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A History of the Law of Assisted Dying in the United States

Alan Meisel
University of Pittsburgh

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A HISTORY OF THE LAW OF ASSISTED DYING IN THE UNITED STATES

*Alan Meisel**

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* Professor of Law Emeritus and Dickie, McCamey & Chilcote Professor of Bioethics Emeritus, University of Pittsburgh.

I. INTRODUCTION

PEOPLE have been killing other people ever since Cain slew Abel.¹ And people have been punished for killing ever since God punished Cain.² Well, at least that is the biblical version. Regardless of its origins, killing another human being—and aiding others in taking their own lives—has long been regarded—or perhaps has always been regarded—as an offense not only against the victim but against society as a whole. These basic beliefs are the historical, cultural, and psychological context in which the practice of assisted dying must be viewed and understood.

II. TERMINOLOGY

To understand the history of assisted dying in the United States, it is first useful, if not necessary, to understand the terminology used to describe this phenomenon, in large part because the terminology is so varied, sometimes fraught with emotion, occasionally overlapping, and sometimes contradictory.

What are we talking about when we talk about assisted dying? The general term we use to refer to killing another human being is *homicide*.³ This term carries no moral connotations—that is, no connotations of legal or ethical wrongdoing.⁴ Homicide includes the crimes of murder and manslaughter,⁵ but not all killings are criminal. Some instances of killing are legally, if not always morally, justifiable or excusable (terms which themselves have distinct meanings in law).⁶ Capital punishment, self-defense, defense of another, killing caused by mental illness, and killing in war are some of the categories in which the killing of another person is not necessarily criminal.⁷ These are, depending on the circumstances, examples of possibly legal homicide.

In any discussion of the meaning of assisted dying, there also needs to be an exploration of the different meanings of suicide. Literally, the word *suicide* means self-killing, the taking of one's own life.⁸ During some periods of American history, the law has treated suicide as an offense against society, and during some periods of English history, English law—the source of the American common law of suicide—has treated failed suicide as a crime and successful suicide as an offense against the state, leading to the imposition of penalties on the body, the estate, or both of the

1. *Genesis* 4:8.

2. *Id.* at 4:10.

3. *Homicide*, BLACK'S LAW DICTIONARY (11th ed. 2019).

4. *Id.*

5. *Id.*

6. *See, e.g., id.* at *Justifiable Homicide*.

7. *See, e.g., id.*

8. *Id.* at *Suicide*.

deceased.⁹ To further confuse things, at some times and in some places, assisted (or, as it is sometimes termed, aiding) suicide has been classified as a type of homicide.¹⁰

These are the general outlines of the law from which contemporary American law has developed around the practice of assisted dying. But in addition to these legal terms, there are a number of other related terms which are not legal terms per se but which affect the understanding of the current debate about the legalization of assisted dying. The more important of these terms are:

1) *Euthanasia*. From the Greek, literally meaning “good death,” euthanasia refers to the practice of ending a person’s life for professionally compassionate or merciful reasons¹¹—hence the frequently used synonym *mercy killing*.¹² Euthanasia usually refers to ending another’s life but is sometimes also used to refer to the practice of providing assistance to another who seeks to end his own life to escape (i.e., assisting suicide) from the burdens of some illness, injury, or disability.¹³ Occasionally, the term *euthanasia* includes suicide by one seeking to end his own life for the same reasons.¹⁴

2) *Voluntary, involuntary, nonvoluntary euthanasia*. Euthanasia may be voluntary—which denotes that the person whose life is ended consented to it.¹⁵ It may be involuntary—denoting that the practice is opposed by the person whose life is ended.¹⁶ It may be nonvoluntary, in which case the person whose life is ended has no ability to approve or disapprove of what is to happen to him because of cognitive impairment.¹⁷ There may be total impairment because of unconsciousness or partial impairment, such as profound dementia, in which case the person may be aware but unable to either consent or refuse.¹⁸

3) *Active euthanasia*. This phrase refers to the kind of euthanasia in which some “act” is taken to end a person’s life.¹⁹ In the contemporary context, it usually refers to the direct administration of a lethal dose of a medication by injection or infusion to a terminally ill patient.²⁰ However, the phrase *active euthanasia* also sometimes includes the provision of a lethal dose of medication or the writing of a prescription for such a dose to a terminally ill patient with the pa-

9. Helen Silving, *Euthanasia: A Study in Comparative Criminal Law*, 103 U. PA. L. REV. 350, 370 (1954).

10. See, e.g., *People v. Roberts*, 178 N.W. 690, 693 (Mich. 1920), *overruled by* *People v. Kevorkian*, 527 N.W.2d 714, 738–39 (Mich. 1994).

11. *Euthanasia*, BLACK’S LAW DICTIONARY.

12. *Id.*

13. *Id.*

14. *Id.*

15. *Id.* at *Voluntary Euthanasia*.

16. *Id.* at *Involuntary Euthanasia*.

17. *Id.* at *Nonvoluntary Euthanasia*.

18. *Id.*

19. *Id.* at *Active Euthanasia*.

20. See *id.*

tient self-administering the lethal agent.²¹ However, it is preferable to refer to the latter as a “physician-assisted suicide” or “physician-aided dying” (or similar terms) when the party providing the medication or prescription is a physician,²² or merely “assisted suicide” or “assisted dying” when the party is not a physician—preferable because of the moral connotation associated with causation.²³ In the former instance (i.e., direct administration), the physician or other third party is the direct cause of the patient’s death,²⁴ whereas in the latter, the patient is the direct cause and the physician or other third party is a more remote actor in the chain of causation.²⁵ The phrase *active euthanasia* is also sometimes used to refer to an act that ends a patient’s treatment, such as removing medical life support from a patient, but as will be seen, this is more properly referred to as “passive euthanasia.”²⁶

4) *Aid-in-dying; assisted dying*. These terms are increasingly used to refer to the practices referred to previously as assisted suicide or physician-assisted-suicide, as a way of avoiding the negative connotations associated with the term *suicide*.²⁷

5) *Passive euthanasia, letting die*. These phrases are used synonymously to refer to a variety of practices that involve forgoing life-sustaining medical treatment for a patient who is terminally ill, critically ill, permanently unconscious, or who fits some similar description.²⁸ They can include both stopping a treatment that is already in progress or not starting a treatment that might prolong the patient’s life.²⁹ Stopping treatment is sometimes referred to as “withdrawing treatment,” and not starting is sometimes referred to as “withholding treatment.”³⁰

Although American case law sometimes uses the *letting die* terminology,³¹ it is rare that the term *passive euthanasia* is used.³² Although withdrawing treatment sometimes involves the performance of an act, American law still does not consider it to be active euthanasia.³³ That term is reserved exclusively for the practice of administering a lethal agent to a patient (or, as previously discussed, it is occasionally applied to

21. *See id.*

22. *Physician-Assisted Suicide*, BLACK’S LAW DICTIONARY.

23. *Id.* at *Assisted Suicide*.

24. *Id.* at *Physician-Assisted Suicide*.

25. *Id.* at *Assisted Suicide*.

26. *Id.* at *Passive Suicide*.

27. *Terminology of Assisted Dying*, DEATH WITH DIGNITY, <https://www.deathwithdignity.org/terminology> [<https://perma.cc/CH25-YVD4>] (last visited Nov. 7, 2019).

28. *Passive Euthanasia*, BLACK’S LAW DICTIONARY.

29. *Id.*

30. *Id.*

31. *See, e.g.*, *Vacco v. Quill*, 521 U.S. 793, 806 (1997).

32. *But see Myers v. Schneiderman*, 30 N.Y.3d 1, 35–36 (N.Y. 2017) (Fahey, J., concurring).

33. *See, e.g.*, *Fosmire v. Nicoleau*, 551 N.E.2d 77, 82 (N.Y. 1990).

providing the patient with the lethal agent or a prescription to obtain that agent).³⁴

My focus here is the history of efforts in the United States to legalize voluntary, physician-aided dying—that is, a physician providing a patient (or someone acting on behalf of a patient) with a prescription for a lethal dose of medication intended for the patient to self-administer.³⁵ The patient must possess decision-making capacity and make the request voluntarily.³⁶

That is not to say that proposals have never been made to legalize nonvoluntary or even involuntary aid-in-dying (with the assistance of physicians, other health care professionals, lay people, or a class of persons designated by law to carry out such tasks),³⁷ but such proposals are so far out of the mainstream that they are not currently worthy of discussion. Furthermore, although there has been some public debate about making physician-aided dying available for persons who are not terminally ill, those too have not gained any traction in the legalization movement and therefore are not the subject of discussion here. I will also discuss passive euthanasia because the development of the law in this area is critical to an understanding of the legalization of physician-aided dying and not because it is considered to be a form of physician-aided dying.

III. HISTORY OF THE LAW OF CRIMINAL HOMICIDE

Historically, under American law and its English antecedent, homicide—the killing of another person—is *prima facie* the crime of murder or manslaughter.³⁸ However, as previously discussed, not all killings of another human being are criminal.³⁹ The important defenses to homicide are rarely relevant in this context. However, three other aspects of the law of homicide are relevant to the current discussion; they are motive, consent, and the shortening of life's duration.

First, in determining whether a killing is criminal, it is generally accepted that the motive of the killer is irrelevant.⁴⁰ Motive may be relevant in the determination of an appropriate punishment, but it is not

34. *Id.*; *Active Euthanasia*, BLACK'S LAW DICTIONARY.

35. *Id.* at *Physician-Assisted Suicide*.

36. *See, e.g.*, OR. REV. STAT. § 127.800 (2017).

37. *See, e.g.*, 'Legalize Euthanasia' Says Expert, BBC NEWS, <http://news.bbc.co.uk/2/hi/health/5056326.stm> [<https://perma.cc/F45M-ALW5>] (last updated June 8, 2006).

38. *See, e.g.*, MODEL PENAL CODE § 210.1(2) (AM. LAW. INST. 1980).

39. *See supra* notes 3–7 and accompanying text.

40. *Barber v. Superior Court*, 195 Cal. Rptr. 484, 487 (Cal. Ct. App. 1983); WAYNE R. LAFAYE, CRIMINAL LAW § 3.6, at 243 (3d ed. 2000) ("One who intentionally kills another human being is guilty of murder, though he does so at the victim's request and his motive is the worthy one of terminating the victim's suffering from an incurable and painful disease."); ROLLIN M. PERKINS & RONALD N. BOYCE, CRIMINAL LAW 927–29 (3d ed. 1982). However, motive may play an informal role in mitigating the criminal process. LAFAYE, *supra*, § 3.6, at 245 ("[T]he existence of a good motive on the part of the guilty person may be taken into account wherever there is room for the exercise of discretion in the proceedings against that person.").

relevant to whether or not a crime has, in the first instance, been committed.⁴¹ Thus, the fact that in killing another, one is motivated by the desire to confer a benefit on the other person—for instance, to be merciful by relieving that person’s suffering, no matter how extreme the suffering is—cannot be taken into account in determining whether the killer has committed a crime.

Second, consent is not a defense to criminal homicide—i.e., to a charge of murder or manslaughter.⁴² That is, if the person who is killed consents to having his life ended, a crime has still been committed, assuming that all the other elements of the offense have been established.⁴³ Indeed, even if the killing takes place at the request of the person who is killed, regardless of the reason, and even if the person is fully mentally competent, consent is not a legally valid defense.⁴⁴ Thus, at least in theory, mercy killing is always a crime. Whether in fact the killer will be subject to punishment is another matter, which will be discussed later.

Finally, the fact that the person whose life is taken was already dying, or was even very close to death, does not excuse the killer.⁴⁵ Shortening a person’s life by killing, no matter what the expected duration of the life was, is still *prima facie* criminal.⁴⁶

A. THE LAWS OF SUICIDE AND ATTEMPTED SUICIDE

For obvious reasons, suicide has never been a crime in the same sense that homicide is. Nonetheless, English common law imposed penalties on people who attempted suicide but failed, and it even imposed penalties on the interests of people who successfully committed suicide.⁴⁷ Attempted suicide was (and still is) seen as a sign of what was then called insanity, and those who unsuccessfully attempted it were usually treated in the same manner as others who were considered to be insane.⁴⁸ To some extent, that is also the case today.⁴⁹ A failed suicide attempt can be a ticket to involuntary psychiatric hospitalization.

Those who successfully committed suicide were, at common law, denied burial in consecrated ground.⁵⁰ In fact, at some times, those who committed suicide were subjected to ignominious burial, which involved

41. *Id.*

42. *Edinburgh v. State*, 896 P.2d 1176, 1180 (Okla. Crim. App. 1995); *People v. Cleaves*, 280 Cal. Rptr. 146, 151 (Cal. Ct. App. 1991); see LAFAVE, *supra* note 40, § 5.11, at 516; PERKINS & BOYCE, *supra* note 40, at 1075.

43. LAFAVE, *supra* note 40, § 5.11, at 516.

44. *Id.*

45. See, e.g., *Barber*, 195 Cal. Rptr. at 486–87.

46. *Id.* at 487.

47. See *State v. Willis*, 121 S.E.2d 854, 855 (N.C. 1961).

48. *McElwee v. Ferguson*, 43 Md. 479, 480 (Md. 1876) (noting that attempted suicide is regarded by some to be “a positive sign or symptom of insanity”); Alex B. Long, *Abolishing the Suicide Rule*, 113 Nw. U. L. REV. 767, 775–76 (2019).

49. Long, *supra* note 48, at 776 (“Suicide is still often linked with mental illness in the minds of many Americans . . .”).

50. See G. Steven Neeley, *Self-Directed Death, Euthanasia, and the Termination of Life-Support: Reasonable Decisions to Die*, 16 CAMPBELL L. REV. 205, 209–10 (1994).

burial in a road with a stake driven through their hearts.⁵¹ At a time when church and state were far less separate than they are today, such a result had religious sanctions, as well as the force of law.⁵² Indeed, religious belief was the source of the legal sanction, originating in even earlier times when ecclesiastical law and secular law were a unitary form of social control.⁵³ Furthermore, if successful suicides had any property, their estates were subject to escheat; that is, their heirs were denied their inheritance and the estate passed to the crown instead.⁵⁴ If this result were ever the law in the American colonies, it ended very early in the nation's existence.

B. THE LAW OF ASSISTED SUICIDE

The way in which the common law treated those who assisted another in committing suicide was not nearly as straightforward, nor as certain, as the way in which it treated homicide, attempted suicide, and suicide. Some jurisdictions viewed assisted suicide as a form of criminal homicide, and the perpetrator could be tried as if he had actually killed the victim.⁵⁵ Others viewed the person assisting in the suicide as an accessory to the crime of homicide with the likelihood of the imposition of a lesser penalty than if the perpetrator was viewed as a killer.⁵⁶ Other jurisdictions created a separate crime of assisted suicide.⁵⁷ And still others—such as Michigan—have refused to criminally convict those who aid another to commit suicide, which is why Dr. Jack Kevorkian was not successfully prosecuted for the suicides that he assisted in Michigan in the 1990s.⁵⁸

IV. THE MODERN AMERICAN LAWS OF HOMICIDE, SUICIDE, ATTEMPTED SUICIDE, AND ASSISTED SUICIDE

The laws of homicide, suicide, attempted suicide, and assisted suicide are almost exclusively a matter of the law of the individual states rather than federal law. Consequently, the laws vary from state to state. Nonetheless, there are some features common to many aspects of the relevant law.

Homicide. The basic outlines of the law of homicide have changed very little from the common law. Most state criminal law is now encompassed in statutes enacted by each state legislature, but it does not deviate

51. See Silving, *supra* note 9, at 370.

52. See Neeley, *supra* note 50, at 209.

53. See *id.* at 209–10.

54. See *id.* at 209.

55. See Derrick Augustus Carter, *Knight in the Duel with Death: Physician Assisted Suicide and the Medical Necessity Defense*, 41 VILL. L. REV. 663, 702 n.56 (1996).

56. *Id.* at 678.

57. *Id.* at 702 n.56.

58. See, e.g., Elizabeth Gmyrek, Comment, *The Debate on Physician-Assisted Suicide Reaches the Federal Courts: A Discussion on the Decisions of the District and Circuit Courts in Compassion in Dying v. Washington State*, 16 PACE L. REV. 359, 368 (1996).

greatly from the traditional judge-made law of homicide. Although each state has its own statutory law, not only of homicide but of all crimes, there is a great similarity among the states because of mid-twentieth century efforts, led by the American Law Institute, which promulgated a *Model Penal Code*.⁵⁹ This code is not law; rather it is, as its name suggests, a model law, which only acquires the force of law if adopted by a particular state's legislature.⁶⁰ Even then, each legislature may make modifications to the model code including the rejection of certain provisions.⁶¹

For present purposes, what is most relevant is the same matter discussed relating to the common law of homicide, namely, that motive is not relevant to whether or not a crime has been committed.⁶² As a result, mercy killing remains criminal, consent is not a defense, and the shortening of a dying person's life by ending it also remains criminal.

Suicide. Unlike the law of homicide, the contemporary law of suicide has changed considerably from the common law. No state now considers suicide to be a criminal offense (nor does British law).⁶³ The practices of ignominious burial and escheat were relegated to the scrap heap of legal history over the course of the nineteenth century.⁶⁴

Attempted suicide. Attempted suicide, however, is still of concern to the law, and it is now considered a matter of public health, usually dealt with by civil statutory and case law, rather than criminal law.⁶⁵ Many states deal with attempted suicide under their mental health laws, which may lead to involuntary confinement in a mental health facility or involuntary treatment as an outpatient.⁶⁶ Although there are no statistics maintained on this matter, it is unlikely that a person nearing death from a medical condition will be subjected to involuntary psychiatric hospitalization for a failed suicide attempt. However, it is probably more likely that a person with a terminal condition who is not actually close to death will, in the aftermath of a failed suicide attempt, be offered psychiatric treatment or even possibly subjected to involuntary inpatient or outpatient treatment.

Assisted suicide. With the exception of those few states (to be discussed later) that have legalized physician-aided dying, aiding another person to end his life—even a terminally ill person and even a terminally ill person who is close to death—remains a criminal offense in all the other states.⁶⁷

59. *Model Penal Code*, BLACK'S LAW DICTIONARY (11th ed. 2019).

60. See Sanford H. Kadish, *Codifiers of the Criminal Law: Wechsler's Predecessors*, 78 COLUM. L. REV. 1098, 1144 (1978).

61. *Id.*

62. See *supra* notes 40–41 and accompanying text.

63. LAFAYE, *supra* note 40, § 7.8, at 699.

64. See generally Long, *supra* note 48, at 775–77 (summarizing changes in societal views of suicide from the eighteenth to the twentieth century).

65. Thomas J. Marzen et al., "Suicide: A Constitutional Right?"—Reflections Eleven Years Later, 35 DUQ. L. REV. 261, 265–66 (1996).

66. Carter, *supra* note 55, at 675.

67. For a list of states that do not criminalize physician-aided dying, see *Death with Dignity Acts*, DEATH WITH DIGNITY, <https://www.deathwithdignity.org/learn/death-with-dignity-acts/> [https://perma.cc/9BNS-8VMN] (last visited Sept. 11, 2019).

Even in those states that have legalized physician-aided dying, aiding another to end his life outside of the strict requirements of the aid-in-dying law is still a criminal offense.⁶⁸ That is, a person who is not a physician but otherwise conforms to the aid-in-dying law is subject to prosecution, as is a physician who fails to comply with the legal requirements for physician-aided dying.⁶⁹ That is not to say that very many prosecutions occur of people who aid another, especially if the person aided is terminally ill, but the laws making such assistance a crime remain on the books and are occasionally enforced, enough such that they probably deter many people from rendering such assistance no matter how merciful it might be to do so. Because aiding suicide remains illegal, it is also extremely difficult to know how frequently it is practiced either by physicians or laypeople.

V. EUTHANASIA AND ASSISTED SUICIDE FOR THE TERMINALLY ILL

Despite the legal prohibitions on euthanasia and aiding another in committing suicide—or more likely because of them—efforts began in the twentieth century to enact laws to legalize either or both of these practices. Separate proposals differed in their goals. Some sought to legalize voluntary mercy killing while others mixed voluntary and involuntary euthanasia. Some sought to legalize mercy killing, others simply sought to legalize assisted suicide, and others sought to legalize both.

A. NINETEENTH AND EARLY TWENTIETH CENTURY

Although it is likely that mercy killing and assisted suicide have been contemplated, discussed, and written about since time immemorial, modern discussions of the subject gained momentum in the latter half of the nineteenth century.⁷⁰ In the early 1870s, a contentious debate in Britain reprised the arguments for and against legalization of voluntary euthanasia,⁷¹ and at the end of the nineteenth century, the debate “had become a topic of speeches at medical meetings and editorials in British and American medical journals.”⁷²

A full-blown debate erupted in the 1930s in the United Kingdom, followed in short order in the United States, and it resurfaced in both countries after World War II.⁷³ Although these proposals were for voluntary euthanasia, they sprang from contentious ideas, proposals, and actual leg-

68. See, e.g., OR. REV. STAT. § 127.890 (2017).

69. See, e.g., *id.*

70. See *infra* note 71.

71. See generally Lionel A. Tollemache, *The New Cure for Incurables*, 19 FORTNIGHTLY REV. 218 (1873); *Euthanasia*, POPULAR SCI. MONTHLY, May 1, 1873, at 93; *Mr. Tollemache on the Right to Die*, SPECTATOR, Feb. 15, 1873, at 10; Lionel A. Tollemache, *The Limits of Euthanasia*, SPECTATOR, Feb. 22, 1873, at 12 (letter to the editor).

72. Ezekiel J. Emanuel, *Euthanasia—Historical, Ethical, and Empiric Perspectives*, 154 ARCHIVES INTERNAL MED. 1890, 1892 (1994).

73. Yale Kamisar, *Some Non-Religious Views Against Proposed Mercy-Killing Legislation*, 42 MINN. L. REV. 969, 969 n.3 (1958).

isolation dealing with eugenics and involuntary sterilization in the United States in the first two decades of the twentieth century.⁷⁴ A number of states enacted laws permitting involuntary sterilization of the “mentally unfit,” a practice that was constitutionality upheld in the infamous 1927 U.S. Supreme Court case of *Buck v. Bell* in which Justice Holmes penned the now immortal phrase, “Three generations of imbeciles are enough.”⁷⁵ In Germany, similar concerns were voiced, leading to the adoption of a law modeled on the Virginia statute that had been ruled constitutional in *Buck*.⁷⁶ In addition, there was popular enthusiasm in Germany for euthanasia of people suffering from incurable illness, including mental illness, and for euthanasia of “severely retarded and defective children.”⁷⁷ After the Nazi party came to power, such euthanasia policies became widespread.⁷⁸ One commentator has observed that “Hitler’s authorization was not so much a command but an extension of ‘the authority of physicians . . . so that a mercy death may be granted to patients’”⁷⁹ This occurred even before the establishment of concentration camps and the practice of mass killing of those groups thought to be inimical to the well-being of German society and culture.⁸⁰ And “[e]ven as late as 1944, severely malformed adults [in Germany] were being brought for ‘euthanasia’ at the request of their families.”⁸¹

A movement to legalize euthanasia also began to develop in the United States in the 1930s.⁸² However, this kind of euthanasia was far different from what was contemplated and eventually practiced in Germany.⁸³ The motivation in the United States was to relieve the suffering of terminally ill patients,⁸⁴ rather than eugenics. This was reflected primarily in the fact that it would only be available to adults who were in possession of decision-making capacity.⁸⁵ In 1932, the Voluntary Euthanasia Legalisation Society was founded in the United Kingdom, and six years later a similar organization, the Euthanasia Society of America, came into existence in the United States.⁸⁶ A bill fashioned by the British organization was introduced in the House of Lords in 1936 permitting a person over the age of twenty-one who was suffering from an incurable and fatal disease to

74. See Emanuel, *supra* note 72, at 1892 n.35.

75. *Buck v. Bell*, 274 U.S. 200, 207 (1927).

76. *Influence of Virginia’s Eugenic Sterilization Act*, UVA CLAUDE MOORE HEALTH SCI. LIBR., <http://exhibits.hsl.virginia.edu/eugenics/4-influence/> [<https://perma.cc/3BNU-T5HV>] (last visited Nov. 7, 2019).

77. D. Alan Shewmon, *Active Voluntary Euthanasia: A Needless Pandora’s Box*, 3 ISSUES L. & MED. 219, 227–28 (1987).

78. *Id.*

79. *Id.* at 228 (quoting FREDRIC WERTHAM, *A SIGN FOR CAIN: AN EXPLORATION OF HUMAN VIOLENCE* 162 (1973)).

80. *Id.*

81. *Id.*

82. See Kamisar, *supra* note 73, at 969 n.3.

83. *Id.*

84. See *id.* at 975, 978.

85. *Id.* at 978–79.

86. Edward J. Gurney, *Is There a Right To Die?—A Study of the Law of Euthanasia*, 3 CUMB.-SAMFORD L. REV. 235, 237 (1972).

request to be euthanized by a physician after specified medical examination and certification and approval by a special court.⁸⁷ The bill was debated but not enacted.⁸⁸ A similar bill was introduced in the Nebraska legislature a year later, and it too was not enacted.⁸⁹

B. THE RENEWAL OF THE DEBATE, POST-WORLD WAR II

During World War II, legislation to legalize euthanasia got sidelined in both the United States and the United Kingdom.⁹⁰ However, it again rose to the surface in the post-war era, though against a decidedly different backdrop.⁹¹ The Nazi euthanasia program and death camps cast a long shadow over post-war discussions of the legalization of euthanasia for terminally ill patients. The post-war debate was initiated by Glanville Williams, an eminent British professor of jurisprudence at the University of Cambridge. His book, *The Sanctity of Life and the Criminal Law*, published in 1958, was primarily responsible for an upsurge of interest in the legalization of euthanasia.⁹² That is not to say that others had not contributed to the debate. According to Professor Yale Kamisar, who later played an extremely influential role in the post-war debate about legalization, the following literature played important roles in the debate, in support of legalization: an article co-authored by an eminent American law professor at Columbia University, Herbert Wechsler; another article by the British intellectual, G. K. Chesterton; and a book by the German criminologist, Hermann Mannheim.⁹³

Kamisar, then a young law professor at the University of Minnesota and destined to become a leading scholar of criminal law, was probably the foremost opponent—at least in this early portion of the debate—and has remained an outspoken and prolific opponent of the legalization of any form of actively hastening death. Williams and Kamisar engaged in a scholarly exchange—beginning with Williams’s book, continuing with a lengthy rebuttal by Kamisar in a law review article,⁹⁴ followed by a rejoinder from Williams⁹⁵—which more or less established the terms of the debate from then until the present time. Williams’s rationale for legalization was humanitarian—to provide release from suffering of the terminally ill when there was no alternative to death.⁹⁶ Kamisar, while sympathetic to that rationale, nonetheless opposed legalization for a number of reasons, his primary fear being that, once legalized for a narrowly defined set of circumstances, it would inevitably expand, possibly

87. *Id.* at 251–52.

88. *Id.* at 252.

89. *Id.*

90. *See* Emanuel, *supra* note 72, at 1892.

91. *See id.*

92. GLANVILLE WILLIAMS, *THE SANCTITY OF LIFE AND THE CRIMINAL LAW* (1958).

93. Kamisar, *supra* note 73, at 970, 976 n.26.

94. *See generally id.*

95. Glanville Williams, “Mercy-Killing” Legislation—A Rejoinder, 43 MINN. L. REV. 1 (1958).

96. *See, e.g., id.* at 1.

even to include involuntary euthanasia.⁹⁷ This fear, of course, had the recent historical precedent of involuntary American sterilization and involuntary Nazi sterilization and euthanasia to help make the case.

One important thing to note about the early post-World War II debate is that it focused on “the cancer victim begging for death,” not the “the *involuntary variety*, that is, the case of the congenital idiot, the permanently insane or the senile.”⁹⁸ That too, no doubt, was the result of the events in Germany preceding and including the Nazi era. This, in effect, took involuntary euthanasia off the table, and it has remained off the table in all subsequent legislative proposals, not only in the United States but in all European countries.⁹⁹

C. THE EFFECT OF MEDICAL TECHNOLOGY AND THE “RIGHT TO DIE”

The now-famous case of Karen Ann Quinlan, commencing in 1975, marked the beginning of a new era in the law of end-of-life decisions.¹⁰⁰ In that year, Karen, a young woman in New Jersey, became unconscious after consuming drugs and drinking alcohol.¹⁰¹ As a result, she stopped breathing.¹⁰² Emergency medical technicians were summoned, and she was transported to a hospital where she was put on a mechanical ventilator to restore her respiration and circulation.¹⁰³ Because too much time had elapsed between the time she stopped breathing and its restoration, she suffered brain damage so severe that she was eventually diagnosed as being in a persistent vegetative state.¹⁰⁴ This meant (at least at that time) that she would never regain consciousness and would remain in a state where she experienced nothing—no cognition, no awareness of her environment, no perception of any sort.¹⁰⁵

Because of this dire prognosis, her parents raised the question about whether life support (in this case, a ventilator) should be continued or whether it should be withdrawn with the inevitable consequence that she

97. See, e.g., Kamisar, *supra* note 73, at 976.

98. *Id.* at 969 (emphasis in original).

99. Although only voluntary euthanasia has been legalized in a number of western European countries, there are periodic reports that involuntary euthanasia is practiced nonetheless. See, e.g., *Review of Countries Where Euthanasia Has Been Legalised. Increasing Involuntary Euthanasia, Without Consent by Patients*, BIOETHICS OBSERVATORY (Aug. 15, 2017), <http://www.bioethicsobservatory.org/2017/08/euthanasia-in-patients-who-have-not-requested-it/12046> [<https://perma.cc/555P-5CT5>]. Whether or not abuse was occurring in the Netherlands was a matter of dispute among the Justices in *Washington v. Glucksberg*. Compare *Washington v. Glucksberg*, 521 U.S. 702, 734 (1997), with *Glucksberg*, 521 U.S. at 786 (Souter, J., concurring) (“There is, however, a substantial dispute today about what the Dutch experience shows.”).

100. *In re Quinlan*, 355 A.2d 647 (N.J. 1976).

101. *In re Quinlan*, 348 A.2d 801, 806 (N.J. Super. Ct. Ch. Div. 1975).

102. *Quinlan*, 355 A.2d at 653–54.

103. *Id.* at 654.

104. *Id.*

105. *Id.* at 655.

would die.¹⁰⁶ The Quinlans were concerned not only with the medical aspects of the situation but also with the moral ones.¹⁰⁷ As Roman Catholics, they consulted their priest and were advised that termination of life-sustaining treatment would not be inconsistent with Catholic teachings.¹⁰⁸ Based on this religious perspective and on medical opinions the Quinlans obtained about Karen's prognosis, they requested that their daughter's physicians discontinue the ventilator that was keeping her alive so she could die peacefully.¹⁰⁹

The physicians refused this request, both out of their concern for potential legal liability for causing Karen's death and because of their view that allowing her to die would violate medical ethics.¹¹⁰ Karen's parents were thus left either to accede to the doctors' views or to obtain a court order permitting the doctors to terminate life support. They chose the latter route and the New Jersey Supreme Court eventually ruled in their favor. It held that Karen's father, as her judicially appointed guardian, had the legal authority to authorize the termination of medical treatment if termination is what Karen would have decided had she been able to do so.¹¹¹ The court also held that physicians who relied on a decision made by a legal guardian would be immune from liability for so doing.¹¹²

The issues in the *In re Quinlan* case arose as the result of vast changes in medical technology beginning in the 1950s, technology that could keep people alive who would previously have inevitably died.¹¹³ The problem was that some of these technologies were what is referred to as *half-way technologies* because, while they could keep people alive, they frequently could not restore them to the status quo ante or anything resembling it.¹¹⁴ Thus, Karen, while alive, was completely nonfunctional.¹¹⁵ And *vegetative state* is an apt term; only Karen's vegetative functions—respiration, circulation, and metabolism—were still operative, all others had ceased.¹¹⁶ The vast majority of patients dependent on half-way technologies are by no means in straits as dire as Karen was but their quality of life is often seriously impaired—some depend on ventilators to breathe, dialysis to

106. *Id.* at 656–57. Ultimately, ventilatory support was withdrawn but Karen Quinlan continued to breathe without it despite predictions to the contrary. She lived another ten years and ultimately died of an untreated infection. See *Karen Quinlan Dies After 10-Year Coma: N.J. Case Prompted Historic Decision to Disconnect Respirator*, L.A. TIMES (June 12, 1985, 12:00 AM), www.latimes.com/archives/la-xpm-1985-06-12-mn-6097-story.html [https://perma.cc/H74S-J5JB].

107. *Quinlan*, 355 A.2d at 657.

108. *Id.* at 658–59.

109. *Id.* at 656.

110. *Id.* at 656–57.

111. *Id.* at 664.

112. *Id.* at 671.

113. See, e.g., Arthur S. Slutsky, *History of Mechanical Ventilation*, 191 AM. J. RESPIRATORY & CRITICAL CARE MED. 1106, 1108 (2015).

114. See Bryan Rowland, *Communicating Past the Conflict: Solving the Medical Futility Controversy with Process-Based Approaches*, 14 U. MIAMI INT'L & COMP. L. REV. 271, 273 (2006).

115. *Quinlan*, 355 A.2d at 655.

116. *Id.* at 654.

cleanse their blood of toxins, or a vast array of medications that frequently have serious side effects and can negatively interact with each other. In many of these cases, the patients, if in possession of decision-making capacity, no longer believe their lives to be worth living or they may have, in advance of becoming so situated but in contemplation of the possibility, issued directions to the same effect.

Quinlan was the first of many similar cases seeking to have life-sustaining medical treatment withheld or withdrawn.¹¹⁷ Resistance from physicians to permit patients to forgo life-sustaining treatment caused many patients (and families of patients who had lost decision-making capacity) to seek judicial relief to permit such treatment to be withheld or withdrawn.¹¹⁸ By 1990, when the first of these cases reached the U.S. Supreme Court, there were approximately 100 similar cases that had been decided by courts in about half of the states.¹¹⁹ In all likelihood, this was just the tip of the iceberg. No one knows how many cases such as these arise each year, but the numbers are at least in the tens, and possibly hundreds, of thousands.

The case before the U.S. Supreme Court, *Cruzan v. Director, Missouri Department of Health*, also involved a young woman in a persistent vegetative state.¹²⁰ Although the Supreme Court's ruling was not nearly as comprehensive as those issued by the state courts in other end-of-life cases—simply because the issue presented in the *Cruzan* case was narrower than in most of the cases in the state courts—the fact that the highest court in the land issued a ruling in such a case was in itself momentous. The Court's decision acknowledged the right of patients to forgo life-sustaining treatment and the right of the families of patients who lacked decision-making capacity to forgo life-sustaining treatment on their behalf in accordance with the law of whatever jurisdiction the patient was in.¹²¹

D. THE “RIGHT TO DIE” AS A TRANSITIONAL STAGE TO ACTIVELY HASTENING DEATH

The impact of the development of the right to die on the acceptance of actively hastening death cannot be underestimated, for what is the right to die but *passively* hastening death?

Prior to cases like *Quinlan* and *Cruzan*, there was tremendous legal uncertainty about whether allowing patients to die—always with their consent (either contemporaneously from a patient possessing decision-making capacity or anticipatorily from a formerly competent patient) or with the consent of their legally authorized representative—was legally

117. ALAN MEISEL, KATHY L. CERMINARA & THADDEUS MASON POPE, *THE RIGHT TO DIE: THE LAW OF END-OF-LIFE DECISIONMAKING* § 1.09 (3d ed. 2019) (collecting cases).

118. *See, e.g.*, *Cruzan v. Dir., Mo. Dept. of Health*, 497 U.S. 261, 261–62, 270 (1990).

119. *Id.*

120. *Id.* at 261.

121. *Id.* at 279–80.

permissible or whether it constituted a criminal wrong, a civil wrong, or both. After these cases, and especially after *Cruzan*, almost all doubt was removed, especially if the participants in the process followed the standards and procedures established by the legislation and judicial decisions of the relevant jurisdiction.¹²²

In the relatively short span of a decade and a half between the *Quinlan* decision in 1976 and the Supreme Court's ruling in *Cruzan* in 1990, a consensus developed in state law about what the standards and procedures should be—a consensus which has only solidified and been consolidated in subsequent years—concerning the legal propriety of forgoing life-sustaining medical treatment.¹²³ Two aspects of this consensus are of particular importance to the development of the law concerning actively hastening death. The first has to do with medically supplied nutrition and hydration. For almost ten years before the *Cruzan* case was decided, the question of whether artificial nutrition and hydration—that is, nutrition and hydration provided to a patient through a feeding tube—could be withheld or withdrawn on the same basis as other medical treatments was hotly debated.¹²⁴ Even among those who viewed withholding or withdrawing life-sustaining medical treatment as medically or morally legitimate, or both, there was disagreement about whether withholding or withdrawing a feeding tube was medically, morally, and legally legitimate.¹²⁵ A variety of arguments were urged as to why feeding tubes are different from other forms of medical treatment. One argument was that they are not a medical treatment because they provide basic sustenance, and basic sustenance is not a medical treatment.¹²⁶ Another argument was that withholding or withdrawing a feeding tube results in starving a patient to death and is therefore active euthanasia—killing the patient—

122. *See id.*

123. *See generally* Alan Meisel, *The Legal Consensus About Forgoing Life-Sustaining Treatment: Its Status and Its Prospects*, 2 KENNEDY INST. ETHICS J. 309, 319–26 (1992). To briefly summarize this consensus:

- Patients possessing decision-making capacity have a virtually absolute right to refuse medical treatment, whether life-sustaining or otherwise.
- Patients who lack decision-making capacity have the right to authorize the forgoing of medical treatment, including life-sustaining medical treatment, through an advance directive; that is, in a living will, health care power of attorney, or both, and an advance directive may be oral as well as written.
- Patients who lack decision-making capacity but who have not issued an advance directive have the right to have a surrogate (usually a close family member) make a decision to forgo life-sustaining medical treatment on their behalf.
- Decisions to forgo life-sustaining treatment ordinarily do not require prior judicial approval.
- Medically supplied nutrition and hydration provided through a feeding tube may be withheld or withdrawn on the same basis as any other medical treatment.
- Although forgoing life-sustaining treatment—i.e., passively hastening death or passive euthanasia—is legally permissible with appropriate legal authorization, as far as the law is concerned there is a bright line between passively hastening death by forgoing treatment and actively hastening death, and the latter is absolutely prohibited.

124. *Id.* at 325.

125. *Id.*

126. *Id.*

unlike forgoing medical treatment which merely allows nature to take its course.¹²⁷

The Supreme Court addressed this issue in *Cruzan* in a concurring opinion by Justice O'Connor.¹²⁸ Justice O'Connor relied on an opinion of the American Medical Association stating that feeding tubes are complex medical devices and are often surgically implanted, and so they may be withheld or withdrawn just as any other medical treatment, as long as there is proper legal authorization from a patient or a patient's surrogate.¹²⁹ Her view was that requiring a patient to have a feeding tube—a patient who did not want one or whose legal representative did not authorize it—constituted an intrusion on the bodily integrity of the patient, which, if practiced or authorized by the state, was a violation of the right to be free of unwanted physical restraint—an aspect of the right to liberty protected by the Fourteenth Amendment to the Constitution.¹³⁰

The second aspect of the consensus relevant to development of the law concerning actively hastening death is the so-called “bright line” between passively and actively hastening death. The Supreme Court's *Cruzan* decision did not condemn, and therefore implicitly approved, the practice of allowing patients to die upon their request or the request of their legally authorized representatives.¹³¹ In doing so, it put the Court's imprimatur on the decisions of the state courts to this same effect. By 1990, this was relatively uncontroversial; nonetheless, the Supreme Court's ruling is very important because of the reasoning that the state courts used in arriving at this conclusion.

One of the reasons that Karen Quinlan's physicians refused to take her off life support when her parents requested it was their fear of being held liable for criminal homicide—that is, for killing Karen should she die when ventilatory support was withdrawn.¹³² In its reasoning to the conclusion that there would be no criminal liability under these circumstances, the New Jersey Supreme Court, and other state courts in subsequent cases, put forth a number of explanations.¹³³ One was that, if a patient died under these circumstances, the *cause* of death would be the patient's underlying illness or injury and not the actions of the physicians who withheld or withdrew treatment.¹³⁴ In the same vein, another was that in such situations the doctors were allowing nature to take its course.¹³⁵ Yet another was that there would be no criminal liability because, when life-sustaining medical treatment was forgone, the *intent* was to honor the patient's wishes and thus to honor the patient's legal right to

127. *Id.* at 326–27.

128. *See Cruzan v. Dir., Mo. Dept. of Health*, 497 U.S. 261, 288–89 (1990) (O'Connor, J., concurring).

129. *Id.*

130. *Id.*

131. *Id.* at 280 (majority opinion).

132. *In re Quinlan*, 355 A.2d 647, 668 (N.J. 1976).

133. *See* MEISEL, CERMINARA & POPE, *supra* note 117, § 12.02.

134. *See* Meisel, *supra* note 123, at 327.

135. *See id.*

be free of unwanted interference with bodily integrity, which is what non-consensual medical treatment is.¹³⁶ Yet another was that the doctors would not have killed Karen, they would have only let her die.

All of these explanations have been subject to a great deal of criticism based on their logic, their conflict with fundamental legal principles of criminal law, or both. Nonetheless, one or more of these explanations has been accepted by every appellate court that has considered this matter. In addition, advance directive and surrogate decision-making statutes enacted by state legislatures have been grounded in the same reasoning. Most of these statutes—which permit (1) patients in possession of decision-making capacity to decide what treatments they would or would not want in the event they lose capacity or to appoint a proxy to make decisions for them if they lose capacity, and/or (2) patients to authorize named individuals to make decisions for patients who lack capacity and did not make provisions in advance for decision making under these conditions—specifically prohibit mercy killing, euthanasia, or assisted suicide.¹³⁷ Consequently, it is now well accepted in American law that there is no criminal liability (and no civil liability) for a patient's death resulting from withholding or withdrawing life-sustaining medical treatment *as long as there is legally valid authorization* from the patient (either contemporaneously from a patient possessing decision-making capacity or anticipatorily from a formerly competent patient) or from the surrogate of a patient who lacks decision-making capacity.¹³⁸

These rationales were intended to draw a clear and bright line between the practice authorized by these cases—what is referred to by courts as “forgoing life-sustaining treatment”¹³⁹ or “withholding or withdrawing treatment”¹⁴⁰ but which might just as well be called “passively hastening death” or “passive euthanasia”—and actively hastening death through mercy killing or by assisting the patient in committing suicide. The former honors patients' rights; the latter impermissibly kills patients and constitutes criminal homicide or criminally abetting suicide.

VI. THE GULF BETWEEN THEORY AND PRACTICE

The increasing acceptance in law, in policy, in medical ethics, and in public opinion of the practice of withholding or withdrawing life-sustaining medical treatment—that is, passively hastening death or passive euthanasia—has undeniably had a major impact on the acceptance of actively hastening death. It is difficult to imagine that nine U.S. jurisdictions¹⁴¹ would have legalized physician-aided dying had the groundwork

136. *Cruzan*, 497 U.S. at 288–89 (O'Connor, J., concurring).

137. MEISEL, CERMINARA & POPE, *supra* note 117, § 7.07.

138. *Id.*

139. *See, e.g.*, *Collins v. Lake Forest Hosp.*, 821 N.E.2d 316, 319 (Ill. 2004).

140. *See, e.g.*, *In re Guardianship of L.W.*, 482 N.W.2d 60, 65–66 (Wis. 1992).

141. The nine jurisdictions are California, Colorado, Hawaii, Maine, New Jersey, Oregon, Vermont, Washington, and the District of Columbia. *See Death with Dignity Acts, supra* note 67.

for it not been laid by the acceptance of passively hastening death. However, that has not been the only factor responsible for this. Another has been the increasing realization and publicity about the gulf between theory and practice in actively hastening death. For all the years—indeed centuries—that mercy killing and assisted suicide have been treated as criminal, they have also been practiced, and often with legal impunity.¹⁴² This increasingly came to light in the twentieth century in two ways. The first was through individual legal cases prosecuting individuals who have committed these offenses and the second was through survey research.

A. PROSECUTION OF LAY PEOPLE

Judging from newspaper accounts, there have been a large number of investigations into and prosecutions of individuals accused of mercy killing and/or assisting seriously ill people with ending their lives.¹⁴³ Very few, however, have reached the appellate court level, which would have permitted them to be tallied as “reported cases,” to use the legal vernacular.¹⁴⁴ There is also no readily available means for collecting data on acquittals of people charged with mercy killing or aiding suicide. Only if the defendant is found guilty can there be an appeal, which is a prerequisite to the case being officially reported and enrolled in legal annals.

Based on the reported cases, we know that there are extremely few criminal convictions.¹⁴⁵ We also know from news accounts that there are a far greater number of instances of individuals who engage in mercy killing or assisted suicide.¹⁴⁶ The fact that there are very few reported cases is an indication that there are very few convictions (because acquittals are not appealable)—and “very few” truly understates the order of magnitude, because there are probably only a handful or less in the entire United States in the twentieth century.¹⁴⁷

What this means is that most cases are being disposed of through the exercise of discretion at one or more points in the criminal process,¹⁴⁸

142. See, e.g., *Washington v. Glucksberg*, 521 U.S. 702, 711 (1997) (“[F]or over 700 years, the Anglo-American common-law tradition has punished or otherwise disapproved of both suicide and assisting suicide.”).

143. See, e.g., Tony Perry, *Man, 75, May Face Charges in Mercy Killing of Wife*, L.A. TIMES (Oct. 13, 1999), <https://www.latimes.com/archives/la-xpm-1999-oct-13-mn-21770-story.html> [<https://perma.cc/Y7JN-G6NG>].

144. Ronald B. Standler, *Annotated Legal Cases on Physician-Assisted Suicide in the USA 18–24* (July 29, 2012) (collecting cases) (on file with author).

145. *Id.*

146. *Beyond Brittany: Assisted Suicides Happen in Every State, Insiders Say*, NBC NEWS, <https://www.nbcnews.com/health/health-news/beyond-brittany-assisted-suicides-happen-every-state-insiders-say-n226966> (last updated Oct. 18, 2014).

147. See, e.g., *People v. Roberts*, 178 N.W. 690, 693–94 (Mich. 1920); *Gilbert v. State*, 487 So. 2d 1185, 1192 (Fla. Dist. Ct. App. 1986).

148. See *Griffith v. State*, 548 So. 2d 244, 247 n.7 (Fla. Dist. Ct. App. 1989) (stating that the holding that there is no legal defense of mercy killing “does not mean that the circumstances of so-called ‘mercy killings’ such as this may not be considered in prosecutorial decisions made by a grand jury or the state attorney concerning whether or on what charge an indictment or information should be returned Furthermore, it cannot impede a petit jury’s exercise of its so-called ‘pardon power’ in finding the defendant guilty of a

and there are many such points at which this may occur. At each such point, often despite rather clear evidence that the accused person did engage in mercy killing or assisted suicide, the relevant legal authority may ignore or underplay the import of that evidence. Starting at the beginning of a criminal prosecution and going toward the end, these are some of the more important of such points:

- The coroner or medical examiner may record a death as natural.
- If the police are called upon to investigate the death, they may conclude that there was no “foul play.”
- If the police refer the case to the prosecutorial authority, the prosecutor may decide not to prosecute.
- If the prosecutor decides to prosecute, a plea bargain may be struck with the defendant or a trial court judge may dismiss the charges.
- If a trial occurs without a jury, the court may refuse to convict without giving any reason for so doing.
- If there is a jury trial, the jury may refuse to convict even if the law and facts direct otherwise (a process known as jury nullification).
- Either a judge or a jury may conclude that the defendant was legally insane at the time of the offense and enter a verdict of not guilty by reason of mental illness.¹⁴⁹
- If the jury does convict, the judge may sentence the defendant so leniently that the defendant does not appeal, such as a sentence to community service or a sentence to “time served,” or may place the defendant on probation rather than in confinement.
- A defendant sentenced to confinement may be granted rapid parole or receive a pardon.

These are merely some of the points in the criminal process at which discretion may be exercised to impose no penalty or a minor penalty even when there is clear technical guilt. There are others, and there is the opportunity to plea bargain throughout much of the criminal process.

The lack of convictions in comparison with the number of suspected mercy killings and assisted suicides clearly demonstrates that criminal justice authorities and juries (i.e., the public) are extremely reluctant to impose any penalty on someone whom they deem to have engaged in a merciful act—whether by directly killing or by aiding another—resulting in the death of a person who is seriously ill, chronically ill and infirm, or terminally ill and suffering greatly. This is even more likely to be the case if the victim has requested his own demise,¹⁵⁰ thereby giving lie to the maxim that consent is no defense to a crime, at least in this context.

lesser or of no offense even though the facts may justify (or even require) a greater offense under the letter of the law.”). See generally LAFAYE, *supra* note 40, § 3.6, at 243; Ann Alpers, *Criminal Act or Palliative Care? Prosecutions Involving the Care of the Dying*, 26 J.L. MED. & ETHICS 308 (1998).

149. See Arval A. Morris, *Voluntary Euthanasia*, 45 WASH. L. REV. 239, 242 (1970).

150. See George C. Garbesi, *The Law of Assisted Suicide*, 3 ISSUES L. & MED. 93, 111 (1987); Gurney, *supra* note 86, at 255–56; Morris, *supra* note 149, at 265–66; Williams, *supra* note 95, at 2.

B. PROSECUTION OF HEALTH CARE PROFESSIONALS

Much the same can be said of investigations and prosecutions of health care professionals. Prior to the 1990s and the advent of Dr. Kevorkian, there do not appear to be any reported cases in the legal annals of the prosecution of a physician for mercy killing. There are some newspaper accounts of physicians being prosecuted for mercy killings, perhaps the best known being the 1950 trial of Dr. Hermann Sander in New Hampshire.¹⁵¹ Because Dr. Sander was found not guilty by a jury,¹⁵² there could be no appeal of the case, so there is no formal reported record. However, it is known that the jury acquitted on the ground that there was inadequate proof that Dr. Sander's actions had caused the patient's death, despite the fact that he "dictated into the hospital record a statement that he had injected ten cubic centimeters of air four times into the veins of an incurably-ill, suffering cancer patient and that 'she expired within ten minutes after this started . . .'"¹⁵³ That is not to say that there have not been other investigations, threatened prosecutions, and actual prosecutions. However, it is very difficult to know the number and the details for the same reason that it is difficult to know about the incidence of prosecutions of lay people.

Furthermore, surveys of health care professionals—primarily physicians and nurses—indicate that they actively aid patients' deaths far more frequently than the reported legal cases or the news accounts suggest.¹⁵⁴ Despite the fact that it is difficult to be certain that respondents to these surveys are honestly reporting their conduct, it is likely that, if they are not honest, the bias is toward understating the extent of their participation in ending a patient's life, thus suggesting that the number of such cases is even greater than the surveys suggest.

VII. CONTEMPORARY EFFORTS TO LEGALIZE "DEATH WITH DIGNITY"

Momentum toward the legalization of mercy killing and/or assisted suicide—resulting in the enactment of death-with-dignity legislation and favorable judicial rulings—increased dramatically in the 1980s and 1990s as the result of the culmination of the trends previously discussed, but there is more to it than that. A number of other factors added to the momentum.

Serious efforts at legalization have overwhelmingly entailed only physician-aided dying and have abjured the legalization of mercy killing or aid-

151. See Rick Holmes, *Before Kevorkian Controversy, There Was Derry's Dr. Sander*, DERRY NEWS (June 30, 2011), https://www.derrynews.com/opinion/column-before-kevor-kian-controversy-there-was-derry-s-dr-sander/article_76a850e2-0897-5b77-8846-346742f78bc3.html [<https://perma.cc/4YAQ-J9YH>].

152. See *id.*

153. Silving, *supra* note 9, at 353.

154. See Griffin Trotter, *Assisted Suicide and the Duty to Die*, 11 J. CLINICAL ETHICS 260, 265 n.31 (2000) (citing *Poll Shows that 1 in 5 Internists Has Helped a Patient Die*, AM. MED. NEWS (Mar. 16, 1992)).

in-dying provided by anyone other than a physician. The reason for this is primarily prudential and, to a lesser extent, ideological. It has been the view of those advocating for legalization that they stood a much better chance of success if they were to take one small step at a time, just as had been done in the legalization of passively hastening death. Had those seeking to recognize the right to refuse life-sustaining medical treatment (i.e., passively hastening death) also advocated for actively hastening death, it is far more likely that they would have failed—not only to legalize actively hastening death but also to legalize passively hastening death. Similarly, many of those who would have liked to legalize mercy killing realized that they were ultimately more likely to achieve this result if they were first to attain the legalization of physician-aided dying. However, some who advocated only for the legalization of physician-aided dying but not mercy killing did so because they believed that the former was morally defensible and that the latter was not.

A. POPULAR ACCOUNTS OF ACTIVELY HASTENING DEATH

A number of popular accounts of actively hastening death provoked significant public interest in the subject in the latter part of the twentieth century. The first, in 1979, was *Jean's Way* by the British newspaper reporter Derek Humphry about how he aided his wife who was terminally ill with cancer to end her life.¹⁵⁵ Afterwards, Humphry received numerous pleas requesting information on the drugs that his wife had used to end her life and numerous invitations to speak to groups, including medical schools in the English-speaking world.¹⁵⁶ “The size and enthusiasm of the crowds astonished him.”¹⁵⁷ He is quoted as saying: “My journalistic antennae [sic] told me this was going to be a big subject.”¹⁵⁸ Humphry remarried and moved to the United States with his new American wife where he abandoned journalism and started the Hemlock Society, which advocated for the legalization of physician-assisted dying.¹⁵⁹ He subsequently published two other books, which provided increasingly greater amounts of specific information about how to end one's life—*Let Me Die Before I Wake* in 1982 and *Final Exit* in 1991.¹⁶⁰ The latter was a detailed guide, including the names of drugs and the amounts needed to end one's life.¹⁶¹ It also contained information on subterfuges that could be used to

155. DEREK HUMPHRY, *JEAN'S WAY: A LOVE STORY* (1978).

156. Trip Gabriel, *A Fight to the Death*, N.Y. TIMES (Dec. 8, 1991), <http://www.nytimes.com/1991/12/08/magazine/a-fight-to-the-death.html?pagewanted=all> [<https://perma.cc/7J48-BC2A>].

157. *Id.*

158. *Id.*

159. See generally *History of Final Exit Network*, FINAL EXIT NETWORK, <http://www.finalexitnetwork.org/About-Us.html> [<https://perma.cc/X33Y-W4PU>] (last visited Sept. 9, 2019).

160. DEREK HUMPHRY, *FINAL EXIT* (1991) [hereinafter HUMPHRY, *FINAL EXIT*]; DEREK HUMPHRY, *LET ME DIE BEFORE I WAKE* (1982).

161. HUMPHRY, *FINAL EXIT*, *supra* note 160.

obtain these drugs from physicians,¹⁶² and it created a storm of protest.¹⁶³

Another account of mercy killing was a commentary in the *Journal of the American Medical Association*, "It's Over, Debbie," published in 1988.¹⁶⁴ Although written anonymously, the author claimed to be a resident physician on overnight call in a hospital.¹⁶⁵ A nurse summoned him in the middle of the night, telling him that a patient was having difficulty sleeping and asking him to see the patient, a twenty-year-old woman dying from ovarian cancer.¹⁶⁶ All treatments had failed, she was clearly in the end stages of the illness, and she was now only receiving palliative care.¹⁶⁷ The author wrote that "[h]er only words to me were, 'Let's get this over with.'"¹⁶⁸ On the basis of that statement, the resident administered a dose of morphine to her that caused her breathing to slow down and eventually to stop.¹⁶⁹

This article engendered a huge debate in both the popular and professional press.¹⁷⁰ Some of the debate was focused on the facts of the case: the author was a resident who did not know the patient and knew only scant information about her based on her paper medical record; he interpreted the phrase, "Let's get this over with," as a request to be euthanized when its meaning was ambiguous; he made no effort to clarify what she meant by the phrase; it was not at all clear that the patient possessed decision-making capacity; and the resident's response to the patient's request was made in haste.¹⁷¹ Other objections were raised on the simple grounds that what the physician did was illegal and therefore should not have been done. Others argued that even if it was not illegal, it violated the ethical precepts of the medical profession.¹⁷² A prosecutor in Chicago sought to subpoena the records of the journal to attempt to ascertain the identity of the physician and presumably to initiate criminal proceedings, but a court denied the request and that ended the matter, as far as the law was concerned.¹⁷³

162. *Id.*

163. See George Papajohn, *Suicide Book Stirring Controversy and Sales*, CHI. TRIB. (Aug. 14, 1991), <https://www.chicagotribune.com/news/ct-xpm-1991-08-14-9103280566-story.html> [<https://perma.cc/T2VN-K5D5>].

164. *It's Over, Debbie*, 259 JAMA 272 (1988).

165. *Id.* at 272.

166. *Id.*

167. See *id.*

168. *Id.*

169. *Id.*

170. See, e.g., Charles Krauthammer, *The 'Death' of 'Debbie'*, WASH. POST (Feb. 26, 1988), <https://www.washingtonpost.com/archive/opinions/1988/02/26/the-death-of-debbie/2f377e77-1a9b-468e-a6d5-9464cea48eb7/> [<https://perma.cc/S6L2-T8SE>].

171. See *supra* notes 165–169.

172. See, e.g., Harold Y. Vanderpool, *It's Over Debbie*, 259 JAMA 2094, 2094 (letter to the editor).

173. See Isabel Wilkerson, *Essay on Mercy Killing Reflects Conflict on Ethics for Physicians and Journalists*, N.Y. TIMES (Feb. 23, 1988), <http://www.nytimes.com/1988/02/23/us/essay-mercy-killing-reflects-conflict-ethics-for-physicians-journalists.html?pagewanted=all> [<https://perma.cc/7SKU-FVZC>]; see also Linnet Myers & Jon Van, *Mercy-Killing Essay Subpoena Is Quashed*, CHI. TRIB. (Mar. 19, 1988), <http://www.chicagotribune.com/news/ct-xpm-1988-03-19-8803010895-story.html> [<https://nb.cc/F53G-J6KN>].

A few years later, another case engendered similar public debate and almost led to a criminal prosecution. Dr. Timothy Quill, a Rochester, New York physician (and later a leader in the movement to legalize physician-aided dying), wrote about providing a patient of his who was dying of leukemia with adequate barbiturates to end her life, which she eventually did.¹⁷⁴ What was unique about this case is that Dr. Quill wrote an article, published in probably the most prestigious medical journal in the United States—the *New England Journal of Medicine*—about this matter.¹⁷⁵ Unlike the piece about Debbie which some claimed was fictional and designed only to provoke discussion of physician-aided dying, Dr. Quill identified himself and took full responsibility for what he did—practically inviting legal inquiry—in a sensitively written and detailed way.¹⁷⁶ The facts of this case were abundantly clear, including the clarity of the patient’s request for medications to end her life.¹⁷⁷ There was no doubt that she possessed decision-making capacity and the decision was not made hastily either by the doctor or the patient,¹⁷⁸ as had been the case with Debbie. And still a grand jury declined to indict.¹⁷⁹

The third, and probably best known, factor in bringing the issue of actively hastening death to the public’s attention was the activities of Dr. Jack Kevorkian, a Michigan pathologist—a doctor who deals with anatomical specimens and corpses rather than live patients—who invented a “suicide machine” by which patients could self-administer a lethal combination of drugs or carbon monoxide supplied by Dr. Kevorkian.¹⁸⁰ His activities, which began in 1990, faced intense criticism and opposition from physicians and the public alike, in part because of his somewhat strange persona and the manner in which he conducted his activities—originally from a dilapidated minivan.¹⁸¹ Other factors contributing to the condemnation of his activities were the fact that many of the people who patronized his services were not terminally ill, he lacked the professional skills and training to determine their decision-making capacity, and he failed to refer some patients to pain specialists.¹⁸²

The criminal authorities in Michigan attempted to prosecute him on a

174. Timothy E. Quill, *Death and Dignity, A Case of Individualized Decision Making*, 324 *NEW ENG. J. MED.* 691 (1991).

175. *Id.*

176. *See id.*

177. *Id.* at 693.

178. *See id.*

179. Lawrence K. Altman, *Jury Declines to Indict a Doctor Who Said He Aided in a Suicide*, *N.Y. TIMES* (July 27, 1991), <http://www.nytimes.com/1991/07/27/nyregion/jury-declines-to-indict-a-doctor-who-said-he-aided-in-a-suicide.html> [<https://perma.cc/BYT4-ZP65>].

180. Lisa Belkin, *Doctor Tells of First Death Using His Suicide Device*, *N.Y. TIMES* (June 6, 1990), <http://www.nytimes.com/1990/06/06/us/doctor-tells-of-first-death-using-his-suicide-device.html?pagewanted=all> [<https://perma.cc/B8C9-VKX9>].

181. *Id.*

182. *See, e.g., Kevorkian Challenges the Motives of 2 Doctors Who Offered to Intervene with His Patient*, *N.Y. TIMES* (Nov. 29, 1994), <https://www.nytimes.com/1994/11/29/us/kevorkian-challenges-motives-2-doctors-who-offered-intervene-with-his-patient.html> [<https://perma.cc/TS3R-XLDB>].

number of occasions for many years,¹⁸³ but their efforts were for naught, primarily because there was no law in Michigan making aiding suicide a crime. Not until he changed from providing the means for 130 patients to end their own lives¹⁸⁴ to actually injecting a patient with lethal drugs—with a video recording of the injection shown on a nationally televised program¹⁸⁵—was Dr. Kevorkian finally convicted of a crime (second-degree murder) and imprisoned for a sentence of ten to twenty-five years.¹⁸⁶

Although Dr. Kevorkian is an excellent example of how physician-aided dying should not be practiced, his activities did have the salutary effect—because of the widespread publicity over a period of almost ten years—of engendering a great deal of public debate about the subject. If nothing else, the manner in which he carried out his activities provided a strong argument for the kinds of safeguards that needed to be incorporated into laws legalizing physician-aided dying should they be enacted.

B. EFFECT OF LEGALIZATION IN OTHER COUNTRIES

Legislation. Another development that has influenced the movement toward legalization of physician-aided dying in the United States has been legalization of mercy killing and/or physician-assisted dying in other countries, most notably the Netherlands. The process in the Netherlands took place over a period of several decades, beginning in 1973.¹⁸⁷ It began informally by individual physicians without any legal protection and eventually resulted in the enactment of legislation recognizing, confirming, and legalizing the practice in 2002.¹⁸⁸ Belgium adopted similar legislation, also in 2002,¹⁸⁹ as did Luxembourg in 2009.¹⁹⁰

Judicial Rulings. Legalization has also occurred through the judicial process. In February 2015, the Supreme Court of Canada ruled that competent adults suffering intolerably and permanently have the right to physician-aided dying.¹⁹¹ The Constitutional Court of Colombia issued a number of rulings between 1997 and 2015 aimed at legalizing physician-

183. *Chronology of Dr. Jack Kevorkian's Life and Assisted Suicide Campaign*, PBS, <https://www.pbs.org/wgbh/pages/frontline/kevorkian/chronology.html> [https://perma.cc/A3TE-ZWV3] (last visited Aug. 30, 2019) [hereinafter *Dr. Kevorkian Chronology*].

184. See Ross Douthat, *Dr. Kevorkian's Victims*, N.Y. TIMES (June 5, 2011), <https://nytimes.com/2011/06/06/opinion/06douthat.html> [https://perma.cc/FLK4-8XGR].

185. See *Dr. Kevorkian Chronology*, *supra* note 183.

186. Keith Schneider, *Dr. Jack Kevorkian Dies at 83; A Doctor Who Helped End Lives*, N.Y. TIMES (June 3, 2011), http://www.nytimes.com/2011/06/04/us/04kevorkian.html?_r=0 [https://perma.cc/6T77-L6FF].

187. MEISEL, CERMINARA & POPE, *supra* note 117, § 12.07.

188. André Janssen, *The New Regulation of Voluntary Euthanasia and Medically Assisted Suicide in the Netherlands*, 16 INT'L J.L. POL'Y & FAM. 260, 260–61 (2002).

189. Loi relative à l'euthanasie [Euthanasia Act] of May 28, 2002, MONITEUR BELGE [M.B.] [Official Gazette of Belgium], June 22, 2002, 28515.

190. Loi du 16 mars 2009 sur l'euthanasie et l'assistance au suicide [Euthanasia and Assisted Suicide Act of Mar. 16, 2009], JOURNAL OFFICIEL DU GRAND-DUCHÉ DE LUXEMBOURG, [Official Gazette of Luxembourg], Mar. 16, 2009.

191. *Carter v. Canada*, [2015] S.C.R. 331, 343–44, 396 (Can.).

aided dying.¹⁹²

Nonprosecution. Two other European countries have become more tolerant of the practice without legislation legalizing it. Switzerland is one of them. Under a 1942 provision of the Swiss penal code, which has been brought to greater public attention as the movement for legalization in other countries has gained momentum, assisting suicide is criminal only if the party providing the assistance acts out of a selfish motive.¹⁹³ As a consequence, Switzerland has become a destination for what is sometimes referred to as “suicide tourism.”¹⁹⁴ This is especially true for the British because, in Britain, physician-aided dying remains a crime despite numerous efforts at legalization.¹⁹⁵ Nonetheless, even the British authorities have taken a more lenient view of the practice. As the result of a ruling in a case decided by the House of Lords in 2009¹⁹⁶ requiring the Director of Public Prosecutions “to clarify what his position is as to the factors that he regards as relevant for and against prosecution” in cases of encouraging and assisting suicide, a lengthy and detailed set of guidelines has been issued to clarify the circumstances under which a prosecution for aiding a patient in committing suicide would occur.¹⁹⁷

While not directly affecting American law, developments in other countries have helped to shape public and professional opinion in the United States. For one thing, they have helped to keep the issue in the news, generating discussion in the popular press and in the journals of health care professionals and lawyers. They have also served as an inspiration to those American organizations with missions to further (or to oppose) legalization efforts.

192. Mike Ceaser, *Euthanasia in Legal Limbo in Colombia*, 371 LANCET 290, 290–91 (2008); *Euthanasia Regularly Practiced in Colombia*, NBC NEWS (July 31, 2005), http://www.nbcnews.com/id/8778072/ns/health-health_care/t/euthanasia-regularly-practiced-colombia/#.VrYuj1IYE9g [<https://perma.cc/2XAB-ZUYN>]; *Legality of Euthanasia in Different Countries and States*, NEW HEALTH GUIDE, <http://www.newhealthguide.org/Where-Is-Euthanasia-Legal.html> [<https://perma.cc/3KPS-SXE9>] (last updated Aug. 30, 2019); Sabrina Martin, *Colombia to Finalize Euthanasia Law in March*, PANAM POST (Feb. 19, 2015), <https://panampost.com/sabrina-martin/2015/02/19/colombia-to-finalize-euthanasia-law-in-march/> [<https://perma.cc/KLD8-AT9X>]; Liz Townsend, *Colombia's Highest Court Legalizes Euthanasia*, NAT'L RIGHT TO LIFE NEWS, <http://www.euthanasia.com/colum2.html> [<https://perma.cc/8MV7-GGXT>] (last visited Aug. 30, 2019).

193. Samia A. Hurst & Alex Mauron, *Assisted Suicide and Euthanasia in Switzerland: Allowing a Role for Non-Physicians*, 326 BRIT. MED. J. 271, 271 (2003).

194. Penny Sarchet, *Tourism to Switzerland for Assisted Suicide Is Growing, Often for Nonfatal Diseases*, WASH. POST (Sept. 22, 2014), https://www.washingtonpost.com/national/health-science/tourism-to-switzerland-for-assisted-suicide-is-growing-often-for-nonfatal-diseases/2014/09/22/3b9de644-2a14-11e4-958c-268a320a60ce_story.html [<https://perma.cc/G9MB-PNGW>].

195. See Suicide Act of 1961, 9 & 10 Eliz 2 c. 60, § 2 (Eng.).

196. *Purdy v. Dir. Pub. Prosecutions* [2009] UKHL 45, [55] (appeal taken from EWCA).

197. Dir. of Pub. Prosecutions, *Suicide: Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide*, CROWN PROSECUTION SERV. Oct. 2014), http://www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.html [<https://perma.cc/R6P5-7CHG>].

Not all of the effects of developments abroad have weighed in favor of more widespread legalization; some have had the opposite effect. Reports of abuse in the Netherlands,¹⁹⁸ whether verifiable or not¹⁹⁹—that mercy killing has been applied to mentally ill individuals with questionable decision-making capacity and infants and children who clearly did not possess decision-making capacity—have helped to strengthen the claim that legalization of voluntary physician-aided dying for patients with decision-making capacity would inevitably erode the requirements of voluntariness and decision-making capacity. Furthermore, after legalization in Belgium of mercy killing for competent adults who voluntarily request it, the Belgian parliament enacted another statute extending mercy killing to children.²⁰⁰ The fact that this law includes safeguards—“the patient must be conscious of their decision and understand the meaning of euthanasia”; “[t]he request must have been approved by the child’s parents and medical team”; “[t]heir illness must be terminal”; “[t]hey must be in great pain, with no available treatment to alleviate their distress”; the request must be voluntarily made by the child; and the child must have the maturity to make the decision, as confirmed by a psychologist²⁰¹—did little to quiet the uproar that this legislation caused both in Belgium and abroad, and the law provided additional ammunition for opponents of legalization of any kind of death-with-dignity legislation in the United States.²⁰²

C. THE ROLE OF ADVOCACY ORGANIZATIONS

The events and factors previously described—the increasing acceptance by courts and legislatures of the practice of passively hastening death; increased public debate about legalization arising from the publication of various books and articles; and the legalization of physician-aided dying in other countries—probably would not have had the impact on legalization in the United States that they did had it not also been for the existence and efforts of several organizations advocating for legislation and undertaking litigation to legalize some form of physician-aided dying.

Organizations advocating for what has been called “euthanasia,” “the right to die,” “death with dignity,” and similar terms, originated in Britain

198. See *Washington v. Glucksberg*, 521 U.S. 702, 734 (1997).

199. See *id.* at 786 (Souter, J., concurring).

200. See Charles Lane, *Children are Being Euthanized in Belgium*, WASH. POST (Aug. 6, 2018), https://www.washingtonpost.com/opinions/children-are-being-euthanized-in-belgium/2018/08/06/9473bac2-9988-11e8-b60b-1c897f17e185_story.html [https://perma.cc/V93F-G7Y8].

201. *Belgian Senate Votes to Extend Euthanasia to Children*, BBC NEWS (Dec. 13, 2013), <https://www.bbc.com/news/world-europe-25364745> [https://perma.cc/DYG8-AXXX]; see also Agence France-Presse, *First Mercy Killing of Minor in Belgium: Report*, ABS CBN NEWS (Sept. 18, 2016), <https://news.abs-cbn.com/overseas/09/18/16/first-mercy-killing-of-minor-in-belgium-report> [https://perma.cc/NG5B-FJXG].

202. See Andrew Higgins, *Belgian Senate Votes to Allow Euthanasia for Terminally Ill Children*, N.Y. TIMES (Dec. 12, 2013), <http://www.nytimes.com/2013/12/13/world/europe/belgian-senate-votes-to-allow-euthanasia-for-terminally-ill-children.html> [https://perma.cc/E7MV-HGMX].

in 1935 with the formation of the Voluntary Euthanasia Legalization Society.²⁰³ A similar organization, the Euthanasia Society of America, was founded in 1938.²⁰⁴ Neither organization made any real progress in the legal acceptance of physician-aided dying, nor did they make much headway in mobilizing public opinion. In the late 1960s, the American organization refocused its efforts on advocating for passively hastening death.²⁰⁵ At some point thereafter, it changed its name to the Society for the Right to Die, which—along with a similar organization founded in 1967, the Euthanasia Educational Council (which changed its name to Concern for Dying in 1978)—promoted public awareness of the growing legal acceptance of the right to refuse life-sustaining medical treatment (passive euthanasia).²⁰⁶ The Society for the Right to Die and Concern for Dying merged in 1990 to form the National Council on Death and Dying.²⁰⁷

While these organizations were promoting the right to refuse life-sustaining medical treatment, other organizations were formed to promote the mission of legalizing actively hastening death, the mission that the Euthanasia Society of America had abandoned somewhat earlier. Derek Humphry's Hemlock Society was founded in 1980, changed its name to End of Life Choices in 2002, and merged with the Compassion in Dying Federation in 2007 to become Compassion & Choices.²⁰⁸ Concurrent with this merger, a splinter group formed another organization, Final Exit Network, devoted not only to advocacy but to providing assistance to people who wished to end their lives.²⁰⁹ The final player among these organizations is Death with Dignity, which evolved out of the Oregon Death with Dignity Legal Defense and Education Center.²¹⁰ It, along with Compassion & Choices, has been in the forefront of the contemporary efforts to legalize physician-aided dying through litigation and legislation. Despite the frequent mergers, dissolutions, infighting, and upheavals among these organizations, they managed to make significant progress toward legalization of physician-aided dying beginning in the 1990s.

203. Anna Hiatt, *The History of the Euthanasia Movement*, JSTOR DAILY (Jan. 6, 2016), <https://daily.jstor.org/history-euthanasia-movement/> [https://perma.cc/XNE5-Q2GB].

204. See *Assisted Dying and the USA*, WORLD FED'N OF RIGHT TO DIE SOCIETIES, <http://www.worldrtd.net/es/assisted-dying-and-usa> [https://perma.cc/YD8F-JM97].

205. See *id.*

206. *From Euthanasia Society of America to the National Hospice & Palliative Care Organization (1938-Present)* (2017), HOSPICE PATIENTS ALLIANCE, <https://www.hospicepatients.org/euthanasia-soc-of-america-to-natl-hosp-and-palliative-care-org.pdf> [https://perma.cc/ZD87-VL7L].

207. Andrew H. Malcolm, *2 Right-to-Die Groups Merging for Unified Voice*, N.Y. TIMES (Apr. 12, 1990), <http://www.nytimes.com/1990/04/12/us/2-right-to-die-groups-merging-for-unified-voice.html> [https://perma.cc/ZKF2-RMWG].

208. See *History of Final Exit Network*, *supra* note 159.

209. See *id.*

210. *History*, DEATH WITH DIGNITY, <https://www.deathwithdignity.org/about/history/> [https://perma.cc/97AJ-FHLY] (last visited Aug. 30, 2019).

D. VOTER INITIATIVES

There was enough momentum behind the legalization of physician-aided dying that efforts began in the late 1980s and early 1990s to put the issue before voters. Many bills had been introduced in numerous state legislatures for many years—going back to the late 1930s in New York and Nebraska²¹¹—to enact some form of physician-aided dying. None had ever come anywhere near succeeding, and contemporary proponents realized that, at least at that time, there was virtually no likelihood of success in state legislatures, so they chose the alternative route of going directly to the voting public.

The first such attempt was in California in 1988,²¹² but proponents were unable to secure enough signatures to put the matter on the ballot. An effort in Washington state in 1991²¹³ and in California in 1992²¹⁴ succeeded in getting the matter on the ballot but were defeated at least in part because they would have also authorized mercy killing.

Having learned from the failed approach in Washington and California, proponents gained enough voter signatures to put a physician-aided dying measure on the Oregon ballot in 1994 but did not attempt to legalize mercy killing.²¹⁵ Realizing that the word *suicide* was toxic, they titled the initiative “Death with Dignity.”²¹⁶ Despite strong opposition from physician groups and the Catholic Church manifested largely through TV advertising, the measure was narrowly approved by voters.²¹⁷ Its implementation was delayed by three years because of a constitutional challenge in federal court²¹⁸ and a second voter initiative to repeal the first one.²¹⁹ After the judicial challenge was resolved in favor of the initiative²²⁰ and after the repeal vote was overwhelmingly defeated,²²¹ the law was approved in 1994 and went into effect in November 1997.

Various advocacy organizations sought to replicate the Oregon victory

211. Ronald P. Kaplan, *Euthanasia Legislation: A Survey and a Model Act*, 2 AM. J.L. & MED. 41, 42 n.6 (1976).

212. Nina Clark & Phoebe S. Liebig, *The Politics of Physician-Assisted Death: California's Proposition 161 and Attitudes of the Elderly*, 15 POL. & LIFE SCI. 273, 274 (1996).

213. *Washington Death with Dignity Act: A History*, DEATH WITH DIGNITY, <https://www.deathwithdignity.org/washington-death-with-dignity-act-history/> [https://perma.cc/RQD3-3NS2] (last visited Aug. 30, 2019).

214. *Death with Dignity in California: A History*, DEATH WITH DIGNITY, <https://www.deathwithdignity.org/death-with-dignity-california-history/> [https://perma.cc/MU4H-4APM] (last visited Aug. 30, 2019).

215. *See Oregon Death with Dignity Act: A History*, DEATH WITH DIGNITY, <https://www.deathwithdignity.org/oregon-death-with-dignity-act-history/> [https://perma.cc/2Y9D-394D] (last visited Aug. 30, 2019).

216. *Id.*

217. *Id.*; OR. REV. STAT. § 127.800–.897 (2017).

218. *Lee v. Oregon*, 891 F. Supp. 1429, 1438–39 (D. Or. 1995) (implementation enjoined).

219. *Oregon Repeal of “Death with Dignity,” Measure 51 (1997)*, BALLOTPEdia, https://ballotpedia.org/Oregon_Repeal_of_%22Death_with_Dignity%22_Measure_51_%281997%29 [https://perma.cc/4Q7B-EC5Z] (last visited Sept. 1, 2019).

220. *Lee v. Oregon*, 107 F.3d 1382, 1392 (9th Cir. 1997).

221. Gail Kinsey Hill, *Assisted-Suicide Supporters Offer to Work with Opponents*, OREGONIAN, Nov. 5, 1997, at A01.

in other states— Michigan in 1998,²²² Maine in 2000,²²³ and Massachusetts in 2012.²²⁴ Despite initially favorable polling results indicating that voters in each of these states supported the legalization of physician-aided dying, all of these efforts failed, possibly because of widespread, last-minute TV advertising portraying the purported dangers of legalization, despite (as will be discussed below) the failure of these dangers to manifest themselves in Oregon over the course of many years.

E. LITIGATION

Federal Courts. While these efforts to legalize physician-aided dying through voter initiatives were occurring, proponents of legalization sought a more sweeping approach through litigation, which in two cases, had it been successful, would have resulted in nationwide legalization. In the early 1990s, lawsuits were filed in federal courts in Washington state²²⁵ and New York²²⁶ challenging the constitutionality of those states' laws that criminalized assisted suicide—insofar as those laws applied to competent, terminally ill patients seeking assistance from a licensed physician in ending their lives.

In the Washington case, the trial court upheld the petitioners' claims that the statute criminalizing assisted suicide, as applied to competent, terminally ill patients, denied them their rights to the due process and equal protection guaranteed by the Fourteenth Amendment to the Constitution.²²⁷ By contrast, the federal trial court in New York denied similar claims.²²⁸ In both cases, the losing parties appealed to the appropriate federal appeals courts and the appeals courts upheld the petitioners' claims. In the Washington case, a three-judge panel of the U.S. Court of Appeals for the Ninth Circuit reversed the trial court's decision,²²⁹ but the court en banc reinstated the trial court's decision, resoundingly holding that the Washington law prohibiting assisted suicide violated the petitioners' claim to due process of law.²³⁰ In the New York case, although the result was the same, the legal basis was different with the Court of Appeals for the Second Circuit holding that the New York law violated the petitioners' claim to the equal protection of the law.²³¹

222. *Michigan*, DEATH WITH DIGNITY, <https://www.deathwithdignity.org/states/michigan/> [https://perma.cc/2QJ9-72CU] (last visited Sept. 1, 2019).

223. *Maine*, DEATH WITH DIGNITY, <https://www.deathwithdignity.org/states/maine/> [https://perma.cc/R4QV-HRWX] (last visited Sept. 1, 2019).

224. *Massachusetts*, DEATH WITH DIGNITY, <https://www.deathwithdignity.org/states/massachusetts/> [https://perma.cc/B7UM-8QVJ] (last visited Sept. 1, 2019).

225. *Compassion in Dying v. Washington*, 850 F. Supp. 1454, 1455–56 (W.D. Wash. 1994).

226. *Quill v. Koppell*, 870 F. Supp. 78, 79 (S.D.N.Y. 1994).

227. *Compassion in Dying*, 850 F. Supp. at 1467–68.

228. *Quill*, 870 F. Supp. at 84.

229. *Compassion in Dying v. Washington*, 49 F.3d 586, 588 (9th Cir. 1995).

230. *Compassion in Dying v. Washington*, 79 F.3d 790, 798 (9th Cir. 1996) (en banc).

231. *Quill v. Vacco*, 80 F.3d 716, 727 (2d Cir. 1996).

The losing parties in both cases sought review by the U.S. Supreme Court, which granted review and then decided the cases together in 1997.²³² The result was not what proponents of legalization had hoped for, with the Court reversing both appellate court decisions and holding that there was no federal constitutional right to have a physician provide competent, terminally ill patients with a prescription for a lethal dose of medication.²³³ However, the Supreme Court did hold that while the Constitution did not prohibit state bans on physician-aided dying, it did not forbid states from repealing those bans if they so choose.²³⁴ In other words, legalization of physician-aided dying did not violate any constitutional protections, as the opponents of legalization had argued in the case challenging the Oregon law.²³⁵ Furthermore, on the side of the ledger more favorable to proponents, a majority of the Justices suggested, but did not hold, that physicians were permitted to administer palliative medications that might have the *effect* of ending a terminally ill patient's life as long as it was not the physician's *intent* to do so.²³⁶ Because the Court's holding was premised on the assumption that terminally ill patients could receive palliative care to treat pain, the Court also suggested that if in fact patients experience significant barriers to obtaining pain relief, the Court might be willing to reconsider its decision.²³⁷

State Courts. Physician-aided dying became legal in Montana in 2009 when the state supreme court ruled that, although the state constitution did not guarantee such a right, "nothing in Montana Supreme Court precedent or Montana statutes indicat[es] that physician aid in dying is against public policy."²³⁸ Thus, while physician-aided dying is not illegal in Montana, there is no statutory procedure for carrying it out as there is in those states where such a right has been embodied in legislation. Subsequent efforts in the Montana legislature to overrule the effect of this court decision were unsuccessful.²³⁹

There have been failed constitutional challenges to laws, as applied to terminally ill patients, that make assisted suicide a crime in state courts in Alaska, California, Florida, Georgia, Massachusetts, Montana, New Mexico, and New York.²⁴⁰ It can be expected that similar lawsuits will be

232. See *Vacco v. Quill*, 521 U.S. 793 (1997); *Washington v. Glucksberg*, 521 U.S. 702 (1997).

233. See *Vacco*, 521 U.S. at 796; *Glucksberg*, 521 U.S. at 705.

234. See *Glucksberg*, 521 U.S. at 735–36.

235. See *Lee v. Oregon*, 107 F.3d 1382, 1386 (9th Cir. 1997).

236. *Glucksberg*, 521 U.S. at 737–38 (O'Connor, J., concurring).

237. See *id.* at 735 n.24 (majority opinion).

238. *Baxter v. State*, 224 P.3d 1211, 1222 (Mont. 2009).

239. Compassion & Choices, *End-of-Life Liberty Survives Another Legislative Session; In a Victory for Terminally Ill Montanans, Aid in Dying Remains a Medical Option*, MARKETWATCH (Apr. 28, 2015), <https://www.marketwatch.com/press-release/end-of-life-liberty-survives-another-legislative-session-in-a-victory-for-terminally-ill-montanans-aid-in-dying-remains-a-medical-option-2015-04-28> [<https://perma.cc/7ATZ-YHSV>].

240. See *Sampson v. State*, 31 P.3d 88 (Alaska 2001); *Donorovich-Odonnell v. Harris*, 194 Cal. Rptr. 3d 579 (Cal. Ct. App. 2015); *Krischer v. McIver*, 697 So. 2d 97 (Fla. 1997); *Final Exit Network, Inc. v. Georgia*, 722 S.E.2d 722 (Ga. 2012); *Kligler v. Healy*, No. SUCV2016-03254-F, 2017 WL 2803074 (Mass. Super. Ct. May 31, 2017); *Baxter v. State*,

initiated in other state courts—indeed, one is pending in the Massachusetts courts.²⁴¹

F. LEGISLATION

As mentioned before, attempts to get state legislatures to enact legislation to legalize physician-aided dying have been uniformly unsuccessful until recently, probably because legislation of this sort is considered, even by many legislators who support it, to be highly toxic. Although public opinion polls usually show significant, if not overwhelming, public support for legalization,²⁴² the opposition is highly vocal and well-organized, and legislators fear retribution at the polls from opponents of legalization. They have learned this lesson from several decades of “abortion wars” dealing with another highly controversial topic and similar opponents. At best, a few legislators have been willing to introduce legislation to legalize physician-aided dying either as a pet project of their own or in order to please a particular group of constituents, but they have known in advance that it is a lost cause; rarely do these bills get out of committee for a vote by the full legislature.²⁴³

This almost changed in 2002, when the Hawaii legislature came within three votes of approving physician-aided dying legislation.²⁴⁴ It did, in fact, change in Vermont in 2013, where the legislature approved a bill to legalize physician-aided dying and the governor signed it.²⁴⁵ Victory in Vermont, however, did not necessarily augur a widespread acceptance of similar legislation in other states, largely because some of the characteristics of Vermont are unusual: a liberal electorate, a very small legislature, and a very small and inexpensive media market all made success in the legislature more feasible than in most other states. Nonetheless, a state with a large legislature and a very expensive media market—California—followed suit in 2015.²⁴⁶ There are bills in many state legislatures in any given session to legalize physician-aided dying,²⁴⁷ and after the victory in

224 P.3d 1211 (Mont. 2009); *Morris v. Brandenburg*, 376 P.3d 836 (N.M. 2016); *Myers v. Schneiderman*, 85 N.E.3d 57 (N.Y. 2017).

241. MEISEL, CERMINARA & POPE, *supra* note 117, § 12.05.

242. *See, e.g.*, Megan Brenan, *Americans’ Strong Support for Euthanasia Persists*, GALLUP (May 31, 2018), <https://news.gallup.com/poll/235145/americans-strong-support-euthanasia-persists.aspx> [<https://perma.cc/W2H2-2EC8>].

243. *See, e.g.*, Anastasia Lennon, *Mass. Lawmakers Restart Debate Over Aid in Dying for the Terminally Ill*, WGBH (June 25, 2019), <https://www.wgbh.org/news/politics/2019/06/25/mass-lawmakers-restart-debate-over-aid-in-dying-for-the-terminally-ill> [<https://perma.cc/FH8B-TCCM>].

244. *Death with Dignity in Hawaii: A History*, DEATH WITH DIGNITY, <https://www.deathwithdignity.org/death-with-dignity-hawaii-history> [<https://perma.cc/F8CA-TD8X>] (last visited Sept. 1, 2019).

245. *Vermont*, DEATH WITH DIGNITY, <https://www.deathwithdignity.org/states/vermont/> [<https://perma.cc/BJ7D-L6XC>] (last visited Sept. 1, 2019).

246. *Death with Dignity in California*, *supra* note 214. Legislation was also enacted in Maine in 2019. *Maine*, *supra* note 223.

247. *See Take Action in Your State*, DEATH WITH DIGNITY, <https://www.deathwithdignity.org/take-action/> [<https://perma.cc/Q7BC-VEXX>] (last visited Sept. 5, 2019).

California, perhaps the road to legalization via the legislative route is more likely to succeed in the future than it has in the past—though it is still likely to be gradual and sporadic.

The foremost obstacle to legalization of physician-aided dying of any kind—whether mercy killing or physician-assisted suicide—has been the numerous arguments put forth by opponents, some of which have at least prima facie validity, some of which are easily dispensed with, and some of which have been disproved by experience in those states where physician-aided dying has been legalized.²⁴⁸

The most basic of these arguments is that killing is always wrong and, when it is put that way, it certainly seems to be true. But as mentioned earlier, the law has long accepted justifications and excuses for killing, thereby implying that not all killing is always wrong. There is nothing to prevent the carving out of another exception through appropriate legal channels, which is exactly what has happened in those states where physician-aided dying has been legalized.

Another important argument against legalization concerns the *voluntariness* of the decision to end one's life.²⁴⁹ It is contended that people who are seriously ill, the elderly, and the infirm are pressured to end their lives by pain, depression, despondency, and a fear of being a burden to others.²⁵⁰ Consequently, it is claimed, they are incapable of making a truly voluntary decision.²⁵¹ Closely related, and sometimes overlapping, is the claim that people who wish to end their lives lack the *mental capacity* to make this decision and the medications that they may be taking to address pain, depression, and despondency may further compromise their decision-making capacity.²⁵² The most extreme version of this argument is that suicide is an inherently irrational act and, thus, those seeking to end their lives—either by themselves or with the assistance of others—are *ipso facto* incompetent to make such a decision. Another related argument is that as palliative care and the education of physicians in palliative care techniques have improved and become more widespread, physicians are capable of controlling or even eliminating those factors that impel terminally ill patients to seek to end their lives.

Another traditional argument against legalization is that diagnosis and prognosis are uncertain. A person diagnosed as being terminally ill may not actually be so, may live far longer than the average person with such a diagnosis, and/or may have a far better quality of life than is the norm. A closely related argument is that a new treatment may be discovered that will render the terminal diagnosis uncertain or incorrect.

The claim is also made that permitting doctors to either prescribe a lethal dose of medication for a patient or to administer it directly would

248. Many of these arguments are discussed (and refuted) in *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir. 1996) (en banc).

249. *Id.* at 825–26.

250. *See id.*

251. *Id.*

252. *Id.* at 833 (proposing safeguards to counteract this argument).

cause patients to distrust doctors, for they would be uncertain whether their doctors were seeking to better their condition or to end their lives.²⁵³ Would it not, it is sometimes added, be easier for doctors dealing with difficult cases to end their patients' lives than to engage in the time-consuming and energy-consuming activities of trying to improve their well-being?

Another argument against legalization is the “wedge” or “slippery slope” argument applicable to almost any policy change, not just legalization of physician-aided dying.²⁵⁴ This is the argument that if society weakens a prohibition on some activity deemed to be undesirable, it will inevitably lead to the weakening of the prohibition on even more undesirable activities. In this context, this means that if, for example, physicians are allowed to prescribe medications for competent, terminally ill patients who made a voluntary decision to end their lives, the claim would soon be made that it would be unfair to deny assistance to dying to people who are no longer able to self-administer the prescribed medications; therefore, physicians ought to be permitted to directly administer the medications in such circumstances, thus transforming physician-aided dying into mercy killing. The most extreme version of the slippery slope argument is that once any kind of aid-in-dying is legalized, it will inevitably lead, over time, to the practices that the Nazis engaged in—the involuntary euthanasia of those deemed by medical or governmental authorities, or even family members, to be unfit to live.²⁵⁵

Perhaps the most ironic argument against legalization is the claim that because doctors are already performing mercy killings they deem to be justified, it is not necessary to legalize the practice. This argument suffers from several flaws. One is that because the practice is still illegal doctors never know if or when they might be investigated and prosecuted. This means that virtually all mercy killings will remain surreptitious; therefore, it cannot be determined whether they were voluntary, nonvoluntary, or even involuntary, and thus whether they may have been abusive. Another flaw is that this seeks to make a virtue of hypocrisy, and another is that it is inequitable and arbitrary. Those patients who are “well connected” may be able to find a physician who will honor their wishes, but others—probably most—will not.

G. THE EFFECTS OF LEGALIZATION

Physician-aided dying is now legal in nine U.S. jurisdictions.²⁵⁶ The Oregon Health Authority has kept very detailed records of the results of Oregon's Death with Dignity Act since it went into effect in November 1997, and Washington state has kept similar records since legalization there in 2009. The experience in both states has been similar and rather

253. *Id.* at 827–30.

254. *Id.* at 830–32.

255. *Id.* at 830.

256. *See supra* note 141 and accompanying text.

clearly puts to rest most of the arguments that opponents of legalization have made—or at least those that can be settled by empirical data. The most relevant data—namely, those relating to the traditional and more contemporary concerns that opponents of legalization have expressed—do not support and, in fact, dispel the concerns of opponents.²⁵⁷

The characteristics of the people who have availed themselves of these two death-with-dignity laws do not support the concerns of opponents of legalization. They are predominantly not members of minority racial groups; they are well-educated; and they have had health insurance and thus were not driven to end their lives by a want of medical care.²⁵⁸ Most who needed it were receiving adequate pain relief—that is, they were enrolled in hospice care and were not motivated to seek physician-aided dying because of unremitting pain, which might have been adequately treated by traditional palliative care medicine.²⁵⁹ Rather, they sought to end their lives mostly because of existential issues including “loss of autonomy (91.7%), decreasing ability to participate in activities that made life enjoyable (90.5%), and loss of dignity (66.7%).”²⁶⁰ Furthermore, there is no evidence in either state that patients have been pressured into seeking physician-aided dying either by their physicians or their families nor that they lacked the capacity to make a decision to avail themselves of physician-aided dying. There has also been no discernible effort in either state to extend the reach of the law to people who lack decision-making capacity or who are unable to self-administer the lethal dose of medication.

Also significant is the fact that although there has been a slow movement toward legalization, at the same time there has been an increasing emphasis on and funding for making hospice services available to people at the end of life and on educating physicians about hospice care so that physician-aided dying is not the only option that terminally ill people have.²⁶¹

257. Paula Span, *Aid in Dying Soon Will Be Available to More Americans. Few Will Choose It*, N.Y. TIMES (July 8, 2019), <https://www.nytimes.com/2019/07/08/health/aid-in-dying-states.html> [<https://perma.cc/4DJU-7VFM>].

258. See OR. HEALTH AUTH. PUB. HEALTH DIV., OREGON DEATH WITH DIGNITY ACT: 2018 DATA SUMMARY (2018), <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year21.pdf> [<https://perma.cc/X72Y-MQPD>]; see also WASH. ST. DEPT. OF HEALTH CTR. FOR HEALTH STAT., 2018 DEATH WITH DIGNITY ACT REPORT (July 2019), <https://www.doh.wa.gov/Portals/1/Documents/Pubs/422-109-DeathWithDignityAct2018.pdf> [<https://perma.cc/3NGB-83TC>].

259. See OR. HEALTH AUTH. PUB. HEALTH DIV., *supra* note 258, at 6.

260. *Id.*

261. See Lisa Schenker, *Assisted-Suicide Debate Focuses Attention on Palliative, Hospice Care*, MODERN HEALTHCARE (May 16, 2015, 1:00 AM), <https://www.modernhealthcare.com/article/20150516/MAGAZINE/305169982/assisted-suicide-debate-focuses-attention-on-palliative-hospice-care> [<https://perma.cc/HQ5Z-LQTC>].

VIII. CONCLUSION: WHAT THE FUTURE HOLDS

Prediction, at least for those who do not have a crystal ball, is always an uncertain proposition and even more so when the prediction concerns human behavior. What appears to be the case, however, is that there is a slow but steady march not only in the United States but also in Canada and Europe toward the legalization of physician-aided dying. It is likely that there will be setbacks along the way—just as there have been since the passage of the Oregon law in 1994—but proponents of legalization will recover and score victories elsewhere. Because of the nature of the activity involved—the purposeful ending of human life—there will always be some fundamental opposition which may prevail in some places but be overcome in others, just as the opposition to passively hastening death has slowly melted away, leaving a small residue of opposition. What is most likely to derail this trend is verifiable reports of serious abuse—the provision of a prescription for a lethal dose of medication to people who lack decision-making capacity, the pressuring of people to end their lives, or the direct administration of a lethal dose of medication where only aid-in-dying has been legalized, and of course, involuntary euthanasia.

