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# WISCONSIN LAW REVIEW

THE LEGALIZATION OF ASSISTED SUICIDE AND THE LAW OF  
UNINTENDED CONSEQUENCES: A REVIEW OF THE DUTCH AND OREGON  
EXPERIMENTS AND LEADING UTILITARIAN ARGUMENTS FOR LEGAL  
CHANGE

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## ARTICLES

### THE LEGALIZATION OF ASSISTED SUICIDE AND THE LAW OF UNINTENDED CONSEQUENCES: A REVIEW OF THE DUTCH AND OREGON EXPERIMENTS AND LEADING UTILITARIAN ARGUMENTS FOR LEGAL CHANGE

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## INTRODUCTION

During the 1990s, Dr. Jack Kevorkian reportedly killed or helped kill over 130 persons.<sup>1</sup> While he is now serving a prison sentence for second-degree murder,<sup>2</sup> Kevorkian's activities attracted massive media attention and spawned both legislative<sup>3</sup> and litigation<sup>4</sup> initiatives aimed at toppling laws banning the practice of assisted suicide. So far, the fruits of the political-legal ferment inspired by Kevorkian have been relatively modest. Litigation challenging the constitutionality of laws banning assisted suicide, while meeting some initial success in the lower courts, reached the U.S. Supreme Court in 1997 and culminated in a decision that (at least for now) leaves those laws intact.<sup>5</sup> And, the vast majority of states (approximately thirty-eight) have retained or recently enacted statutes expressly banning the practice of assisted suicide.<sup>6</sup> At least sixteen of these states have considered—and rejected—recent initiatives seeking to legalize assisted suicide.<sup>7</sup> With regard to those states without statutes formally prohibiting assisted suicide, most have disapproved of assisted suicide in some other way. One, Michigan, has a statute banning assisted suicide that may or may not have lapsed,<sup>8</sup> but, in any event, treats assisted suicide as a common law crime.<sup>9</sup> Another, Montana, treats assisting a failed suicide as an independent statutory crime,<sup>10</sup> but appears to classify assisting a successful suicide as a species of homicide and thus, subject to the general homicide statute.<sup>11</sup> Of the

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1. Brian Murphy, *Kevorkian, Silent, Starts Prison Term*, DETROIT FREE PRESS, Apr. 14, 1999, available at <http://www.freep.com/news/extra2/qkevo14.htm>.

2. See *id.*

3. Since 1992, bills seeking to legalize assisted suicide have been introduced in at least sixteen state legislatures. Neil M. Gorsuch, *The Right to Assisted Suicide and Euthanasia*, 23 HARV. J.L. & PUB. POL'Y 599, 603-04 (2000).

4. See, e.g., *id.* at 600 n.1, 604-05.

5. See *Washington v. Glucksberg*, 521 U.S. 702 (1997) (rejecting a due process-based right to assisted suicide); *Vacco v. Quill*, 521 U.S. 793 (1997) (rejecting an equal protection-based right to assisted suicide).

6. See *infra* app. A.

7. See Gorsuch, *supra* note 3, at 603-04.

8. See MICH. COMP. LAWS ANN. § 752.1027 (West 2004).

9. See *People v. Kevorkian*, 527 N.W.2d 714, 716 (Mich. 1994).

10. See MONT. CODE ANN. § 45-5-105 (West 2003) (defining the crime of assisted suicide as occurring only when "[a] person who purposely aids or solicits another to commit suicide, but such suicide does not occur"); see also ANNOTATIONS TO THE MONTANA CODE ANNOTATED § 45-5-105 note (2004) ("This section makes it a felony to aid or solicit a suicide attempt which does not result in the death of the victim.").

11. As explained by an annotator's note, those who assist a *successful* suicide may be found guilty of other offenses: "[u]nder the new sections on Causal Relationship Between Conduct and Result, MCA, 45-2-201, and Accountability, MCA, 45-2-302, a person may be convicted of Criminal Homicide, MCA, 45-5-101 (repealed—now deliberate or mitigated homicide, 45-5-102 and 45-5-103, respectively), for causing

remaining states, some appear to treat assisted suicide as a common law crime<sup>12</sup> and several have health care directive statutes expressly disavowing any approval of assisted suicide.<sup>13</sup> At the federal level, a Republican Congress and Democratic President adopted a law in 1997 denying the use of federal funds in connection with any act of assisted suicide.<sup>14</sup>

In a (very) notable exception to the general trend, Oregon voters approved a referendum in 1994, by a vote of 51% to 49%,<sup>15</sup> permitting assisted suicide in their state,<sup>16</sup> although the administration of George W. Bush issued an interpretative regulation in late 2001 contending that the use of controlled pharmacological substances to assist a suicide contravenes the federal Controlled Substances Act.<sup>17</sup> The Bush administration's move has precipitated a legal battle over the scope of the federal government's authority to interfere with Oregon's experiment. Oregon has won so far, convincing both a federal district court judge<sup>18</sup> and a panel of the U.S. Court of Appeals for the Ninth

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another to commit suicide—notwithstanding the consent of the victim.” ANNOTATIONS TO THE MONTANA CODE ANNOTATED, *supra* note 10, § 45-5-105 note.

12. See, e.g., *McMahan v. State*, 53 So. 89, 90-91 (Ala. 1910) (stating that suicide is a common law crime and anyone who is present when someone commits suicide, or advises or counsels someone to commit suicide, is guilty of murder); *Commonwealth v. Mink*, 123 Mass. 422, 428-29 (1877) (discussing involuntary manslaughter), *modified by*, *Commonwealth v. Catalina*, 556 N.E.2d 973, 975-80 (1990) (same); *Kevorkian*, 527 N.W.2d at 716; *State v. Mays*, 307 S.E.2d 655, 656 (W. Va. 1983) (discussing the facts of a case in which a man was convicted of murder for helping another man commit suicide).

13. See, e.g., ALA. CODE ANN. § 22-8A-10 (Michie 1997); MASS. ANN. LAWS ch. 201D, § 12 (Law. Co-op. 1994); NEV. REV. STAT. ANN. § 449.670(2) (Michie 2000); OHIO REV. CODE ANN. § 2133.12(D) (Anderson 2002); UTAH CODE ANN. § 75-2-1118 (1993); W. VA. CODE ANN. § 16-30-2(a) (Michie 2001).

14. See Assisted Suicide Funding Restriction Act of 1997, Pub. L. No. 105-12, 111 Stat. 23 (codified at 42 U.S.C. §§ 14401-14408 (2000)).

15. See CTR. FOR DISEASE PREVENTION & EPIDEMIOLOGY, OR. HEALTH DIV., OREGON'S DEATH WITH DIGNITY ACT: THE FIRST YEAR'S EXPERIENCE 1 (1999), available at <http://www.ohd.hr.state.or.us/pas/year1/pas-rpt.pdf> [hereinafter FIRST YEAR'S EXPERIENCE].

16. See The Oregon Death with Dignity Act, OR. REV. STAT. § 127.800-.995 (2003).

17. See Memorandum from Sheldon Bradshaw, Assistant Attorney General, U.S. Department of Justice, and Robert J. Delahunty, Special Counsel, U.S. Department of Justice, to the Attorney General, U.S. Department of Justice, *Whether Physician-Assisted Suicide Serves a "Legitimate Medical Purpose" Under the Drug Enforcement Administration's Regulations Implementing the Controlled Substances Act* (June 27, 2003), in 17 ISSUES L. & MED. 269 (2002) (concluding that assisted suicide is not a "legitimate medical purpose" and that dispensing federally controlled substances to assist a suicide therefore violates the federal Controlled Substances Act); see also Controlled Substances Act, 21 U.S.C. §§ 801-971; 21 C.F.R. pt. 1306 (2004).

18. See *Oregon v. Ashcroft*, 192 F. Supp. 2d 1077, 1092-93 (D. Or. 2002).

Circuit to reject the Bush administration's regulations,<sup>19</sup> although the administration is, as this Article goes to press, seeking certiorari in the U.S. Supreme Court.<sup>20</sup>

While Kevorkian's campaign to inspire political and legal change has not (at least for now) yielded many concrete results, the debate he helped spark certainly has not died, as Oregon's experiment amply attests. And, among the central questions in the ongoing debate over assisted suicide is one that might be labeled practical, or perhaps consequentialist or utilitarian in nature: would the "benefits" flowing from any decision to legalize assisted suicide outweigh the attendant "costs" associated with such a change in our legal rules? Justices Sandra Day O'Connor and David Souter have alluded to this question, explaining in *Washington v. Glucksberg* their desire to see the practical results of state legislative "experiments" such as Oregon's, and whether the legalization of assisted suicide might carry with it more societal benefits than harms.<sup>21</sup>

Plainly, the legalization of assisted suicide *would* carry with it benefits for certain persons. Persons who wish to die, but who either cannot, or do not, wish to kill themselves without assistance, would be at liberty to do so, thereby fulfilling their own autonomously chosen wishes and plans. What may not be so obvious is whether there are also any *costs* associated with normalizing assisted suicide, particularly if we do so only for competent adults who are, say, suffering from untreatable pain or a terminal illness. And, if there are such costs, it also remains to be asked how these costs compare in balance against the benefits legalization offers. This Article explores such questions.

To begin, Parts I through III examine recent empirical evidence from the Netherlands, Oregon, and elsewhere. I conclude that anyone seeking to deploy utilitarian or consequentialist arguments in the assisted suicide debate cannot, on the basis of currently available evidence, easily rule out the possibility that nontrivial costs *would* attend the legalization of assisted suicide and euthanasia—and would do so *even if*

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19. See *Oregon v. Ashcroft*, 368 F.3d 1118, 1131 (9th Cir. 2004).

20. See Associated Press, *White House Wants Assisted Suicide Law Blocked: Bush Administration Asks Supreme Court to Block Assisted Suicide Law in Oregon*, Nov. 10, 2004, at <http://abcnews.go.com/Politics/wireStory?id=241365>.

21. See 521 U.S. at 737 (O'Connor, J., concurring) ("States are presently undertaking extensive and serious evaluation of physician-assisted suicide and other related issues. In such circumstances, 'the . . . challenging task of crafting appropriate procedures for safeguarding . . . liberty interests is entrusted to the laboratory of the States . . . in the first instance.'") (omissions in original) (citation omitted); *id.* at 785–89 (Souter, J., concurring) ("[E]vents could overtake [the Court's] assumptions, as experimentation in some jurisdictions confirmed or discredited the concerns about progression from assisted suicide to euthanasia.").

legal permission for the practices is limited to those suffering pain or enduring a terminal illness.

Next, Parts IV and V review certain leading contrary arguments from John Griffiths, Helga Kuhse, and Seventh Circuit Court of Appeals Judge Richard Posner. Each contends, on the basis of certain empirical data, that the legalization of assisted suicide would be a relatively "costless" enterprise—that is, legalization would carry with it few and insignificant unwanted side effects. After a detailed review of their arguments, however, I submit that each contains serious flaws.

Finally, having suggested that the repeal of laws banning assisted suicide has not been shown, convincingly, to be a costless enterprise, I pose in Part VI what is, I think, the critical question at the end of the day: how are we to weigh the competing benefits and costs associated with legalization in a purely consequentialist calculus? How are we to judge whether the benefits associated with normalization are "enough" to outweigh the costs? I see no convincing answer and ultimately suggest that any effort aimed at comparing the benefits and costs of assisted suicide rests on a conceptually flawed premise—namely that there exists a single scale or currency which we can use to measure fundamentally incommensurate goods. The assisted suicide debate, I submit, ultimately cannot be resolved by any utilitarian-style calculation of competing costs and benefits.

Before proceeding further, two cautionary notes about verbiage. First, there is no crime called "assisted suicide" and no legal penalty for a person who seeks help in dying; instead, the crime at issue is *assisting* suicide and it is targeted solely to those who help another commit suicide.<sup>22</sup> The legal right sought by proponents is, to be precise, a right to receive assistance in killing oneself without the *assistant* suffering adverse legal consequences. Recognizing its imprecision, I will defer nonetheless to pervasive usage and employ the term "assisted suicide" as a shorthand description for the proffered right to receive assistance in suicide.

Second, it is important to note that Kevorkian and many other advocates of legal change seek to establish not only a right to receive assistance in suicide, but also a right to be killed by another person, so long as the act is performed with the consent of the decedent and the killer is motivated by compassion or mercy—an act not properly

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22. See e.g., Suicide; Aiding, Advising, or Encouraging, CAL. PENAL CODE § 401 (West 1999) ("Every person who deliberately aids, or advises, or encourages another to commit suicide, is guilty of a felony."); Promoting a Suicide Attempt, N.Y. PENAL LAW § 120.30 (McKinney 2004) ("A person is guilty of promoting a suicide attempt when he intentionally causes or aids another person to attempt suicide. Promoting a suicide attempt is a class E felony.").

denominated "assisted suicide" at all, but rather one of euthanasia.<sup>23</sup> According to this line of thinking, there is no meaningful moral or practical reason for distinguishing between assisted suicide and euthanasia. And, it is certainly true that in the Netherlands, where both assisted suicide and euthanasia are legal, as well as in most of the rest of the world, rarely is any distinction drawn between the two practices in either academic debate or medical practice.<sup>24</sup>

Within the United States, by contrast, some have expressly sought to obtain legal permission only for assisted suicide<sup>25</sup> (note, in this regard, that Oregon's law permits only assisted suicide, not euthanasia).<sup>26</sup> But, does this position rest on a defensible moral principle or does it perhaps reflect instead a tactical decision to fight political-legal battles piecemeal in order to enhance the chances of ultimate success? Notably, Richard Epstein, who strongly supports the legalization of assisted suicide, has charged compatriots who fail to endorse the legalization of euthanasia with a "certain lack of courage."<sup>27</sup> And, in *Compassion in Dying v. Washington*, the Ninth Circuit all but admitted that any attempt at drawing a legal distinction between the practices would prove impossible.<sup>28</sup>

Those who do see a meaningful moral line between assisted suicide and euthanasia frequently suggest that the patient exercises more control in assisted suicide, remaining the final causal actor in his or her own death, while in euthanasia, another person assumes that role, thus

23. In 1999, after assisting in scores of suicides over several years, Dr. Kevorkian killed a patient for a nationwide television audience on the CBS program *60 Minutes* specifically to provoke a new debate over euthanasia (Dr. Kevorkian was later convicted of second-degree murder for this act, after a trial in which he chose to act as his own counsel). See Murphy, *supra* note 1.

24. See JOHN GRIFFITHS ET AL., *EUTHANASIA AND LAW IN THE NETHERLANDS* 113 (1998) [hereinafter GRIFFITHS ET AL., *EUTHANASIA AND LAW*] (noting that, in Dutch law or practice, "from the point of view of the justification of necessity, [the practices are] not distinguished"); Gerrit Kimsma & Evert van Leeuwen, *Euthanasia and Assisted Suicide in the Netherlands and the USA: Comparing Practices, Justifications and Key Concepts in Bioethics and Law*, in *ASKING TO DIE: INSIDE THE DUTCH DEBATE ABOUT EUTHANASIA* 35, 51 (David C. Thomasma ed., 1998) [hereinafter *ASKING TO DIE*] (explaining that "[i]n the Netherlands no distinct moral difference is maintained between [euthanasia] and [assisted suicide]").

25. See, e.g., John Deigh, *Physician-Assisted Suicide and Voluntary Euthanasia: Some Relevant Differences*, 88 J. CRIM. L. & CRIMINOLOGY 1155, 1157-59 (1998); Timothy E. Quill et al., *Care of the Hopelessly Ill: Proposed Clinical Criteria for Physician Assisted Suicide*, 327 NEW ENG. J. MED. 1380, 1381 (1992).

26. See OR. REV. STAT. § 127.800-.995.

27. RICHARD EPSTEIN, *MORTAL PERIL: OUR INALIENABLE RIGHT TO HEALTH CARE?* 340 (1999).

28. See *Compassion in Dying v. Washington*, 79 F.3d 790, 831 (9th Cir. 1996) (noting that the court "agree[s] that it may be difficult to make a principled distinction" between assisted suicide and euthanasia), *rev'd & remanded sub nom. Glucksberg*, 521 U.S. 702.

creating a greater chance for physician malfeasance.<sup>29</sup> But can this distinction withstand scrutiny or the test of time? Morally, in cases of assisted suicide and euthanasia alike, the patient forms an intent to die and the physician intentionally helps the patient end his or her life. Indeed, as bioethicists Gerrit Kimsma and Evert van Leeuwen have explained, the acts are “considered to be identical [in Dutch practice] because intentionally and effectively they both involve actively assisting death.”<sup>30</sup> The physical difference, too, between assisted suicide and euthanasia certainly need not be, and frequently is not, very great: as John Keown has asked, “[w]hat, for example, is the supposed difference between a doctor handing a lethal pill to a patient; placing the pill on the patient’s tongue; and dropping it down the patient’s throat?”<sup>31</sup>

# I. THE DUTCH EXPERIENCE: “VIRTUALLY ABUSE-FREE”?

The Netherlands is one of very few countries in the world with a regularly operating assisted suicide and euthanasia regime.<sup>32</sup> As such, it is a natural focus of attention for those looking to see how such a regime might be applied elsewhere. And, despite concerns expressed by some,<sup>33</sup> the Dutch experience is frequently held out by proponents of

29. See *supra* note 25.

30. Kimsma & van Leeuwen, *supra* note 24, at 51.

31. JOHN KEOWN, EUTHANASIA, ETHICS AND PUBLIC POLICY: AN ARGUMENT AGAINST LEGALISATION 33 (2002) [hereinafter KEOWN, EEPP]; see also Rights of the Terminally Ill Act, 1995, pt. 1, §§ 3–4 (N. Terr. Austl. Laws) (defining “assist[ance]” in suicide to embrace euthanasia—namely, to include “the administration of a substance to the patient”), available at [http://www.notes.nt.gov.au/dcm/legislat/legislat.nsf/d989974724db65b1482561cf0017cbd2/4d6231fd5c4f4e396925657000094754/\\$FILE/Repr030.pdf](http://www.notes.nt.gov.au/dcm/legislat/legislat.nsf/d989974724db65b1482561cf0017cbd2/4d6231fd5c4f4e396925657000094754/$FILE/Repr030.pdf); Kimsma & van Leeuwen, *supra* note 24, at 51 (arguing that there is no “difference . . . perceived if a physician hands over a cup to drink or gives an injection by needle”).

32. Belgium’s law has been in force for only a short period, as of this writing. See Reuters, *Belgium Approves Euthanasia Bill*, May 16, 2002, at [http://www.chninternational.com/belgium\\_approves\\_bill\\_on\\_euthana.htm](http://www.chninternational.com/belgium_approves_bill_on_euthana.htm). The Australian law was in place only for a matter of months. See Rights of the Terminally Ill Act, 1995. And, little has been published about Switzerland’s experience. See, e.g., Samia A. Hurst & Alex Mauron, *Assisted Suicide and Euthanasia in Switzerland: Allowing a Role for Non-Physicians*, Feb. 1, 2003, at <http://bmj.bmjournals.com/cgi/content/full/326/7383/271> from Feb 1, 2003. At least some of the published evidence from the brief Australian experiment does not offer reason for much confidence that assisted suicide was practiced there with tremendous care. See generally David W. Kissane, *Deadly Days in Darwin*, in THE CASE AGAINST ASSISTED SUICIDE: FOR THE RIGHT TO END-OF-LIFE CARE 192 (Kathleen Foley & Herbert Hendin eds., 2002) [hereinafter THE CASE AGAINST ASSISTED SUICIDE].

33. See, e.g., THE CASE AGAINST ASSISTED SUICIDE, *supra* note 32; CARLOS F. GOMEZ, REGULATING DEATH: EUTHANASIA AND THE CASE OF THE NETHERLANDS (1991); KEOWN, EEPP, *supra* note 31.



legalizing assisted suicide as a model for emulation and described in glowing terms.

Margaret Pabst Battin, of the University of Utah, for example, has argued that the practice of assisted suicide and euthanasia in the Netherlands is "virtually abuse-free."<sup>34</sup> Jocelyn Downie has suggested that the Dutch experience shows that euthanasia, even when legalized, is rarely employed.<sup>35</sup> Epstein has asserted that "Dutch physicians are not euthanasia enthusiasts and they are slow to practice it in individual cases,"<sup>36</sup> and Posner has submitted that the "fear of doctors' rushing patients to their death" in the Netherlands "has not been substantiated and does not appear realistic."<sup>37</sup> In this Part, I consider such claims in light of the formal legal-medical rules associated with the practice of assisted suicide and euthanasia in the Netherlands, as well as data reflecting the actual practices and attitudes of Dutch physicians.

### A. *An Outline of Dutch Procedures*

While voluntary euthanasia societies existed in Britain and the United States as early as the 1930s, no counterpart Dutch movement arose until considerably later.<sup>38</sup> Indeed, the Dutch euthanasia story does not begin in earnest until 1973, when a Dutch physician, who killed her seventy-eight-year-old mother at her request, was tried for homicide and received only a conditional one-week jail sentence along with one year of probation.<sup>39</sup> Though a notable event in Dutch law, however, even that case hardly portended an irrevocable break with the past: between 1969 and 1980, at least three other prosecutions for assisted suicide in the Netherlands resulted in jail sentences ranging from six to eighteen months.<sup>40</sup> The pace of change began to accelerate in 1981, however, when a seventy-six-year-old lay person received a conditional sentence of six months subject to one year probation (after the court found that a jail term would have been too burdensome on the aged defendant), and the court went on to advise in dicta that a *physician* might be exempt

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34. Margaret Pabst Battin, *Should We Copy the Dutch? The Netherlands' Practice of Voluntary Euthanasia as a Model for the United States*, in EUTHANASIA: THE GOOD OF THE PATIENT, THE GOOD OF SOCIETY 95, 102 (Robert I. Misbin ed., 1992).

35. See Jocelyn Downie, *The Contested Lessons of Euthanasia in the Netherlands*, 8 HEALTH L.J. 119, 128 (2000) (claiming that the notion that euthanasia is widespread "is simply not supported by the data").

36. EPSTEIN, *supra* note 27, at 322.

37. RICHARD A. POSNER, AGING AND OLD AGE 242 & n.23 (1995) (footnote omitted).

38. See Herbert Hendin, *The Dutch Experience*, in THE CASE AGAINST ASSISTED SUICIDE, *supra* note 32, at 97, 99.

39. See GRIFFITHS ET AL., EUTHANASIA AND LAW, *supra* note 24, at 51-52.

40. See *id.* at 53.

from any punishment for killing a patient suffering severe physical duress (arguably approving not just assisted suicide but also euthanasia, without drawing any distinction between them).<sup>41</sup>

In 1984, events reached a crescendo in a case involving an unnamed ninety-three-year-old woman who was bedridden due to a hip fracture, no longer able to eat or drink, and who was slipping in and out of consciousness.<sup>42</sup> At one point, when the patient regained consciousness, she asked to be euthanized and her physician consented.<sup>43</sup> The case was later reported to the police and ultimately reached the country's supreme court.<sup>44</sup> The Dutch Supreme Court used the dispute to announce an exception, or defense, to the country's express penal laws banning the practice of assisted suicide.<sup>45</sup> The court defended the doctor's conduct, moreover, not because of a perceived need to vindicate patient autonomy, but rather because of the perceived "necessity" resulting from a conflict of duties or *force majeure* (*overmacht*) confronting the doctor, explaining that the killing was justified by the *doctor's judgment* about the quality of his patient's life (or, more precisely, the doctor's judgment about the lack thereof):

in accordance with [the] norms of medical ethics, and with the expertise which as a professional he must be assumed to possess—[he] balanced the duties and interests which, in the case at hand, were in conflict, and made a choice that—objectively considered, and taking into account the specific circumstances of this case—was justifiable.<sup>46</sup>

The Royal Netherlands Society for the Promotion of Medicine and the

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41. See *id.* at 58–59; Hendin, *supra* note 38, at 99. For detailed, if sometimes conflicting, accounts of all Dutch cases and experience prior to 1984's seminal Dutch Supreme Court decision, see GOMEZ, *supra* note 33; GRIFFITHS ET AL., EUTHANASIA AND LAW, *supra* note 24; and Hendin, *supra* note 38.

42. See GRIFFITHS ET AL., EUTHANASIA AND LAW, *supra* note 24, app. 2, at 323–24. A translation of the Dutch *Schoonheim* case is provided in *id.* app. 2, at 322–28.

43. See *id.* app. 2, at 324. In the previous year, the patient had signed a living will in which she manifested her wish to have euthanasia be performed if she suffered from a condition "in which no recovery to a tolerable and dignified condition of life was to be expected." *Id.* app. 2, at 323.

44. See *id.* app. 2, at 322–23.

45. See GRIFFITHS ET AL., EUTHANASIA AND LAW, *supra* note 24, app. 2, at 326–28. Article 293 of the Dutch Criminal Code forbade an individual from taking the life of another even after the latter's "express and earnest request"; Article 294 made it unlawful to "intentionally incite[] another to commit suicide, assist[] in the suicide of another, or procure[] for that other person the means to commit suicide." *Id.* app. 1, at 308 (translating Dutch statutes).

46. GRIFFITHS ET AL., EUTHANASIA AND LAW, *supra* note 24, app. 2, at 326–27.

Recovery Interest Society for Nurses and Nursing Aids, at about the same time, set forth certain criteria for assisting suicide or performing euthanasia in conformity with the court's newly recognized necessity defense,<sup>47</sup> and the Minister of Justice made clear that physicians following these guidelines would not be prosecuted.<sup>48</sup>

In 1994, the Dutch Supreme Court substantially extended the physician "necessity" defense in the *Chabot* case.<sup>49</sup> There, the court considered the justifiability or excusability of the killing of a fifty-year-old woman (identified in court papers as "Ms. B") by a psychiatrist, Dr. Chabot.<sup>50</sup> Ms. B's son had committed suicide in 1986; in 1988, her father died; in 1990, she was divorced and her second son was injured in a traffic accident.<sup>51</sup> In the course of her son's treatment, cancer was discovered, and he died in 1991.<sup>52</sup> The same year, Ms. B attempted suicide, unsuccessfully, using drugs supplied by a doctor.<sup>53</sup> Later, through the Dutch Association for Voluntary Euthanasia, Ms. B was referred to a psychiatrist, Dr. Chabot, who examined Ms. B in four series of meetings over a five week period, for a total of twenty-four actual hours (although apparently amounting to thirty "billable" hours).<sup>54</sup> Dr. Chabot also consulted with four psychiatrists, a clinical psychologist, a general practitioner, and a professor of ethics,<sup>55</sup> though none of these professionals actually examined Ms. B.<sup>56</sup> Dr. Chabot then concluded that Ms. B was suffering psychologically in a manner that was subjectively "unbearable" to her, and that she was "without prospect of improvement."<sup>57</sup> In Dr. Chabot's judgment, Ms. B's "rejection of therapy was . . . well-considered."<sup>58</sup> Seven weeks after meeting Ms. B, Dr. Chabot supplied lethal medication to her.<sup>59</sup> She

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47. See *Guidelines for Euthanasia*, 3 ISSUES L. & MED. 429 (Dr. Walter Lagerway trans., 1988). Under the guidelines, a request for assistance in dying had to be voluntary, well-considered, and persistent, and the patient had to be experiencing unacceptable suffering; the physician was also required to consult a colleague. *Id.* at 431-33.

48. See Executive Summary, *Physician-Assisted Suicide and Euthanasia in the Netherlands: A Report to the House Judiciary Subcommittee on the Constitution*, 14 ISSUES L. & MED. 301, 313 (1998) ("[The Guidelines] made clear that physicians could practice euthanasia under the Guidelines and not fear prosecution.").

49. GRIFFITHS ET AL., EUTHANASIA AND LAW, *supra* note 24, app. 2, at 329-38. A translation of the Dutch *Chabot* case is provided in *id.* app. 2, at 329-38.

50. See *id.* app. 2, at 329-30.

51. See *id.* app. 2, at 330.

52. See *id.*

53. See *id.*

54. *Id.* app. 2, at 331 & n.23.

55. See *id.* app. 2, at 331 & n.24.

56. See *id.* app. 2, at 332.

57. *Id.*

58. *Id.*

59. See *id.* app. 2, at 329.

consumed the medication and died a half-hour later.<sup>60</sup>

The Dutch Supreme Court held that, for a request for assisted suicide or euthanasia to be justified on "necessity" grounds, the patient's suffering need not be physical, the patient need not be terminally ill, and purely psychological suffering can qualify a patient for an act of euthanasia.<sup>61</sup> The court held that Dr. Chabot erred only by failing to have the colleagues he consulted examine Ms. B before agreeing to help kill her, though the court ultimately declined to impose any penalty for this oversight.<sup>62</sup> Given the *Chabot* decision, John Griffiths, Professor of Sociology of Law at the University of Groningen in the Netherlands, and a leading defender of decriminalization in that country, has surmised that the requirement of unbearable suffering in any form, physical or mental, is likely on the way out: "the decision in *Chabot* may later be seen as having opened the way to a legal development that accepts assistance with suicide to persons who are not 'sick' at all."<sup>63</sup>

And, in fact, that prediction seems well on its way to being proven correct. Between 1986 and 1993, at least three legislative efforts to codify the judiciary's expanding necessity defense failed.<sup>64</sup> Finally, in 2001, a bill was approved by the Dutch Parliament permitting assisted suicide and euthanasia when the physician:

- a. holds the conviction that the request by the patient was voluntary and well-considered,
- b. holds the conviction that the patient's suffering was lasting and unbearable,
- c. has informed the patient about the situation he was in and about his prospects,
- d. and the patient [held] the conviction that there was no other reasonable solution for the situation he was in,
- e. has consulted at least one other, independent physician who has seen the patient and has given his written opinion on the requirements of due care, referred to in parts a-d, and,
- f. has terminated a life or assisted in a suicide with due care.<sup>65</sup>

Under these standards, terminal illness plainly is not a prerequisite to euthanasia, and neither is a physical ailment of any kind. While the

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60. See *id.* app. 2, at 329-30.

61. *Id.* app. 2, at 334-35.

62. See *id.* app. 2, at 337-38.

63. *Id.* at 153.

64. See 1 H.L., REPORT OF THE SELECT COMMITTEE ON MEDICAL ETHICS 65 (1993-1994) [hereinafter H.L. REPORT].

65. Termination of Life on Request and Assisted Suicide (Review Procedures) Act, Stb. 2001, nr. 137, ch. 2, art. 2, § 1 (Neth.), available at <http://www.nvve.nl/english> [hereinafter 2001 Dutch Act] (translating the Dutch law).

doctor must consider his or her patient to be "suffering," that suffering need not be physical or even really present at all: the doctor need only show that he or she believed (or "[held] the conviction") that the patient endured some sort of (unspecified) suffering.<sup>66</sup> And, procedurally, there is no specified waiting period after the request for euthanasia before it may be performed and no requirement that the patient place his or her wishes in writing.<sup>67</sup>

Griffiths's prediction about the future of assisted suicide in the Netherlands, in fact, actually fails to capture the speed and scope of developments there insofar that the 2001 Dutch Act also extends assisted suicide and euthanasia to children as young as twelve:

[i]f the minor patient is aged between twelve and sixteen years and may be deemed to have a reasonable understanding of his interests, the physician may [carry] out the patient's request [for termination of life or assisted suicide], provided always that the parent or the parents exercising parental authority or his guardian agree with the termination of life or the assisted suicide.<sup>68</sup>

By contrast, minors between sixteen and eighteen who "may be deemed to have a reasonable understanding of [their] interests" can obtain assisted suicide or euthanasia *without* parental consent, although the parents must be "involved" in the decision-making process.<sup>69</sup> Going yet a step further, in late 2004, the Groningen University Hospital issued a press release announcing that it has proposed guidelines for killing unwanted malformed children (infanticide).<sup>70</sup> The hospital's guidelines are, as of this writing, under review by the Dutch government and have not yet been published. According to the hospital's press release, it seems that the proposal is primarily aimed at malformed infants, but would nonetheless apply to any child under twelve who is "suffering" in a manner that "cannot be relieved by means of other ways."<sup>71</sup> While parental consent is required, consent is of course impossible to obtain

66. *Id.* ch. 2, art. 2, § 1(b).

67. *See id.* ch. 2, art. 2.

68. *Id.* ch. 2, art. 2, § 4.

69. *Id.* ch. 2, art. 2, § 3.

70. Academisch Ziekenhuis Groningen, Protocol waarborgt zorgvuldigheid bij levenseinde kind (Oct. 29, 2004), available at <http://www.azg.nl/azg/nl/nieuws/persberichten/43604>. An English translation of the hospital's press release is available at Blog, Target="Blank", Groningen Protocol: The Press Release of the University Hospital Groningen, English Translation, A Protocol to Guarantee Carefulness When Actively Ending a Child's Life, at <http://blogger.xs4all.nl/wdegroot/articles/16952.aspx> (last visited Dec. 20, 2004).

71. Blog, *supra* note 70.

from the newborn children who are the targets of this proposal and it is unclear whether consent would even be required from older children killed under this protocol. Nor is not clear whether the "suffering" need be physical or might also include mental anguish (as the Dutch courts have already held in *Chabot*). And, if the latter comes to qualify, the question will surely arise: might the suffering of the parents qualify without respect to whether the child's physical suffering can be addressed by palliative treatments? All of this, at the moment, remains unclear.

*B. The Dutch Practice of Assisted Suicide and Euthanasia*

To date, two large-scale studies have been published regarding Dutch assisted suicide and euthanasia practices, one in 1990 ("1990 Survey") and the other in 1995 ("1995 Survey") (collectively the "Surveys").<sup>72</sup> A third survey was published in *The Lancet* in 2003, albeit in abbreviated form and using data from 2001, the year *before* the passage of the Dutch statute formally legalizing assisted suicide and euthanasia, thus leaving us without definitive data on the impact of that landmark legislation.<sup>73</sup> All three studies were performed under the auspices of Gerrit van der Wal of the Institute for Research in Extramural Medicine at Vrije Universiteit in Amsterdam, and Paul J. van der Maas of the Department of Public Health at Erasmus University in Rotterdam.<sup>74</sup>

The Surveys employed two central methods. First, the authors confidentially interviewed a random sample of slightly more than 400 physicians, reflecting general practitioners, and representatives from five different specialties (cardiology, surgery, internal medicine, pulmonology, and neurology).<sup>75</sup> Second, the Surveys examined a random sample of death certificates over the course of a four month period for each year under review, followed up by a questionnaire directed to the physicians identified in each death certificate in the

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72. See Paul J. van der Maas & Gerrit van der Wal et al., *Euthanasia, Physician-Assisted Suicide, and Other Medical Practices Involving the End of Life in the Netherlands, 1990-1995*, 335 NEW ENG. J. MED. 1699 (1996) [hereinafter van der Maas & van der Wal et al., *Euthanasia 1996*].

73. See Bregje D. Onwuteaka-Philipsen, Paul J. van der Maas & Gerrit van der Wal et al., *Euthanasia and Other End-of-Life Decisions in the Netherlands in 1990, 1995, and 2001*, 362 LANCET 395 (2003) [hereinafter Onwuteaka-Philipsen, van der Maas & van der Wal et al., *Euthanasia 2001*].

74. See *id.* at 395; van der Maas & van der Wal et al., *Euthanasia 1996*, *supra* note 72, at 1699.

75. See Onwuteaka-Philipsen, van der Maas & van der Wal et al., *Euthanasia 2001*, *supra* note 73, at 395-96; van der Maas & van der Wal et al., *Euthanasia 1996*, *supra* note 72, at 1699-1700.

sample under study.<sup>76</sup>

Some of the central findings of the Surveys' physician interviews are summarized in Table 1.

Table 1  
Central Findings of 1990 and 1995 Surveys<sup>77</sup>

	1995	1990	% change
Total Deaths	135,546	128,786 <sup>78</sup>	5%
Number of explicit requests for euthanasia or assisted suicide later in disease	34,500	25,100	37%
Number of requests for euthanasia or assisted suicide at a particular time	9700	8900	9%
End-of-life practices performed			
Euthanasia	3118	2447	27%
As % of all deaths	2.3%	1.9%	
Assisted suicide	542	386	40%
As % of all deaths	0.4%	0.3%	
Ending life without patient's explicit request	949	1030	-8%
As % of all deaths	0.7%	0.8%	

As reflected in Table 1, the 1990 Survey found that fully 1.9% of all Dutch deaths (2447) were attributable to the practice of euthanasia. Substantially more people died in the Netherlands as a result of euthanasia than HIV, leukemia or homicide.<sup>79</sup> The 1990 Survey found that an additional 0.3% of all deaths—or nearly 400 cases—were the product of physician-assisted suicide. By 1995, these figures had grown measurably: 2.3% of all deaths nationwide that year were the result of euthanasia (a 27% increase) and 0.4% were due to assisted suicide (a 40% increase). The Surveys also reveal that requests for euthanasia increased dramatically between 1990 and 1995 (prospective requests for

76. Onwuteaka-Philipsen, van der Maas & van der Wal et al., *Euthanasia 2001*, *supra* note 73, at 396; van der Maas & van der Wal et al., *Euthanasia 1996*, *supra* note 72, at 1700.

77. The figures in this Table are extrapolated from data in van der Maas & van der Wal et al., *Euthanasia 1996*, *supra* note 72, at 1700-01 & 1701 tbl.1.

78. The Netherlands has a total population of approximately sixteen million. World Health Org., Netherlands, at <http://www.who.int/countries/nld/en> (last visited Dec. 20, 2004).

79. See WHO Statistical Information System, World Health Org., Table 1: Numbers of Registered Deaths, Netherlands—1999, at [http://www3.who.int/whosis/mort/table1\\_process.cfm](http://www3.who.int/whosis/mort/table1_process.cfm) (last visited Dec. 20, 2004).

euthanasia at a later stage of a disease grew 37% and requests for euthanasia at a particular time rose 9%). The actual incidence of euthanasia and assisted suicide also jumped substantially, 27% and 40%, respectively.

Physician interview data from the 2001 survey suggests that the significant rise in the incidence of euthanasia experienced between 1990 and 1995 was consolidated and persisted: euthanasia continued to account for approximately 2.2% of all deaths in the Netherlands in 2001, approximating the results found in the 1995 survey.<sup>80</sup> The physician interview results for 2001, however, diverge somewhat from the results of the death certificate study.<sup>81</sup> The latter study suggests that euthanasia became even more common—rising from 1.7% of all deaths in 1990, to 2.4% in 1995, and to 2.6% in 2001.<sup>82</sup> And, again, we currently have no data suggesting how, if at all, the 2001 statute may have affected these numbers.

We do know, however, that things do not always go smoothly. Dutch researchers have found that problems with “completion” arise in 16% of assisted suicide cases and 6% of euthanasia cases, and “complications” arise in 7% of assisted suicide cases and 3% of euthanasia cases.<sup>83</sup> These complications include nausea and vomiting, and the problems with completion include patients waking from drug-induced comas and living as long as fourteen days after the administration of death-inducing medication.<sup>84</sup>

In 1995, the authors of the Surveys for the first time systematically examined the frequency with which physicians euthanize their patients without consent. As shown in Table 1, they found that 0.7% of all deaths nationwide that year were the result of nonconsensual killings (approximately 950). Although the 1990 Survey did not seek to study this issue on a systematic basis, the more limited death certificate study conducted suggested that nonconsensual killings represented 0.8% of deaths nationwide (approximately 1000). Data from 2001 suggest little improvement, with nonconsensual killings persisting at a rate of

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80. Onwuteaka-Philipsen, van der Maas & van der Wal et al., *Euthanasia 2001*, *supra* note 73, at 396 & tbl.1.

81. *See id.*

82. *See id.* There is a similar divergence in the data for physician-assisted suicide. *Id.* The physician interview results show that the incidence of assisted suicide rose from 0.3% of all deaths in 1990 to 0.4% in 1995, and then dropped to 0.1% in 2001. *Id.* Meanwhile, the death certificate data suggests that the incidence of assisted suicide remained constant in all three years—at 0.2% of all deaths. *Id.*

83. Johanna H. Groenewoud et al., *Clinical Problems with the Performance of Euthanasia and Physician-Assisted Suicide in the Netherlands*, 342 NEW ENG. J. MED. 551, 551 (2000).

84. *See id.* at 555 tbl.5.



approximately 0.7% of all deaths in the country that year.<sup>85</sup>

Downie has sought to downplay the significance of these nonconsensual killings, noting that "in 600 of the 1000 cases [of nonconsensual euthanasia in 1990], something about the patients' wishes was known although explicit consent according to the [Dutch Medical Association's] guidelines had not been given."<sup>86</sup> This interpretation, however, does not address the 400 cases in which patients' wishes were not known *at all*.<sup>87</sup> And, in the 600 remaining cases, the patient was adjudged even by the euthanizing physician to have expressed something less than the "explicit consent" required under the Dutch guidelines to avoid potential prosecution.<sup>88</sup> These comments ranged—according to the physicians themselves—from a "rather vague earlier expression of a wish for euthanasia, as in comments like, 'If I cannot be saved anymore, you must give me something,' or 'Doctor, please don't let me suffer for too long,' to much more extensive discussions" that were still insufficient, in the doctor's own judgment, to satisfy the explicit request required by Dutch law.<sup>89</sup>

In 1995, the New York State Task Force on Life and the Law recommended against legalizing assisted suicide in part on the strength of the then-available 1990 Survey data.<sup>90</sup> Referring to the 2700 reported deaths by assisted suicide and euthanasia in the Netherlands and the 1000 cases of nonconsensual terminations, the task force reasoned that:

If euthanasia were practiced in a comparable percentage of cases in the United States, voluntary euthanasia would account for about 36,000 deaths each year, and euthanasia without the patient's consent would occur in an additional 16,000 deaths.

The Task Force members regard this risk as unacceptable. They also believe that the risk of such abuse is neither speculative nor distant, but an inevitable byproduct of the

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85. See Onwuteaka-Philipsen, van der Maas & van der Wal et al., *Euthanasia 2001*, *supra* note 73, at 396 & tbl.1. While these data seem to suggest that nonconsensual killings decreased slightly, the Surveys' authors have been cautious to reach such a conclusion, explaining that "chance fluctuation cannot be ruled out as an explanation" for the change between 1990 and 1995, adding that their "1990 interview study did not permit sufficiently reliable estimates of this variable." van der Maas & van der Wal et al., *Euthanasia 1996*, *supra* note 72, at 1704.

86. Downie, *supra* note 35, at 132.

87. See MARGARET PABST BATTIN, *A Dozen Caveats Concerning the Discussion of Euthanasia in the Netherlands*, in *THE LEAST WORST DEATH: ESSAYS IN BIOETHICS ON THE END OF LIFE* 130, 137 (1994) [hereinafter *THE LEAST WORST DEATH*].

88. See *id.*

89. *Id.*

90. See THE N.Y. STATE TASK FORCE ON LIFE & THE LAW, *WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT* 133-34 (1994) [hereinafter *N.Y. STATE TASK FORCE*].

transition from policy to practice in the diverse circumstances in which the practices would be employed.<sup>91</sup>

All of the foregoing statistics and analyses, moreover, arguably understate both the incidence of euthanasia in the Netherlands and the frequency with which patients are killed without consent. The later Dutch Surveys include only *affirmative* acts of euthanasia in their analysis of the incidence of mercy killings with and without consent.<sup>92</sup> They do not count omissions or withdrawals of care performed without patient consent and with the intention of killing the patient<sup>93</sup>—even though these are acts that Dutch medical guidelines expressly recognize as euthanasia.<sup>94</sup> The 1990 Survey sought to count such deaths separately, but the 1995 and 2001 Surveys, surprisingly and without explanation, simply omitted any such discussion—an unhelpful development for anyone trying to comprehend the facts of the Dutch practice.<sup>95</sup> The 1990 data reveal, however, that 4000 deaths were caused that year by the withdrawal or withholding of treatment without explicit patient consent and “[w]ith the explicit purpose” of shortening life.<sup>96</sup> The 1990 Survey found an additional 4750 deaths were caused by withdrawing or withholding without explicit consent but “[p]artly with the purpose” of ending life.<sup>97</sup>

Combined, these figures represent 8750 cases where care was discontinued by a doctor who intended to kill the patient, and who acted without the explicit consent of the patient; such deaths accounted for some 6.78% of all deaths in the Netherlands in 1990.<sup>98</sup> It is hard to understand why the Surveys’ authors failed to report data regarding nonconsensual killings by omission in the 1995 and 2001 Surveys and it would certainly be unfortunate if they did so simply to diminish attention to those facts (though it seems clear their decision not to report the data has that effect). In any event, when added to the 1000 nonconsensual *affirmative* acts of euthanasia, the total number of intentional killings without patient consent in 1990 was 9750, or 7.56% of all deaths.<sup>99</sup> Extrapolating to the U.S. population, this would translate into approximately 173,650 medically accelerated deaths per year without

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91. *Id.*

92. See Onwuteaka-Philipsen, van der Maas & van der Wal et al., *Euthanasia 2001*, *supra* note 73.

93. *See id.*

94. *See supra* notes 47–48 and accompanying text.

95. See Onwuteaka-Philipsen, van der Maas & van der Wal et al., *Euthanasia 2001*, *supra* note 73.

96. KEOWN, EEPP, *supra* note 31, at 95–96.

97. *Id.*

98. *See id.* at 93, 95–96.

99. *See id.*

explicit patient consent (based on the approximately 2.3 million deaths that occur in the United States annually).<sup>100</sup>

Nor is it clear that killing has been used only in extremis to prevent suffering. In the 1990 Survey, physicians involved in nonconsensual affirmative killings volunteered that ending pain and suffering motivated them in only 18.8% of the cases.<sup>101</sup> Reasons physicians gave more frequently for terminating life without consent included the "absence of any prospect of improvement (60%) . . . avoidance of 'needless prolongation' (33%); the relatives' inability to cope (32%); and [the physician's judgment that the patient enjoyed only a] 'low quality of life' (31%)." <sup>102</sup> In fact, a 2003 regression analysis spanning twenty-five years worth of data found that patient pain had become a "significantly less important" consideration even in cases of *voluntary* euthanasia and assisted suicide. While cited as a major reason for requesting euthanasia and assisted suicide in over 50% of cases in 1977, by 2001, pain was cited as a major reason for requested assisted suicide and euthanasia in less than 25% of cases of consensual killings.<sup>103</sup> Meanwhile, a patient's sense of "deterioration" and "hopelessness" have both increased markedly as reasons cited as motivating assisted suicide and euthanasia requests.<sup>104</sup>

Some studies suggest, too, that Dutch physicians may be undertrained in palliative care techniques that might mitigate the perceived need to resort to assisted suicide and euthanasia. A 1987 Dutch Health Council study found, for example, that a majority of cancer patients in pain suffered because of their caregivers' lack of expertise in pain management,<sup>105</sup> and a 1989 study found that palliative care was "inadequate in slightly more than 50% of evaluated cases."<sup>106</sup> Even among Dutch doctors, most of whom support assisted suicide and

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100. See WHO Statistical Information System, World Health Org., Table 1: Numbers of Registered Deaths, United States of America—1999, at [http://www3.who.int/whosis/mort/table1\\_process.cfm](http://www3.who.int/whosis/mort/table1_process.cfm) (last visited Dec. 20, 2004).

101. See Onwuteaka-Philipsen, van der Maas & van der Wal et al., *Euthanasia 2001*, *supra* note 73, at 396 & tbl.1 (using statistics from the death certificate study).

102. KEOWN, EEPP, *supra* note 31, at 105 (footnotes omitted); see also John Keown, *Further Reflections on Euthanasia in the Netherlands in the Light of the Rummelink Report and the Van Der Maas Survey*, in EUTHANASIA, CLINICAL PRACTICE AND THE LAW 219, 230 (Luke Gormally ed., 1994) [hereinafter Keown, *Further Reflections*] (discussing the 1990 Survey results); R.L. Marquet et al., *Twenty Five Years of Requests for Euthanasia and Physician Assisted Suicide in Dutch General Practice: Trend Analysis*, 327 BRIT. MED. J. 201, 201 (2003).

103. R.L. Marquet et al., *supra* note 102, at 201.

104. See *id.*

105. See John Keown, *The Law and Practice of Euthanasia in the Netherlands*, 108 LAW Q. REV. 51, 65 (1992).

106. Karin L. Dorrepaal et al., *Pain Experience and Pain Management Among Hospitalized Cancer Patients: A Clinical Study*, 63 CANCER 593, 598 (1989).

euthanasia, fully 40% have signaled their "agreement with the proposition that '[a]dequate alleviation of pain and/or symptoms and personal care of the dying patient make euthanasia unnecessary.'"<sup>107</sup>

Ultimately, a government panel charged with reviewing the 1990 Survey results sought to explain and even defend the seemingly large number of nonconsensual killings, doing so on the ground that:

The ultimate justification for the intervention is in both cases [that is, where there is and is not an explicit request for assistance in dying] the patient's unbearable suffering. So, medically speaking, there is little difference between these situations . . . because in both cases patients are involved who suffer terribly. The absence of a special . . . request for the termination of life stems partly from the circumstance that the party in question is not (any longer) able to express his will because he is already in the terminal stage, and partly because the demand for an explicit request is not in order when the treatment of pain and symptoms is intensified. The degrading condition the patient is in confronts the doctor with a case of [*force majeure*]. According to the Commission, the intervention by the doctor can easily be regarded as an action that is justified by necessity, just like euthanasia.<sup>108</sup>

Thus, it appears that it is not patient autonomy or even the alleviation of pain that, to the Dutch government at least, stands as the ultimate justification for assisted suicide and euthanasia. Instead, it is the *physician's* assessment of the patient's *quality of life* as "degrading" or "deteriorating" or "hopeless" that stands as the ultimate justification for killing. Echoing the Dutch Supreme Court's decision of 1984, the Dutch government panel found that the "necessity" of assisted suicide stems not from the patient's consent (let alone autonomous choice), but from the *physician's quality of life assessment*.<sup>109</sup> And, as of late 2004, the Dutch are considering the legalization of infanticide—that is, killing children without consent.

As reflected in Table 2, it also appears that the incidence of nonvoluntary euthanasia is closely related to age. The 1995 Survey's death certificate study found that younger patients (especially those from birth to age forty-nine) are far more likely than older persons to be killed without their consent.<sup>110</sup>

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107. KEOWN, EEPP, *supra* note 31, at 111.

108. Keown, *Further Reflections*, *supra* note 102, at 229 (quoting the government's report).

109. *Id.*

110. Onwuteaka-Philipsen, van der Maas & van der Wal et al., *Euthanasia*

Table 2  
End-of-Life Decisions in 1995  
by Age<sup>111</sup>

	0-49	50-64	65-79	> 80
Total death certificates studied	661	652	1792	2041
% of all deaths in Netherlands (n=135,675)	8%	12%	36%	44%
% of all end-of-life decisions (n=2604)	6%	14%	34%	46%
% ending life without explicit request (n=64)	18%	16%	31%	36%
% ending life without explicit request vs. % of all end-of-life decisions	300%	114%	91%	78%

While the young (from birth to age forty-nine) represented 6% of all end-of-life cases surveyed in 1995, they accounted for 18% of all cases found where life was ended without an express request; the young were, thus, vastly overrepresented (300%) among cases where patients were killed without express consent when compared with their population in the pool of all end-of-life cases. Those between fifty and sixty-four years of age were also overrepresented (114%), constituting 14% of all end-of-life cases, but 16% of cases where life was ended without clear consent. And, the 2001 Survey suggests that little has changed since 1995;<sup>112</sup> indeed, the 2001 Survey authors confirm that “[e]nding of life without a patient’s explicit request occurred most frequently among people dying at [an] age younger than 65 years” and data concerning the incidence of such problems “remained virtually unchanged” between 1995 and 2001.<sup>113</sup>

Remarkably, the Surveys have consistently found that a significant proportion of assisted suicides and acts of euthanasia go unreported, even though Dutch professional and legal guidelines allow the practices and expressly require them to be reported to public authorities; state approval of assisted suicide and euthanasia simply has not, it seems, ended the “grey market” for such services. For example, of the 2700

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2001, *supra* note 73, at 395-96. Such an age-based study was not performed in 1990.

111. The data in this Table are extrapolated from van der Maas & van der Wal et al., *Euthanasia 1996*, *supra* note 72, at 1703 tbl.3.

112. The materials reported in Onwuteaka-Philipsen, van der Maas & van der Wal et al., *Euthanasia 2001*, *supra* note 73, are less specific than those found in prior surveys. For example, they do not disaggregate 2001 data for persons between birth and forty-nine, and between fifty and sixty-four, as the 1995 Survey did.

113. *Id.* at 396-97.

cases of assisted suicide and euthanasia recorded in 1990, only 486 were reported pursuant to Dutch medical guidelines, meaning, in effect, that doctors illegally certified 82% of these cases as death by "natural causes."<sup>114</sup> Of the 147 physicians interviewed in the 1995 Survey who reported participating in cases of assisted suicide or euthanasia, eighty-four—or 57%—admitted they had not reported at least one other case, and none identified any adverse legal consequence from his or her behavior.<sup>115</sup> In the 2001 Survey, the proportion of unreported cases declined, but the authors found that, even after years of unfavorable attention to this issue and the repeated commitment of Dutch authorities to improve physician reporting, as many as 46% of all cases of assisted suicide and euthanasia still go unreported.<sup>116</sup>

As reflected in Table 3, physicians have also admitted that they are far less likely to consult with colleagues or family members, or ensure an explicit patient request, in the cases of assisted suicide and euthanasia they choose not to report to state authorities. Doctors likewise admit that they are far less likely to leave a written record in unreported cases—a record that might permit subsequent inquiries into their conduct.

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114. KEOWN, EEPP, *supra* note 31, at 113.

115. Gerrit van der Wal & Paul J. van der Maas et al., *Evaluation of the Notification Procedure for Physician-Assisted Death in the Netherlands*, 335 NEW ENG. J. MED. 1706, 1708 (1996) [hereinafter van der Wal & van der Maas et al., *Notification Procedure*].

116. Reporting data is not included in Onwuteaka-Philipsen, van der Maas & van der Wal et al., *Euthanasia 2001*, *supra* note 73, but it is summarized in Tony Sheldon, *Only Half of Dutch Doctors Report Euthanasia, Study Says*, 326 BRIT. MED. J. 1164, 1164 (2003). See also World Federation of Right to Die Societies, *Netherlands: Euthanasia Reports Decline by 15 Percent over 4 Years* (Apr. 29, 2003) (noting that "it is suspected the actual 'mercy killing' figure is double the amount of recorded cases" and that "many doctors still do not trust the commissions and get annoyed and worried when the commission seeks additional information about specific cases," and quoting Reina de Valk, chairperson for the national body encompassing the various regional reporting commissions, that "[t]ime is needed to win the confidence of many doctors"), at <http://www.worldrtd.net/news/world/?id=534>.

Table 3  
Characteristics of Reported and Unreported Cases of Euthanasia and  
 Assisted Suicide: 1995<sup>117</sup>

	Reported Cases (N=68)	Unreported Cases (N=68)
Patient request was:		
Highly explicit	100%	92%
"Rather" explicit	0%	8%
Written will present	73%	44%
Express written report on decision	36%	0%
Notes in medical record	84%	57%
No writing	3%	43%
Discussion with colleagues	100%	58%
Contact with patient's relatives	99%	92%

When asked about their unreported cases, sixteen of the eighty-four responding physicians—or 19%—stated that their *most recent* unreported case involved killing the patient without an explicit request.<sup>118</sup> Physicians stated that they had complied with guidelines requiring them to consult with colleagues 100% of the time in their reported cases, but had respected this requirement only 58% of the time in their unreported cases; they likewise revealed that they left behind no written record of their conduct in just 3% of reported cases, but left no such record (again in violation of professional requirements) in 43% of their unreported cases. And, fully 40% of general practitioners simply dismissed the rule requiring them to consult with another colleague before killing a patient as being not very important.<sup>119</sup>

### *C. The Future: Decriminalization of Nonconsensual Killings?*

Faced with the data regarding the prevalence of unreported and nonconsensual killings, the *Chabot* decision extending euthanasia to those suffering subjective mental anguish, new laws affording a right to lethal assistance to minors, and a proposal now on the table to legalize infanticide, one might ask what the future might hold for the practice of assisted suicide and euthanasia in the Netherlands.

Looking particularly at the prevalence of unreported killings,

117. van der Wal & van der Maas et al., *Notification Procedure*, *supra* note 115, at 1709 tbl.2.

118. *Id.* at 1708.

119. KEOWN, EEPP, *supra* note 31, at 113.

Griffiths has acknowledged that, his support for legalized assisted suicide and euthanasia notwithstanding, "the present control-regime [in the Netherlands] does not offer effective control,"<sup>120</sup> and that it "is a bit of a paper tiger, in the sense that only a minority of cases (and these the least problematic ones) are reported, and that little serious enforcement is undertaken in reported cases that do not meet the legal criteria."<sup>121</sup> In fact, of all the data gathered on Dutch assisted suicide and euthanasia practices, the low reporting rate is the issue that, to Griffiths at least, "most gives rise to concern."<sup>122</sup>

To encourage greater reporting, especially of cases that do not meet current legal criteria, Griffiths does not argue for greater vigilance and enforcement of laws against killing patients without consent. Instead, somewhat surprisingly, he advocates for the elimination of any criminal penalty associated with such nonconsensual killings.<sup>123</sup> If doctors do not fear criminal prosecution even for killing their patients without consent, Griffiths's reasoning goes, they will be more apt to report their conduct.<sup>124</sup> Echoing and building on the sentiments of the Dutch governmental commission reviewing (and seeking to justify) the data on nonconsensual killings, Griffiths gives us a hint where the Dutch ultimately may find themselves—namely routinizing "euthanasia and termination of life *without an explicit request* [such that they are] handled in the same way [as voluntary requests for assisted suicide and euthanasia]: deemed 'normal medical practice' and subjected to the controls applicable to other behavior of doctors."<sup>125</sup>

Absent here, once again, is any linkage between assisted suicide and patient autonomy. A physician would be free to kill his patients *without their consent* and have no reason to fear criminal prosecution. Though Griffiths believes that the decriminalization of nonvoluntary euthanasia would lead to better compliance with self-reporting requirements, he (curiously) does not pause to give any significant consideration to the question whether allowing doctors to kill without consent might also lead to additional cases of abusive, coercive, and mistaken killings. In fact, Griffiths's proposal seemingly would preclude the criminal prosecution not just of those acting out of motives of mercy, but even mass murderers like Dr. Harold Shipman.<sup>126</sup> In

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120. GRIFFITHS ET AL., EUTHANASIA AND LAW, *supra* note 24, at 268.

121. *Id.* at 245–46.

122. *Id.* at 282.

123. *See generally id.* at 267–98.

124. *Id.* at 286–87.

125. *Id.* (emphasis added).

126. *See* U.K. DEP'T OF HEALTH, HAROLD SHIPMAN'S CLINICAL PRACTICE 1974–1998: A CLINICAL AUDIT COMMISSIONED BY THE CHIEF MEDICAL OFFICER 1–2 (2000) (finding that Shipman, who was convicted of murdering fifteen of his patients, had 297 "excess" deaths compared to other similarly situated physicians), *available at*



Griffiths's preferred regime, only professional and civil sanctions would be available as remedies when doctors kill without consent—and even these remedies would be available only if and when doctors kill in the absence of what he calls “normal medical practice”—although Griffiths fails to specify when he thinks killing a patient without consent should be considered “normal.”<sup>127</sup>

Nor does Griffiths fairly make out the case that his proposal would even guarantee better self-reporting: doctors who fail to meet the guidelines for “normal” nonvoluntary killings (whatever those might be) may very well still choose to avoid reporting their activities for fear of professional and civil penalties which, for doctors, can mean the end of their careers and financial security. Indeed, Griffiths himself acknowledges that *any* regime relying on physician self-reporting is “intrinsic[ally] ineffective[].”<sup>128</sup> Simply put, the absence of *criminal* penalties may not suffice to ensure that physicians report all cases of killing without consent; the continued presence of financial and professional consequences may still serve as strong deterrents to full and accurate reporting. Meanwhile, Griffiths's proposal would abjure patient autonomy as the touchstone for when assisted suicide is appropriate, in favor of physicians' quality of life judgments, and radically rewrite the boundary of acceptable Dutch medical practice from voluntary to nonvoluntary euthanasia.

## II. THE OREGON EXPERIENCE: AN “ALL-TOO-CONSCIENTIOUS” STATUTORY REGIME?

Among American jurisdictions, only Oregon has experimented with assisted suicide. Epstein has hailed Oregon's assisted suicide law as “tightly drafted legislation” and an “all-too-conscientious attempt” to avoid cases of abuse, mistake, and pressure.<sup>129</sup> And, Oregon's statute is certainly more refined than the medical guidelines long in force in the Netherlands or the recent Dutch statute. But, Epstein's enthusiastic endorsement is itself subject to question in light of certain deficiencies in both the structure of the Oregon law and its practice in the field.

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<http://www.dh.gov.uk/assetRoot/04/06/50/46/04065046.pdf>; see also James M. Thunder, *Quiet Killings in Medical Facilities: Detection and Prevention*, 18 ISSUES L. & MED. 211, 213 (2003) (noting that, over the last twenty-five years, at least eighteen American health workers suspected of being responsible for approximately 455 “mercy killings” inside medical facilities have been charged with attempted murder, murder or manslaughter, and that twelve have been convicted).

127. GRIFFITHS ET AL., EUTHANASIA AND LAW, *supra* note 24, at 286–87.

128. Compare *id.* at 292, with *id.* at 257.

129. EPSTEIN, *supra* note 27, at 326–27.

*A. An Outline of Oregon's Procedures*

To qualify for assistance in dying under the Oregon Death with Dignity Act (the "Act"), a patient must be "[a]n adult who is capable . . . and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die"; meeting these qualifications allows a patient to make "a written request for medication for the purpose of ending his or her life."<sup>130</sup>

The term "capable" is defined by statute to mean "that in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, psychiatrist or psychologist, a patient has the ability to make and communicate health care decisions to health care providers."<sup>131</sup> A "terminal disease" is defined as "an incurable and irreversible disease that . . . will, within reasonable medical judgment, produce death within six months."<sup>132</sup> Written requests for assisted suicide must be "witnessed by at least two individuals who, in the presence of the patient, attest that to the best of their knowledge and belief the patient is capable, acting voluntarily, and is not being coerced to sign the request."<sup>133</sup>

An attending physician is required, among other things, to "[m]ake the initial determination of whether a patient has a terminal disease, is capable, and has made the request voluntarily," and to refer the patient to a consulting physician for confirmation of all three of these findings.<sup>134</sup> If the attending or consulting physician believes that "a patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment, either physician shall refer the patient for counseling," and no medication to end the patient's life may "be prescribed until the person performing the counseling determines that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment."<sup>135</sup>

Once the medical review process is complete, the attending physician may prescribe life-ending medications.<sup>136</sup> "No less than

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130. OR. REV. STAT. § 127.805(1).

131. *Id.* § 127.800(3).

132. *Id.* § 127.800(12).

133. *Id.* § 127.805(1). One of the witnesses cannot be related to the patient, stand to benefit under the patient's estate or be connected to the medical facility where the patient is being treated. *Id.* § 127.810(2). Nor can the attending physician serve as a witness. *Id.* § 127.810(3). If the patient is a resident in a long-term care facility, one of the witnesses must be an individual designated by the facility that meets qualifications imposed by Oregon's Department of Human Services. *Id.* § 127.810(4).

134. *Id.* § 127.815(a), (d).

135. *Id.* § 127.825.

136. *See id.* § 127.815(l).

fifteen . . . days [must] elapse between the patient's initial oral request and the writing of a prescription"; in addition, forty-eight hours must "elapse between the patient's written request and the writing of a prescription."<sup>137</sup> Doctors who write death-inducing prescriptions in good faith compliance with the Act's requirements are shielded from criminal, civil, and professional sanctions.<sup>138</sup>

Physicians are responsible for maintaining records regarding each act of assisted suicide, including documents reflecting all of the patient's oral and written requests for assistance in dying; the attending and consulting physician's diagnosis, prognosis, and finding that the patient was capable, acting voluntarily, and with full information; and all reports reflecting any counseling that occurred.<sup>139</sup> Oregon's Department of Human Services is charged with reviewing a sample of these records annually.<sup>140</sup>

While perhaps representing a drafting improvement over the Dutch statute, a great many questions might still be asked about how the Oregon law is written and practiced. It is, for example, unclear from the language of the statute whether "terminal" means that the patient is expected to die within six months assuming she is given medical care or assuming she is not.<sup>141</sup> And, approximately 50% of Oregon physicians have acknowledged that they simply are not confident in their own ability to predict whether patients have more or less than six months to live.<sup>142</sup> In point of fact, putatively terminal patients have received lethal prescriptions in Oregon and waited to use them for as long as 466 days—over fifteen months.<sup>143</sup> Although proponents have argued that Oregon's regime helps dying patients avoid unnecessary pain and suffering, Oregon's law (unlike even the Dutch guidelines) nowhere conditions access to assisted suicide on the existence of pain of any kind, let alone pain that cannot be fully treated by readily available medicines.

Because the attending physician under Oregon law is allowed to choose a consulting physician who may be related to the attending doctor or the patient professionally or personally, the consultant is not guaranteed to be free to render a dispassionate judgment (something even Dutch guidelines purport to mandate). Nor does the Oregon statute

137. *Id.* § 127.850.

138. *See id.* § 127.855(1).

139. *Id.* § 127.855.

140. *Id.* § 127.865(1)(a).

141. KEOWN, EEPP, *supra* note 31, at 171.

142. Melinda A. Lee et al., *Legalizing Assisted Suicide—Views of Physicians in Oregon*, 334 NEW ENG. J. MED. 310, 334 (1996).

143. OFFICE OF DISEASE PREVENTION AND EPIDEMIOLOGY, OR. DEP'T OF HUMAN SERVS., FIFTH ANNUAL REPORT ON OREGON'S DEATH WITH DIGNITY ACT 21 tbl.3 (2003), available at <http://www.ohd.hr.state.or.us/chs/pas/year5/02pasrpt.pdf> [hereinafter FIFTH ANNUAL REPORT].

require that either physician have any special expertise; trainees are free to render judgments on whether an illness is "terminal."<sup>144</sup> Thus, while approximately 86% of patients seeking assisted suicide in 2001 suffered from cancer, prescribing physicians were predominately internal medicine and family practitioners (collectively representing 69% of prescribers); oncologists prescribed death-inducing medication in just 25% of assisted suicide cases.<sup>145</sup> Significantly, there is also no requirement that any of the physicians involved review with the patient potential alternatives (for example, hospice or pain killers), or that those with expertise in such areas (for example, pain management specialists) be brought in to review care options that may alleviate the patient's perceived need for assisted suicide.

While Oregon's statute requires that the attending and consulting physicians make a finding that the patient is mentally capable, it does not require any mental health qualifications or expertise of either doctor, again leaving potentially specialized questions regarding the diagnosis of potential psychological disorders (for example, depression) to individuals without any relevant expertise—this despite evidence suggesting that a great many suicides are caused in whole, or part, by clinical depression or mental illness.<sup>146</sup> In fact, 28% of Oregon physicians polled have admitted that they do not feel competent to recognize depression.<sup>147</sup> And, a recent study of depression in cancer patients (one notably not dependant on physicians' self-assessed ability to detect depression) found that oncologists detected the condition in only approximately 13% of patients who described themselves as suffering from moderate to severe levels of depression.<sup>148</sup>

Oregon's statute (again, in contrast to Dutch medical guidelines)

144. See KEOWN, EEPP, *supra* note 31, at 171.

145. OFFICE OF DISEASE PREVENTION AND EPIDEMIOLOGY, OR. DEP'T OF HUMAN SERVS., FOURTH ANNUAL REPORT ON OREGON'S DEATH WITH DIGNITY ACT 9-10 (2002), available at <http://www.ohd.hr.state.or.us/chs/pas/year4/01pasrpt.pdf> [hereinafter FOURTH ANNUAL REPORT]; see also Katrina Hedberg et al., *Legalized Physician-Assisted Suicide in Oregon, 2001*, 346 NEW ENG. J. MED. 450, 451 (2002).

146. See ELI ROBINS, THE FINAL MONTHS: A STUDY OF THE LIVES OF 134 PERSONS WHO COMMITTED SUICIDE 10-12 (1981); ERWIN STENGEL, SUICIDE AND ATTEMPTED SUICIDE 51-53 (1964); B. Barraclough et al., *A Hundred Cases of Suicide: Clinical Aspects*, 125 BRIT. J. PSYCHIATRY 355 (1974); Yeates Conwell & Eric D. Caine, *Rational Suicide and the Right to Die: Reality and Myth*, 325 NEW ENG. J. MED. 1100 (1991); Thomas Grisso & Paul S. Applebaum, *The MacArthur Treatment Competence Study. III: Abilities of Patients to Consent to Psychiatric and Medical Treatments*, 19 LAW & HUM. BEHAV. 149 (1995); Herbert Hendin & Gerald Klerman, *Physician Assisted Suicide: The Dangers of Legalization*, 150 AM. J. PSYCHIATRY 143 (1993); Edwin S. Shneidman, *Rational Suicide and Psychiatric Disorders*, 326 NEW ENG. J. MED. 889 (1992).

147. See Lee et al., *supra* note 142, at 312-13.

148. Steven D. Passik et al., *Oncologists' Recognition of Depression in Their Patients with Cancer*, 16 J. CLINICAL ONCOLOGY 1594, 1597 (1998).

also does not require the presence of a doctor when the patient commits suicide, and between 1998 and 2002 prescribing physicians were absent 66% of the time.<sup>149</sup> Given this fact, there is no guarantee that a doctor will assess the patient's mental condition at the time of death; indeed, "capability" is assessed only once under Oregon's regime, when the prescription is written, on a day that may be weeks, months or perhaps even years removed from the patient's decision to die. The physician's absence also means that reviewing state authorities do "not all have information about what happened when the patient ingested the medication,"<sup>150</sup> including information about what, if any, complications may arise.<sup>151</sup> It also means that the complications themselves may also go unaddressed. A nationwide survey of U.S. oncologists found that as many as 15% of all attempts at physician-assisted suicide are unsuccessful,<sup>152</sup> and data from the Netherlands, noted above, are similar.<sup>153</sup> In Oregon in 2002, thirty-eight patients ingested lethal medications<sup>154</sup> and the time to death after ingestion varied widely: one patient lived for fourteen hours, another lived for nine hours, and a third lived for twelve hours;<sup>155</sup> in at least four cases since 1998, a patient has vomited or expectorated immediately after taking the prescribed medication<sup>156</sup> and patients have lived as long as thirty-seven hours after ingestion.<sup>157</sup>

All of the data that Oregon has collected on completed suicides, moreover, come entirely from the very physicians who participate in the assisted suicide process rather than a more neutral source—and the physicians must report their activities only after the patient is dead.<sup>158</sup> Consequently, Oregon has no way to review individual cases for compliance with its law until after it is too late to prevent any error or abuse. The Oregon Health Division, which is charged with administering the law, has further acknowledged that this statutory

149. FIFTH ANNUAL REPORT, *supra* note 143, at 20 tbl.3.

150. FOURTH ANNUAL REPORT, *supra* note 145, at 8. Other "health care providers" (presumably nurses, but this is not clear from the Oregon report) were present in 52% of 2001 cases, *id.* at 10, and 78% percent of cases in 2002, FIFTH ANNUAL REPORT, *supra* note 143, at 10.

151. FIFTH ANNUAL REPORT, *supra* note 143, at 13, 21 tbl.3 (describing that complications include coughing, vomiting, living for hours or days after consuming lethal medication, and seizures).

152. Ezekiel J. Emanuel et al., *The Practice of Euthanasia and Physician-Assisted Suicide in the United States: Adherence to Proposed Safeguards and Effects on Physicians*, 280 JAMA 507, 509 (1998).

153. See *supra* notes 83–84 and accompanying text.

154. FIFTH ANNUAL REPORT, *supra* note 143, at 4.

155. *Id.* at 13.

156. *Id.* at 21 tbl.3.

157. *Id.*

158. FIRST YEAR'S EXPERIENCE, *supra* note 15, at 2.

arrangement raises "the possibility of physician bias," and means that it "cannot detect or collect data on issues of noncompliance with any accuracy."<sup>159</sup> Additionally, quite unlike the Dutch regime, Oregon does not have any mechanism for surveying doctors confidentially; all reporting is done "on the record."

Without a means of privately asking doctors about their practices, one might question whether we will ever obtain a true and complete picture of the events on the ground in Oregon. And, even if a doctor were actually to take the extraordinary step of turning himself or herself in for having violated the law, Oregon's statute imposes no duty on the health division to investigate or pursue such cases, let alone root them out in the absence of any such self-reports. Thus, while Oregon is often touted as a "laboratory" or an "experiment" for whether assisted suicide can be successfully legalized elsewhere in the United States, Oregon's regulations are crafted in ways that make reliable and relevant data and case descriptions difficult to obtain. Given this, it is unclear whether and to what extent Oregon's experiment, at least as currently structured, will ever be able to provide the sort of guidance needed and wanted by other jurisdictions considering whether to follow Oregon's lead.

Separately, it is also rather remarkable that, while physicians in Oregon are held to a standard of professional competence in administering all other treatments they provide, the Oregon assisted suicide statute creates an entirely different regime when it comes to administering this "treatment," specifically and uniquely immunizing doctors from criminal prosecution, civil liability or even professional discipline for any actions they take in assisting a suicide, as long as they act in "good faith."<sup>160</sup> Thus, while a doctor may be found liable for mere negligence in any other operation or procedure, there is absolutely no recourse for family members even when a doctor kills a patient on the basis of gross negligence by misdiagnosing the patient as terminal or by misassessing the patient as competent.<sup>161</sup>

### B. Oregon's Practice of Assisted Suicide

According to the limited, nonconfidential, and self-reported data available from Oregon physicians, in the first five years of implementation (1998 to 2002), a total of 198 lethal prescriptions were written, and the number of prescriptions increased significantly each

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159. *Id.* at 9; see also FIFTH ANNUAL REPORT, *supra* note 143, at 14 ("[O]ur numbers . . . do not include patients and physicians who may act outside the law.").

160. Kathleen Foley & Herbert Hendin, *The Oregon Experiment, in THE CASE AGAINST ASSISTED SUICIDE*, *supra* note 32, at 144, 159 [hereinafter Foley & Hendin, *The Oregon Experiment*].

161. See *id.*

year: from 1999 to 2002, the overall number of lethal dosages prescribed rose 76%.<sup>162</sup> Many of these prescriptions appear to have been written, moreover, by a very small handful of politically active physicians. In its first-year questionnaire, the Oregon Health Division specifically asked physicians whether the patients they helped kill were referred to them by advocacy organizations, such as Compassion in Dying or the Hemlock Society, but the state inexplicably declined to publish the answer.<sup>163</sup> However, it was later revealed by the media that:

[T]he first fifteen assisted suicide cases reported involved fourteen different doctors. Compassion in Dying, an out-of-state assisted suicide group that moved to Oregon just weeks after the law was implemented, claimed eleven of the fourteen doctors were theirs. . . . [A]t least one additional case came through the Hemlock Society. So at least twelve of fourteen, or 86 percent, of the assisted suicide cases were handled by groups politically active in promoting legalization of assisted suicide. This unsettling fact was the one held back, suggesting to many that OHD had become selective in its silence . . . .<sup>164</sup>

Just as it is inexplicable that Oregon would suppress results from its first-year questionnaire, it is equally troubling that the state has chosen to drop this question from each of its subsequent annual surveys, and to do so without public mention (let alone defense) of its decision—an incident reminiscent of the Dutch Surveys authors' decision to stop reporting on the incidence of euthanasia by omission after 1990.<sup>165</sup>

Of the 198 patients who have received prescriptions for lethal medication, 129 (or 65%) have used them to date.<sup>166</sup> Though these figures provide a small sample, the data do reveal certain correlations, reflected in Table 4.

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162. FIFTH ANNUAL REPORT, *supra* note 143, at 4.

163. N. Gregory Hamilton, *Oregon's Culture of Silence*, in THE CASE AGAINST ASSISTED SUICIDE, *supra* note 32, at 175, 180–81; *see also* Foley & Hendin, *The Oregon Experiment*, *supra* note 160, at 144–45.

164. Hamilton, *supra* note 163, at 180–81 (footnote omitted); *see also* Foley & Hendin, *The Oregon Experiment*, *supra* note 160, at 145.

165. *See supra* notes 92–95 and accompanying text.

166. *See* FIFTH ANNUAL REPORT, *supra* note 143, at 11.

Table 4  
Oregon Assisted Suicide Demographics: 1998–2002<sup>167</sup>

Year	1998	1999	2000	2001	2002
Total deaths	16	27	27	21	38
% change from prior year	–	+69%	0%	–22%	+81%
Median age	69	71	69	68	69
Age range	25–94	31–87	51–93	51–87	38–92
% male	53	59	44	38	71
% female	47	41	56	62	29
% married	13	44	67	38	53
% divorced	27	30	11	33	24
% widowed	33	22	22	24	18

As shown in Table 4, the number of deaths in 1999 appeared to increase greatly over 1998, although a firm comparison cannot be drawn because the law was not in effect for all of 1998. While the number of deaths in 2001 declined 22% compared to 2000, this represented a difference of just six persons. Also, the total number of lethal prescriptions increased in 2001,<sup>168</sup> and two of these prescriptions were apparently filled in 2002,<sup>169</sup> when total deaths increased 81% over 2001, to thirty-eight persons, by far the largest number of deaths in any year since the Oregon law went into effect, and representing 41% more deaths than occurred in 1999, the first full year of legalization.

The median age for assisted suicide seems to be hovering around seventy, although patients have sought assisted suicide at much younger ages—including as young as twenty-five-years-old in 1998, thirty-one-years-old in 1999, and thirty-eight-years-old in 2002. Surprisingly, no special examination has been made into these cases, although it would clearly be useful to have more information about the physical and mental

167. See FIRST YEAR'S EXPERIENCE, *supra* note 15, at 13 tbl.1, 15 tbl.3; CTR. FOR DISEASE PREVENTION AND EPIDEMIOLOGY, OR. DEP'T OF HUMAN SERVS., OREGON'S DEATH WITH DIGNITY ACT: THE SECOND YEAR'S EXPERIENCE tbl.1 (2000), available at <http://www.ohd.hr.state.or.us/pas/year2/99pasrpt.pdf> [hereinafter SECOND YEAR'S EXPERIENCE]; CTR. FOR DISEASE PREVENTION AND EPIDEMIOLOGY, OR. DEP'T OF HUMAN SERVS., OREGON'S DEATH WITH DIGNITY ACT: THREE YEARS OF LEGALIZED PHYSICIAN-ASSISTED SUICIDE 16 tbl.1 (2001), available at <http://www.ohd.hr.state.or.us/pas/year3/00pasrpt.pdf> [hereinafter THREE YEARS OF LEGALIZED PHYSICIAN-ASSISTED SUICIDE]; FOURTH ANNUAL REPORT, *supra* note 145, at 14 tbl.1; FIFTH ANNUAL REPORT, *supra* note 143, at 18 tbl.1.

168. There were forty-four prescriptions for lethal doses of medication in 2001, compared to thirty-nine in 2000, thirty-three in 1999, and twenty-four in 1998. FIFTH ANNUAL REPORT, *supra* note 143, at 4.

169. See *id.*



condition of such young persons committing suicide.

There also appears to be a persistent correlation between assisted suicide and divorce. As shown in Table 5, in each year except 2000, divorced persons have represented over 24% of all assisted suicides in Oregon, well in excess of their representation in the population of all deaths due to similar underlying illnesses:

Table 5  
Relative Incidence of Assisted Suicide:  
Married vs. Divorced Patients: 1998-2002<sup>170</sup>

	Married	Divorced
Assisted suicides	47%	25%
Oregon deaths due to same diseases	49%	18%
Estimated proportion of assisted suicide deaths per 10,000 Oregon deaths	29.2	54.5
Relative risk	Reference	1.9

As reflected in Table 5, divorced persons constituted 25% of all assisted suicides in 1998 through 2002, but 18% of all deaths in Oregon due to similar underlying maladies as those afflicting the assisted suicide patients. Meanwhile, married persons constituted 47% of all assisted suicides, but 49% of all deaths due to similar illnesses. These data suggest that divorced persons are nearly twice as likely to commit assisted suicide than similarly situated married patients. And, this persistent correlation between divorce and assisted suicide serves to underscore the question whether other things besides terminal illness (for example, social isolation or depression) may drive the decision to seek death.

Of potential concern as well, data show that Oregon physicians are increasingly unlikely to refer their patients for psychiatric or psychological consultation before declaring them competent to make the decision to die, despite the evidence consistently linking suicidal impulses to depression and psychological illness.<sup>171</sup> Physicians referred patients in just 13% of cases in 2002 (five of thirty-eight), compared with 14% of cases in 2001 (three of twenty-one), 19% of cases in 2000 (five of twenty-seven), 37% of cases in 1999 (ten of twenty-seven), and 31% of cases in 1998 (five of sixteen).<sup>172</sup> Even when evaluations are

170. See *id.* at 19 tbl.2.

171. See *supra* note 146 and accompanying text.

172. See SECOND YEAR'S EXPERIENCE, *supra* note 167, at tbl.2; THREE YEARS OF LEGALIZED PHYSICIAN-ASSISTED SUICIDE, *supra* note 167, at 19 tbl.3; FOURTH

done, given the fact that many patients are apparently being shepherded to doctors affiliated with advocacy groups that favor assisted suicide, the possibility exists that "a bias may be introduced into the competency evaluation. On balance, the psychiatrists' conclusions may reflect personal values and beliefs more than psychiatric expertise."<sup>173</sup>

Further, physicians in the Netherlands often have longstanding relationships with patients; as a result, they arguably have some basis for assessing the "patient's concerns, values, and pressures that may be prompting the . . . request [for assistance in dying]."<sup>174</sup> By contrast, the American Medical Association (AMA) has opposed the legalization of assisted suicide in part because American physicians, increasingly employees or agents of large corporate health maintenance organizations, lack such long-term relationships with their patients: in the AMA's view, American "physicians rarely have the depth of knowledge about their patients that would be necessary for an appropriate evaluation of the patient's [assisted suicide] request."<sup>175</sup> And, there is data from Oregon that speaks to this concern. In 2002, the median length of the relationship between patients seeking assisted suicide and the physicians who agreed to help them was just eleven weeks, and in some cases was not even a matter of weeks, but of days or hours.<sup>176</sup>

Table 6  
Duration of Patient-Physician Relationship<sup>177</sup>  
(weeks)

	1998	1999	2000	2001	2002	Total
Median	11	22	8	14	11	13
Range	2-540	2-817	1-851	0-500	0-379	0-851

While Oregon reports the duration of the patient-physician relationship, it fails to collect any similar data regarding the length, if

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ANNUAL REPORT, *supra* note 145, at 16 tbl.3; FIFTH ANNUAL REPORT, *supra* note 143, at 20 tbl.3.

173. Linda Ganzini et al., *Attitudes of Oregon Psychiatrists Toward Physician-Assisted Suicide*, 153 AM. J. PSYCHIATRY 1469, 1474 (1996) [hereinafter Ganzini et al., *Attitudes*].

174. Council on Ethical and Judicial Affairs, Am. Med. Ass'n, *Decisions Near the End of Life*, 267 JAMA 2229, 2232 (1992).

175. *Id.*

176. FIFTH ANNUAL REPORT, *supra* note 143, at 21 tbl.3.

177. See SECOND YEAR'S EXPERIENCE, *supra* note 167, at tbl.2; THREE YEARS OF LEGALIZED PHYSICIAN-ASSISTED SUICIDE, *supra* note 167, at 20 tbl.3; FOURTH ANNUAL REPORT, *supra* note 145, at 17 tbl.3; FIFTH ANNUAL REPORT, *supra* note 143, at 21 tbl.3.

any, of the relationship between the patient and the psychiatrist or psychologist who may be called in to assess competency. Given that such a consultation is entirely optional under Oregon's law, it seems likely that these relationships are extremely short, often just a single visit—this despite the fact that a survey of Oregon psychiatrists found that only 6% of the psychiatrists surveyed said they were very confident that they could determine whether a patient is competent to commit suicide without a long-term doctor-patient relationship.<sup>178</sup>

Finally, while loss of autonomy topped the list of reasons proffered by patients seeking assisted suicide (a concern in 85% of cases between 1998 and 2002), many other reasons were also given, as shown in Table 7.

Table 7  
Reasons Given by Oregon Patients  
Seeking Assisted Suicide<sup>179</sup>

	1998	1999	2000	2001	2002	Total
Financial implications of treatment	0	5%	4%	6%	3%	2%
Inadequate pain control	7%	53%	30%	6%	26%	22%
Burden on family, friends, and caregivers	13%	47%	63%	24%	37%	35%
Losing control of bodily functions	53%	68%	78%	53%	47%	58%
Decreasing ability to participate in activities that make life enjoyable	67%	47%	78%	76%	84%	79%
Losing autonomy	80%	63%	93%	94%	84%	85%

Again, this data comes from after the fact self-reporting performed by the attending physicians, not a more objective source. Even so, the data reveal that 22% of cases between 1998 and 2002 were motivated in part by inadequate pain control, which, taken together with the evidence that many Oregon doctors lack sufficient training in palliative care,<sup>180</sup> suggest that suicide may have been substituted for adequate care in some cases. In contrast to the official state numbers, moreover, a 1999 survey of Oregon doctors who received requests for assisted suicide

178. Ganzini et al., *Attitudes*, *supra* note 173, at 1473.

179. See FIRST YEAR'S EXPERIENCE, *supra* note 15, at 16 tbl.3; SECOND YEAR'S EXPERIENCE, *supra* note 167, at tbl.4; THREE YEARS OF LEGALIZED PHYSICIAN-ASSISTED SUICIDE, *supra* note 167, at 18 tbl.3; FOURTH ANNUAL REPORT, *supra* note 145, at 16 tbl.3; FIFTH ANNUAL REPORT, *supra* note 143, at 20 tbl.3.

180. See *supra* notes 105–07 and accompanying text.

revealed that 43% of patients requesting assisted suicide cited pain as an important reason motivating their request; the same survey shows that physicians recommended a palliative care consultation in just 13% of cases.<sup>181</sup> Also of concern is the role the cost of care may play in the decision to die and the possibility that requesting continued expensive end-of-life care may be seen as selfish or extravagant when assisted suicide is available: 35% of cases involved patients who sought to kill themselves because they were worried about becoming a "burden" on their family and friends; even more pointedly, 2% of cases were expressly motivated by concerns over the financial implications of continued treatment (this in one of the nation's most affluent states where one would expect financial concerns to be less pressing than in other jurisdictions where assisted suicide might be legalized).

### C. "Helen" and Ms. Cheney

Kathleen Foley and Herbert Hendin have investigated in detail the case of "Helen" (last name unknown), the first person to obtain assisted suicide under Oregon's regime,<sup>182</sup> and of Ms. Kate Cheney, a more recent applicant.<sup>183</sup> Foley and Hendin's findings offer vivid case studies illustrating some of the questions and concerns I have raised regarding Oregon procedures and practices. Helen was a breast cancer patient in her mid-eighties when the Oregon law went into effect.<sup>184</sup> Helen's regular physician refused to assist in her suicide (for unknown reasons); a second doctor was consulted but also refused, on the stated ground that Helen was depressed.<sup>185</sup> At that point, Helen's husband called Compassion in Dying.<sup>186</sup> The medical director of the group spoke with Helen and later explained that Helen was "frustrated and crying because she felt powerless."<sup>187</sup> Helen was not, however, bedridden or in great pain, but enjoyed aerobic exercises until two weeks before contacting Compassion in Dying, and apparently, she was still performing housework.<sup>188</sup> The Compassion in Dying employee recommended a physician to Helen.<sup>189</sup> That physician, in turn, referred Helen to a specialist (whose specialty is unknown), as well as to a

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181. Linda Ganzini et al., *Physicians' Experiences with the Oregon Death with Dignity Act*, 342 NEW ENG. J. MED. 557, 559-60 (2000).

182. See Foley & Hendin, *The Oregon Experiment*, *supra* note 160, at 146-50.

183. See *id.* at 156-58.

184. *Id.* at 146.

185. See *id.*

186. See *id.*

187. See *id.*

188. See *id.*

189. See *id.* at 147.

psychiatrist who met Helen only once.<sup>190</sup> A lethal prescription was then supplied.<sup>191</sup>

After Helen died, the prescribing physician was quoted as saying that he regrets that he did not contact Helen's regular physician, as well as that he had only a "very cursory" discussion with the second doctor Helen approached: "[h]ad I felt there was a disagreement among the physicians about my patient's eligibility"—and no doubt there was—"I would not have written the prescription."<sup>192</sup> The prescribing physician further explained that the thought of Helen dying by lethal medication was "almost too much to bear," but that he felt compelled to proceed because he feared how Helen's family might view him otherwise: "I found even worse the thought of disappointing this family. If I backed out, they'd feel about me the way they had [felt] about their previous doctor, that I had strung them along, and in a way, insulted them."<sup>193</sup> An *Oregonian* newspaper reporter who interviewed the family was told that Helen was worried that further care would threaten her financial assets.<sup>194</sup>

When Cheney, an eighty-five-year-old widow, more recently sought a lethal prescription from a physician, her daughter Erika, a retired nurse, accompanied her.<sup>195</sup> Erika described the doctor as "dismissive," so she and her mother requested and received a referral to another physician in the same health maintenance organization (HMO) (in this case, Kaiser Permanente).<sup>196</sup> The second doctor arranged for a psychiatric evaluation; the psychiatrist found that Cheney "did 'not seem to be explicitly pushing for assisted suicide,' and lacked 'the very high level of capacity to weigh options about it.'"<sup>197</sup> The psychiatrist noted that Cheney accepted his assessment when he presented it, but that the daughter became angry.<sup>198</sup>

The HMO then, apparently at Erika's (not Cheney's) request, suggested that the family obtain a second psychiatric evaluation, and agreed to pay for it.<sup>199</sup> The second psychologist found that Erika might have been "somewhat coercive," but concluded nonetheless that Cheney was competent to make the decision to die.<sup>200</sup> Cheney thereafter received a lethal prescription and the drugs were placed under her

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190. *See id.*

191. *See id.*

192. *Id.* at 149.

193. Peter Reagan, *Helen*, 353 LANCET 1265, 1266 (1999).

194. *See* Foley & Hendin, *The Oregon Experiment*, *supra* note 160, at 169.

195. *See id.* at 156.

196. *See id.*

197. *Id.*

198. *See id.*

199. *See id.*

200. *Id.*

daughter's care.<sup>201</sup> As time went by, Cheney ate poorly, became weaker, and to afford Erika and her husband a respite, went to a nursing home on a temporary basis to regain her strength.<sup>202</sup> On the day she returned home, Cheney said "that something had to be done given her declining health," that she did not want to go into a nursing home again, and that she would like to use the lethal pills in Erika's custody.<sup>203</sup> After the daughter consented, Cheney took the pills and died.<sup>204</sup>

Helen and Cheney's cases encapsulate and illustrate some of the many difficult questions about Oregon's assisted suicide regime alluded to by the data reviewed above: what is the role of depression, as opposed to terminal illness, actually playing in patient decisions to die in Oregon? Are alternative options, including treatment for depression, being fully presented (or presented at all)? Are the doctors prescribing death even knowledgeable about the alternatives that exist? To what extent are family members unduly influencing patient choices and physician evaluations? What would have happened if family members in each case had argued *against* the request to die and offered care? Should patients be allowed to "shop" around for physicians and psychologists who will find them competent? Do psychologists and physicians have an obligation to do more than a cursory examination? Should they consult the patient's primary care providers and other doctors or psychologists who may have refused prior requests for lethal medication by the patient? Would Cheney's HMO have offered to pay for a second opinion if the first psychologist had found Cheney competent? Do HMOs have a conflict of interest—given that assisted suicide is unquestionably cheaper than continuing care—that may provide an incentive for them to encourage patients to seek death?

### III. LEGALIZATION AND OTHER UNINTENDED CONSEQUENCES

Whether the evidence from the Netherlands and Oregon leaves you with brimming confidence or deep concern that legalization will be attended by additional nonconsensual killings due to abuse, mistake, and coercion, that does not entirely end the conversation about the potential "costs" associated with legalization. It bears considering whether yet other unintended costs might also attend legalization including, for example, the possibility of discrimination against minority populations like the elderly, African Americans, and the poor or disabled. Concerned about what might happen to them, many elderly Dutch patients have actually taken to insisting on written contracts assuring

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201. *See id.*

202. *Id.* at 157.

203. *Id.*

204. *See id.*

against nonvoluntary euthanasia before they will admit themselves to hospitals.<sup>205</sup> And, poll after poll suggests that ethnic minorities in the United States are relatively more troubled by the prospect of legalized euthanasia and its impact on them than their white counterparts. Indeed, it is an unanswered, but interesting, question whether Oregon's highly homogenous population (approximately 90% white)<sup>206</sup> contributed in any way to its adoption of the first-ever U.S. law allowing assisted suicide.

The *Detroit Free Press* has found, for example, that while 53% of whites sampled in Michigan could envision requesting assistance in suicide, only 22% of blacks could.<sup>207</sup> A poll in Ohio revealed that, while roughly half those sampled favored legalization of assisted suicide, those most likely to favor the practice were those with higher income and education levels, and young adults, and those most likely to oppose the practice were black, people sixty-five and older, and those with low levels of income and education.<sup>208</sup>

Empirical evidence concerning the medical treatment presently provided to minority groups suggests that their relative unease with the legalization of assisted suicide may not be irrational. The *New England Journal of Medicine* has reported that female, African American, elderly, and Hispanic cancer patients are all less likely than similarly situated nonminorities to receive adequate pain-relieving treatment that may obviate a patient's perceived need to resort to assistance in suicide or euthanasia.<sup>209</sup> Indeed, minority cancer patients are fully three times less likely than nonminority patients to receive adequate palliative care.<sup>210</sup> Minorities also receive poorer AIDS treatment: only 48% of blacks receive medicines designed to slow the progress of AIDS, compared to 63% of whites; while 82% of whites receive effective treatments for preventing AIDS-related pneumonia, only 58% of black patients receive similar attention.<sup>211</sup> African Americans have higher mortality rates than whites across disease categories and recent declines in breast cancer mortality rates have been enjoyed among white, but not

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205. See H.L. REPORT, *supra* note 64, at 66.

206. See U.S. CENSUS BUREAU, STATISTICAL ABSTRACT OF THE UNITED STATES: 2001, at 27 (121st ed. 2001).

207. See Joseph P. Shapiro & David Bowermaster, *Death on Trial: The Case of Dr. Kevorkian Obscures Critical Issues—and Dangers*, U.S. NEWS & WORLD REP., Apr. 25, 1994, at 31, 39.

208. See *Ohioans Divided on Doctor Assisted Suicide Issue*, UPI, June 28, 1993 (on file with author).

209. See Charles S. Cleeland et al., *Pain and Its Treatment in Outpatients with Metastatic Cancer*, 330 NEW ENG. J. MED. 592, 595 (1994).

210. See *id.*

211. See Richard D. Moore et al., *Racial Differences in the Use of Drug Therapy for HIV Disease in an Urban Community*, 330 NEW ENG. J. MED. 763, 763 (1994).

black, women.<sup>212</sup> African Americans have fewer physician visits and receive different treatment than whites even within the federally funded Medicare and Veteran's Affairs programs.<sup>213</sup> African Americans are also 3.5 times more likely than whites to have one or more of their limbs amputated, even though diabetes, the most common reason for amputation, is only 1.7 times more common among blacks than whites.<sup>214</sup>

In the events leading up to the consideration of the failed California voter referendum on assisted suicide in 1992, advocates of the measure turned to the American Bar Association (ABA) for support. The ABA, however, ultimately recommended against legalization and did so specifically on the ground that "[t]he proposed right to choose aid-in-dying freely and without undue influence is illusory and, indeed, dangerous for the thousands of Americans who have no or inadequate access to quality health and long-term care services."<sup>215</sup> The Canadian Medical Association, the British Medical Association, the World Medical Association, the American Hospital Association, and the American Nurses Association have all argued against legalizing euthanasia on similar grounds.<sup>216</sup>

The State of New York convened a task force composed of twenty-four members representing a wide variety of ethical, philosophical, and religious views and asked the task force to consider whether the state should drop or revise its laws banning assisted suicide; the commission

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212. Patricia A. King & Leslie E. Wolf, *Lessons for Physician-Assisted Suicide from the African-American Experience*, in *PHYSICIAN ASSISTED SUICIDE: EXPANDING THE DEBATE* 91, 101 (Margaret P. Battin et al. eds., 1998) [hereinafter *EXPANDING THE DEBATE*].

213. *See id.*

214. *See id.*

215. ABA Comm'n on Legal Problems of the Elderly, *ABA Memorandum in Opposition to Resolution No. 8 on Voluntary Aid in Dying*, 8 *ISSUES L. & MED.* 117, 120 (1992) (emphasis omitted). "The lack of access to or the financial burdens of health care hardly permit voluntary choice for many. What may be voluntary in Beverly Hills is not likely to be voluntary in Watts. Our national health care problem should be our priority—not endorsement of euthanasia." *Id.* at 118.

216. *See* Brief of Am. Med. Ass'n, Am. Nurses Ass'n & Am. Psychiatric Ass'n, et al. as Amici Curiae in Support of Petitioners, *Glucksberg* (No. 96-110), available at 1996 WL 656263; Brief Amicus Curiae of Am. Hosp. Ass'n in Support of Petitioners, *Glucksberg* (No. 96-110) & *Quill* (No. 96-1858), available at 1996 WL 656278; Can. Med. Ass'n, CMA Policy, Euthanasia and Assisted Suicide (1998), available at [http://www.cma.ca/index.cfm/ci\\_id/3214/la\\_id/1.htm](http://www.cma.ca/index.cfm/ci_id/3214/la_id/1.htm); Med. Ethics Dep't, Brit. Med. Ass'n, Euthanasia & Physician Assisted Suicide: Do the Moral Arguments Differ? (Apr. 1998), available at <http://www.bma.org.uk/ap.nsf/Content/Euthanasia+and+physician+assisted+suicide:+Do+the+moral+arguments+differ%3F>; World Med. Ass'n, Policy, World Medical Association Statement on Physician-Assisted Suicide (Sept. 1992), available at <http://www.wma.net/e/policy/p13.htm>.



returned with a lengthy report, published in 1994, that unanimously favored retaining existing law.<sup>217</sup> The New York task force recommended against legalization in part because it would, in the commission's words, impose severe risks on "the poor, minorities, and those who are least educated and least empowered."<sup>218</sup> "Officially sanctioning [euthanasia] might also provide an excuse for those wanting to spend less money and effort to treat severely and terminally ill patients, such as patients with acquired immunodeficiency syndrome (AIDS)."<sup>219</sup> Even those task force members who thought euthanasia was justified in some instances concluded that, weighing the costs and benefits, continued criminalization would: "[C]urtail[] the autonomy of patients in a very small number of cases when assisted suicide is a compelling and justifiable response, [but would] preserve[] the autonomy and well-being of many others. It [would] also prevent[] the widespread abuses that would be likely to occur if assisted suicide were legalized."<sup>220</sup>

Michigan appointed a similar commission to study the assisted suicide issue after Kevorkian brought attention to the subject there.<sup>221</sup> While the commission was unable to achieve a unanimous judgment, those who concluded that euthanasia should not be legalized focused specifically on the dangers of "social biases."<sup>222</sup> Although "[p]roponents of assisted suicide would . . . point out that the criteria for allowing assisted suicide should be blind to the factors of age or disability," commission members argued that: "[t]o suggest that legalizing assisted suicide will not continue to reinforce negative stereotypes and prejudices against [the] disabl[ed] . . . is to ignore the practical realities of how, and for whom, assisted suicide would be applied."<sup>223</sup>

The British House of Lords Committee on Medical Ethics, after lengthy hearings, reached much the same conclusion, recommending against legalization out of

concern[] that vulnerable people—the elderly, lonely, sick or distressed—would feel pressure, whether real or imagined, to request early death. . . . [W]e believe that the message which society sends to vulnerable and disadvantaged people should

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217. N.Y. STATE TASK FORCE ON LIFE & THE LAW, *supra* note 90, at vii-ix.

218. *Id.* at 125.

219. *Id.* at 96.

220. *Id.* at 141.

221. See MICH. COMM'N ON DEATH & DYING, FINAL REPORT OF THE MICHIGAN COMMISSION ON DEATH AND DYING (1994).

222. See *id.* at 5-7.

223. *Id.* at 6.

not, however obliquely, encourage them to seek death, but should assure them of our care and support in life.<sup>224</sup>

Because normalizing assisted suicide and euthanasia would represent such a sea change in our end-of-life laws and ethics, it would undoubtedly carry with it other consequences for medicine, law, and social norms that cannot now be predicted or foreseen. Still, we might ask, what glimmers can we make out, if only barely, on the horizon?

By way of example, as a cheaper and easier option (killing) becomes available as a legitimate medical response to terminal illness or grave physical suffering, might it create disincentives to the development and dissemination of other more expensive end-of-life options? A 1988 study strongly suggested that physician incompetence and the lack of adequate palliative medicines in the Netherlands has, in fact, contributed to the number of requests made for assisted suicide and euthanasia in that country: more than 50% of Dutch cancer patients surveyed suffered treatable pain unnecessarily, and 56% of Dutch physician practitioners were found to be inadequately trained in pain relief techniques.<sup>225</sup> Another study conducted under the auspices of the U.S. Department of Health and Human Services similarly concluded that:

Patients with cancer often have pain from more than one source, but in up to 90 percent of patients the pain can be controlled by relatively simple means. Nevertheless, undertreatment of cancer pain is common because of clinicians' inadequate knowledge of effective assessment and management practices, negative attitudes of patients and clinicians toward the use of drugs for the relief of pain, and a variety of problems related to reimbursement for effective pain management.<sup>226</sup>

Providing assisted suicide and euthanasia is a cheap means of responding to patients suffering grave pain—cheaper surely than

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224. H.L. REPORT, *supra* note 64, at 49. During the brief experiment with legalization in the Northern Territory of Australia, a consultant was commissioned by the government to explain its goals and operation to Aboriginal communities. See John Finnis, Euthanasia, Morality, and Law, Comments at the Fritz B. Burns Lecture (Nov. 22, 1996), in 31 LOY. L.A. L. REV. 1123, 1144 n.75 (1998). Despite his initial support for the law, the deep fear Aboriginal communities expressed about the law's implications for them led the consultant to advise the Northern Territory legislature to repeal the statute. See *id.* (referring to unpublished reports on file with John Finnis).

225. See H.L. REPORT, *supra* note 64, at 67.

226. Ada Jacox et al., *New Clinical-Practice Guidelines for the Management of Pain in Patients with Cancer*, 330 NEW ENG. J. MED. 651, 651 (1994).

guaranteeing the care, attention, and pain medication required for some patients to die in comfort. Accordingly, it is only reasonable to ask whether the recognition of killing as a valid medical response to patient discomfort might create disincentives not just to the development of new palliative treatments, but also to the full dissemination of nursing and hospice care as well as existing and readily available pain suppressants that can prevent suffering and the perceived need for assistance in dying. Griffiths, while defending the Dutch euthanasia regime and advocating its extension to nonvoluntary killings, has expressly acknowledged that "there are occasional indications" that economic considerations do play a role in the administration of assisted suicide in the Netherlands, noting that "some 12% of the doctors and 15% of the prosecuting officials interviewed [in 1995] expect[ed] that drastic budget-cutting in the health-care system could lead to increased pressure on doctors to engage in life-shortening practices."<sup>227</sup> And these findings come in a society where, quite unlike America, virtually everyone is guaranteed medical insurance.<sup>228</sup>

We may see in the case of Cheney what may, in this respect, be a glimpse of the future for American patients—even ones with medical insurance. The HMO in her case was quite willing to pay (at the daughter's urging) for a second opinion after the first psychologist refused to certify Cheney for death; subsequently, it agreed to allow the assisted suicide to proceed despite evidence of coercion and patient incompetence; and at no point did the HMO intervene to offer continued psychiatric counseling or a palliative care consultation.<sup>229</sup> More recently, the very same HMO has even solicited its doctors to participate in assisted suicide.<sup>230</sup> A Kaiser executive e-mailed more than 800 Kaiser doctors asking them to "'act as Attending Physician under the [assisted suicide] law for YOUR patients' and [soliciting doctors] 'willing to act as 'Attending Physician under the law for members who ARE NOT your patients' to contact 'Marcia L. Liberson or Robert H. Richardson, MD, KPNW Ethics Services.'"<sup>231</sup> As one observer has noted, "Kaiser is apparently willing to permit its doctors to write lethal prescriptions [even] for patients [within Kaiser's HMO system whom] they have not treated."<sup>232</sup>

What others have left implicit, or perhaps chosen to turn a blind eye to, Derek Humphry, cofounder of the Hemlock Society, an assisted

227. GRIFFITHS ET AL., EUTHANASIA AND LAW, *supra* note 24, at 304 n.5.

228. *See id.* at 31 (describing the Dutch health care system).

229. Foley & Hendin, *The Oregon Experiment*, *supra* note 160, at 156.

230. *See* Wesley J. Smith, *Doctors of Death: Kaiser Solicits Its Doctors to Kill*, NAT'L REV. ONLINE (Aug. 19, 2002), at <http://www.nationalreview.com/comment/comment-smith081902.asp>.

231. *Id.*

232. *Id.*

suicide advocacy organization, has made remarkably explicit, candidly acknowledging that money is an “‘unspoken argument’” in favor of his position: “‘the hastened demise of people with only a short time to [live] would free resources for others,’” an amount Humphry estimates could run into the “‘hundreds of billions of dollars.’”<sup>233</sup>

Even overlooking the economic forces that come into play if we treat assisted suicide and euthanasia as legitimate forms of medical treatment, we cannot ignore the possibility that we may also wind up establishing a new standard of care—imposing, in essence, a professional *duty* on physicians to offer to “treat” patients with assisted suicide under certain circumstances, perhaps even opening medical care professionals to suits in negligence by families upset that their relatives suffered needlessly because a doctor or nurse did *not* advocate their death. Far-fetched as this may seem today, some advocates of legalization are already openly discussing putative professional and legal “duties” along just these lines.<sup>234</sup>

More modestly, we might also ask whether legalization would foster a culture in which physicians at least feel freer to disregard patient wishes for what doctors may perceive as futile or unduly expensive care. Certainly such a result would *harm*, not help, the objective of patient autonomy that many assisted suicide advocates claim as their goal. But, it is a possibility that cannot be considered implausible or remote in an environment where some, like Griffiths and the Dutch government itself, have expressly defended, and even advocated, the decriminalization of *nonvoluntary* killings.<sup>235</sup>

Indeed, at least one U.S. court has already endorsed the notion that physicians may override a patient’s autonomous desire for treatment. In April of 1995, a Massachusetts court ruled “that a hospital and its doctors need not provide [life-sustaining] care they deem futile,” even if the patient expressly requests it.<sup>236</sup> The case involved an elderly woman, Mrs. Catherine Gilgunn, who became comatose after suffering irreversible brain damage.<sup>237</sup> Gilgunn’s daughter instructed the hospital that her mother wished everything medically possible be done for her should she become incompetent.<sup>238</sup> The hospital, however, ignored the

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233. *Id.* (emphasis added).

234. *See, e.g.,* GRIFFITHS ET AL., EUTHANASIA AND LAW, *supra* note 24, at 285–92; Frances M. Kamm, *Physician-Assisted Suicide, Euthanasia, and Intending Death*, in EXPANDING THE DEBATE, *supra* note 212, at 28, 35–36 (stating that a doctor has a “duty to relieve physical suffering” and provide a requested legal dose as well as kill); Patricia S. Mann, *Meanings of Death*, in EXPANDING THE DEBATE, *supra* note 212, at 11, 21–22.

235. *See supra* Part I.C.

236. Gina Kolata, *Court Ruling Limits Rights of Patients: Care Deemed Futile May Be Withheld*, N.Y. TIMES, Apr. 22, 1995, § 1, at 6.

237. *See id.*

238. *See id.*

daughter's instructions and refused to place Gilgunn on a respirator or provide cardiopulmonary resuscitation.<sup>239</sup> The lawyer defending the hospital provided his forthright assessment of the ruling: the court's "real point," he said, was that, "physicians can't be required to do things that they feel would be inappropriate and harmful to the patient"—regardless of how the patient herself "feels" (that is, instructs her fiduciary caregiver).<sup>240</sup>

Patricia Mann, who, notably, takes no position in the assisted suicide debate, describes in vivid detail some of the cultural consequences that a shift to legalization might entail for the medical profession:

[M]any doctors will adjust their practices, and gradually their values . . . . Insofar as assisted suicide is a cost-efficient means of death, doctors are . . . likely to be rewarded by healthcare companies for participating in it. As institutional expectations and rewards increasingly favor assisted suicide, expectations and rewards within the medical profession itself will gradually shift to reflect this. Medical students will learn about assisted suicide as an important patient option from the beginning of their training. We may expect that a growing proportion of doctors will find themselves sympathetic to the practice, and will find themselves comfortable with recommending it to their patients.<sup>241</sup>

But, as Mann notes, the medical profession would not be the only one affected:

Family members may want a loved one to remain alive as long as possible, while also harboring secret desires to be done with this painful process. Many people today are ashamed of such secret desires . . . . But if assisted suicide becomes legal, such desires will cease to be wrongful in such an obvious way. If patients themselves may decide to put an end to this painful process of dying, then it is not blameworthy for relatives of such a patient to inquire whether he or she may be thinking along these lines, and to offer sympathetic support for the idea.

. . . Once assisted suicide ceases to be illegal, its many advantages to busy relatives will become readily apparent. More than merely an acceptable form of ending, relatives and

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239. *See id.*

240. *Id.*

241. Mann, *supra* note 234, at 21.

friends may come to see it as a preferred or praiseworthy form of death.<sup>242</sup>

Nor can Mann's predictions be dismissed as the stuff of science fiction; the former Governor of Colorado, Richard Lamm, for one, has openly and repeatedly defended the view that the elderly have a duty to die to make room (and save resources for) the young.<sup>243</sup>

And, of course, we already accept that economic incentives play a role for HMOs in the care they choose to dispense (and not disperse); why should this arena prove any different? Although doctors and hospitals may have incentives to keep patients alive to generate higher bills for additional care, if assisted suicide comes to be considered a legitimate (or perhaps even a professionally preferred) form of "care" in such cases, wouldn't we *expect* HMOs to cut back on reimbursement for more expensive options? Is it not possible—even likely—that more expensive forms of end-of-life care may come to be seen as luxuries, "elective," and nonreimbursable (or only partially reimbursable) options? Perhaps even extravagant? Or selfish? As Mann notes:

If dying sooner is more cost efficient, their profit-based concerns will make them prefer patients to choose assisted suicide. . . . Economic interests may still seem crass in relation to dying patients, and yet we are already accustomed to recognizing them in the context of treatment, as well as in all other contexts of daily life. When we legalize assisted suicide, it too becomes a part of daily life.<sup>244</sup>

Indeed, "[i]n our society, where almost everyone is pressed for time, and many are pressed for money, individual notions of agency and the fabric of social agency relations may evolve very quickly to reflect [assisted suicide's] conveniences and cost efficiency."<sup>245</sup> If anyone should doubt how quickly economic forces can change cultural norms and expectations, Mann asks us only to look back to the 1950s and 1960s and compare "how rapidly we have come" to alter our views on women working outside the home, with many today even "consider[ing] it somewhat indulgent and eccentric" for highly educated women to give up professional careers in favor of remaining at home.<sup>246</sup> How can we doubt that our views of dying (and what amounts to self-indulgent

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242. *Id.* at 21–22.

243. See Nat Hentoff, *Duty to Die?*, WASH. POST, May 31, 1997, at A19.

244. Mann, *supra* note 234, at 22.

245. *Id.*

246. *Id.* at 23.

behavior in the dying process) would change just as radically if assisted suicide were legalized?<sup>247</sup>

#### IV. GRIFFITHS AND KUHSE: DECRIMINALIZATION AS A "COSTLESS" ENTERPRISE

##### A. Griffiths's Argument

Griffiths has sought to press the somewhat counterintuitive notion that the decriminalization of assisted suicide is an essentially "costless" enterprise. Just because assisted suicide is routine today in the Netherlands, Griffiths submits, that fact does not necessarily mean that the number of such deaths "increased after legalization" or that the number of such deaths "is higher in the Netherlands than elsewhere."<sup>248</sup> In fact, Griffiths argues, assisted suicide and euthanasia are practiced on a "widespread, if hidden," basis in the United States "at rates roughly comparable [to] those in the Netherlands," a "fact" which leads Griffiths to conclude that the "[l]egalization of euthanasia apparently does not lead to an increase even in the rate of euthanasia itself."<sup>249</sup>

To be sure, Griffiths is right to note that the data we have from the Netherlands, like the data from Oregon, only tells us about the incidence of assisted suicide and euthanasia *after* they became legally permissible in those jurisdictions, and that we lack much data regarding the rate of voluntary or nonvoluntary killings in those jurisdictions *before* legalization. But Griffiths does nothing to dispel concerns that Dutch and Oregon procedures and practices raise on their own terms, and Griffiths goes far beyond noting the limitations of current data to an argument that is itself unwarranted on the available evidence.

First, Griffiths's hypothesis—that decriminalization of assisted suicide and euthanasia does not result in any additional cases of those practices—runs directly contrary to the intuitive principle of the law of

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247. The unintended consequences of legalization would surely include, as well, the fact that it would leave some set of persons who remain morally and religiously opposed to assisted suicide and euthanasia in a position similar to the one in which abolitionists found themselves in antebellum America or contemporary abortion and capital punishment opponents find themselves today—in distress at even passive participation in a regime which facilitates what they believe to be wrong. The social division and unrest associated with such discontent is yet one more "cost" that would have to be figured into any utilitarian calculus hoping to encompass comprehensively the assisted suicide debate.

248. GRIFFITHS ET AL., EUTHANASIA AND LAW, *supra* note 24, at 26 (emphasis omitted).

249. John Griffiths, *The Slippery Slope: Are the Dutch Sliding Down or Are They Clambering Up?*, in ASKING TO DIE, *supra* note 24, at 93, 100 [hereinafter Griffiths, *Slippery Slope*]; see also GRIFFITHS ET AL., EUTHANASIA AND LAW, *supra* note 24, at 27 (arguing to the same effect).

demand. The law of demand holds that, other things being equal, the quantity demanded of a good falls when the price of the good rises.<sup>250</sup> Consistent with the law of demand, one would expect that if certain "costs" associated with assisted suicide and euthanasia (for example, the social stigma and difficulty of finding a willing physician to help when the practices remain illegal) are lowered or eliminated by legalization, *more*, not fewer, people would take advantage of this fact and seek an early death. Advocates of legalization usually champion exactly this point, arguing for the regularization of assisted suicide precisely because doing so would allow *more* people the autonomy to decide to kill themselves. Griffiths gives us no reason to adopt a contrary, and entirely counterintuitive, assumption.

Second, while Griffiths asserts that assisted suicide and euthanasia are secretly practiced in the United States on approximately the same scale as they are openly practiced in the Netherlands, the only authority he provides for this claim is a citation to an amicus brief in *Glucksberg* signed by Ronald Dworkin, among others, and described by its authors as the "Philosophers' Brief"; that legal advocacy piece hardly purported to provide a systematic study of assisted suicide and euthanasia rates in the United States.<sup>251</sup>

Griffiths's empirical assertion is, in fact, contradicted by available data—data which is entirely consistent with what one would expect under the law of demand. The 1995 Survey of Dutch physicians found that 63% of general practitioners and 37% of clinical specialists in the Netherlands (53% of all physicians) had performed euthanasia or assisted suicide.<sup>252</sup> By contrast, a survey of physicians in Oregon

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250. See N. GREGORY MANKIW, *PRINCIPLES OF ECONOMICS* 68 (2d ed. 2001). Theoretically, some goods may violate the law of demand ("Giffen goods," so named for economist Robert Giffen); their demand curves slope upward because of an exceptionally large negative income effect which dominates the substitution effect. *Id.* at 479. Thus, some

suggest that potatoes were in fact a Giffen good during the Irish potato famine of the nineteenth century. Potatoes were such a large part of people's diet that when the price of potatoes rose, it had a large income effect. People responded to their reduced living standard by cutting back on the luxury of meat and buying more of the staple food of potatoes.

*Id.*

Whether any Giffen good has ever been discovered, however, remains a matter of substantial dispute among economists, and, in any event, Griffiths does not invoke the Giffen good theory in his argument for an assisted suicide exception to the law of demand.

251. See GRIFFITHS ET AL., *EUTHANASIA AND LAW*, *supra* note 24, at 27 & n.23; Griffiths, *Slippery Slope*, *supra* note 249, at 100 & nn. 6–8; see also Brief of Amicus Curiae Bioethicists Supporting Respondents, *Quill* (No. 95-1858) & *Glucksberg* (No. 96-110).

252. See van der Maas & van der Wal et al., *Euthanasia 1996*, *supra* note 72, at 1702 tbl.2.



conducted prior to the legalization of assisted suicide in that state found that only 21% had received a request for euthanasia or assisted suicide and just 7% had written a lethal prescription at a patient's request.<sup>253</sup> Further, a 1996 nationwide survey of over 1900 U.S. physicians (conducted by, among others, Timothy Quill, a highly vocal assisted suicide advocate)<sup>254</sup> found that, over the entire course of their careers, 11.1% of physicians had received a request for euthanasia, 18.3% had received a request for assisted suicide, and approximately 6% had acceded at least one request for either euthanasia or assisted suicide.<sup>255</sup> One of Quill's coauthors remarked that the "most important finding" in this survey was that "[t]his is really not happening very often . . . . It's a rare event."<sup>256</sup> As van der Maas himself has noted, the figures from the United States "are consistently lower than those we found" for the Netherlands,<sup>257</sup> and extant data suggest that "the proportion of deaths in the United States that involve physician-assisted suicide and euthanasia is likely to be small."<sup>258</sup> The American Geriatrics Society has concurred, suggesting that the widespread practice of assisted suicide and euthanasia "seems unlikely. Three-quarters of all deaths happen in institutions where a regularized practice would require the collusion of a

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253. *Id.* at 1705. In Washington State, a survey found that 12% of physicians had received requests for physician-assisted suicide and 4% had received a request for euthanasia in the prior year; 24% of these requests were granted. *Id.*

254. See, e.g., Timothy E. Quill, *The Ambiguity of Clinical Intentions*, 329 NEW ENG. J. MED. 1039, 1039-40 (1993); Timothy E. Quill, *Death and Dignity: A Case of Individualized Decision Making*, 324 NEW ENG. J. MED. 691 (1991); Timothy E. Quill et al., *The Rule of Double Effect—A Critique of Its Role in End-of-Life Decision Making*, 337 NEW ENG. J. MED. 1768 (1997).

255. See Diane E. Meier et al., *A National Survey of Physician-Assisted Suicide and Euthanasia in the United States*, 338 NEW ENG. J. MED. 1193, 1193 (1998).

256. Daniel Q. Haney, *Six Percent of Doctors Say They Helped Patients End Lives with Drugs*, WASH. POST, Apr. 23, 1998, at A9 (referring to a survey performed by Diane E. Meier of the Mount Sinai School of Medicine and quoting Dr. Ezekiel Emanuel of the National Institutes of Health who has estimated that 3% to 13% of all physicians have "hastened" the death of a patient); see also KEOWN, EEPP, *supra* note 31, at 62 (noting the results of that study); Dick L. Willems et al., *Attitudes and Practices Concerning the End of Life: A Comparison Between Physicians from the United States and from the Netherlands*, 160 ARCHIVES INTERNAL MED. 63, 66 (2000) (reporting the results of a study comparing Dutch and Oregonian doctors, and concluding that far fewer American doctors receive requests for euthanasia and physician-assisted suicide, as well as intentionally assist patients in dying).

257. van der Maas & van der Wal et al., *Euthanasia 1996*, *supra* note 72, at 1705.

258. Paul van der Maas & Linda L. Emanuel, *Factual Findings*, in REGULATING HOW WE DIE: THE ETHICAL, MEDICAL, AND LEGAL ISSUES SURROUNDING PHYSICIAN-ASSISTED SUICIDE 151, 159 (Linda L. Emanuel ed., 1998); see also KEOWN, EEPP, *supra* note 31, at 61-62 (discussing British and American evidence that suggests that the practice of euthanasia and assisted suicide is uncommon).

large number of persons.”<sup>259</sup>

Third, even supposing, counterfactually, that the rates of voluntary assisted suicide and euthanasia in the United States (where the practices are generally illegal) and the Netherlands (where the practices are allowed) are presently comparable, it would be error to leap to the conclusion that legalization in the United States would therefore be a “costless” enterprise. It would be equally consistent with the facts to suppose that different countries have different baseline (prelegalization) rates of assisted suicide and euthanasia because of unrelated cultural phenomena and that, consistent with the law of demand, legalizing voluntary assisted suicide and euthanasia (and thus reducing the “price” associated with the practices) would lead to an *increase* in the frequency of the practices when compared with baseline, prelegalization rates in any given country.

### B. Kuhse's Argument

In a variation of Griffiths's hypothesis, Kuhse rejects any suggestion that “the rate at which doctors intentionally end patients' lives without an explicit request is higher in a country where voluntary euthanasia is [practiced] openly . . . than in a comparable country which prohibits the practice.”<sup>260</sup> Simply put, in her view, “laws prohibiting the intentional termination of life . . . do not prevent doctors from intentionally ending the lives of some of their patients” without consent.<sup>261</sup>

As with Griffiths's theory, however, the foundation on which Kuhse seeks to build her argument is not free from question. Kuhse argues that nonvoluntary killings in her home country of Australia, where assisted suicide is now illegal, occur more frequently than in the Netherlands,<sup>262</sup> and, therefore, that legalization is likely to reduce (or at least not increase) the total number of cases of nonvoluntary killings.<sup>263</sup> But, again, the fact that nonvoluntary killings in Australia may already be high when compared with the Netherlands does not mean that the problem of nonconsensual killings won't be exacerbated in Australia if voluntary assisted suicide and euthanasia are legalized there. Kuhse's

259. Brief of the Am. Geriatrics Soc'y as Amicus Curiae Urging Reversal of the Judgments Below at \*10, *Glucksberg*, 1996 WL 656290 (No. 96-110).

260. Helga Kuhse, *From Intention to Consent: Learning from Experience with Euthanasia*, in *EXPANDING THE DEBATE*, *supra* note 212, at 252, 263 [hereinafter *Kuhse, From Intention to Consent*].

261. *Id.*

262. See Kuhse et al., *End of Life Decisions in Australian Medical Practice*, 166 *MED. J. AUSTRALIA* 191, 194-95 (1997) [hereinafter *Kuhse et al., Australian Medical Practice*]; Kuhse, *From Intention to Consent*, *supra* note 260, at 263.

263. See Kuhse, *From Intention to Consent*, *supra* note 260, at 263-66.

empirical claim is equally consistent with the supposition that Australia simply starts from a different (higher) baseline of nonconsensual killings and that, as voluntary assisted suicide and euthanasia become more common, so too will nonconsensual killings due to abuse, mistake or coercion.

Similarly, Kuhse's thesis—like Griffiths's—is in tension with the law of demand. As nonconsensual killings become more acceptable—as they surely have in the Netherlands, where the government has sought to justify them as a “necessity,”<sup>264</sup> and where some, such as Griffiths, have urged their complete decriminalization<sup>265</sup>—one would expect the number of such cases to increase, not remain constant as Kuhse seems to suppose. While an exception to the law of demand is not inconceivable, any theory that depends on such an extraordinary exception would require considerable proof.

The empirical data Kuhse cites, like her theory itself, are open to question. Kuhse's data come from a postal survey of physicians that Kuhse conducted together with Peter Singer.<sup>266</sup> Beyond her academic and survey work, Kuhse is, perhaps not incidentally, past president of a euthanasia advocacy group, the World Federation of Right-to-Die Societies.<sup>267</sup> Singer, formerly at Monash University in Australia but now DeCamp Professor at Princeton University's Center for Human Values, is, like Kuhse, a vocal exponent of legalizing assisted suicide.<sup>268</sup> Indeed, Singer even advocates killing unwanted infants—that is, infanticide.<sup>269</sup> Kuhse's and Singer's survey was limited to Australian doctors and makes no findings that would permit them to reach any conclusions about the frequency of assisted suicide in America.<sup>270</sup> Within Australia, their most fundamental finding was that voluntary euthanasia and assisted suicide collectively represent approximately 1.8% of all deaths.<sup>271</sup> By comparison, however, voluntary euthanasia and assisted suicide accounted for 2.2% of all deaths in the Netherlands in 1990, and 2.7% of all deaths in 1995.<sup>272</sup> These data, standing alone, are hardly consistent with the thesis that legalization does not result in more killings; rather, it suggests that euthanasia and physician-assisted

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264. See *supra* note 108 and accompanying text.

265. See *supra* notes 120–25 and accompanying text.

266. See Kuhse et al., *Australian Medical Practice*, *supra* note 262.

267. See Voluntary Euthanasia Society of Victoria Inc., The World Federation of Right to Die Societies at <http://www.vesv.org.au/docs/worldfed.htm> (last visited Dec. 22, 2004).

268. See generally, e.g., PETER SINGER, *PRACTICAL ETHICS* 169–76, 181–91 (2d ed. 1993).

269. See, e.g., *id.*

270. See Kuhse et al., *Australian Medical Practice*, *supra* note 262, at 191–92.

271. See *id.* at 191.

272. See *supra* tbl.1.

suicide were 50% more common in the Netherlands in 1995 than in Australia in 1996, exactly what one would expect given the law of demand.

Kuhse and Singer, perhaps unsurprisingly, seek to emphasize other findings from their survey. By way of example, Kuhse claims that passive (that is, by omission) nonvoluntary euthanasia is more common in Australia than the Netherlands, despite its greater acceptability in the Netherlands.<sup>273</sup> But, at least some of the data on which Kuhse and Singer base this conclusion do not seem to bear out their assertion. For example, Kuhse and Singer claim that 22.5% of all deaths in Australia were the result of omissions of care without "explicit" patient request, and they seek to contrast this figure with the Dutch experience, noting that *all* decisions to omit treatment, consensual and nonconsensual, accounted for 13.3% of deaths in the Netherlands in 1995.<sup>274</sup> After unearthing data buried in a table, however, one finds that *included within* the critical 22.5% figure of supposedly nonconsensual killings is a very large number of cases (21% of all omission cases) where patient-physician discussions, if any, are *unknown*, because the participating physicians simply declined to provide any information in the write-in postal survey.<sup>275</sup> The analogous nonreport rate in the Netherlands was far lower (5%).<sup>276</sup> This large difference could, perhaps, be attributed to the fact that Kuhse's survey depended on voluntarily mailed-in results, while the van der Maas survey relied on in-person interviews and studies of mandatory death certificates filed with the state; accordingly, it would have been relatively easy (and understandable) for doctors in the Australian survey to bypass questions about what, if any, private (and privileged) doctor-patient discussions they may have had.

In any event, an apples to apples comparison of nonvoluntary euthanasia by omission, avoiding nonreport cases, seems to undercut Kuhse's and Singer's thesis. According to Kuhse and Singer, 28.6% of

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273. See Kuhse, *Australian Medical Practice*, *supra* note 262, at 195. The Kuhse-Singer study was poorly designed to identify true cases of passive euthanasia. Participants were asked whether they had withheld or withdrawn treatment with the "explicit intention of not prolonging life or of hastening death." *Id.* at 194; *see also* Kuhse, *From Intention to Consent*, *supra* note 260, at 262. But this question obviously risks conflating different things; physician-assisted suicide and euthanasia, as we have discussed, involve actions where an intent to end life is present. An intention "not to prolong life" is unclear and not necessarily the same thing at all, arguably embracing decisions where no intent to end life is present at all, but simply an intent to avoid burdensome or futile care. *See* KEOWN, *EEPP*, *supra* note 31, at 18-30; Gorsuch, *supra* note 3, at 652-53.

274. Kuhse, *Australian Medical Practice*, *supra* note 262, at 195.

275. *See id.* at 194 tbl.3 (reporting that in sixty-two of 289 surveys regarding omissions of care, doctors simply did not report their discussions, if any, with patients).

276. *See* van der Maas & van der Wal et al., *Euthanasia 1996*, *supra* note 72, at 1704 tbl.4.

all deaths in Australia are the result of omissions of care with or without consent.<sup>277</sup> Of that universe, only 27% occurred without *some* indication, explicit or less than explicit, of patient consent;<sup>278</sup> thus, deaths by omission of care without any indication of patient consent amounted to just 7.72% of all deaths in Australia. From the 1995 survey, by comparison, we know that omissions of care accounted for about 20.2% of all deaths in the Netherlands in 1995.<sup>279</sup> And, we know that 51% of these cases involved no physician-patient discussion at all—nearly double the same applicable percentage for Australia.<sup>280</sup> Accordingly, approximately 10.3% of patients in the Netherlands—or 33% more persons than in Australia—appear to have died as a result of omissions of care without any indicia of consent.<sup>281</sup>

Other problems exist in Kuhse's and Singer's data. Robert Manne of Australia's LaTrobe University, for example, has questioned the finding that 64.8% of all deaths in Australia are the result of some medical decision, formally labeled as a "medical decisions concerning the end of life" ("MDELs").<sup>282</sup> By comparison, Dutch data shows that MDELs occur in approximately 40% of all deaths.<sup>283</sup> This considerable disparity has led Manne to ask:

As about 30 per cent of deaths in Australia must be, as in Holland, sudden or acute where MDELs could not take place, what [the authors] are effectively claiming is that while in Holland an MDEL takes place in a little over *one-half* of non-acute deaths, in Australia a medical decision concerning the end of life takes place in *almost every case*. . . . To my mind

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277. See Kuhse, *Australian Medical Practice*, *supra* note 262, at 191.

278. See *id.* at 194 tbl.3.

279. See van der Maas & van der Wal et al., *Euthanasia 1996*, *supra* note 72, at 1701 tbl.1.

280. See *id.* at 1704 tbl.4.

281. Kuhse and Singer suggest that nonvoluntary active euthanasia is also more pervasive in Australia than in the Netherlands—representing fully 3.5% of all deaths, compared with 0.8% and 0.7% of deaths in the Netherlands in 1990 and 1995, respectively. Kuhse, *Australian Medical Practice*, *supra* note 262, at 196 tbl.5. This, if reliable, could be a significant finding, although the authors do not draw much attention to the fact that Australian doctors are apparently more likely to have some discussion with their patients before killing them: 65% of Australian doctors who killed without "explicit" consent reported that the patient either expressed a wish for the procedure, or at least discussed the action, compared with 52% of similarly situated Dutch doctors. See *id.* at 194 tbl.3; van der Maas & van der Wal et al., *Euthanasia 1996*, *supra* note 72, at 1704 tbl.4.

282. Robert Manne, Opinion, *Research and Ye Shall Find*, BIOETHICS RES. NOTES, Mar. 1997, at 1, 1–2; see also Kuhse, *Australian Medical Practice*, *supra* note 262, at 196 tbl.5.

283. van der Maas & van der Wal et al., *Euthanasia 1996*, *supra* note 72, at 1701 tbl.1.

this finding calls into question the scientific rigour of the whole study . . . .<sup>284</sup>

Finally, *even if* Griffiths and Kuhse could convincingly prove their counterintuitive hypotheses that decriminalization does not encourage more cases of voluntary and nonvoluntary assisted suicide and euthanasia, it would not necessarily demonstrate that decriminalization is necessarily the appropriate policy response. As the U.S. Department of Justice has observed,

[b]y parity of reasoning, if it could be shown that physicians violated traditional medical canons of ethics more often than is usually supposed, e.g., by engaging in sexual relations with their patients or disclosing patient confidences, it would follow that the evidence of such deviations overturned the professional standards prohibiting such misconduct.<sup>285</sup>

Simply put, evidence about the pervasiveness of the “clandestine” practice of assisted suicide and euthanasia under current law can be wielded by partisans on *both* sides of the debate—constituting to some a reason for greater vigilance and enforcement rather than a reason for legalization; certainly, the contemporary debate over the status of illicit drugs illustrates this point, with politicians and the public on *both* sides agreeing that drug usage occurs on a large scale, but utterly disagreeing on whether to step up enforcement measures or repeal possession laws. And, of course, we have seen how the argument has played out so far in the American debate over assisted suicide: the recent activities of Kevorkian and his followers have induced state legislatures across the country, along with the U.S. Congress and the U.S. Attorney General, to take steps aimed at enhancing, not watering down, the enforcement of laws against the practice.<sup>286</sup>

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284. Manne, *supra* note 282, at 1–2 (emphasis added). Further calling into question Kuhse’s and Singer’s results, a Belgian study also showed that all medical decisions concerning the end of life (“MDEL”) accounted for 39.3% of deaths, a figure in line with findings in the Netherlands, and only a fraction of the findings Kuhse and Singer reported in Australia. See Luc Deliens et al., *End-of-Life Decisions in Medical Practice in Flanders, Belgium: A Nationwide Survey*, 356 LANCET 1806, 1808 tbl.1 (2000). The Belgian study did suggest that patients actively killed without consent represented 3.2% of all deaths, approximating the result found in Australia, *id.* at 1810 tbl.5, although the Belgium study estimates that in 38% of these cases some discussion had been held or a wish had been stated, *id.* at 1809 tbl.4.

285. Bradshaw & Delahunty, *supra* note 17, at 280 (original pagination omitted).

286. See *supra* notes 5–20 and accompanying text; see also KEOWN, EEPP, *supra* note 31, at 63.

One might, at this point, respond that legalization would at least allow the state to oversee and regulate the practice of assisted suicide and euthanasia, ensuring that safeguards are respected by bringing the practices out of the closet and into the light of day. But the evidence from the Netherlands and Oregon does not offer great comfort that decriminalization would result in zealous regulatory reporting or enforcement. Again, Oregon officials admit that they have no idea how often state law is violated, and no way to detect cases of abuse and mistake.<sup>287</sup> Meanwhile, nearly half of Dutch doctors admitted in 2001 that, *despite* the acceptability of assisted suicide and euthanasia in the Netherlands, they have refused to comply with reporting requirements—and they have done so disproportionately in cases where they kill the patient without consent and fail to consult professional colleagues.<sup>288</sup> Even Griffiths has acknowledged that the present control regime in the Netherlands “is a bit of a paper tiger,”<sup>289</sup> one apparently so irremediable that the only solution Griffiths offers is the decriminalization of *nonconsensual* homicide—an alternative that may well make enhanced enforcement of existing law look preferable by comparison to many.

#### V. POSNER’S ARGUMENT FOR LEGALIZATION

Posner argues for legalization of assisted suicide primarily on the strength of an empirical claim that it would lead to fewer, not more, suicides.<sup>290</sup> Without assisted suicide as a viable legal option, the argument runs, people frightened of disability associated with terminal illness are forced either to kill themselves while they still can or face the prospect of losing self-control.<sup>291</sup> If assisted suicide were legalized, people would not feel compelled to kill themselves early, but would instead rest assured that assistance in dying will be available to them even after they become physically incapacitated:

If the only choice is suicide now and suffering later, individuals will frequently choose suicide now. If the choice is suicide now or suicide at no greater cost later, they will choose suicide later because there is always a chance that they are mistaken in believing that continued life will impose unbearable suffering or incapacity on them. They would give up that chance by committing suicide now. The possibility of

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287. See *supra* notes 158–59.

288. See *supra* tbl. 3 and accompanying text.

289. GRIFFITHS ET AL., EUTHANASIA AND LAW, *supra* note 24, at 245–46; see also KEOWN, *EEPP*, *supra* note 31, at 63.

290. See POSNER, *supra* note 37, at 243–53.

291. See *id.*

physician-assisted suicide enables them to wait until they have more information before deciding whether to live or die.<sup>292</sup>

Posner's hypothesis—that the primary benefit of legalization accrues to elderly persons faced with the prospect of oncoming disability—is, however, in notable tension with his simultaneous assertion that “some of the strongest cases of rational suicide” do not involve the elderly at all, but “people who face an indefinite lifetime of paralysis, severe pain, or other terrible disability.”<sup>293</sup> In this case, one thinks not of the aged patient facing a terminal illness, but the young quadriplegic with years to live. The primary empirical benefit Posner claims for legalization (fewer and older suicides), thus, seemingly has little to do with what he identifies as the most compelling cases for assisted suicide (young persons who suffer from neither a terminal illness nor unendurable pain). Posner's hypothesis also depends heavily on the supposition that people frequently use suicide as a rationally calculated means of escaping future and oncoming disabilities. But, Posner presents no evidence for this supposition; in fact, extant evidence strongly suggests that suicide is more closely linked not with such careful rational reflection but with depression and psychological ailments.<sup>294</sup> Further, by far the highest rates of suicide in the United States today belong not to younger or middle-aged adults supposedly responding in a reasoned way to the fear of future illness and disability, but to the very elderly (those over seventy-five)—thus suggesting that one of the primary benefits Posner seeks to achieve through legalization (later suicides) may have been accomplished already.<sup>295</sup>

While the foregoing analysis indicates an unresolved tension between Posner's thesis and his stated goal, and while it raises the question whether there really is a significant unresolved problem with relatively younger persons coolly choosing to kill themselves rather than risk the prospect of future illnesses, none of this directly addresses the specific empirical data that Posner offers in support of his fewer-and-later-suicides hypothesis.

#### A. Posner's Argument from U.S. Data

The first piece of evidence Posner presents in support of his fewer-and-later-suicide hypothesis is a regression analysis testing the

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292. *Id.* at 247–48.

293. *Id.* at 237.

294. *See supra* note 146 and accompanying text.

295. *See* World Health Org., Suicide Rates (Per 100,000), by Gender and Age, USA, 2000, at [http://www.who.int/mental\\_health/media/en/374.pdf](http://www.who.int/mental_health/media/en/374.pdf) (last visited Dec. 20, 2004).



relationship between suicide rates and the status of state law on assisted suicide:

The question whether allowing physician-assisted suicide in cases of physical incapacity would increase or reduce the suicide rate can be studied empirically. Table 10.1 regresses state suicide rates in the United States on state per capita income, the percentage of the state's population that is black (blacks have much lower suicide rates than whites), and a dummy variable that takes a value of 1 if a state has a law criminalizing physician-assisted suicide and 0 otherwise.

Table 10.1 Regression of Suicide Rate on Assisted-Suicide Law and Other Variables (t-statistics in parentheses)

Per Capita Income	Percentage Black	Assisted- Suicide Law	R <sup>2</sup>
-.0005 (-3.388)	-.1287 (-2.999)	-.7601 (-0.951)	.31

The coefficients of the income and percentage-black variables are negative and highly significant statistically, and these two variables explain a good deal of the variance across states in the suicide rate. The coefficient of the law variable is also negative, implying that states that forbid physician-assisted suicide do have lower suicide rates than states that permit it. But it is not statistically significant, though perhaps only because most suicides are not committed by terminally ill or otherwise desperately ill people and thus do not come within the scope of the hypothesis that I am trying to test. Although these results do not suggest that repealing an assisted-suicide law is a sound method of reducing a state's suicide rate, they cast at least some doubt on the hypothesis, which I have been questioning despite its intuitive appeal, that making suicide easier is likely to lead to more suicides.<sup>296</sup>

Posner here concedes that he finds no statistically significant relationship between assisted suicide laws and the rate of suicide. Yet, somewhat remarkably, Posner proceeds to argue that the data lend

296. POSNER, *supra* note 37, at 250-51 (footnote omitted).

support to his hypothesis anyway: “[a]lthough these results do not suggest that repealing an assisted-suicide law is a sound method of reducing a state’s suicide rate, they cast at least some doubt on the hypothesis . . . that making suicide easier is likely to lead to more suicides.”<sup>297</sup> But Posner’s findings simply are not helpful to his own thesis. Before a regression’s findings are deemed sufficiently reliable for an economist to offer them in evidence in a federal court, typically they must reflect a 95% confidence level (with a t-statistic of 1.96).<sup>298</sup> Posner’s t-statistic for assisted suicide laws is less than 1.00 (0.951), suggesting a possibility of sampling error of approximately 40%.

Making matters worse, Posner reveals that his data regarding the status of state assisted suicide laws are drawn from a single footnote in a student-written law review note.<sup>299</sup> That student note, however, merely declared that “most states” ban assisted suicide by statute and proceeded to cite a great many state laws as *examples* to support that claim.<sup>300</sup> When constructing his regression, Posner apparently (mis)inferred that the remaining, unlisted states do not have statutes banning the practice. In fact, at least ten states not identified by the student note have statutes banning assisted suicide.<sup>301</sup> Posner’s “dummy variable” column, thus, actually runs counter to available evidence.

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297. *Id.* at 251.

298. *See, e.g.,* Moultrie v. Martin, 690 F.2d 1078, 1083 n.7 (4th Cir. 1982) (“Statisticians usually use 95% or 99% confidence levels.”); FTC v. Swedish Match, 131 F. Supp. 2d 151, 160–61 (D.D.C. 2000) (rejecting use of an 85% confidence level); Procter & Gamble Co. v. Chesebrough-Pond’s Inc., 588 F. Supp. 1082, 1088 & n.19 (S.D.N.Y. 1984) (stating that a 95% confidence level is sufficient to be considered statistically significant).

299. *See* POSNER, *supra* note 37, at 250 n.34 (“Data on assisted-suicide laws are from Julia Pugliese, ‘Don’t Ask—Don’t Tell: The Secret Practice of Physician Assisted Suicide,’ 44 *Hastings Law Journal* 1291, 1295 n.20 (1993).”).

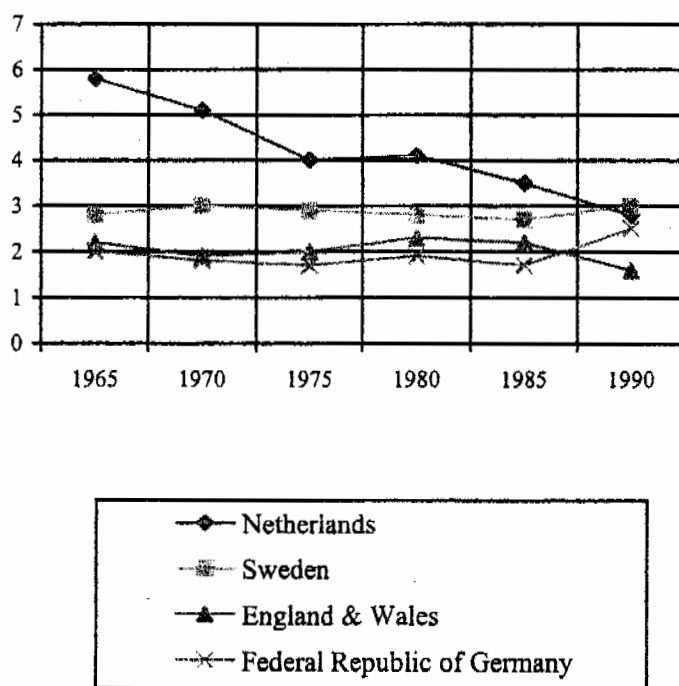
300. Julia Pugliese, Note, *Don’t Ask—Don’t Tell: The Secret Practice of Physician-Assisted Suicide*, 44 *HASTINGS L.J.* 1291, 1295 n.20 (1993).

301. States which, although not mentioned in Julia Pugliese’s note, do have statutes banning assisted suicide include Georgia, Offering to Assist in Commission of Suicide; Criminal Penalties, GA. CODE ANN. § 16-5-5 (Lexis 2003); Illinois, Inducement to Commit Suicide, 720 ILL. COMP. STAT. ANN. 5/12-31 (West 2002); Iowa, Assisting Suicide, IOWA CODE ANN. § 707A.2 (West 2003); Kentucky, Causing a Suicide—Assisting in a Suicide, KY. REV. STAT. ANN. § 216.302 (Michie 1999); Louisiana, Criminal Assistance to Suicide, LA. REV. STAT. ANN. § 14:32.12 (West 1997); Maryland, Assisting Another to Commit or Attempt Suicide, MD. CODE ANN., CRIM. LAW § 3-102 (Michie 2002); North Dakota, Assisting the Commission of Suicide—Causing Death by Suicide—Penalties, N.D. CENT. CODE § 12.1-16-04 (Michie 1997); Rhode Island, Prevention of Assisted Suicide, R.I. GEN. LAWS ANN. § 11-60-03 (Lexis 2002); South Carolina, Assisted Suicide; Penalties; Injunctive Relief, S.C. CODE ANN. § 16-3-1090 (West 2003); and Tennessee, Assisted Suicide, TENN. CODE ANN. § 39-13-216 (Lexis 2003). *See also infra* app. A. Still other states not on Pugliese’s list condemn assisted suicide as a matter of common law. *See, e.g.,* Kevorkian, 527 N.W.2d at 716 (permitting prosecution of Kevorkian under common law before

*B. Posner's Argument from Dutch Data*

Lacking meaningful support for his thesis based on American data, Posner also seeks to rest his argument on data from the Netherlands. Posner posits that the rate of elderly male suicide was "very high in the Netherlands before euthanasia became common in the early 1970s and has fallen since, both absolutely and relatively" compared to other Western European countries,<sup>302</sup> and Posner points to data reproduced here in Graph 1.

Graph 1  
Suicide Rate of Elderly Dutch Males as a  
Multiple of the Total Dutch Male Suicide Rate  
1965-1990<sup>303</sup>



Posner asserts that the legalization of assisted suicide caused the drop in the Dutch male suicide rate between 1965 and 1990, yet he, somewhat surprisingly, makes no effort whatsoever to consider—let alone rule out—the statistical significance of other potential causal

Michigan enacted a statute banning assisted suicide); *see also supra* note 12.

302. POSNER, *supra* note 37, at 252-53.

303. *Id.* at 253.

factors for the phenomenon he observes in the data.<sup>304</sup> There are, moreover, ample reasons to question Posner's untested causal assertion.

First, as discussed above, assisted suicide became legally permissible only with a decision by the Dutch Supreme Court in 1984 recognizing a limited "necessity" defense to homicide charges for physicians who kill the terminally ill.<sup>305</sup> The fact that the male suicide rate, as depicted in Graph 1, declined profoundly between 1970 and 1984—before the key judicial decision—suggests that other factors, besides legalization, may have been responsible for reducing the incidence of suicide. Since the Dutch effectively legalized assisted suicide in 1984, moreover, Graph 1 reveals that the rate of Dutch male suicides has followed roughly the same trajectory as the rate of male suicides in England and Wales, where assisted suicide remains unlawful, casting doubt on whether one can attribute the decline between 1984 and the present to any factor unique to the Netherlands.

Second, Posner notably rests his argument on suicide data for *men*. He relegates to a footnote any mention of—equally available—data for women.<sup>306</sup> And, as reflected in Graph 2 below, an examination of the data for Dutch women shows that the rate of elderly Dutch female suicides *has not declined* since de facto legalization in 1984.<sup>307</sup>

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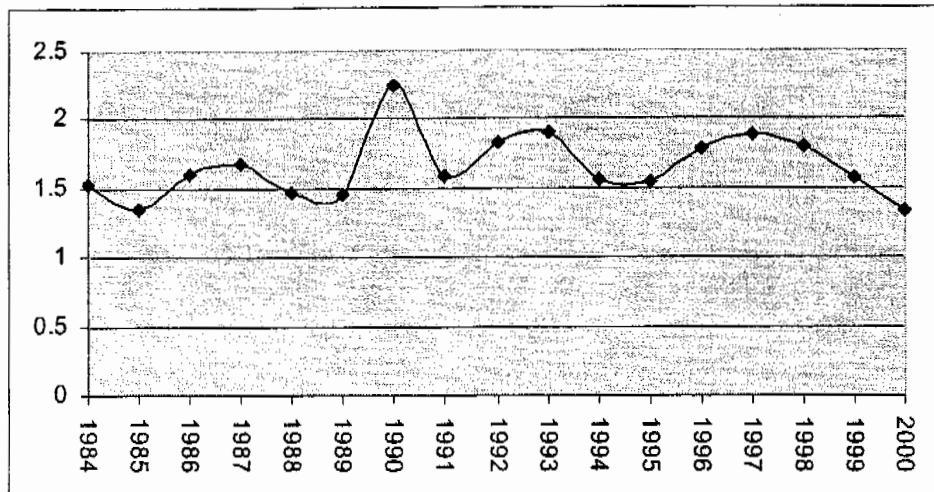
304. See *id.* at 252–53; cf. *Daubert v. Merrell Dow Pharms., Inc.*, 509 U.S. 579, 592–95 (1993).

305. See *supra* Part I.A.

306. See POSNER, *supra* note 37, at 252 n.39.

307. But see *id.*

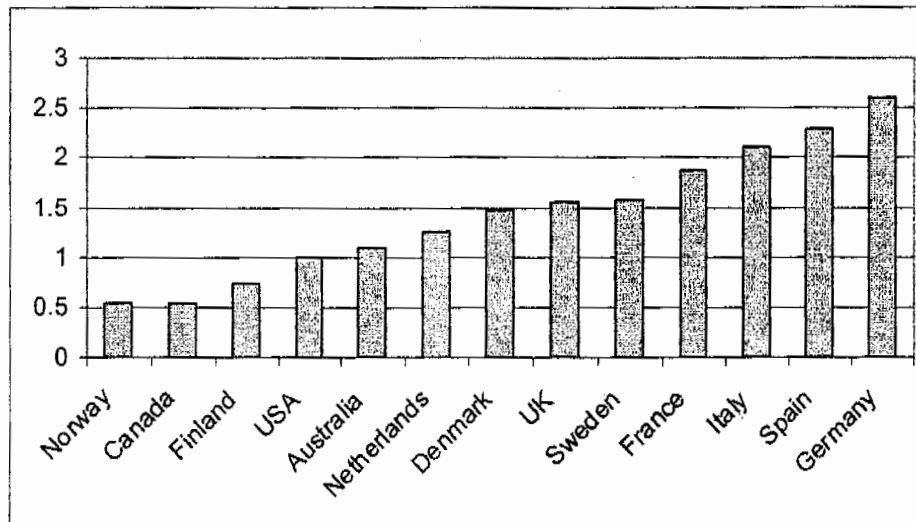
Graph 2  
Suicide Rate of Elderly Dutch Women as a Multiple  
of the Total Female Suicide Rate, 1984-2000<sup>308</sup>



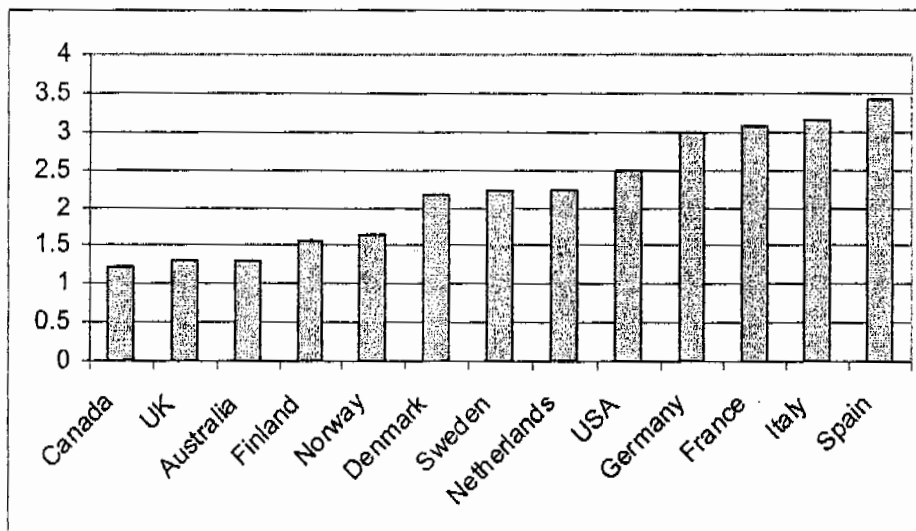
Third, World Health Organization data depicted in Graphs 3 and 4 reflect that, after nearly two decades of de facto legalization (and the very large number of deaths now attributable to assisted suicide and euthanasia in the Netherlands), the rate of *unassisted* suicides among the elderly in the Netherlands remains comparable to the rate of elderly suicides in many other countries where assisted suicide is unlawful. For example, the suicide rate for elderly women is actually *higher* in the Netherlands than it is in the United States (meanwhile the suicide rate for elderly men is only slightly lower in the Netherlands than it is in America, but still higher than the comparable suicide rate for elderly men in Britain or Canada or Australia). Arguably, the most one might venture to state with confidence about the Dutch experience is that decades ago the elderly suicide rate was out of kilter with many other western countries and in recent years has more or less fallen in line.

308. See *infra* app. B for data and calculations underlying this graph.

Graph 3  
Suicide Rate of Elderly Women as a  
Multiple of the Total Female Suicide Rate<sup>309</sup>



Graph 4  
Suicide Rate of Elderly Men as a  
Multiple of the Total Male Suicide Rate<sup>310</sup>



Fourth, while Posner focuses on the rate of elderly Dutch suicides as compared to that country's overall suicide rate, such a comparison tells us only the relative percentage of suicides committed by *elderly*

309. See *infra* app. B for data and calculations underlying this graph.

310. See *infra* app. B for data and calculations underlying this graph.

persons. Posner's comparison sheds little or no light on his own hypothesis, namely that legalization of assisted suicide should result in younger and healthier persons committing suicide less frequently.

Indeed, if Posner's hypothesis were true—and younger and healthier persons commit fewer suicides when assisted suicide is legally tolerated—one might expect to find that the *overall* number of Dutch suicides, including those committed by younger, healthier persons, declined after 1984 when assisted suicide was effectively legalized. Posner, however, does not squarely address that question, nor would doing so appear to aid his argument. The overall suicide rate in the Netherlands is nearly double what it was fifty years ago—9.4 deaths per 100,000 persons in 2000 versus 5.5 per 100,000 persons in 1950.<sup>311</sup> Since 1980, four years before de facto legalization, the Dutch suicide rate has consistently hovered somewhere in the range of 9.4 and 11.3 deaths per 100,000 persons.<sup>312</sup> Simply put, the Dutch have been unable to effect meaningful decreases in the overall suicide rate despite de facto legalization of assisted suicide in 1984.

Finally, and perhaps most remarkably, Posner's thesis—much like the theories offered by Griffiths and Kuhse<sup>313</sup>—appears to be in tension with the law of demand, suggesting that legalizing assisted suicide (that is, reducing the costs and barriers associated with its practice) would result in fewer, rather than more, cases of suicide and assisted suicide overall. Unlike Griffiths or Kuhse, however, Posner recognizes the inconsistency between his argument for assisted suicide and the law of demand and openly argues for a rather extraordinary exception to the rule:

It may be objected that my entire analysis violates the economist's Law of Demand; that lowering the price of a good or service—here, suicide—must increase rather than reduce the demand for it. This is not the correct way to frame the issue. We have two goods, not one: unassisted suicide, and physician-assisted suicide. They are substitutes, so lowering the price of the second (by legalizing it) will reduce the demand for the first, and nothing in economics teaches that this reduction must be fully offset by the increased demand for the second good. A razor blade that retains its sharpness for ten shaves is a substitute for one that retains it for only one shave, but if the former takes over the market the total number

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311. See World Health Org., Suicide Rates (per 100,000), by Gender, Netherlands, 1950–2000, at [http://www.who.int/mental\\_health/meadia/en/338.pdf](http://www.who.int/mental_health/meadia/en/338.pdf) (last visited Dec. 20, 2004) [hereinafter Netherlands Suicide Rates].

312. See *id.*

313. See discussion *supra* Part IV.

of razor blades produced and sold will decline even if the longer-lasting blade is no more expensive than the other blade.<sup>314</sup>

Essentially, Posner supposes that demand will simply shift from unassisted suicide to assisted suicide, and that *no* additional demand will be generated from the latter's legalization. But, Posner offers no evidence that assisted suicide is a one-for-one substitute for unassisted suicide, and available data do not seem to support this proposition. Contrary to what one would expect to find if Posner's hypothesis were true, the Dutch suicide rate has *not* changed substantially since assisted suicide was effectively legalized in 1984.<sup>315</sup> At the same time, although we do not have pre-1984 data for assisted suicide and euthanasia, we know that assisted suicide and euthanasia have become leading causes of death: more deaths now result from those practices combined than from many other significant causes (for example, HIV, leukemia or homicide).<sup>316</sup> In 1995 alone, the Dutch recorded 3118 acts of euthanasia, 542 assisted suicides, and 949 affirmative killings without patient consent, for a total of 4609 deaths, amounting to 3.4% of all deaths in the Netherlands that year.<sup>317</sup>

Posner's exception to the law of demand hypothesis runs not only against the grain of the available empirical data, but his hypothetical analogy lacks explanatory value in the "market" for end-of-life services. In Posner's hypothetical, unassisted suicide is like a disposable, single-use razor blade.<sup>318</sup> With the introduction of a reusable, ten-shave razor (which Posner likens to assisted suicide) the overall output of razor blades declines.<sup>319</sup> But, notably, Posner's analysis omits any discussion about consumer *demand* for the service rendered by both products (that is, the total number of shaves) in his hypothetical market. Nor, in fact, is there reason to suppose that the advent of a new razor would lead consumers to wish to shave less often. If anything, one could imagine reasons why the advent of reusable disposable razors would lead consumers to shave more often.

Likewise, there is no reason to suppose that the introduction of

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314. POSNER, *supra* note 37, at 249–50.

315. See Netherlands Suicide Rates, *supra* note 311 (stating that suicides per 100,000 deaths in the Netherlands were 10.1 in 1980, 11.3 in 1985, 9.7 in 1990, 9.8 in 1995, and 9.4 in 2000).

316. See *supra* note 79.

317. See *supra* tbl. 1. The Dutch also record thousands of cases where patients are intentionally killed by omission without their consent, including some 8750, or 6.78% of all deaths, in 1990 (again, 1995 data was not published). See *supra* notes 96–98 and accompanying text.

318. POSNER, *supra* note 37, at 249–50.

319. See *id.*



assisted suicide would reduce total consumer demand for end-of-life services. The only reason Posner supposes for a decline in razor sales in his hypothetical market has nothing to do with a reduction in consumer demand for shaves, but rather, with an innovation (the reusable razor) that permits manufacturers to satisfy a constant (or even growing) consumer demand for shaves with a smaller supply. Translating to the suicide market, Posner's imaginary razor market gives us no reason to think that overall *demand* in the unassisted suicide-assisted suicide market would decline, and quite unlike a ten-shave razor that is capable of satisfying higher demand with a smaller supply, the "new product" he promotes (assisted suicide) is, like the original product (unassisted suicide), good for just one use per customer.

Rather than analogizing to a ten-shave razor, perhaps a more accurate analogy might be between razors with equally long useful lives for the consumer. The disposable single-use razor blade (like unassisted suicide) has been available to consumers for years, but some find it uncomfortable to use. Eventually, the razor merchants devised the "sensitive skin" single-use razor, which sports a "moisturizing strip." Like assisted suicide, this new razor has the same basic use as the original disposable, but it also contains an added feature that some consumers find superior and thus, prefer. One would expect the introduction of such a product to lead to an *increase* in overall sales of disposable razors; indeed, this is precisely why manufacturers introduce line extensions of this sort and business scholars develop complex models for evaluating how to use line extensions to maximize consumer demand and profits.<sup>320</sup> Similarly, as progressively easier and less stigmatizing options to suicide become available, first assisted suicide and then euthanasia, the overall use of such "end-of-life services" might be expected to increase. Posner offers little evidence that this particular arena of human activity presents any exception to the law of demand, and his analogy to a hypothetical razor market simply does not prove the point on its own terms.<sup>321</sup>

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320. See, e.g., Richard D. McBride & Fred S. Zufryden, *An Integer Programming Approach to the Optimal Product Line Selection Problem*, 7 *MARKETING SCI.* 126 (1988); Kamalini Ramdas & Mohanbir S. Sawhney, *A Cross-Functional Approach to Evaluating Multiple Line Extensions for Assembled Products*, 47 *MGMT. SCI.* 22 (2001).

321. Posner seeks to supplement his empirical case for legalization by positing that terminally ill persons would find comfort in knowing that they could choose to die on demand even if they never use the option. See POSNER, *supra* note 37, at 239. Living would become more bearable, the argument runs, knowing that death is easily available. See *id.* at 239-40. But Posner makes no attempt to quantify how many people would find an unrealized option to obtain assisted suicide to be valuable, how valuable they would find it or how the psychic benefit of a never-used option compares against the harms that may attend the regularized practice of assisted suicide—both actual (for example, people killed without their consent as a result of accident or abuse)

C. *Posner's Analysis of the Costs Associated with Assisted Suicide*

The purpose of a utilitarian project like Posner's is to weigh the competing costs and benefits of alternatives to determine which, on balance, produces the "best" or "most efficient" result. While Posner's own analysis focuses intently on the possible benefits associated with legalization, he readily, and significantly, admits that his argument for legalization can be considered only "tentative" precisely because he does not attempt to enumerate or consider the costs associated with legalization.<sup>322</sup>

That said, through a colorful anecdote about his grandfather, Posner at least implicitly touches on the possibility that legalization would bring with it the unwanted "cost" of some patients being killed erroneously. Physicians told Posner's grandfather, then in his forties, that he had a fatal kidney disease but might manage to live a year or two if he gave up meat.<sup>323</sup> Posner's grandfather refused to give up meat, lived to be eighty-five, and died of an unrelated ailment.<sup>324</sup> "Like other professionals," Posner explains, "doctors sometimes speak with greater confidence than the facts warrant."<sup>325</sup> Although Posner does not directly acknowledge the point, in the very regime he advocates, his grandfather would have been a prime candidate for an early, and mistaken, act of euthanasia.

While Posner gives only the briefest attention to the potential for mistaken and abusive killings, he does discuss in some detail another possible cost associated with legalization. If, as Posner hypothesizes, fewer people would decide to kill themselves and those who do decide to kill themselves would do so later, medical costs would rise in a regime where assisted suicide is lawful.<sup>326</sup> People who decide not to end their lives early would incur substantial additional costs as they age and become sicker, and in our society many of these costs would be borne by third party payers, not the individual patient.<sup>327</sup> We cannot, Posner tells us, "disregard [such] tangible costs borne by people who through their taxes, health-insurance premiums or doctors' bills are forced to pay other people's medical expenses."<sup>328</sup> Although he stops short of saying so explicitly, Posner seems to suggest (remarkably) that we might not

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as well as psychic (for example, people who are frightened that they might be killed without consent even if they are never so killed).

322. *See id.* at 244.

323. *See id.* at 245 n.27.

324. *See id.*

325. *Id.*

326. *See id.* at 243-44.

327. *See id.* at 244.

328. *Id.*

want to legalize assisted suicide because it is cheaper for society to have more people commit suicide at a younger age (as Posner posits they now do) rather than linger longer, spend more on health care, and raise our taxes and health insurance premiums in the process.

#### VI. HOW TO "BALANCE" THE BENEFITS AND COSTS ASSOCIATED WITH LEGALIZATION

To this point, I have sought to suggest that legalization, even if narrowly limited to the terminally ill or gravely suffering, cannot readily be labeled a "costless" enterprise in any utilitarian calculus. It is perhaps equally important, however, to emphasize what I have *not* done: I have not proven that the costs we might associate with legalization outweigh the benefit of permitting people who really wish to kill themselves the liberty of doing so. I have not even sought to show that the costs and benefits of normalization are in equilibrium. All I have done or sought to do, to this point, is to question whether the application of a utilitarian analysis inexorably leads to the conclusion that legalization represents the best solution for the greatest number of persons. Having suggested that the utilitarian scales do not obviously or necessarily tip in the direction of legalization, the question remains: how are we to balance the competing costs and benefits? Accepting that legalization may bring with it unintended and unwanted consequences, as well as real benefits, the utilitarian wants to somehow try to "sum up" these competing costs and benefits and arrive at the most efficient or optimal social policy result. But how?

Utilitarians do not, of course, uniformly line up in favor of legalizing assisted suicide or euthanasia. In the 1950s, Glanville Williams wrote *The Sanctity of Life and the Criminal Law*, the classic utilitarian case for euthanasia.<sup>329</sup> Soon afterward, however, Yale Kamisar published an article arguing for the opposite conclusion while applying the same utilitarian approach and methods.<sup>330</sup> The most interesting feature of the Williams-Kamisar debate is not that two utilitarians disagree. Nor is it in trying to determine who offered the more complete or accurate utilitarian calculation. Instead, the interesting question raised by the debate they began (and which, as we have seen, continues with vigor to this day) is whether—even if one could definitively identify *all* of the positive and negative consequences associated with assisted suicide or euthanasia—one could then rationally and objectively weigh those consequences to ascertain the "correct"

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

330. See Yale Kamisar, *Some Non-Religious Views Against Proposed "Mercy-Killing" Legislation*, 42 MINN. L. REV. 969 (1958).

result. On a purely utilitarian account, how can we compare, for example, the interest the rational adult seeking death has in dying with the danger of mistakenly killing persons without their consent?

Such questions suggest a fundamental problem besetting *both* Williams's and Kamisar's projects: the absence of any agreed scale on which the utilitarian can weigh or compare radically different competing values. Endeavoring to compare or weigh, say, the interest the rational adult tired with life has in choosing death against the interest the incompetent elderly widow has in avoiding being killed by a greedy guardian and heir, without reference to any extrinsic, agreed upon moral rule or code is a seemingly impossible, even senseless, enterprise. It is senseless in the way that it is senseless to compare or commensurate the virtues of apples to those of oranges, or "in the way that it is senseless to try to sum up the quantity of the size of this page, the quantity of the number six, and the quantity of the mass of this book."<sup>331</sup>

Posner himself hints at this incommensurability problem confronting his utilitarian argument for assisted suicide after explaining his fear that legalizing assisted suicide could also mean higher medical costs, insurance premiums, and taxes. Fearful of such costs, Posner ultimately backs away from his argument for legalization, submitting that it would be "difficult to say whether allowing physician-assisted suicide would be socially cost-justified."<sup>332</sup> Posner, at least here, sees real costs and benefits on *both* sides of the ledger and admits that he is not sure how the "balance" should be struck. Nor is the problem merely one of enhancing our ability to measure costs and benefits with exactitude. Even supposing we could estimate with complete accuracy the increased medical costs Posner identifies, how could we as a society measure the (hypothesized) benefit of fewer and later suicides against increased medical costs to be borne by the public through increased taxes or health insurance premiums? In the end, Posner seems to admit the inability of a purely utilitarian calculus to resolve such dilemmas—such competition between fundamentally incommensurate goods or objectives—and in doing so makes a tactical retreat to the harm principle, or what he calls "Mill's approach,"<sup>333</sup> to resolve the problem. "Mill's approach" (a.k.a. the harm principle) holds that each person must be afforded the right to exercise self-control "[o]ver himself, over his own body and mind," and that the state may coerce an individual to take actions against his or her will only to "prevent harm to others."<sup>334</sup>

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331. JOHN FINNIS, *NATURAL LAW AND NATURAL RIGHTS* 115 (1980). See generally JOSEPH RAZ, *THE MORALITY OF FREEDOM* 321–68 (1986).

332. POSNER, *supra* note 37, at 244.

333. *Id.*

334. JOHN STUART MILL, *ON LIBERTY* 9 (Elizabeth Rapaport ed., Hackett Publ'g Co. 1978) (1859).

Assuming that assisted suicide is a purely self-regarding (or "harmless-to-others") activity, Posner argues that Mill's approach "enables us to exclude (*as a strictly economic or utilitarian analysis would not*) the disutility"<sup>335</sup> associated with legalization, thereby vindicating a right to assisted suicide and euthanasia regardless of any negative side effects that would have to be carefully considered in a utilitarian analysis.<sup>336</sup>

Battin also appears to identify the incommensurability problem underlying utilitarian arguments against assisted suicide and euthanasia, acknowledging that:

The wedge argument against euthanasia [that is, the fact that allowing voluntary euthanasia may lead to acceptance of nonvoluntary euthanasia] usually takes the form of an appeal to the welfare or rights of those who would become victims of later, unjustified practices. Usually, however, when the conclusion is offered that euthanasia therefore ought not be permitted, no account is taken of the welfare or rights of those who are to be denied the benefits of this practice. Hence, even if the causal claims advanced in the wedge argument are true . . . they still do not establish the conclusion. *Rather, the argument sets up a conflict.* Either we ignore the welfare and abridge the rights of persons for whom euthanasia would clearly be morally permissible in order to protect those who would be the victims of corrupt euthanasia practices, or we ignore the potential victims in order to extend mercy and respect for autonomy to those who are the current victims of euthanasia prohibitions.<sup>337</sup>

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335. POSNER, *supra* note 37, at 244 (emphasis added).

336. A full consideration of harm principle arguments for and against assisted suicide is beyond the scope of this paper, but it is far from a foregone conclusion that the principle would, as Posner seems to suppose, *mandate* legalization of assisted suicide. Even John Stuart Mill argued that states may ban slavery contracts and other "harmless" consensual practices, under certain circumstances, without offending his harm principle, MILL, *supra* note 334, at 101, and Joel Feinberg has argued that the harm principle can be reconciled with an absolute legal ban against the (consensual) practice of dueling, 3 JOEL FEINBERG, *THE MORAL LIMITS OF THE CRIMINAL LAW: HARM TO SELF* 18-19 (1986). See also FEINBERG, *supra*, at 75-79 (commenting on Mill's discussion of slavery contracts). To the extent that the harm principle is used to justify the legalization of assisted suicide, moreover, it is unclear whether many restraints on the practice—for example, limiting access to assisted suicide to the terminally ill or those suffering from grave physical pain—could be sustained, or whether such restrictions might instead be deemed improper limitations on "harmless" consensual activity. One cannot help but ask whether the logical end of an unadulterated harm principle approach would be to adopt a consensual homicide "right" open to all competent adults. See Gorsuch, *supra* note 3, at 669-77.

337. MARGARET PABST BATTIN, *Euthanasia: The Fundamental Issues*, in *THE LEAST WORST DEATH*, *supra* note 87, at 101, 119 (emphasis added).

Although she seemingly identifies the incommensurability problem—namely, that utilitarian reasoning merely “sets up a conflict” between competing goods without resolving it—Battin claims to see a way out on utilitarian grounds:

To protect those who might wrongly be killed or allowed to die might seem a stronger obligation than to satisfy the wishes of those who desire release from pain, analogous perhaps to the principle in law that “better ten guilty men go free than one be unjustly convicted.” However, the situation is not in fact analogous and does not favor protecting those who might wrongly be killed. To let ten guilty men go free in the interests of protecting one innocent man is not to impose harm on the ten guilty men. But to require the person who chooses to die to stay alive in order to protect those who might unwillingly be killed sometime in the future is to impose an extreme harm—intolerable suffering—on that person, which he or she must bear for the sake of others. Furthermore, since, as I have argued, the question of which is worse, suffering or death, is person-relative, we have no independent, objective basis for protecting the class of persons who might be killed at the expense of those who would suffer intolerable pain; perhaps our protecting ought to be done the other way around.<sup>338</sup>

In this latter passage, Battin intimates that the conflict between the competing autonomy interests of those who wish to die and those who wish not to be killed without their consent *can* be resolved, and perhaps resolved in favor of allowing euthanasia—that is, “perhaps our protecting ought to be done the other way around.”<sup>339</sup> Battin begins, however, by acknowledging that the “ten guilty men” maxim, frequently cited as an ideal of our justice system, seems to cut against her position.<sup>340</sup> Battin responds to this by suggesting that the maxim is not properly applicable in, or analogous to, the assisted suicide and euthanasia debate.<sup>341</sup> She suggests that society’s traditional willingness to protect the one innocent man even at the expense of letting ten guilty men go free is based, at least in part, on the fact that doing so imposes no “harm” on the guilty men; by contrast, Battin observes, preventing

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338. *Id.* (footnote omitted).

339. *Id.*

340. *See id.*

341. *See id.*

persons from seeking assistance in dying does impose real harms on them.<sup>342</sup>

This argument does not seem to work. The point of the "ten guilty men" is not that we protect innocent human life against the risk of mistaken or wrongful killings *only* when it imposes no harm on the guilty, as Battin seems to suggest. Rather, it is that society protects the innocent individual life against such risks *even when* it means accepting harms to the guilty men's potential future victims and to other innocent victims of those emboldened by the state's leniency. Any attempt to apply the maxim in the consensual homicide context would therefore surely result in the conclusion that it is wrong to risk killing one innocent person even if it means accepting the fact that other innocent persons may be forced to forgo the opportunity to obtain assisted suicide or euthanasia.

Other utilitarians seeking a way around the incommensurability problem sometimes seem to resort to the principle of double effect, arguing that the undesirable consequences associated with permitting assisted suicide and euthanasia (for example, deaths caused by abuse, mistake or pressure) may be discounted because they are *unintended*; in legalizing assisted suicide, society *intends* not to do anyone any harm but only to permit freely chosen decisions to die.<sup>343</sup> Joel Feinberg, for one, argues that we should

consider reasonable mistakes in a legalized voluntary euthanasia scheme to be "the inevitable by-products" of efforts to deliver human beings, at their own requests, from intolerable suffering, or from elaborate and expensive

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342. *See id.*

343. The principle of double effect is commonly interpreted as setting forth certain conditions for assessing whether a person may morally perform an action from which two effects will follow, one bad, and the other good:

(1) The act itself must be morally good or at least indifferent. (2) The agent may not positively will the bad effect but may merely permit it. If [the agent can] attain the good effect without the bad effect, he should do so. . . . (3) The good effect must flow from the action at least as immediately (in the order of causality, though not necessarily in the order of time) as the bad effect. In other words, the good effect must be produced directly by the action, not by the bad effect. Otherwise, the agent would be using a bad means to a good end, which is never allowed. (4) [Finally], [t]he good effect must be sufficiently desirable to compensate for the allowing of the bad effect.

4 NEW CATHOLIC ENCYCLOPEDIA 1021 (1967). As suggested by these conditions, the principle of double effect categorically rules out any action that is *intended* to bring about a morally "evil" effect. *See id.* Meanwhile, actions that bring about such effects *unintentionally*, even if fully foreseen, are not categorically prohibited, but are instead analyzed to determine whether the intended (good) effect is proportional to the unintended (bad) consequence. *See id.*



prolongations of a body's functioning in the permanent absence of any person to animate that body.<sup>344</sup>

Williams similarly downplays the fact that legalizing assisted suicide is likely to carry with it (additional) killings due to abuse, mistake or pressure: "[i]t may be allowed that mistakes are always possible, but this is so in any of the affairs of life."<sup>345</sup> Yet, Williams's apparent reliance on double effect doctrine in this context—distinguishing between "mistakes" or other unintended consequences associated with legalization, and those consequences that are intended—is distinctly at odds with his vociferous attack on the principle elsewhere.<sup>346</sup> It is also, fundamentally, a recognition that utilitarianism cannot, by itself, solve the assisted suicide question. In suggesting that *intended* consequences are more important or weighty than *unintended* ones, Feinberg and Williams step outside a purely utilitarian analysis aimed at enhancing pleasurable or social welfare-maximizing consequences to endorse a *separate, independent moral theory* for ranking or scoring different kinds of consequences, one that is foreign to a strictly utilitarian account.

Even if they could somehow rank consequences based on the intent behind them without undermining the promise of their consequentialist-utilitarian enterprise (and it is hard to see how they could), Feinberg's and Williams's argument still does not end the assisted suicide debate. Rather, it only raises the question whether a state that chooses legalization, with the *intent* to permit freely chosen deaths (with the unintended and unwanted "expense" of new cases of killing due to abuse, mistake, and pressure), is preferable, by reference to some moral principle, to a state that chooses to make assisted suicide illegal, with, say, the *intent* of protecting innocent life against nonconsensual killings due to abuse, mistake or pressure (with the unintended and unwanted "expense" of denying some people who wish to die a legal right to obtain help from others). Simply put, merely referencing intent is hardly enough: Feinberg and Williams still owe us some explanation why a regime that *intends* to allow some persons the freedom to engage legally in assisted suicide is to be preferred to one that *intends* to protect innocent life by prohibiting such practices.

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344. JOEL FEINBERG, *An Unpromising Approach to the "Right to Die"*, in *FREEDOM AND FULFILLMENT: PHILOSOPHICAL ESSAYS* 260, 273–74 (1992).

345. WILLIAMS, *supra* note 329, at 283.

346. See GLANVILLE WILLIAMS, *TEXTBOOK OF CRIMINAL LAW* 37 (2d ed. 1983) (rejecting the notion that punishment is justified on the theory that society's intent is not to harm offenders through incarceration but to prevent crime (with punishment being an unintended side effect), and arguing that punishment is justified by "utilitarian opinion" under the theory that any harm done to offenders is outweighed by the benefit of preventing graver evils from occurring to future victims).



## CONCLUSION

In this Article, I have sought to show that the utilitarian case for assisted suicide and euthanasia is not altogether free from doubt. To be sure, benefits would flow from legalization. I do not seek here to discount such benefits or suggest that they are "outweighed" by attendant costs. Instead, I have sought only to show that legalization may also entail real and material costs, and thus, that the utilitarian interested in selecting the legal rule that serves the greatest good for the greatest number is presented with a nontrivial choice.

Such practical concerns about the costs attendant to legalization have, in fact, persuaded many authorities to retain laws against assisted suicide. The Canadian Supreme Court declined to find a right to assisted suicide precisely because, in its judgment, "the concerns about abuse and the great difficulty in creating appropriate safeguards" make it impossible to say that a blanket prohibition on assisted suicide is inappropriate or fails to reflect "fundamental values at play in our society."<sup>347</sup> The British House of Lords also recommended against legalization, in part, because "it would not be possible to frame adequate safeguards against non-voluntary euthanasia if voluntary euthanasia were to be legalised. It would be next to impossible to ensure that all acts of euthanasia were truly voluntary, and that any liberalisation of the law was not abused."<sup>348</sup> In the United States, Justice Souter, concurring in *Glucksberg*, declined to find a constitutional right to assisted suicide because, in his view,

[t]he case for the slippery slope is fairly made out here . . . because there is a plausible case that the right claimed would not be readily containable by reference to facts about the mind that are matters of difficult judgment, or by gatekeepers who are subject to temptation, noble or not."<sup>349</sup>

Such judgments, I submit, cannot be ruled out as unreasonable on the available evidence.

In the end, moreover, I submit that the utilitarian focus on competing costs and benefits—such as the interest in allowing patients to exercise their autonomy versus the interest in preventing the nonconsensual killing of innocent persons—may help sharpen our thinking about the policy choice we face, but it provides us with no definitive guidance when it comes to choosing between such radically

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347. *Rodriguez v. Attorney Gen. of Canada & Attorney Gen. of B.C.*, [1993] 3 S.C.R. 519, 522 (Can.).

348. H.L. REPORT, *supra* note 64, at 49.

349. 521 U.S. at 785 (Souter, J., concurring).

different, and ultimately incommensurate, interests. A utilitarian approach to the assisted suicide question may help clarify the consequences of legalization or nonlegalization, but it will not—and, more fundamentally, cannot—resolve the debate.

## APPENDIX A

CERTAIN AMERICAN STATUTORY LAWS BANNING OR  
DISAPPROVING OF ASSISTED SUICIDE

42 U.S.C. §§ 14401-14408 (2000) (denying the use of federal funds in connection with acts of assisted suicide).

ALA. CODE ANN. § 22-8A-10 (Michie 1997) (stating that Alabama's medical directive statute shall not be construed to condone assisted suicide).

ALASKA STAT. ANN. § 11.41.120(a)(2) (Lexis 2002).

ARIZ. REV. STAT. ANN. § 13-1103(A)(3) (West 2001).

ARK. CODE ANN. § 5-10-104(a)(2) (Michie 1997).

CAL. PENAL CODE § 401 (West 1999).

COLO. REV. STAT. ANN. § 18-3-104(1)(b) (West 2004).

CONN. GEN. STAT. ANN. § 53a-56(a)(2) (West 2001).

DEL. CODE ANN. tit. 11, § 645 (Michie 2001).

FLA. STAT. ANN. § 782.08 (West 2000).

GA. CODE ANN. § 16-5-5 (2003).

HAW. REV. STAT. ANN. § 707-702(1)(b) (Michie 2003).

IDAHO CODE § 56-1022 (Michie 2002) (stating that Idaho's medical directive statute shall not be construed to make legal or condone mercy killing, assisted suicide or euthanasia).

720 ILL. COMP. STAT. ANN. 5/12-31 (West 2002).

IND. CODE ANN. § 35-42-1-2, -2.5(b) (Lexis 2004).

IOWA CODE ANN. § 707A.2 (West 2003).

KAN. STAT. ANN. § 21-3406 (Supp. 2003).

KY. REV. STAT. ANN. § 216.302 (Michie 1998).

LA. REV. STAT. ANN. § 14:32.12 (Michie 1998).

ME. REV. STAT. ANN. tit. 17-A, § 204 (West 1983).

MD. CODE ANN., CRIM. LAW § 3-102 (Michie 2002).

MASS. ANN. LAWS ch. 201D, § 12 (Law. Co-op. 1994) (stating that Massachusetts's medical directive statute shall not be construed to condone assisted suicide).

MICH. COMP. LAWS ANN. § 752.1027 (West 2004). "Regarding the recommendations referred to in subsection (5), at the time of publication [2001] recommendations had been submitted to both houses but it was not certain whether the recommendations were those of the full commission or whether both houses 'accepted' the recommendations were presented." MICH. COMP. LAWS SERV. § 752.1027 ed. note (Lexis 2001).

MINN. STAT. ANN. § 609.215 (West 2003).

MISS. CODE ANN. § 97-3-49 (West 1999).

MO. ANN. STAT. § 565.023.1(2) (West 2003).

MONT. CODE ANN. § 45-5-105 (West 2003). An annotator noted: “[u]nder the new sections on Causal Relationship Between Conduct and Result, MCA, 45-2-201, and Accountability, MCA, 45-2-302, a person may be convicted of Criminal Homicide, MCA, 45-5-101 (repealed—now deliberate or mitigated homicide, 45-5-102 and 45-5-103, respectively), for causing another to commit suicide—*notwithstanding the consent of the victim.*”

ANNOTATIONS TO THE MONTANA CODE ANNOTATED § 45-5-105 note (2004).

NEB. REV. STAT. ANN. § 28-307 (Lexis 2003).

NEV. REV. STAT. ANN. § 449.670(2) (Michie 2000) (stating that Nevada’s medical directive statute shall not be construed to condone assisted suicide or euthanasia).

N.H. REV. STAT. ANN. § 630:4 (Michie 1996).

N.J. STAT. ANN. § 2C:11-6 (West 1995).

N.M. STAT. ANN. § 30-2-4 (Michie 2004).

N.Y. PENAL LAW § 120.30 (McKinney 2004).

N.D. CENT. CODE § 12.1-16.04 (1997).

OHIO REV. CODE ANN. § 2133.12(D) (Anderson 2002) (stating that Ohio’s medical directive statute shall not be construed to condone assisted suicide).

OKLA. STAT. ANN. tit. 21, § 813 (West 2002).

18 PA. CONS. STAT. ANN. § 2505 (West 1998).

R.I. GEN. LAWS ANN. § 11-60 (Lexis 2002).

S.C. CODE ANN. § 16-3-1090 (West 2003).

S.D. CODIFIED LAWS § 22-16-37 (Michie 1998).

TENN. CODE ANN. § 39-13-216 (Lexis 2003).

TEX. PENAL CODE ANN. § 22.08 (Vernon 2003).

UTAH CODE ANN. § 75-2-1118 (Michie 1993) (stating that Utah’s medical directive statute shall not be construed to condone assisted suicide).

VA. CODE ANN. § 8.01-622.1 (Lexis 2000) (enacting a civil statute providing that a person may be enjoined from assisting suicide or may be liable for monetary damages by assisting or attempting to assist suicide).

WASH. REV. CODE ANN. § 9A.36.060 (West 2000).

W. VA. CODE ANN. § 16-30-2(a) (Michie 2001) (presenting the legislative finding that West Virginia’s medical directive statute does not legalize, condone, authorize or approve of assisted suicide).

WIS. STAT. § 940.12 (2003–2004).

## APPENDIX B

Below are certain calculations used in preparing certain graphs in the text. All calculations are based on mortality statistics from the World Health Organization.

Graph 2

Suicide Rate of Dutch Elderly (75 years +) Women as a Multiple of the Total Female Suicide Rate, 1984-2000<sup>350</sup>

Year	Elderly (75+) Female Suicide Rate per 100,000	Total Female Population Suicide Rate per 100,000	Suicide Rate of Elderly Women as a Multiple of Total Female Suicide Rate
1984	14.6	9.6	1.5208333
1985	10.8	8.0	1.35
1986	13	8.1	1.6049383
1987	13.8	8.2	1.6829268
1988	10.7	7.3	1.4657534
1989	10.7	7.4	1.4459459
1990	15.3	6.8	2.25
1991	11.3	7.1	1.5915492
1992	12.2	6.7	1.8208955
1993	12.2	6.4	1.90625
1994	9.5	6.1	1.557377
1995	9.6	6.1	1.5737704
1996	11.2	6.3	1.7777778
1997	11.7	6.2	1.8870968
1998	10.8	6.0	1.8
1999	9.3	5.9	1.5762711
2000	7.7	5.8	1.3275862

350. Reg'l Office of Eur., World Health Org., Mortality Indicators by 67 Cause of Death, Age and Sex, at [http://www.euro.who.int/InformationSources/Data/20011017\\_1](http://www.euro.who.int/InformationSources/Data/20011017_1) (last visited Dec. 22, 2004).

Graphs 3 & 4  
Suicide Rate of Elderly Persons (75 yrs. +)  
as a Multiple of the Total Suicide Rate<sup>351</sup>

Country (Year)	Elderly (75+) Suicide Rate per 100,000	Total Suicide Rate per 100,000 Population	Suicide Rate of Elderly as Multiple of Total Suicide Rate
Finland (2002)			
Men	50.3	32.3	1.56
Women	7.5	10.2	0.74
Canada (2000)			
Men	22.7	18.4	1.23
Women	2.8	5.2	.54
Australia (2001)			
Men	26.3	20.1	1.31
Women	5.8	5.3	1.09
Norway (2001)			
Men	30.0	18.4	1.63
Women	3.2	6.0	0.53
USA (2000)			
Men	42.4	17.1	2.48
Women	4.0	4.0	1.00
U.K. (1999)			
Men	15.5	11.8	1.31
Women	5.1	3.3	1.55
Sweden (2001)			
Men	42.2	18.9	2.23
Women	12.7	8.1	1.57
France (1999)			
Men	80.5	26.1	3.08
Women	17.5	9.4	1.86
Netherlands (2000)			
Men	28.3	12.7	2.23
Women	7.8	6.2	1.26

351. World Health Org., Mental Health, Country Reports and Charts Available, at [http://www.who.int/mental\\_health/prevention/suicide/country\\_reports/en/](http://www.who.int/mental_health/prevention/suicide/country_reports/en/) (last visited Dec. 20, 2004). All data is for the most recent year for which the World Health Organization has published online statistics for the country in question.

Italy (2000)			
Men	34.2	10.9	3.14
Women	7.4	3.5	2.11
Denmark (1999)			
Men	46.6	21.4	2.18
Women	10.9	7.4	1.47
Germany (2001)			
Men	60.9	20.4	2.99
Women	18.2	7.0	2.6
Spain (2000)			
Men	44.9	13.1	3.43
Women	9.1	4.0	2.28