I. INTRODUCTION

The accompanying monologue, *A Small Decision*, briefly recounts the passing of the author’s mother-in-law who decided to end her life through starvation. Perhaps surprisingly, there is currently no law in the United States that prevents a person from making the decision to stop eating, even if this decision results in the death of the individual. However, this issue has increasingly become a subject of concern in response to the controversy over assisted suicide. If a person seeking to end her life, for one reason or another, resides in a state where assisted suicide is completely banned, she may decide to employ legal options such as refusing food or drink to hasten death. Refraining from eating or drinking, as well as other life-ending decisions, are common practices in the United States.

Thus, a difficult legal and moral issue has arisen as to whether society is prepared to decriminalize assisted suicide. There are legitimate societal interests in discouraging the assistance of suicide. However, denying a person the option to receive safe and proper aid in dying serves, in effect, to encourage starvation or other distasteful ways to die. This note explores some of the legal history surrounding assisted suicide and comments on the future of assisted suicide laws in the United States. Section II introduces and explains the various classifications of life-ending decisions. Section III reviews the historical background of assisted suicide laws in the United States. Section IV discusses the current state of such laws. Finally, section V deals with the possible future of assisted suicide laws in the United States.

II. CLASSIFICATIONS OF LIFE-ENDING DECISIONS

There are several classifications of life-ending decisions that courts and activists use to distinguish between what is legal and what is not. These include assisted suicide, voluntary or involuntary active euthanasia, voluntary or involuntary passive euthanasia, and non-voluntary euthanasia. These classifications can usually be distinguished by whether there was an act or
omission by the parties involved, whether the act or omission was consented to by
the patient, and the intentions of the parties involved.

Assisted suicide occurs when an individual who has decided to end her life is
provided assistance in doing so by either a physician or other willing individual.\(^2\)
In assisted suicide, “the patient herself performs the last death-causing act.”\(^3\) For
example, the physician might connect the patient to a machine that dispenses a
lethal injection. The patient is the one who then pushes the button that releases the
fatal fluid into her body. Voluntary active euthanasia ("VAE") is very similar to
assisted suicide, and is often opined to be the same thing.\(^4\) However, with VAE, a
person other than the patient is the one who “commits the death-causing act.”\(^5\)
Using the example above, the physician would push the button that releases the
fatal fluid into the patient’s body. Assisted suicide and VAE are described as
indistinguishable because both forms involve consent on the part of the patient and
an action by an involved party that causes the resulting death.\(^6\) Also, in both
classifications the party performing the act intends that the act will result in the
patient’s death.

Voluntary passive euthanasia ("VPE") occurs when a patient refuses the
administration of life-sustaining medical treatment with the intent to die.\(^7\) Usually
the physician will withhold or withdraw any further medical treatment, including
feeding tubes, oxygen masks, or other life support, pursuant to the patient’s request
or consent. VPE contains the word “passive” because the patient is requesting an
omission to act (not providing medical care) rather than a specific action by means
of injection or poison.\(^8\) Also with VPE, both parties either intend or have
knowledge that the omission to act will result in the patient’s death.\(^9\) Another type
of VPE involves a patient who is not relying on any life-sustaining medical
treatment, but has made the decision to end her life by refusing to eat or drink.
Because VPE can be painful for the patient as the body begins to dehydrate and
weaken, the administration of pain medication will often be used in conjunction
with VPE.

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\(^2\) Yale Kamisar, *On the Meaning and Impact of the Physician-Assisted Suicide Cases*,
82 Minn. L. Rev. 895, 899 (1998).
\(^3\) Id.
\(^4\) See id.
\(^5\) Id.
\(^6\) Yale Kamisar, *Can Glucksberg Survive Lawrence? Another Look at the End of Life
\(^8\) See id.
\(^9\) Id.
Involuntary active euthanasia ("IAE") is very much like VAE in that it involves an act by another person that is the cause of the patient’s death. However, IAE is done against the patient’s will or without the patient’s (or legal guardian’s) consent. For example, a physician may intentionally administer a lethal amount of pain medication to help lessen the pain a patient is experiencing, and to effectuate that patient’s death. This was a common occurrence in Nazi Germany, as well as an idea proposed in an article written by the president of the Euthanasia Society, to advocate mercifully and kindly relieving children diagnosed as “defective” from the “agony of living.” This is also a current legal practice in the Netherlands.

Involuntary passive euthanasia ("IPE") occurs when another person withholds or withdraws life-sustaining medical treatment from a patient against that patient’s (or their legal representative’s) will. In contrast, non-voluntary euthanasia ("NVE") occurs when another person withholds or withdraws life-sustaining medical treatment from a patient, but does so pursuant to the consent of the patient’s representative. In this case, the patient typically does not consent because she is either incompetent (for example, mentally disabled or a minor child), or is in a persistent vegetative state which prevents her from giving informed consent. Typically, the patient will have executed an advanced directive or medical power of attorney that legally authorizes the withdrawal of medical treatment.

III. LEGAL HISTORY

A. Early American Colonies

The Common Law of England, which strongly condemned both attempted and completed suicide, was adopted by the early American colonies. Suicide was defined as an individual “deliberately put[ting] an end to his own existence, or commit[ting] any unlawful malicious act, the consequence of which is his own death.” Under the English common law, suicide was originally an ecclesiastical crime, but evolved into a crime against the State. The penalties for suicide victims included the denial of the right to a “Christian” blessing or burial and mandated burial in a highway—with a stake driven through the body—to dishonor
the victim.18 Surviving relatives surrendered the property of the suicide victims to their feudal superiors.19 The Crown eventually confiscated suicide property,20 which it justified by classifying suicides as felonies.21 Common law also classified assisted suicide as a felony.22 By equating suicide with murder, any person who advised or directed an individual to commit suicide and who witnessed the crime could be liable for murder.23

Early American colonies followed this paradigm, punishing suicide and assisted suicide as felonies, and imposing the penalties of dishonorable “burial and forfeiture of goods.”24 This practice continued long after the Revolutionary War and the adoption of the Constitution.25 Similarly, “[early American] historical treatment of voluntary active euthanasia has been unremittingly condemnatory.”26 Any individual who killed another committed murder, even if she did so at the request of the victim or as a mercy killing to relieve pain or misery.27

Over time, many states recognized that it was impractical to punish a suicide victim since the individual was already dead. Also, if the theory of punishment was to deter further crime, as opposed to enriching state coffers, then such punishment would be useless.28 Furthermore, punishing a suicide victim’s heirs for such crime unfairly punishes the innocent for the perpetrator’s wrongdoing.29 These insights led to the rise of decriminalization of suicide in the United States during the mid-1800s.30 However, many states continued to criminalize the assistance of suicide.31 In the mid-to-late 1800s, several states codified assisted suicide laws that prohibited acts such as “furnish[ing] another person with any deadly weapon or poisonous drug, knowing that such person intends to use such weapon or drug in taking his own life.”32 Drafters of these codes noted that “the interests in the sanctity of life that are represented by the criminal homicide laws are threatened by one who expresses a willingness to participate in taking the life of another, even though the act may be accomplished with the consent, or at the request, of the suicide victim.”33

18 Id.
19 Id.
20 Id.
21 Id.
22 Id. at 374.
23 Id.
24 Id.
25 Id.
26 Id. at 376.
27 Id.
28 Id. at 375.
29 Id.
30 Id.
31 Id. at 377.
33 Id. at 716.
B. Twentieth Century United States

Despite such deep-rooted beliefs about assisted suicide, these laws have recently been re-examined—primarily due to advances in medicine and “Kevorkian” technology. Upon judicial review, assisted suicide statutes typically have been upheld. Likewise, prohibitions on euthanasia have consistently been validated.

Although assisted suicide bans eventually became virtually “absolute” in the United States, one exception remained. In 1902, a criminal appeals court in Texas attempted to legalize assisted suicide, reasoning that if suicide was no longer a crime, then assisting suicide should not be a crime either. This ruling was short-lived, however, and immediately overruled by the legislature.

Several decades later, in 1976, the New Jersey Supreme Court faced the first “right-to-refuse” medical treatment case, In re Quinlan. In that case, the court held that a twenty-one-year-old girl in a persistent vegetative state was incompetent and thus, unable to make a decision on whether to disconnect her life-sustaining respirator. The court further held that the father of the girl, as her guardian, should be allowed the opportunity to demonstrate that the girl would have made the decision to die in these circumstances. However, the father failed to establish the girl’s intent, despite evidence of statements the girl made to her friends regarding her wishes. Almost nine years later, in 1985, the New Jersey Court overruled its holding when it decided In re Conroy. In that case, the court held that any evidence of “information bearing on the person’s intent, may be appropriate aids in determining what course of treatment the patient would have wished to pursue.”

Since the decisions in these cases came down, nearly every state in the United States “has recognized the right of at least competent adults to refuse even basic, life-sustaining medical care, such as tubes supplying food and water.” In 1990,
the Supreme Court again affirmed that the protection of liberty includes the right to reject life-sustaining medical treatment. However, the Court also held that states could require clear and convincing evidence of the incompetent person’s “prior expressed wishes” before discontinuing life-support.

Proponents of assisted suicide argue that the states are already condoning a form of suicide by recognizing the right to refuse care. Thus, if patients have a right to refuse life-sustaining medical care, then they should also have the right to assisted suicide or euthanasia. However, the United States Supreme Court has expressly denied this proposition. In 1997, several physicians argued before the Court that New York’s assisted suicide ban violated the Equal Protection Clause of the Fourteenth Amendment. The Court disagreed with the physicians and held that there is a recognized “distinction between letting a patient die [right to refuse] and making that patient die [assisted suicide or euthanasia].” That same day, the Court heard Washington v. Glucksberg. In Glucksberg, the plaintiffs argued that a Washington state statute banning assisted suicide violated the due process clause. The Court held the right to assisted suicide was not grounded in our Nation’s history and traditions, and that the assisted suicide ban was rationally related to legitimate governmental interests.

Though possibly viewed as a blow to proponents of assisted suicide, the above cases may also be interpreted as a victory. The immediate consequence of the Supreme Court’s decisions was to return the assisted suicide and euthanasia issue to the states and the political process. A less obvious, but perhaps even more important consequence is the fact that five votes on the Court appeared to be leaning in favor of recognizing a constitutional right to assisted suicide “for competent, terminally ill persons suffering severe pain.” This significant step in support of constitutionalizing assisted suicide lends credence to the view that helping others to effectuate death might not be as terrible as originally believed. Accordingly, society ought to allow any individual to seek assistance in death

48 Id. at 284.
49 Gorsuch, supra note 36, at 654.
50 Id. at 642. One notorious advocate of this viewpoint was Dr. Jack Kevorkian who on June 4, 1990, assisted an Alzheimer’s patient, Janet Adkins, in taking her life. In 1999, after Kevorkian performed euthanasia on a nationwide televised 60 Minutes program intended to provoke a debate over legalizing his practice, he was found guilty of second-degree murder. See id. at 600–01.
52 Id. at 807.
54 Id. at 728.
55 Id. at 734.
56 Gorsuch, supra note 36, at 619.
under safe and controlled circumstances by someone who possesses such expertise, instead of through more dangerous and undesirable means.

IV. CURRENT STATE OF THE LAW

“Since 1992, bills have been introduced to legalize assisted suicide or euthanasia in various state legislatures, including Alaska, Arizona, Colorado, Connecticut, Hawaii, Iowa, Maine, Maryland, Massachusetts, Michigan, Nebraska, New Hampshire, New Mexico, [Oregon], Rhode Island, Vermont, and Washington.”57 Two states, Oregon and Washington, have successfully passed assisted suicide bills into law. In addition, in the state of Montana a District Court judge recently ruled that mentally competent, terminally ill patients should have the “right to die with dignity.”58

In November of 1994, Oregon became the first state to legalize physician-assisted suicide under the Oregon Death With Dignity Act (ODWDA).59 The ODWDA went into effect three years later.60 The ODWDA allows physicians to provide lethal doses of medication to patients who are terminally ill, subject to specific conditions designed as safeguards for the requesting patient.61 These conditions include: ensuring that a physician diagnose the patient with a terminal illness that will cause the patient’s death within six months; that the patient have voluntarily, and with informed consent, requested a lethal dosage of medication; that the diagnosing physician refer the patient to counseling if it is suspected that the patient is suffering from a psychological disorder or depression that might impair her decision making; and that the patient have obtained a second opinion with another physician that confirms the findings of the first physician. Also, although Oregon physicians can prescribe the requested prescription, they may not administer the drug—it must be self-administered.62 The ODWDA also requires that the request for the drug be made orally and in writing. There is also a required waiting period, and there are “documentation and reporting requirements.”63

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57 Id. at 603.
60 See OR. REV. STAT. § 127.800 (West 2009); see also Susan R. Martyn, Henry J. Bourguignon, Now is the Moment to Reflect: Two Years of Experience With Oregon’s Physician-Assisted Suicide Law, 8 ELDER L.J. 1, 1 (2000).
62 Id.
63 Emily P. Hughes, The Oregon Death With Dignity Act: Relief of Suffering at the End of Medicine’s Ability to Heal, 95 GEO. L.J. 207, 234 (2006).
Despite attempts in 1997 to repeal the ODWDA, the Act survived another ballot measure and continues to exempt state-licensed physicians from incurring liability for providing lethal doses of medication to terminally ill patients.\textsuperscript{64}

Fourteen years later, in November 2008, Washington voters passed into law the “Washington Death With Dignity Act” (WDWDA), which became effective on Mar. 5, 2009.\textsuperscript{65} Virtually identical to the ODWDA, the WDWDA legalizes assisted suicide by permitting physicians to prescribe lethal doses of medication for terminally ill patients pursuant to their request.\textsuperscript{66} Also like the ODWDA, the WDWDA places conditions upon the assisted suicide process to act as safeguards to protect the requesting patient from any potential abuse.\textsuperscript{67}

Approximately one month later, on December 6, 2008, a Montana district court judge, Dorothy McCarter, ruled that the Montana state constitutional right to individual privacy and human dignity entails the right of mentally competent, terminally ill patients to obtain physician-assistance to end their lives.\textsuperscript{68} This ruling was scheduled to take effect immediately. However, Montana’s Attorney General “filed a motion to stay the decision, pending an appeal to the Montana Supreme Court which the Judge denied.”\textsuperscript{69} On January 27, 2009, the state initiated an appeal to the Montana Supreme Court, which is scheduled to be heard in the spring.\textsuperscript{70}

Thus far, the recent changes to the law in three states have remained free of abuse of the process.\textsuperscript{71} Again, the existence of these laws, as well as the lack of abuse that has occurred, substantiates the idea that assistance in death need not be such an immoral and disagreeable process.

\section*{V. Future of Assisted Suicide Laws}

Based on these recent cases and legislation, there appears to be a trend in support of the legalization of assisted suicide. Still, many states continue to resist. Nonetheless, the majority of states have adopted living will and health care power of attorney laws that tend to lend support to assisted suicide, despite express statements included in the bills that indicate the law is not meant to endorse the practice.\textsuperscript{72} Resistance to legalizing assisted suicide seems to stem from the fear that

\begin{itemize}
\item \textsuperscript{64} Gonzales, 546 U.S. at 249.
\item \textsuperscript{65} WASH. REV. CODE ANN. § 70.245 (West 2009).
\item \textsuperscript{66} Id.
\item \textsuperscript{67} See id. at § 70.245.020–245.150.
\item \textsuperscript{68} Montana Judge Endorses Right to Assisted Suicide, supra note 55.
\item \textsuperscript{70} Steven Ertelt, Montana Won’t See Bills Limiting Assisted Suicide, State Must Pay Attorney Fees, LIFENEWS.COM, Feb. 23, 2009, http://www.lifenews.com/bio2763.html.
\item \textsuperscript{71} Erwin Chemerinsky, Washington v. Glucksberg was Tragically Wrong, 106 MICH. L. REV. 1501, 1513 (2008).
\item \textsuperscript{72} Gorsuch, supra note 36, at 640.
\end{itemize}
abuse will occur—similar to the abuses that occurred in the Netherlands after assisted suicide and euthanasia became legal in that country.

“There are dangers both in legalizing and refusing to legalize” assisted suicide.73 If the United States were to legalize assisted suicide, legislatures would be required to make determinations as to the limits of who can and who cannot obtain assistance in suicide.74 Also, the role of physicians would expand from healing ailments into ending lives as well.75 The taking of one’s life would become a “public process” of which all members of society would participate.76 On the other hand, if states continue to refuse to legalize assisted suicide, individuals may look to other legal, life-ending options that are available to them. A patient may choose to discontinue life-prolonging nutrition by consciously refusing to eat or drink in order to die. Furthermore, physicians or other persons supportive of assisted suicide may seek more creative ways to assist individuals in hastening their death. Also, family members might take their loved-ones home from the hospital in order to hasten the dying process, instead of leaving them connected to life-preserving apparatuses in a hospital room. Physicians might intentionally, but stealthily, prescribe an overdose of pain medication with the justification that they were seeking to lessen the patient’s pain. Society may also see an increase in the creation of fraudulent living wills or powers of attorney in order to enable family members to hasten death.

Our society must weigh these potential dangers when deciding whether assisted suicide should be legalized. Two states have elected to permit the assistance of suicide, in limited and under highly regulated circumstances to counteract the potential danger of abuse found in the Netherlands. As society becomes reassured that the dangers of abuse can be successfully regulated and prevented, as has occurred thus far under Oregon law, more and more states are likely to legislate for the legalization of assisted suicide.

VI. CONCLUSION

Throughout United States history, society has viewed assisted suicide unfavorably. Recently, however, Americans seem to be more accepting of the controversial procedure. Although assisted suicide is legal in only three states, it appears that as society grows increasingly comfortable with regulation of the issue, it may be more inclined to allow the practice.

73 Id. at 678.
74 Id. at 690.
75 Id.
76 Id.