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Introduction

WHETHER to permit assistance in suicide and euthanasia is among the most contentious legal and public policy questions in America today. The issue erupted into American public consciousness on June 4, 1990, with the news that Dr. Jack Kevorkian—a slightly built, greying, retired Michigan pathologist—had helped Janet Adkins, a fifty-four-year-old Alzheimer's patient, kill herself.[1] Dr. Kevorkian later revealed that he had not taken the medical history of Ms. Atkins, conducted a physical or mental examination, or consulted Ms. Adkins's primary care physician.[2] Dr. Kevorkian had simply agreed to meet Ms. Adkins in his Volkswagen van, which he had outfitted with a "suicide machine" consisting of three chemical solutions fed into an intravenous line needle. Dr. Kevorkian tried five times to insert the needle before eventually succeeding.[3] Ms. Adkins then pressed a lever releasing death-inducing drugs into her body. Dr. Murray Raskind, one of the physicians who cared for Ms. Adkins in the early stages of her disease, later testified that she was physically fit but probably not mentally competent at the time of her death.[4]

Since Janet Adkins's death first made national headlines, Dr. Kevorkian claims to have assisted more than 130 suicides.[5] Derek Humphry, founder of The Hemlock Society,[6] a group devoted to promoting the legalization of euthanasia, has praised Dr. Kevorkian for "breaking the medical taboo on euthanasia."[7] The American Civil Liberties Union (ACLU) aggressively took up his legal defense.[8]

While perhaps the most notorious contemporary American proponent of assisted suicide and euthanasia, Dr. Kevorkian hardly stands alone. In 1984 the Netherlands became the first country in the world to endorse certain forms of assisted suicide and euthanasia. The Dutch Supreme Court declared that, although euthanasia was punishable as murder under the nation's penal code, physicians could claim an "emergency defence" under certain circumstances.[9] After several failed attempts, in November 2000 the lower house of the Dutch Parliament voted 104–40 in favor of a physician-assisted suicide exception to the nation's homicide laws, codifying—and liberalizing in some key respects—the prior judicial "emergency defence"; the Dutch Senate gave its assent in April 2001.[10] The Northern Territory of Australia passed a law permitting as-

sisted suicide in 1996, but that legislation was criticized by the Australian Medical Association and quickly voided months later by Australia's federal parliament.[11] Belgium has now also followed the Dutch example, adopting a law that took effect in September 2002.[12]

Within the United States, Dr. Timothy Quill, a University of Rochester professor, provoked early debate on the assisted suicide question in 1991, writing an article in the *New England Journal of Medicine* discussing and defending his decision to prescribe barbiturates to a cancer patient, even though she admitted that she might use them at some indefinite time in the future to kill herself.[13] A New York grand jury was convened but ultimately declined to bring an indictment for assisted suicide; the state medical board also considered pressing disciplinary charges but eventually relented, reasoning that Dr. Quill had written a prescription for drugs that had a legitimate medical use for his patient (as a sleeping aid for her insomnia), and that he could not have definitely known that the patient would use them to kill herself. Ruling, in essence, that the evidence was too equivocal to conclude that Dr. Quill *intended* to cause the death of his patient, the board declared the matter closed.[14]

In 1992 a gynecology resident submitted an anonymous article to the *Journal of the American Medical Association* that was the subject of a long-running debate in prominent American medical journals. Entitled "It's Over Debbie," the article described how the author administered a lethal injection to a terminal cancer patient (an act of euthanasia, not assisted suicide), whom he had never previously met, after her plea to "get this over with."[15]

After its publication in the early 1990s, the Hemlock Society's book, *Final Exit*, quickly rocketed to the *New York Times*'s best-seller list. With more than a half million copies sold, it provides step-by-step instructions (in easy-to-read large print) on various methods of "self-deliverance." In February 2006 its sales on Amazon.com still ranked 9,845 among all books on offer (which is very high indeed), and it was priced at $10.20 ("you save $4.80; usually ships within 24 hours").[16] Chapter titles range from "Self-Deliverance by Plastic Bag" (a recommended method) to "Bizarre Ways to Die" (discussing the relative merits of guns, ropes, and firecrackers) and "Going Together" (ideas for double suicides). A *New England Journal of Medicine* study found that instances of asphyxiation by plastic bag increased markedly shortly after the book's publication.[17]

The public discussion sparked in the early 1990s by Kevorkian, Quill, *Final Exit*, and Dutch practices quickly matured into a growing debate in academic circles. By the mid- to late 1990s, thinkers from a variety of moral and philosophical perspectives began publishing books pressing the case for legalizing assisted suicide and euthanasia—including Ronald Dworkin in 1993,[18] Seventh Circuit Judge Richard Posner in 1995,[19] and Richard Epstein in 1999.[20]

The growing academic and public discussion of assisted suicide and euthanasia was accompanied by increasing political and legal activism. In 1988

an early voter referendum campaign in California aimed at toppling the state's law banning the assistance of suicide failed to attract the necessary 450,000 verified signatures to secure a spot on the ballot.[21] Another effort just four years later not only secured a spot on the ballot, but garnered 48 percent of the vote. A similar 1991 effort in Washington State obtained 46.4 percent of the vote.[22] By 1993 the referenda campaign bore its first fruit when Oregon voters narrowly voted to legalize assisted suicide, 51 percent to 49 percent, though subsequent legal challenges delayed implementation until 1997.[23]

Since 1994, over fifty bills have been introduced to legalize assisted suicide or euthanasia in at least nineteen state legislatures, and two voter referenda modeled on Oregon have been attempted. All have failed so far. In fact, several states have moved to reaffirm or strengthen their laws prohibiting assisting suicide, including Michigan, New York, Maryland, Iowa, Oklahoma, and Virginia. In all, the vast majority of states (approximately thirty-eight) have chosen to retain or have recently enacted statutes expressly banning assisted suicide, and most of the remaining states either treat assisted suicide as a common law crime or have health care directive statutes expressly disapproving of the practice.[24] In 1997 Congress entered the fray, too, and adopted a new law denying the use of federal funds in connection with any act of assisted suicide.[25] In the last several years, a number of other countries, including England,[26] Canada,[27] Australia,[28] New Zealand,[29] and Hungary,[30] have likewise considered and rejected proposals to overturn their laws banning assisted suicide.

With relatively little to show for their early voter referenda and legislative efforts, American euthanasia proponents opened a new front in the mid-1990s, filing federal law suits in Washington State and New York seeking to have statutes banning assisted suicide declared unconstitutional.[31] Wildly disparate trial court rulings resulted. One trial court found a constitutional right to assistance in suicide; another held that no such right exists.[32] Appellate courts reviewing these decisions eventually produced opinions supporting a right to assisted suicide but using very different rationales and only over vociferous dissents.[33] In 1997 the cases culminated in argument before the United States Supreme Court in a pair of cases, *Washington v. Glucksberg* and *Quill v. Vacco.* In 9–0 decisions, the Court upheld the Washington and New York laws banning assisted suicide.[34] At the time, the press hailed the Court's rulings as major victories for opponents of euthanasia and assisted suicide.[35] But few noticed that critical concurring justices addressed only the question whether laws banning assisted suicide are *facially* unconstitutional—that is, unconstitutional in all possible applications—and specifically reserved for a later case the question whether those laws are unconstitutional *as applied* to terminally ill adults seeking death. Thus, far from definitively resolving the assisted suicide issue, the Court's decisions seem to assure that the debate over assisted suicide and euthanasia is not yet over—and may have only begun.

A great many people support legalizing assisted suicide and euthanasia. One of the central purposes of this book is to identify and explore the strengths and weaknesses of the legal and moral arguments deployed by those who seek to overthrow existing laws against those practices. Specifically, in chapter 2, I discuss the Washington and New York cases and seek to ascertain their implications for future legal and ethical debate over assisted suicide and euthanasia. I suggest that these cases raise four key questions, or arguments, on which future debate is likely to focus: Is there historical precedent for legalization? Do principles of equal protection or fairness dictate that, if we permit patients to refuse life-sustaining care like food and water, we must also as a matter of logical consistency allow assisted suicide and euthanasia? Does proper respect for principles of personal autonomy and self-determination compel legalization? And would legalization, in a purely utilitarian calculus, represent the legal rule or solution that would provide the greatest good for the greatest number of persons?

On each and every one of these points, various contemporary moral and legal writers have given conflicting views. Some have suggested that history is moving inexorably toward legalization; others contend that there is no meaningful way to distinguish between the right of a patient to refuse care and the right of a patient to seek out euthanasia; a virtual chorus has argued that proper respect for personal autonomy and self-determination demands that we respect the right of individuals to take their lives with willing assistants; and others still submit that legalization would carry with it more benefits than costs and would thus maximize social happiness on a utilitarian scale. In chapters 3 through 8, I analyze each of these various contemporary arguments for legalization in turn. In the end, I submit, the force of some of these arguments is overstated while the power of others is actually understated. Readers interested in particular lines of argument can focus on individual chapters that address those issues. Chapter 3 focuses on the historical record. Chapter 4 addresses the arguments from equal protection or fairness suggesting that recognizing a right to refuse life-sustaining medical care is tantamount to adopting a right to assisted suicide or euthanasia. Chapters 5 and 6 look to the arguments from personal autonomy. Chapter 7 discusses empirical and utilitarian arguments based on the experiments and experience in the Netherlands and Oregon. Chapter 8 takes a closer look at two leading arguments for legalization from autonomy and utility posed by Judge Posner and Richard Epstein.

Having reviewed extant arguments for legalization suggested by the case law and in contemporary moral-legal debate, in the final part of the book, chapters 9 and 10, I pursue the second purpose of this book, outlining an argument for retaining current laws banning assisted suicide and euthanasia that has received relatively little attention in the American debate over assisted suicide and euthanasia. It is an argument premised on the idea that all human beings are intrinsically valuable and the intentional taking of human life by private

persons is always wrong. In chapter 9, I examine the roots of this principle in secular moral theory and the common law, consider its application to the assisted suicide and euthanasia debate, and address a number of potential criticisms along the way. In chapter 10, I suggest that the principle that all human life is intrinsically valuable may help illuminate and provide guidance in end-of-life disputes beyond assisted suicide and euthanasia, including in the increasingly frequent cases involving the discontinuation of life-sustaining medical care for incompetent persons.

Finally, in late 2001 the presidential administration of George W. Bush issued an executive order that sought to prevent Oregon doctors from dispensing federally regulated medicines to assisted suicides. The administration argued that Oregon doctors helping patients commit suicide were not engaged in a "legitimate medical practice" under the Controlled Substance Act, the federal law regulating the use of pharmacological substances. The federal government's order precipitated a legal battle with the state of Oregon and its allies that culminated in a Supreme Court hearing in October 2004 and a ruling—rendered as this book was going to print—that perhaps raises as many questions as it answers. The lawsuit, its resolution, and its implications for future debate over assisted suicide and euthanasia in America are discussed briefly in the epilogue.

Distilled to its essence, this book might be said to have two purposes—to introduce and critically examine the primary legal and ethical arguments deployed by those who favor legalization, and to set forth an argument for retaining existing law that few have stopped to consider. It aims to be of interest to all of those curious about the ethical and legal aspects of the assisted suicide debate, whatever views they espouse, and to contribute to a fuller and more fully informed debate.

Before proceeding further, a definitional note is important. While the term "assisted suicide" is often used to describe Dr. Kevorkian's practices, it is really something of a misnomer. There is no crime called "assisted suicide," and, as we shall see in chapter 3, no legal penalty for the patient who seeks help in dying. Instead, the crime at issue is *assisting* suicide, and it is targeted solely at those who help another commit suicide. The legal right sought by proponents is thus, to be precise, a right to receive assistance in killing oneself without the *assistant* suffering adverse legal consequences. Recognizing its imprecision, I will nonetheless defer to pervasive usage and employ the term "assisted suicide" as a short-hand description for the proffered right.

Using the term "assisted suicide" to describe Dr. Kevorkian's practices is, however, a misnomer in yet another respect. Dr. Kevorkian has sought to establish not only a right to receive assistance in suicide (what we shall call assisted suicide), but also a right to be killed by another person, so long as the act is performed with the consent of the decedent and the killer is motivated by compassion or mercy (what is properly labeled euthanasia). In fact, in 1999 Dr.

Kevorkian killed a patient for a nationwide television audience on the program *60 Minutes*, and he did so specifically to provoke a public debate on the distinct practice of euthanasia. (Dr. Kevorkian was later convicted of second-degree murder, after a trial in which he chose to act as his own counsel.)[36]

Though an analytical distinction exists between assisted suicide and euthanasia, there is a great deal they share in common, and those who support legalizing one tend to support legalizing the other for the same or similar reasons—whether it be out of a sense that fairness requires killing those who wish to die but who cannot kill themselves, a desire to promote individual autonomy whether it is expressed in terms of a desire to kill oneself or have another do so, or a sense that the actions serve a similar social utility in allowing patients to avoid needless suffering. That said, some advocates of assisted suicide, especially in the United States in the last several years, have sought to draw a line between the practices, seeking to obtain legal permission only for assisted suicide but not euthanasia.[37] Oregon's law, for example, permits only assisted suicide, not euthanasia.[38] But is there really any meaningful moral distinction that can be drawn between assisted suicide and euthanasia? If not, what is at work here?

Those who attempt to draw a moral line between the practices often emphasize that the patient exercises more control in assisted suicide, remaining the final causal actor in his or her own death, while in euthanasia another person assumes that role, thus creating a greater chance for physician malfeasance.[39] Yet, morally, in cases of assisted suicide and euthanasia alike, the patient forms an intent to die and the physician *intentionally* helps the patient end his or her life. As Dutch bioethicists Gerrit Kimsma and Evert van Leeuwen (supporters of legalization) have explained, in Dutch practice both are legal and they are "considered to be identical because intentionally and effectively they both involve actively assisting death."[40] The physical difference, too, between assisted suicide and euthanasia certainly need not be, and frequently is not, very great. As John Keown has asked, "[w]hat, for example, is the supposed difference between a doctor handing a lethal pill to a patient; placing the pill on the patient's tongue; and dropping it down the patient's throat?"[41] The view among legalization proponents in much of the rest of the world is summarized by Kisma: "[t]hinking that physician-assisted suicide is the entire answer . . . is a fantasy. There will always be patients who cannot drink, or are semiconscious, or prefer that a physician perform this act."[42]

Ultimately, it is hard to avoid asking whether the assisted suicide–euthanasia distinction some seek to draw reflects anything more than a calculated tactical decision by euthanasia proponents to fight political-legal battles piecemeal in order to enhance their chances of ultimate success. The distinction between the practices is made almost exclusively in American debate—the Dutch and most others who have contemplated legalization see little reason to distinguish between the practices. The notion that assisted suicide is different in kind from euthanasia has emerged as a significant point in the American di-

alogue, moreover, only in recent years. For decades, American advocates openly pushed for legalized euthanasia and dubbed their leading organization the Euthanasia Society of America, shifting ground and adopting a new nomenclature for their advocacy groups only in the 1970s and 1980s. As we shall see in chapter 3, American euthanasia proponents also have a history of carefully choosing to fight discrete and targeted policy battles to avoid total defeat and to build a public consensus along the way toward their ultimate and more ambitious goals. And at least some contemporary assisted suicide advocates candidly suggest that this is exactly what is going on today. Richard Epstein, for one, has charged his fellow assisted suicide advocates who fail to endorse the legalization of euthanasia openly and explicitly with a "certain lack of courage."[43] Margaret Otlowski has put the point even more strongly: to her, assisted suicide alone simply "is not . . . a satisfactory legal response."[44] And in the case that led to *Glucksberg v. Washington* in the United States Supreme Court, the judges of the Ninth Circuit en banc court, while ruling only in favor of an assisted suicide right, all but admitted that it would prove impossible for litigants in any subsequent case to draw a "principled distinction" between the assisted suicide right that court approved and a claimed right to euthanasia.[45]