or no

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65 See MEISEL, supra note 24, § 4.12, at 96.
66 See Saikewicz, 370 N.E.2d at 425.
67 See MEISEL, supra note 24, § 4.12, at 97; see also Leach v. Akron Gen. Medical Ctr., 68 Ohio Misc. 1, 9 (Ct. C.P. 1980) (stating that "[t]he constitutional right to privacy is paramount to a state interest unless that interest can be demonstrated to be compelling or outweighs the individual's constitutional right").
68 See MEISEL, supra note 24, § 4.12, at 97.
69 Gray, 697 F. Supp. at 588. This interest really encompasses the preservation of the individual patient’s life and the preservation of all life. See MEISEL, supra note 24, § 4.13, at 100.
70 Saikewicz, 370 N.E.2d at 426.
71 Id. "The value of life as so perceived is lessened not by the decision to refuse treatment, but by the failure to allow a competent human being the right of choice . . . . The constitutional right to privacy . . . is an expression of the sanctity of individual free choice and self-determination as fundamental constituents of life." Id.
72 See MEISEL, supra note 24, § 4.13, at 101; In re Guardianship of Crum, 580 N.E.2d 876 (Ohio 1991) (holding that the state has no interest in the preservation of the life of an individual inflicted with viral encephalitis who has been in a chronic and
benefit by briefly extending a patient's life against his or her will.73

Furthermore, the argument concerning the state's interest in
the preservation of all life is less likely to succeed than the argument
concerning the interest in the preservation of the individual's life. The
state's abstract and indirect interest in the preservation of life
will generally give way to the individual's much stronger and
personal "interest in directing the course" of his existence.74 Cases
that do not involve the state's interest in protecting actual or potential
individuals will generally be decided in the individual's favor75
because it is "grossly unfair to make the sick and the dying bear the
burden of preserving society's devotion to the sanctity of life."76

The state interest in the prevention of suicide has been
summarily dismissed by most courts. The majority of courts deciding
right-to-die cases do not view the foregoing of treatment as suicide.77
"[T]he underlying State interest in this area lies in the prevention of
irrational self-destruction,"78 not the rational decision of self-
determination. Suicide commands the individual to specifically intend
to terminate his or her life by some affirmative action.79 However,
courts generally view the withdrawal of life prolonging measures as
an intent to let nature take its course.80 Furthermore, many courts do

73 See MEISEL, supra note 24, § 4.13, at 102.
74 In re Conroy, 486 A.2d 1209, 1223 (N.J. 1985).
75 See id.
76 Stephen A. Newman, Euthanasia: Orchestrating "The Last Syllable Of... Time,"
sustaining medical treatment may not properly be viewed as an attempt to commit
suicide." Id. (citing In re Conroy, 486 A.2d at 1224).
78 Saikewicz, 370 N.E.2d at 426 n.11.
80 Id.; see In re Guardianship of Doe, 583 N.E.2d 1263, 1270 (Mass.), cert. denied
Rptr. 297, 306 (1986). But compare Cruzan, 497 U.S. at 296-97 (Scalia, J., concurring)
("Starving oneself to death is no different from putting a gun to one's temple... If
the State may interrupt one mode of self-destruction, it may with equal authority..."
not even discuss this interest when deciding such cases. Thus, the prevention of suicide usually is not thought of as a legitimate state interest sufficient to override an individual’s interest in self determination.

However, the state’s interest in the protection of third parties, such as minor children, is more compelling than the interest in the prevention of suicide. The state’s interest in the welfare of minors may "justify compulsory medical treatment when necessary to save the life of the mother of young children or of a pregnant woman." However, in most situations, the decision to forego life support is in the third party’s best interest because the medical condition has already put the parties under an intolerable amount of stress. The decision is usually made as a family, with the best interests of the children being paramount.

The remaining state interest deals with the protection of medical ethics. This interest is, perhaps, the most justified. The truly dedicated physician wants only to heal the sick. Some physicians view removing life support treatment as tantamount to aiding a suicide, and that therefore, it is against their professional, moral, and ethical codes. However, the modern ethical view does

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81 See Meisel, supra note 24, § 4.15, at 102-03 (stating that protection of third parties is responsible for more overrulings than any other state interest).


83 See In re Farrell, 529 A.2d at 413.

84 See Delio v. Westchester County Med. Ctr., 516 N.Y.S.2d 677 (App. Div. 1987) (holding that the state’s interest does not exist when the person who the state seeks to protect is a proponent of the withdrawal of treatment).

85 See, e.g., Saikewicz, 370 N.E.2d at 426-27 (discussing the state’s interest in the maintenance of the ethical integrity of the medical profession).

86 See Bartling v. Superior Court. 209 Cal. Rptr. 220, 225 (1984); see also WORLD MEDICAL ASSOCIATION, THE GENEVA OATH (1948), reprinted in GEORGE M. BURNELL, FINAL CHOICES: TO LIVE OR TO DIE IN AN AGE OF MEDICAL TECHNOLOGY 344-45 (1993) (reprinting a new version of the Hippocratic Oath that makes no mention of either
not mandate that all efforts towards maintaining life be made in all circumstances.\textsuperscript{87} The American Medical Association recognizes the need to treat the patient, at all times, with dignity.\textsuperscript{88} The physician should decide if life sustaining treatment will outweigh the burden it imposes.\textsuperscript{89} This state interest, therefore, takes us full circle back to the benefit-burden test.\textsuperscript{90}

This two part test approach has been widely used in post-	extit{Quinlan} right-to-die cases.\textsuperscript{91} The benefit-burden test usually served as a threshold question to determine the patient’s prognosis.\textsuperscript{92} If the prognosis revealed that the burdens associated with the treatment outweighed the potential benefit, the individual-state interest test was usually applied to determine if there was any compelling state interest that could override the interest of the individual.\textsuperscript{93} If the state’s interest could not override the interests of the individual, the extraordinary treatment could be withdrawn.\textsuperscript{94} But, eventually, individuals and physicians started to question this extraordinary treatment limitation.\textsuperscript{95} Thereafter, it was not enough to weigh the benefits against the burdens and the state’s interests against those of the individual.\textsuperscript{96} The treatment itself was also being scrutinized.\textsuperscript{97}
3. Extraordinary v. Ordinary Life-Sustaining Treatment

It is clear that extraordinary means of treatment or life support systems may be terminated if there is no hope of a cure, and if this is the wish of the patient and his family.98 Medical ethics not only permits this decision, but also supports it.99 It is, however, only a "myth that only extraordinary treatment may be foregone but that a patient is obliged to accept ordinary treatment."100 Much of the ordinary medical technology used today was once considered extraordinary.101 Furthermore, what is extraordinary for some patients, under certain circumstances, may merely be ordinary for the same patients under different circumstances, or for different patients under the same circumstances.102 Therefore, "the terms . . . have assumed too many conflicting meanings to remain useful,"103 and courts will rarely distinguish the two.104

A competent adult, who has control over his or her own body, has the right to determine whether or not to surrender to lawful medical treatment.105 This being true, a patient has the right to refuse medical treatment, which may save or prolong his or her life.106 One

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99 See id. at 393.
102 See MEISEL, supra note 24, § 4.6, at 86.
103 Id. at 85 (quoting In re Conroy, 486 A.2d 1209, 1235 (N.J. 1985)). The Supreme Court has stated that "there is no reason to suppose that the definition of a medical term of art should coincide with the parameters of a constitutional standard." Winston v. Lee, 470 U.S. 753, 764 n.8 (1985) (quoting Lee v. Winston, 551 F. Supp. 247, 260 (E.D. Va. 1982)).
104 See MEISEL, supra note 24, § 4.6, at 83 (citing In re Browning, 568 So. 2d 4, 12 n.6 (Fla. 1990)).
106 See Bouvia v. Superior Court, 225 Cal. Rptr. 297, 300 (1986). "People are entitled to make decisions that others think are foolish as long as their choices are arrived at through a competently reasoned process and are consistent with their personal values." Council on Ethical and Judicial Affairs, AMA, Decisions Near the End of Life, 267 JAMA 2229, 2230 (1992) [hereinafter Decisions].
court boldly declared that any patient has the right to refuse any medical treatment or medical service, even if the exercise of such a right creates a life threatening condition.\textsuperscript{107} The distinction between extraordinary and ordinary treatment is virtually "one without meaning."\textsuperscript{108} The ultimate decision regarding any treatment should be left to the patient because only he or she will fully understand the ramifications. But, as in the distinction between types of treatment, limitations were also being imposed on the type of patients that could assert the right to refuse treatment. Thus, distinctions were being made between individual patients that were receiving the same treatment.

4. Classifications of Patients

In the past few decades, medical science has made great advances. It is now possible for the medical profession to intervene and forestall death for most patients.\textsuperscript{109} Although these breakthroughs have worked miracles in certain situations, they also have "prolonged the slow deterioration and death of some patients."\textsuperscript{110} This has most profoundly affected comatose, incompetent patients who are not free to explicitly communicate their wishes.\textsuperscript{111} However, the right to refuse medical treatment has been found to extend to incompetent, as well as competent, patients because the value of human dignity must extend to both.\textsuperscript{112} "Any other view would permit obliteration of an incompetent's panoply of rights merely because the patient could no longer sense the violation of those rights."\textsuperscript{113} An incompetent

\textsuperscript{107} Bouvia, 225 Cal. Rptr. at 300.
\textsuperscript{109} See Decisions, supra note 106, at 2229.
\textsuperscript{110} In re Farrell, 529 A.2d 404, 406 (N.J. 1987).
\textsuperscript{113} Norman L. Cantor, Quinlan, Privacy, and the Handling of Incompetent Dying Patients, 30 RUTGERS L. REV. 243, 252 (1977).
individual is still an individual in the eyes of the law.

However, competency was not the only factor considered when determining whether life-prolonging treatment should be withdrawn. Questions also surfaced about what type of illness (i.e., terminal, incurable, etc.) would trigger a right to refuse treatment. Courts then began to realize that there was no practical reason why only terminally ill patients were free to exercise this right. \(^{114}\) "[T]he right to refuse treatment does not need the sanction or approval by any legislative act, directing how and when it shall be exercised." \(^{115}\)

It is extremely difficult for physicians, let alone the legal community, to distinguish between life-threatening conditions, terminal illnesses, and serious illnesses. \(^ {116}\) Every competent individual has the right to determine what treatment his or her body will be subjected to regardless of his or her illness. \(^ {117}\) Therefore, the type of illness and treatment are virtually irrelevant if the burden of such treatment outweighs the benefits, and the interest of the individual is not overridden by any compelling state interest. \(^ {118}\) However, prior to 1990, the Supreme Court was silent on an individual’s constitutional

\(^{114}\) See Bouvia v. Superior Court, 225 Cal. Rptr. 297, 302 (1986); see also State v. McAfee, 385 S.E.2d 651, 652 (Ga. 1989) (holding that a quadriplegic had the right to disconnect his ventilator even though he was not terminally ill and had a long life expectancy); Public Health Trust v. Wons, 541 So. 2d 96, 97-98 (Fla. 1989) (holding that a Jehovah’s Witness can refuse a blood transfusion even though "in all probability" she would die); Bartling v. Superior Court, 209 Cal. Rptr. 220, 226 (Ct. App. 1984) (holding that competent adult patients who have not been diagnosed as terminally ill have the right to disconnect life-support equipment even though this may hasten death).

\(^{115}\) Bouvia, 225 Cal. Rptr. at 302.

\(^{116}\) See In re Guardianship of Browning, 543 So. 2d 258, 268 (Fla. Dist. Ct. App. 1989) (stating that "[d]istinguishing between serious illnesses is frequently difficult for physicians and really impossible for the legal community”).


\(^{118}\) See MEISEL, supra note 24, § 4.15, at 103. Meisel states:

However most of these overrulings [of the right to die] have occurred in cases in which the patient’s condition is such that he can probably be returned to status quo ante if treatment is administered, and consequently the cases really concern the state’s interest in preserving life when it can be meaningfully done.

Id.
right to withdraw any type of life-support.119

III. The Right to Die and Cruzan v. Director, Missouri Department of Health

The most heated debate concerning the right-to-die issue has been over whether to allow the withdrawal of artificial nutrition and hydration. Some saw this as causing the patients' deaths by "creating the malnutrition by virtue of which [the patients] die."120 These critics contend that artificial nutrition and hydration is not a medical treatment at all, and that termination results in a patient's starving to death and constitutes active euthanasia.121 Although some do assign an "emotional symbolism" to artificial feeding, there really is "no legal difference between a mechanical device that allows a person to breathe artificially and a mechanical device that artificially allows a person nourishment."122 The majority of appellate courts that have decided this issue have held that artificial nutrition and hydration are medical procedures that may be foregone just like any other forms of life support.123 These conflicting views finally gave the Supreme Court the proper opportunity to voice its opinion on the "right-to-die" issue.

A. The United States Supreme Court's Recognition of the Right to Die

In 1990, the Supreme Court finally addressed the issue of "whether the United States Constitution grants what is in common


120 Clouser, supra note 10, at 307.
121 See Meisel, supra note 24, § 5.10, at 129.
123 Id.
parlance referred to as a 'right to die,'"\(^{124}\) by deciding *Cruzan* v. *Director, Missouri Department of Health*. Nancy Cruzan, had sustained severe injuries in an automobile accident.\(^{125}\) She was incompetent and lying in a persistent vegetative state\(^{126}\) in a Missouri state hospital when her case was reviewed by the Supreme Court.\(^{127}\) Nancy's parents sought the termination of artificial nutrition and hydration after it became apparent that Nancy had virtually no chance of ever regaining her mental faculties.\(^{128}\) Although hospital employees refused to honor Nancy's parents' wishes, the state trial court authorized the termination of artificial nutrition and hydration, finding that "a person in Nancy's condition had a fundamental right under the State and Federal Constitution to refuse or direct the withdrawal of 'death prolonging procedures.'"\(^{129}\)

The trial court also relied on Nancy's previous conversations with friends and family which expressed her wish not to delay the inevitable by such medical procedures.\(^{130}\)

The Missouri Supreme Court reversed, holding that, although there is a recognized right to refuse unwanted treatment under the doctrine of informed consent, such a right is not found in every circumstance,\(^{131}\) and expressed skepticism about the application of that doctrine in the circumstances of this case.\(^{132}\) The court found Nancy's previous statements "unreliable for the purpose of

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\(^{125}\) *Id.* at 261.

\(^{126}\) An individual in a persistent vegetative state has neither self-awareness nor awareness of the surroundings. *See In re Jobes*, 529 A.2d 434, 438 (N.J. 1987). The body is "functioning entirely in terms of its internal controls;" maintaining heart beat, temperature, pulmonary ventilation, digestive, and reflex activity. *Id.*

\(^{127}\) *Cruzan*, 497 U.S. at 266 & n.1.

\(^{128}\) *Id.* at 267.

\(^{129}\) *Id.* at 268.

\(^{130}\) *Id.*


\(^{132}\) *Id.* at 418.
determining her intent. Furthermore, Nancy’s parents could not exercise substitute judgment on Nancy’s behalf because the formalities required under Missouri’s Living Will statutes were not present, and there was no clear and convincing evidence illustrating Nancy’s wishes.

The Supreme Court granted certiorari, and, in a five-to-four decision authored by Chief Justice Rehnquist, upheld “[t]he principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment.” The Court found that the right to refuse unwanted medical treatment was best analyzed as a liberty interest protected by the Fourteenth Amendment. In finding such a right, the Court relied on prior decisions that balanced the state’s interests against the individual’s interests. However,

133 Id. at 424.
134 Id. at 425.
135 Cruzan, 497 U.S. at 278. The majority also assumed that a competent person has a constitutionally protected right to refuse lifesaving hydration and nutrition, and thus implicitly held that this type of “treatment” was no different then other forms of life-sustaining treatment. See id. at 279. Justice O’Connor, in a concurring opinion, stated the premise explicitly by declaring: “Artificial feeding cannot readily be distinguished from other forms of medical treatment.” Id. at 288 (O’Connor, J., concurring) (citing COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, AMA, AMA ETHICAL OPINION 2.20, WITHHOLDING OR WITHDRAWING LIFE PROLONGING MEDICAL TREATMENT, CURRENT OPINIONS 13 (1989)). The remaining issue, one to which the majority was dedicated, was whether an incompetent patient possesses these same rights and, if so, by what standard must it be proven. Id. at 279. One Justice of the majority found no basis for such rights in the Constitution, and would have rather left the decision to the states. Id. at 293 (Scalia, J., concurring). Scalia wrote:

[The point at which life becomes ‘worthless’ and the point at which the means necessary to preserve it become ‘extraordinary’ or ‘inappropriate,’ are neither set forth in the Constitution nor known to the nine Justices of this Court any better than they are known to nine people picked at random from the Kansas City telephone directory . . .

Id. 136 Cruzan, 497 U.S. at 279 n.7. The court believed that the right-to-die issue is more properly analyzed under the Fourteenth Amendment liberty interest, and not under a “generalized constitutional right to privacy.” Id.

finding a constitutionally protected liberty interest was not enough. In order to determine if Missouri violated this right, the Court had to balance Nancy Cruzan's interests against those interests relevant to the State.  

B. Individual Interests v. State Interests

1. The Individual's Interest Under Cruzan

The majority in Cruzan found that the State's interest in the preservation of life outweighed any interests Nancy Cruzan had. The majority, however, never discussed any of the individual's interests common in right-to-die cases, such as autonomy, self-determination, privacy, and bodily integrity. It merely discussed the State's interest in the preservation of life, and held that this interest could only be overcome by clear and convincing evidence. In so doing, the Supreme Court and Missouri "discarded evidence of [Nancy Cruzan's] will, ignored her values, and deprived her of the right to a decision as closely approximating her own choice as humanly possible."  

Although the majority did not find an individual's interest important enough to discuss, two of the dissenters, Justices Brennan and Stevens, relied on such interests. Justice Brennan defined a


139 Cruzan, 497 U.S. at 279 (citing Youngberg v. Romeo, 457 U.S. 307, 321 (1982)).

140 See MEISEL, supra note 24, § 4.12, at 96 (stating that the individual interests at stake are autonomy, self determination, privacy and bodily integrity).

141 Cruzan, 497 U.S. at 280. Justice O'Connor's concurring opinion touches on the subject, but her opinion does not fully address perhaps the most important aspects of this case: Nancy Cruzan's interests and what was best for her. Id. at 288-90 (O'Connor, J., concurring).

142 Id. at 330 (Brennan, J., dissenting).

143 See id. at 302 (Brennan, J., dissenting) ("I believe that Nancy Cruzan has a fundamental right to be free of unwanted artificial nutrition and hydration, which right is not outweighed by any interests of the State . . . ." (emphasis added)); see also id. at 331 (Stevens, J., dissenting) ("In my view, the Constitution requires the State to care for Nancy Cruzan's life in a way that gives appropriate respect to her own best interests.").
right to withdraw artificial hydration and nutrition as the "right to evaluate the potential benefit of treatment and its possible consequences according to one's own values and to make a personal decision whether to subject oneself to the intrusion." For many, what is important is a "proud death" with "bodily integrity intact;" not "an ignoble end, steeped in decay." Justice Brennan believed that the Constitution required that Nancy Cruzan's best interests be afforded the appropriate respect. However, Justice Brennan concluded that "the State Supreme Court largely ignored" Nancy Cruzan's interests.

The individual's interest in dignity, how one will be remembered, and the effect on his or her family were perceived by two of the dissenters as being very important. Justice Brennan found a tremendous amount of humility and sorrow attached to the constant vigil undertaken by the incompetent's family. People want to be remembered as they were before their illness or accident, and it is very disturbing when the lasting impression is when they were in a persistent vegetative state. Justice Stevens believed that Nancy Cruzan's interests included how she would be remembered after her death by those people that mattered most to her. Unfortunately, these people will remember her death more than her life.

2. The State's Interest Under Cruzan

The only state interest asserted in Cruzan was the interest in

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144 Id. at 309 (emphasis added).
145 Id. at 310-11.
146 Cruzan, 497 U.S. at 331.
147 Id. at 334.
148 Id. at 311 (Brennan, J., dissenting) ("Such conditions are, for many, humiliating to contemplate as is visiting a prolonged and anguished vigil on one's parents, spouse, and children.").
149 Id. at 353 (Stevens, J., dissenting) ("Insofar as Nancy Cruzan has an interest in being remembered for how she lived rather than how she died, the damage done to those memories by the prolongation of her death is irreversible.").
150 See id. at 344 (Stevens, J., dissenting); see also id. at 329 (Brennan, J., dissenting) ("In these unfortunate situations, the bodies and preferences and memories of the victims do not escheat to the State.").
the protection and preservation of human life. The majority reasoned that "the choice between life and death is a deeply personal decision of obvious and overwhelming finality," and that States are "entitled to guard against potential abuses in such situations." There will be times when the best interest of the patient will not be looked after, and "there is no automatic assurance that the view of close family members will necessarily be the same as the patient's would have been." The Court held that an incompetent individual does have a conditional right to refuse lifesaving treatment, but only if clear and convincing evidence is shown. In accordance with the Court's decision, under Missouri Law, the decision of the individual must be shown by clear and convincing evidence. Therefore, this procedural requirement is not forbidden by the Constitution.

The State's interest in the preservation of life allows it to impose heightened requirements so that dangers associated with the individual's right will be minimized. The Court arrived at this decision by concluding that any "erroneous decision not to terminate [artificial nutrition and hydration] results in a maintenance of the status quo." Any wrong decision may potentially be "corrected or its impact mitigated." However, "from the point of view of the patient, an erroneous decision in either direction is irrevocable."
By erroneously deciding not to withdraw life support, the patient is robbed of the very interests the right was established to protect: the right against degradation, the right not to prolong his or her family’s suffering, and the right to be remembered for who that individual was, not what he or she has become. The majority’s "maintenance of the status quo" is, unfortunately, only consistent with the State’s interest, not the interest of Nancy Cruzan.

Furthermore, in discussing the state’s interest in the preservation of life, the Court attacked the judicial proceedings aimed at determining the incompetent’s wishes regarding the continuation of life support. These judicial proceedings may not be adversarial, especially in situations where all the parties agree that termination of life support is in the best interest of the patient. Even though everyone may be acting in good faith, the consideration of the proceedings is "meant to illustrate the limits which may obtain on the adversarial nature of this type of litigation." However, as Justice Brennan’s dissent maintains, if everyone agrees, the process has not failed, and there was merely no dispute as to Nancy’s preference.

The Court also believed that a state may decline, if it so chooses, to make "[value] judgments about the 'quality' of life that a particular individual may enjoy," and merely assert an "unqualified interest in the preservation of human life to be weighed against the constitutionally protected interests of the individual." However, a state’s constitutional attack must be based on a legitimate state

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161 Id.
162 Cruzan, 497 U.S. at 353 (Stevens. J., dissenting).
163 Id. at 281.
164 "In such a case, a guardian may act in entirely good faith, and yet not maintain a position truly adversarial to that of the family." Id. at 281 n.9. In Cruzan, the family members, friends, doctors, and even the guardian ad litem all agreed that termination of the artificial nutrition and hydration was what Nancy would have wanted, and that it was in her best interest. Id. at 318-19 (Bennan, J., dissenting). However, the guardian ad litem believed an appeal should be made, not because it was in the best interest of Nancy, but because of the responsibility to pursue the matter fully. Id. at 281 n.9.
165 Cruzan, 497 U.S. at 281 n.9.
166 Id. at 319 (Bennan, J., dissenting).
167 Id. at 282.
concern, other than a mere disagreement with the individual choice.168 Anything else would render the liberty interest, protected by the Due Process Clause, a "nullity."169 It was hard to tell if the State was merely disagreeing with Nancy's choice, or if it was just trying to fully ascertain what that choice was by "clear and convincing" evidence.

C. The "Clear and Convincing" Evidence Standard

The clear and convincing evidence standard170 has been warranted "when the individual interests at stake in a state proceeding are both 'particularly important' and 'more substantial than mere loss of money.'"171 This standard ordinarily acts as a "shield" for the individual, rather than a "sword," because it usually acts to protect the individual.172 Here, ironically, the clear and convincing standard acts as the sword, keeping the body alive, instead of being the shield that lays the individual to rest.

Under Missouri law, the incompetent patient must show by clear and convincing evidence that she would choose to disconnect the life support, if she were competent.173 However, when deciding whether the burden is satisfied, the Court only looks at evidence of specific statements of treatment choice made by the patient, when he or she was competent, in order to support a finding that the patient, now in a persistent vegetative state, would wish to avoid further

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168 Id. at 313-14 (Brennan, J., dissenting) (quoting Hodgson v. Minn., 497 U.S. 417, 435 (1990)).
169 Id.
170 "The clear and convincing standard of proof has been variously defined in this context as 'proof sufficient to persuade the trier of fact that the patient held a firm and settled commitment to the termination of life supports under the circumstances like those presented . . . .' Cruzan, 497 U.S. at 285 n.11 (quoting In re Westchester County Med. Ctr., 531 N.E.2d 607, 613 (N.Y. 1988)).
173 See Cruzan, 497 U.S. at 280.
medical treatment.\textsuperscript{174} According to the Court, only those explicitly expressed wishes of the individual, regarding treatment choices should they become incompetent, will be given any weight at all.\textsuperscript{175}

In \textit{Cruzan}, the petitioners urged the Missouri court to accept the "substituted judgment" of close family members.\textsuperscript{176} The substituted judgment standard requires that a surrogate attempt to reach the decision that the incapacitated person would make if he or she were able to choose.\textsuperscript{177} This standard can only be used if the patient was once able to express his or her wishes, and reliable evidence concerning these wishes is required.\textsuperscript{178} The Court, however, rejected this standard, and concluded that the State may rely only on the incompetent's wishes that have been proven by clear and convincing evidence.\textsuperscript{179}

However, under \textit{Cruzan}, the only evidence that could be proven by clear and convincing evidence are prior statements made by a competent individual concerning the specific life support treatment being employed.\textsuperscript{180} The Supreme Court found that the Missouri Supreme Court did not commit error by holding that there was not clear and convincing evidence that Nancy wished to have the artificial hydration and nutrition withdrawn.\textsuperscript{181} It, therefore, appears that an individual, with no advance directive, would be unable to discontinue a specific medical treatment, unless he or she specifically stated while competent that it should be disconnected if the situation

\textsuperscript{174} \textit{Id.} at 316 (Brennan, J., dissenting). Furthermore, the majority seemed to weigh the option of forbidding oral testimony to determine the wishes of the patient; comparing this terrible situation to contract disputes and will contests. \textit{See id} at 284. Fortunately, the holding of this case does not seem to reach that far.

\textsuperscript{175} \textit{Id.} at 286-87.

\textsuperscript{176} \textit{Id.} at 285-86.


\textsuperscript{178} \textit{Id.} at 133.

\textsuperscript{179} \textit{Cruzan}, 497 U.S. at 286-87.

\textsuperscript{180} \textit{See id.} at 285. "The [trial testimony] did not deal in terms with withdrawal of artificial hydration and nutrition." \textit{Id.}

\textsuperscript{181} \textit{Id.}
ever arose.\textsuperscript{182} This view also fails to consider the protection of children and mentally incompetent individuals who never had the opportunity to express their desires. These individuals were never capable of forming "value preferences which treatment/nontreatment decisions require."\textsuperscript{183} Under \textit{Cruzan}, such individuals will have to be kept alive for years, maybe decades, because they never had the ability to state: "Let me go." In such situations, knowledge of what the individual would choose to do is not as important because the individual never had the capacity to choose. Instead, knowledge of the individual's feelings and perceptions of events becomes paramount when exercising the right to decline treatment.\textsuperscript{184} Only family and friends who have had contact with the never-competent individual understand his or her wishes. However, under the clear and convincing evidence standard, these wishes could never be recognized and the individual would have to put his or her faith in the hands of the state legislature instead of where it properly belongs—in the hands of his or her family.\textsuperscript{185}

Justices Brennan and Stevens agreed with the majority that the individual's choice, if he or she ever had the ability to choose, should be proven with indisputable accuracy.\textsuperscript{186} According to Justice Brennan, "accuracy . . . must be [the] touchstone,"\textsuperscript{187} and the critical question, according to Justice Stevens, is "not how to prove the controlling facts but rather what proven facts should be

\textsuperscript{182} \textit{Id.} at 338-39 (Stevens, J., dissenting) ("An innocent person's constitutional right to be free from unwanted medical treatment is thereby categorically limited to those patients who had the foresight to make an unambiguous statement of their wishes while competent."). Furthermore, it appears that even if the individual had an advanced directive, the specific treatment may not properly be withdrawn if it is not specifically mentioned in the document. \textit{See id.} at 323 (Brennan, J., dissenting). "Too few people execute living wills or equivalently formal directives for such an evidentiary rule to ensure adequately that the wishes of incompetent persons will be honored." \textit{Id.}

\textsuperscript{183} \textit{See} Newman, \textit{supra} note 59, at 48.

\textsuperscript{184} \textit{See id.}

\textsuperscript{185} \textit{See} Cruzan, 497 U.S. at 339 (Stevens, J., dissenting).

\textsuperscript{186} \textit{Id.} at 316 (Brennan, J., dissenting); \textit{id.} at 350 (Stevens, J., dissenting).

\textsuperscript{187} \textit{Id.} at 316 (Brennan, J., dissenting).
controlling.\textsuperscript{188} When the proven facts clearly show that an incompetent individual, with virtually no chance of recovery, would choose to discontinue life support, the best interest of the individual has been accurately demonstrated, and no general state policy should prevail.\textsuperscript{189} However, under the majority opinion, such a finding is not clear and convincing, because the state is more concerned about other people, instead of the individual who is in need.\textsuperscript{190} Unfortunately, under \textit{Cruzan}, the state ignores those actively struggling, and makes its commitment in the abstract.\textsuperscript{191}

Under the clear and convincing standard, unless there are express wishes from the individual, the state’s interest in the preservation of life will win out over conclusive evidence presented by family, friends, and doctors.\textsuperscript{192} The burden of avoiding an erroneous decision is thus on those seeking to terminate the life support treatment, which presumably reflects the seriousness of the proceeding.\textsuperscript{193} This seems to suggest that the state is in a better position to determine what the individual’s best interests are.\textsuperscript{194} However,"[f]amily members have a unique knowledge of the patient which is vital to any decision on his or her behalf."\textsuperscript{195} Nancy

\begin{itemize}
\item \textsuperscript{188} \textit{Id.} at 350 (Stevens, J., dissenting).
\item \textsuperscript{189} \textit{Id.}
\item \textsuperscript{190} \textit{Cruzan}, 497 U.S. at 350. "A State that seeks to demonstrate its commitment to life may do so by aiding those actively struggling for life and health." \textit{Id.} at 357 (Stevens, J., dissenting).
\item \textsuperscript{191} \textit{See id.} at 356-57 (Stevens, J., dissenting). Nancy Cruzan was ultimately granted the right to die. Several months after the Supreme Court decision, new evidence was discovered and judicial permission was granted to withdraw the life support. This time, the State of Missouri did not oppose the Cruzan's family request. \textit{See Andrew H. Malcolm, Missouri Family Renews Battle Over Right to Die, N.Y. TIMES, Nov. 2, 1990, at A14. Nancy Cruzan died 11 days after judicial permission was granted to discontinue the tube feeding and almost eight years after her quest for self-determination began. \textit{See ALAN MEISEL, THE RIGHT TO DIE, at xii (Supp. 1994).}}
\item \textsuperscript{192} \textit{See Cruzan, 497 U.S. at 282-83.}
\item \textsuperscript{193} \textit{See John N. Suhr, Jr., Cruzan v. Director, Missouri Department of Health: A Clear and Convincing Call for Comprehensive Legislation to Protect Incompetent Patients’ Rights, 40 Am. U. L. Rev. 1477, 1505 (1991).}
\item \textsuperscript{194} \textit{See id.} at 1505-06.
\item \textsuperscript{195} Newman, \textit{supra} note 59, at 46. The individual’s family will know the incompetent’s "life style, values, medical attitudes, and general world view." \textit{Id.} In nearly all situations, the personal knowledge possessed by one’s family, regarding an incompetent individual, will be much deeper and more insightful than hospital staff,
Cruzan’s family and friends knew her views and testified at trial. The State, however, was a stranger to Nancy, and had no way of knowing what her interests were. Therefore, this extremely personal decision should have been left to Nancy’s family, absent clear and convincing evidence that removing the treatment would not have been in her best interest.

D. The Right to Die After Cruzan

The Supreme Court’s decision in *Cruzan* did not limit the constitutional right to die. The Court merely determined that when a guardian seeks to discontinue nutrition and hydration from an incompetent individual, a state *may* apply a clear and convincing evidence standard in such proceedings. This does not “prevent other states from applying a lower standard of proof to determine a patient’s intent or merely deferring to the decisions of close family attending physicians, guardians ad litem, judges and, most importantly, the State.”

The evidence presented at trial showing Nancy’s interests included the testimony of a long-time friend, co-worker and housemate, who, after recalling a conversation the two had, testified that “Nancy . . . would never want to live [in a vegetative state]” because “she didn’t want to live that way, . . . she wanted to be able to live, not to just lay in bed and not be able to move because you can’t do anything for yourself.” *Cruzan*, 497 U.S. at 321-22 n.19. This friend also stated that Nancy said she hoped all of her family knew that she didn’t want to live in a vegetative state because she thought it would be up to them. *Id.* at 322. Other evidence adduced at trial included testimony from Nancy’s sister—describing two very serious conversations on the subject—Nancy’s mother, and another friend. *Id.* at 322 n.19. The Missouri Supreme Court dismissed Nancy’s statements to the long time friend as “‘unreliable’ on the ground that it was an informally expressed reaction to other people’s medical condition.” *Id.* at 322 n.19 (citing *Cruzan*, 760 S.W.2d at 424). The Missouri Supreme Court never referred to any other evidence or why it was rejected. *Id.*

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197 See *id.* at 328 (Brennan, J., dissenting).

196 See *id.*

199 See *Suhr, supra* note 193, at 1517.

200 See *id.* at 1512.

201 *Cruzan*, 497 U.S. at 284.
Because there is no national consensus on this sensitive problem, the decision, therefore, rests with the individual states. Because there is no national consensus on this sensitive problem, the decision, therefore, rests with the individual states. Later cases have made it clear that Cruzan does not mandate the use of the "clear and convincing evidence" standard when deciding "right to withdraw treatment" cases. Some courts have held that cases involving important personal rights will not be governed by the "clear and convincing" standard or the "beyond a reasonable doubt" standard. Rather, "the seriousness of the decision will be more forcefully impressed on judges if they are required to set forth findings in 'meticulous detail' than if they merely label their findings as meeting a particular standard. Furthermore, the courts that have retained the clear and convincing standard have not applied it in such a rigid fashion, as applied by the Supreme Court in Cruzan. For example, in DeGrella v. Elston, the facts were extremely analogous to those in Cruzan. However, Martha Sue DeGrella received her wish while Nancy

202 Suhr, supra note 193, at 1512; see Cruzan, 497 U.S. at 292 (O'Connor, J., concurring) (stating that this decision "does not preclude a future determination that the Constitution requires the States to implement the decisions of a patient's duly appointed surrogate. Nor does it prevent States from developing other approaches for protecting an incompetent individual's liberty interest in refusing medical treatment.").

203 See Cruzan, 497 U.S. at 292 (O'Connor, J., concurring).

204 See In re Doe, 583 N.E.2d 1263, 1272 n.19 (Mass.), cert. denied sub nom. Doe v. Gross, 112 S. Ct. 1512 (1992). While some cases have used the clear and convincing standard (see, e.g., Mack v. Mack, 618 A.2d 744, 753 (Md. 1993)), some have not (see, e.g., Doe, 583 N.E.2d at 1271 (employing a "'preponderance of the evidence' [standard] with an 'extra measure of evidentiary protection' [by reason of] specific findings of fact after a 'careful review of the evidence.'"))

205 See, e.g., Doe, 583 N.E.2d at 1271.

206 Id. at 1271 (quoting Custody of a Minor, 393 N.E.2d. 836, 844 (Mass. 1978)).

207 858 S.W.2d 698 (Ky. 1993).

208 In DeGrella, the individual at issue was an incompetent patient in a persistent vegetative state with no chance of recovery. Id. at 700-01. She was being kept alive through the use of a gastrostomy tube implanted into her stomach so that she could receive nutrition and hydration. Id. at 700. No advance directive was executed and the individual did not specifically state, when she was competent, that she desired the removal of artificial nutrition and hydration, if such a need ever existed. Id. at 703. She did state, as did Nancy Cruzan, that she did not want to be kept alive by artificial means. Id. at 702.
Cruzan did not.\textsuperscript{209} Martha’s wish was granted because the court recognized "it would be unreasonable to require such a high degree of specificity on her part" to state that she did not want artificial nutrition and hydration administered.\textsuperscript{210} The court found that the statements made to family and friends before her incompetency constituted "competent evidence upon which a surrogate decision-maker could exercise substitute judgment in the circumstances presented."\textsuperscript{211} Therefore, statements made regarding life threatening situations will sometimes, depending on the court, be accepted as competent evidence of an individual’s wishes.

Not all cases after Cruzan involved the withdrawal of artificial nutrition and hydration. \textit{McKay v. Bergstedt,}\textsuperscript{212} decided a few months after Cruzan, involved a mentally competent quadriplegic, who sought a court order permitting the removal of his respirator.\textsuperscript{213} While originally presented as a Cruzan "right-to-die" case, one distinguishing factor made this a case of first impression. Kenneth Bergstedt, the individual seeking court permission to terminate life prolonging treatment, sought to have a sedative administered when his respirator was disconnected, thereby relieving any pain accompanying his demise.\textsuperscript{214} In deciding Kenneth’s plight, the Nevada Supreme Court added a fifth state interest after discussing the

\textsuperscript{209} Nancy Cruzan ultimately was granted the right to die, but not by the United States Supreme Court. \textit{See supra} note 191. The opinion in \textit{Cruzan} seems to suggest that if Martha DeGrella’s case was before the Court, Martha’s wish would not have been granted either because she did not expressly state that artificial nutrition and hydration should be discontinued if the situation ever presented itself.

\textsuperscript{210} \textit{DeGrella,} 858 S.W.2d at 703.

\textsuperscript{211} \textit{Id.} According to the \textit{DeGrella} court, Martha Sue DeGrella:

\begin{quote}
\begin{flushleft}
\texttt{[R]epeatedly expressed the view that she would not want to be kept alive by artificial means. She found the plight of Karen Ann Quinlan and Quinlan’s continued treatment to be abhorrent to her. She hated any limitations on her abilities and she feared being reduced to being dependent on others. She went so far as to protest being put on a respirator after her second automobile accident, even though no question ever existed that she would recover.}
\end{flushleft}
\end{quote}

\textit{Id.} at 702-03 (quoting the trial court’s Finding of Fact, Conclusions of Law and Judgment, Sept. 3, 1992) (footnote omitted).

\textsuperscript{212} 801 P.2d 617 (Nev. 1990).

\textsuperscript{213} \textit{Id.} at 620.

\textsuperscript{214} \textit{Id.} at 620.
four traditional state interests.\textsuperscript{215} This fifth interest involves the State's ability to "encourag[e] the charitable and humane care of those lives [that] may be artificially extended under conditions which have the prospect of providing at least a modicum of quality living."\textsuperscript{216} This state interest seeks to encourage humane care and treatment for all citizens stricken with disabilities.\textsuperscript{217} Its underlying purpose is to enhance the quality of life of these individuals so that they can more fully enjoy their lives, no matter how limited.\textsuperscript{218}

However, when no compelling state interest exists to countervail the removal of life support, the court must recognize that "a patient's 'right to be free from pain at the time the ventilator [or other life support system] is disconnected is inseparable from his right to refuse medical treatment.'"\textsuperscript{219} The \textit{Bergstedt} court immunized any physician, who assisted the patient or administered medication to minimize pain, from any civil or criminal liability.\textsuperscript{220} The \textit{Bergstedt} court has, therefore, gone a step further than the \textit{Cruzan} Court, and seems to be condoning physicians actively assisting their patient's death. Unfortunately, the Nevada Supreme Court granted Kenneth's wish after he had passed away.\textsuperscript{221}

\textbf{IV. Is it Really a Big Step From the Right to Die to the Right to Obtain Assistance to Die?}

The \textit{Bergstedt} case suggests that this country is moving towards legalizing assisted suicide or voluntary active euthanasia. The natural progression of this body of law seems to show that this is precisely the direction in which we are going.\textsuperscript{222} Twenty years

\textsuperscript{215} The four traditional state interests are: (1) preserving the sanctity of life; (2) preventing suicide; (3) protecting third parties; and (4) preserving the integrity of the medical profession. \textit{See discussion supra} part II.B.2.

\textsuperscript{216} \textit{McKay}, 801 P.2d at 621.

\textsuperscript{217} \textit{Id.} at 628.

\textsuperscript{218} \textit{Id.}

\textsuperscript{219} \textit{Id.} at 631 (quoting \textit{State v. McAfee}, 385 S.E.2d 651, 652 (Ga. 1989)).

\textsuperscript{220} \textit{Id.} The dissent argued that this case was nothing less than a homicide, and that it decreed the legality of assisted suicide. \textit{Id.} at 633 (Springer, J., dissenting).

\textsuperscript{221} \textit{Bergstedt}, 801 P.2d at 619 n.1.

\textsuperscript{222} \textit{See generally supra} part II (analyzing the right-to-die background).
ago, doctors, lawyers, and ethicists were debating whether to merely withhold life support treatment. Then the Quinlan decision shifted the debate to withholding versus withdrawing extraordinary life support. The debate subsequently changed again, focusing on the withdrawal of extraordinary life support versus ordinary life support. It then refocused on the rights of incompetent patients versus competent patients, and then finally on the rights of terminally ill patients versus non-terminally ill patients with incurable disease. Twenty years later, the "right-to-die" issue continues to evolve.

A. Are Assisted Suicide and Active Euthanasia Proper Terms?

Before going further, we should ask whether a terminally or incurably ill person's decision to end his or her pain and suffering is properly categorized as "suicide." Suicide has been defined as "the deliberate termination of one's own life."223 However, suicide is currently viewed as the "act of a mentally ill, sick, and depressed individual, who require[s] medical treatment."224 People like Diane, Louise, and countless others should not be insulted or


224 Maria T. CeloCruz, Aid-in-Dying: Should We Decriminalize Physician-Assisted Suicide and Physician-Committed Euthanasia?, 18 AM. J.L. & MED. 369, 375 (1992). This was a primary reason why suicide is no longer considered a criminal offense. See T. Patrick Hill, The Right to Die: Legal and Ethical Considerations, 85 S. MED. J. 55, 55 (1992). However, most states have prohibitions against assisted suicide. See John A. Alessandro, Suicide and New York Law, 57 ALB. L. REV. 819, 858 (1994).

Oregon has recently passed legislation, known as Measure 16, that will allow doctors to hasten death for terminally ill individuals. See The 1994 Elections: Ballot Issues; Voters in Oregon Allow Doctors to Help the Terminally Ill Die, N.Y. TIMES, Nov. 11, 1994, at A28. However, on December 27, 1994, a federal judge issued a preliminary injunction so that legal arguments could be made on the issue. See Paul Leavitt, Assisted Suicide Law on Hold in Oregon, USA TODAY, Dec. 28, 1994, at 3A.

225 Diane was the patient Dr. Timothy E. Quill helped "over the edge into death in the face of such severe suffering." See Timothy E. Quill, Death and Dignity—A Case of Individualized Decision Making (Sounding Board), 324 NEW ENG. J. MED. 691, 694 (1991). Timothy Quill's description of Diane does not paint a picture of a mentally ill, depressed person in need of treatment. In fact, Diane was a strong willed, independent person who overcame much adversity. Id. She merely wanted to maintain her dignity, and die peacefully. Id.
belittled by classifying their deaths as a suicide. They were strong willed, proud people who dearly wanted to live, but were unable to do so in the manner in which they were accustomed. This is not suicide, this is self-determination at its final stage. For these reasons, "suicide" is an unjust label pinned upon those courageous individuals who have endured so much suffering. Therefore, the term "assisted suicide" will no longer be used in this Note when referring to a patient's right to receive assistance in dying.

Similarly, active euthanasia is not a proper term to use when discussing an individual's desire for peace and serenity. Euthanasia is a term synonymous with Nazi death camps, and the extermination of specific groups of people. Hitler's maddening programs ultimately sought the purification of the Volk. Hitler also, however, sought to free national resources that were being "wasted" on the State's mental and physical dependents. Contrary to today's society, the Nazi regime's determination of whose life was worth living was made by physicians, not the individual. These were acts of murder perpetrated on helpless victims without their consent or knowledge. Today, the "right to die with assistance" movement is grounded in individual choice, and has no resemblance, whatsoever, to the Nazi euthanasia programs of the not too distant past.

Active euthanasia is also often referred to as "mercy killing." The term "mercy killing" generally refers to methods of shooting or strangulation, which have never been methods employed

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226 Louise (not her real name) was a patient with an unidentified disease, who terminated her pain and suffering with the assistance of Compassion in Dying (an organization that helps terminally ill people end their lives). See Lisa Belkin, There's No Simple Suicide, N.Y. TIMES MAG., Nov. 14, 1993, at 51. Louise was lucid and competent at the time of her death. Id. She wanted to avoid the debilitating effects of her terminal illness, which included the eventual disintegration of her brain. Id.


228 Volk is German for "people." Hitler's ultimate goal was to create a "pure" Volk. See Mary M. Penrose, Assisted Suicide: A Tough Pill to Swallow, 20 PEPP. L. REV. 689 (1993).

229 See id.

230 See id.

231 See BURNELL, supra note 86, at 248.

232 Id. at 248.
by today's euthanasia practitioners. Although euthanasia practitioners are driven by mercy, they do not deserve to be thrown in the same category as depraved murderers or ruthless thugs. Therefore, as with suicide, the term euthanasia will not be used hereinafter because of its connotations to Nazi death camps and mercy killings. The psychological effects of using "suicide" or "euthanasia" make it nearly impossible to erase the negative images so as to properly see the positive aspects.

The right to self-determination has been defined as "an individual's 'strong . . . personal interest in directing the course of his own life, an individual's right to behave and act as he deems fit.'" An individual's interest in directing his own death should be just as personal. Therefore, the term defining a physician's assistance, in either prescribing drugs to bring about a consenting patient's death or affirmatively performing the act that brings about that patient's death, will hereinafter be referred to as "assisted self-determination." While this is merely a linguistical alteration, the term more properly respects all the parties involved.

Assisted self-determination would encompass a dying patient's general right to receive a physician's assistance in order to end his or her pain and suffering. This right is not limited to receiving a physician's aid in merely obtaining potentially deadly medication. It includes a patient's right to have the affirmative assistance of the physician (or other third party), who performs the act which brings about death. To have one without the other would deprive hopelessly ill patients of a right that others have merely because they

233 Id.

234 In re Jobes, 529 A.2d 434, 453 (N.J. 1987) (Handler, J., concurring) (quoting In re Conroy, 486 A.2d 1209, 1223, 1228 (N.J. 1985)).

235 The term "assisted self-determination," therefore, encompasses the meaning of both assisted suicide and active euthanasia. For definitions of these two terms, see Cheryl K. Smith, What About Legalized Assisted Suicide, 8 ISSUES L. & MED. 503, 504 (1993). See MEISEL, supra note 24, §§ 3.9, 3.10, at 62-66 (defining assisted suicide and active euthanasia).

236 This is generally considered Assisted Suicide. See Smith, supra note 235, at 504.

237 This affirmative assistance is what distinguishes active euthanasia from assisted suicide. See id.
have reached the point where they can not act for themselves.\textsuperscript{238} Therefore, assisted self-determination does not distinguish between patients. It treats them equally and with compassion.

\textit{B. The Right to Assisted Self-Determination is Not Absolute}

Just as the right to withdraw life sustaining medical treatment is not absolute,\textsuperscript{239} the right to receive life ending medical treatment is also not absolute.\textsuperscript{240} Such a right would depend on the condition of the patient, the illness, and the same competing state interests highlighted in the right-to-die cases.\textsuperscript{241} After all, the right to die and the right to assisted self-determination are extremely analogous. In both situations, an individual ultimately wants his or her suffering ended, and to be rid of a seemingly endless burden. However, there must be safeguards to protect against abuse.

Voluntariness is the most important requirement that must be present when deciding whether a right to assisted self-determination exists.\textsuperscript{242} As in committing suicide, a terminally ill patient's rational decision to obtain assisted self-determination must be "an exercise of free will."\textsuperscript{243} If such a decision is not based on free will, the patient does not make an informed choice about the type of treatment desired. This would amount to no more than involuntary euthanasia, which is contrary to the very idea of assisted self-determination. Therefore, an individual's choice would have to "entail[] an

\textsuperscript{238} An example of this would be two patients with Lou Gehrig's disease. For a description of the symptoms of this dreaded disease, see \textit{supra} text accompanying notes 2-5. If one patient has unfortunately progressed to the point of paralysis, he or she will not have the means of performing the final act, while the other patient, who is just as terminal, has "fortunately" not reached the point of total dependence, and thus may perform the final act. See Scenario 1 & 2, \textit{supra} pp. 115-16.


\textsuperscript{240} See CeloCruz, \textit{supra} note 224, at 386-88.

\textsuperscript{241} See discussion \textit{supra} part II.B.2.

\textsuperscript{242} See MEISEL, \textit{supra} note 24, § 2.16, at 30 (arguing that "a patient's permission is not legally effective unless it is voluntary").

opportunity to evaluate knowledgeably the options available and the risks attendant upon each."\(244\)

To determine whether this decision was voluntarily made would seem to require that the patient be competent so as to be able to make the informed choice.\(245\) An individual that was in an accident and has subsequently lapsed into a persistent vegetative state would not be able to arrive at an informed decision, and presumably would not have planned for such a situation in a living will or other advanced directive.\(246\) However, this would seem to preclude an individual whose disease renders her incompetent before she takes the final steps that will end her misery.\(247\) Assisted self-determination could be an answer for them if their wishes were known. However, the severity of the action would warrant a clear and convincing standard.\(248\) Unlike *Cruzan*,\(249\) where only passive steps were to be taken, the "clear and convincing" standard is warranted here because of the active steps to be taken and the severity of the treatment. Therefore, only competent individuals who can give their informed decision will generally be able to assert this right, although an incompetent individual who was prepared to assert this right but was ultimately unable to, will be given the chance if such wishes can be proven by clear and convincing evidence.

A further limitation on the right to assisted self-determination would be the severity of the illness and the stage to which it has progressed. Although, the right to withdraw life-sustaining treatment

\(244\) *Id.* at 366 n.15. This passage refers to the informed consent doctrine, discussed supra notes 37-43 and accompanying text.


\(246\) Living wills generally govern situations dealing with withholding or withdrawing life-sustaining treatment in the event the individual is rendered incompetent. See BLACK’S LAW DICTIONARY 1102 (Abridged 6th ed. 1991). As of today, living wills do not encompass assisted suicide or active euthanasia treatment because such treatment is currently illegal. See Leslie Laurence, *Physicians Ponder Dealing with Patient Choosing Death*, HOU S. CHRON., Sept. 22, 1993, at 2.

\(247\) See MEISEL, supra note 24, § 1.3, at 6. "[M]any patients are not able to participate in decisionmaking for the very reason that a decision needs to be made—that is, because they are incapacitated by the severity of their illness." *Id.*

\(248\) See discussion supra part III.C. (analyzing the clear and convincing standard).

\(249\) 497 U.S. at 273.
exists for terminal and non-terminal patients, the right to assisted self-determination, unfortunately, cannot be so broad. This right can only exist for patients who are terminally or incurably ill, and who are in advanced stages of their illnesses as determined by an independent physician. This limitation protects against abuses, including coercion, undue influence, and fraud. For example, there may be "some unfortunate situations in which family members will not act to protect a patient." By limiting the individuals eligible to exercise this option to terminally or incurably ill patients in advanced stages of their illnesses, these abuses will be protected. Furthermore, this serves to protect patients who have treatable illnesses, such as depression. For most of those patients that are not in the final stages of life, but are incurably ill and in pain, there is a built-in safeguard available to them. Most incurably ill patients who are suffering a great deal are presumably on some type of life-support apparatus. They can merely direct its removal.

The remaining limitations on the right to assisted self-determination are the state's interests that may counter the individual's decision. These state interests are the same interests

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250 See Bouvia v. Superior Court, 225 Cal. Rptr. 297, 302 (1986). "We conclude that the trial court was incorrect when it held that the right to have life-support equipment disconnected was limited to comatose, terminally ill patients, or representatives acting on their behalf." Id.; see discussion supra part II.B.4 (analyzing classifications of patients with respect to the right to die issue).

251 See Sidney H. Wanzer et al., The Physician's Responsibility Toward Hopelessly Ill Patients, 320 NEW ENG. J. MED. 844, 848 (1989) (arguing that assisted suicide is permissible when the patient is beyond all help, as determined by the physician, and not merely suffering from depression, which can be treated by therapeutic means).

252 Cruzan, 497 U.S. at 281.

253 See supra note 224.

254 See generally Bouvia, 225 Cal. Rptr. at 299. In this case, it was argued that Elizabeth Bouvia's ability to tolerate physical discomfort did not diminish her right to immediate relief. Id. Her mental and emotional feelings are equally entitled to respect. Id. Moreover, "she has a right to refuse the increased dehumanizing aspects of her condition created by the insertion of an [artificial mechanism] into her stomach, and therefore, she has the right to remove it." Id.

255 See discussion supra part II.B.4.
that were present in the right to die cases. But, there has been a fifth state interest, enunciated by at least one court in Nevada, that tries to enhance the quality of life of those who are disabled. Unfortunately, for patients in the final stages of a terminal illness, whose quality of life can not be enhanced, the only thing that can be done for them is to try and ease their suffering. However, for some of these patients, the suffering is just too great because the treatment merely extends their lives without alleviating their pain. For these patients, upon their consent, something should be done.

C. Arguments For and Against Assisted Self-Determination

Although actively taking one's own life is no longer considered a crime in the United States, it is generally considered illegal to actively aid a person in committing suicide. Currently, at least two states have actively sought to legalize an individual's right to receive assistance in dying. Although both measures failed, public opinion polls evidence popular support for these measures. Today, majorities of up to sixty-four percent have favored proposals that would permit a physician to actively end the suffering of a terminal patient. Even more striking is that seventy-nine
percent of adults under the age of thirty-five would permit physician
assisted suicide for terminally ill patients who requested it. To
understand why the legislation in the two states failed, the arguments
for and against the right to assisted self-determination must be
examined.

Perhaps the most important argument for the legalization of
assisted self-determination is relief from pain and suffering.
Opponents of this argument stress that most physical pain can be
relieved by some type of medication. However, in cancer patients
alone, it has been reported that ten to fifteen percent of these patients
have significant pain and troublesome symptoms in the last few weeks
of life. Furthermore, physicians often undertreat pain in
individuals who are severely ill because they are afraid to be
perceived as assisting in their death. One reason for inadequate
pain treatment is that physicians often lack knowledge regarding
proper pain management. Therefore, education about symptom
control, specifically pain management, is desperately needed and
should be fostered in this country.

Another principle encompassed in this argument about pain
and suffering is referred to as the "double effect" principle, which
consists of performing an act with a good effect intended, which also

264 For purposes of this Note, the arguments for and against assisted suicide and
active euthanasia will be used.
265 See BURNELL, supra note 86, at 256 (citing K. M. Foley, The Treatment of
Cancer Pain, 313 NEW ENG. J. MED. 84 (1985); Robert I. Misbin, Physicians' Aid in
Dying, 325 NEW ENG. J. MED. 1307 (1991)).
266 See BURNELL, supra note 86, at 255.
267 See Leslie Laurence, Physicians Ponder Dealing With Patient Choosing Death,
HOUS. CHRON., Sept. 22, 1993, at 2. Dr. Timothy E. Quill stated that "[w]hen you're
afraid, the safest way to go is to underpalliate, undermedicate and keep going with
medical treatment. This is not good care. We need to make a commitment not to
abandon our dying patients." Id.
268 See Kathleen M. Foley, The Relationship of Pain and Symptom Management to
Patient Requests for Physician-Assisted Suicide, 6 J. PAIN & SYMPTOM MGMT. 289,
269 See id. at 291 (citing Sidney H. Wanzer et. al., The Physician's Responsibility
Toward Hopelessly Ill Patients, 320 NEW ENG. J. MED. 844 (1989)).
causes an indirect or unintended effect. Proponents of this principle argue that while intending a patient's death is immoral, not intending that death but letting the patient die is not. However, there really is no difference because the outcome for each is the same. In a 1991 survey, nearly fifty percent of physicians polled indicated that they have deliberately taken steps that would indirectly cause a patient's death. Therefore, even though such a practice is against the law, many physicians do assist their patients in their time of need.

A physician's duty to assist a patient in his or her time of need relates to the physician's responsibility to his patients. The Hippocratic Oath states: "I [the physician] will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect." However, the World Medical Association issued an updated version of the oath in 1948, which makes no mention of deadly drugs. Furthermore, today, the Hippocratic oath is "sworn to by only 6 percent of medical students [and modified versions of the oath are offered in 42 percent of the [medical] schools. Technologies progress and values change. To strictly adhere to an oath formed centuries ago is ludicrous, and denies the advancements made in the medical sciences.

Some critics also argue that this type of "treatment" will adversely affect the current physician-patient relationship. This argument insists that if a physician is permitted to assist some patients in dying, this practice will "reduce the public's trust in doctors and in the health care system." However, it is generally not treatment

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270 See Smith, supra note 235. This double effect principle is illustrated by Dr. Timothy Quill in his much discussed article in The New England Journal of Medicine. See Quill, supra note 225. Dr. Quill prescribed a lethal dose of barbiturates so that his patient, Diane, could end her suffering. Id.

271 See Smith, supra note 235, at 512.

272 See BURNELL, supra note 86, at 259.

273 See id. at 344-45.

274 See id. at 64-65.

275 Smith, supra note 235, at 516.

276 Furthermore, the Hippocratic Oath has already been violated by numerous doctors who have performed abortions, and who have charged fees for teaching others the art of medicine. See BURNELL, supra note 86, at 344-45.

277 See Newman, supra note 76, at 170.
alternatives that affect trust in the physician-patient relationship. It is the physician's professional attitude, degree of compassion, and level of caring that wins or loses trust. Assisted self-determination may actually foster this relationship because the dying experience is truly profound, and to share it with someone who understands and who will acknowledge the suffering "surely must create one of the most trusted bonds that can be possible."

Additionally, assisted self-determination would not mandate that physicians perform something that will violate their ethical code. In a recent survey, seventy percent of physicians were found to have supported the right of patients to choose active euthanasia. Furthermore, depending on the case, "anywhere from 10 to 88 percent of physicians would accede to patients' requests for death if all liability for civil and criminal liability were removed." These statistics illustrate that ethical codes are not the only factors that deter physicians—liability is also a major deterrent. If the liability was removed, perhaps more physicians would be willing to assist patients. This would allow physicians who do not want to assist the dying patient the added assurance that his or her patient's needs would be addressed. To lay down a blanket rule and state that it is morally against a physician's ethical code to assist a dying patient ignores reality and is over-inclusive. Instead of fighting the patient, a physician's primary goal should be to ease that patient's suffering through treatment, medication, or by assistance in dying as a last resort.

An argument has also been made that assisting the patient in his or her death will ultimately result in a "slippery slope" effect, where allowing assisted suicide for some patients will lead to assisted

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278 See id. at 171. "Doctors who display the traditional virtues—warmth, compassion, skill and attentiveness—will win their patients' trust. Doctors who are too busy, too machine oriented, or too emotionally frozen, will not." Id.

279 Id. at 172 (quoting Should Physicians Perform Euthanasia?, AM. MED. NEWS Jan. 7, 1991, at 12, 15 (response of Anne I. Davis, Professor of Nursing Ethics, University of California, San Francisco)).

280 See BURNELL, supra note 86, at 259.

281 Id.


283 See, e.g., id. at 514; BURNELL, supra note 86, at 257.
suicide for others. However, this would ignore the fact that lines are drawn and distinctions are often made. Instead of defining the change in right to die legislation as being on a slippery slope, the change is more appropriately defined as "a gradual recognition . . . of one's right of self determination over against tradition, law, and technology." By accepting the slippery slope argument, one believes that physicians are murderers, and do not care about their patients. However, the majority of physicians in this country are deeply dedicated, and only care about their patients' well being and happiness. They want to help ease their patient's suffering and most presumably will go the extra step and assist in their death to accomplish this end. When there is no hope there is no justifiable reason to prolong suffering.

V. Closing Thoughts

When there is no hope left for a dying individual, the knowledge that one has the legal right to end the suffering is often a great consolation. Dying individuals need to know they are not alone and that there are people who care about them. This Note does not argue for an absolute right to assisted self-determination. The right to assisted self-determination should, in all cases, be viewed as a dying patient's last resort. Advancements in technology occur daily, and a patient must exhaust all avenues of treatment before considering this "deeply personal decision of obvious and overwhelming finality." But once exhausted, the patient should

284 Smith, supra note 235, at 514. Some have suggested the slippery slope argument has proven true, given the state of the right-to-die cases. See Clouser, supra note 10, at 306.
285 Smith, supra note 235, at 514-15. "If the argument were true, then legal abortion should by now have led to legal infanticide." Id. at 515.
286 Clouser, supra note 10, at 307.
287 See Pugliese, supra note 57, at 1305 (finding that many physicians have privately admitted that they have helped terminally ill patients end their suffering by prescribing drugs potent enough to end their lives).
288 "[P]hysicians, like most people, still find death distasteful and prefer to help people to continue living as long as there is still hope." Smith, supra note 235, at 517.
289 Cruzan, 497 U.S. at 281.
have a right to end his or her suffering.

The Canadian Supreme Court recently decided this very point. Although, the Court, in a five-to-four ruling, denied the individual's plea to be exempted from a criminal law making assisted suicide illegal, one dissenter set out a number of conditions which would have allowed the relief sought. These conditions included: permission from a superior court judge, certification of competency and impending physical deterioration from a physician and psychiatrist, mandatory presence by a doctor at the scene, daily examinations, and that the final act be performed by the terminal individual. While these guidelines are significant, they fail to

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291 Id. at 3.


293 Rodriguez, File No. 23476, at 64-65 (Lamer C.J., dissenting). Canada's Chief Justice Antonio Lamer's conditions included:

1. A dying person must first apply to a superior court judge for permission to end his or her life.
2. A physician and a psychiatrist must certify in court that the person wishing to die is competent to make the decision. They must also confirm that the individual's decision was made freely and voluntarily.
3. A doctor must also agree to be present at the time the individual commits assisted suicide.
4. The physician and psychiatrist must also certify that the dying person will become physically incapable of committing suicide unassisted and that they have advised the person of the right to a change of mind.
5. The dying person must be examined daily by one of the certifying physicians to ensure that the individual still wishes to take his or her life.
6. The act causing the death of the dying person must be done by that individual. This would be done through medical/technological means that would allow an extremely ill person to simply push a button.

Id.

294 See id. Chief Justice Lamer's guidelines, at a minimum, show that proper safeguards can be implemented in the area of assisted self-determination. See generally Rodriguez, File No. 23476, at 52-65 (Lamer J., dissenting) (discussing safeguards that need to be implemented). In the future, these guidelines will no doubt play an important role in the continuing expansion of the right to die doctrine in Canada and possibly here
protect those individuals who do not have the capacity to simply push a button. For these patients who can not affirmatively cause their own death, an added guideline should be included. The attending physician, if he so consents, may affirmatively "push the button." If the physician does not consent, he may defer to a second physician who will be willing to perform the act. This requirement affords a competent incapacitated individual the same rights as other individuals, and also protects the physician if his ethical code forbids him to actively assist in the process.

There is no justifiable reason to support why the individuals in Scenarios 1 and 2 at the beginning of this Note are not afforded the same rights. Under Cruzan, the individual in Scenario 1 will presumably not receive the assistance desired because this would constitute active euthanasia. While the individual in Scenario 2 will most probably get his wish under Cruzan. The only recognizable difference between the two scenarios is time. For some, time is a blessing, full of precious moments with family and friends. Many, perhaps most, people want to hang on until the very last moment, and relish what time they have left. These courageous people have the right to live as long as they wish, in the condition they wish, and deserve the finest treatment available.

But if someone has the right to live as long as he wishes, that individual should also have the right to live as short as he wishes. For these individuals, time is a dreaded curse, full of agony and despair. An individual should not suffer because he "unfortunately" has not reached the stage of his or her illness where life-sustaining treatment is necessary. Whichever route they take, they deserve the support and understanding of their family, physicians and, more importantly, society. This Note does not contend that all terminally or incurably ill people want to end their lives sooner than nature intends. But, for those individuals who are in unbearable pain, the state should not have the right to prolong suffering and despair merely because of an abstract interest in the preservation of all life.

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in the United States. See id. at 65 (stating that these guidelines may be used for future petitioners who suffer from a condition similar to Ms. Rodriguez).

295 See supra pp. 115-16.
296 But see supra note 8.
297 See Cruzan, 497 U.S. at 262, 277.
Not long ago, an article was published in the *Saturday Evening Post* describing a family’s painful experience watching a loved one waste away with cancer. The cancer was everywhere in the patient, and was causing vomiting and uncontrollable bladder and bowel movements. The body was deteriorating, full of pain and fatigue. The patient’s family finally realized that they "were keeping [the loved one] alive for us, not for him . . . . For him, death would surely be a welcomed relief." This painful story was not describing a human being, although it very well could. It was describing a beloved family dog, named Foxy.

The title of this Note and the *Saturday Evening Post* article illustrates that society has compassion and understanding for the animal kingdom. The practice of euthanasia is humane for animals but, presently, assisted-self determination is not for human beings. It is time we show terminally ill individuals the same compassion, understanding, and respect we show animals, and assist them when they need the help the most.

*Scott I. Davidson*

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299 *Id.*

300 *Id.*

301 *Id.*

302 *Id.* The final paragraph of the article stated that the veterinarian’s best advice was "to let the animal die with dignity, [w]hich is, after all, the best one could ask for a human being." *Id.* at 22.

303 "If an animal is terminally ill, aged and suffering from a number of irreversible ailments that cause it pain, or has suffered injuries from which no successful recovery can be expected within a reasonably short period of time, euthanasia is unquestionably the best and most humane solution." Emil P. Dolensek & Barbara Burn, *The Penguin Book of Pets: A Practical Guide to Animal-Keeeping* 307 (1978) (emphasis added).