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Articles

KNIGHT IN THE DUEL WITH DEATH: PHYSICIAN ASSISTED SUICIDE AND THE MEDICAL NECESSITY DEFENSE

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I. INTRODUCTION

SUICIDE and attempted suicide are legal in America. While self-destruction may be ethically reprehensible, no state bans suicide and few states ban the inchoate act of attempted suicide.2

1. As a matter of public policy, many states discourage suicide through legislative enactment and case law. For a discussion of state public policy on suicide, see infra notes 48-53 and accompanying text. Nearly every state has an involuntary forensic commitment proceeding for those who are deemed suicidal and dangerous. For a further discussion of involuntary commitment, see infra note 51 and accompanying text. Many states encourage third parties to prevent suicide and many states explicitly discourage suicide as a moral wrong. For a further discussion of state law aimed at preventing and discouraging suicide, see infra notes 49-51 and accompanying text.


Under American law, suicide has never been punished and the ancient English attitude has been expressly rejected. Rather than classifying suicide as criminal, suicide in the United States “has continued to be considered an expression of mental illness.” As one commentator has noted, “punishing suicide is contrary to modern penal and psychological theory.”

Attempted suicide was also a crime at common law. A few American jurisdictions have adopted this view, but most . . . attach no criminal liability to one who makes a suicide attempt.

Id. (citations omitted); see also Thomas J. Marzen et al., Suicide: A Constitutional Right?, 24 Duq. L. Rev. 1, 148-242 (1985) (providing historical summary of each state’s legal history with suicide, attempted suicide and assisted suicide). In the seminal American case of Burnett v. People, 68 N.E. 505, 510 (Ill. 1903), the court stated that it had never “seen fit to define what character of burial our citizens shall enjoy . . . [nor] regarded the English law as to suicide as applicable.” Id. In Sanders v. State, 112 S.W. 68, 70 (Tex. Crim. App. 1908), overruled by State v. Aven, 277 S.W. 1080 (Tex. Crim. App. 1925), the court declared, “Whatever may have been the law in England . . . so far as our law is concerned, . . . suicide is innocent of criminality.” Id. In the few states which regarded suicide as criminal, punish-
Most states prohibit assisted suicide, however, as being equivalent to murder, manslaughter or a lesser felony.\(^3\) Physician assisted suicide contemplates the assistance of a physician who prescribes lethal drugs or provides other lethal means, to a terminally ill patient.\(^4\) In such cases, the physician does not administer the drugs; the final choice to consume the drugs rests with the patient. This assistance allows the patient to die peacefully, rather than prolong death's assault. Those who aid in a suicide may be caught, however, in a web was unenforced. See Herbert Hendin, Suicide in America 44 (1995) (observing that American courts never embraced English common law view of suicide).

\(^3\) For a discussion of the treatment of assisted suicide by the various states, see infra note 56 and accompanying text. Only the State of Oregon has legislatively authorized physician assisted suicide, after the proposed measure met with public passage as a ballot referendum. This progressive state statute provides a detailed procedure for physician assisted suicide when one is tormented by a terminal illness. The Oregon Death with Dignity Act, OR. REV. STAT. §§ 127.800-127.897 (1995) [hereinafter Measure 16]. The validity of this statute, however, is in question. See Lee v. Oregon, 891 F. Supp. 1421, 1428 (D. Or. 1995) (holding that Measure 16 violates Equal Protection Clause of the Fourteenth Amendment). For a further discussion of Measure 16, see infra note 80 and accompanying text. Conversely, the United States Courts of Appeals for the Ninth and Second Circuits have recently held that statutes banning assisted suicide for terminally ill patients are unconstitutional based on equal protection and substantive due process grounds. See Quill v. Vacco, 80 F.3d 716, 718 (2d Cir.) (holding that ban on physician assisted suicide violated Equal Protection Clause), cert. granted, 117 S. Ct. 36 (1996); Compassion in Dying v. Washington, 79 F.3d 790, 799-839 (9th Cir.) (en bane) (holding that ban on physician assisted suicide unconstitutionally interferes with liberty interest of terminally ill patients to hasten their own deaths), cert. granted sub nom Washington v. Glucksberg, 117 S. Ct. 37 (1996). While the United States Supreme Court may very well reject the liberty interest and equal protection holdings of the Ninth and Second Circuits, the Court might honor a state's statutory scheme as invoking a choice in the manner of death. See Cruzan v. Director, Missouri Dep't of Health, 497 U.S. 261, 286-87 (1990) (holding that state's statutory scheme regulating decision to terminate life of person in persistent vegetative state does not violate Due Process Clause). For a further discussion of Cruzan, see infra note 55 and accompanying text. Although the Ninth and Second Circuits have carved a sudden protected interest in the face of century-old statutes banning assisted suicide, many states continue to statutorily ban assisted suicide. Michigan, however, is one of the states that judicially bans assisted suicide. Michigan is also where former physician Jack Kevorkian has been prosecuted in three cases for assisted suicide, all of which have resulted in acquittal.

\(^4\) Several definitions are noteworthy. "Active or positive euthanasia" is the affirmative killing by any person for the sake of relieving suffering. See Joseph Fletcher, In Defense of Suicide, reprinted in Suicide: Right or Wrong? 61, 70 (John Donnelly ed., 1990) (discussing current attitudes toward suicide). "Passive or neg-ative euthanasia" is the killing by omission in letting one die to relieve suffering. Id. at 69. "Active suicide" is the intentional killing of oneself by an affirmative act, and "passive suicide" is the intentional killing of oneself by omission. Id. "Assisted suicide" involves a person actively aiding in another person's suicide. For a collection of philosophical and legal essays on killing versus "letting die," see Killing and Letting Die (Bonnie Steinbock & Alastair Norcross eds., 1994).
of criminality,^ because consent is not a defense to physician assisted suicide.\footnote{6} Traditionally, courts have viewed a life as sacred, regardless of how muted its quality or how kindly the motive to kill. The criminal law tolerates no lesser standard based on the victim's quality of life.\footnote{7}

Criminal prosecutions generally and necessarily hinge on the purpose, exculpation and justification of the actor, yet assisted suicide prosecutions ignore purpose and excuse.\footnote{8} Thus, in attempting to defend against such prosecutions, the physician may attempt to invoke defenses such as causation or mistake of law.\footnote{9} In recent as-


\footnote{7. See, e.g., People v. Roberts, 178 N.W. 690, 691 (Mich. 1920) (holding that providing means of suicide to terminally ill wife is murder at common law), overruled in part by People v. Kevorkian, 527 N.W.2d 714, 716 (Mich. 1994) (overruling Roberts to extent that it holds that providing means of suicide is murder rather than common law felony), cert. denied, 115 S. Ct. 1795 (1995).

\footnote{8. See John D. Conomy, The Death of a Person: Ethics, the Practice of Medicine and the Law, 20 Ohio N.U. L. Rev. 717, 721 (1993) ("The law deals with intent, not motivation. It doesn't look to that reason when it comes to the life of another person, or the taking of that person's life."). See generally William E. Mikell, Is Suicide Murder?, 3 Colum. L. Rev. 379 (1903) (describing various decisions holding suicide to be murder, yet imposing punishment of mere forfeiture).

\footnote{9. See Joshua Dressler, Understanding Criminal Law 144 (1987). The mistake of law defense requires that: (1) the accused mistakenly believed that his or her conduct fell outside the scope of the criminal statute, and (2) the accused's misunderstanding of the law was based on an official but erroneous interpretation of the law, such as from reliance on judicial opinions. Id. See, e.g., Joan Bovins & Thomas Oehmke, Dr. Death: Dr. Jack Kevorkian's Rx 45-61 (1993) (hearing about assisted suicide acquittals of Jack Kevorkian, Mr. Bertram Harper flew his terminally ill wife from their home in California to Michigan, he then assisted in his wife's suicide and was acquitted of second degree murder).

Moreover, after Jack Kevorkian's third trial for assisted suicide ended in an acquittal, one juror explained her reasoning in finding that Dr. Kevorkian should not have been even charged for wrongdoing. Kevorkian Again Cleared by Jury; Lawmaker Says Legislature Must Confront Issue, Chi. Trib., May 15, 1996, § 1, at 4 (finding case was unique in that prosecution attempted to retroactively apply 1994 Michigan Supreme Court decision to acts that occurred in 1991). The juror explained that the fundamental principles of legality and ex post facto law guided their decision in the verdict, such that no conduct is criminal and punishable unless and until the legislature makes the conduct a crime. Id. The juror also stated that the jury believed Dr. Kevorkian's testimony that he did not think assisted sui-
sisted suicide prosecutions against Michigan physician Jack Kevorkian, a new defense emerged, which asserts the theory of “double-effect” in order to challenge the issue of purpose in the physician’s allegedly unlawful actions. The theory of “double effect” posits that the physician’s intent was not to cause death, but to relieve suffering, and that death was a collateral consequence. In addition to this stated defense, the physician may also receive the benefits of jury nullification. While jury nullification may explain the prevailing number of historical acquittals in cases concerning euthanasia, it is not a legally cognizable defense.

This Article proposes a formal recognition of a medical necessity defense to assisted suicide. This defense incorporates the

10. For a discussion of the “double effect” principle, see infra notes 209, 271-77 and accompanying text.

11. See David R. Schanker, Note, Of Suicide Machines, Euthanasia Legislation, and the Health Care Crisis, 68 IND. L.J. 977, 985-86 (1993) (suggesting that acquittals in euthanasia cases hinge on tolerance of assisted suicide by juries). The jury nullification theory accounts for the prevailing number of historical acquittals for those indicted for assisted suicide. Under jury nullification, the jury has the power to enter an acquittal contrary to the prevailing number of assisted suicide cases. While the jury is not instructed on this power and is specifically told that the case must be based, not on sympathy, but on the evidence and the court’s instructions, the jury can simply refuse to enforce a law of which it disapproves. Id. Defense attorneys are not allowed to argue or even suggest a jury nullification defense. Id. If the jury nullifies the law, however, the verdict will stand. Id.; see also Stanley M. Rosenblatt, Murder of Mercy 13-15, 289-90 (1992) (describing attorney’s defense in Florida euthanasia case by indirectly relying on jury nullification).

Nearly all reported cases of physician assisted suicide have resulted in dismissed charges or an acquittal. See Schanker, supra, at 986-91 (noting cases since 1949 where physicians were acquitted for assisted suicide); see also Michael Betzold, Appointment with Doctor Death 328 (1993) (noting former physician Jack Kevorkian was acquitted in assisted suicide of Thomas Hyde, although prosecutions for dozens of his other assisted suicides remain pending); Rosenblatt, supra, at 536-37 (recounting acquittal of Dr. Peter Rosier in Florida for assisting in suicide of his wife); Antonios P. Tsarouhas, The Case Against Legal Assisted Suicide, 20 OHIO N.U. L. REV. 793, 798-99 (1993) (describing several more reported prosecutions of physician assisted suicide since 1935 where none of physicians were convicted). There have been, however, a couple cases where the person assisting in another’s suicide either plead guilty or was actually found guilty. See, e.g., Brovins & Oehmke, supra note 9, at 236 (noting that, in 1988, Dr. Donald Caraccio pled guilty in Michigan and served five years probation for injecting potassium chloride into terminally ill patient); Rosenblatt, supra, at 15 (noting that Roswell Gilbert was convicted in Florida and received 25 years in prison for assisting in death of his terminally ill wife, only to be later pardoned by governor); id. at 342 (detailing how Dr. Timothy Quill was nearly indicted for assisting in suicide of his wife).

12. Several authors and cases propose, without elaboration, a medical necessity defense to euthanasia. See, e.g., Robin Isenberg, Note, Medical Necessity as a Defense to Criminal Liability: United States v. Randall, 46 GEO. WASH. L. REV. 275,
value of both the “double effect” principle and jury nullification. While a number of courts have examined the constitutionality of the issue of an individual’s “choice” surrounding the right to die or have gone on to declare assisted suicide statutes unconstitutional, this Article assumes the validity of assisted suicide statutes and traditional murder theories. Further, it conceptualizes a criminal defense based on medical necessity or choice of evils. The virtue of the medical necessity defense is that it implements a new right of “choice” through an old “necessity” remedy which balances individual needs, values concerning life and governmental prohibitions. The defense also legitimizes the jury’s predisposition to acquit the physician in the face of a clear violation of the law and avoids the impropriety of jury nullification. On a case-by-case determination, the defense offers a uniform resolution to a compelling issue; it circumvents constitutional quagmires, provides a remedy in extreme cases and provokes legislative reform.

Part II of this Article details the history of suicide and attempted suicide and then explores the reasons most states prohibit assisted suicide. In addition, it analyzes the clinical environment of those suffering from terminal illnesses and their consequent legal dilemma. Part III describes “the choice of evils” embedded in
the medical necessity defense and the paradox of asserting a defense that enlists death rather than life. 17 Part IV applies the medical necessity factors to an assisted suicide prosecution. 18 Part V concludes with a discussion of the societal ramifications of the medical necessity defense. 19

II. Suicide and Assisted Suicide

A. History of Suicide

Physician assisted suicide is a form of euthanasia and has its recorded origins with the ancient Greeks. The term “euthanasia” means painless, happy death 20 and contemplates the termination of human life by tranquil means for the purpose of ending severe physical suffering. 21 Some of the ancient Greeks and Romans encouraged suicide by teaching that it was a person’s right to die by choice and without compromise. 22

17. For a discussion of the medical necessity defense, see infra notes 133-74 and accompanying text.
19. For a discussion of the societal ramifications of the medical necessity defense, see infra notes 286-94 and accompanying text.
20. Tsarouhas, supra note 11, at 794; see BLACK’s LAW DICTIONARY 554 (6th ed. 1990) (defining euthanasia as “[t]he act or practice of putting to death persons suffering from incurable and distressing disease as an act of mercy”).
22. See A.W. Mair, Suicide, in 12 ENCYCLOPEDIA OF RELIGION AND ETHICS 26-27 (James Hastings ed., 1922) (stating that earliest reference to suicide is found in poems of Homer, wherein suicide is not condemned, but is celebrated as heroic nature). Classical Greek suicide allowed citizens the opportunity to plead their cause for suicide before the Senate. The precepts were clear:

  Whoever no longer wishes to live shall state his reasons to the Senate, and after having received permission shall abandon life. If your existence is hateful to you, die; if you are overwhelmed by fate, drink the hemlock. If you are bowed with grief, abandon life. Let the unhappy man recount his misfortune, let the magistrate supply him with the remedy, and his wretchedness will come to an end.

ALFRED ÁLVAREZ, THE SAVAGE GOD: A STUDY OF SUICIDE 61 (1972). This pro-suicide view was reinforced by Roman law. According to the Justinians, “if someone puts an end to his life through taedium vitae or unendurable pain of some kind, or otherwise, he has a successor . . . . [A] person’s motive for committing suicide is
Conversely, many philosophers rallied against suicide as being cowardly, undignified and abusive. The influence of Christianity that followed then instructed that euthanasia was immoral and uncivilized because human life belonged to the deity alone. Follow-

relevant . . . For he should by all means be punished unless he was compelled to do so by taedium vitae or unendurable pain of some kind.” \textit{4 The Digest of Justinian} 858 (Theodor Mommsen et al. eds., 1985). Roman philosopher and Stoic, Lucius Annaeus Seneca (4 B.C.- 65 A.D.), who was accused of conspiring to kill the Roman Emperor Nero and who subsequently committed suicide, also sanctioned suicide. Seneca proclaimed:

If one death is accompanied by torture, and the other is simple and easy, why snatch the latter? Just as I shall select my ship when I am about to go on a voyage, or my house when I propose to take a residence, so I shall choose my death when I am about to depart from life. Moreover, just as a long-drawn-out life does not necessarily mean a better one, so a long-drawn-out death necessarily means a worse one. There is no occasion when the soul should be humored more than at the moment of death. Let the soul depart as it feels itself impelled to go, whether it seeks the sword, or the halter, or some draught that attacks the veins, let it proceed and burst the bonds of its slavery. Every man ought to make his life acceptable to others besides himself, but his death to himself alone.

Lucius Annaeus Seneca, \textit{On the Proper Time to Slip the Cable}, reprinted in \textit{Suicide: Right or Wrong?}, supra note 4, at 27, 29 (footnote omitted).

23. According to Pythagoras of Samos (580-500 B.C.), death was a process of reincarnation, and suicide constituted a violation of the continuum of a divine law and was consequently immoral. See Marzen et al., \textit{supra} note 2, at 21 (articulating role of suicide in ancient Greco-Roman culture). The Greek philosopher Socrates also thought suicide was immoral. He believed that all humans were the subjects of the gods, and that no one had the right to dispose of their own lives because this would provoke the gods. \textit{Id}. at 21-22. Ironically, Socrates committed suicide at the direction of the State upon his conviction for irreligion. \textit{Id}. \textit{See generally} I.F. Stone, \textit{The Trial of Socrates} 133-247 (1989) (discussing prosecution of Socrates). The Greek philosopher Plato found suicide to be an act of cowardice. Plato reasoned that “the man who thus gives unrighteous sentence against himself from mere poltroonery and unmanly cowardice . . . (and such people) must have no companions whatsoever in the tomb. Furthermore, they must be buried ignominiously in waste and nameless spots . . . and the tomb shall be marked by neither headstone nor name.” \textit{Plato, Laws} 873c-e, \textit{reprinted in Collected Dialogues of Plato} 1432 (Edith Hamilton & Huntington Cairns eds., 1961); \textit{see Plato, Apology, in Ten Great Works of Philosophy} 11-36 (Robert Paul Wolff ed., 1969). The Greek philosopher Aristotle also believed that suicide was the act of a coward:

But to seek death in order to escape from poverty, or the pangs of love, or from pain or sorrow, is not the act of a courageous man, but rather of a coward; for it is weakness to fly from troubles, and the suicide does not endure death because it is noble to do so, but to escape evil.

\textit{Aristotle, Nicomachean Ethics} III 161 (H. Rackham trans., 1926).

24. Saint Augustine (354-430 A.D.) condemned suicide as violative of the Sixth Commandment, “Thou shalt not kill.” \textit{See 2 Whitney J. Oates, Basic Writings of Saint Augustine} 27, 28 (1948) (explaining why Christians have no authority for committing suicide). Saint Augustine recognized only two exceptions for murder: (1) killing pursuant to a just, generally applicable law, such as in war or capital punishment, and (2) killing by special edict from God, such as with Samson and Abraham. \textit{Id}; \textit{see also St. Thomas Aquinas, Whether It Is Lawful to Kill Oneself?}, \textit{reprinted in Suicide: Right or Wrong?}, supra note 4, at 33-36 (noting that Thomas Aquinas shared view that suicide is always sinful).
ing Christ’s crucifixion and legacy, “suffering” promised a rewarding afterlife.25

Throughout the ages, religious intolerance, political strife, health crises and the ravages of war have created natural scripts for individual and mass suicides.26 During the times of the black plague and cholera epidemics, great numbers of people committed suicide rather than suffer the slow and painful indignities of the disease.27 In the Middle Ages, many treatises re-introduced the art of dying well, ars moriendi, as a way to avoid a tortuous death.28 At the time, the Catholic Church’s opprobrium towards suicide was compromised by its own need to excuse the voluntary suicides of the devout Christian martyrs, who accelerated their own deaths by

25. See Fletcher, supra note 4, at 66 (noting that Saint Augustine held suicide to be objectionable because “[o]ur duty is to bear suffering with fortitude; to escape is to evade our role as soldiers of Christ”); see also Jacques Choron, Suicide 103 (1972) (discussing religious opposition to suicide and euthanasia). Choron observed:

As far as an “easy death” is concerned, it is not what the true Christian primarily aspires to. “The believer has the extraordinary advantage of knowing that in reality death is punishment imposed for having sinned, and necessary for man in order for him to be able to expiate his crime.”

Thus, for a Christian, physical death is not even supposed to be “easy.” Christ himself suffered a horrible and painful death. The agony of dying is made easier to bear by the hope of eternal life, but the ordeal must be borne with resignation.

Id. (quoting Blaise Pascal, Vie de Blaise Pascal, in Pensees et Opuscules 37 (12th ed. 1924)).


27. See Daniel Defoe, History of the Plague in London 87 (1894) (detailing sufferings of Londoners during plague epidemic of 1665); see also Johannes Nohl, The Black Death: A Chronicle of the Plague 32 (C.H. Clarke trans., 1924) (describing suicides to escape torments of plague). Commenting upon the suffering endured by Londoners during the plague epidemic, Defoe stated:

It is scarce credible what dreadful cases happened in particular families every day,—people, in the rage of the distemper, or in the torment of their swellings, which was indeed intolerable, running out of their own government, raving and distracted, and oftentimes laying violent hands upon themselves, etc.; mothers murdering their own children in their lunacy; some dying of mere grief as a passion, some of mere fright and surprise without any infection at all; others frightened into idiotism and foolish distractions, some into despair and lunacy, others into melancholy madness.

Defoe, supra, at 87.

28. See Jacques Choron, Death and Western Thought 97, 135, 267 (1963) (finding ars moriendi involves “mastering the fear of death and preventing it from poisoning the enjoyment of life”).
self-deprivation, asceticism and self-sacrifice,\textsuperscript{29} as well as the chaste women who killed themselves to protect their virginity.\textsuperscript{30} Nonetheless, at the Council of Braga in 563 A.D., the Church decided that all who committed suicide were to be punished posthumously.\textsuperscript{31}

Despite the practical inability to prevent suicide, the English common law proscribed it for the secular reason that the King had a superior legal interest over his subjects and for the moral reason that every life belonged to God.\textsuperscript{32} The English courts attempted to

\begin{itemize}
\item \textsuperscript{29} Saint Augustine condemned the practice of liberal martyrdom. G. Steven Neeley, \textit{The Constitutional Right to Suicide: A Legal and Philosophical Examination} 40 (1994). Neeley writes:
\begin{quote}
It became commonplace for fanatical Christians to taunt their Roman persecutors into acts of violence. The sect whom Saint Augustine particularly noted for this practice was the Circumcelliones: “these people not only sought out martyrdom, profaning the temples of paganism in order to be executed, but, when all other expedients failed, cast themselves by the hundred in ecstasy from lofty cliffs, till the rocks below were reddened with their blood.” “To kill themselves,” said Augustine, “out of respect for martyrdom is their daily sport.”
\end{quote}

\item \textsuperscript{30} Oates, \textit{supra} note 24, at 24. Saint Augustine attempted to reverse self-imposed martyrdom by teaching that chastity is not lost through external circumstances when one is compelled to yield to the control of another. Saint Augustine explained that:
\begin{quote}
[A] woman who has been violated by the sin of another, and without any consent of her own, has no cause to put herself to death; much less has she cause to commit suicide in order to avoid such violation, for in that case she commits certain homicide to prevent a crime which is . . . not her own.
\end{quote}

\item \textsuperscript{31} St. John-Stevas, \textit{supra} note 26, at 249. Several canonical directives prohibited suicide. “The Council of Arles (452 A.D.), for example, incorporated the Roman law’s forfeiture of a suicide’s estate. The Council of Braga (563 A.D.) banned religious rites for suicides. The Antisidor Council (590 A.D.) provided penalties for suicide, and the Synod of Nimes (1284 A.D.) denied suicides Christian burial.” Marzen et al., \textit{supra} note 2, at 28-29; \textit{see also} St. John-Stevas, \textit{supra} note 26, at 249 (discussing Church doctrine on suicide as expressed in Church law).

\item \textsuperscript{32} The early English decision of \textit{Hales v. Petit}, 75 Eng. Rep. 387 (1562), prohibited suicide for several reasons:
\begin{quote}
[Suicide is a]gainst nature, because it is contrary to the rules of self-preservation, which is the principle of nature, for every thing living does by instinct of nature defend itself from destruction, and then to destroy one’s self is contrary to nature, and a thing most horrible. Against God, in that it is a breach of His commandment, \textit{thou shalt not kill}; and to kill himself, by which act he kills in presumption his own soul, is a greater offence than to kill another. Against the King in that hereby he has lost a subject, and . . . he being the head has lost one of his mystical members. Also he has offended the King, in giving such an example to his subjects, and it belongs to the King, who has the government of the people, to take care that no evil example be given them, and an evil example is an offence against him.
\end{quote}

\end{itemize}
enforce a ban on suicide through threatened forfeiture of real and personal property, ignominious burial and bodily desecration, unless the person was proven to have been insane. See John Locke, Two Treatises of Government 288-89 (Peter Laslett ed., 1960) ("For Men being all the Workmanship of one Omnipotent ... are his Property, ... made to last during his, not one others Pleasure.... Every one ... is bound to preserve himself.").

33. See 2 Henricus de Bracton, Henrici de Bracton de Legibus et Consuetudinibus Angliae 505-09 (Sir Travers Twiss ed., 1883) (noting that penalty for suicide depended on circumstances and could include forfeiture of goods and/or depriving heirs of inheritance); see also L.B. Curzon, English Legal History 241-42 (2d ed. 1979) ("[S]elf-slaughter was a felony and, hence, resulted in forfeiture of the good belonging to the person who had killed himself ... [T]he corpse of the suicide was transfixed with a stake and was buried along a highway."); 3 William S. Holdsworth, A History of English Law 315-16 (3d ed. 1923) (noting that suicide resulted in forfeiture of goods except when person was of "unsound mind" or "slew himself by misadventure").

34. See Mikell, supra note 8, at 379 ("If he commits suicide 'from weariness of life or impatience of pain,' his lands descend to his heir and his chattells only are to be confiscated.").

35. See Keith Burgess-Jackson, The Legal Status of Assisted Suicide in Early America: A Comparison with the English Experience, 29 Wayne L. Rev. 57, 75 (1982) (stating that madness or illness often established defense to suicide under English law).

36. See Marzen et al., supra note 2, at 31-32 (stating John Donne's view that each suicide must be judged individually and may even be justified and acceptable to God). Clergyman Robert Burton explored the cure of melancholy and questioned the accepted value that those who commit suicide are eternally damned. Id. Other Enlightenment thinkers in Europe, such as Montesquieu and Voltaire also presented new and changed views on suicide. Id. at 31; see also John Donne and the Renaissance, in Alvarez, supra note 22, at 149 (noting that Donne offered first English defense of suicide). Philosopher David Hume argued that the Laws of Nature do not prohibit suicide because we have the right and obligation to interfere with nature for the evolution of society. David Hume, On Suicide, in Suicide: Right or Wrong?, supra note 4, at 37-43 (applying principles of natural law to decision whether to commit suicide). But see Immanuel Kant, Lectures in Ethics, reprinted in Suicide: Right or Wrong?, supra note 4, at 47-48 ("Man cannot have any power of disposal in regard to himself and his life.").

37. William Shakespeare, Hamlet act 3, sc. 1, at 56-84 (G.R. Hibbard ed., 1987) (quoting portion of Hamlet's famous "to be or not to be" soliloquy on yearn-
Speare's Hamlet was the epitome of the beguiled Renaissance man: "To be or not to be, that is the question." 38

American common law abolished the prohibitions against suicide and attempted suicide because such acts lacked criminal culpability and necessitated compassion, medical treatment and sympathy for both the legacy of the decedent and innocent surviving relatives. 39 Forfeiture, ignominious burial and bodily desecrations became contrary to penal, medical and psychological theory. Moreover, such treatment would contravene the cruel and unusual punishment prohibition of the United States Constitution by disproportionately isolating excusable mental illness as criminal conduct. 40 Additionally, American homicide statutes eliminated the prerequisite element of the taking of any life, which formerly included one's own life, and substituted the taking of the life of another in order to constitute murder. 41

For a brief time, attempted suicide remained criminal so as to deter others and to enable the person to receive treatment. 42 Thereafter, attempted suicide statutes were rescinded for several reasons. The French novelist Camus recognized that: "There is but one truly serious philosophical problem, and that is suicide. Judging whether life is or is not worth living amounts to answering the fundamental question of philosophy." John Donnelly, Introduction to Suicide: Right or Wrong?, supra note 4, at 7. 38. SHAKESPEARE, supra note 37, act 3, sc. 1, at 56-84; see also DANIEL J. KORNSTEIN, KILL ALL THE LAWYERS? SHAKESPEARE'S LEGAL APPEAL 97 (1994) (proffering that Hamlet exhibits traits of melancholy law student).

39. For a discussion of the American legal approach to suicide, see supra notes 2-3 and accompanying text.

40. Thomas Jefferson also opposed the English laws against suicide because forfeiture was too severe a measure in punishing innocent heirs. He believed these provisions of English law to be overbearing and stated:

[T]hat your petitioner hath been further advised that under the present form of government the disposal of confiscated chattels is in your Excellency and your honors, and hopes it will appear to you that the rigorous laws of escheat and forfeiture, invented by a spirit of rapine and hostility of princes towards their subjects in the most barbarous times, and relinquished in practice by them in later and more humanized ages will be thought inconsistent with the principles of moderation and justice which principally endear a republican government to its citizens. . . .


41. See, e.g., ALA. CODE § 13A-6-1(1) (1975) (stating that Alabama Criminal Code does not apply to suicide, because requisite killing must be of "another person" (emphasis added)). 18 PA. CONS. STAT. § 2501(a) (1996) ("[A] person is guilty of criminal homicide if he intentionally, knowingly, recklessly or negligently causes the death of another human being."); MODEL PENAL CODE § 210.1(1) (1980) ("A person is guilty of criminal homicide if he purposely, knowingly, recklessly or negligently causes the death of another human being.").

42. See ST. JOHN-STEVAS, supra note 26, at 257-59 (discussing arguments for and against retaining crime of attempted suicide).
reasons. First, as an inchoate offense, “attempt crimes” were predicated on the criminality of a completed offense. When the completed act of suicide was no longer a criminal offense, then attempting to commit suicide, as a matter of law, could no longer be a crime.\footnote{A seminal case reflecting this view is Commonwealth v. Dennis, 105 Mass. 162 (1870). In Dennis, the court noted that a Massachusetts statute provided that punishment for any attempted crime was to be no more than one-half the punishment for such a completed crime. \textit{Id.} The court also noted, however, that the completed act of suicide was not punishable. \textit{Id.} Therefore, the court reasoned an attempted suicide could not be punishable. \textit{Id.} This view was also shared by other states. \textit{See, e.g.}, May v. Pennel, 64 A. 885 (Me. 1906) (holding that attempted suicide is not illegal); Commonwealth v. Wright, 11 Pa. D. 144, 145-46 (Phila. 1902) (same).} Second, the policy of forfeiture unjustly punished innocent relatives.\footnote{See Marzen et al., \textit{supra} note 2, at 68-69 (1985) (discussing effects of forfeiture on innocent heirs). Zephaniah Swift, later Chief Justice of the Connecticut Supreme Court, wrote in a 1796 treatise that the abolition of forfeiture was primarily directed to the innocent relatives: “There can be no greater cruelty, than the inflicting a punishment, as the forfeiture of goods, which must fall solely on the innocent offspring of the offender. This odious practice has been attempted to be justified upon the principle, that such forfeiture will tend to deter mankind from the commission of such crimes, from a regard to their families. But it is evident that where a person is so destitute of affection for his family, and regardless of the pleasures of life, as to wish to put an end to his existence, that he will not be deterred by a consideration of their future subsistence.” \textit{Id.} (quoting S. MILSOM, HISTORICAL FOUNDATIONS OF THE COMMON LAW, at vi (2d ed. 1982); see also \textit{id.} at 181 (noting that Supreme Judicial Court of Massachusetts recognized that forfeiture “may well have had its origin in consideration for the feelings of innocent surviving relatives” (citing Commonwealth v. Mink, 123 Mass. 422, 429 (1877))); \textit{cf.} St. John-Stevas, \textit{supra} note 26, at 258 (discussing Roman law punishment of forfeiture).} Third, those who attempted suicide suffered mental illness, diminished capacity and despondency comparable to those who completed their suicides.\footnote{See St. John-Stevas, \textit{supra} note 26, at 258 (noting that “it is difficult to see what deterrent value the law [on attempt] has, and it seems more likely to ensure that the person genuinely attempting to end his life will make a good job of it”). St. John-Stevas further explains that imprisonment may well retard recovery and does nothing to stop a second and successful attempt on release. \textit{Id.} Furthermore, the knowledge that attempted suicide is a crime may discourage an attempter from seeking help, or lead his relations and friends to conceal it. \textit{Id.}} Finally, attempted suicide statutes only encouraged and
fostered the commitment to succeed in the suicide.\textsuperscript{47} The decriminalization of suicide and attempted suicide occurred because the criminal law was inadequate to deal with acts which were the result of mental illness or despondency.

The right to commit suicide was never considered a "fundamental right" or a liberty interest.\textsuperscript{48} Many states condemn suicide as immoral\textsuperscript{49} and have even passed legislation immunizing good Samaritans, who attempt to thwart a suicide, from liability.\textsuperscript{50} These exemption statutes encourage the prevention of suicide and authorize involuntary commitment to forcibly confine a suicidal person in a mental health facility.\textsuperscript{51} Moreover, suicide often places an undue burden on the government to inherit the care of surviving

\textsuperscript{47} See id. at 211 (describing how one commentator felt that North Carolina's anti-suicide measure would merely make suicide attempts more successful).

\textsuperscript{48} In \textit{Bisenius v. Karns}, 165 N.W.2d 377 (Wis.), \textit{appeal dismissed}, 395 U.S. 709 (1969), the Wisconsin Supreme Court held that "successful suicide is no longer within the reach of the law, but it does not follow that self-destruction is a legally protected right of individuals, ... It is a 'grave public wrong.'" \textit{Id.} at 382 (quoting \textit{Stiles v. Clifton Spring Sanatorium Co.}, 74 F. Supp. 907, 909 (W.D.N.Y. 1947)). In \textit{Tennessee ex rel. Swann v. Pack}, 527 S.W.2d 99 (Tenn. 1975), the Supreme Court of Tennessee similarly held that "[a]n attempt to commit suicide is probably not an indictable offense under Tennessee law; however, such an attempt would constitute a grave public wrong, and we hold that the state has a compelling interest in protecting the life ... of its citizens." \textit{Id.} at 113 (holding public policy militated that practice of handling poisonous snakes as part of religious services be perpetually enjoined).

\textsuperscript{49} See Marzen et al., supra note 2, at 212 (noting that Dakota Territory provided that: "Although suicide is deemed a grave public wrong, yet from the impossibility of reaching the successful perpetrator, no forfeiture is imposed").

The Supreme Judicial Court of Maine considered attempted suicide "ethically reprehensible" and "inconsistent with the public welfare." \textit{Id.} at 178 (citing \textit{May v. Pennel}, 101 Me. 516 (1906)). An intermediate appellate court upheld an order authorizing the forced feeding of Mark Chapman, John Lennon's assassin, on the grounds that "the preservation of life has a high social value in our culture and suicide is deemed a 'grave public wrong.'" \textit{Id.} at 210 (citing \textit{Von Holden v. Chapman}, 87 A.2d 66, 68 (N.Y. App. Div. 1982)).

\textsuperscript{50} See id. at 148-242 (discussing suicide laws of every state). For example, the Arkansas Code provides that: "A person who reasonably believes that another person is about to commit suicide or to inflict serious physical injury upon himself may use non deadly physical force upon that person to the extent reasonably necessary to thwart the result," \textit{Ark. Code Ann.} \textsection{} 5-2-605(4) (Michie 1993). These exemption statutes are common in many states. \textit{See}, e.g., \textit{Colo. Rev. Stat.} \textsection{} 18-1-703(d) (1986) (allowing exemption); \textit{Conn. Gen. Stat.} \textsection{} 53a-18 (1994) (same); \textit{N.Y. Penal Law} \textsection{} 35.10(4) (McKinney 1975) (same).

\textsuperscript{51} Most states have enacted statutes requiring a showing of "dangerousness" to oneself or to others be manifested in recent overt behavior. \textit{See}, e.g., \textit{Cal. Welf. & Inst. Code} \textsection{}

5260, 5300 (West 1981) (allowing involuntary commitment when person "presents an imminent threat" of suicide); \textit{Haw. Rev. Stat.} \textsection{}

334-359 (1993) (allowing involuntary commitment when person is "imminently dangerous to self and others"); \textit{Wash. Rev. Code Ann.} \textsection{}

71.05.020 (West 1992) (allowing involuntary commitment when person "presents likelihood of serious harm to others or himself"); \textit{Wis. Stat. Ann.} \textsection{}

51.15, 51.20 (West 1987) (allowing involun-
dependents.52 Further, in an attempt to prevent insurance fraud, courts deny life insurance claims to the beneficiaries of those who commit suicide.53

While there is no fundamental right to commit suicide or to attempt to commit suicide, there is a liberty interest recognized in the right-to-die cases that sanctions an individual's choice to terminate medical care.54 This right of choice is embedded in the privacy claim that one may reject invasive medical procedures. This liberty interest is not absolute and must be balanced against the state's interest in preserving the integrity of life. The state's interest in preserving life wanes, however, and the individual's right of choice grows as the person nears death.55

52. See, e.g., Prudential Ins. Co. of Am. v. Rice, 52 N.E.2d 624, 627 (Ind. 1944) ("Aside from the purely moral aspects of self-destruction, the most plausible argument in favor of the view that public policy forbids recovery in a case like the one at bar is that suicide places an undue burden upon the government to care for the perpetrator's dependents.").

53. ROSENBLAT, supra note 11, at 186. A standard provision exists in life insurance policies called a three-year contemplation of death clause, which provides that a suicide within three years of the policy would deem the insurance null and void. Id. In Ritter v. Mutual Life Ins. Co., 169 U.S. 139 (1898), the Supreme Court held that even an insurance policy, which was silent with regard to suicide, could not obligate an insurance company to pay benefits on behalf of an insured who took his life. Id. at 154. Justice Harlan explained:

If, therefore, a policy ... expressly provided for the payment of the sum stipulated when or if the assured, in sound mind, took his own life, the contract, even if not prohibited by statute, would be held to be against public policy, in that it tempted or encouraged the assured to commit suicide in order to make provision for those dependent upon him or to whom he was indebted.

Id.

54. See Barber v. Superior Court, 195 Cal. Rptr. 484, 489 (Ct. App. 1983) (recognizing that competent adult patient has legal right to refuse treatment); In re Quinlan, 355 A.2d 647, 663 (N.J. 1976) (presuming that constitutional right to privacy extends to patient's decision to terminate medical care).

55. See Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261 (1989) (discussing balancing test for liberty interest in refusing medical care). Writing for the majority in Cruzan, Chief Justice Rehnquist acknowledged the balancing test promulgated in Quinlan:

Recognizing that this right [of privacy] was not absolute, however, the court balanced it against asserted state interests. Noting that the State's interest "weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims," the court concluded that the state interests had to give way in that case.

Id. at 270 (quoting Quinlan, 355 A.2d at 664) (emphasis added).
B. Assisted Suicide and Euthanasia

cessory who, for selfish motives, could improperly and expeditiously lead a weak-minded, vulnerable person to self-destruction. At common law, one who was present and assisted in a suicide was considered an accessory before the fact. This was an offense tantamount to murder and manslaughter because such influence and assistance helped to cause the death of another.\textsuperscript{57} The second reason is one defendant's conduct consisted of causing or aiding, without the use of duress or deception, another person to commit suicide.\textsuperscript{58} N.D. CENT. CODE § 12.1-16-04 (Supp. 1995) (“(1) Any person who intentionally or knowingly aids, abets, facilitates, solicits, or incites another person to commit suicide, or who provides to, delivers to, procures for, prescribes for another person any drug or instrument with knowledge that the other person intends to attempt to commit suicide with the drug or instrument is guilty of a class C felony. (2) Any person who, through deception, coercion, or duress, willfully causes the death of another person by suicide is guilty of a class AA felony.”); OKLA. STAT. ANN. tit. 21, § 815 (West 1983) (“Every person who willfully, in any manner, advises, encourages, abets, or assists another person in taking his own life, is guilty of aiding suicide.”); OKLA. STAT. ANN. tit. 21, § 813 (West 1983) (“Every person who willfully, in any manner, advises, encourages, abets, or assists another person in attempting to take his own life... is guilty of aiding an attempt at suicide.”); 18 PA. CONS. STAT. ANN. § 2505 (West 1983) (“A person who intentionally aids or solicits another to commit suicide is guilty of a felony of the second degree if his conduct causes such suicide or an attempted suicide.”); P.R. LAWS ANN. tit. 33, § 4009 (1983) (“Every person who deliberately permits, aids, advises, encourages, or coerces another to commit suicide... shall be punished by imprisonment.”); S.D. CODIFIED LAWS § 22-16-37 (Michie 1988) (“Any person who intentionally in any manner advises, encourages, abets or assists another in taking his own life is guilty of a class 6 felony.”); TEX. PENAL CODE ANN. § 22.08 (West 1994) (“A person commits an offense if, with intent to promote or assist the commission of suicide by another, he aids or attempts to aid the other to commit or attempt to commit suicide.”); V.I. CODE ANN. tit. 14, § 2141 (1996) (“Whoever deliberately aids, advises or encourages another to commit suicide shall be imprisoned for not more than 5 years.”); WASH. REV. CODE ANN. § 9A.36.060 (West 1988) (“A person is guilty of promoting a suicide attempt [a class C felony] when he knowingly causes or aids another person to attempt suicide.”); WIS. STAT. ANN. § 940.12 (West 1996) (“Whoever with intent that another take his or her own life assists such person to commit suicide is guilty of a Class D felony.”).

Minnesota does, however, exempt health care providers from liability under its criminal statute by stating:

A health care provider... who administers, prescribes, or dispenses medications or procedures to relieve another person's pain or discomfort, even if the medication or procedure may hasten or increase the risk of death, does not violate this section unless the medications or procedures are knowingly administered, prescribed, or dispensed to cause death.

MINN. STAT. ANN. § 609.215, Subd. 3(a) (West Supp. 1996). Additionally, the Michigan Supreme Court in People v. Kevorkian, 527 N.W. 2d 714 (Mich. 1994), held that assisted suicide is a common law felony. Id. at 716.

\textsuperscript{57} See Blackburn v. State, 23 Ohio St. 146, 162-63 (1872) (holding that act of assisting in another's suicide constitutes murder). Historically, some states refused to call assisted suicide a distinct crime; instead, the acts of encouraging a suicide constituted murder. The Supreme Courts of Ohio, Illinois and Michigan acknowledged that suicide was not a crime, but providing poison to another with the intent that it would cause death constituted murder.

In Blackburn, the Ohio Supreme Court held that “[i]t is immaterial whether the party taking the poison took it willingly, intending thereby to commit suicide,
who assists in a suicide is not necessarily mentally ill or despondent and arguably, does not share the same claim to compassion and pity. The final reason is that at common law there is a general duty to rescue imposed on one who places another at peril. The accessory in a suicide has that general duty to rescue due to his or her role in placing the person at risk.

or was overcome by force, or overreached by fraud." Id. The Blackburn court stated that "the real criminal act being charged here is not suicide, but administering poison." Id. at 163-64. Additionally, the Blackburn court stated that killing another person is "murder . . . irrespective of the wishes or the condition of the party to whom the poison is administered, or the manner in which, or the means by which, it is administered." Id. at 163.

In People v. Roberts, 178 N.W. 690 (Mich. 1920), overruled in part by People v. Kevorkian, 527 N.W.2d 714, 716 (Mich. 1994), cert. denied, 115 S. Ct. 1795 (1995), the Michigan Supreme Court adopted the rationale of Blackburn. Id. at 693. In explaining its interpretation of the Blackburn rationale, the Roberts court stated:

Where one person advises, aids, or abets another to commit suicide, and the other by reason thereof kills himself, and the adviser is present when he does so, he is guilty of murder as a principal, or in some jurisdictions of manslaughter . . . . But if the one who encourages another to commit suicide is not present when the act is done, he is an accessory before the fact and at common law escapes punishment because his principal cannot be first tried and convicted. The abolition of the distinction between aiding and accessory in some jurisdictions has, however, carried away this distinction, so that a person may now be convicted of murder for advising a suicide, whether absent or present at the time it is committed, provided the suicide is the result of his advice. Id. (citations omitted).

In 1994, the Michigan Supreme Court overruled, in part, the holding of Roberts. Kevorkian, 527 N.W.2d at 716. In a memorandum opinion, the court held that common law murder did not include "providing the means by which a person commits suicide." Id. The court emphasized, however, that an individual could be charged with murder if "there is probable cause to believe that death was the direct and natural result of a defendant's act . . . ." Id. The court further stated that the Michigan court could still charge a person providing the means to a suicide with "a common-law felony." Id.

The Illinois Supreme Court also adopted the rationale of Blackburn. See Burnett v. People, 68 N.E. 505, 510-11 (Ill. 1903) (determining that if person aids, encourages individual to commit suicide then person may be found guilty of murder). The Burnett court held that the "acts of the principal are the acts of the accessory, and that the latter may be charged with having done the acts himself," regardless of whether crime was committed by the principal. Id. at 511.

58. See JOSHUA DRESSLER, UNDERSTANDING CRIMINAL LAW 90 (2d ed. 1995) (recognizing that "a person who wrongfully, or perhaps innocently, harms another or another's property, or who places a person or her property in risk of harm, has a common law duty to aid the injured or endangered party. . . . A duty to act may arise from non-culpable risk-creation").

59. See, e.g., BETZOLD, supra note 11, at 251 (stating that prosecutor in Kevorkian trial argued that "the law imposes a duty to save a drowning man if you pushed him in"). During the prosecution of Dr. Jack Kevorkian, Macomb County Prosecutor Carl Marlinga stressed that Kevorkian had a duty to stop the suicides because he helped place the people in the suicidal position. Id.
Efforts to legitimize assisted suicide and euthanasia were initiated in Europe and America before World War II. Although unsuccessful, the “Voluntary Euthanasia Bill” introduced in England in 1936 foreshadowed many of the current physician assisted suicide proposals. This bill provided two primary safeguards against abuse. First, it required the opinions of two medical personnel to certify the patient’s medical status. Second, it provided for a “Euthanasia Referee” who would interview the patient and, if satisfied that the patient was rational, issue a “medical certificate.” Reports of Nazi medical experimentations, conducted in the name of euthanasia, however, surfaced during World War II. Subsequently, the English bill was defeated and support for assisted suicide and euthanasia diminished in not only Europe but also the United States.

In America, unsuccessful efforts to allow euthanasia began during the 1930s, specifically in Nebraska and New York. In subse-

60. See St. John-Stevas, supra note 26, at 265-68 (discussing history of euthanasia in England and United States); see also Messinger, supra note 21, at 191-92 (noting efforts in Great Britain and United States to enact legislation allowing for euthanasia); Schanker, supra note 11, at 998-99 (discussing legislative attempts to legitimize euthanasia in United States and Europe).


62. See St. John-Stevas, supra note 26, at 267 (“A formal unsuccessful application is to be signed by the patient in the presence of two witnesses . . . together with two medical certificates, one from the attendant doctor and the other from a specially qualified practitioner.”). A similar bill, supported by the Euthanasia Society of America, required court participation. See id. (stating that bill “provide[d] for application to the courts for a certificate, the courts being empowered to appoint a committee of physicians and others to investigate the case” (footnote omitted)).

63. See id. (stating that referee was to perform “a personal interview . . . and establish that he fully understands what is being done”).

64. See id. at 265 (describing Nazi atrocities and effects upon euthanasia movement); Schanker, supra note 11, at 999 n.136 (explaining that Nazi practices caused New York legislature to reject euthanasia bill). Prior to World War II, compulsory euthanasia of the old and terminally ill was advocated by some. St. John-Stevas, supra note 26, at 265. During the war, however, the Nazis ordered the deaths of 275,000 people through euthanasia. Id. Additionally, the Nazis supported their actions by mathematically comparing “the cost of caring for the disabled with the cost of building new housing units or marriage allowance loans for newly married couples.” Schanker, supra note 11, at 999 n.136. See generally Yale Kamisar, Are Laws Against Assisted Suicide Unconstitutional?, 36 L. Quadrangle 29 (1993) (opposing euthanasia and physician assisted suicide and citing to abuses exhibited by Nazi practices).

65. See St. John-Stevas, supra note 26, at 266 (noting legislative attempt to legitimate euthanasia in Nebraska and New York). In 1938, the Reverend Charles Potter founded a euthanasia society. Id. The group adopted the English Bill as a model. Id. In the same year, a bill was introduced into the Nebraska legislature. Messinger, supra note 21, at 191. The legislature, however, never took action on
sequent years, most other states retained their prohibition against assisted suicide, but reduced the offense to manslaughter or to some lesser penalty where unbearable diseases were involved.\textsuperscript{66} Despite the lesser penalties, euthanasia activists were not satisfied with this mere sentence mitigation.\textsuperscript{67} In the late 1960s and early 1970s, unsuccessful efforts to authorize euthanasia reappeared in Idaho, Oregon and Montana.\textsuperscript{68} Several maverick doctors and spouses of the terminally ill began to embark on missions to assist in the "deaths" of comatose patients, who lingered indefinitely on life support systems.\textsuperscript{69} Finally, in 1976, the New Jersey Supreme Court allowed for the withdrawal of life support measures from a comatose patient in the landmark case of In re Quinlan.\textsuperscript{70} While the Quinlan court did not discuss the question of euthanasia, it relied instead on the individual's right in choosing to disallow invasive medical procedures that prolong life.\textsuperscript{71} Following the Quinlan case, the United States Supreme Court also recognized a similar liberty interest in

the bill. \textit{Id.} at 192 n.166. In 1939, a bill also similar to the English Bill, was proposed but was never introduced into the New York legislature. \textit{Id.} at 192.

\textsuperscript{66} For a detailed analysis of the laws of the various states that have prohibitions against assisted suicides, see \textit{supra} note 56 and accompanying text.

\textsuperscript{67} Schanker, \textit{supra} note 11, at 1000.

\textsuperscript{68} See Messinger, \textit{supra} note 21, at 200 (summarizing unsuccessful bills introduced in Florida, Montana, Oregon, West Virginia, Wisconsin, New York and Idaho). For instance, "[i]n 1969, the Health and Welfare Committee of the Idaho House of Representatives introduced a Voluntary Euthanasia Bill to legalize voluntary euthanasia 'when the patient is suffering from an irremediable condition.'" \textit{Id.} (quoting O. \textsc{Ruth} \textsc{Russell}, \textsc{Freedom} \textsc{To} \textsc{Die}: \textsc{Moral} \textsc{And} \textsc{Legal} \textsc{Aspects} \textsc{Of} \textsc{Euthanasia} 53-214 (rev. ed. 1977)).

\textsuperscript{69} See St \textsc{John-Stevas}, \textit{supra} note 26, at 268-69 (citing Dr. Glanville Williams, \textsc{Mercy} \textsc{Killing} \textsc{Legislation}—\textsc{A} \textsc{Reply}, 43 \textsc{Minn.} \textsc{L.} \textsc{Rev.} 1, 1-12, (1958); Dr. W.R. Matthews, \textsc{Address} at the \textsc{Voluntary} \textsc{Euthanasia} \textsc{Society} \textsc{Annual} \textsc{Meeting} (May 2, 1950).

\textsuperscript{70} 355 A.2d 647, 671 (N.J. 1976). In Quinlan, Karen Quinlan stopped breathing for fifteen minutes. \textit{Id.} at 654. A doctor concluded that she suffered from a lack of oxygen to the brain. \textit{Id.} She existed in a "chronic persistent vegetative state." \textit{Id.}

\textsuperscript{71} See \textit{id.} at 663 (finding that right of privacy "is broad enough to encompass a patient's decision to decline medical treatment under certain circumstances"). In Quinlan, the court balanced the interests of the State against Quinlan's right of privacy. \textit{See id.} at 663-64 (comparing state's interest in protecting human life against individual's privacy right). The court determined that the "State's interest weakens and the individual's right to privacy grows as the degree of bodily invasions increases and the prognosis dims." \textit{Id.} at 664. The court also held that at some point the individual's right becomes superior to the state's interest. \textit{Id.} Despite this language, the court did not find "an absolute or general 'right to die.'" Kamisar, \textit{supra} note 64, at 30. On the contrary, the court observed that there is a difference between committing suicide and removing life support or refusing surgery. \textit{See Quinlan}, 335 A.2d at 665 (emphasizing "a real distinction between committing the self-infliction of deadly harm and a self-determination against life support or radical surgery").
These two cases helped to trigger the modern proliferation of living wills, which allow a person to indicate his or her choice concerning medical care in cases of irremedial physical conditions.

In 1980, the Hemlock Society was formed. Through educating people about the issue and raising the public’s awareness, the Society has sought to advocate and encourage the practice of euthanasia, including physician assisted suicide. By the time the Society was formed, individual physicians had already become involved in euthanasia by actively assisting their patients or loved-ones in committing suicide. These cases were rare and periodic, until Dr. Jack Kevorkian made assisted suicide a cause célèbre by assisting in several dozen suicides during the 1980s and 1990s. Assisted suicide is now part of a national debate. While several states have conducted studies, assigned commissions and circulated referenda on

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73. See Schanker, supra note 11, at 1000 (“After the 1976 Quinlan decision, the development and proliferation of living wills statutes largely preempted the euthanasia debate until the 1980s . . . “).

74. For a discussion of living wills, see infra note 230 and accompanying text. In 1990, Congress passed the Patient’s Self-Determination Act, Pub. L. No. 101-508, 104 Stat. 1388-115 to -117 (1990) (codified at 42 U.S.C. §§ 1395cc(a)(1)(Q), (f) (1994)). The Act requires that “a provider of services or prepaid or eligible organization . . . provide written information about . . . an individual’s rights under State law [about] . . . the right to formulate advance directives . . . .” 42 U.S.C. § 1395cc(f)(1)(A)(i). Advance directives include “written instruction[s], such as a living will or durable power of attorney for health care . . . .” Id. § 1395cc(f)(3).

75. For a general discussion of the Hemlock Society, see Derek Humphry, Final Exit: The Practicalities of Self Deliverance and Assisted Suicide for the Dying (1991). Derek Humphry was the founder of the Hemlock Society and wrote many books on euthanasia. In Final Exit, Humphry explored the variety of ways one could commit suicide. Id.

76. Id.

77. See Schanker, supra note 11, at 986-91 (discussing unsuccessful prosecution of several physicians).

78. For a general discussion of Dr. Kevorkian, see Betzold, supra note 11, at 7-37. By October 1996, Kevorkian had assisted in approximately 42 suicides. Kevorkian Present at MS Patient’s Suicide, THE RECORD, Oct. 11, 1996, at A23. The number of assisted suicides that Jack Kevorkian participates in seems to change monthly.
the issue of euthanasia, the states have generally retained their prohibitions against physician assisted suicide.

79. See, e.g., New York State Task Force on Life and the Law, When Death Is Sought—Assisted Suicide in the Medical Context, in Kadish & Schulhofer, supra note 5, at 890-91 (reporting of New York Task Force's rejection of legalizing assisted suicide). In New York, a comprehensive study was conducted by a commission appointed by Governor Mario Cuomo in 1985. The Task Force was composed of 24 members representing a broad spectrum of ethical and religious views. In May 1994, the Task Force finally issued its report. Id. at 890. While the members disagreed on the legality and morality of physician assisted suicide, the members unanimously agreed not to change New York law which banned assisted suicide. Id. The Task Force believed "that the dangers of such a dramatic change in public policy would far outweigh any possible benefits." Id. It concluded that legalizing assisted suicide would be too dangerous to many patients. See id. (describing possible abuses and problems that could occur if euthanasia was legalized).

In 1992, the Michigan legislature was in the process of appointing a blue-ribbon commission when news broke that Dr. Jack Kevorkian had been involved in yet another one of his highly publicized assisted suicides. The bill creating the commission passed; however, a last minute amendment to the legislation made assisting a suicide a criminal offense. See Robert A. Sedler, Constitutional Challenges to Bans on "Assisted Suicide": The View from Without and Within, 21 Hastings Const. L.Q. 777-78 (1994) (discussing legislative efforts in Michigan in response to Dr. Kevorkian's activities).

80. For a listing of the various state statutes banning assisted suicide, see supra note 56 and accompanying text. Despite some states' continued prohibition against assisted suicide, other states have attempted, with varying degrees of success, to introduce pro-euthanasia legislation. See Schanker, supra note 11, at 1000-03 (describing attempts of several states to enact legislation permitting euthanasia). Recently, Oregon presented its voters with Measure 16 which would exempt physician assisted suicide from the definition of murder, among other things. The ballot description of Measure 16 stated:

This measure would allow an informed and capable adult resident of Oregon, who is terminally ill and within six months of death, to voluntarily request a prescription for medication to take his or her life. The measure allows a physician to prescribe a lethal dose of medication when conditions of the measure are met. . . .

The process begins when the patient makes the request of his or her physician, who shall:

• Determine if the patient is terminally ill, is capable of making health care decisions, and has made the request voluntarily.
• Inform the patient of his or her diagnosis and prognosis; the risks and results of taking the medication; and alternatives, including comfort care, hospice care, and pain control. . . .
• Ask that the patient notify next of kin. . . .
• Refer the patient for counseling, if appropriate.
• Refer the patient to a consulting physician.

A consulting physician, who is qualified by specialty or experience, must confirm the diagnosis and determine that the patient is capable and acting voluntarily. If either physician believes that the patient might be suffering from a psychiatric or psychological disorder, or from depression causing impaired judgment, the physician must refer the patient to a licensed psychiatrist or psychologist for counseling. The psychiatrist or psychologist must determine that the patient does not suffer from such a disorder before medication may be prescribed. . . .

At least fifteen days must pass from the time of the initial oral request and 48 hours must pass from the time of the written request before
Prosecution for assisted suicide only works to reveal the contradiction inherent in its criminal complicity. Historically, an accessory to an act was innocent unless the principal was convicted. If the principal was acquitted or immune from prosecution, the accomplice was also acquitted or immune. Today, guilt of the principal is unnecessary to convict the accessory, although there must be some showing of the principal's involvement in the criminal offense. In assisted suicide prosecutions, there is no guilty princi-

the prescription may be written. Before writing the prescription, the attending physician must again verify the patient is making a voluntary and informed request, and offer the patient the opportunity to rescind the request. Those who comply with the requirements of the measure are protected from prosecution and professional discipline. The measure does not authorize lethal injection, mercy killing or active euthanasia. Actions taken in accordance with this measure shall not constitute suicide, assisted suicide, mercy killing or homicide, under the law.

Measure 16, in Kadish & Schulhofer, supra note 5, § 6.6, at 888 (alterations in original). In November 1994, Measure 16 passed with 51% of the vote. Measure 16 History, Portland Oregonian, Feb. 6, 1995, at A6. On December 7, 1994, however, the day before the law was to take effect, Judge Michael Hogan placed an injunction on its enforcement. Id. In August 1995, Judge Hogan held that Measure 16 was unconstitutional. Lee v. Oregon, 891 F. Supp. 1429, 1438 (D. Or. 1995). The court determined that the Measure violated the Equal Protection Clause of the United States Constitution. Id. at 1437. Specifically, the court agreed with the plaintiffs that Measure 16 does not provide adequate safeguards against individuals wrongly choosing suicide. Id. at 1434-37 (noting lack of medical safeguards monitoring and preventing improper decisions of suicide). Moreover, the court found Measure 16 was irrational and unconstitutional because “there is no set of facts under which it would be rational for terminally ill patients under Measure 16 to receive a standard of care from their physicians under which it did not matter whether they acted with adequate reasonableness . . . .” Id. at 1437.

81. See LaFave & Scott, supra note 5, § 6.6, at 573 (discussing defense of legal impossibility). The necessity of convicting the principal had tremendous ramifications:

The most significant procedural limitation on conviction of an accessory at common law was that conviction of the principal was an absolute prerequisite. An accessory could not be placed on trial in advance of the principal, and this was so even if the principal was amenable to prosecution because he could not be apprehended or had died.

Id. (footnote omitted).

82. See Brovins & Oehmke, supra note 9, at 107 (noting that Circuit Judge David Breck dismissed murder charge against Dr. Kevorkian in death of Marjorie Wantz, ruling “[c]ommon logic dictates that if suicide is not a crime (and it is not, in Michigan), then someone who assists should not be criminally responsible”).

83. Dressler, supra note 58, at 445. It is still true that “a defendant may not be convicted as an [accomplice] where the guilt of a principal has not been shown.” People v. Vaughn, 465 N.W.2d 365, 369 (Mich. Ct. App. 1990). Or, put another way, logically, for an accomplice to be guilty of a crime, there must have been a crime committed by another person from whom the accomplice's liability originates.
physician, because suicide and attempted suicide are legal. In a sense, general complicity law has conflicted with the legislative prerogative to ban assisted suicide. If the physician is not guided by improper or selfish motives, a prosecution that singles out the physician for criminal treatment lacks equitable symmetry. Moreover, if the physician has assented to the rational wishes of the patient, then the physician merely intended to solemnize a legal act. There is a certain perverseness in the notion that a person can be charged with the crime of aiding and abetting a lawful act.

1. The Model Penal Code

The Model Penal Code reflects a conservative view towards the prosecution of assisted suicide. Section 210.5 of the Code provides:

(1) Causing Suicide or Criminal Homicide. A person may be convicted of criminal homicide for causing another to commit suicide only if he purposely causes such suicide by force, duress or deception.

(2) Aiding or Soliciting Suicide as an Independent Offense. A person who purposely aids or solicits another to commit suicide is guilty of a felony of the second degree if his conduct causes such suicide or an attempted suicide, and otherwise of a misdemeanor.

In addressing issues of causation and suicidal predisposition, the Model Penal Code requires the showing of a greater causal link to

84. For a discussion of the legality of suicide and attempted suicide, see supra notes 2-55 and accompanying text.

85. See Silving, supra note 6, at 371-76 (describing three types of statutes dealing with aiders, instigators and abettors and their relationship in participating in euthanasia).


87. MODEL PENAL CODE § 210.5 (1980). The drafters of the Model Penal Code realized that:

[T]here is no form of criminal punishment that is acceptable for a completed suicide and that criminal punishment is singularly inefficacious to deter attempts to commit suicide . . . . It seems preposterous to argue that the visitation of criminal sanctions upon one who fails in the effort is likely to inhibit persons from undertaking a serious attempt to take their own lives. Moreover, it is clear that the intrusion of the criminal law into such tragedies is an abuse. There is a certain moral extravagance in imposing criminal punishment on a person who has sought his own self-destruction, who has not attempted direct injury to anyone else, and who more properly requires medical or psychiatric attention.

Id. at cmt. 2.
establish assistance than do many state court decisions.\textsuperscript{88} The Code also requires that the accessory either cause or force the suicide, a stricter form of causation than that accepted in some of the state cases.\textsuperscript{89} For example, one older decision established that placing poison before a suicidal person is murder.\textsuperscript{90} Under the Code, placing poison before a suicidal person does not actually "cause" the suicide as it is the suicidal person's predisposition and actions that may account for the death.\textsuperscript{91} The accessory often assents to the active and relentless pressure created by the suicidal person's desire to die.\textsuperscript{92} Thus, the Code may be interpreted to find that assisting a rational, predisposed suicidal person would be legal, because the person's suicidal predisposition would sever the causal chain. This interpretation of legality would also show that the

\footnotesize{\textsuperscript{88} Id. § 210.5. Many states recognize that any act of assisting or encouraging is sufficient for the offense of manslaughter or murder. See, e.g., State v. Marti, 290 N.W.2d 570, 579 (Iowa 1980) (holding assistance sufficient to constitute involuntary manslaughter where defendant gave suicidal person loaded gun in order to commit suicide); Persampieri v. Commonwealth, 175 N.E.2d 387, 390 (Mass. 1961) (finding husband guilty of manslaughter after he taunted drunk, emotionally disturbed, suicidal wife and assisted her in procuring and firing loaded gun).

\textsuperscript{89} See Model Penal Code § 210.5 (stating person is guilty of criminal homicide if he or she "purposely causes such suicide by force, duress, or deception" and guilty of felony of second degree if he or she "causes such suicide or an attempted suicide").

\textsuperscript{90} See People v. Roberts, 178 N.W. 690 (Mich. 1920), overruled in part by People v. Kevorkian, 527 N.W.2d 714, 716 (Mich. 1994), cert. denied, 115 S. Ct. 1795 (1995) (holding that acting "purposefully and maliciously to kill a human being, by administering . . . poison is murder, irrespective of the wishes . . . or the manner in which, or the means by which, it is administered").

\textsuperscript{91} See Model Penal Code § 210.5 (noting that conduct must cause suicide or attempted suicide). Since 1920, there has not been a single defendant found guilty of assisting in a suicide. See People v. Campbell, 335 N.W.2d 27, 30 (Mich. Ct. App. 1983) (recognizing that defendants "have been found guilty of crimes ranging from the equivalent of negligent homicide to voluntary manslaughter," instead of murder). Some courts require a heightened level of assistance to determine causation. For example, in Campbell, the accessory placed a gun before the decedent and encouraged the person to shoot himself. Id. at 28. In acquitting the defendant, the court reasoned that the "[d]efendant had no present intention to kill. He provided the weapon and departed. Defendant hoped Basnaw would kill himself but hope alone is not the degree of intention requisite to a charge of murder." Id. at 30. Additionally, the court found that two-thirds of the states do not criminalize incitement to suicide and that incitement to suicide was never considered a crime under the common law. Id.; see also Marti, 290 N.W.2d at 579 (holding assistance only constituted involuntary manslaughter where defendant gave individual loaded gun); Persampieri, 175 N.W.2d at 390 (holding husband guilty of manslaughter despite providing gun to his wife with instruction on how to pull trigger); State v. Bier, 591 P.2d 1115, 1118 (Mont. 1979) (affirming husband's conviction for negligent homicide because he cocked gun that wife used in committing suicide).

\textsuperscript{92} For a discussion of cases where the accessory relents to the pressures of the principal's wish to die, see supra note 57 and accompanying text.}
Code identifies with the ordeal of one suffering from a terminal illness. For if the accessory to the suicide has acted not from malice, but from compassion and duress, a criminal charge would seem unnecessarily harsh.

2. The Environment of Pain

One cannot understand the assisted suicide issue and the medical necessity defense without understanding the personal suffering caused by a painful, terminal disease. Legal abstractions do not convey the ordeal of terminal affliction. Relatives and physicians see the physical deterioration caused by incurable diseases at its worst. For example, in cancer cases, the patients suffer "cachexia," which is characterized by insufficiency of the liver, chronic chemical imbalances and dangerous toxicity from chemotherapy and other forms of treatment. While drugs are used in a preventative fashion, they cannot eliminate extreme forms of suffering in some cases. A certain percentage of lung cancer patients bleed to death and literally drown in their own blood. Tumorous cancer


94. See Nuland, supra note 93, at 217-19 (discussing cancer and its effects on those afflicted with this disease). Cancer cells affect the body both directly and indirectly. Id. at 217. Directly, cancer cells block tubular organs, prevent metabolic processes, cause bleeding and alter delicate biochemical balances. Id. Indirectly, cancer leads to nutritional depletion called "cancer cachexia." Id. Cachexia "is characterized by weakness, poor appetite, alterations in metabolism, and wasting of muscle and other tissues." Id. Additionally, malnutrition limits the effectiveness of the immune system, which inhibits the body's response to cancer growth. Id. at 218. Finally, depletion of nutrients can give rise to other deadly conditions, such as stroke, myocardial infarction or heart disease. Id. at 219.

95. See Rosenblatt, supra note 11, at 186 (discussing painful ordeal of woman who could not ease her terminal affliction with pain-killing drugs); see also Nuland, supra note 93, at 217-19 (discussing pain suffered by cancer patients).

96. See Rosenblatt, supra note 11, at 279 (recounting trial testimony of Yale Medical School physician Dr. Raymond Yesner regarding violent deaths of lung cancer patients). After performing thousands of autopsies on patients with cancer, Dr. Yesner testified as to the physiological development of cancer and the associated pain:

Q: [Defense attorney Rosenblatt]: And based upon the rapid growth of the adrenal tumors, what would be your prognosis for successful treatment?

A: [Dr. Yesner]: Zero.

Q: What is the danger of a violent death?

A: Well, a certain percentage of patients with lung cancer bleed to death, a certain number—those who have brain metastases—have probably the worst deaths because brain metastases are pretty horrible and patients can have convulsions, can have projectile vomiting, and there is
cells invade the nerve sheath and fibers causing intense pain.\textsuperscript{97} Often, a metastasis occurs where a transplant of the primary malignant tumor travels to another part of the body and renews the assault.\textsuperscript{98} Additionally, patients are spared no indignity as they suffer seizures, incontinence and stool-soaked beds.\textsuperscript{99}

Like cancer, other diseases present a host of agonies. Amyotrophic lateral sclerosis (ALS), commonly called “Lou Gehrig’s disease,” has neither a known cause nor cure.\textsuperscript{100} ALS leads to a

always the possibility that this tumor might erode into an adjacent large blood vessel. A lung tumor could erode into a large blood vessel where the patient literally drowns in his or her own blood . . . .

Q: Doctor, what is it about the disease or process of cancer that makes it so very painful?

A: It involves pain nerves. The tumor or the cancer cells actually invade the pain nerves. Tumor cells actually invade the pain nerves. Tumor cells will grow into the nerve sheath and into the pain fibres.

\textit{Id.}

\textsuperscript{97} \textit{Id.; see also} NULAND, \textit{supra} note 93, 202-17 (discussing characteristics and vitality of cancerous cells).

\textsuperscript{98} \textit{See} NULAND, \textit{supra} note 93, at 216 (discussing meaning of metastasis). Nuland notes:

In modern times, this one word, metastasis, has come to articulate the defining feature of malignancy—cancer is a neoplasm that has the potential to go beyond its home and travel to some other place. A metastasis is, in effect, a transplant of a sample of the primary tumor to another structure or even a distant part of the body.

Cancer’s ability to metastasize is both its hallmark and its most menacing characteristic. If a malignant tumor did not have the ability to travel, surgeons would be able to cure all but those that involve vital structures, which cannot be removed without compromising life. In order to travel, the tumor must erode through the wall of a blood vessel or lymph channel, and then some of its cells must become detached and pass into the flowing stream. Either individually or clumped into an embolus, the cells are then carried to some other tissue, where they implant and grow. Determined by the route of blood or lymph flow as well as other still-unclear factors, various cancers have a predilection to be deposited in certain specific organs. For example, a breast cancer is most likely to metastasize to bone marrow, lungs, liver, and, of course, the lymph nodes in the armpit, or axilla. A cancer of the prostate commonly travels to bone. Bones, in fact, along with the liver and kidney, are the most common sites for metastatic deposits, regardless of the malignancy’s organ of origin.

\textit{Id.}

\textsuperscript{99} \textit{See} BROVINS & OEHMKE, \textit{supra} note 9, at 143, 169 (recounting problems faced by terminally ill patients).

\textsuperscript{100} \textit{See id.} at 226. Amyotrophic lateral sclerosis (ALS) can affect individuals differently. \textit{See id.} at 226-31 (recounting disease’s effects on two person stricken with ALS). ALS is a “motor neuron ailment.” \textit{Id.} at 153. Victims of the disease lose the ability to move and speak. \textit{Id.} In its terminal phase, ALS is hideous. Patients require feeding tubes and respirators to survive. These patients may eventually choke on their own saliva while conscious due to their total loss of muscle control. For a discussion of the sufferings of two ALS patients who were assisted in their suicides by Dr. Kevorkian, see \textit{id.} at 153-54, 226-91.
cessation of all neurological functions. Persons afflicted with ALS eventually have no muscular movement and cannot even eat; they release inaudible mumbles because they are unable to speak, choke on their own saliva and suffer extreme pain. Similarly, Alzheimer's disease is a progressive, physiological brain deterioration that causes dementia. The nerves of the brain "degenerate into a matted plaque of fibrous material," with very little prospect of reversing such advanced deterioration. Patients in the late stages of Alzheimer's lose substantially all memory of their earlier lives and cannot even recognize their closest relatives and friends. They are often incontinent, frequently fall and usually sit idly in their weakened condition. Multiple sclerosis and acquired immune deficiency syndrome (AIDS) also present debilitating, terminal illnesses with no effective medical cures. Additionally, these

102. Id.
103. See Nuland, supra note 93, at 91 (discussing effects of Alzheimer's disease). Alzheimer's effects "higher functions, such as memory, learning and judgment." Id. The disease is possibly caused by a decrease in not only the nerve-cell population but also the chemical, acetylcholine, which is used by the body to transmit messages between nerve-cells. Id. Much, however, is still not known about the disease. See id. ("Many of the details of the pathophysiology of the disease still elude the most determined efforts of medical science.").

In 1990, the Alzheimer's Association estimated that four million Americans had the disease, and as Alzheimer's is a disease of the elderly, the number is expected to increase as the population continues to age. In 1989, a Harvard Medical School study estimated that 11.3 percent of the American population sixty-five or over probably had Alzheimer's. The estimated prevalence increased sharply with age: 16.4 percent of people between seventy-five and eighty-five. (Other studies, using a narrower definition of the disease, suggest a significantly lesser but still alarming prevalence.)

Id. at 219 (footnote omitted); see also Nuland, supra note 93, at 103 (describing potential impact of disease in future years).
105. See Dworkin, supra note 104, at 218 (describing effects of Alzheimer's disease on stricken individuals).
106. Id.
107. See Brovins & Oehmke, supra note 9, at 65-66 (recounting how individual with multiple sclerosis lost use of arms, legs and neck muscles). Multiple sclerosis affects the nerve coverings over the brain and spinal cord. Id. at 111. The disease causes these coverings to deteriorate. Id. Effects of the disease can include, among other things, the inability to walk, write own's name or go to the bathroom. Id. at 113. Most individuals with multiple sclerosis, however, do not die from the disease. See id. at 111 (noting that "less than five percent die from the disease"). Like multiple sclerosis, AIDS also brings about numerous painful and debilitating conditions. Unlike multiple sclerosis, AIDS is a terminal disease and a frequent killer. See Nuland, supra note 93, at 172 (noting that, in Northeast United States, AIDS is leading cause of death among men between the ages of 25 and 45). More-
diseases cause a loss of personal control and dignity, the destruction of one's sense of security and normalcy, the painful awareness of one's former physical powers and present incapacities, and the unwanted intrusion of machines, needles and medical personnel.\(^{108}\)

The dying experience horror, fear and pain as such debilitating diseases destroy both their physical and mental conditions. These lessons of despair and agony instruct each new generation about such a deplorable existence. Thus, many may view physician assisted suicide as a way to circumvent this personal and unnecessarily painful tragedy. Generally, preserving one's life is an instinctive and morally obliged act; however, to some, the more sensible and courageous act would be to prematurely terminate their lives.

C. Status of the Law

1. The Active-Passive Distinction

"Thou shalt not kill, but need'st not strive [o]fficiously to keep alive."\(^{109}\)

The active-passive distinction is the barometer that measures the legality of assisted suicide.\(^{110}\) "Active" assisted suicide, which is illegal, is the act of a physician affirmatively placing some instrument, drug or gas before the patient, who then elects to complete

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\(^{108}\) See generally Elisabeth Kübler-Ross, On Death and Dying (1969) (illustrating sequence of responses to diagnosis of terminal illness and identifying several stages of pre-death assault: denial and isolation, anger, bargaining and hope, depression, and acceptance).


\(^{110}\) See N. Ann Davis, The Priority of Avoiding Harm, in Killing and Letting Die, supra note 4, at 299-301 (discussing moral significance between acts and omissions in assisted suicide). Proponents of passive euthanasia believe that "to act and to thereby bring about a bad outcome is to harm, while to omit an act . . . is merely to fail to benefit." Id. at 300. In one of the assisted suicide prosecutions against Dr. Jack Kevorkian in Michigan, however, Circuit Judge David Breck noted, in dismissing a first degree murder charge: "The distinction between assisted suicide and the withdrawal of life support is a distinction without merit." Brovins & Oehmke, supra note 9, at 107.
the act of suicide.111 “Passive” euthanasia, which is legal, is exemplified by a physician withdrawing life support treatment from a patient who chooses to die.112 The leading authority establishing a right to withdraw life support treatment is *Cruzan v. Director, Missouri Department of Health.*113 In *Cruzan,* the Supreme Court allowed a third party to testify that a comatose patient had previously made statements suggesting that she rejected continued life support.114 Although the Court held that this testimony did not adequately express the patient’s intent, *Cruzan* now stands for the proposition that there is a constitutionally protected liberty interest of being able to refuse invasive and undesired medical treatment.115 The

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111. Tsarouhas, supra note 11, at 793.
112. Id. Other commentators note that the proper terms of art no longer include “passive euthanasia”; instead, “assisted suicide” is used to describe a physician’s actions in providing the necessary means or information used by the person committing suicide. Council on Ethical and Judicial Affairs, AMA, *Decisions Near the End of Life,* 276 JAMA 2229, 2229 (1992). Conversely, “euthanasia” describes the situation when the physician “performs the immediate life-ending action.” Id.
113. 497 U.S. 261, 280 (1990). In *Cruzan,* the Court assumed that “the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition.” Id. at 279. Although the Court questioned an incompetent person’s ability to make an informed and voluntary choice, the Court nonetheless also extended this right to incompetent persons. See id. (“Such a ‘right’ must be exercised by her, if at all, by some sort of surrogate.”). The Court, however, did not discuss whether a state must follow the decision of a surrogate. See id. at 289 (O’Connor, J., concurring) (emphasizing that Court did not “decide issue whether a State must also give effect to the decisions of a surrogate decisionmaker”). More importantly, the Court refused to extend fundamental interest status to the right to refuse life-saving treatment. See id. at 279 n.7 (recognizing only liberty interest). In refusing to find a fundamental right, the Court stated: “Although many state courts have held that a right to refuse treatment is encompassed by a generalized constitutional right of privacy, we have never so held. We believe this issue is more properly analyzed in terms of a Fourteenth Amendment liberty interest.” Id.
114. Id. at 284. In *Cruzan,* Nancy Cruzan was left in a persistent vegetative state following an automobile accident. Id. at 266. Because this condition was permanent, Nancy’s parents sought the stoppage of life-supporting measures. Id. at 267. The Court held that “a state may apply a clear and convincing evidence standard in proceedings where a guardian seeks to discontinue nutrition and hydration of a person diagnosed to be in a persistent vegetative state.” Id. at 284. In reaching its decision, the Court found that Missouri had a legitimate interest in the preservation of human life. Id. at 280. Additionally, the Court stated that the State had an interest in protecting an incompetent individual against potential abuses by an unsympathetic or partial surrogate decision-maker. Id. at 281. The Court rationalized that the risk of error from the higher standard of “clear and convincing” evidence was proper because “[a]n erroneous decision to withdraw life-sustaining treatment ... is not susceptible of correction.” Id. at 283. Although the Court acknowledged that Nancy Cruzan made statements suggesting that she did not want to live in a vegetative state, the Court agreed with the Supreme Court of Missouri that this evidence “did not amount to clear and convincing proof of [Cruzan’s] desire to have hydration and nutrition withdrawn.” Id. at 285.
115. Id. at 278-79. Chief Justice Rehnquist, who wrote for the majority, noted that, “for purposes of this case, we assume that the United States Constitution
interest recognized by *Cruzan* would allow one to refuse medical treatment and passively die, not to actively intervene to hasten one's death. In concurring, Justice Scalia identified the absurdity of the active-passive distinction:

It would not make much sense to say that one may not kill oneself by walking into the sea, but may sit on the beach until submerged by the incoming tide; or that one may not intentionally lock oneself into a cold storage locker, but may refrain from coming indoors when the temperature drops below freezing.\(^{116}\)

In a literary analogy, Shakespeare also ridicules such active-passive distinctions of suicide. In *Hamlet*, a gravedigger explains the legal effect of Ophelia's suicide, for if she killed herself, she was not entitled to a Christian burial:

"Here lies the water—good. Here stands the man—good. If the man go to this water and drown himself, it is, will he, nill he, he goes. Mark you that. But if the water come to him and drown him, he drowns not himself, argal he that is not guilty of his own death shortens not his own life."

After hearing such a tortuous explanation, the other gravedigger can only shake his confused and doubting head and ask, "But is this law?"\(^ {117}\)

The active-passive distinction is unacceptable, as the intent of the actor is the same in both cases.\(^ {118}\) The physician who either

\(^{116}\) Id. at 279. In a concurring opinion, Justice O'Connor added that "a protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions . . . and that the refusal of artificially delivered food and water is encompassed within that liberty interest." Id. at 287 (O'Connor, J., concurring).

\(^{117}\) Kornstein, supra note 38, at 104 (quoting WILLIAM SHAKESPEARE, THE TRAGEDY OF HAMLET act 5, sc.1). Kornstein explained that "Shakespeare's witty mention of *se offendendo*, with the final question translated as, 'But could anything so ridiculous be law?' underscores the jurisprudential hairsplitting." Id.

\(^{118}\) Michael Tooley, An Irrelevant Consideration: Killing Versus Letting Die, in KILLING AND LETTING DIE, supra note 4, at 103-04. The illogic of such a distinction may be shown by the hypothetical of the two sons. One of the sons put poison in his father's drink while the other son silently watched his father drink the poisonous concoction. The first son actually killed his father; however, the other son's intent and inaction should make him also culpable. Id.
disconnects a life-support system or fails to connect a life-support system is engaged in conduct which causes the death of the patient.\textsuperscript{119} The intent is the same. Moreover, a medical omission by a physician is an affirmation, because the physician has a duty of care, subject to civil and criminal liability.\textsuperscript{120} In addition, the line between the active-passive distinction is not always self-evident.\textsuperscript{121} One has the right to refuse invasive medical procedures on one's body and the reciprocal right to grant invasive and even experimental medical procedures on one's body. Whether one refuses or grants bodily invasion, the linchpin is the patient's consent.\textsuperscript{122}

2. \textit{Desuetude and Estoppel}

The question of how a physician might lawfully influence, encourage or induce a suicide remains unclear.\textsuperscript{123} Some courts have found causation with the least bit of encouragement or assistance, while others have demanded a greater degree of physician participation.\textsuperscript{124} Euthanasia is a prevalent but surreptitious medical custom, which occurs primarily through the administration of excessive morphine.\textsuperscript{125} Criminal prosecutions are rare; their ab-

\textsuperscript{119}. See James Rachels, \textit{Active and Passive Euthanasia}, in \textit{KILLING AND LETTING DIE}, supra note 4, at 112-17 (arguing that, while many accept active-passive distinction, "a strong case can be made against this doctrine").

\textsuperscript{120}. See \textit{NORMAN L. CANTOR, LEGAL FRONTIERS OF DEATH AND DYING} 33 (1987) ("[A] doctor who omits life preserving measures in a situation where such measures are demanded by professional norms risks civil and criminal liability despite the passive nature of his conduct.").

\textsuperscript{121}. \textit{Id.} at 34. "The line between manipulation of medical equipment and active administration of death" is usually blurred. \textit{Id}. For example, when a doctor administers pain-killing narcotics, it may happen to accelerate the death of the terminal patient. \textit{Id}. Thus, the physician's act has a "double effect," with pain relief being the primary, intended consequence and accelerated death a secondary consequence. \textit{Id}. at 35.

\textsuperscript{122}. See \textit{id.} at 33-35 (discussing medical trends that recognize that medical care should be "in accordance with dying patient's wishes"); see also \textit{Cruzan v. Director, Mo. Dep't of Health}, 497 U.S. 261, 279 (1990) (stating that competent person has constitutional right to refuse lifesaving hydration and nutrition).

\textsuperscript{123}. See \textit{Schanker, supra} note 11, at 985 (stating that, because active euthanasia is illegal in the United States, physicians who assist patient in committing suicide may be prosecuted under homicide statutes or laws prohibiting assisted suicide which exist in thirty-one states).

\textsuperscript{124}. See \textit{id.} at 985-87 (providing summary of cases in which physicians were charged for assisting in suicide).

\textsuperscript{125}. See \textit{ROSENBLATT, supra} note 11, at 279 (noting that primary method of euthanasia is accomplished through administering excessive morphine into suffering patient). For example, in the trial of Dr. Peter Rosier, the physician was charged with murdering his wife. During cross-examination, Dr. Anthony Iannone, a professor of neurology at the Medical College of Ohio, admitted that the use of morphine drips was a surreptitious manner in which doctors hastened the death of the terminally ill:
sence reflects a recognition of sympathy and absence of proof.\textsuperscript{126} The prosecution is aware of the practice and their consequent silence on this custom admits to tacit consent of the act.\textsuperscript{127} The state may be accused of “desuetude” in that the law has been nullified through disuse and acquiescence, prompting reliance on the medical practice.\textsuperscript{128} The Supreme Court recognized these principles in \textit{Poe v. Ullman},\textsuperscript{129} when it held that an unenforced Connecticut anti-contraceptive law could not be the basis of a legal controversy. The

\begin{quote}
Q [Defense Counsel Rosenblatt]: Would you not agree that in many American hospitals today that frequently what happens with terminally ill patients is that doctors secretly increase morphine drips or take such other steps as may be necessary to hasten the patient’s demise?

A [Dr. Iannone]: I would agree with that; yes, it certainly has happened.

Q: It goes on all the time, doesn’t it?

A: Yes.

\textit{Id.}; see also \textit{id.}; at 19, 70-71, 182-83 (discussing how morphine and other respiratory depressants are given by doctors to hasten death and not just to reduce pain).
\end{quote}

\textsuperscript{126} See \textit{id.} at 180 (contending euthanasia is prevalent, but unprosecuted criminal offense). During the trial of Dr. Peter Rosier for the murder of his wife, a Florida medical examiner testified on cross-examination that assisted suicide prosecutions are a rare occurrence, even though suicides among the elderly are commonplace:

\begin{quote}
Q [Defense Counsel Rosenblatt]: In your work, Dr. Graves, you have seen hundreds of suicides. Isn’t that correct?

A [Dr. Graves]: Yes sir.

Q: Yet you have never had occasion to investigate a charge brought by a prosecutor against a person for assisting a suicide. Isn’t that correct?

A: That is correct.

Q: In your work as a medical examiner you have learned that there are a lot of suicides among the terminally ill. Isn’t that correct?

A: There appear to be increasing numbers as our aging population increases and more people develop terminal diseases. And I think this is a nationwide if not universal phenomena—we see more and more suicides among the elderly and particularly those who have terminal disease.

\textit{Id.}
\end{quote}

\textsuperscript{127} See \textit{id.} at 178 (stating that medical examiner had no jurisdiction to perform autopsy in case of natural home death confirmed by attending physician); see also Schanker, \textit{supra} note 11, at 985 (noting that few indictments have been returned despite practice of active euthanasia by physicians). Recently Newton County Prosecutor Greg Bridges agreed to drop assisted suicide charges against a 77 year-old husband and the 50 year-old son of a terminally ill woman who died in December of 1995 under suspicious circumstances. \textit{Husband, Son off the Hook in Assisted Suicide Case}, AP, CHI. TRIB., § 1, at 20 (Dec. 26, 1996). Judge Tim Perigo dismissed the charges against Bernard A. Howard of Garland, Texas. \textit{Id.} Velma Howard, 76, had Lou Gehrig’s disease and was found dead on December 9, 1995 in a Joplin motel room. \textit{Id.} She ingested sleeping medicine and alcohol and was found with a bag over her head. \textit{Id.}

\textsuperscript{128} See \textit{BLACK’S LAW DICTIONARY} 449 (6th ed. 1990) (defining desuetude as “disuse; cessation or discontinuance of use” and noting that it is “[a]pplied to obsolete practices and statutes”).

\textsuperscript{129} 367 U.S. 497 (1961).
Court dismissed the action for declaratory judgment, stating that a policy of not carrying out a law was "'truer law than the dead words of the written text.'"\footnote{130} Like Poe, the state has ignored countless incidents of physician assisted suicide, and a sudden prosecution arouses the suspicion of a discriminatory and ad hoc approach towards justice.\footnote{131}

As a consequence of a perceived indiscriminate prosecution, juries have acquitted physicians on the basis of jury nullification, which presents the disturbing anomaly that a jury can surreptitiously disregard the law.\footnote{132} By providing a medical necessity defense, the jury can find a cohesive legal doctrine of exculpation which has the derivative effect of provoking legal reform.

III. The Defenses of Necessity and Medical Necessity

A. Origins of the Necessity Defense

Historically, there was no single accepted definition of the necessity defense, which recognizes that one may violate the law to avoid a greater evil.\footnote{133} Biblical parables illustrate the principle that one may at times violate the law to serve a higher purpose.\footnote{134} In the New Testament for instance, Jesus responds to criticism of acts performed in violation of the Sabbath:

What man shall there be among you, who shall have one sheep, and if it falls into a pit on the Sabbath, will he not take hold of it, and lift it out? Of how much more

\footnote{130. Id. at 502 (quoting Nashville, Chattanooga & St. Louis Ry. v. Browning, 310 U.S. 362, 369 (1940)). The Court stated: The undeviating policy of nullification by Connecticut of its anti-contraceptive laws throughout all the long years that they have been on the statute books bespeaks more than prosecutorial paralysis. What was said in another context is relevant here. "Deeply embedded traditional ways of carrying out state policy . . ."—or not carrying it out—"are often tougher and truer law than the dead words of the written text." Id. (quoting Nashville, 310 U.S. at 369)).}

\footnote{131. See ROSENBLATT, supra note 11, at 277, 349 (stating that medical examiners see many suicides among terminally ill, however, no one is usually prosecuted for these).}

\footnote{132. For a discussion of the phenomena of jury nullification, see supra note 11 and accompanying text.}

\footnote{133. See GEORGE E. DIX & M. MICHAEL SHARLOT, CRIMINAL LAW 718-32 (3d ed. 1987) (discussing necessity, duress and justification defenses).}

\footnote{134. See, e.g., Luke 6:1-10 (recounting parables by Jesus that teach of eating sacred bread through necessity of hunger and of Jesus invoking necessity in order to heal people on Sabbath).}
value is a man than a sheep! So then, it is lawful to do good on the Sabbath.\footnote{Matthew 12:11-13.}

The necessity defense found marginal acceptance in English common law and was discussed in Regina v. Dudley & Stephens.\footnote{14 Q.B.D. 273 (1884).} Although the court recognized the defense in this early landmark case, it rejected the defense's application in this instance.\footnote{Id. at 288; Dressler, supra note 9, at 255 ("Some commentators have suggested that Dudley & Stephens did not . . . categorically reject the defense of necessity in homicide prosecutions." (footnote omitted)).} In Regina, three sailors and a cabin boy found themselves adrift after being shipwrecked at sea.\footnote{Id. at 274.} After days of starvation and dehydration, two of the three sailors decided to kill the sickly boy. Afterward, all three sailors ate his body.\footnote{Id.} Thereafter, the sailors were rescued and subsequently charged with murder.\footnote{Id. at 274-75.} The sailors invoked a necessity defense, claiming a numerical calculus that one sick life should be sacrificed to save three.\footnote{Id. at 277. The sailors claimed that they were under "the pressure of necessity" when they killed the cabin boy. Id. The court stated that "[n]ecessity will excuse an act which would otherwise be a crime." Id. The court also found that the sailors were not actin"self-defense. Id. at 276.} The English court held that such a killing was murder and refused to recognize a necessity defense because such a defense would create a legal cloak for "unbridled passion and atrocious crimes."\footnote{Id. at 288. The court stated that if the necessity defense was adopted, it would leave "to him who is to profit by it to determine the necessity which will justify him in deliberately taking another's life to save his own." Id. at 287. The court did acknowledge that on the facts of this case, the sailors were subjected to awful suffering. Id. at 288. The court still found, however, that there was "no legal justification for the homicide." Id.} The sailors were sentenced to be executed but the sentence was later commuted by the Crown.\footnote{Id. Although originally sentenced to death, the Crown later commuted the sentence to six months imprisonment. Id.} Since then, English and American courts have accepted the necessity defense.\footnote{See Joshua Dressler, Cases and Materials on Criminal Law 472-93, 514-15 (1994) (noting that Lord Hailsham distinguished Regina v. Dudley & Stephens "as an authority on the availability of the supposed defence of necessity rather than duress. But I must say frankly that, if we were to allow this appeal, we should, I think, also have to say that Dudley & Stephens was bad law."); see also LaFave & Scott, supra note 5, at 442 (noting that "most but not all of the modern recodifications following the Model Penal Code [Sec. 3.02] contain a broader choice-of-evils defense which is not limited to any particular source of danger"); Arnolds & Garland, supra note 18, at 291-92 (discussing necessity defense).} Approximately one-half of the states rec-
The necessity defense by statute, and the remaining states accept the contours of the defense through case law.\(^{145}\)

The Model Penal Code similarly recognizes the necessity defense as a “choice of evils,” in which the actor asserting the defense must satisfy the following essential elements to claim the defense:

1. The threatened injury must be worse than the legal violation;
2. The law does not provide exceptions or defenses in the particular situation;
3. There must be no legislation that specifically forbids the necessity defense; and
4. The actor must not have recklessly or negligently caused the predicament which necessitated the breaking of the law.\(^{146}\)


Unless otherwise limited by the ensuing provisions of this article defining justifiable use of physical force, conduct which would otherwise constitute an offense is justifiable and not criminal when:

1. Such conduct is required or authorized by law or by a judicial decree, or is performed by a public servant in the reasonable exercise of his official powers, duties or functions; or
2. Such conduct is necessary as an emergency measure to avoid an imminent public or private injury which is about to occur by reason of a situation occasioned or developed through no fault of the actor, and which is of such gravity that, according to ordinary standards of intelligence and morality, the desirability and urgency of avoiding such injury clearly outweigh the desirability of avoiding the injury sought to be prevented by the statute defining the offense in issue. The necessity and justifiability of such conduct may not rest upon considerations pertaining only to the morality and advisability of the statute, either in its general application or with respect to its application to a particular class of cases arising thereunder. Whenever evidence relating to the defense of justification under this subdivision is offered by the defendant, the court shall rule as a matter of law whether the claimed facts and circumstances would, if established, constitute a defense.

N.Y. Penal Law § 35.05 (emphasis added); see also Dressler, supra note 58, at 263 (noting that “approximately one-half of the states now statutorily recognize [necessity] defense. Some of the statutes define ‘necessity’ in general terms; others are more specific in their descriptions. In states without a statutory defense, the vague contours of the common law apply.”).

146. Model Penal Code § 3.02 (1985). Section 3.02 provides that:

1. Conduct that the actor believes to be necessary to avoid a harm or evil to himself or to another is justifiable, provided that:

a. the harm or evil sought to be avoided by such conduct is greater than that sought to be prevented by the law defining the offense charged; and
The necessity defense allows the actor to act as judge and jury in fashioning a one-time exception to the law.\textsuperscript{147} The circumstances prompting the criminal violation must be immediate, overwhelming and genuine. Typical cases of necessity include: the destruction of property to prevent the spread of fire, violating the speed laws to rush a spouse to a hospital, disposing of valuable cargo to save a floundering vessel, and dispensing a drug without the requisite prescription to alleviate grave distress in an emergency.\textsuperscript{148} The necessity defense is restricted and does not apply to acts of civil disobedience or protest, which are interpreted as populist efforts to renounce or rescind political policy.\textsuperscript{149} Political questions remain for legislative and electoral reform, and protestors must subscribe to alternative avenues of social change, not to breaking the law.\textsuperscript{150} While the necessity defense admits to the legitimacy of the law, it dismisses the law's applicability to the unique factual circumstances.\textsuperscript{151} A successful necessity defense invokes significant

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\item (b) neither the Code nor other law defining the offense provides exceptions or defenses dealing with the specific situation involved; and
\item (c) a legislative purpose to exclude the justification claimed does not otherwise plainly appear.
\end{itemize}

(2) When the actor was reckless or negligent in bringing about the situation requiring a choice of harms or evils or in appraising the necessity for his conduct, the justification afforded by this Section is unavailable in a prosecution for any offense for which recklessness or negligence, as the case may be, suffices to establish culpability.

\textit{Id.}

147. \textit{See generally} Arnolds & Garland, \textit{supra} note 18, at 294 (discussing exceptions to necessity defense).

148. \textit{See} DRESSLER, \textit{supra} note 144, at 475; \textit{see also} MODEL PENAL CODE AND COMMENTARIES § 3.02 cmts., at 9-14 (ALI 1985) (discussing typical necessity defense cases); \textit{LaFave & Scott, supra} note 5, at 444 (same).


150. \textit{See} Brent D. Wride, Comment, \textit{Political Protest and the Illinois Defense of Necessity}, 54 U. CHI. L. REV. 1070, 1083 (1987) ("In a society based on democratic decision making, this is how values are ranked—a protester cannot simply assert that her view of what is best should trump the decision of the majority of elected representatives."). Former physician Jack Kevorkian proclaimed, however, that one has a duty to violate assisted suicide laws:

The first thing you do is check the morality of the law and, if it's immoral, you disobey it. You pass any law against assisted suicide and euthanasia and I will disobey it . . . because it is immoral medically. When the law itself is intrinsically immoral, there is a greater duty to violate the law. \textit{See} BROVINS & OEHMKE, \textit{supra} note 9, at 140 (discussing immorality and law).

151. \textit{See} Wride, \textit{supra} note 150, at 1083 (noting that "where a protest is registered against a legally sanctioned activity . . . the balance of the harms must weigh against the protester").
policy implications, because it creates a precedent to violate the law. It may also drive legislative reform to redress the situation that caused the invocation of the necessity defense in the first place.\textsuperscript{152} 

As previously illustrated, the immorality of suicide invites exceptions, such as insanity and the ravages of an incurable disease. In the cases of a painful, incurable illness, suicide is coerced.\textsuperscript{153} For those oppressed by such an illness, victimized by a debilitating disease, or in pain, death may be a release. If the patient’s pain and suffering is refractory to treatment, then the wish for suicide should be considered compelling and defensible.\textsuperscript{154} The defense of force majeure\textsuperscript{155} is standard in Dutch euthanasia cases and represents the idea that the patient’s extreme and enduring pain forces the physician to assent to the patient’s wishes to take extraordinary measures.\textsuperscript{156} Force majeure is specifically applicable to the Dutch physician as mental duress or necessity from the compelling circumstances, but the defense has not yet achieved legal status in the United States. An act of euthanasia is not murder in the Nether-

\begin{itemize}
\item See Suzanne Stern-Gillet, The Rhetoric of Suicide, in Suicide: Right or Wrong?, supra note 4, at 93, 95-99 (analyzing theory of coercive suicide in light of historical figures like Socrates, Jesus Christ and I.R.A. protestor Bobby Sands, who went on hunger strike).
\item See Brovins & Oehme, supra note 9, at 144-67 (discussing how patients facing sheer agony seek help to end their lives when there is no hope of medical cure).
\item See Black’s Law Dictionary 645 (6th ed. 1990) (defining force majeure as “[i]n the law of insurance, superior or irresistible force”). Force majeure literally means “superior force.” It is also a “clause . . . common in construction contracts to protect the parties in the event that a part of the contract cannot be performed due to causes which are outside of the control of the parties and could not be avoided by exercise of due care.” Id.
\item See Schanker, supra note 11, at 994 n.98 (stating that “the concept of force majeure has historically been used to excuse defendants who broke the law under coercion”); see also Hendin, supra note 2, at 250-77 (1995) (discussing de facto legislation in Netherlands regarding euthanasia and assisted suicide).
\end{itemize}
lands, but is treated as a death attributed to nature's compelling inequities.\textsuperscript{157}

\section*{B. Distinguishing Necessity and Duress}

The defense of duress is often confused with the necessity defense, and modern courts have minimized the distinction between the two.\textsuperscript{158} The major difference is that duress occurs where the source of the coercion is in the action of others, while necessity covers situations where there are physical forces beyond the actor's control.\textsuperscript{159} The theory of necessity holds that the defendant's free will was properly exercised to achieve a greater good. Conversely, the theory of duress holds that the defendant's free will was overcome by another person.\textsuperscript{160} While necessity occurs when one chooses the lesser of two evils,\textsuperscript{161} duress occurs when one is unable to exercise a free choice.\textsuperscript{162} To a significant extent, the defenses

\textsuperscript{157} Hendin, supra note 2, at 250-77. "Most recently the Dutch have begun to accept psychological distress as justification for assisted suicide or euthanasia whether or not physical illness is present." Id. at 258.

\textsuperscript{158} See United States v. Bailey, 444 U.S. 394, 410 (1980) ("Modern cases have tended to blur the distinction between duress and necessity."). In Bailey, two federal prisoners were prosecuted for escaping custody. Id. at 396. Their defense was duress and necessity. Id. at 397. The Court held that "where a criminal defendant is charged with escape and claims that he is entitled to an instruction on the theory of duress or necessity, he must proffer evidence of a bono fide effort to surrender or return to custody as soon as the claimed duress or necessity had lost its coercive force." Id. at 415.

\textsuperscript{159} See id. at 409-10 (discussing historical common law distinction between duress and necessity). An example of duress may be illustrated where: "A destroyed a dike because B threatened to kill him if he did not, A would argue that he acted under duress, whereas if A destroyed the dike in order to protect more valuable property from flooding, A could claim a defense of necessity." Id. at 410.

\textsuperscript{160} See Dressler, supra note 58, at 274 (citing United States v. Contento-Pachon, 723 F.2d 691 (9th Cir. 1984) (concerning necessity and duress defense to drug possession charge); People v. Unger, 362 N.E.2d 319 (Ill. 1977) (concerning distinction of necessity and duress to prison escape case)).

\textsuperscript{161} See Contento-Pachon, 723 F.2d at 695 (explaining necessity defense). The court stated:
The defense of necessity is available when a person is faced with a choice of two evils and must then decide whether to commit a crime or an alternative act that constitutes a greater evil. . . . Traditionally, in order for the necessity defense to apply, the coercion must have had its source in the physical forces of nature. . . . The theory of necessity is that the defendant’s free will was properly exercised to achieve the greater good. . . .

\textsuperscript{162} Id. (citations omitted).

Id. According to the court:
The duress defense was applicable when the defendant's acts were coerced by a human force. . . . It has been suggested that "the major difference between duress and necessity is that the former negates the existence of the requisite mens rea for the crime in question, whereas under the latter theory there is no actus reus."
overlap with both recognizing a commonality of compulsion that would force a suicide-assisting physician to violate the law.\textsuperscript{163}

If one accepts the paradox that one may be a criminal accessory to the lawful act of suicide, then the derivative influences of necessity and duress are material to the ultimate resolution of the physician's guilt or innocence. The past failure of juries to convict physicians in medically assisted suicide cases reflect more than faulty or capricious judgment.\textsuperscript{164} It represents the adoption of a de facto medical necessity defense and represents the factfinder's intolerance of contradictory legal policies of punishing an obliging physician who assists in the legal act of suicide.\textsuperscript{165}

C. The Medical Necessity Defense

Medical necessity is a variation on the necessity defense because it incorporates medical judgments and amplifies one's liberty interest in personal health matters.\textsuperscript{166} Medical necessity requires that the accused act under a reasonable belief, supported by medical evidence, that some action to disobey the law was necessary as an emergency measure to avert an imminent injury. The harm threatened is often less immediate than that required for the ordinary necessity defense. Medical necessity cases introduce the consequence of interest-balancing where individual decisions concerning death and health supersede the state's interest in preserving a terminal life.\textsuperscript{167}

Typical medical necessity cases concern violating drug laws to alleviate the debilitating effects of terminal diseases. In \textit{Jenks v. State},\textsuperscript{168} the court found that the statute outlawing the possession and cultivation of marijuana did not preclude a medical necessity defense when no other treatment was available to ameliorate the nausea and pain suffered by the defendants, who had contracted

\textit{Id.} (quoting \textit{United States v. Micklus}, 581 F.2d 612, 615 (7th Cir. 1978)) (emphasis added).

\textsuperscript{163} \textit{Id.} "[M]odern courts have tended to blur the distinction between duress and necessity." \textit{Id.}

\textsuperscript{164} For a discussion of jury nullification, see \textit{supra} note 11 and accompanying text.

\textsuperscript{165} For a discussion of defenses to medically assisted suicide cases, see \textit{supra} note 9 and accompanying text.

\textsuperscript{166} \textit{See} Isenberg, \textit{supra} note 12, at 297 (examining medical necessity defense).

\textsuperscript{167} \textit{See id.} (discussing how interests to be balanced can be demonstrated by medical testimony).

\textsuperscript{168} 582 So. 2d 676 (Fla. Dist. Ct. App. 1991).
AIDS. Similarly, in *State v. Diana*, the court remanded the case to give the accused the opportunity to demonstrate the beneficial effect of marijuana to treat his multiple sclerosis symptoms. Medical necessity amplifies individual viewpoints on personal health care matters. Often, the medical choices that run counter to the law present difficult value judgments, but the right of bodily autonomy is paramount and should supersede the interests of the state when death nears. The physician must qualify for the necessity defense by satisfying critical elements in proving the reasonableness of the physician’s conduct.

IV. APPLYING THE MEDICAL NECESSITY FACTORS TO AN ASSISTED SUICIDE PROSECUTION

A. Belief in Medical Emergency

Medical necessity recognizes that suicide is sometimes a reasonable response to a debilitating, terminal illness. Peril is evident from the patient’s medical state and the ineffectiveness of conventional alternatives for treatment. The reasonableness of the physician’s belief in the patient’s terminal condition can be verified through diagnosis and second medical opinions. Moreover, the physician must ascertain the patient’s competence. Competency exists if the patient has substantial capacity and fair opportunity to

169. *Id.* The defendants, a married couple, were convicted of cultivating marijuana and possessing drug paraphernalia. *Id.* at 677. While the defendants admitted to the crimes, they claimed that they needed the marijuana to relieve their AIDS-related symptoms. *Id.* The court reversed the convictions and acquitted the defendants, holding that the necessity “defense was recognized at common law and that there was no clear legislative rejection of that defense.” *Id.* at 678, 680.


171. *Id.* at 1317. In remanding the case, the court stated that “[t]o support the defendant’s assertions that he reasonably believed his actions were necessary to protect his health, corroborating medical testimony is required.” *Id.* Further, in making its decision, “the court must balance the defendant’s interest in preserving his health against the States’s interest in regulating the drug involved.” *Id.*


173. For a discussion of the right of bodily autonomy, see supra note 71 and accompanying text.

174. For a discussion of applying the medical necessity defense to assisted suicide, see infra notes 175-285, and accompanying text.

175. See Isenberg, supra note 12, at 273 (discussing medical necessity as justification for assisted suicide and defense to criminal liability in assisted suicide cases).

176. See *Bachman*, 595 P.2d at 287 (stating that defense of medical necessity cannot be effective unless there is supportive medical testimony).
understand the pertinent facts relating to his or her medical condition. The competency test focuses on the patient's capacity to comprehend the situation, risks and alternatives. The patient must knowingly and intelligently assess the dangers of his or her choice. Thus, there must be the capacity for a "reasoned choice" and "rational understanding" of the medical proceedings. Admittedly, the association between mental illness and suicide is difficult to gauge. Some contend that suicide is proof of mental imbalance or lunacy. Others claim that suicide is the result of diminished capacity or depression, while still others profess that some suicides are rational.

Capacity to choose death may be rational, even though a person may be medicated and depressed. In Godinez v. Moran, the Supreme Court determined that a defendant who committed murder and then attempted suicide was competent to waive his right to counsel and plead guilty to a capital offense, despite the fact that he was being medicated at the time. Two psychiatrists testified at the plea phase of the trial that the defendant was informed and understood the nature of the proceedings against him, even though he was depressed at the time. The defendant later appealed the resulting death sentence, but the Court held that the
defendant had been competent to plead guilty, and in effect, volunteer for his own execution. 183

Competent medical choices rest on the disclosure and understanding of available alternatives regarding proposed therapy and cures. As Justice Brennan noted in his dissent in Cruzan, "[t]he possibility of a medical miracle is indeed part of the calculus, but it is a part of the patient's calculus." 184 It is rational to want to avoid a debilitating death and to expect no miraculous cures or spontaneous remissions.

B. Expert Medical Authority

The defense of medical necessity must be supported by medical evidence to substantiate the patient's peril and to establish that no other means are available to alleviate the patient's pain. 185 This supporting medical evidence must establish three conditions: (1) the person who committed suicide must have suffered from a terminal disease; (2) no other reasonable alternatives existed; and (3) the person who committed suicide was rational. 186 If these condi-

183. Id. at 392. The Court stated that the standards for determining competency for pleading guilty or waiving the right to counsel and standing trial are the same. Id. at 399-400. Furthermore, the Court stated that in addition to proving a defendant competent to plead guilty or stand trial, a trial court must be satisfied "that the waiver of his constitutional rights is knowing and voluntary." Id. at 400.

184. Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261, 321 (1990) (Brennan, J., dissenting). Justice Brennan went on to state that "if current research suggests that some hope for cure or even moderate improvement is possible within the lifespan projected, this is a factor that should be and would be accorded significant weight in assessing what the patient himself would choose." Id. (Brennan, J., dissenting).

185. Robert L. Risley, Ethical and Legal Issues in the Individual's Right to Die, 20 Ohio N.U. L. Rev. 597, 604-05 (1993) (endorsing active euthanasia when patient is terminally ill and recommending that such determination should be confirmed by two physicians).

186. Many of the proposed "Death with Dignity" acts include all of the factors encompassed in a medical necessity defense. See, e.g., Risley, supra note 185, at 619 (providing proposed California Death with Dignity Act). The California electorate defeated the proposed Death with Dignity Act in November 1992, which sought to legalize physician assisted suicide. Nancy W. Dickey, Euthanasia: A Concept Whose Time Has Come?, ISSUES IN LAW AND MEDICINE, Mar. 22, 1993, at 521. Forty-six percent voted in favor of the act while 54% voted against it. Id. A similar proposed act was defeated in Washington in 1991. Id. In November 1994, Oregon became the first state to legalize doctor assisted suicide by a 51% to 49% vote. William Carlsen, When Patients Chose to Die, S.F. CHRON., June 3, 1996, at A1. Prior to the enactment of Oregon's Death with Dignity Act, a federal judge deemed the Act unconstitutional. Id. The Oregon State Attorney General and the Act's sponsors have appealed this decision to the Ninth Circuit. David G. Savage, Northwest Effort on Right to Die Faces High Court, L.A. TIMES, Sept. 30, 1996, at A1. The Oregon law is much more detailed than the earlier California and Washington models, including "guidelines to make clear that the assisted suicide would be carefully limited and that the patient, not the doctor, would be in control at all times." Id. Further-
tions are satisfied, then the decision to assist the suicide would appear reasonable and justified.

A nonphysician may also commit medically assisted suicide. A spouse, a health care administrator, a relative or a minister may assist a suicide and be entitled to the medical necessity defense if the prerequisites of the defense are established. The assistance must be predicated upon the wishes of the suicidal person, the existence of a terminal illness and the availability of no other reasonable alternatives. 187 Physician assisted suicide concerns the assistance of the physician; medically assisted suicide concerns the assistance of anyone who alleviates a medical condition. 188 The medical necessity defense would conceivably encompass both. Conversely, if future statutes carve a narrow exception allowing physician assisted suicide, then all others may be preempted from raising the defense. 189 Nonphysicians could not proclaim a medical necessity defense, barring unusual circumstances, if methods were available through the physician.

C. Imminent Harm to Another

The physician may defend the patient from imminent harm. The necessity defense allows one to avoid an evil to oneself or to another. 190 The requisite element of imminent harm is actually a misnomer in the end-of-life cases, because the terminal condition is permanent. Attempts to apply the imminent harm requirement to medical cases are complicated by the nature of the disease at hand, its stage of development and differing medical opinions concerning appropriate treatment. 191 Although there may be some disagreement in projecting the exact time of death, there can be no disa-

187. See generally Lisa Belkin, There's No Simple Suicide, N.Y. Times Mag. 50, 50 (Nov. 14, 1993) (discussing suicide patient who had only weeks to live, who desired to commit suicide in absence of other reasonable alternative).

188. Id.

189. For example, the proposed California Death with Dignity Act provided only "mentally competent terminally ill adults the legal right to voluntarily request and receive physician aid-in-dying." Risley, supra note 185, app. B at 619 (emphasis added). A physician was then defined as "a physician and surgeon licensed by the Medical Board of California." Id.

190. See Model Penal Code § 3.02(1) (1980) ("Conduct which the actor believes to be necessary to avoid a harm or evil to himself or to another is justifiable." (emphasis added)).

191. See Nuland, supra note 93, at 222-62 (discussing various approaches in two terminally ill cancer cases). Dr. Nuland recounted the story of Harvey Nuland, a man afflicted with cancer of the bowel, and his slow decline prior to his ultimate death. Id. at 224-33. Dr. Nuland then recounted the story of Robert DeMatteis,
greement that the illness is terminal. Without the requirement of a terminal illness, one may be unable to separate out the disabled, temporarily forlorned and depressed. Imminent harm is a question for the jury and depends on the circumstances of each case.

D. Reasonable Alternatives

Medical necessity is available if there is no reasonable alternative. Health care professionals have an ethical duty to provide optimal palliative care to dying patients, but many physicians are uninformed about the appropriate doses, frequency of doses and alternate modalities of pain control for patients with severe chronic pain. Physicians attempt to balance a patient’s distress with psychological stimulations of hope and drugs. Drugs are often withheld, however, because physicians need some indicators of the level of the patient’s pain to make a proper diagnosis and treatment. Nearly all physicians agree that, in about ten percent of the terminally ill cases, no drug can soothe extreme pain. It is in these cases where the physician may have met the exhaustion requirement because conventional medical alternatives are useless.

The most frequently mentioned alternative to physician assisted suicide is hospice care. “[H]ospice is known as a philoso-
phy of care; a medically oriented team approach to managing the pain and symptoms for individuals with a limited life expectancy.” All treatment is palliative and directed toward tranquility and comfort, while integrating the families and friends with the life of the patient. Family members are instructed on methods to minimize the patient’s distress: organize the house, administer medications for pain and nausea, and accompany the patient throughout the peculiarities of the disease. Hospice care is in its infancy. It is expensive and the quality of care and experience differs among various programs.

There are other alternatives for the physician if the affliction cannot be controlled by medication. Some alternatives offer controversial results and have not withstood the test of law. For instance, the principle of double effect allows the physician to aggressively treat the patient’s pain, even though the practical consequences are death. Patient refusal of hydration and nutrition allows a terminally ill patient to refuse food and water and die in a

198. Id.
199. Id. One commentator defines palliative treatment as the “treatment of the symptoms of the disease and not the disease itself, there is no intent to cure, instead there is emphasis on whole-person care.” Id.
200. Id.; see also Nancy K. Rhoden, Litigating Life and Death, 102 HARV. L. REV. 375, 426 (1988) (stating “dying person is made as comfortable as possible, but death, being inevitable is not naturally forestalled”); Schanker, supra note 11, at 1008 (stating hospice “is intended to meet the physical, social, physiological, and spiritual needs of both the dying patient and family”).
201. See NULAND, supra note 93, at 265 (describing hospice care as “ability to manage the process of death, making it as tranquil as professional kindness could”); Timothy E. Quill, Risk Taking By Physicians in Legally Gray Areas, 57 ALB. L. REV. 693, 699 (1994) (“[W]e cannot ameliorate the disease process, so we give intensive attention and care to the person. We give each individual as much choice and control as possible.”); Schanker, supra note 11, at 1008 (stating hospice “provides a caring response to many patients’ fear of pain, of dying alone and of the tyranny of medical technology”).
202. See Chris Petiakos, Comfort Zone: Hospices Fill Medical, Emotional Needs of Patient’s Family, CHI. TRIB., Aug. 14, 1995, § 6, at 1 (stating that there are about 1,700 hospices in America as of 1995). The first hospice opened in the United States in 1974. Id. Some credit the rapid growth of hospices in the last twenty years to our society’s “discomfort with a medical system that places most of its attention on prolonging life rather than the patient’s need for dignity and comfort.” Id.
203. Id. (quoting hospice director as saying “[n]ot every hospice is the same”). With the medical reimbursement, the average daily cost for a hospice stay is roughly $90. Id. Many insurance companies and managed care providers have also extended their coverage to include hospice stay. Id.
204. See N. Ann Davis, The Priority of Avoiding Harm, in KILLING AND LETTING DIE, supra note 4, at 298-354 (detailing doctrine of double effect).
benign fashion. 205 The physician’s choices are limited if pain cannot be remedied. Otherwise, the patient must suffer through the ordeal. Whether the proposed alternatives are reasonable is a question for the jury, but each of the previously mentioned recommendations pose social and legal difficulties which are unresolved.

E. No Fault, No Legislation

One cannot assert a medical necessity defense if one created the crisis. 206 In the case of a terminal disease, the physician has not created the patient’s medical crisis. 207 Although some might argue that the patients have brought this scourge upon themselves, that should not preclude the physicians from trying to help people near death. 208 The source of many degenerative, terminal illnesses is unknown and is not deemed to be the fault of the patient. 209


206. See MODEL PENAL CODE § 3.02(2) (1985) (discussing necessity defense). Section 3.02 states that “[w]hen the actor was reckless or negligent in bringing about the situation requiring a choice of harms or evils or in appraising the necessity for his conduct, the justification afforded . . . is unavailable.” Id. For a further discussion of the necessity defense, see supra notes 133-57 and accompanying text.


I have to tell you that I abandon you to your bad constitution, to the distemper of your bowels, to the corruption of your blood, to the acrimony of your bile, and to the feculence of your humors. And I wish that before four days have passed you may be in an incurable state . . . that you fall sick of bradypepsia . . . go from bradypepsia to dyspepsia . . . from dyspepsia to aepsia . . . from aepsia to lientery . . . from lientery to dysentery . . . from dysentery to dropsy . . . from dropsy to the loss of life to which your folly has led you.

Id.

208. See MODEL PENAL CODE § 3.02(1) (allowing one to come to aid of another).

209. If the physician is at fault in creating a terminal condition, then the physician cannot assist the patient in committing suicide. If, by an intentional or negligent operation, the patient is placed near death, then the physician cannot conveniently escape liability by assisting the patient die. This could introduce interesting complications. If the physician, through a negligent diagnosis, “caused” or could have prevented the terminal condition, then this physician must not assist in a consequent suicide because his or her civil liability poses a conflict. Yet, physician assisted suicide proposals rest on the availability and continued treatment of the family doctor, but it might be the family doctor who “caused” the affliction. See generally Hendin, supra note 2, 252-58 (discussing situation in Netherlands where physicians “admitted they had actively caused or hastened death without the request of the patient” in 1000 cases).
Additionally, when some provision of the law explicitly deals with the specific situation that presents the choice of evils, then one may be preempted from claiming a necessity defense. Only one state has a physician assisted suicide exemption. Minnesota has a double effect exemption, and one might argue that any act of euthanasia or assisted suicide in Minnesota must follow the statutory procedure which allows the physician to relieve severe pain when death is a foreseeable consequence of the drugs. Most states have not amended their assisted suicide statutes to exempt physicians. Thus, generally speaking, no legislative action precludes the medical necessity defense in the United States.

F. Balance of Harms

Courts will determine whether assisted suicide is justified or excusable conduct. Justified conduct concerns a theory of utilitarian values, that is whether the unlawful act is commendable and whether society benefits from the act. Excusable conduct, on the other hand, concerns a theory of particularized excuse, negating the individual's moral blameworthiness. Courts will weigh the proportionate harm to society resulting from allowing the medical necessity defense and will review the jeopardy placed on the integ-

210. For a further discussion of applying the statutory provisions of the Model Penal Code regarding necessity, see supra note 146 and accompanying text.

211. Oregon has provided a physician assisted suicide exemption, but this statute has been ruled unconstitutional by a federal court. For a further discussion of Oregon's Death with Dignity Act, see supra note 186 and accompanying text.

212. MINN. STAT. ANN. § 609.215(3) (a) (West 1996) (exempting health care provider "who administers, prescribes, or dispenses medications or procedures to relieve another person's pain or discomfort, even if the medication or procedure may hasten or increase the risk of death").

213. See, e.g., People v. Kevorkian, 527 N.W.2d 714 (Mich. 1994), cert. denied, 115 S. Ct. 1795 (1995). Irrespective of Dr. Kevorkian's intent to assist in Mr. Hyde's death by administering poisonous gasses, the jury acquitted the doctor based on the overall sentiment of the double effect exemption. BROWINS & OEHMRE, supra note 9, at 225-41. For a further discussion of double effect, see infra notes 271-77 and accompanying text.

214. For a discussion of states which have enacted assisted suicide laws, see supra note 56 and accompanying text.

215. See Tsarouhas, supra note 11, at 800-06 (analyzing arguments for and against active euthanasia and assisted suicide).

216. See DRESSLER, supra note 58, at 261 (discussing necessity as "lesser evil" or "choice of evil" defense available when person is presented with choice between two evils and must pick one).

217. See id. at 493-99 (discussing principle of excuse).
rity of the medical profession as well as other advantages and disadvantages. 218

1. The Integrity of the Medical Profession

Physicians must weigh the principles of patient autonomy, the sanctity of life and the potential consequences of a policy that permits them to collaborate in deaths. 219 Physicians often disagree on diagnosis, treatment and on the probability of miraculous cures. 220 An environment of distrust in the medical profession would undermine whether the physician is acting in the best interests of the patient. Some patients may seek the assistance of a physician because the patient is unable to obtain the drugs for a tranquil death and may be inept at the attempt, making the situation worse. 221 The patient may possibly harm innocent persons in the attempt, or the patient may be so physically debilitated as to be unable to successfully complete an attempt. 222 This places the physician in a

218. A few courts allow the balancing of harms to weigh in favor of precluding the necessity defense. See, e.g., Commonwealth v. Hutchins, 575 N.E.2d 741, 745 (Mass. 1991) (refusing to accept necessity defense when weighing use of marijuana to alleviate symptoms from scleroderma against potential harm to public). The court stated that it could not "dismiss the reasonably possible negative impact of such a judicial declaration on the enforcement of our drug laws ... nor can we ignore the government's overriding interest in the regulation of such substances." Id. Most other courts overwhelmingly accept the necessity defense. See Kadish & Schulhofer, supra note 5, at 860-80 (discussing residual principle of justification).

Other courts have held that the determination of sufficient evidence of a medical necessity defense "requires the trial and appellate courts to interpret the evidence most favorably for the defendant." State v. Cole, 874 P.2d 878, 882-83 (Wash. Ct. App. 1994). Additionally, the court stated "[b]ecause the State challenged the sufficiency of [the defendant's] evidence in support of the medical necessity defense, the trial court was required to interpret this evidence in a light most favorable to [the defendant]." Id. at 883.

219. See Steven H. Miles, Physicians and Their Patients' Suicides, 271 JAMA 1786, 1787 (June 8, 1994) (explaining motives of suicide). Miles observed:

Patients' suicides engender anger, guilt, and loss of self-esteem on the part of treating physicians. Collegial consultation does not mitigate these feelings. The relevance of these findings for physician-assisted suicide must be established as was discussed above. The relevance is supported by the findings of a study of Dutch physicians who assisted suicide that they felt ill prepared for such acts and that the "heavy emotional burdens" and psychiatric morbidity from assisting a patient's suicide left them disinclined to repeat the act.

Id.

220. See id. (noting that "as the dying process progresses and accelerates, we often lose the strength to help ourselves").

221. See Risley, supra note 185, at 607 ("[M]ost people lack the knowledge and the means to end their own lives in a way that is acceptable to them. Nor do they possess the license needed to obtain life-ending substances, even if they knew how to use them.").

222. Id.
bind—to assist the suicide or allow the disease to take its toll. The antiquated Hippocratic Oath, which initially declares allegiance to Greek gods, prohibits euthanasia: “I will give no deadly medicine to anyone if asked, nor suggest any such counsel.”228 The American Medical Association officially opposes euthanasia and physician assisted suicide, but many doctors are supportive in exceptional cir-


Many American medical schools either do not insist that the Hippocratic Oath be taken by graduating doctors or have made changes to the wording of the Oath. See BROVINS & OEHMKE, supra note 9, at 5 (discussing former physician Jack Kevorkian's reference to the University of Michigan Medical School). Kevorkian stated:

I never took the oath, and as far as I know it was never officially administered to my graduating class in 1952 at the University of Michigan. Indeed, it is now uncommon for any American medical faculty to insist that the oath be taken by graduating doctors. That alone renders suspect the hallowed oath's importance or relevance to modern medical practice.

Id.
cumstances.\(^\text{224}\) There are approximately 30,000 suicides a year.\(^\text{225}\) The terminally ill commit approximately three percent of all suicides.\(^\text{226}\) For the terminally ill patients, for whom pain medication does not work, physician assisted suicide would be an option. Nevertheless, the credo for the medical profession is to preserve life, not destroy it. Physician assisted suicide revolutionizes that medical credo.

2. Other Disadvantages of Physician Assisted Suicide

Allowing the medical necessity defense may lead to abuses, aggravated practices and a veritable slippery slope.\(^\text{227}\) History teaches that widespread euthanasia perpetuates an atmosphere of dis-easism, ageism and geriatric futility.\(^\text{228}\) A progression of cases which embrace the right to die illustrates the legitimacy of the slippery slope concern. One may have the right to forbid life-saving blood transfusions on First Amendment religious grounds.\(^\text{229}\) One has the right to refuse extraordinary and even ordinary medical treatment, a concept espoused by living wills.\(^\text{230}\) An inmate has a


\(^{225}\) Hendin, supra note 2, at 33. In addition, there are hundreds of thousands of attempted suicides each year. Id.

\(^{226}\) Id. at 242. Dr. Hendin notes that “the overwhelming majority of terminally ill fight for life to the end.” Id. at 243.

\(^{227}\) See Tsarouhas, supra note 11, at 812 (discussing Dutch system of euthanasia and its rise in abuses leading to “ride on the ‘slippery slope’”).

\(^{228}\) For a further discussion of the historical approach to euthanasia, see supra notes 20-55 and accompanying text.

\(^{229}\) See In re Estate of Brooks, 205 N.E.2d 435, 442-43 (Ill. 1965) (holding that lower court interfered with patient’s constitutional rights by allowing conservator to consent to blood transfusions, which were against express will of patient). The court concluded that “what has happened here involves a judicial attempt to decide what course of action is best for a particular individual, notwithstanding that individual’s contrary views based upon religious convictions. Such action cannot be constitutionally countenanced.” Id. at 442.

\(^{230}\) See generally Luis Kutner, The Living Will, Coping with the Historical Event of Death, 27 Baylor L. Rev. 39 (1975) (discussing history of living wills and guidelines for making such wills). Every state recognizes the concept of living wills—documents stipulating that specified medical procedures should not be used to keep the patient alive in medical situations. Dworkin, supra note 104, at 180. Alternatively, health care proxies are documents appointing third parties to make health care decisions when the patient is disabled. Id.
right to deny forced feedings in terminal situations. The patient's guardian has a right to refuse life-support systems for food and water. Next, medical euthanasia will be allowed for patients who are physically unable to commit the act themselves. Disturbing reports have surfaced regarding abusive practices in the Netherlands. One study revealed that in over one thousand cases, Dutch physicians admitted they had actively caused or hastened death without the request of the patient, and that doctors, nurses and families often pressured the patient to request euthanasia. Additionally, some individuals or cultures prefer that a physician avoid the question of anticipated death as it undermines the patient's confidence in the physician's competence.

Case studies have also legitimized the domino theory, in that one suicide will induce other suicides. Physician assisted suicide sentimentalizes a tranquil death, making the living feel they have

231. See, e.g., Thor v. Superior Court, 855 P.2d 375, 390 (Cal. 1993) ("[W]e find no duty on [the physician] to provide further life sustaining procedures and therefore decline to authorize him to take any action inconsistent with or contrary to [the competent inmate's] express choice regarding the course of his medical treatment.").


233. Kamisar, supra note 64, at 36. University of Michigan Professor Yale Kamisar, a renowned advocate against assisted suicide and euthanasia, wrote: "In a climate in which suicide is the 'rational' thing to do, or at least a 'reasonable' option, will it become the unreasonable thing not to do? The noble thing to do?"

234. See Hendin, supra note 2, at 250-77 (discussing Netherland's experience with legalized euthanasia); see also Schanker, supra note 11, at 992-97 (same).

235. Hendin, supra note 2, at 252. A Dutch commission, headed by Professor Jan Remmelink, studied the medical practices of euthanasia and issued the "Remmelink Report" which summarized alleged abuses. Id. at 252-53. The Remmelink Commission considered that these cases were not morally troublesome because the suffering of those patients had become unbearable and they would usually have died soon anyhow. Id. at 253.

236. See Dworkin, supra note 104, at 190 (discussing vulnerability of terminally ill individuals). Dworkin notes that:

Such a person [who is terminally ill] is especially vulnerable to pressure: he might prefer that a doctor not even raise the question of whether he would like to consider dying with medical assistance; he might prefer that the question never arise, or that he not even have the right to request death. Many of the people who voted against the Washington and California referendums were worried about putting sick people in that position, and some critics of the Dutch scheme claim that in that country the elderly are beginning to look upon doctors as their enemies.

missed something by staying alive. Once assisted suicide becomes policy, the young and the depressed may be susceptible to imitative influences that glorify and destigmatize suicide.\textsuperscript{288} It is unclear whether the allowance of physician assisted suicide would increase the overall suicide rate, but, once it is legal, death becomes a guaranteed peaceful future interest—a contingency plan.

The poor might be grossly affected by assisted suicide because they are notoriously less provided for in the alleviation of pain.\textsuperscript{289} The desire to reduce costs would immediately affect those who cannot afford the high costs of treatment.\textsuperscript{240} Economic vulnerabilities would make the poor the ideal candidates for physician assisted suicide and physician-recommended suicide.\textsuperscript{241} The elderly might also be susceptible to fraud and deceit.\textsuperscript{242} The death experience is communal and has attractive probate and insurance consequences.\textsuperscript{243} Women, too, might suffer in that they outlive men and may encounter reduced financial resources.\textsuperscript{244} “A system which fails to care adequately for the living must not be empowered with the license to kill.”\textsuperscript{245}

\textsuperscript{238} See Peter M. Marzuk et al., \textit{Increase in Suicide by Asphyxiation in New York City After the Publication of Final Exit}, 329 NEW ENG. J. MED. 1508, 1510 (1993) (noting that after Derek Humphry, founder of Hemlock Society, published his book, \textit{Final Exit: The Practicalities of Self Deliverance and Assisted Suicide for the Dying}, describing various ways one can commit suicide, there was significant increase in number of suicides, which may be attributed to suggestions in that book).

\textsuperscript{239} Compassion in Dying v. Washington, 850 F. Supp. 1454 (W.D. Wash. 1994), rev’d, 49 F.3d 586 (9th Cir. 1995), aff’d, 79 F.3d 790 (9th Cir.) (en banc), cert. granted, sub nom. Washington v. Glucksberg, 117 S. Ct. 37 (1996); see Schanker, supra note 11, at 1005-06 (“An institution providing an indigent patient with care would be called upon to resist substantial incentives to encourage the patient to avail himself of euthanasia, including financial savings and the release of resources to insured patients.”).

\textsuperscript{240} See CANTOR, supra note 120, at 87-89 (noting recent report by respected group of medical experts recommended that “[f]inancial ruin of the patient’s family, as well as the drain on resources for treatment of other patients who are not hopelessly ill should be weighed . . . although the patient’s welfare obviously remains paramount”).

\textsuperscript{241} Compassion in Dying, 79 F.3d at 851.

\textsuperscript{242} Id. at 826.

\textsuperscript{243} See CANTOR, supra note 120, 89 (noting that survivors participating in decision-making process will not be “oblivious to the resources—physical, emotional, and monetary—being devoted to a dying patient” who has no hope of recovery).

\textsuperscript{244} Compassion in Dying, 79 F.3d at 853-54.

\textsuperscript{245} Tsarouhas, supra note 11, at 811; see also George J. Annas, \textit{Physician-Assisted Suicide—Michigan's Temporary Solution}, 20 OHIO N.U. L. REV. 561, 568 (1993) ("The most powerful argument against the legislative expansion of the power of physicians to assist patients in suicide is the danger that this greater latitude will
3. Various Societal Approaches Towards Death

Given the present perception of a health care crisis, patients, insurers, families and the government are concerned about rising medical costs. Prolonged health care depletes savings and inheritance. Some medical personnel financially gain from prolonged patient care. The current political landscape reflects a society characterized by technological change, personal autonomy, overpopulation and fear of economic turmoil. The sudden mass call for physician assisted suicide might reflect a public imperative.

Dr. Hendin proposes four reasons why euthanasia or physician assisted suicide would be unwise in America: (1) "The United States is not characterized by either a legal or medical system that fosters social harmony, but that instead pits one profession against the other"; (2) Hospitals would be subject to economic pressures to get rid of the terminally ill because of inequitable health plans; (3) The absence of the "family" doctor eliminates a major source of patient protection; and (4) Americans have not sufficiently studied the issue and have an insufficient body of case law to define acceptable parameters for all.

Schanker observes:

On the one hand, it is possible to imagine a safe and compassionate administration of euthanasia, with physicians and families working together to create a supportive and loving environment in which to make the crucial decision .... On the other hand, it is equally possible, and perhaps closer to reality, to imagine deathbed scenes fraught with anxiety, conflict, and mistrust.

An example of cost containment can be found in a 1991 case where Minnesota physicians filed suit to disconnect the respirator of an 87 year-old woman whose family insisted on continued care and life-support systems. Despite the fact that the physicians demonstrated that the woman suffered an irreversible coma and that the financial costs of her care amounted to nearly one million dollars a year, they lost the suit. Minnesota law establishes that a patient has a right to demand unceasing medical treatment even in an arguably hopeless case.

Conversely, see Hendin supra note 2, at 276-77 (discussing opposite view that public imperative demands rejection of physician assisted suicide). Hendin observes:

How we deal with illness, age, and decline says a great deal about who and what we are, both as individuals and as a society. The growing number of people living to old age and the increasing incidence of depression in people of all ages presents us with a medical challenge. Our efforts should concentrate on providing treatment, relieving pain for the intrac-
The disadvantages of physician assisted suicide may be controlled by well-defined guidelines. To insure trust in the medical and legal profession, the patient must be entitled to a medical "bill of rights," which would define the nature of the terminal illness, explain the diagnosis, suggest the remedies, describe the physical toll and assess the financial costs.\textsuperscript{250} The patient must be allowed the reciprocal right of consent to accept or reject therapy and treatment.\textsuperscript{251} The patient has a right to religious, ethnic, cultural and familial influences in making a decision, yet strict regulations can insure that the patient is not coerced into committing suicide by doctors, relatives or friends.\textsuperscript{252} One may seek advisory opinions from medical ethics boards or from the courts.\textsuperscript{253} Judicial intervention should be the last resort. \"[J]udicial intervention \ldots tends to denigrate the principle of personal autonomy, substituting a species of legal paternalism for the medical paternalism the concept of informed consent seeks to eschew,\"\textsuperscript{254} Additionally, judicial intervention may create unconstituted impediments, a prior restraint upon choice.\textsuperscript{255}

Others argue that the entire issue of euthanasia is prompted and guided by an improper restraint by religious dogma. Noted commentator Glanville Williams, who resurrected the consideration of euthanasia in the 1950s, stated: \"[T]he case against euthanasia legislation is inseparably connected to religious convictions about the sanctity of life and human prerogative to take it. Such a connection renders the current law deeply suspect as the basis of a policy in a secular regime.\"\textsuperscript{256}

The competence of a person who elects to commit suicide may be compromised by the onslaught of the illness. Consequently, the patient must undergo psychiatric examinations and be counseled on alternatives.\textsuperscript{257} The patient must reaffirm the decision to com-


\textsuperscript{251} \textit{Id.} at 29.

\textsuperscript{252} \textit{Id.}

\textsuperscript{253} \textit{Id.} at 28-29.

\textsuperscript{254} Thor v. Superior Court, 855 P.2d 375, 389 (Cal. 1993).

\textsuperscript{255} \textit{Id.}

\textsuperscript{256} See \textit{Sherlock}, supra note 61, at 120 (citing \textit{Glanville Williams, The Sanctity of Life and the Criminal Law} 311-19, 333-50 (1957)).

\textsuperscript{257} Brovins & Oehmke, supra note 9, at 162-64. For example, Dr. Kevorkian, the leading advocate of physician assisted suicide, recommends a procedure consistent with those previously mentioned. His procedure includes efforts to per-
mit suicide, but must not be forced to beg. There must be a meaningful doctor-patient relationship so that the doctor has experience with the patient and the patient’s family and can thus rely on the patient’s choice.\textsuperscript{258}

In the Netherlands, euthanasia is accepted. Although technically illegal, Dutch physicians are not prosecuted as long as certain guidelines are followed.\textsuperscript{259} Additionally, the Dutch Reformed Church has sanctioned euthanasia.\textsuperscript{260} The Dutch guidelines require a second physician to corroborate the patient’s medical condition and competence.\textsuperscript{261} Once the doctors agree to perform euthanasia, the attending physician usually induces a deep sleep with barbiturates and then injects a muscle-paralyzing drug that causes cessation of breathing.\textsuperscript{262} Frequently, the act of euthanasia occurs in the patient’s home.\textsuperscript{263} Each year, between 4,000 and 6,000 Dutch patients undergo euthanasia in a nation of some 14.5 million people.\textsuperscript{264} The great majority of requests are refused by the

suade patients to prolong their lives, clinical diagnosis, second opinions and exhaustion of all efforts. \textit{Id.} Dr. Kevorkian’s procedure requires videotaped death counseling with the patient and family, in which he guarantees each patient the irrevocable right to reverse their decision at any moment, and that the patient alone must activate the switch to terminate life. \textit{Id.}

\textsuperscript{258} \textit{Id.} Attorney Geoffrey Fieger argues that the current medical practice offers no greater doctor-patient relationship than the one suggested by Jack Kevorkian. Fieger, \textit{supra} note 86, at 665. Feiger notes:

\textquote[Feiger, supra note 86, at 665.]{[M]ost of the medical practice now, if you go into the hospital, deals with specialists. Specialists have no prior contact with you. The doctor says “Well, you need a gall bladder surgery, call in the surgeon.” The surgeon comes in on roller skates, he says, “Oh yeah, you need the surgery, schedule it.” The first time you really see the guy is in the operating room when you’re unconscious! You never see him again. That’s a physician-patient relationship that’s more respectable than Kevorkian spending months and years with the patient?}

\textit{Id.}

\textsuperscript{259} \textit{Id.} at 27 (concluding that quality of life is more important than length of life).

\textsuperscript{260} \textit{Id.} at 23 (attending physician must consult with colleague regarding patient’s condition and genuineness and appropriateness of request).

\textsuperscript{261} \textit{Id.} at 23 (attending physician must consult with colleague regarding patient’s condition and genuineness and appropriateness of request).

\textsuperscript{262} \textit{NULAND, supra note 93, at 258.}

\textsuperscript{263} \textit{de Wachter, supra note 259, at 24.}

\textsuperscript{264} \textit{Id.} at 23-24.
doctors because many patients have not exhausted every reasonable alternative or have failed to satisfy one of the previously mentioned criteria.265

a. Patient Refusal of Hydration and Nutrition

Several doctors propose another alternative to physician assisted suicide that is consistent with existing case law—allowing death through the refusal of hydration and nutrition.266 These doctors suggest that death by starvation and dehydration may be accomplished without suffering because intrinsic thirst and hunger are usually diminished in terminally ill patients.267 Chronically or terminally ill patients who wish to gain more control over their deaths can then refuse to eat and drink and refuse enteral or parenteral feedings or hydration. "The failure of the present debate to include this alternative may be the result of the confusion that thirst and hunger remain strong drives in terminal illness, and a misconception that failure to satisfy these drives causes intractable suffering."268 According to these doctors, terminally ill patients dying of dehydration or lack of nutrition do not suffer, at least in regards to the stereotypic image of the parched person scrambling in the desert for water. "In fact, maintaining physiologic hydration and adequate nutrition is difficult in most seriously ill patients because intrinsic thirst and hunger are usually diminished or ab-

265. See Hendin, supra note 2, at 251-54 (discussing reports of Remmelink Commission on results of euthanasia requests). Hendin notes that despite accepting euthanasia, prior to 1991 the Dutch did not have hard facts about the practice. Estimates of the number of euthanasia cases had ranged from 5,000 to 20,000 of the 130,000 deaths in the Netherlands each year. Id. at 251; see also Henk A.M.J. ten Have & Jos V.M. Welie, Euthanasia: Normal Medical Practice?, 22 Hastings Ctr. Rep. 34-38 (Mar.-Apr. 1992) (discussing research and data of euthanasia practice in Netherlands).

266. See Bernat & Mogielnicki, supra note 205, at 2723-28. Bernat and Mogielnicki suggest that:

[E]ducat[ing] chronically and terminally ill patients about the feasibility of patient refusal of hydration and nutrition . . . can empower them to control their own destiny without requiring physicians to reject the taboos on physician assisted suicide and voluntary active euthanasia that have existed for millennia. To be feasible, this alternative requires confirmation of the preliminary scientific evidence that death by starvation and dehydration need not be accompanied by suffering.

Id. at 2723.

267. Id.

268. See id. at 2726 (discussing natural versus other causes of death).
sent.” This is a form of passive euthanasia, consistent with prior case law allowing the withdrawal of food and water.

b. The Double Effect Principle

The double effect principle permits aggressive medical treatment that has the double effect of alleviating pain as well as the collateral effect of causing death. Death is an unfortunate consequence of the means chosen, rather than the ultimate goal, which is the alleviation of pain. The basic premise is that the disease kills, not the medications. As such, double effect represents a compromise, short of explicit euthanasia. Minnesota is one of the few states that has statutorily adopted a form of this “double effect” principle. The Minnesota statute bans assisted suicide, but exempts a licensed health care professional “who administers, prescribes, or dispenses medications or procedures to relieve another person’s pain or discomfort, even if the medication or procedure may hasten or increase the risk of death . . . .” The Catholic Church, which also opposes physician assisted suicide, subscribes to the “double effect” doctrine. Some interpret the double effect the-

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269. Id.

270. Others, however, disagree that patient refusal of hydration and nutrition is a benign method towards death. See Cantor, supra note 120, at 39 (stating that “feeding or nutrition may carry with it no benefit to the patient, or may even prolong a torturous dying process, and thus lose its usual symbolic cast”).

271. Killing and Letting Die, supra note 4, at 266-67. “The doctrine of the double effect is based on a distinction between what a man foresees as a result of his voluntary action and what, in the strictest sense, he intends.” Id. at 267. Here the person administering the drugs foresees the death, but in the strictest sense he seeks to alleviate pain rather than to cause death. Id. at 270-71. The current law in Minnesota represents the double effect theory and reads as follows:

Acts or omissions not considered aiding suicide or aiding attempted suicide: (a) A health care provider . . . who administers, prescribes, or dispenses medications or procedures to relieve another person’s pain or discomfort, even if the medication or procedure may hasten or increase the risk of death, does not violate this section unless the medications or procedures are knowingly administered, prescribed, or dispensed to cause death.


272. See Kadish, supra note 207, at 70-71 (providing example of double effect principle). “When one uses deadly force against an assailant to save one’s own life, one’s action in causing the death of the assailant is not the intended effect, but the known effect of that action. The intended effect is to remove the threat and no more.” Id.


274. Id. (emphasis added).

275. See Catechism of the Catholic Church § 2279, at 549 (1994) (stating double effect principle). According to the Catholic Church:

Even if death is thought imminent, the ordinary care owed to a sick person cannot be legitimately interrupted. The use of painkillers to alleviate
ory as a charade for euthanasia, but the principle does legitimize the prevalent use of excessive morphine which is administered by physicians who know or suspect that it will cause death.276

The “double effect” and “patient refusal of hydration and nutrition” theories are alternative approaches to death which may minimize the fears generated by the speculative disadvantages of physician assisted suicide. These alternatives demonstrate that there are multiple defensible methods in the dying process.277 The “double effect” theory was successfully employed in the trilogy of cases against Dr. Jack Kevorkian. Defense attorney Geoffrey Fieger argued that Dr. Kevorkian’s intent in assisting the suicides was to relieve suffering, not cause death. Death was a necessary collateral consequence.

G. A Jury Question

A necessity case invariably concerns a question of values. Typical necessity cases are not difficult because the choice would seem apparent. For instance, breaking the speeding laws would seem reasonable when one needs to rush another to the hospital. But when the question of values concerns a moral issue, people may reasonably disagree.278 A trial judge need only decide whether the

the sufferings of the dying, even at the risk of shortening their days, can be morally in conformity with human dignity if death is not willed as either an end or a means, but only foreseen and tolerated as inevitable. Palliative care is a special form of disinterested charity. As such it should be encouraged.

Id. The “double effect” doctrine conflicts with the legal proscription of second degree murder or involuntary manslaughter. If one administers pain medication knowing that there is a likelihood of death, then one may be prosecuted for the extremely reckless act of murder or the reckless act of involuntary manslaughter. See Dressler, supra note 58, at 478. Dressler states that a person kills recklessly if he or she consciously disregards substantial and unjustifiable risk to human life. This constitutes involuntary manslaughter. Id. When such recklessness is extreme, i.e., when the risk of death is very great, and the justification for taking the risk is weak or nonexistent, the actor is guilty of murder. Id.

276. See Killing and Letting Die, supra note 4, at 270-71 (discussing problem of abortion and doctrine of double effect).


278. Arnolds & Garland, supra note 18, at 294-96. As the historical section has shown, differences in the philosophies of life affect the resolution in the manner of death. Id.
question of values presented is frivolous and unsupportive. The jury, as the "conscience of the community," should then decide whether the accused made an objectively correct choice of values.

The weakness in proofs of one of the necessity conditions does not alone disprove the defense nor automatically preclude an instruction on the defense. The conditions are matters which go to the weight and credibility of the defense, which are jury questions. When the facts support the defense and when the accused requests the instruction, he or she has a constitutional right to have the trier of fact instructed on the defense. Once the accused has presented some supporting evidence, the jury must determine its sufficiency. The accused bears the burden of proving the existence of necessity because it is an affirmative defense which rests within

279. Id. at 296.

280. Id. For a discussion of cases regarding medical necessity, see supra note 166-74 and accompanying text.

281. See People v. Unger, 362 N.E.2d 319, 325 (1977) (discussing jury's role of determining necessity defense of prison escape). "The rule is well settled that a court will not weigh the evidence where the question is whether an instruction is justified." Id. (citations omitted). The absence of one or more of the elements listed in People v. Lovercamp, 118 Cal. Rptr. 110 (Ct. App 1974) (regarding admissibility of factors of necessity defense to prison escape), is not dispositive. Id. at 114. This would not necessarily mandate a finding that the defendant could not assert the defense of necessity. The absence of one of the Lovercamp preconditions does not alone disprove the claim of necessity and should not, therefore, automatically preclude an instruction on the defense. Id. at 115.


The Anglo-Saxon tradition of criminal justice, embodied in the United States Constitution and in federal statutes, makes jurors the judges of the credibility of testimony offered by witnesses. It is for them, generally, and not for appellate courts, to say that a particular witness spoke the truth or fabricated a cock-and-bull story.... It is the jury that is the judge of whether the prisoner's account of his reason for flight is true or false. But precisely because a defendant is entitled to have the credibility of his testimony, or that of witnesses called on his behalf, judged by the jury, it is essential that the testimony given or proffered meet a minimum standard as to each element of the defense so that, if a jury finds it to be true, it would support an affirmative defense—here that of duress or necessity.

Id.

283. See id. at 415 (discussing the defense of necessity in prison escape cases).

The Court held:

[Where a criminal defendant is charged with escape and claims that he is entitled to an instruction on the theory of duress or necessity, he must proffer evidence of a bona fide effort to surrender or return to custody as soon as the claimed duress or necessity had lost its coercive force.

Id.]
the defendant's knowledge and understanding. Once the accused submits and proves the defense, the prosecution must rebut it beyond a reasonable doubt.

V. CONCLUSION

Physician assisted suicide is a response to the capitulation from a disease, not an act of criminal complicity. Nearly every criminal prosecution for physician assisted suicide has resulted in an acquittal, reflecting the jury's willingness to nullify the law and adopt a de facto medical necessity defense. A necessity defense places trust in the jury to determine whether the physician reasonably believes that aiding a suicide would be a lesser evil than allowing the patient to suffer.

Medical necessity balances choice, values and the law. To ascertain that measure of balance, an analogy is gained from the "evolving standards of decency" enunciated in death penalty cases that prohibit the excessive infliction of pain during a state execution. State imposed executions are frighteningly similar to nature's imposed terminal diseases. Both present the near certainty

284. For a discussion of the medical necessity defense, see supra notes 133-174 and accompanying text. The legal strategy, however, concerns whether the accused will elect to prove the affirmative defense rather than rest on a jury nullification verdict. If the prosecution charges assisted suicide as a form of murder, then the accused stands a good chance at nullification because historically juries have acquitted physicians of murder. For a discussion of the acquittal of Dr. Jack Kevorkian, see supra note 9 and accompanying text. Conceivably, a defendant can fail to meet his or her burden of proof in satisfying all of the elements to the jury. See ROSENBLATT, supra note 11, at 13-15, 289-90 (regarding tactical decision to run defense or rest with jury nullification).

285. See Patterson v. New York, 432 U.S. 197, 207-08 n.19 (1976) (recognizing that "the trend over the years appears to have been to require the prosecution to disprove affirmative defenses beyond a reasonable doubt").

286. Arnolds & Garland, supra note 18, at 294-301. As Judge Leventhal wrote when rejecting the jury nullification defense: Human frailty being what it is, a prosecutor disposed by unworthy motives could likely establish some basis in fact for bringing charges against anyone he wants to book, but the jury system operates in fact . . . so that the jury will not convict when they empathize with the defendant, as when the offense is one they see themselves as likely to commit, or consider generally acceptable or condonable under the mores of the community. United States v. Dougherty, 473 F.2d 1113, 1131-32 (D.C. Cir. 1972).

287. Rupe v. Wood, 863 F. Supp. 1307, 1313-15 (W.D. Wash. 1994) (finding that hanging obese man posed significant risk of decapitation and thus constituted cruel and unusual punishment). Some forms of hanging, for instance, involve the painful process of strangulation, causing a dislocated vertebrae and crushed spinal cord. Id. Inadvertent decapitation of an excessively obese man might have added the ignominy of blood spurting uncontrollably from a headless shoulder. But see Campbell v. Wood, 18 F.3d 662, 668 (9th Cir.) (holding that execution by judicial hanging is not cruel and unusual punishment), cert. denied, 114 S. Ct. 2125 (1994).
of death and both present tortuous circumstances. The courts are sensitive even to brutal murderers who claim cruel and unusual punishment in the manner of their execution.\footnote{See, e.g., Fierro v. Gomez, 865 F. Supp. 1387, 1415 (N.D. Cal. 1994) (holding that gas chamber violated Eighth Amendment prohibition). The Fierro court noted that: [T]he key question to be answered in a challenge to a method of execution is how much pain the inmate suffers. . . . Death where unconsciousness is "likely to be immediate or within a matter of seconds," is apparently within constitutional limits. . . . [T]he persistence of consciousness "for over a minute" or for "between a minute and a minute-and-a-half, but no longer than two minutes" might be outside constitutional boundaries. Id. at 1410-11 (citations omitted) (footnotes omitted). The court further determined that "the objective evidence of pain and suffering upon administration of lethal gas demonstrates that death by [gas] is not instantaneous. . . . [I]nmates are likely to be conscious for anywhere from fifteen seconds to one minute from the time that the gas strikes their face." Id. at 1413. During executions by gas, the primary cause of intense physical pain is cellular suffocation, which includes symptoms of intense chest pains and exquisitely painful muscle spasms. Id.}

Those suffering from the compelling inequities of nature's diseases deserve similar compassion in the manner of their deaths. Many terminally ill people do not wish to suffer unnecessarily. As the court in \textit{Campbell v. Wood} noted regarding a state execution: "If medical science has developed a method of terminating life relatively painlessly and peacefully, and with comparative dignity, the Constitution requires that we employ that procedure rather than the savage, ugly, and antiquated methods of earlier times."\footnote{18 F.3d 662 (9th Cir.), cert. denied, 114 S. Ct. 2125 (1994).} In many states, there is some choice in the manner of execution. A terminally ill patient seeks a similar choice.

A successful necessity defense drives legislative reform. For instance, once necessity was recognized as a valid defense to prison escape to avoid sexual assault, a state legislature reformed prison conditions.\footnote{See People v. Harmon, 220 N.W.2d 212, 215 (Mich. Ct. App. 1974), aff'd, 232 N.W.2d 187 (Mich. 1975) (declaring that successful duress defense of prison escape would result in fewer escapes and spur penal reform).} Once medical necessity was recognized as a valid defense in drug cases to allow marijuana to alleviate the effects of diseases, the Washington state legislature enacted a statute authorizing the medicinal uses of marijuana to alleviate glaucoma and cancer.\footnote{See State v. Diana, 604 P.2d 1312, 1316 (Wash. Ct. App. 1979) (noting response of Washington state legislature to District of Columbia case of \textit{United States v. Randall}, 104 Daily Wash. L. Rptr. 2249 (D.C. Super. Ct. Nov. 24, 1976), which permitted medical necessity defense where defendant used marijuana to relieve pain attributed to glaucoma). In response to \textit{Diana}, the Washington state legislature enacted the Controlled Substances Therapeutic Research Act recognize-}

\footnote{288. See, e.g., Fierro v. Gomez, 865 F. Supp. 1387, 1415 (N.D. Cal. 1994) (holding that gas chamber violated Eighth Amendment prohibition). The Fierro court noted that: [T]he key question to be answered in a challenge to a method of execution is how much pain the inmate suffers. . . . Death where unconsciousness is "likely to be immediate or within a matter of seconds," is apparently within constitutional limits. . . . [T]he persistence of consciousness "for over a minute" or for "between a minute and a minute-and-a-half, but no longer than two minutes" might be outside constitutional boundaries. Id. at 1410-11 (citations omitted) (footnotes omitted). The court further determined that "the objective evidence of pain and suffering upon administration of lethal gas demonstrates that death by [gas] is not instantaneous. . . . [I]nmates are likely to be conscious for anywhere from fifteen seconds to one minute from the time that the gas strikes their face." Id. at 1413. During executions by gas, the primary cause of intense physical pain is cellular suffocation, which includes symptoms of intense chest pains and exquisitely painful muscle spasms. Id.}

\footnote{289. Id. at 702.}

\footnote{290. Id. at 702.}


medical necessity factors. Similarly, a successful medical necessity defense would prompt the medical profession and the state to re-examine and reform the health care industry for the terminally ill. The preceding historical analysis of suicide, assisted suicide and euthanasia reveals a natural anthropological defense in the duel with death. Forfeiture policies of Roman and English law, American statutory schemes and jury verdicts of acquittal have mitigated or eliminated the punishment for those who have committed and assisted suicides based on the ravages of a terminal disease. The proposed medical necessity defense assimilates the historical roots that recognizes medical determinism in the beginning stages of one's death. History has sustained "euthanatic suicide" 293 as an anthropological defense to self-murder. 294 Suicide is generally the wrong thing to do, but euthanatic suicide from a crippling, terminal infirmity is not suicide to escape a miserable life, but suicide to escape a miserable death. The invocation of the medical necessity defense will provide a governing standard of conduct, provoke legislative reform, circumvent constitutional quagmires, provide an equitable remedy in justified cases and sanction the efforts of those who wish to revolutionize the legal manner of death.

...ing the medicinal uses of marijuana to alleviate glaucoma and cancer. See Diana, 604 P.2d at 1316-17 (citing Controlled Substances and Therapeutic Research Act, WASH. REV. CODE ANN. § 69.51.010 (West 1996), effective Mar. 27, 1979).

In the November 1996 elections, the voters in California and Arizona approved laws allowing marijuana to be prescribed for medical purposes. Kevin Johnson, Doctors Told Not to Prescribe Marijuana, USA TODAY, at Al (Dec. 31, 1996). The effect of the statutes is unclear because White House drug czar Barry McCaffrey and Attorney General Janet Reno have issued warnings to physicians in Arizona and California that they could be charged with a federal crime and have prescription writing privileges revoked if they prescribe marijuana. Id.

293. See CHORON, supra note 25, at 103 (suggesting that physician assisted suicide is "euthanatic suicide" and that euthanatic suicide is not suicide in proper meaning of this word). Moreover, the Justinian Roman Codes have long excused "acts done under duress" and acts done from the compulsion of outside forces. 1 THE DIGEST OF JUSTINIAN, supra note 22, at 113. ("[D]uress is to be understood not as any alarm whatever but as fear of a serious evil.")

294. LESTER G. CROCKER, AN AGE OF CRISIS 75-77 (1959). Montesquieu provides an example of the dilemma as follows:

Laws are "the necessary relationships that derive from the nature of things." Man, in other words, is regarded as a part of nature, and the explanation of historical events is sought in the facts of the natural world. History becomes anthropology, a natural history of man, in which institutions appear . . . as the necessary effects of natural cause.

Id. (emphasis added); see also SHERLOCK, supra note 61, 177-78 ("To transfer the right to kill oneself from nature to society requires transferring this natural man as well.").