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**TURNING TO STATE LEGISLATURES TO
LEGALIZE PHYSICIAN-ASSISTED SUICIDE
FOR SERIOUSLY ILL, NON-TERMINAL
PATIENTS AFTER *VACCO V. QUILL** AND
*WASHINGTON V. GLUCKSBERG*****

*Katherine C. Glynn****

INTRODUCTION

During a squabble over whose turn it was at bat, eleven-year-old Kelly Niles was punched in the back of his head by a playmate.¹ A few hours later, Kelly's father brought the child to a hospital where he was misdiagnosed as having a concussion and sent home.² Unfortunately, the doctors at the hospital failed to discover the expanding blood clot in Kelly's brain.³ Emergency neurosurgery later saved Kelly's life, but he would never be able to control the movement of his body again.⁴ Kelly was confined to a wheelchair for the rest of his life and required the assistance

*117 S. Ct. 2293 (1997).

**117 S. Ct. 2258 (1997).

*** Brooklyn Law School Class of 1998; B.A. University at Albany, 1994. The author would like to thank Christopher C. Novak for his unending support and encouragement.

¹ LONNY SHAVELSON, A CHOSEN DEATH 113 (1995).

² *Id.* at 113-14.

³ *Id.* Kelly had sustained a "small fracture of the skull which tore an artery under the fracture." *Niles v. San Rafael*, 116 Cal. Rptr. 733, 735 (1st Dist. 1974). "The resulting bleeding between the dura and the skull caused an accumulation of clotted blood that caused severe pressure on the brain." *Id.* Due to the clot, Kelly suffered irreparable brain damage. SHAVELSON, *supra* note 1, at 114.

⁴ SHAVELSON, *supra* note 1, at 114. After the surgery, Kelly was in a coma for six weeks. SHAVELSON, *supra* note 1, at 114. When he finally awoke, he was mute and unable to control the movement of his arms and legs. SHAVELSON, *supra* note 1, at 114.

of five full-time attendants.⁵ "He could not walk, talk, clean himself, urinate, or make love without help."⁶ Kelly's intelligence was not impaired, but he lacked the ability to communicate without the assistance of a computerized communication device and an attendant.⁷

As Kelly aged, he began to appreciate the limitations this malady imposed upon him.⁸ When Kelly was thirty-three-years-old, twenty-two years after his accident, he decided to end his pain by committing suicide.⁹ However, he lacked the capacity to end his own life.¹⁰ His family agreed to assist him on the condition that he wait until they thought of a way in which they would not be criminally implicated.¹¹ Kelly grew impatient.¹² Eventually he

⁵ SHAVELSON, *supra* note 1, at 115. Kelly's family sued the doctors for malpractice and the jury awarded him four million dollars. *Niles*, 116 Cal. Rptr. at 734-35. The family also sued the city of San Rafael and the San Rafael School District and was awarded twenty-five thousand dollars. *Niles*, 116 Cal. Rptr. at 734. The money was used to provide Kelly with rehabilitation training and around the clock attendants. SHAVELSON, *supra* note 1, at 110.

⁶ SHAVELSON, *supra* note 1, at 110.

⁷ SHAVELSON, *supra* note 1, at 110. Because Kelly was mute, his family and doctors were unsure if his intelligence had been affected by the accident. SHAVELSON, *supra* note 1, at 114. Kelly was trained to use an Elkomi machine which allowed him to type words and eventually communicate with others. SHAVELSON, *supra* note 1, at 105. It soon became apparent that his intelligence was not adversely affected. SHAVELSON, *supra* note 1, at 105-14.

⁸ SHAVELSON, *supra* note 1, at 127.

⁹ SHAVELSON, *supra* note 1, at 133. Kelly believed that committing suicide was a positive act that would allow him to grow and move forward. SHAVELSON, *supra* note 1, at 127. He deeply believed in an afterlife, an afterlife without a crippled body. SHAVELSON, *supra* note 1, at 127.

¹⁰ SHAVELSON, *supra* note 1, at 127.

¹¹ SHAVELSON, *supra* note 1, at 120-21. Kelly's family considered drowning him, allowing him to accidentally choke on food, or giving him a drug overdose. SHAVELSON, *supra* note 1, at 120-21. However, every possible scenario they invented would probably lead to a criminal investigation. SHAVELSON, *supra* note 1, at 120-21.

¹² SHAVELSON, *supra* note 1, at 122. Kelly became very frustrated and angry that his disability deprived him of the ability to kill himself. SHAVELSON, *supra* note 1, at 122.

began to starve himself.¹³ On the forty-third day of Kelly's fast, he began to vomit and the pain became overwhelming.¹⁴ "If you loved me, you'd kill me," said Kelly to anyone who approached him. No one offered."¹⁵ After forty-eight days, the pain became too much for Kelly and he quit his fast.¹⁶ However, Kelly's desire to die was not defeated. He would fast again and succeed in ending his life with his mother's assistance.¹⁷

Kelly is not the only example of a seriously ill, non-terminal patient who has attempted to end his or her life in order to avoid the painful existence that was thrust upon him. Dax Cowert and his father were unaware that they parked their car near a pipeline that was leaking propane gas.¹⁸ When they started the car, the propane ignited, causing an explosion that killed his father and severely

¹³ SHAVELSON, *supra* note 1, at 127. Kelly stopped eating on March 2, 1992. SHAVELSON, *supra* note 1, at 127. Kelly only ingested water and espresso, neither of which had any nutritional value. SHAVELSON, *supra* note 1, at 127.

¹⁴ SHAVELSON, *supra* note 1, at 132.

¹⁵ SHAVELSON, *supra* note 1, at 133.

¹⁶ SHAVELSON, *supra* note 1, at 132-33. See DEREK HUMPHRY, *THE FINAL EXIT* 63 (1991) (discussing the lack of medical documentation regarding the effects of death by starvation; some medical studies report that after an individual has lost 20% of their body weight, usually severe indigestion occurs as well as muscle weakness and eventually mental incapacity).

¹⁷ SHAVELSON, *supra* note 1, at 150. During his second fast, Kelly's mother, Joan Agnes, agreed to help him die. SHAVELSON, *supra* note 1, at 148. Mrs. Agnes decided to employ a method described in Derek Humphry's book *THE FINAL EXIT*. SHAVELSON, *supra* note 1, at 142-47 (*referring to* HUMPHRY, *supra* note 16, in which the author provides practical advice on how to commit suicide in the least painful manner). The method required Kelly to take over-the-counter sleeping pills and place a plastic bag over his head, with rubber bands around the bottom of his neck. SHAVELSON, *supra* note 1, at 150. Then he had to hold the rubber bands and plastic bag away from his neck, allowing air to enter. SHAVELSON, *supra* note 1, at 150. When the sleeping pills caused him to fall asleep, his fingers let go of the rubber bands causing the bag to close tightly around his neck. SHAVELSON, *supra* note 1, at 150. Kelly died within 30 minutes. SHAVELSON, *supra* note 1, at 143. Mrs. Agnes practiced this method with Kelly the night before he died to ensure the procedure was comfortable. SHAVELSON, *supra* note 1, at 148.

¹⁸ EUTHANASIA - THE MORAL ISSUES 16 (Robert M. Baird & Stuart E. Rosenbaum eds., 1989).

burned Dax.¹⁹ "For fourteen months, nurses dipped him almost every day into a tank of Clorox solution and scrubbed his burned skin. It took several people to hold down his atrophied, eighty-five-pound body during the tankings."²⁰ Both of his hands were amputated, his eyes were removed, his nostrils, lips and eyelids burned off.²¹ "The scars and skin graphs are a multicolored quilt of ribbed and twisted, stretched and puffed, patched-together bits of skin."²² Throughout this process, Dax begged for someone to let him die.²³

Both Kelly and Dax are examples of seriously ill, non-terminal individuals. They must rely on other people to perform the most basic tasks. Their faces and bodies bear no resemblance to the ones their accidents stole away from them, and the effects were irreversible. The physical and mental pain they endured is unimaginable and strong enough to make them choose death over life. Although Dax survived the accident and no longer feels physical pain from the burns, he still believes that the hospital "should have let him die."²⁴ Kelly dreamed of being free from his body in the afterlife, an afterlife he could not enter without the assistance of another.²⁵ Kelly could have committed suicide in a less painful and more dignified manner if he were allowed to seek the assistance of a physician.

¹⁹ *Id.* After the explosion Dax ran for almost a mile in an attempt to escape walls of flames. *Id.* Eventually he came upon a neighboring farmer. *Id.* Dax begged the man to kill him. *Id.*

²⁰ *Id.*

²¹ *Id.* at 16-17. The only undamaged skin on Dax's body was on the bottom of his feet, and that was later used for skin grafts. *Id.* at 16.

²² *Id.* at 17.

²³ *Id.* at 16. At the time of the accident, Dax was 25 years old. *Id.* at 15. Dax is now a leading advocate for the right to die. *Id.* at 15-16. Even though he no longer feels pain from the burns themselves, he strongly believes that the doctors "should have let him die." *Id.* at 15. After he was released from the hospital, he attempted to kill himself several times. *Id.* at 17. He tried to slash his wrists, overdose on sleeping pills, and jump in front of oncoming traffic. *Id.*

²⁴ *Id.* at 15.

²⁵ SHAVELSON, *supra* note 1, at 121.

Physician-assisted suicide refers to a patient ending his or her life with the aid of a doctor who prescribes life-ending medication.²⁶ Although the practice is illegal in thirty-seven states,²⁷

²⁶ 26 CATHLEEN DESIMONE, DEATH ON DEMAND: PHYSICIAN-ASSISTED SUICIDE IN THE UNITED STATES, LEGAL RESEARCH GUIDES 9 (1996). Physician-assisted suicide has been described as "active euthanasia" or "voluntary euthanasia." See *infra* note 123 (outlining various forms of euthanasia).

²⁷ Kevin M. Stansbury, in his article *Physician Assisted Suicide-Due Process, The Right to Die, Equal Protection and Slippery Slopes*, 31 LAND & WATER L. REV. 623, 637 n.132 (1996) lists the 33 states that have criminalized assisted suicide: ALASKA STAT. § 11.41.100(a)(1)(B) (Michie 1994) (first degree murder); ARIZ. REV. STAT. ANN. § 13-1103(3) (West 1989) (manslaughter); ARK. CODE ANN. § 5-10-104(a)(2) (Michie 1993) (manslaughter); CAL. PENAL CODE § 401 (West 1993) (separate crime, felony); COLO. REV. STAT. § 18-3104(1)(b) (1986) (manslaughter); CONN. GEN. STAT. ANN. § 53a-56(a)(2) (West 1994) (manslaughter in the second degree); DEL. CODE ANN. tit. 11, § 645 (1994) (separate crime, felony); FLA. STAT. ANN. § 782.08 (West 1982) (separate crime, felony); GA. CODE ANN. § 16-5-5 (1995) (separate crime, felony); HAW. REV. STAT. § 707-702(1)(b) (1993) (manslaughter); 720 ILL. COMP. STAT. 5/12-31 (West 1995) (separate crime, felony if suicide is successful, misdemeanor if suicide unsuccessful); IND. CODE ANN. § 35-42-1-2.5 (Michie 1994) (separate crime, felony); KAN. STAT. ANN. § 21-3406 (1992) (separate crime, felony); ME. REV. STAT. ANN. tit. 17A, § 204 (West 1993) (separate crime, felony); MD. CODE ANN., CRIM. LAW § 102 (1995) (reckless endangerment); MINN. STAT. ANN. § 609.215 (West 1994) (separate crime, felony); MO. REV. STAT. § 565.023(2) (1992) (voluntary manslaughter); MISS. CODE ANN. § 97-3-49 (1994) (separate crime, felony); MONT. CODE ANN. § 45-5-105 (1993) (separate crime, felony); NEB. REV. STAT. § 28-307 (1989) (separate crime, felony); N.H. REV. STAT. ANN. § 630.4 (1994) (separate crime, felony); N.J. STAT. ANN. § 2C:11-6 (West 1994) (separate crime, felony); N.M. STAT. ANN. § 30-2-4 (Michie 1994) (separate crime, felony); N.Y. PENAL LAW § 120.30 (McKinney 1987) (separate crime, felony); N.D. CENT. CODE § 12.1-16-04 (1993) (separate crime, felony); OKLA. STAT. ANN. tit. 21, § 813 (West 1993) (separate crime, felony); 18 PA. CONS. STAT. § 2505 (1993) (separate crime, felony if suicide is successful, misdemeanor if suicide attempt is unsuccessful); S.D. CODIFIED LAWS § 22-16-37 (Michie 1993) (separate crime, felony); TENN. CODE ANN. § 39-13-216 (1995) (separate crime, felony); TEX. PENAL CODE ANN. § 22.08 (West 1994) (separate crime, felony if suicide is successful, misdemeanor if suicide attempt is unsuccessful); WASH. REV. CODE ANN. § 9A.36.060 (West 1988) (separate crime, felony); WIS. STAT. ANN. § 940.12 (West 1982) (separate crime, felony).

Since the publication of his Note, four additional states have criminalized physician-assisted suicide. IOWA CODE ANN. §§ 707 A.2, 707A.3 (West 1997)

including California, twenty-three percent of surveyed physicians in California admitted to assisting patients with ending their lives.²⁸ Eighty-one percent of those doctors confessed to assisting more than one patient.²⁹

The American public has learned about physician-assisted suicide as a result of the press Dr. Jack Kevorkian has received.³⁰ "What was once medicine's little secret has been brought to the forefront of the public consciousness through the work of Dr. Jack Kevorkian."³¹ Dr. Kevorkian, who is popularly regarded as a renegade of the medical profession, is a retired pathologist whose medical license has been suspended in Michigan and revoked in California for practicing assisted suicide.³² Kevorkian uses two

(separate crime, felony); KY. REV. STAT. ANN. § 216.302 (Michie 1994) (separate crime, felony); MICH. COMP. LAWS ANN. § 752.1027 (West 1992) (separate crime, felony); R.I. GEN. LAWS §§ 11-60-1, 11-60-3 (1997) (separate crime, felony).

²⁸ JAMES M. HUMBER, *PHYSICIAN-ASSISTED DEATH* 14 (1993). The survey was conducted in 1987 by the National Hemlock Society. *Id.* at 13-14. 5,000 California physicians that were members of the American Medical Association were surveyed anonymously by mail. *Id.* at 13. Only 12% of the physicians surveyed responded. *Id.* at 14. In 1988, the Center for Health Ethics and Policy at the University of Colorado conducted a similar survey of all licensed doctors in Colorado. *Id.* Thirty-one percent of the 7,095 doctors surveyed responded, 37% of whom admitted to giving life-shortening medication to patients. *Id.*

²⁹ *Id.*

³⁰ See, e.g., *Kevorkian Brings Suicide Victim To Hospital*, CHI. TRIB., Oct. 11, 1996, at 12 (detailing how Dr. Kevorkian dropped off the deceased body of Wallace Joseph Spolar at a Detroit hospital, after he assisted the man in committing suicide); *Killer on the Loose; Legislature Can't Allow Kevorkian to Continue Dispensing Death*, GRAND RAPIDS PRESS, Aug. 30, 1996, at A12 (criticizing Dr. Kevorkian's ability to practice assisted suicide without any state regulations); Phil Mintz, *The Kevorkian Files*, N.Y. NEWSDAY, Sept. 8, 1996, at A49 (listing personal biographies of the first 38 patients that Dr. Kevorkian assisted in committing suicide).

³¹ Christopher N. Manning, Note, *Live and Let Die?: Physician-Assisted Suicide and the Right to Die*, 9 HARV. J.L. & TECH. 513, 513 (1996).

³² Thomas Maier, *Autopsy Reports Raise Red Flag on Kevorkian Crusade / Only 9 of His 40 Assisted Suicides Found Terminally Ill*, MORNING NEWS TRIB. (Tacoma Wash.), Sept. 15, 1996, at F2 [hereinafter Maier, *Kevorkian Crusade*]. In 1991, the Michigan Board of Medicine suspended Dr. Kevorkian's medical license after he assisted two non-terminal patients with their respective suicides

methods when assisting patients with ending their lives.³³ The first method allows the patient to achieve death via Kevorkian's "suicide machine."³⁴ The machine consists of a large frame with two syringes attached.³⁵ One syringe is filled with the anesthetic sodium pentothal and the other syringe is filled with a lethal dose of potassium chloride.³⁶ This method begins by Dr. Kevorkian inserting an intravenous needle into one of the patient's veins.³⁷ The patient is then responsible for pushing a button that releases sodium pentothal, putting the patient to sleep.³⁸ Soon after, potassium chloride is automatically released into the patient's vein, thus causing his or her death.³⁹ The second method simply

in Michigan. Jim Persels, Commentary, *Forcing the Issue of Physician-Assisted Suicide, Impact of the Kevorkian Case on the Euthanasia Debate*, 14 J. LEGAL MED. 93, 99 (1993). Consequently, Kevorkian was charged with two counts of murder and one count of unlawful delivery of a controlled substance. *Id.* However, all charges were later dismissed. *Id.* In 1994, the California Medical Board revoked Kevorkian's medical license because he lacked the qualifications and skills to determine whether his patients were competent when they made the decision to commit suicide. Maier, *Kevorkian Crusade*, *supra*, at F2. The Board criticized Kevorkian's assistance in the suicide of Marjorie Wantz, a non-terminal woman that complained of severe pelvic pain, the existence of which could not be verified. Thomas Maier, *Kevorkian's Claims At Odds With Coroner*, AUSTIN AM.-STATESMAN, Sept. 12, 1996, at A1 [hereinafter, Maier, *Kevorkian's Claims At Odds With Coroner*].

³³ See Mintz, *supra* note 30, at A49; *infra* notes 34-40 (discussing the methods used by Dr. Kevorkian). Since 1990, Dr. Jack Kevorkian has assisted patients committing suicide by either lethal injection or carbon monoxide poisoning. Mintz, *supra* note 30, at A49.

³⁴ Mintz, *supra* note 30, at A49. Dr. Kevorkian built the machine in September of 1989 and named it the "Mercitron." DR. JACK KEVORKIAN, PRESCRIPTION: MEDICIDE 209 (1991). Dr. Kevorkian admitted that he constructed the "Mercitron" on his kitchen table. MICHAEL BETZOLD, APPOINTMENT WITH DOCTOR DEATH 35 (1993). On June 4, 1990, the first patient to use the "Mercitron" was Janet Adkins, a woman that was not terminally-ill, but had been diagnosed as having Alzheimer's disease. KEVORKIAN, *supra*, at 230.

³⁵ Persels, *supra* note 32, at 97.

³⁶ Persels, *supra* note 32, at 97.

³⁷ KEVORKIAN, *supra* note 34, at 208.

³⁸ Persels, *supra* note 32, at 97.

³⁹ Persels, *supra* note 32, at 97. The sodium pentothal and the potassium chloride are released through the same intravenous needle. KEVORKIAN, *supra*

requires the patient to inhale carbon monoxide through a gas mask provided by Dr. Kevorkian.⁴⁰

Kevorkian's methods have stirred up a significant amount of public debate for two major reasons.⁴¹ First, unlike most individuals who fear their mortality, he appears to embrace death in an almost fanatical manner.⁴² Consequently, he has been nicknamed "Dr. Death."⁴³ Second, while most of the public may sympathize with terminal patients expediting their deaths in order to avoid additional pain and suffering associated with their illnesses,⁴⁴

note 34, at 208.

⁴⁰ Mintz, *supra* note 30, at A49.

⁴¹ Kevorkian's work is in direct conflict with both secular and religious laws which promote the preservation of life and prohibit the practice of suicide. See MARGARET PABST BATTIN, *THE LEAST WORST DEATH* 206 (1994) (noting that Christianity considers suicide to be the greatest sin an individual can commit); Steve Kloehn, *Now Is the Time To Bring Religion Back Into Decisions, Many Believe*, CHIC. TRIB., June 27, 1997, at 19 (discussing how Judaism, Christianity, and Islam believe that physician-assisted suicide is morally repugnant and quoting a professor of Islamic Studies as saying that committing physician-assisted suicide is "like committing a crime in Islam"). See also *supra* note 27 (listing 37 states that have criminal statutes prohibiting assisted suicide).

⁴² In addition to supporting physician-assisted suicide, Dr. Kevorkian has supported medical experimentation on death row inmates, and has recommended that they be allowed to auction off their organs. Jeff Hooten, *A Slippery Slope to the Real Dr. Death, What Happens When Respectable Doctors Begin Using Kevorkian's Tactics?*, L.A. TIMES, Sept. 17, 1996, at B7. Some of his experiments have included "transfusing blood from corpses into living patients." *Id.* At one time he mixed cadaver blood with his own and used it to paint a picture frame. *Id.*

⁴³ BETZOLD, *supra* note 34, at 7. During Dr. Kevorkian's medical residency, he specifically requested to work the shift during which more patients died, and he photographed patients' eyes at the moment of their death. BETZOLD, *supra* note 34, at 7. As a result of his apparent interest in death, his co-workers nicknamed him "Dr. Death." Hooten, *supra* note 42, at B7.

⁴⁴ "A 1991 Roper Poll/Hemlock Society survey of a representative sample of 1,500 adults (in California, Oregon, and Washington State) found that 68% believed that doctors should be legally allowed to assist in the death of a person who has a painful and distressing terminal disease." HUMBER, *supra* note 28, at 11-12. That same year, the results of a national poll conducted by the Boston Globe and Harvard found that 64% favored physician-assisted suicide for terminal patients. HUMBER, *supra* note 28, at 12.

some do not agree with Dr. Kevorkian assisting non-terminal patients.⁴⁵

Dr. Kevorkian (with the assistance of the media) has succeeded in raising public consciousness and in some cases has evoked public sympathy for terminal and non-terminal individuals who live in incurable pain or deteriorate in an undignified manner.⁴⁶ Consequently, an increasing number of ailing individuals who are not terminally-ill, nor in the final stages of disease, have sought the assistance of physicians like Kevorkian in hastening their death.⁴⁷

⁴⁵ At their times of death, many of Kevorkian's patients were suffering from multiple sclerosis, Alzheimer's, Lou Gehrig's disease, or cancer. Mintz, *supra* note 30, at A49. However, the overwhelming majority of those patients were not in the terminal phases of their illnesses at the time of their deaths. Mintz, *supra* note 30, at A49. According to the autopsy reports for the first 40 patients Dr. Kevorkian assisted with committing suicide, only nine were terminal. Maier, *Kevorkian Crusade*, *supra* note 32, at F2. Dr. Nancy Dickey, head of the American Medical Association's Board of Trustees, believes that Kevorkian's practice of assisting non-terminal patients with committing suicide forces the medical community to avoid assisting patients with suicide. Maier, *Kevorkian Crusade*, *supra* note 32, at F2.

⁴⁶ DEREK HUMPHRY, *LAWFUL EXIT* 26 (1993). Hemlock Society founder Derek Humphry admitted that Dr. Kevorkian had successfully illustrated that some hopelessly ill patients want physician-assisted suicide. *Id.* However, Humphry believes that Dr. Kevorkian's conduct is responsible for making it more difficult for patients to commit physician-assisted suicide. *Id.* Due to Dr. Kevorkian's efforts, Humphry argues that physicians that were once willing to discretely assist patients in hastening death have refrained from acting out of fear of criminal prosecution. *Id.* Also, Humphry blames Dr. Kevorkian for provoking the state of Michigan to enact legislation criminalizing assisted suicide. *Id.*

⁴⁷ For example, Janet Adkins contacted Dr. Jack Kevorkian after she had been diagnosed with Alzheimer's disease. KEVORKIAN, *supra* note 34, at 221-22. Although Alzheimer's is not a terminal condition, it makes the individual vulnerable to other illnesses and deteriorates the mind. GEORGE BURNELL, *FINAL CHOICES* 319 (1993). Ms. Adkins participated in an experimental program for treatment of the disease, but, as her conditioned worsened, she became certain that she wanted to commit suicide. KEVORKIAN, *supra* note 34, at 222. Sherry Miller also sought Dr. Kevorkian's services when her multiple sclerosis left her unable to use her arms and legs. Mintz, *supra* note 30, at A49. Although multiple sclerosis is not a terminal condition, it is a degenerative disease of the central nervous system marked by hardening of tissue in the brain or spinal cord. WEBSTER'S II NEW RIVERSIDE DICTIONARY 463 (1st ed. 1984). With the help of Dr. Kevorkian, Ms. Miller committed physician-assisted suicide on October

Even more recently, public debate and interest in physician-assisted suicide have been heightened by the United States Supreme Court's decisions in *Washington v. Glucksberg*⁴⁸ and *Vacco v. Quill*.⁴⁹ Both of these cases were brought by physicians and their terminally-ill patients who were seeking to commit physician-assisted suicide. The Court concluded that the New York and Washington laws that banned assisted suicide were constitutional.⁵⁰ However, the Court's decision did not destroy all hope for the legalization of physician-assisted suicide. In fact, the Court mentioned that its decision will allow this nation to continue to debate the legality of physician-assisted suicide.⁵¹ In fact, the State of Oregon is currently debating whether to uphold its law that legalized physician-assisted suicide.⁵²

23, 1991. Mintz, *supra* note 30, at A49. When Marjorie Wantz suffered from severe pelvic pain for which doctors could not find a physical cause or cure she too committed physician-assisted suicide on October 12, 1991. Mintz, *supra* note 30, at A49.

⁴⁸ *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997). In January, 1994, respondents, three terminally-ill patients, and the nonprofit organization Compassion in Dying, who counsels patients contemplating physician-assisted suicide, sued in the United States District Court in the case entitled *Compassion in Dying v. Washington*, 850 F. Supp. 1454 (W.D. Wash. 1994). The District Court held that the Washington ban of assisted suicide was unconstitutional. *Id.* at 1459. On appeal, the Ninth Circuit reheard the case en banc and affirmed the District Court, holding that terminal patients do have a protected liberty interest under the Due Process Clause of the 14th Amendment in seeking physician-assisted suicide. *Compassion in Dying v. Washington*, 79 F.3d 790, 813 (9th Cir. 1996). The Due Process Clause provides that no state shall "deprive any person of life, liberty, or property, without due process of law" U.S. CONST. amend. XIV, § 1. The United States Supreme Court granted certiorari and the non-profit organization Compassion in Dying was replaced as named respondent by Harold Glucksberg, M.D., a Washington physician. Thus, hereinafter the case will be referred to as *Glucksberg v. Washington*, 117 S. Ct. at 2262.

⁴⁹ *Vacco v. Quill*, 117 S. Ct. 2293 (1997).

⁵⁰ *Quill*, 117 S. Ct. at 2302; *Glucksberg*, 117 S. Ct. at 2274.

⁵¹ *Glucksberg*, 117 S. Ct. at 2274. In his concurrence Justice Souter stated that "[w]hile I do not decide for all time that respondents' claim should not be recognized, I acknowledge the legislative institutional competence as the better one to deal with that claim at this time." *Id.* at 2293.

⁵² See *infra* notes 131-36 and accompanying text (discussing the enactment of the Oregon Death With Dignity Act and the upcoming referendum).

In 1994, the state of Oregon passed the Oregon Death With Dignity Act, a statute legalizing physician-assisted suicide for terminally-ill patients.⁵³ Simultaneously, other states were campaigning to legalize the practice.⁵⁴ The fact that Oregon and other state campaigns limited the right to terminal patients indicates that if the practice is legalized in other states, its benefits might also be limited to the terminally-ill.⁵⁵ This begs the question of whether a legal distinction should be drawn between the rights of a terminal patient and the rights of a non-terminal patient. This Note discusses why the right to commit physician-assisted suicide has not been extinguished by the United State Supreme Court's recent decisions in *Quill* and *Glucksberg*. It then explains why access to assisted suicide should be expanded to include seriously ill, non-terminal patients like Kelly and Dax.

Part I of this Note discusses the judicial development of cases that led the Second Circuit and Ninth Circuit to find a constitutional right to physician-assisted suicide for the terminally-ill, both under a Due Process and an Equal Protection analysis. Part II addresses the Supreme Court's decision to uphold state laws prohibiting physician-assisted suicide and discusses its impact upon future state campaigns to legalize physician-assisted suicide. Part III compares the similarities between terminally-ill patients and seriously ill, non-terminal patients seeking physician-assisted suicide and explains how dissimilar treatment of these two groups violates the Equal Protection Clause. Part IV explains the problems which can arise from limiting the right of physician-assisted suicide to the terminally-ill. Finally, Part V urges state legislators to adopt statutes which will legalize physician-assisted suicide for terminally-ill and seriously ill, non-terminal patients, and proposes a model act. This Note concludes that the United State Supreme Court's decisions in *Quill* and *Glucksberg* have not eliminated the

⁵³ OR. REV. STAT. §§ 127.800-127.897 (1994).

⁵⁴ See *infra* note 130 (discussing how Washington and California nearly passed legislation legalizing physician-assisted suicide for the terminally-ill).

⁵⁵ The Supreme Court in *Glucksberg* acknowledged that since the Oregon Death With Dignity Act, numerous proposals have been submitted to state legislatures which seek to legalize assisted-suicide for the terminally-ill. *Glucksberg*, 117 S. Ct. at 2266.

possibility for legalization of physician-assisted suicide. Instead, it has left the responsibility for legalizing assisted suicide to individual state legislatures. This Note predicts that groups and organizations supporting physician-assisted suicide will revitalize their legislative campaigns to legalize physician-assisted suicide. However, it is likely that these groups will propose legislation that ignores seriously ill, non-terminal individuals who endure physical pain and suffering equivalent to that experienced by terminal patients.

I. THE RIGHT TO DIE: A CONSTITUTIONAL ANALYSIS

A. *The Due Process Clause*

In *Bouvia v. Superior Court*, a 1986 California Court of Appeals case, the court held that an individual has a right to commit passive euthanasia and thus laid the foundation for future judicial battles to legalize physician-assisted suicide.⁵⁶ In *Bouvia*, a hospitalized, mentally competent quadriplegic suffering from severe cerebral palsy, desired to end her life.⁵⁷ What is significant in *Bouvia* is the fact that the patient was not terminally-ill.⁵⁸ She was a twenty-eight year old woman completely confined to her bed, who required assistance in feeding, washing, cleaning, toileting,

⁵⁶ *Bouvia v. Superior Court*, 225 Cal. Rptr. 297 (2d Dist. 1986). See *infra* note 123 (defining "passive euthanasia"). For examples of subsequent judicial battles, see *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 278 (1990) (stating that individuals possess a constitutionally protected liberty interest in refusing unwanted medical treatment); *Quill v. Vacco*, 80 F.3d 716, 729 (2d Cir. 1996) (concluding that a New York statute that criminalized assisted suicide was violative of the Equal Protection Clause of the 14th Amendment); *Compassion in Dying v. Washington*, 79 F.3d 790, 816 (9th Cir. 1996) (concluding that a liberty interest in hastening one's own death exists).

⁵⁷ *Bouvia*, 225 Cal. Rptr. at 300. Ms. Bouvia also suffered from degenerative and severely crippling arthritis which caused her to live in constant pain. *Id.* at 1136.

⁵⁸ Yale Kamisar, *Against Assisted Suicide-Even a Very Limited Form*, 72 U. DET. MERCY L. REV. 735, 742 (1995).

turning, and other bodily functions.⁵⁹ Furthermore, she was intelligent and completely aware of her overwhelming limitations.⁶⁰ Due to her physical limitations, the only manner in which she could achieve death was to starve herself. Although she was able to eat food, spoon-feeding was required.⁶¹ When she began consuming less and less food, the hospital implanted a feeding tube against Ms. Bouvia's expressed wishes, in order to increase her consumption and keep her alive.⁶²

In *Bouvia*, the court recognized that the state's interest in preserving life did not always outweigh the patient's right to reject treatment, even when refusing treatment could result in the patient's death.⁶³ The court noted that Ms. Bouvia's non-terminal illness was of little significance when compared to the substandard quality of life she was living.⁶⁴ The court described Ms. Bouvia's life as follows:

It diminished to the point of hopelessness, uselessness, unenjoyability and frustration. She, as the patient, lying helplessly in bed, unable to care for herself, may consider her existence meaningless Who shall say what the minimum amount of available life must be? Does it matter if it be fifteen to twenty years, fifteen to twenty months, or fifteen to twenty days, if such life has been physically destroyed and its quality, dignity and purpose gone? As in all matters lines must be drawn at some point, somewhere, but that decision must ultimately belong to the one whose life is in issue.⁶⁵

This decision was the precursor to the United State Supreme Court's decision in *Cruzan v. Missouri, Department of Health*.⁶⁶

In *Cruzan*, the United States Supreme Court recognized that a competent person has a constitutionally protected liberty interest in

⁵⁹ *Bouvia*, 225 Cal. Rptr. at 300.

⁶⁰ *Id.* See Kamisar, *supra* note 58, at 742.

⁶¹ *Bouvia*, 225 Cal. Rptr. at 300.

⁶² *Bouvia*, 225 Cal. Rptr. at 300.

⁶³ *Bouvia*, 225 Cal. Rptr. at 304.

⁶⁴ *Bouvia*, 225 Cal. Rptr. at 304.

⁶⁵ *Bouvia*, 225 Cal. Rptr. at 304-05.

⁶⁶ 497 U.S. 261 (1990).

refusing unwanted life-saving medical treatment.⁶⁷ Nancy Cruzan was in a serious automobile accident that left her in a persistent vegetative state.⁶⁸ Ms. Cruzan was not terminally ill; she could have lived for decades with the assistance of artificial feeding and hydration.⁶⁹ However, her parents and her doctors were convinced that she would be unaware of her own existence as long as she lived.⁷⁰ Consequently, her parents sought to end her life by removing her feeding and hydration tubes.⁷¹ Before Nancy's life support could be removed, the State of Missouri required clear and convincing evidence that Nancy preferred death to artificial treatment.⁷²

The Court held that a state may impose a requirement of clear and convincing evidence that a patient would prefer that his or her life-support systems be removed in order to hasten death.⁷³ Nancy Cruzan's parents were unable to meet this evidentiary requirement and consequently were prohibited from removing their daughter's artificial life support.⁷⁴ However, the Court's holding recognizes that an individual possesses a liberty interest in refusing life-sustaining medical treatment.⁷⁵ This was a monumental move

⁶⁷ *Id.* at 279.

⁶⁸ *Id.* at 266. A person in a persistent vegetative state "exhibits motor reflexes but evinces no indications of significant cognitive function." *Id.*

⁶⁹ *Id.* "Medical experts testified that she could live another thirty years." *Id.*

⁷⁰ *Id.* A body in a vegetative state maintains temperature, heartbeat, pulmonary ventilation, digestive functions and low levels of conditioned responses. *Id.* However, there is no evidence of self-awareness or awareness of one's surroundings. *Id.*

⁷¹ *Id.* at 267. When Nancy Cruzan's parents requested that the hospital staff remove their daughter's artificial treatment, the staff refused to do so without a court order. *Id.* The Supreme Court held that close family members of patients like Nancy Cruzan cannot make the decision to remove life-saving treatment in substitution of the incompetent patient. *Id.* at 286. The Court explained that in Missouri, clear and convincing evidence must exist that proves the patient would prefer death over life. *Id.* at 282.

⁷² *Id.* at 282.

⁷³ *Id.* at 284.

⁷⁴ *Id.* at 286.

⁷⁵ *Id.* at 285.

forward for proponents of euthanasia.⁷⁶ *Cruzan* was the first United States Supreme Court decision acknowledging an individual's "right to die."⁷⁷ Although the *Cruzan* Court did not explicitly recognize a fundamental right to die,⁷⁸ its holding lent support for the Ninth Circuit's decision in *Compassion in Dying v. Washington* that mentally competent, terminally-ill patients have a right to physician-assisted suicide.⁷⁹

In 1996, the Ninth Circuit in *Compassion in Dying* partially relied upon *Cruzan* to extend the right to die to include mentally competent, terminally-ill individuals who were seeking to hasten death with a doctor's assistance.⁸⁰ The plaintiffs in *Compassion in Dying* contended that a Washington statute that made it unlawful to aid someone in committing suicide, prevented terminally-ill patients from exercising their constitutionally protected liberty interest in violation of the Due Process Clause of the Fourteenth Amendment.⁸¹ The Ninth Circuit held that under the Due Process Clause, there is a "realm of personal liberty" that the government may not enter.⁸² Within this realm is the right to control the time and manner of one's death.⁸³ The court concluded that, because *Cruzan* recognized that the right to reject life-sustaining medical

⁷⁶ George J. Annas, *The "Right to Die" in America: Sloganeering From Quinlan and Cruzan to Quill and Kevorkian*, 34 DUQ. L. REV. 875, 883 (1996) (noting that, at the time, the *Cruzan* decision was the only "right to die" case that the Supreme Court had decided).

⁷⁷ *Cruzan* is no longer the only United State Supreme Court "right to die" case. On June 26, 1997, the Supreme Court decided that a mentally competent, terminally-ill patient does not have a protected right under the 14th Amendment to commit physician-assisted suicide. See *Vacco v. Quill*, 117 S. Ct. 2293 (1997); *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997).

⁷⁸ See generally *Cruzan*, 497 U.S. 261.

⁷⁹ 79 F.3d 790, 816 (9th Cir. 1996) (concluding that the United States Supreme Court's decision in *Cruzan* to recognize an individual's right to refuse life-sustaining medical treatment, "necessarily recognizes a liberty interest in hastening one's own death").

⁸⁰ *Id.*

⁸¹ *Id.* at 797. The Due Process Clause provides that no state shall "deprive any person of life, liberty, or property, without due process of law . . ." U.S. CONST. amend. XIV, § 1.

⁸² *Compassion in Dying v. Washington*, 79 F.3d 790, 806 (9th Cir. 1996).

⁸³ *Id.* at 813.

treatment is a liberty interest, it follows that an individual also has "a liberty interest in hastening one's own death."⁸⁴

The Ninth Circuit also relied upon the Supreme Court's decision in *Planned Parenthood v. Casey*.⁸⁵ In *Casey*, the Court concluded that "matters involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment."⁸⁶ Accordingly, the Ninth Circuit stated that the decision to end one's life is perhaps the most personal and intimate choice a person may make in their lifetime, and is central to personal dignity and autonomy.⁸⁷ This decision therefore, recognizes a liberty interest within the meaning of the Due Process Clause.⁸⁸ Consequently, the Ninth Circuit, relying on both *Cruzan* and *Casey*, held that mentally competent, terminally-ill patients have a fundamental right under the Fourteenth Amendment to commit physician-assisted suicide.⁸⁹

The Ninth Circuit's decision was a clear victory for proponents of physician-assisted suicide. For the first time in history, a court legitimized an act that had been historically prohibited.⁹⁰ However, the victory was short-lived. On June 26, 1997, the United States Supreme Court rejected the Ninth Circuit's decision.⁹¹ The Court repudiated the respondent's claim that physician-assisted suicide falls within the line of substantive-due-process cases in which personal autonomy and self-control are emphasized.⁹² In

⁸⁴ *Id.* at 816.

⁸⁵ 505 U.S. 833 (1992).

⁸⁶ *Casey*, 505 U.S. at 851.

⁸⁷ *Compassion in Dying*, 79 F.3d at 813-14.

⁸⁸ *Id.* at 813.

⁸⁹ *Id.* at 814.

⁹⁰ See *supra* note 27 (listing 37 states that criminalize assisted suicide).

⁹¹ *Washington v. Glucksberg*, 117 S. Ct 2258 (1997) (deciding that the Washington law that prohibited assisted suicide did not unconstitutionally violate the Due Process Clause of the 14th Amendment).

⁹² *Id.* at 2269. The Court explained how the lower court inappropriately "transmuted" the fundamental right to refuse unwanted medical treatment, which was established in *Cruzan*, into a right to commit physician-assisted suicide. *Id.* at 2270. The Court further explained that although the *Casey* decision reaffirmed the right of a woman to seek an abortion, it does not allow a court to reach the

fact, the Court stated that its decision in *Cruzan* was consistent with this nation's tradition of "protecting the decision to refuse unwanted medical treatment,"⁹³ and was not based upon the principle of personal autonomy.⁹⁴ Furthermore, the Court criticized the lower court's decision for concluding from *Casey* that "any and all important, intimate, and personal" choices are protected under the Due Process Clause.⁹⁵ The Court thereafter held that the Washington law prohibiting physician-assisted suicide did not violate the Due Process Clause.⁹⁶

"sweeping conclusion" that all personal choices are protected by the Due Process Clause. *Id.* at 2271.

⁹³ *Id.* at 2270.

⁹⁴ *Id.* at 2270-71. The Court stated that it did not intend for its decision in *Cruzan* to be "transmuted into a right to assistance in committing suicide." *Id.*

⁹⁵ *Id.* The Court pointed out that its decision in *Casey* to protect a personal liberty could not be broadly extended to assisted suicide. *Id.* at 2271.

⁹⁶ *Id.* In determining the constitutionality of the Washington statute, the Court also had to determine whether the state's ban of physician-assisted suicide was rationally related to legitimate government interests. *Id.* at 2271. The interests asserted by the state included protecting citizens who may choose to commit suicide while suffering from depression; protecting the integrity of the medical profession by banning a practice that would blur the "time-honored line between healing and harming"; and banning a practice that could not be limited to the terminally-ill if it were legalized. *Id.* at 2272-74. The Court relied upon evidence presented by the New York State Task Force on Life and the Law, which showed that "more than 95% of those who commit suicide had a major psychiatric illness at the time of death; among the terminally ill, uncontrolled pain is a 'risk factor' because it contributes to depression." *Id.* at 2272. The New York State Task Force asserted that since depression is difficult to diagnose, patients with untreated pain may become depressed and seek assisted suicide. *Id.* at 2273. The state of Washington also asserted that it had an interest in protecting individuals who may be coerced into committing assisted suicide. *Id.* at 2272. Such individuals would include the poor, the elderly and disabled persons who are susceptible to undue influence. *Id.* at 2273. The Court also considered the American Medical Association's Code of Ethics § 2.211 (1994), which states that a physician's role in assisting suicide would be incompatible with his or her role as a healer. *Id.* at 2272. The Court also contemplated the practice of assisted suicide in the Netherlands where studies have shown that the procedure has not been limited to the terminally-ill and that abuse of the practice has led to the death of vulnerable individuals who never consented to assisted suicide. *Id.* at 2273-74. The state also feared situations in which patients would be physically unable to independently take their lethal medication and conse-

B. The Equal Protection Clause

In 1996, a group of terminally-ill patients and their doctors challenged the constitutionality of New York statutes that prohibited assisted suicide.⁹⁷ In *Quill v. Vacco*, the Second Circuit concluded that New York's statutes were unconstitutional, but not because it believed that physician-assisted suicide was a fundamental right.⁹⁸ Instead, it held that the statutes prohibiting physician-assisted suicide violated the Equal Protection Clause of the Fourteenth Amendment.⁹⁹ The court reasoned that the statutes failed to treat similarly situated persons alike because terminal patients attached to artificial life-support could end their lives by removing such support, while terminal patients not attached to life support could not end their lives by taking a lethal dose of prescribed medication.¹⁰⁰ Furthermore, the court held that the State of New York does not have a legitimate interest in distinguishing these two classes of people.¹⁰¹

quently require either physicians, family members or friends to administer the medication for them. *Id.* at 2274. The Court concluded that Washington's ban of physician-assisted suicide was rationally related to its interests. *Id.* at 2271.

⁹⁷ *Quill v. Vacco*, 80 F.3d 716, 718-19 (2d Cir. 1996). The physicians alleged that they were prevented from prescribing life-ending medication to terminal patients for fear of prosecution under New York law. *Id.* The New York Penal law states, "[a] person is guilty of manslaughter in the second degree when . . . he intentionally . . . aids another person to commit suicide." N.Y. PENAL LAW § 125.15 (McKinney 1987). The law further states, "a person is guilty of promoting a suicide attempt when he intentionally . . . aids another person to attempt suicide." *Id.* § 120.30.

⁹⁸ 80 F.3d at 725. Compare *Quill*, 80 F.3d at 727 (holding that the New York statutes violated the Equal Protection Clause by failing to treat similarly circumstanced persons alike) with *Compassion in Dying v. Washington*, 79 F.3d 790, 816 (9th Cir. 1996) (holding that terminally-ill individuals have a fundamental right to seek physician-assisted suicide).

⁹⁹ *Quill*, 80 F.3d at 716. The Equal Protection Clause provides that equal protection of individuals under the law cannot be denied by any state. U.S. CONST. amend. XIV, § 1.

¹⁰⁰ *Quill*, 80 F.3d at 729.

¹⁰¹ *Id.* at 727. The court stated that there cannot be an interest in preserving the life of a terminal patient because such a person's life is almost over. *Id.* at

As was the Ninth Circuit's decision in *Compassion in Dying*, the Second Circuit's decision in *Quill* was a temporary historical victory for proponents of physician-assisted suicide. The United States Supreme Court overturned the Second Circuit's decision and held that there is a distinction between ending one's life by removing life-saving medical treatment and receiving assistance from a physician.¹⁰² The Court distinguished the acts by considering both the intent of the physician and the patient's cause of death.¹⁰³ The intent of a physician who discontinues a patient's medical treatment is to respond to a patient's request to stop treatment that is no longer beneficial to him or her.¹⁰⁴ The cause of death under such circumstances would be the underlying illness.¹⁰⁵ This differs from a physician who prescribes life-ending medication. The intent of a physician prescribing life-ending medication is not to stop ineffective treatment, but rather to ensure the patient's death.¹⁰⁶ Moreover, the cause of death is not the terminal illness, but rather the prescribed medication.¹⁰⁷ Since the Court established that the two procedures are distinguishable in terms of "causation and intent," terminally-ill patients may be treated dissimilarly without violating the Equal Protection Clause.¹⁰⁸

729. Furthermore, the state cannot legitimately require a terminal patient to endure prolonged pain and indignity when the inevitable result is death. *Id.* at 730.

¹⁰² *Vacco v. Quill*, 117 S. Ct. 2293, 2298 (1997).

¹⁰³ *Id.* at 2298.

¹⁰⁴ *Id.* The theory that a patient has a right to reject medical treatment has been based upon the notion of "bodily integrity and freedom from unwanted touching." *Id.* at 2301 (quoting *Cruzan v. Mo. Dep't of Health*, 497 U.S. 261 (1990)).

¹⁰⁵ *Id.* at 2298.

¹⁰⁶ *Id.*

¹⁰⁷ *Id.*

¹⁰⁸ *Id.* "When the basic classification is rationally based, uneven effects upon particular groups within a class are ordinarily of no constitutional concern." (quoting *Personnel Administrator of Mass. v. Feeney*, 442 U.S. 256, 272 (1979)).

II. LEGALIZATION OF PHYSICIAN-ASSISTED SUICIDE IS LEFT TO THE STATES

Although the United States Supreme Court upheld both New York and Washington's bans on physician-assisted suicide, the Court's opinions made it clear that it did not eliminate all possibilities for the legalization of physician-assisted suicide. In his majority opinion in *Glucksberg*, Chief Justice Rehnquist expressed the Court's desire to steer clear of creating new fundamental rights or liberty interests under the Due Process Clause since such action would transform protected liberties into "policy preferences" of the Court.¹⁰⁹ The Court intimated that if it extended constitutional protection to physician-assisted suicide, it would be usurping the powers of state legislatures and ignoring public debate over this controversial issue.¹¹⁰ Essentially, the Court decided that if the right to physician-assisted suicide is to be established, it must be done by a state legislature and not the Court.¹¹¹

In conducting its Due Process analysis, the Court in *Glucksberg* examined this country's "history, legal traditions, and practices"¹¹² and concluded that assisted suicide has no roots in this nation's history.¹¹³ The Court also concluded that if it upheld the

¹⁰⁹ *Washington v. Glucksberg*, 117 S. Ct. 2258, 2267-68 (1997) (citing *Moore v. East Cleveland*, 431 U.S. 494, 502 (1937) (plurality opinion)).

¹¹⁰ *Glucksberg*, 117 S. Ct. at 2267-68.

¹¹¹ Ellen Goodman, *Assisted Suicide; Court's Decision Leaves Many Legal Doors Open*, DALLAS MORNING NEWS, June 29, 1997, at 5J (commenting on how the Supreme Court's decision essentially left the matter to the states to decide by leaving open enough legal doors "to make the future look like a hospital hallway").

¹¹² *Glucksberg*, 117 S. Ct. at 2262.

¹¹³ *Id.* at 2263-65. The Court pointed out that presently, almost every state and western democracy criminalizes assisted suicide. *Id.* at 2263. Furthermore, "for over 700 years, the Anglo-American common-law tradition has punished or disapproved of both suicide and assisting suicide." *Id.* The Court asserted that this nation's disapproval of assisting suicide has been reaffirmed by recent ballot initiatives in Washington and California where the public voted against legalizing assisted suicide. *Id.* at 2266. The Court did acknowledge that the existence of these ballot initiatives has proved that these states were "engaging in serious,

lower court's decision and found that access to physician-assisted suicide was a fundamental right, such a decision would upset centuries of legal tradition which rejected assisted suicide and would replace the law of nearly every single state.¹¹⁴ It appears that the Court was reluctant to single-handedly change history by determining that access to physician-assisted suicide is a fundamental right.¹¹⁵ Seemingly, it would prefer that a majority of each state's citizenry vote to legalize physician-assisted suicide, rather than having the Court make one law for the nation. In its final words, the Court stated that its decision would allow the "debate to continue as it should in a democratic society."¹¹⁶ Therefore, proponents of physician-assisted suicide must now return their focus to passing state legislation that will legalize assisted suicide.¹¹⁷

It is feasible that more laws legalizing physician-assisted suicide will be passed by state legislatures for two reasons. First, advocates of physician-assisted suicide have experience with introducing legislation that legalizes such suicide. Second, public support exists for the practice. Proponents of physician-assisted suicide began their legislative campaign nearly a century ago. In 1906, the Ohio legislature proposed a bill before its Committee on Medical

thoughtful examinations of physician-assisted suicide." *Id.* at 2267.

¹¹⁴ *Id.* at 2269.

¹¹⁵ Chief Justice Rehnquist's final words in the majority opinion acknowledge that the Court is conscious of the country's ongoing debate over the "morality, legality, and practicality of physician-assisted suicide." *Id.* at 2275.

¹¹⁶ *Id.* at 2269. It should be noted that debates in a democratic society are customarily resolved by the opinion of a majority. For example, in the State of Oregon, the enactment of the Oregon Death with Dignity Act, which legalized physician-assisted suicide for mentally competent, terminally-ill patients, signified that the majority of Oregon's citizenry shared the opinion that assisted suicide is a fundamental right. OR. REV. STAT. §127.800 (1994). The Supreme Court acknowledged that since the Oregon Death With Dignity Act, numerous proposals have been submitted to state legislatures which seek to legalize physician-assisted suicide. *Glucksberg*, 117 S. Ct. at 2266.

¹¹⁷ Janny Scott, *Ruling Against Assisted Suicide Won't Kill 'Right To Die' Debate*, N.Y. TIMES, June 29, 1997, at A18 (suggesting that, as a result of the Court's decision in *Glucksberg*, many states will renew their efforts to legalize assisted suicide, and predicting that patients will be forced to cross state lines in order to commit physician-assisted suicide).

Jurisprudence to allow physicians to ask their mentally competent patients who were fatally injured, seriously ill or enduring severe physical pain with an unlikelihood of recovery whether they wanted to die.¹¹⁸ If the patient consented, the physician would be required to confer with three other physicians regarding the patient's condition.¹¹⁹ If the four physicians agreed that the patient's "case was hopeless,"¹²⁰ the doctors would make arrangements to end the patient's life in the most comfortable manner possible.¹²¹ Although the bill was ultimately defeated by the Committee, its significance is two-fold.¹²² First, it signified public support for euthanasia in the United States.¹²³ Second, the bill did not attempt to limit the right to physician-assisted suicide to the terminally-ill. Instead, it recognized that incurable pain and suffering may create a hopeless existence for both terminal and non-terminal patients.

Through the years, proponents of assisted suicide organized themselves and began introducing more legislation in an attempt to legalize euthanasia. The Euthanasia Society of America, founded in 1938, was the first American organization to advocate euthanasia.¹²⁴ It was the Society's directive to "crusade for legalization of euthanasia on the belief that with adequate safeguards, the choice

¹¹⁸ Persels, *supra* note 32, at 101.

¹¹⁹ Persels, *supra* note 32, at 101.

¹²⁰ Persels, *supra* note 32, at 101.

¹²¹ Persels, *supra* note 32, at 101.

¹²² Persels, *supra* note 32, at 101 (stating that the bill was defeated by a vote of 78 to 22).

¹²³ The term "euthanasia" refers to the decisions or actions that induce the gentle and peaceful death of an individual. JOHN LADD, *ETHICAL ISSUES RELATING TO LIFE AND DEATH* 3 (1979). "Passive euthanasia" refers to death caused by an underlying illness after artificial, life-sustaining treatment has been removed. Peter M. McGough, M.D., *A Symposium: Physician-Assisted Suicide, Medical Concerns About Physician-Assisted Suicide*, 18 SEATTLE U. L. REV. 521, 521 (1995). "Active euthanasia" requires one individual taking the life of another by either lethal injection or medication. *Id.* It requires "taking steps to end your life" with the assistance of another person. HUMPHRY, *supra* note 46, at 20. Physician-assisted suicide has been categorized as a type of "active euthanasia." McGough, *supra*, at 521.

¹²⁴ Persels, *supra* note 32, at 101.

of immediate death rather than prolonged agony should be available to the dying."¹²⁵ On several occasions the Society submitted proposals to the New York legislature which advocated legalizing euthanasia.¹²⁶ However, each of the legislative proposals failed to be introduced.¹²⁷ Over the years, the size of the Euthanasia Society increased and new organizations were founded.¹²⁸ This growth in membership confirms the fact that an increased number of citizens support assisted suicide.

Further support for physician-assisted suicide is reflected in the results of a 1996 Gallup poll, which showed that seventy-five percent of Americans favor physician-assisted suicide.¹²⁹ Perhaps this high approval rating explains why so many states have come close to legalizing physician-assisted suicide.¹³⁰ Public support for

¹²⁵ Persels, *supra* note 32, at 101.

¹²⁶ Persels, *supra* note 32, at 102 (discussing how the Society attempted to introduce legislation in New York in 1939, 1947 and 1952).

¹²⁷ Persels, *supra* note 32, at 101-02.

¹²⁸ In 1967, the Euthanasia Society of America formed the Euthanasia Education Council. Persels, *supra* note 32, at 102. The Council's goal was to change public opinion about death, dying and euthanasia. Persels, *supra* note 32, at 102. In 1975, the Society changed its name to the Society for the Right to Die and it began focusing upon self-determination and patient autonomy. Persels, *supra* note 32, at 102. In 1980, the California Hemlock Society, which also advocates for the right to die, was founded. Persels, *supra* note 32, at 102.

¹²⁹ See Hooten, *supra* note 42, at B7. Since 1947 there has been a dramatic increase in public support for physician-assisted suicide. HUBER, *supra* note 28, at 78 (reporting that in 1947, 37% of those polled supported physician-assisted suicide compared to 70% in 1991).

¹³⁰ In 1991, Washington was on the brink of being the first state in the union to legalize physician-assisted suicide. Stansbury, *supra* note 27, at 628. The legislation, entitled Measure 119, would have allowed mentally competent adults with a proven terminal condition to commit physician-assisted suicide. Stansbury, *supra* note 27, at 628. However, voters rejected the legislation by a small majority, 54 to 46%. Stansbury, *supra* note 27, at 628. In 1992, California Proposition 161 proposed the legalization of physician-assisted suicide for the terminally-ill. Jody B. Gabel, *Release From Terminal Suffering? The Impact of Aids on Medically Assisted Suicide Legislation*, 22 FLA. ST. U. L. REV. 369, 413 (1994). Coincidentally, California's legislation was also defeated by a 54 to 46% margin. Catherine M. Larson, *A Commentary on Physician-Assisted Suicide*, 9 UTAH B.J. 8, 10 (1996). In 1993, Senator Pamela Cahill of Maine introduced "An Act Concerning the Terminally Ill," which proposed the legalization of

physician-assisted suicide manifested itself in 1994 when a majority of Oregon's voters approved the Oregon Death With Dignity Act.¹³¹ The Act allowed mentally competent, terminally-ill citizens to make written requests for lethal prescriptions from a licensed physician.¹³² Fifteen days before the Act was to take effect, the Oregon statute was successfully challenged by four terminally-ill individuals, their physicians, residential care facilities, and facility owners opposed to physician-assisted suicide.¹³³ As

physician-assisted suicide. Gabel, *supra*, at 415. However, it was rejected by both the Maine Senate Judiciary Committee and the Maine House of Representatives. Gabel, *supra*, at 415. The Colorado "Dignity in Death Act" was introduced in January 1996. Stansbury, *supra* note 27, at 630-31. If passed, it would have allowed terminally-ill patients to request a life-ending prescription from a physician. Stansbury, *supra* note 27, at 630-31. However, the Act was defeated in the Health, Environment, Welfare and Institutions Committee of the Colorado House. Stansbury, *supra* note 27, at 630-31.

¹³¹ OR. REV. STAT. §§ 127.800-127.897 (1994). The Act allows terminally-ill residents from the State of Oregon, to make a written request for lethal medication for the purpose of ending his or her life "in a humane and dignified manner." *Id.* § 127.805. The request must be signed and dated by the patient, and witnessed by two unrelated and uninterested individuals who attest to the voluntariness of the patient's signature. *Id.* § 127.810. Both an attending and consulting physician must meet with the patient and confirm that he or she is mentally competent, suffering from a terminal disease, and has made the request voluntarily. *Id.* §§ 127.815, 127.820. The attending physician must also inform the patient of alternatives to physician-assisted suicide. *Id.* § 127.815.

¹³² *Id.* § 127.805.

¹³³ *Lee v. Oregon*, 891 F. Supp. 1429 (D. Or. 1995), *vacated*, *Lee v. Oregon*, 107 F.3d 1382 (9th Cir. 1997). The Oregon District Court found that the Act was unconstitutional for violating the Equal Protection Clause of the 14th Amendment because it failed to provide the terminally-ill the same protection against suicide that the majority of citizens possess. *Id.* See Maureen M. Devlin, J.D., *Lee v. State of Oregon*, 11 ISSUES L. & MED. 433, 433-34 (1996). The statute contained inadequate safeguards which included the allowance of physicians to use a "good faith" standard of care, a much lower standard than "ordinary diligence." *Lee*, 891 F. Supp. at 1436-37. Such a low standard would allow a physician to "negligently misdiagnose a person's condition and competency and negligently prescribe a drug overdose, so long as those actions are in good faith." *Id.* at 1437. Also, Oregon's Act failed to provide mental and social evaluations by trained professionals that would identify mental disorders and would protect patients from coercion by third parties. *Id.* at 1436. Finally, the Act lacked appropriate supervision at the time of death. *Id.* at 1438. In sum,

a result, the Oregon District Court permanently enjoined the Act from taking effect.¹³⁴ However, the District Court's decision was ultimately vacated by the Ninth Circuit based upon its finding that the plaintiffs lacked standing for their claims.¹³⁵ The State of Oregon is preparing for a referendum in which the citizens will determine whether to uphold the Act.¹³⁶

At its origins, the legislative battle for physician-assisted suicide was fought for terminally-ill and seriously ill, non-terminal patients. However, as the foregoing illustrates, the interest in securing similar rights for seriously ill, non-terminal patients has vanished. Since 1906, all proposed legislation advocating a right to physician-

the court found that these inadequate safeguards did not further any legitimate state interests. *Id.* at 1437.

¹³⁴ Lee v. Oregon, 891 F. Supp. 1439 (D. Or. 1995) (declaring that the Oregon Death With Dignity Act violates the 14th Amendment of the Constitution and consequently a permanent injunction shall immediately take effect).

¹³⁵ Lee v. Oregon, 107 F.3d 1382 (9th Cir. 1997). The terminally-ill plaintiffs claimed that if they sought physician-assisted suicide under the terms of the Oregon Death With Dignity Act, the Act's inadequate safeguards would probably cause them to take their own lives against their will. *Id.* at 1388. The Ninth Circuit concluded that such reasoning would require it to assume that the plaintiffs would eventually become depressed to the point of being either unable to make an informed decision or unduly influenced by a third party. *Id.* It would also require the court to assume that the plaintiffs would request physician-assisted suicide and that the attending and consulting physicians would misdiagnose them as being competent to make the decision. *Id.* For the court to assume that this chain of events would occur is "conjectural and hypothetical" at best. *Id.* Consequently, the plaintiffs failed to assert an "injury in fact" and therefore lacked standing. *Id.* The other plaintiffs included a physician, residential care facilities, and owners and administrators of residential care facilities. *Id.* at 1391. The court concluded that these plaintiff's claims lacked standing and ripeness because the Act would not penalize them if they failed to abide by its provisions. *Id.* Since these plaintiffs did not allege a "concrete and particularized injury," their claims were dismissed. *Id.*

¹³⁶ *Assisted-Suicide Law in Oregon Again Faces Vote; Referendum on Repeal Bid Scheduled For Nov. 4*, BALTIMORE SUN, Sept. 30, 1997, at 3A. The Catholic Church as well as anti-abortion groups have pressured the Oregon legislature to hold a referendum on November 4, 1997 in which the state's citizenry will be forced to reconsider whether physician-assisted suicide should be legalized. *Id.* The ballot will be mailed to residents during mid-October. *Measure 51 Campaign*, PORTLAND OREGONIAN, Sept. 15, 1997, at A9.

assisted suicide has excluded seriously ill, non-terminal patients. The enactment of the Oregon Death With Dignity Act was a major accomplishment for proponents of physician-assisted suicide. It represents the future pathway for the legalization of such suicide. However, the Act's failure to include non-terminal patients within its purview suggests that this class of individuals has been ignored in the legislative forum. As the following will show, the similarities between terminally-ill patients and seriously ill, non-terminal patients may make it constitutionally impermissible to limit the right to physician-assisted to terminal patients.

III. CONSTITUTIONAL CONSEQUENCES OF STATE LEGISLATION LEGALIZING ASSISTED SUICIDE

As demonstrated by Oregon's Death With Dignity Act,¹³⁷ when states succeed in passing legislation that legalizes physician-assisted suicide, it is likely that the right will only exist for mentally competent, terminally-ill patients.¹³⁸ However, it is probable that such a limitation will be constitutionally challenged by seriously ill, non-terminal patients like Kelly Niles and Dax Cowert,¹³⁹ alleging that such a limited right violates the Equal Protection Clause.

Under the Equal Protection Clause, if two groups of individuals are similarly situated, they must receive equal treatment under the law.¹⁴⁰ Both seriously ill, non-terminal patients and terminally-ill

¹³⁷ OR. REV. STAT. § 127.805 (1994) (stating that only adult residents of Oregon who are suffering from a terminal disease may request lethal medication for the "purpose of ending his or her life"). The Act defines terminal disease as "an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six (6) months." *Id.* § 127.800.

¹³⁸ See *supra* Part II (discussing how recent legislative proposals legalizing physician-assisted suicide have limited the right to the terminally-ill).

¹³⁹ See *supra* notes 1-25 and accompanying text (discussing the plight of both Kelly Niles and Dax Cowert). See *Washington v. Glucksberg*, 117 S. Ct. 2258, 2274 (1997) (stating that if physician-assisted suicide is protected as a constitutional right, it will be impossible to deny citizens who are not terminally-ill from committing physician-assisted suicide).

¹⁴⁰ U.S. CONST. amend. XIV, § 1.

patients are similar in that both groups share an unimaginable amount of pain and indignity caused by their illnesses. More importantly, both groups share the desire to avoid their suffering by committing physician-assisted suicide. However, one distinguishing characteristic is that seriously ill, non-terminal patients are forced to live in excruciating mental and physical pain for longer periods of time.

The Ninth Circuit's decision in *Compassion in Dying* included descriptions of the debilitating pain that each of the three terminally-ill plaintiffs endured.¹⁴¹ Jane Roe, one of the three terminally-ill patients, was a sixty-nine-year-old pediatrician whose cancer had "metastasized throughout her skeleton."¹⁴² She was bedridden for several years and lived in constant pain that was heightened by any attempt to move.¹⁴³ In addition, Jane Roe suffered from "bed sores, poor appetite, nausea and vomiting, impaired vision, incontinence of bowel and general weakness."¹⁴⁴

John Doe, the second patient described by the court, was dying of AIDS.¹⁴⁵ He lost his sight,¹⁴⁶ had pneumonia twice, and suffered from chronic, severe skin and sinus infections, grand mal seizures and extreme fatigue.¹⁴⁷ The third patient, James Poe, suffered from the constant sensation of suffocating as a result of emphysema.¹⁴⁸ He also suffered from pulmonary disease, which prevented the flow of blood to his extremities causing severe leg

¹⁴¹ *Compassion in Dying v. Washington*, 79 F.3d 790, 794-95 (9th Cir. 1996).

¹⁴² *Id.* at 794.

¹⁴³ *Id.* Although she took medication for her pain, it did not successfully alleviate it. *Id.*

¹⁴⁴ *Id.*

¹⁴⁵ *Id.* AIDS is the acronym for Acquired Immune Deficiency Syndrome.

¹⁴⁶ *Id.* John Doe suffered from a condition normally associated with the AIDS virus called cytomegalovirus retinitis. *Id.* This condition would eventually blind Mr. Doe and thus, render him unable to continue painting as an artist. *Id.*

¹⁴⁷ *Id.*

¹⁴⁸ *Id.* John Poe was attached to an oxygen tank and took morphine in order to reduce the anxiety he felt from the perpetual feeling of asphyxia. *Id.*

pain.¹⁴⁹ The Ninth Circuit recognized that all three patients lived with terrible pain and suffering while they were alive.¹⁵⁰

However, non-terminal patients that are seriously ill are doomed to an intolerable existence for a prolonged period and consequently deserve the same recognition as terminally-ill patients.¹⁵¹ If the terminally-ill are deemed to possess a right to commit physician-assisted suicide in order to avoid a few weeks or months of a reprehensible existence, seriously ill, non-terminal patients certainly cannot be expected to survive in a similar condition for many years.¹⁵² Take for example Kelly Niles or Dax Cowert, or the "mangled survivor of a road accident,"¹⁵³ a quadriplegic, an Alzheimer's patient anticipating their mental deterioration, a cancer patient or someone suffering in the preliminary stages of AIDS. Unlike terminally-ill patients, none of these people can rely on dying as a result of their physical ailment within the next six months.¹⁵⁴ Nor can they rely upon a doctor to prescribe life-ending medication.¹⁵⁵ Seriously ill, non-terminal patients are left

¹⁴⁹ *Id.*

¹⁵⁰ *Id.* The three terminally-ill plaintiffs died before the court's final decision. *Id.*

¹⁵¹ "If personal autonomy and the termination of suffering are supposed to be the touchstones for physician-assisted suicide, why exclude those with non-terminal illnesses or disabilities who might have to endure greater pain and suffering for much longer periods of time" than terminally-ill patients who are "expected to die in the next few weeks or months?" Kamisar, *supra* note 58, at 740.

¹⁵² See Kamisar, *supra* note 58, at 740-41.

¹⁵³ Kamisar, *supra* note 58, at 740.

¹⁵⁴ See OR. REV. STAT. §§ 127.800, 127.805 (1994) (limiting eligibility for physician-assisted suicide to the terminally-ill, who are defined as individuals suffering from incurable diseases that will cause their death within the next six months).

¹⁵⁵ Furthermore, as demonstrated by the Oregon Death With Dignity Act, once states legalize physician-assisted suicide, they will provide safeguards to protect terminally-ill patients from hasty decision making or coercion. See OR. REV. STAT. § 127.815 and § 127.820 (1994) (requiring that both an attending physician as well as a consulting physician confirm that a patient is suffering from a terminal illness, that the patient is capable of making the decision to end his or her life, and has made the decision voluntarily). If either physician determines that the patient's reasoning is impaired by a psychiatric or psycholog-

to fend for themselves even though they live with the same pain and suffering as terminal patients.

IV. THE REPERCUSSIONS OF PREVENTING SERIOUSLY ILL, NON-TERMINAL PATIENTS FROM LEGALLY COMMITTING PHYSICIAN-ASSISTED SUICIDE

The legalization of physician-assisted suicide for the terminally-ill will lead to the implementation of adequate safeguards to ensure that patients are both competent and informed.¹⁵⁶ However, seriously ill, non-terminal patients will still be left to fend for themselves. Similar to "back-alley abortions," "back of the van assisted-suicides" will be a non-terminal patient's alternative.¹⁵⁷ Whether in the back of a van or elsewhere, non-terminal patients will nevertheless find doctors willing to help them hasten death.¹⁵⁸ For example, physicians like Dr. Kevorkian have been assisting non-terminal patients commit assisted suicide, although the practice is illegal in most states.¹⁵⁹ This is problematic since these

ical disorder, or depression, the physician must refer the patient for counseling. The physicians may not prescribe any medication until the counselor determines that the patient is not suffering from any form of psychological disorder that would interfere with the patient's judgment. *Id.* § 127.825. The Act only allows patients who have made an informed decision to receive a prescription for medication. *Id.* § 127.830. An informed patient is defined as an individual who has been instructed by his or her attending physician of his or her medical diagnosis, prognosis, potential risks and probable result associated with taking the medication, and alternatives to physician-assisted suicide. *Id.* § 127.800(7). The Act also contains a mandatory fifteen day waiting period which enables a patient to reflect upon his or her decision and prevents hasty decision making. *Id.* § 127.850. Finally, the Act requires the Health Division to annually review the records maintained in compliance with the Act. *Id.* § 127.865.

¹⁵⁶ See *supra* note 155 (discussing the various safeguards within the Oregon Death With Dignity Act).

¹⁵⁷ Dr. Kevorkian assisted some patients end their lives in the back of his 1968 Volkswagen camper van. Mintz, *supra* note 30, at A49.

¹⁵⁸ See HUMBER, *supra* note 28 and accompanying text (discussing surveys in which physicians in California admitted to assisting patients commit suicide).

¹⁵⁹ See *supra* notes 33-40 and accompanying text (describing methods Dr. Kevorkian employs when assisting patients commit suicide); *supra* note 27 (listing 37 states in which assisted suicide is illegal).

doctors are not obligated to screen their patients in order to ensure that patients are mentally competent and suffer from a severe physical illness. The lack of adequate safeguards has already led to irreversible mistakes.¹⁶⁰

For example, Rebecca Badger, Marjorie Wantz, and Judith Curren are three victims of Kevorkian's sloppy procedures.¹⁶¹ Ms. Badger complained of pain from multiple sclerosis.¹⁶² However, her neurologist had only given her a tentative diagnosis in 1988,¹⁶³ and the coroner found no sign of multiple sclerosis in her body.¹⁶⁴ Marjorie Wantz complained of severe pelvic pain for years.¹⁶⁵ Again, the coroner found no physical ailment which could have caused her "phantom pain."¹⁶⁶

Finally, Kevorkian was sharply criticized for assisting in the death of Mrs. Judith Curren.¹⁶⁷ Mrs. Curren was not terminally-ill, but suffered from chronic fatigue syndrome, generally a treatable condition.¹⁶⁸ Mrs. Curren was also suffering from

¹⁶⁰ See Timothy Quill & Betty Rollin, *Dr. Kevorkian's Quick-Fix Death Store*, DES MOINES REG., Sept. 3, 1996, at 9 (discussing the inadequacy of Dr. Kevorkian's screening process because he only requires a satisfactory response to the three following questions: (1) is there any trouble in the family; (2) are there any squabbles over money; (3) do you have a will). See Maier, *supra* note 32, at F2 (discussing how Dr. Kevorkian's screening process has been criticized for failing to thoroughly review the patient's medical, psychiatric and family history; according to Dr. Kevorkian's outspoken legal representative Geoffrey Fieger, Kevorkian requires that his patients have no possibility of a cure for their ailment, all family members must be notified of the patient's decision and the patient must not appear as if she is changing her mind).

¹⁶¹ *News Report Questions 3 Kevorkian Suicides, Autopsies Indicated No Signs of Physical Disease*, DALLAS MORNING NEWS, Sept. 14, 1996, at 5A.

¹⁶² *Id.*

¹⁶³ *Id.* Dr. Michael Stein stated that "she was diagnosed as possibly having multiple sclerosis." *Id.*

¹⁶⁴ Maier, *Kevorkian's Claims At Odds With Coroner*, *supra* note 32, at A1.

¹⁶⁵ *News Report Questions 3 Kevorkian Suicides, Autopsies Indicated No Signs of Physical Disease*, *supra* note 161, at 5A.

¹⁶⁶ *News Report Questions 3 Kevorkian Suicides, Autopsies Indicated No Signs of Physical Disease*, *supra* note 161, at 5A.

¹⁶⁷ Bob Sisson, *Ailing Woman Opposes Certain Assisted Suicides*, COLUMBIAN (Vancouver, Wash.), Sept. 4, 1996, at C1.

¹⁶⁸ *Id.* Chronic fatigue syndrome is "characterized by an acute or gradual

fibromyalgia, which is a form of rheumatism with flu-like symptoms.¹⁶⁹ Finally, Mrs. Curren was seriously overweight; at five foot one she weighed 260 pounds.¹⁷⁰ It is questionable whether Dr. Kevorkian should have assisted Mrs. Curren in committing suicide because she was not seriously ill. Ethicists have argued, that as a former doctor, Kevorkian had an ethical duty to ensure that his patient had no other alternative to death.¹⁷¹

However, Mrs. Curren's death became even more complicated. An autopsy revealed that she had multiple drugs in her system, indicating that she may have been addicted to pain killers.¹⁷² In addition, she was having serious marital problems.¹⁷³ Only twenty days before her suicide, her husband was arrested for assaulting her.¹⁷⁴ However, Kevorkian denies knowing anything about Mrs.

onset of mononucleosis-like symptoms." David Lipkin, *A Troubling Death*, CHIC. TRIB., Sept. 7, 1996, at N23. "It is not a derivative of depression," and its symptoms include "fevers, night sweats, sudden onset, exercise intolerance and lymph node swelling." *Id.* It is a disease that has occasional spontaneous remissions. *Id.*

¹⁶⁹ Sisson, *supra* note 167, at C1. Fibromyalgia causes achy feelings and shooting pains to the extremities. Sisson, *supra* note 167, at C1.

¹⁷⁰ *Kevorkian Suicide Role A Mistake*, DALLAS MORNING NEWS, Aug. 21, 1996, at 3A.

¹⁷¹ Carol Jouzaitis, *New Scrutiny For Kevorkian as Ethicists Question a Case Last Week, He Assists in Two More Suicides*, CHI. TRIB., Aug. 23, 1996, at N1. Ethics experts have asserted that Mrs. Curren's death underscored the need for legal or professional standards for doctors such as Kevorkian to follow when screening candidates for physician-assisted suicide. *Id.*

¹⁷² Perri Peltz, *Judith Curren, Dr. Jack Kevorkian's 25th Assisted Suicide*, NBC NEWS, (NBC television broadcast, Sept. 6, 1996).

¹⁷³ See *Kevorkian Suicide Client Reportedly Discussed Suing Spouse*, BOSTON GLOBE, Aug. 24, 1996, at 6A (noting that Judith Curren filed criminal charges against her husband, a psychiatrist, for physical abuse and considered bringing a civil suit against him for psychiatric malpractice). Over the course of seven years, the police had been called into the Curren home at least nine times to interrupt "loud fights." Jouzaitis, *supra* note 171, at N1.

¹⁷⁴ Jouzaitis, *supra* note 171, at N1.

Curren's turbulent home life.¹⁷⁵ He said he assisted her because she was incurably ill.¹⁷⁶

The case of Judith Curren illustrates the need for a screening process that ensures the mental competency of patients seeking physician-assisted suicide. In order to achieve that goal, one alternative is to draft thoughtful legislation that considers the plight of seriously ill, non-terminal patients. Since seriously ill, non-terminal patients are similar to terminal patients seeking physician-assisted suicide, both groups warrant equal protection under the law. In this case, equal protection includes legislation that imposes an obligation upon physicians to ensure that their patients are incurable, seriously ill, mentally competent, and not making a hasty or coerced decision. Without such legislation, women like Rebecca Badger, Marjorie Wantz and Judith Curren will continue to lose their lives at the hands of doctors like Jack Kevorkian.

V. LEGISLATION FOR SERIOUSLY ILL, NON-TERMINAL PATIENTS SEEKING PHYSICIAN-ASSISTED SUICIDE

Although the United States Supreme Court held that physician-assisted suicide is not a fundamental right, state legislatures like Oregon will continue to propose legislation legalizing physician-assisted suicide for the terminally-ill. Therefore, state legislatures must enact statutes similar to the Oregon Death With Dignity Act, but with two distinguishable differences. First, the legislation cannot limit the right to physician-assisted suicide to terminal patients. Instead it must extend the right to include non-terminal patients. Second, such legislation should contain adequate safeguards for terminal and non-terminal patients in order to withstand constitutional scrutiny.¹⁷⁷

¹⁷⁵ Jouzaitis, *supra* note 171, at N1. Dr. Kevorkian claimed that he learned of Mrs. Curren's troublesome home life only after her death. Jouzaitis, *supra* note 171, at N1.

¹⁷⁶ Jouzaitis, *supra* note 171, at N1.

¹⁷⁷ For example, in *Lee v. Oregon*, 891 F. Supp. 1429, 1437 (D. Or. 1995), *vacated*, *Lee v. Oregon*, 107 F.3d 1382 (9th Cir. 1997) the District Court held that the Oregon Death With Dignity Act violated the Equal Protection Clause. The court reasoned that the violation was a result of inadequate safeguards that

Under the proposed Act, a patient must make a written request for a lethal dose of medication from a physician. After such patient has made her request, a state appointed panel consisting of one general practitioner and two doctors specializing in the patient's condition will meet with and examine the patient. These doctors must describe every step of the procedure to the patient so that she is capable of making a fully informed decision. These doctors will also be required to discuss her case among one another and confirm the existence of the candidate's physical illness and presence of pain. The doctors must consider the patient's inability to perform daily activities as a consequence of her pain, paralysis or other similar condition. They must also concur upon the degree and severity of the patient's pain and indignity. Furthermore, they will consider whether any reasonable alternatives to death are advisable. Finally, they will determine whether the patient's condition is serious enough for assisted suicide to be an option.

Simultaneously, one psychiatrist will meet with the patient on a daily basis for a period of at least seven days to determine whether the patient is mentally competent to make the decision to die. A competent individual is someone that is able to independently decide to end one's life with the assistance of a physician without undue influence resulting from depression, coercion from third parties or pressure resulting from financial difficulties covering medical costs. The psychiatrist will also be required to advise the patient of alternatives to death.

Upon the filing of the patient's request for physician-assisted suicide, the panel will have access to any past or present criminal or civil proceedings filed by or against the patient in order to ensure that the patient's desire to commit physician-assisted suicide is not influenced by either domestic violence, physical coercion or financial insolvency.

If the panel of doctors and the psychiatrist unanimously decide that such patient is a likely candidate for assisted suicide, they will

failed to provide terminally-ill individuals the same protection from suicide that the majority of citizens possess. Although the District Court's decision was vacated based upon the plaintiff's lack of standing, the lower court's decision highlights the problems with the Act. *Lee v. Oregon*, 107 F.3d 1382 (9th Cir. 1997).

notify the patient and discuss the procedure, and its consequences in depth with her. If the patient is still adamant about committing suicide, the general practitioner will prescribe a lethal dose of medication. While the patient ingests the medication, the general practitioner and the psychiatrist must be present with two other neutral parties to ensure the patient takes the medication voluntarily and properly.

CONCLUSION

The purpose of physician-assisted suicide is to allow seriously ill individuals to avoid the prolonged pain and indignity that is associated with their illnesses. Pain and indignity are not characteristics exclusive to diseases in their terminal stages. It appears as if physician-assisted suicide will be legalized through state legislation. However, only terminally-ill patients will be allowed to practice it. The consequence of this is two-fold. First, it will foster an atmosphere in which individuals will have to take matters into their own hands. Consequently, individuals will be assisted in hastening death without proper safeguards. Secondly, such legislation will be violative of the Equal Protection Clause because terminally-ill patients are the same in fact as seriously ill, non-terminal patients, and consequently merit equal protection in the eyes of the law. In order to avoid such results, legislation must be enacted that affords seriously ill, non-terminal patients the right to commit physician-assisted suicide.