A DEATH IN THE FAMILY: HOW ASSISTED SUICIDE HARMS FAMILIES AND SOCIETY

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"The conditions peculiar to our age have made those who are dying . . . profoundly vulnerable. The bonds of community are weak, and insistence of individual rights is strong . . . . [Terminal] patients have multiple physical and psychosocial symptoms compounded by a substantial degree of existential distress."[1]

Outline:

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1. Kathleen Foley & Herbert Hendin, *Introduction: A Medical, Ethical, Legal, and Psychosocial Perspective,* in THE CASE AGAINST ASSISTED SUICIDE: FOR THE RIGHT TO END-OF-LIFE CARE 1 (Kathleen Foley et al., eds., 2002).

I. INTRODUCTION: THE INVERSE RECIPROCAL RELATIONSHIPS BETWEEN ASSISTED SUICIDE AND HEALTHY FAMILY RELATIONS

Today, there are strong, popular movements to legalize assisted suicide and in which many people view killing as kindness in the context of dealing with some distressing end-of-life difficulties (e.g., incurable illness, suffering, loneliness, chronic pain, and other adversity). However, the dangerous implications for society and for families of legalizing assisted suicide are seldom carefully considered.

Professor Margaret Somerville, a world-renown authority on biomedical ethics,[2] described an exchange with her students that captures the attitudes of the current generation of young adults about assisted suicide. Professor Somerville was teaching her course on "Ethics, Law, Science and Society" to upper-division and graduate students at McGill University in Montreal, Quebec, Canada.[3] After teaching a class about physician-assisted suicide, the ethics and law of palliative care, and related subjects, she felt that she had failed to connect well with the students regarding the subjects.[4] So, she emailed the students a draft of an article she was writing on the general topic and invited their responses. Professor Somerville reported:

> One student explained that she thought I was giving far too much weight to concerns about how legalizing euthanasia would harm the community and our shared values, especially that of respect for life, and too little to individuals' rights to autonomy and self-determination, and to euthanasia as a way to relieve people's suffering.
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> She emphasized that individuals' rights have been given priority in contemporary society, and they should also prevail in relation to death.

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2. Margaret Somerville "is a Professor of Bioethics in the School of Medicine at The University of Notre Dame Australia and is affiliated with the Institute for Ethics and Society, also at Notre Dame." A world-renowned bioethicist, "[s]he was previously Professor of Law, Professor in the Faculty of Medicine, and Founding Director of the Centre for Medicine, Ethics and Law at McGill University, Montreal." *See* Event Flyer, Margaret Somerville, *Euthanasia and Palliative Care: Medical and Ethical Perspectives,* at The University of Notre Dame Australia: Institute for Ethics & Society, www.nd.edu.au/research/ies/events (last visited: Sept. 29, 2016).

3. Margaret Somerville, *Excerpt, Is Legalizing Euthanasia an Evolution or Revolution in Societal Values?*, 34 QUINNIPIAC L. REV. 747, 748–49 (2016) [hereinafter *Evolution or Revolution*].

4. *Id.* at 749.

> Moreover, legalizing euthanasia was consistent with other changes in society, such as respect for women and access to abortion, she said.[5]

In response to Professor Somerville's suggestion that extensive exposure to death in the media may have overwhelmed our sensitivities, one of her students responded: "I think many of our reactions come not from an overexposure to death, but from *an aversion to suffering, and an unwillingness or hesitancy to prolong pain*."[6]

The students' responses capture the challenge that opponents of legalizing assisted suicide face in trying to convince our peers why it is dangerous and a very bad idea. As Professor Somerville explained in her recent Quinnipiac Law Review article:

> One of the challenges in responding to this argument in the euthanasia debate is that it's not easy to give meaning to suffering other than through religion, which was the way many people dealt with suffering in the past. But today, many people are not religious. When suffering cannot be given any worth or meaning and a person does not believe that there is anything inherently wrong in inflicting death on a suffering person, at least one who requests and gives informed consent to it—that is, they believe this is not unethical—it is very difficult to convince them that legalizing euthanasia is a bad idea.[7]

Thus, advocates of assisted suicide view it primarily as a means to relieve people's suffering and as an expression of individual autonomy. They view suffering as the ultimate evil and the relief of suffering—especially when seeking that relief is an expression of the sufferer's autonomous will—as having priority over nearly all other values.[8]

This paper addresses the support for assisted suicide that results from general sympathy with the sufferer's desire to exercise their autonomy to escape from persistent pain or distress when medicine offers no hope of relief. Opponents of legalizing assisted suicide face challenges to convince well-meaning supporters of legalizing assisted suicide that—as much as we, too, sympathize deeply with end-of-life sufferers—legalizing assisted suicide carries enormous risks of causing even greater suffering for individuals,

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5. *Id.*; Margaret Somerville, *Killing as Kindness: The Problem of Dealing with Suffering and Death in a Secular Society,* 12 NEWMAN RAMBLER 1, 1–2 (2016).

6. *Evolution or Revolution, supra* note 3, at 749 (emphasis added).

7. *Id.* at 748.

8. *Id.*

families, and society. Not only would the individuals, families, and friends of those who engage in assisted suicide suffer more, but legalizing assisted suicide would transform the normative environment of society in a way that would make it more dangerous, threatening, and hostile for the weak, the disadvantaged, and the sufferers struggling with dilemmas that cause some to consider assisted suicide. It also would be corrosive of genuine respect and protection for individual liberties.

Much sympathetic publicity has been given to the tragedies of persons with terminal medical conditions who have sought to end their lives in order to avoid suffering for themselves and/or their loved ones. When they succeed in the quest for death they are often portrayed as courageous martyrs, and those who assist them are portrayed as compassionate and true friends and/or family. When they do not succeed in dying, they are often portrayed as victims of a heartless and sterile immorality masquerading as public morality.

If such views are romanticized, this paper suggests that they are seriously flawed and misleading misperceptions for many reasons. For example, advances in palliative care have been so great that severe suffering is often avoidable and unnecessary. Moreover, the claim that assisted suicide enables autonomy is as incoherent as the claim that helping a person who chooses to become a slave enables his autonomy.

This paper argues that family members of the person who commits suicide are neglected victims of assisted suicide. The evidence reviewed shows that the impact of assisted suicide upon the family is overwhelmingly destructive and devastating. Suicide imposes huge burdens upon the loved ones, especially family, of the suicide victim. When family members are asked to assist the suicide, it is a request that creates a painful moral dilemma, a tension between the desire to show compassion and solidarity with the wishes of the suffering loved one, and the moral duties to reject the ethic of killing, which endangers all members of society. Also, the request for assisted suicide may reveal ignorance of the many benefits of palliative care. Assisted suicide may be evidence that the victim has not received adequate information about palliative treatment options but was given (or myopically perceives) a quick-and-dirty false choice between suffering and death.

This paper reviews the status of assisted suicide in the United States and globally. It summarizes historical values and recent trends regarding assisted suicide. It reviews the philosophy, legal theory, values, and messages of assisted suicide, noting why and how communities accept and reject assisted suicide. It discusses the neglected alternative of palliative care. Following some recommendations for legal reforms regarding assisted suicide, this paper concludes by suggesting the push to legalize assisted suicide indicates that

there is great need for communities that value and affirm the equal worth of all persons, including (especially) those who are suffering and/or in terminal conditions.

To begin, a definition of what is meant by the terms "assisted suicide" (and "euthanasia") is in order. "The word euthanasia was coined from the Greek language (*eu* for 'good' or 'noble,' and *thanatos* for 'death') in the seventeenth century by Francis Bacon to refer to an easy, painless, happy death. In modern times it has come to mean the active causation of a patient's death by a physician . . . ."[9] Initially, "the word 'euthanasia' had meant providing pain relief to dying patients, but by the late nineteenth century the meaning had shifted to a medical hastening of death."[10] While the terms are often used interchangeably, some writers emphasize a final-actor (or an active-passive medical assistance) distinction between them.[11] "Palliative care" needs to be understood as well. According to the World Health Organization, "palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual."[12] It "'affirms life and regards dying as a normal process' and 'intends neither to hasten or postpone death.'"[13] Thus, by definition, palliative care excludes assisted suicide, but it accepts and supports dying as a natural life process.

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9. Foley & Hendin, *supra* note 1, at 5.

10. Richard Weikart, *Does Science Sanction Euthanasia or Physician-Assisted Suicide?,* 42 THE HUMAN LIFE REV. 30, 30 (2016).

11. Rita L. Marker & Kathi Hamlon, *Frequently Asked Questions: Euthanasia and Assisted Suicide,* PATIENTS RIGHTS COUNCIL, http://www.patientsrightscouncil.org/site/frequently-asked-questions/ (last visited Oct. 11, 2016).

> 2. What is the difference between euthanasia and assisted suicide?
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> One way to distinguish them is to look at the last act—the act without which death would not occur.
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> Using this distinction, if a third party performs the last act that intentionally causes a patient's death, euthanasia has occurred. For example, giving a patient a lethal injection or putting a plastic bag over her head to suffocate her would be considered euthanasia.
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> On the other hand, if the person who dies performs the last act, assisted suicide has taken place. Thus, it would be assisted suicide if a person intentionally swallows an overdose of drugs that has been provided by a doctor for the purpose of causing death. It would also be assisted suicide if a patient pushes a switch to trigger a fatal injection after the doctor has inserted an intravenous needle bearing a lethal drug into the patient's vein.

12. L. Herx, *Physician-Assisted Death Is Not Palliative Care*, 22 CURRENT ONCOLOGY 82, 82 (2015).

13. *Id.*

The revival of interest in euthanasia and assisted suicide in our generation has been primarily motivated by "compassion for suffering patients."[14] Thus, today assisted suicide refers to the information, encouragement, material provision, or acts by one (or more) persons that helps another person to end his or her life. It is "suicide committed by someone with assistance from another person . . . ."[15] The "other person" assisting with the suicide is often expected to be a doctor.[16]

Of course, words matter. Thus, as Doctors Herbert Hendin and Kathleen Foley wrote in their book, *The Case Against Assisted Suicide: For the Right to End-of-Life Care:*

> In physician-assisted suicide, the patient self-administers the lethal dose that has been prescribed by a physician who knows the patient intends to use it to end his or her life. Both the terms "physician-assisted suicide" and "euthanasia" are often avoided by their advocates, who prefer the nonspecific euphemism "assistance in dying."[17]

It is not surprising that advocates of assisted suicide generally use other terms than "suicide" to describe the action they advocate. Indeed, "'[s]uicide' is a word that nearly all campaigners [for assisted suicide] avoid as it carries negative connotations."[18] Instead, they often use nice euphemisms – like "medical aid in dying."[19] That is because "[t]he language used to describe physician-assisted suicide is directly correlated with support or opposition to the practice."[20]

Assisted suicide (generally physician-assisted) raises serious social, legal, and moral questions that go beyond those raised by other suicides. Those

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14. Foley & Hendin, *supra* note 1, at 8.

15. *Assisted Suicide*, MERRIAM-WEBSTER DICTIONARY ONLINE, http://www.merriam-webster.com/dictionary/assisted%20suicide (last visited Oct. 5, 2016) (providing the medical definition of Assisted Suicide).

16. *Id.* The simple definition of assisted suicide is "suicide with help from another person (such as a doctor) to end suffering from severe physical illness." *Id.*

17. Foley & Hendin, *supra* note 1, at 5.

18. Michael Cook, *Words matter in assisted suicide, UK society changes its name,* MERCATORNET (Oct. 25, 2016), http://www.mercatornet.com/careful/view/words-matter-in-assisted-suicide/18875.

19. COMPASSION & CHOICES, MEDICAL AID IN DYING IS NOT ASSISTED SUICIDE 1, available at https://www.compassionandchoices.org/wp-content/uploads/2016/02/FS-Medical-Aid-in-Dying-is-Not-Assisted-Suicide-FINAL-1.27.16-Approved-for-Public-Distribution.pdf.

20. Eliyahu Federman, *Physician-Assisted Suicide Debate: Are We Using the Right Language,* FORBES (Oct. 27, 2014, 3:43 PM), http://www.forbes.com/sites/realspin/2014/10/27/physician-assisted-suicide-debate-are-we-using-the-right-language/#5628129e49d4.

issues include the "allocation of health care resources, the nature of the medical profession, the patient-physician relationship, and the prospect that allowing relatively benign forms of killing, such as voluntary euthanasia of PAS, will lead down a 'slippery slope' to more morally worrisome killings."[21] This paper briefly addresses these concerns, and suggests that informed, disciplined compassion combined with personal caring and civic virtue provide a sound basis to fulfill both duties of personal compassion and of civic responsibility.

II. THE TREND TOWARD LEGAL AND SOCIAL ACCEPTANCE OF ASSISTED SUICIDE GENERALLY

The incidence of suicide in the world is significant.

> [T]he World Health Organization (WHO) has compiled summaries of nation-level statistics, with aggregated numbers on a global scale.
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> On this basis, we can conclude the following. In each recent year, an estimated 750,000 to 1.2 million death certificates were filed where one of the suicide or intentional self-injury codes were listed as a cause of death.[22]

Globally, "[s]uicide is one of the top ten leading causes of death across all age groups. Worldwide, suicide ranks among the three leading causes of death among adolescents and young adults."[23]

While assisted suicide appears to be widely-practiced in many western societies today, historically it has raised significant ethical issues. For example, historically, assisting suicide has been a violation of long-established traditional principles of medical ethics. For example, assisted suicide appears to contravene the Hippocratic Oath, the Declaration of Geneva, and the International Code of Medical Ethics.

The Hippocratic Oath is attributed to the legendary physician Hippocrates and dates to about 400 B.C.E.; it states: "I will not give a lethal drug to anyone

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21. Michael Cholbi, *Suicide,* STAN. ENCYCLOPEDIA OF PHIL., http://plato.stanford.edu/archives/sum2016/entries/suicide/ (last visited Oct. 11, 2015).

22. HUI CHENG ET AL., *Global Epidemiology: Projected Trends in Suicide and Suicide-Related Behavior*, in SUICIDE FROM A GLOBAL PERSPECTIVE: PUBLIC HEALTH APPROACHES 11, 12 (Amresh Shrivastava et al. eds., 2012) [hereinafter GLOBAL PERSPECTIVE].

23. Ilanit Tal Young et al., *Suicide Bereavement and Complicated Grief*, 14 DIALOGUES IN CLINICAL NEUROSCIENCE 177, 177 (2012).

if I am asked, nor will I advise such a plan."[24] Few modern medical schools adhere to the Hippocratic Oath in its original form, though some have adopted modern versions of it.

The Declaration of Geneva is a revision of the Hippocratic Oath that was drafted by the World Medical Association in 1948 as evidence of wide-spread involuntary euthanasia, eugenics, medical experimentation and treatments, and other medical crimes performed by Nazi German doctors came to light. It obligates doctors to agree: "I will maintain the utmost respect for human life . . . ."[25]

The International Code of Medical Ethics, also adopted by the World Medical Association and last revised in 2006, provides: "A physician [shall] always bear in mind the obligation to respect human life" in the section "Duties of physicians to patients."[26]

The American Medical Association (AMA) also prohibited participation by physicians in assisted suicide.[27] Instead, the AMA has encouraged doctors to facilitate advance care planning, advance directives, withhold or withdraw life-sustaining treatment, orders not to attempt resuscitation (DNAR), and avoid medically ineffective interventions.[28] While assisted suicide was often condemned and generally forbidden in many western societies, it also was advocated by some leading sages at various times.[29] The eighteenth and nineteenth centuries appear to have been especially significant times for such discussions.[30]

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24. National Library of Medicine, *Greek Medicine,* NAT'L INST. OF HEALTH (2002), https://www.nlm.nih.gov/hmd/greek/greek_oath.html (last visited Nov. 7, 2016).

25. *WMA Declaration of Geneva*, WORLD MED. ASS'N INT'L CODE OF MED. ETHICS, https://www.wma.net/en/publications/10policies/g1 (last visited Nov. 7, 2016).

26. *WMA International Code of Medical Ethics*, WORLD MED. ASS'N INT'L CODE OF MED. ETHICS, http://www.wma.net.en/30publications/10policies/c8 (last visited Sept. 23, 2016).

27. Lonnie Bristow, *Physician's Role as Healer: American Medical Association's Opposition to Physician-Assisted Suicide*, 12 J. C.R. & ECON. DEV. 653, 653 (1997).

28. *See Code of Medical Ethics,* AMERICAN MEDICAL ASSOCIATION, https://www.ama-assn.org/delivering-care/ama-code-medical-ethics (last visited Oct. 7, 2016). The AMA still explicitly prohibits physicians from participating in active euthanasia because it "would ultimately cause more harm than good," and because "[e]uthanasia is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks." *Id.* at § 5.8.

29. Weikart, *supra* note 10, at 30–34.

30. *Id. See generally American Medical Association approves resolution to 'study' assisted suicide,* LIFE SITE NEWS (June 21, 2016, 9:30 PM), https://www.lifesitenews.com/news/american-medical-association-approves-resolution-to-study-assisted-suicide.

One historian has noted: "[t]hough discussion about suicide began in earnest in the eighteenth century, the debate over euthanasia only surfaced in the late nineteenth century."[31]

During the eighteenth-century Enlightenment, several prominent thinkers believed that their scientific outlook should replace traditional notions of religion and morality, including the Christian prohibitions on suicide. In his posthumously published essay "On Suicide," for instance, Hume argued that suicide should be permitted because human life, in his arresting words, "is of no greater importance to the universe than that of an oyster."[32]

By the end of the nineteenth century, "growing secularism, combined with the increasing acceptance of Darwinism, contributed to a climate that made euthanasia more acceptable."[33]

Given that erratic history of euthanasia, "[h]ow, then, does and should the law [today] deal with suffering?"[34] Advocacy of assisted suicide has long been popular among scholars, intellectuals, and some professional groups.[35] As there has been consistent supportive discussion about assisted suicide in influential circles in society, one might expect to see some trend toward legalization of assisted suicide in this country and in the world generally.

However, the traditional repudiation of legalizing assisted suicide remains in the legal systems of most Western nations. Indeed, only seven sovereign nations and six American states permit assisted suicide, according to the most recent report of the "Final Exit Network" (also known as Euthanasia Research & Guidance Organization or "ERGO").[36] That means that only 3.6 percent of

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31. Weikart, *supra* note 10, at 30.

32. *Id*.

33. *Id.* at 31. "Trends such as eugenics, positivism, social Darwinism, and scientific naturalism had the effect of convincing a small yet articulate group in the early twentieth century that traditional ethics no longer applied to decisions about death and dying." *Id.* at 32, (quoting IAN DOWBIGGIN, A MERCIFUL END: THE EUTHANASIA MOVEMENT IN MODERN AMERICA at 2. (2003)).

34. *Evolution or Revolution, supra* note 3, at 748.

35. *See History of the World Federation Right to Die Societies*, *THE WORLD FED'N OF RIGHT TO DIE SOC'YS*, http://www.worldrtd.net/member-organizations (last visited Nov. 1, 2016), (for a list of world organizations that support assisted suicide. The World Federation Right to Die Societies has existed since 1980); *see generally Jack Kovorkian*, WIKIPEDIA, https//en.wikipedia.org/wiki/Jack_Kevorkia (last updated Jan. 21, 2017).

36. Derek Humphry, *World Laws on Assisted Suicide*, EUTHANASIA RES. & GUIDANCE ORG., http://finalexit.org/assisted_suicide_world_laws.html (last updated Sept. 13, 2015) [hereinafter *World Laws on Assisted Suicide*]. At least thirteen additional American states are considering bills to legalize assisted suicide (Alaska, Arizona, Colorado, Hawaii, Iowa, Maryland, Michigan, Nebraska, New Jersey, New York, Rhode Island, Tennessee, and Utah). *2016 Doctor-Prescribed Suicide Bills Proposed*, Patients Rights Council, http://www.patientsrightscouncil.org/site/2016-doctor-prescribed-suicide-bills-proposed/ (last visited Oct. 28, 2016); *Death With Dignity Around the U.S.*, TAKE ACTION, https://www.deathwithdignity.org/take-action/ (last visited Jan. 24, 2017).

193 sovereign nations and merely twelve percent of American states permit assisted suicide.[37] Six of the seven nations that allow assisted suicide (Colombia, the Netherlands, Belgium, Luxembourg, England & Wales, and Canada) restrict assisted suicide to their own citizens and do not allow foreigners to engage in assisted suicide within those jurisdictions; only Switzerland allows "suicide tourism."[38] So over ninety-six percent of the nations in the world and eighty-eight percent of the U.S. States prohibit assisted suicide, and only one of the one hundred ninety three nations (1:193) allows non-residents to have access to assisted suicide, but support for assisted suicide seems to be growing.

There are many differences in legal regulations and few significant or practical restrictions upon the practice of assisted suicide where it is permitted. Not surprisingly, "European laws on medically assisted death are broader than those in the U.S., with most allowing physicians to prescribe and administer lethal drugs and not setting conditions tied to life expectancy."[39] On the other hand:

> All U.S. States require patients receiving PAS [physician-assisted suicide] to have a prognosis for survival of 6 months or less. In the

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37. Final Exit reports that there are Right-to-Die organizations in twenty-six (26) nations (that amounts to just thirteen and one-half percent (13.5%) of the nations in the world). The nations are: Australia, Belgium, Britain (presumably, the United Kingdom), Canada, Colombia, Denmark, Finland, France, Germany, India, Israel, Ireland, Italy, Japan, Luxembourg, The Netherlands, New Zealand, Norway, South Africa, Spain, Sweden, Switzerland, United States of America, Venezuela, and Zimbabwe. Derek Humphry, *World Right to Die Organizations Directory*, Euthanasia Res. & Guidance Org., http://www.finalexit.org/world_right-to-die_organizations_directory.html (last updated Aug. 03, 2012).

38. *World Laws on Assisted Suicide*, *supra* note 36. Some sources list Germany as allowing assisted suicide, but that seems to be uncertain if not dubious.

> Killing somebody in accordance with his demands is always illegal under the German criminal code (Paragraph 216, "Killing at the request of the victim; mercy killing").
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> Assisting with suicide by, for example, providing poison or a weapon, is generally legal. Since suicide itself is legal, assistance or encouragement is not punishable by the usual legal mechanisms dealing with complicity and incitement (German criminal law follows the idea of "accessories of complicity" which states that "the motives of a person who incites another person to commit suicide, or who assists in its commission, are irrelevant"). Nor is assisting with suicide explicitly outlawed by the criminal code. There can however be legal repercussions under certain conditions for a number of reasons. Aside from laws regulating firearms, the trade and handling of controlled substances and the like (e.g. when acquiring poison for the suicidal person), this concerns three points: [Free vs. manipulated will, Neglected duty to rescue, and Homicide by omission].

Assisted Suicide, Wikipedia, http://en.wikipedia.org/wiki/Assisted_suicide#Germany (last visited Sept. 24, 2016) (footnote omitted).

39. *Assisted Suicide: Where do Canada, Other Counties Stand?*, CBS NEWS (Oct. 11, 2014, 9:54 PM), http://www.cbc.ca/news/canada/assisted-suicide-where-do-canada-other-countries-stand-1.2795041.

> U.S., patients do not have to have unbearable pain or any symptom(s) despite treatment. For adults, the Netherlands, Belgium, and Luxembourg require that patients have "unbearable physical or mental suffering" without prospect of improvement but do not require them to be terminally ill. Belgium does require that children receiving euthanasia be terminally ill.[40]

There seems to be substantial popular support for assisted suicide in many European nations. For example, in a poll in 2016 "*The Economist* [UK] found majorities in support of such [assisted suicide] laws in 13 out of 15 countries surveyed—including the United States, Britain, Australia, Canada and Germany."[41] In the United Kingdom, "Jackie Baker's children had planned a fund raising party to help her fulfil her final wish until authorities said they could be prosecuted . . . . [A]ssisting a suicide is illegal in the UK with a possible jail sentence of up to 14 years."[42] There are numerous stories of persons who have sought to end their lives, all poignant to some degree.[43]

In the United States, a 2013 Pew Research poll reported that 47% of Americans approved of "laws to allow doctor-assisted suicide for terminally ill patients," while 49% disapproved of such laws.[44] The results were "virtually unchanged from a 2005 Pew Research survey," and similar results were reported by Gallup surveys.[45] Race, ethnicity, religion, and other factors influence opinions about assisted suicide. For example, Pew reported that:

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40. Ezekiel J. Emanuel et al., *Attitudes and Practices of Euthanasia and Physician-Assisted Suicide in the United States, Canada, and Europe*, 316 [J]AMA. 79, 80 (2016).

41. *"24 and Ready to Die": A Documentary from Economist Films*, THE ECONOMIST (Nov. 10, 2015), http://www.economist.com/sites/default/files/economist_films_right_to_die_press_release_final.pdf.

42. Ian Hughes & Tyler Mears, *Grandmother Ends Life at Dignitas Despite Police Warning Over Raunchy Party to Raise Cash for Clinic,* MIRROR (Nov. 9, 2015, 1:10 PM), http://www.mirror.co.uk/news/uk-news/grandmother-ends-life-dignitas-despite-6796361. ("Her daughters had been desperately trying to raise £8,000 to send Jackie to euthanasia unit Dignitas, reports Wales Online. However, hairdresser Tara was seen at her salon by two police officers who warned that the mother-of-one and her younger sister could face prosecution.") *Id.*

43. For a chronological list of some significant events, stories, and personalities involved in developments concerning suicide and assisted suicide, *see e.g.*, Derek Humphry, *Chronology of Right-to-Die Events During the 20th Century and into the Millennium* [sic] *1900-2013,* EUTHNASIA RESEARCH GUIDANCE ORGANIZATION, http://finalexit.org/chronology_right-to-die_events.html (last updated Aug. 31, 2013).

44. PEW RESEARCH CTR., VIEWS ON END-OF-LIFE MEDICAL TREATMENTS 31 (Nov. 21, 2013) http://www.pewforum.org/2013/11/21/chapter-1-opinion-about-laws-on-doctor-assisted-suicide/.

45. *Id.*

> More whites than blacks and Hispanics favor laws allowing doctor-assisted suicide.
> A majority of white mainline Protestants and about half of white Catholics approve of laws for this purpose. Two-thirds of the unaffiliated also approve of laws to allow physician-assisted suicide. However, majorities of black Protestants, white evangelical Protestants and Hispanic Catholics disapprove of laws for doctor-assisted suicide by about a two-to-one margin or more.[46]

The law governing assisted suicide seems to reflect these popular trends, as well. In Europe, the trend of legal decisions by the European Court of Human Rights ("ECtHR" or "the Court") appears to establish a "right to assisted suicide" under the European Convention of Human Rights (ECHR).[47] In four cases decided between 2002 and 2013, the ECtHR moved from rejecting a claim for a right to assistance in dying to recognizing such a right.[48]

In 2002, in *Pretty v United Kingdom*,[49] the ECtHR considered the application of a paralyzed British woman who was dying of a motor neuron disease.[50] To avoid what she considered intolerable suffering and indignity, she wanted her husband to help her commit suicide, but British law criminalized assisted suicide.[51] The ECtHR opinion noted:

> 7. The applicant is a 43-year-old woman. She resides with her husband of twenty-five years, their daughter and granddaughter. The applicant suffers from motor neurone disease (MND). This is a progressive neuro-degenerative disease of motor cells within the central nervous system. The disease is associated with progressive muscle weakness affecting the voluntary muscles of the body. As a result of the progression of the disease, severe weakness of the arms and legs and the muscles involved in the control of breathing are affected. Death usually occurs as a result of weakness of the breathing muscles, in association with weakness of the muscles controlling

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46. *Id.*

47. *See* Grégor Puppinck, *Study on Assisted Suicide in The Case Law of The European Court of Human Rights,* TURTLE BAY & BEYOND (Jul. 25, 2014), https://c-fam.org/turtle_bay/study-on-assisted-suicide-in-the-case-law-of-the-european-court-of-human-rights/.

48. *See id.*

49. Pretty v. United Kingdom, 2002-III Eur. Ct. H.R. 155 (2002).

50. *Id.* at 162.

51. *Id.* at 163.

> speaking and swallowing, leading to respiratory failure and pneumonia. No treatment can prevent the progression of the disease.
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> 8. The applicant's condition has deteriorated rapidly since MND was diagnosed in November 1999. The disease is now at an advanced stage. She is essentially paralysed from the neck down, has virtually no decipherable speech and is fed through a tube. Her life expectancy is very poor, measurable only in weeks or months. However, her intellect and capacity to make decisions are unimpaired. The final stages of the disease are exceedingly distressing and undignified. As she is frightened and distressed at the suffering and indignity that she will endure if the disease runs its course, she very strongly wishes to be able to control how and when she dies and thereby be spared that suffering and indignity.[52]

The applicant claimed, *inter alia,* that the British law forbidding her husband to assist her in committing suicide violated Article 2 (right to life), Article 3 (prohibition of degrading treatment), and other Articles of the ECHR.[53] However, the ECtHR rejected her claims noting that Article 2, which requires states to refrain from the unlawful taking of life and to protect human lives, cannot be read to grant a right to die, and since Article 3 had to be construed in conjunction with Article 2, it also was not violated.[54] The court declared:

> Article 2 [guaranteeing the right to life] cannot, without a distortion of language, be interpreted as conferring the diametrically opposite right, namely a right to die; nor can it create a right to self-determination in the sense of conferring on an individual the entitlement to choose death rather than life.[55]

It added that "no right to die, whether at the hands of a third person or with the assistance of a public authority, can be derived from Article 2 of the Convention. It is confirmed in this view by the recent Recommendation 1418 (1999) of the Parliamentary Assembly of the Council of Europe . . . ."[56]

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52. *Id.* at 162–63.
53. *Id.* at 161, 163.
54. *Id.* at 186, 191–92.
55. *Id.* at 186.
56. *Id.* at 187.

That Recommendation encouraged all States "to respect and protect the dignity of terminally ill or dying persons in all respects" including "by upholding the prohibition against intentionally taking the life of terminally ill or dying persons, while: . . . recognizing[sic] that a terminally or dying person's wish to die never constitutes any legal claim to die at the hand of another person," and "recognizing[sic] that a terminally ill or dying person's wish to die cannot of itself constitute a legal justification to carry out actions intended to bring about death."[57] As the European Court later explained:

> In the *Pretty* judgment, the Court established that the notion of personal autonomy is an important principle underlying the guarantees of Article 8 of the Convention (see *Pretty*, ibid.). Without in any way negating the principle of sanctity of life protected under the Convention, the Court considered that, in an era of growing medical sophistication combined with longer life expectancies, many people were concerned that they should not be forced to linger on in old age or in states of advanced physical or mental decrepitude which conflicted with strongly held ideas of self and personal identity (*Pretty*, cited above, § 65). By way of conclusion, the Court was "not prepared to exclude" that this [preventing the applicant by law from exercising her choice to avoid what she considered would be an undignified and distressing end to her life] constitute[d] an interference with her right to respect for private life as guaranteed under Article 8 § 1 of the Convention (*Pretty*, cited above, ¶ 67).[58]

The Court concluded that the prohibition against assisted suicide "may be justified as 'necessary in a democratic society' for the protection of the rights of others."[59]

Nine years later, *in Haas v. Switzerland*,[60] the ECtHR again rejected a claim that European states have a duty to permit assisted suicide. In that case, the applicant (Haas) was a Swiss national who suffered from severe bipolar affective disorder.[61] Haas unsuccessfully attempted to take his own life two times.[62] Finally, he decided to use sodium pentobarbital which was

57. *Id.* at 181.

58. Koch v. Germany, HUDOC at 14 (Jul. 19, 2012), http://hudoc.echr.coe.int/eng?i=001-112282.

59. Pretty, 2002-III Eur. Ct. H.R. at 197.

60. Haas v. Switzerland, 2011-I Eur. Ct. H.R. 95 (2011).

61. *Id.* at 102.

62. *Id.*

only available by prescription.[63] Haas had written to 170 psychiatrists but had received no supportive responses.[64] Haas's own psychiatrist refused to prescribe the drug, and he then unsuccessfully sought to compel Swiss authorities to allow him to obtain the lethal medicine without a prescription.[65] Haas appealed to the ECtHR arguing that Article 8 of the ECHR protected his right to end his life in a dignified and safe manner without interference by the State.[66] While reaffirming its declaration in *Pretty* that an individual's right to voluntarily decide the moment and manner of his own death is protected by Article 8 of the Convention, the ECtHr noted that the applicant was not in the terminal stage of an incurable condition, was not denied the right to die (because he could still act for himself to assert his own claim, if he wished), and no request for immunity from prosecution for an assister was pending.[67] The ECtHR rejected the argument that the State was obligated to take action to help a citizen realize his or her desire to commit suicide by a particular method when another person declined to facilitate such an act.[68] The ECtHR noted that the law forbidding assisted suicide furthers important State interests including prevention of abuses and protection of the free will of such persons.[69] Thus, the ECtHR's ruling protected the state against private compulsion to facilitate assisted suicide.[70] As the ECtHR later explained:

> In the case of *Haas v. Switzerland*, the Court further developed this case-law by acknowledging that an individual's right to decide in which way and at which time his or her life should end, provided that he or she was in a position freely to form her own will and to act accordingly, was one of the aspects of the right to respect for private life within the meaning of Article 8 of the Convention (see *Haas*, cited above, § 51). Even assuming that the State was under an obligation to adopt measures facilitating a dignified suicide, the Court considered, however, that the Swiss authorities had not violated this obligation in the circumstances of that specific case (*Haas*, cited above, § 61).[71]

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63. *Id.*

64. *Id.*

65. Shawn H.E. Harmon & Nayha Sethi, *Preserving Life and Facilitating Death: What Role for Government After Haas v. Switzerland?*, 18 EUROPEAN J. HEALTH L. 355, 356 (2011).

66. *Haas*, 2011-I Eur. Ct. H.R. at 111–12.

67. *Id.* at 116–17, 119; Harmon & Sethi, *supra* note 65, at 359.

68. *Haas*, 2011-I Eur. Ct. H.R. at 119; Harmon & Sethi, *supra* note 65, at 359.

69. *Haas*, 2011-I Eur. Ct. H.R. at 118–19.

70. *Id.* at 119–20.

71. Koch v. Germany, HUDOC at 14 (Jul. 19, 2012), http://hudoc.echr.coe.int/eng?i=001-112282.

Koch v. Germany[72] involved a German woman who was a quadriplegic and "needed artificial ventilation and constant care and assistance from nursing staff. She further suffered from spasms."[73] Moreover, "[a]ccording to the medical assessment, she had a life expectancy of at least fifteen more years. She wished to end what was, in her view, an undignified life by committing suicide with the applicant's help."[74] She requested a lethal substance in Germany, but her request was denied.[75] She and her husband appealed the denial, but while their appeal was pending they traveled to Switzerland where she obtained an assisted suicide.[76] Her husband's attempt to continue the proceedings in the German courts were rejected because he had not been refused the lethal substance.[77] He petitioned the ECtHR claiming that the refusal of his wife's request had violated both her and his right to privacy under Article 8 of the Convention.[78] The ECtHR rejected his claim and emphasized that:

> [T]he applicant's wife had not sought protection from State interference with the realisation of her wish to end her life, but had sought to oblige the State to facilitate the acquisition of a specific drug so that she could take her life in the manner she desired. Such a duty would be diametrically opposed to the values of the Convention, and especially to the State's duty under Article 2 to protect life.[79]

The ECtHR precedents had "refused to derive a positive obligation from Article 8 to facilitate suicide in dignity."[80]

As one commentator critically noted:

> According to the Court, suicide is an expression of individual autonomy. Consequently, the primary reason for a "right to assisted suicide" would not be due to suffering or the inevitable death, but due to respect for individual freedom. To base the right to assisted suicide

72. *Id.*
73. *Id.* at 2.
74. *Id.*
75. *Id.*
76. *Id.* at 3.
77. *Id.*
78. *Id.* at 8.
79. *Id.* at 9.
80. *Id.* at 10.

> on individual freedom makes incoherent reserving access to assisted suicide to only bedridden individuals whose freedom is strongly affected by their state. Logically, according to this approach, exercising a "right to assisted suicide" should be reserved for persons whose physical and mental capacities are intact.
>
> With this approach, the State's responsibility would not be to prevent suicide and protect people's lives but solely to ensure the quality of the suicidal will to die, to protect his freedom and to prevent abuses of a state of weakness. By adopting such reasoning; the court transcribes contemporary post-humanism, revolutionizing a foundation of the Convention: human dignity would no longer be inherent in human nature, but relative and reflexive, absorbed by individual freedom.[81]

The *Koch* court declared that Section 16 of the Model Professional Code for German Doctors allowed doctors to refrain from life-prolonging measures but emphasized that: "Doctors may not actively curtail the life of the dying person."[82]

In *Gross v. Switzerland*,[83] in 2013, the second section of the ECtHR considered the application of a woman who did not suffer from any particular disease or disability, but who did not want to grow older.[84] Since no physician would issue her a lethal prescription, and the laws forbade providing the drug without a prescription,[85] she asserted a claim that the state's failure to provide her with the means to commit suicide infringed her right to life protected by Article 2, and constituted degrading treatment under Article 3.[86] The panel ruled 4-3 that Switzerland's law banning lethal poison in such circumstances violated Article 8 of the ECHR, protecting private and family life.[87] However, in September 2014, while the appeal was pending in the Grand Chamber, it learned that the woman had actually committed suicide in 2011, and the Grand

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81. Puppinck, *supra* note 47.

82. Koch v. Germany, HUDOC at 14 (Jul. 19, 2012), http://hudoc.echr.coe.int/eng?i=001-112282.

83. Gross v. Switzerland, HUDOC, http://hudoc.echr.coe.int/eng?i=001-119703 (May 14, 2013).

84. *Id.* at 4, ¶ 15.

85. *Id.* at 4–5. *See generally The Right to Assisted Suicide, A Fundamental Right?*, GÈNÉTHIQUE, http://www.genethique.org/en/content/right-assisted-suicide-fundamental-right#.V_LpTCgrLcs (May 1, 2013).

86. Grégor Puppinck, *Euthanasia: The European Court Must Rule on Two New Cases*, TURTLE BAY & BEYOND (June 15, 2012), https://c-fam.org/turtle_bay/euthanasia-the-european-court-must-rule-on-two-new-cases/.

87. *See generally* Gross v. Switzerland, HUDOC, http://hudoc.echr.coe.int/eng?i=001=119703 (May 14, 2013).

Chamber nullified the panel's decision against Switzerland and dismissed the proceeding.[88]

So it appears that a right to assisted suicide without state restriction has been established to some extent under the European Convention of Human Rights. Nevertheless, the scope of the rights are conservatively narrow.

The increasing number of persons being euthanized in Belgium and Holland, as well as the widening classes of persons who being euthanized are cause for concern. In 2015, the Journal of American Medical Association (AMA) noted there were "reports that 1 (3.3%) in 30 people in the Netherlands died by euthanasia in 2012, roughly triple the percentage in 2002 when the practice was first decriminalized."[89] As one commentator put it: "where euthanasia is legalised the record is clear - its availability generates rapid and ever-expanding use and wider legal boundaries. Its rate and practice quickly exceeds the small number of cases based on the original criteria of unacceptable pain."[90]

Certainly, that same set of utilitarian values seems to have been adopted by the Supreme Court of Canada. Last year, in *Carter v. Canada*[91] (hereinafter "*Carter*"), the Canadian Supreme Court unanimously ruled that provisions of the Canadian Criminal Code, which prohibited and criminalized assisting suicide, violated Section 7 of the Canadian Charter of Rights and Freedoms.[92] That Charter Section provides that: "Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice."[93]

The *Carter* decision on assisted suicide was a significant ruling on a profound issue of biomedical-legal ethics. It is a matter of great interest and concern in many nations.[94] Since *Carter*, there have been several other "right to die" cases in Canada.[95]

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88. Paul Coleman, *Top Human Rights Court Throws Out Decision that Permitted Doctor-Prescribed Death*, ALLIANCE DEFENDING FREEDOM (Sept. 30, 2014) http://www.adfmedia.org/News/PRDetail/8546.

89. Barron H. Lerner & Arthur L. Caplan, *Euthanasia in Belgium and the Netherlands on a Slippery Slope?*, 175 [J]AMA INTERNAL MED. 1640, 1640 (2015).

90. Paul Russell, *Leading Australian journalist decries push for euthanasia*, MERCATORNET (Oct. 3, 2016), http://www.mercatornet.com/careful/view/leading-australian-journalist-decries-push-for-euthanasia/18766.

91. *See generally* Carter v. Canada (Att'y Gen.), [2015] 1 S.C.R. 331 (Can.).

92. *Id.* at para. 70.

93. Canadian Charter of Rights and Freedoms, Part 1 of the Constitution Act, 1982, *Being Schedule B to the Canada Act*, 1982, c 7 (U.K.).

94. *See infra,* notes 28–63 and accompanying text.

95. *See generally Judge Grants Suffering Woman Right to Die In B.C. First*, THE CANADIAN PRESS (Apr. 1, 2016, 4:24 PM), http://www.huffingtonpost.ca/2016/04/01/assisted-dying-bc_n_9595110.html (noting that a woman with MS is first to be granted the right to die in British Columbia); *1st doctor-assisted*

However, the *Carter* decision was intriguing for several reasons. First, the criminal law prohibition of suicide was repealed by the Canadian Parliament much earlier, in 1972.[96] So for more than four decades Canadian law did not "deprive" any "person" (e.g., competent adult) of the right or liberty to commit suicide. However, the criminal code's prohibition of *assisting* suicide remained.

Second, in 1993, two decades after suicide was decriminalized, the Supreme Court of Canada rejected (5-4) in *Rodriguez v. British Columbia,*[97] the claim of a terminally-ill adult woman that criminal prohibitions against assisting suicide violated Section 7 (the right to "life, liberty, and security of the person), Section 12 (protection against "cruel and unusual punishment"), and Section 15 (1) (equality) of the Canadian Charter of Rights and Freedoms.[98]

Yet, in 2015, the Canadian Supreme Court in *Carter* significantly broadened the category of persons eligible to claim constitutional protection for physician-assisted suicide to include "many people not dying, but diagnosed with a serious illness or disabled or, simply, suffering."[99] Thus, "the [Canadian] Supreme Court [in *Carter*] did not require a person to be terminally ill to have access to 'physician assisted death.'"[100] It extended constitutional protection for a right to:

> physician-assisted death for a competent adult person who (1) clearly consents to the termination of life and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition.[101]

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death in Ontario granted to terminally ill Toronto man, CBC NEWS (Mar. 17, 2016, 5:00 AM), http://www.cbc.ca/news/canada/toronto/doctor-assisted-death-application-1.3494187 (discussing that an 81-year-old man that had advanced stages of aggressive lymphoma was granted the right for physician assisted suicide); *Calgary woman dies after being granted right to physician-assisted suicide,* CBC NEWS (Mar. 3, 2016, 9:15 AM), http://www.cbc.ca/news/canada/calgary/right-to-die-legislation-canada-calgary-sheilah-martin-supreme-court-1.3471363 (discussing that a Calgary woman with advance stages of ALS was given an exemption from the court for physician assisted suicide); B.A. Robinson, *A 25 Year Struggle to Legalize Physician Assisted Suicide (PAS) in Canada,* RELIGIOUS TOLERANCE (Feb. 29, 2016) http://www.religioustolerance.org/euthcan.htm.

96. *See* Florence Kellner, *Suicide in Canada*, THE CANADIAN ENCYCLOPEDIA, http://www.thecanadianencyclopedia.ca/en/article/suicide/ (last edited Oct. 3, 2016).

97. Rodriguez v. British Columbia (Att'y Gen.), [1993] 3 S.C.R. 519, 520 (Can.).

98. *Id.*

99. *Evolution or Revolution, supra* note 3, at 758.

100. *Id.* at 757.

101. Carter v. Canada, [2015] 1 S.C.R. 331, para. 147 (Can.).

Professor Somerville has commented about the *Carter* court evasion of the main point of laws prohibiting assisted suicide.

> The Supreme Court [*in Carter*] also held that rights to refuse life-support treatment, including artificial hydration and nutrition, show that there is no overriding goal of "the *preservation of life*". That is correct, but this goal or object should have been argued as *maintaining "respect for life,"* including at the societal level, and emphasis should have been placed on the argument that there is *a difference-in-kind, not just a difference-in-degree*, between justifiably allowing someone to die of natural causes and killing them with a lethal injection or helping them to kill themselves. Both the trial judge and the Supreme Court expressly rejected this distinction.[102]

She further noted that: "while it's correct [as the *Carter* court noted] 'that all human life [need not] be preserved at all costs,' that does not mean that it may be intentionally taken. Not preserving human life and taking it are not commensurable and are not the same ethically or legally."[103]

Yet, the *Carter* decision has been largely applauded around the world.[104] And on June 17, 2016, Bill C-14 codifying the legalization of assisted suicide was passed into law by the Parliament of Canada.[105]

In June 2016, the College of Physicians and Surgeons of Ontario adopted and published a new ethical policy binding doctors in that Canadian province. The policy mandates:

> Where a physician declines to provide medical assistance in dying for reasons of conscience or religion, the physician must not abandon the patient. An effective referral must be provided. An effective referral means a referral made in good faith, to a non-objecting, available, and accessible physician, nurse practitioner or agency. The referral must be made in a timely manner to allow the patient to access medical

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102. *Evolution or Revolution, supra* note 3, at 753 (italicized and underlined for emphasis).

103. *Id.* at 756.

104. *See generally* Grace Pastine, *The death with dignity decision explained*, B.C. C.L. ASS'N (Feb. 6, 2015), https://bccla.org/2015/02/the-death-with-dignity-decision-explained/ ("This [the *Carter v. Canada* ruling] is a tremendous victory for the protection of human rights and compassion at the end of life.").

105. Medical Assistance in Dying Act, S.C. 2016, C- 14 (Can.).

> assistance in dying. Patients must not be exposed to adverse clinical outcomes due to delayed referrals.[106]

The Protection of Conscience Project (PCP) in Canada (administered by Sean Murphy) reported that the decision to mandate that all physicians must refer patients for euthanasia and assisted suicide despite the objections of the doctor was actually made by College of Physicians and Surgeons of Ontario (CPSO) in the first week of November 2015.[107] That was a month before the College began its official public consultation period.[108]

The Canadian assisted suicide law has been touted as a model. Yet there are grave concerns that it allows and masks coercive practices that drive vulnerable people to "voluntarily" commit suicide. To deny access to palliative care which could relieve suffering, and instead offer suicide assistance, is it any wonder that some sufferers opt for suicide? But is that truly non-coercive?

There are concerns that there is no oversight, no monitoring, no investigation, and no serious reporting of assisted suicide in Canada. As one commentator noted:

> What seems obvious is that the whole nature of this death is not going to be reported to the Minister of Health or the Minister of Justice—there is no transparency to this system.
>
> Five years from now, the mandatory report is going to be full of bland and self-justifying statistics presented by the very doctors who have done the killing. By sanitizing these medicalized suicides and homicides with the now-familiar euphemisms about "medical aid in dying," the uninvolved public will be reassured that nothing has gone wrong.
>
> Canada has simply created a system which offers, and completes, suicide for people whose personalities, disabilities and personal situations put them at high risk for it.[109]

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106. *Medical Assistance in Dying*, COLL. OF PHYSICIANS AND SURGEONS OF ONT. 5 (June 2016), http://www.cpso.on.ca/CPSO/media/documents/Policies/Policy-Items/medical-assistance-in-dying.pdf.

107. *College of Physicians and Surgeons of Ontario decided results of consultation before it started,* PROTECTION OF CONSCIENCE PROJECT (Jan. 18, 2016), http://consciencelaws.org/blog/?p=6420.

108. *Id*.

109. Will Johnston, *Euthanasia: learn from Canada's mistakes*, MERCATORNET (Oct. 5, 2016), https://www.mercatornet.com/careful/view/euthanasia-learn-from-canadas-mistakes/18778. ("What surprised his wife was 'how easy' it was for her depressed, self-isolated husband to be killed under the new regime.").

In the United States, public support for assisted suicide is reported to have "plateaued since the 1990s."[110] However, assisted suicide enjoys "increasing and strong public support" in Western Europe, but decreasing popularity and support in Central and Eastern Europe according to one article in the Journal of the American Medical Association.[111]

Reasons motivating persons to seek assisted suicide are varied. Reports from Oregon have noted that:

> [P]atients requesting physician-assisted suicide reported being concerned about "losing autonomy" (91.5%), being "less able to engage in activities making life enjoyable" (88.7%), "loss of dignity" (79.3%), "losing control of bodily functions" (50.1%), and being a "burden on family, friends/caregivers" (40%). Only 1 in 4 (24.7%) even reported "concern about" inadequate pain control.[112]

Other studies also support the finding that fear of loss of autonomy rather than fear of pain is the major motivation for suicide and assisted suicide.

> [I]t turns out that physical pain is not a major driver in the use of PAS [physician-assisted suicide]. The 2014 annual Oregon Public Health Division DWDA report says, "The three most frequently mentioned end-of-life concerns were: loss of autonomy (91.4%), a decreasing ability to participate in activities that made life enjoyable (86.7%), and the loss of dignity (71.4%)."[113]

Similarly, studies of assisted suicide in Switzerland confirm that "[t]he strongest message conveyed by the interviewees was that patients had a fear of the future, fear of loss of dignity, a lack of independence in daily activities and bodily functions. These were recalled as a strong motivation in the patients to enact their previously considered assisted suicide."[114]

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110. Ezekiel J. Emanuel, *Euthanasia and Physician-Assisted Suicide Increasingly Being Legalized, Although Still Relatively Uncommon*, [J]AMA NETWORK (July 5, 2016), http://www.media.jamanetwork.com/news-item/euthanasia-and-physician-assisted-suicide-increasingly-being-legalized-although-still-relatively-uncommon/.

111. *Id.*

112. Y. Tony Yang & Farr A. Curlin, *Why Physicians Should Oppose Assisted Suicide,* 315 [J]AMA 247, 247 (2016).

113. Joseph J. Kotva Jr., *Dying in Oregon: A Critical Look at Death with Dignity,* CHRISTIAN CENTURY (Mar. 29, 2016), http://www.christiancentury.org/article/2016-03/dying-oregon.

114. C. Gamondi et al., *Families' Experiences with Patients Who Died After Assisted Suicide: a retrospective interview study in southern Switzerland,* 24 ANNALS OF ONCOLOGY 1639, 1641 (2013).

Clearly, pain is not the main reason why people commit suicide. It is fear of future pain and potential loss of dignity or lifestyle. "A report by the National Institute of Health notes that in published studies, pain is not the dominant motivating factor in patients seeking PAS. The reasons for seeking to die are usually depression, hopelessness, issues of dependency, and loss of control or autonomy."[115]

In light of those concerns, it is deeply disturbing that the mental health status of persons seeking assisted suicide is largely neglected in places that it is permitted.

Reported referrals for psychiatric evaluation [in Oregon] are low. In 2014, when 155 prescriptions were written for lethal medication, only three people were referred for psychiatric evaluation. Only 1.9 percent of those progressing toward PAS were candidates for a consultation. Furthermore, studies show that physicians tend to underdiagnose and undertreat depression, especially among the elderly.[116]

Still, the sentiment in favor of assisted suicide persists in popular opinion. It is exemplified by a quote from Stephen Hawking, who favored allowing assisted suicide. He said: "We don't let animals suffer, so why humans?"[117] He agreed that "family members of those who wish to die should be able to assist a suicide without fear of prosecution . . . ."[118]

III. THE TREND TOWARD LEGAL AND SOCIAL ACCEPTANCE OF ASSISTED SUICIDE IN THE UNITED STATES

Decriminalization of assisting suicide might seem to follow from the legalization of suicide. However, that has not been how the law has developed generally. Suicide was almost universally prohibited in American jurisdictions in 1960. By 1990 most states had repealed criminal prohibitions of suicide.[119] Yet, perhaps surprisingly, in 2016 assisted suicide is legal in

115. Joe Carter, *9 Things You Should Know About Physician-Assisted Suicide,* THE GOSPEL COAL, https://www.thegospelcoalition.org/article/9-things-you-should-know-about-physician-assisted-suicide (June 21, 2016).

116. Kotva Jr., *supra* note 113.

117. Scott Neuman, *Stephen Hawking Backs Assisted Suicide For The Terminally Ill,* NPR NEWS (Sept. 17, 2013, 5:36 PM), http://www.npr.org/sections/thetwo-way/2013/09/17/223475856/steven-hawking-backs-assisted-suicide-for-the-terminally-ill ("He added, however: 'There must be safeguards that the person concerned genuinely wants to end their life and they are not being pressurized into it or have it done without their knowledge or consent as would have been the case with me.'").

118. *Id*; *see also* Abby Phillip, *Why Stephen Hawking says he'd consider assisted suicide*, THE WASHINGTON POST (June 4, 2015).

119. Robert E. Litman, *Medical-Legal Aspects of Suicide,* 6 WASHBURN L.J. 395, 395–96 (1967).

only six American states. State law expressly allows assisted suicide in four states:[120] California (California's End of Life Option Act, approved by Governor Brown in October 2015—the most recent),[121] Oregon (Oregon Death with Dignity Act), [122] Vermont (Vermont Patient Choice at End of Life Act),[123] and Washington (Washington Death with Dignity Act).[124] Reportedly, assisted suicide is legal in Hawaii by the absence of legislation expressly prohibiting it.[125] Additionally, the Montana Supreme Court has ruled that no state laws or precedents proscribe suicide assistance and that Montana's Terminally Ill Act, which protects physicians from criminal prosecution in engaging in "physician aid in dying," is not against public policy.[126] In all of the other forty-four American states assisted suicide continues to be prohibited.[127]

The District of Columbia's law is in transition. Historically, assisted suicide has been prohibited in the nation's capital, but Bill B21-0038, the so-called "Death with Dignity Act of 2015," passed a committee by a 3-2 vote on October 5, 2016, and will come before the full City Council on October 18.[128] The D.C. bill, reportedly modeled after the Oregon assisted suicide law,[129] would allow an adult resident "with a terminal illness and six months or less to live (a prognosis which is nearly impossible for a doctor to make with any reasonable certainty) could obtain a lethal prescription,"[130] if two doctors agree with a repeated request made by the patient. The bill has already identified

120. *See generally* Matthew Santiago, *California Superior Court rejects challenge to 'aid-in-dying' law*, JURIST TWENTY PAPER CHASE (Aug. 28, 2016, 4:08 PM), http://www.jurist.org/paperchase/2016/08/california-superior-court-rejects-challenge-to-aid-in-dying-law.php

121. End of Life Option Act, CAL. HEALTH & SAFETY CODE § 443 (West 2016).

122. Oregon Death with Dignity Act, OR. REV. STAT. ANN. §§ 127.800–127.897 (West 2015).

123. Patient Choice at End of Life Act, VT. STAT. ANN. tit. 18 §§ 5281–5293 (West 2015).

124. Washington Death with Dignity Act, WASH. REV. CODE ANN. §§ 70.245.010–70.245.904 (West 2009).

125. *See* Morris v. Brandenburg, 356 P.3d. 564, 570 (N.M. Ct. App. 2015). However, one wonders if ordinary homicide or manslaughter laws would not apply to assisted suicide, even in Hawaii.

126. Baxter v. Montana, 224 P.3d 1211, 1222 (Mont. 2009).

127. *World Laws on Assisted Suicide*, *supra* note 36.

128. Cameron Thompson, *DC council committee passes physician-assisted suicide bill,* DCW50 (Oct. 6, 2016, 5:15 PM) http://dcw50.com/2016/10/05/dc-council-committee-passes-physician-assisted-suicide-bill/. The bill was passed by a 11-2 vote on November 15, 2016. *District of Columbia*¸ DEATH WITH DIGNITY, https://www.deathwithdignity.org/states/district-of-columbia/ (last seen March 27, 2018).

129. Kelsey Harkness, *Veteran With Terminal Brain Cancer Explains Why He's Against Assisted Suicide,* THE DAILY SIGNAL, (Oct. 4, 2016), http://dailysignal.com/2016/10/004/veteran-with-terminal-brain-cancer-explains-why-hes-against-assisted-suicide.

130. Elyse M. Smith, *Assisted Suicide in D.C.,* CULTURE OF LIFE FOUND, (Sept. 29, 2016, 12:40 PM), http://www.cultureoflife.org/2016/09/29/assisted-suicide-d-c/.

and authorized several potential abuses, such as the absence of required mental health screening, requiring face-to-face meetings between doctor and patient seeking the death prescription, the lax (or no) restrictions on "doctor shopping," and the absence of family involvement.[131]

> The [D.C. assisted suicide] bill was sponsored by Councillor Mary Cheh, who believes the State "should not stand in the way" of someone wishing to "peacefully" end their life.

The Washington Post has expressed its support for the proposed legislation, saying that "the District should add its name to the list of places that offer their citizens compassion and control at life's end."[132]

However, there have been strong objections to the bill. For example, two bioethicists described the proposed D.C. assisted suicide law as "an indirect threat to 'individual dignity.'"[133] They observed that:

> When we make human dignity merely a matter of human autonomy, we risk devaluing the dignity of human community, and we neglect the importance of the individual as a member of a broader community that itself enriches dignity. Such a balance between the individual and the community safeguards against radical individualism like the type that we see expressed in the D.C. Death With Dignity Act.[134]

The Oregon Death With Dignity law seems to be the most popular and most frequently-imitated law for legalizing assisted suicide, in part because of alleged "safeguards" in the law. However, as two experts on suicide, Doctors Herbert Hendin and Kathleen Foley, have noted: "The evidence strongly suggests that these safeguards are circumvented in ways that are harmful to patients."[135] They describe anecdotal cases in which patients were medically approved for assisted suicide despite contrary medical opinions that were simply brushed aside (including for patient "Helen" where one doctor who had known her for some time and another doctor who considered her depressed

131. *Id.*

132. Xavier Symons, *DC debates euthanasia,* BIOEDGE (Oct. 8, 2016), http://www.bioedge.org/bioethics/the-district-debates-euthanasia/12033.

133. *Id.*

134. *Id.*

135. Herbert Hendin & Kathleen Foley, *Physician-Assisted Suicide in Oregon: A Medical Perspective*, 106 MICH. L. REV. 1613, 1614 (2008).

both opposed).[136] They conclude by questioning "of what real meaning or value Oregon's prohibition of coercion [in assisted suicide] has if it can be circumvented so easily."[137] They cite:

> [D]ata contradict[ing] the OPHD's contention of adequate care. A study at the Oregon Health & Science University indicated that there has been a greater percentage of cases of inadequately treated pain in terminally ill patients since the Oregon law went into effect. However, among patients who requested PAS but availed themselves of a substantive intervention by a physician, forty-six percent changed their minds about having PAS.[138]

Diane Coleman, President and CEO of "Not Dead Yet," a national disability rights group, has summarized some of the most trenchant criticisms of the ineffectiveness of the "safeguards" in the Oregon Death With Dignity Assisted Suicide Act.[139] She notes that the Oregon reporting officials admit that "[u]nder reporting and noncompliance is . . . difficult to assess because of possible repercussions for noncompliant physicians . . . ."[140] Indeed, State agencies and officials "have no authority to investigate Death with Dignity cases."[141] While the Oregon law requires that a patient have a "terminal disease,"[142] Coleman observes that "Oregon Health Division assisted suicide reports show that non-terminal people receive lethal prescriptions every year."[143] While a doctor's prediction that the patient will die within 180 days is required for the patient to receive the deadly prescription, the actual time lapse between obtaining the prescription for suicide pills and the patient's death has been as long as 1009 days.[144] That shows that physicians' predictions of patient death within six months may be very unreliable and manipulable. Determination of a terminal condition depends upon many factors including treatments prescribed and whether/when they are used.[145]

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136. *Id.* at 1618.

137. *Id.* at 1627.

138. *Id.* at 1621 (footnotes omitted).

139. Diane Coleman, *The Real Story About Safeguards Around Assisted Suicide in Oregon,* MERCATORNET (Oct. 11, 2016), http://www.mercatornet.com/careful/view/the-real-story-about-safeguards-around-assisted-suicide-in-oregon/18810.

140. *Id.*

141. *Id.*

142. OR. REV. STAT. ANN. § 127.805 (1); *see also* OR. REV. STAT. ANN. § 127.800 (12).

143. Coleman, *supra* note 139.

144. *Id.*

145. *Id.*

"The Oregon state reports say that the median duration of the physician patient relationship is 12 weeks. Thus, lack of coercion is not usually determined by a physician with a longstanding relationship with the patient. This is significant in light of well-documented elder abuse . . . ."[146] The absence of medical supervision continues to be a concern: "In about half the reported cases, the Oregon Health Division reports also state that no health care provider was present at the time of ingestion of the lethal drugs or at the time of death."[147] Moreover, "there is no evidence of consent or self-administration at the time of ingestion of the lethal drugs. If the drugs were, in some cases, administered by others without consent, no one would know."[148] Concerns such as these may explain why at least sixteen national disability rights organizations—"every major disability rights organization in the country that has taken a position on assisted suicide" —oppose legalization of assisted suicide.[149]

Ironically, while relief from pain is a leading reason cited in support of legalizing assisted suicide, it does not appear to be a main motivation in Oregon suicide requests. Indeed,

> [t]he top five reasons doctors give for their patients' assisted suicide requests are not pain or fear of future pain, but psychological issues that are all-too-familiar to the disability community: "loss of autonomy" (92%), "less able to engage in activities" (90%), "loss of dignity" (79%), "losing control of bodily functions" (48%), and "burden on others" (41%).[150]

Thus, there is great reason for concern about lethal abuse and exploitation of the elderly, ill, and disabled to dispose of them when their lives become inconvenient to others.

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146. *Id.*

147. *Id.*

148. *Id.*

149. Diane Coleman, *Who's Really Hurt by Assisted Suicide,* CNN (Nov. 4 2014, 9:54 AM), http://www.cnn.com/2014/11/03/opinion/coleman-assisted-suicide/index.html; *see also Disability Groups Opposed to Assisted Suicide Laws*, NOT DEAD YET, http://notdeadyet.org/disability-groups-opposed-to-assisted-suicide-laws (last visited Oct. 11, 2016) [hereinafter NOT DEAD YET] (The disability groups against assisted suicide include: ADAPT (American Disabled for Attendant Programs Today), American Association of People with Disabilities, Assn of Programs for Rural Independent Living, Autistic Self Advocacy Network, Disability Rights Center, Disability Rights Education and Defense Fund, National Council on Disability, National Council on Independent Living, National Organization of Nurses with Disabilities, National Spinal Cord Injury Association, Not Dead Yet, TASH, The Arc of the United States, and United Spinal Association.).

150. Coleman, *supra* note 139.

Pain-avoidance appears to be a major driver of the movement to legalize assisted suicide. Yet, ironically, the legalization of assisted suicide has led to "a trend of increasing rates of moderate to severe pain reported among patients dying in acute-care hospitals throughout Oregon. This trend led the BME [Oregon Board of Medical Examiners] to conclude that inadequate palliative care was a problem in the state."[151] Doctors Foley and Hendin note that: "[s]ince the passage of Oregon's Death with Dignity Act, however, various sources—patients, families, healthcare professionals, physicians, nurses, social workers, chaplains, and advocacy groups—have supplied more detailed information that suggests that the implementation of the law has had unintended, harmful consequences for patients."[152] They conclude that under the Oregon law "patients are left unprotected while believing they have acquired a new right."[153]

The Disability Rights Education and Defense Fund agrees. It notes that:

> [R]esearch strongly suggests that Oregon has seen a *reduction in the quality of end-of-life palliative care* during the years since the Oregon law went into effect. A 2004 Journal of Palliative Care Medicine study showed that dying patients in Oregon are nearly twice as likely to experience moderate or severe pain during the last week of life, as reported by surviving relatives, compared with patients before the Oregon law took effect.[154]

Among the abuses that have been noted in Oregon are doctor-shopping (going from one to another until a doctor is found who will prescribe the

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151. Hendin & Foley, *Physician-Assisted Suicide in Oregon*, *supra* note 135, at 1621.

152. *Id.* at 1614.

153. *Id*. at 1645.

> [U]nder the current monitoring system, Oregon physicians appear to have been given great power without being in a position to exercise it responsibly. They are expected to inform patients that alternatives are possible without being required to be knowledgeable about such alternatives or to consult with someone who is. They are expected to evaluate patient decision-making capacity and judgment without a requirement for psychiatric expertise or consultation. They are expected to make decisions about voluntariness without having to see those close to the patient who may exert a variety of pressures, from subtle to coercive. They are expected to do all of this without necessarily knowing the patient for more than fifteen days. Since physicians cannot be held responsible for wrongful deaths if they have acted in good faith, substandard medical practice is permitted, physicians are protected from the consequences, and patients are left unprotected while believing they have acquired a new right. *Id.* at 1644–45.

154. *Why Assisted Suicide Must Not Be Legalized,* DISABILITY RIGHTS EDUCATION & DEFENSE FUND, https://dredf.org/public-policy/assisted-suicide/why-assisted-suicide-must-not-be-legalized/#deteriorating (last visited Oct. 8, 2016) (emphasis added).

desired suicide pills), depression, economic pressures, other forms of coercion, medical complications from unsuccessful attempts, and other aspects of "[a] broken health care system . . . ."[155]

Views about assisted suicide generally reflect an individual's deeper worldview paradigm. For example: "Religious identity correlates with attitudes toward the ethical status of assisting in suicide. Catholics, Protestants and Orthodox Jews believe in the majority that it is unethical to assist, while Conservative, Reform and secular Jews say assistance is ethical."[156]

The practice of physician-assisted suicide already exists in America. Nearly twenty years ago the New England Journal of Medicine published the results of a national survey of 3,102 American physicians to which 1,902 doctors responded. The survey results revealed that:

> [e]leven percent of the physicians said that under current legal constraints, there were circumstances in which they would be willing to hasten a patient's death by prescribing medication, and 7 percent said that they would provide a lethal injection; 36 percent and 24 percent, respectively, said that they would do so if it were legal. Since entering practice, 18.3 percent of the physicians (unweighted number, 320) reported having received a request from a patient for assistance with suicide and 11.1 percent (unweighted number, 196) had received a request for a lethal injection. Sixteen percent of the physicians receiving such requests (unweighted number, 42), or 3.3 percent of the entire sample, reported that they had written at least one prescription to be used to hasten death, and 4.7 percent (unweighted number, 59), said that they had administered at least one lethal injection.[157]

So, at least a minority of American physicians already engage in assisted suicide. They acknowledge that laws prohibiting assisted suicide are a substantial reason why it is done infrequently. Three to four times as many

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155. *Some Oregon and Washington State Assisted Suicide Abuses and Complications,* DISABILITY RIGHTS EDUCATION & DEFENSE FUND, https://dredf.org/public-policy/assisted-suicide/some-oregon-assisted-suicide-abuses-and-complications/ (last visited Oct. 8, 2016). *See also* Emanuel et al., *supra* note 40, at 86.

156. The Louis Finkelstein Institute for Religious and Social Studies, *Is the Debate over Euthanasia and Physician-Assisted Suicide Primarily Religious in Nature?,* ProCon.org (June 5, 2008, 9:14 AM), http://euthanasia.procon.org/view.answers.php?questionID=000152#answer-id-000773. [hereinafter ProCon.Org].

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

doctors admit that they would more often participate in assisted suicide if the laws allowed them to do so.

In the United States, "[i]t is estimated that 85% of people in the United States will know someone personally who has completed suicide. For each suicide completed, at least 6 loved ones are directly affected by the death."[158] During one recent twelve-month period (2008-2009),

> 8.3 million people over age 18 in the United States (3.7% of the adult US population) reported having suicidal thoughts in the last year, and approximately 1 million people (0.5% of the adult US population) reported having made a suicide attempt in the last year. There were just under 37,000 reported deaths by suicide (completed suicides) during the same time period, and almost 20 times that number of emergency room visits after nonfatal suicide attempts.[159]

The public opinion trend in favor of allowing assisted suicide still continues. A May 2015 Gallup poll reported that

> [n]early seven in 10 Americans (68%) say doctors should be legally allowed to assist terminally ill patients in committing suicide, up 10 percentage points from [2014]. More broadly, support for euthanasia has risen nearly 20 points in the last two years and stands at the highest level in more than a decade.[160]

The poll results showed that support for doctor assisted suicide had ranged from 51% to 53% for four years until 2013, but the next two years it shot up seventeen points.[161] Support for euthanasia rose steadily from 36% in 1950 to 75% in 1996, and remained relatively between 64% and 75% from 1996-2016.[162] Nonetheless, a year later Gallup reported that 69% of polled Americans agreed that "doctors should be allowed to end a patient's life by painless means," and "51% [said] they would consider ending their lives if faced with terminal illness."[163]

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158. Young, et al., *supra* note 23, at 178 (footnote omitted).

159. *Id.* at 177 (footnote omitted).

160. Andrew Dugan, *In U.S., Support Up for Doctor-Assisted Suicide,* GALLUP (May 27, 2015), http://www.gallup.com/poll/183425/support-doctor-assisted-suicide.aspx?version=print.

161. *Id.*

162. Art Swift, *Euthanasia Still Acceptable to Solid Majority in U.S.,* GALLUP (June 24, 2016), http://www.gallup.com/poll/193082/euthanasia-acceptable-solid-majority.aspx?version=print.

163. *Id.*

Reports of sympathetic cases involving individuals with terrible dilemmas seeking to end their lives influence public attitudes about assisted suicide. As the 2015 Gallup report noted:

> This year finds an uptick in support for euthanasia after the high-profile story last year of 29-year-old Brittany Maynard. Dying from terminal brain cancer, Maynard left her home state of California, where physicians are barred from assisting suicide, and ended her life in Oregon, where the practice is legal. Somewhat in response to this well-publicized story, the California state Legislature is currently considering [and passed] a bill [to] . . . legalize doctor-assisted suicide.
>
> The larger effect that Maynard's story will have is uncertain, but some notable changes in support are evident compared with last year. The percentage of young adults aged 18 to 34 who support doctor-assisted suicide climbed 19 points this year, to 81%.[164]

The Brittany Maynard story gave a tremendous boost to public opinion polls for assisted suicide that has not diminished since her death.[165] "One newspaper opinion columnist spoke with almost religious awe when she noted that 'Maynard has ascended to martyr-saint status as an advocate for the right to suicide in the throes of terminal illness.'"[166] Indeed, media coverage of the issue has been overwhelming supportive of assisted suicide. For instance, *The Economist* recently published more than a dozen pro-assisted-suicide stories but presented no significantly contradictory articles.[167]

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164. Dugan, *supra* note 160. *See also* Art Swift, *Brittany Maynard's Story and Americans' Views on Assisted Suicide,* GALLUP (Nov. 5, 2014), http://www.gallup.com/opinion/queue/179159/brittany-maynard-story-americans-views-assisted-suicide.aspx ("However, the phrasing of the topic affects Americans' level of support for physician-assisted death. When Gallup asked whether doctors should be allowed by law to 'assist the patient to commit suicide,' support dipped [from about 69%] to 58%.").

165. *See, e.g.*, Dugan, *supra* note 160; *see also* Swift, *supra* note 162.

166. Aaron Kheriaty, *Apostolate of Death,* 252 FIRST THINGS 19, 19 (Apr. 2015).

167. *See Doctor-Assisted Dying A Patient's Right*, THE ECONOMIST, http://www.economist.com/assisted-dying (last visited Oct. 8, 2016). *See also Doctor-assisted dying will be legal in California from June 9th,* THE ECONOMIST (Apr. 5, 2016), http://www.economist.com/news/international/21696245-after-agonising-delay-americas-largest-state-will-let-doctors-help-terminally-ill; *California's governor has signed a bill legalising doctor-assisted dying*, THE ECONOMIST (Oct. 6, 2015), http://www.economist.com/news/united-states/21671379-jerry-brown-decides-californias-governor-has-signed-bill-legalising-doctor-assisted-dying; *The Right to Die*, THE ECONOMIST (June 27, 2015), http://www.economist.com/news/leaders/21656182-doctors-should-be-allowed-help-suffering-and-terminally-ill-die-when-they-choose (stating "[d]octors should be allowed to help suffering and terminally ill die when they choose"); *Final Certainty,* THE ECONOMIST (June 27, 2015),

According to data released by the Oregon Public Health Division in February 2016, the most frequently cited reasons for choosing assisted suicide in Oregon are "decreasing ability to participate in activities that made life enjoyable," a "loss of autonomy," and a "loss of dignity."[168] Those who chose to use assisted suicide are 93% white and 43% well-educated, 78% are sixty-five years old and older, and 72% had cancer.[169] Less than 0.4% of Oregon's population sought physician-assisted suicide in 2015, but extrapolated over the entire United States, that would amount to 10,529 persons who die annually by assisted suicide.[170] Moreover, as Wesley Smith, consultant to the Patients Rights Council and a senior fellow at the Discover Institute's Center on Human Exceptionalism has noted: "Once a society or a state or a culture starts accepting this agenda, the numbers go up . . . ."[171]

Equally troubling are the classes of persons who opt for assisted suicide when it is legal. For example:

> A study published . . . by JAMA Psychiatry raised serious concerns among opponents, finding that 56 percent of people who were prescribed life-ending drugs refused treatment that could have helped their condition. Of the results, the authors wrote:
>
> The results show that the patients receiving [euthanasia or assisted suicide] are mostly women and of diverse ages, with various chronic psychiatric conditions, accompanied by personality disorders, significant physical problems, and social isolation or loneliness. Refusals of treatment were common, requiring challenging physician judgments of futility.[172]

Death by suicide or assisted suicide is not necessarily a "death with dignity." Complications are not uncommon, including traumatic

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http://www.economist.com/news/briefing/21656122-campaigns-let-doctors-help-suffering-and-terminally-ill-die-are-gathering-momentum.

168. OREGON PUBLIC HEALTH DIVISION, OREGON DEATH WITH DIGNITY ACT: 2015 DATA SUMMARY (Feb. 4, 2016).

169. *Id.*

170. Kelsey Harkness, *According to Oregon's Numbers, Here's What Will Happen If Assisted Suicide Is Legalized Nationwide,* THE DAILY SIGNAL (Feb. 12, 2016), http://dailysignal.com/2016/02/12/according-to-oregons-numbers-heres-what-would-happen-if-assisted-suicide-was-legalized-nationwide/.

171. *Id.*

172. *Id.*

"awakenings" and convulsions in the process of dying by suicide.[173] "A study from the Netherlands . . . reports that in at least 18% of reported physician-assisted suicides, doctors felt compelled to intervene and administer a lethal injection themselves because of 'complications.'"[174] An Oregon study of assisted suicide published by the American Medical Association noted that "[t]he median time between ingestion of barbiturate and death was 25 minutes, but the range extends to 104 hours—more than 4 days."[175] While data from Washington state is incomplete, for 2014 and 2015, "[o]nly 66.8% of patients died in less than 90 minutes, while the range extends to 30 hours."[176]

Once introduced, the practice of assisted suicide spreads continuously. It is now reported that nearly one in every seven deaths in the Netherlands is by doctor-assisted suicide.

> Euthanasia is now becoming so prevalent in the Netherlands, Professor Boer said, that it is 'on the way to becoming a default mode of dying for cancer patients'.
>
> He said assisted deaths have increased by about 15 percent every year since 2008 and the number could hit a record 6,000 this year [2014].
>
> He said he was concerned at the extension of killing to new classes of people, including the demented and the depressed, and the establishment of mobile death units of 'travelling euthanasing doctors'.[177]

Likewise, in 2015 the number of euthanasia cases in Belgium hit a record high with more than 2,000 such mercy killings.[178]

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173. Sharon Kirkey, *Anesthesiologists Warn Assisted Death Not Simple: Convulsions and 'Awakenings' Possible Complications*, NAT'L POST (CANADA) (Jan. 19, 2016, 12:30 PM), http://news.nationalpost.com/news/canada/death-not-simple.

174. *Assisted Suicide,* FAM. INST. OF CONN., http://www.ctfamily.org/assisted-suicide/ (last visited Oct. 13, 2016).

175. Emanuel, et al., *supra* note 40, at 86 (footnote omitted).

176. *Id.*

177. Steve Doughty, *Don't make our mistake: As assisted suicide bill goes to Lords, Dutch watchdog who once backed euthanasia warns UK of 'Slippery Slope' to mass deaths,* DAILY MAIL.COM (July 10, 2014, 4:44 AM), http://www.dailymail.co.uk/news/article-2686711/Dont-make-mistake-As-assisted-suicide-bill-goes-Lords-Dutch-regulator-backed-euthanasia-warns-Britain-leads-mass-killing.html.

178. *Belgian Euthanasia Cases Hit Record High,* YAHOO! NEWS (Jan. 27, 2016), https://www.yahoo.com/news/belgian-euthanasia-cases-hit-record-high-183359489.html?ref=gs (The head of the Belgian euthanasia commission admitted that "there could be some euthanasia cases carried out but which are not declared so we cannot say for certain" how many people were killed).

The historical precedents of societies that have embraced assisted suicide are very troubling. In Germany, the euthanasia program that evolved into the Holocaust where millions of persons deemed inferior, undesirable, and unwanted were killed began with the "mercy killing" of disabled children.[179] The most vulnerable, neglected, lonely members of society are those who "choose" to become the victims of assisted suicide.[180]

One study published in the Journal of the American Medical Association (JAMA) about physician-assisted suicide noted:

> The frequency of these deaths increased after legalization. More than 70% of cases involved patients with cancer. Typical patients are older, white, and well-educated. Pain is mostly ***not*** reported as the primary motivation. A large portion of patients receiving physician-assisted suicide in Oregon and Washington reported being enrolled in hospice or palliative care, as did patients in Belgium. In no jurisdiction was there evidence that vulnerable patients have been receiving euthanasia or physician-assisted suicide at rates higher than those in the general population. Conclusions and Relevance: Euthanasia and physician-assisted suicide are increasingly being legalized, remain relatively rare, and *primarily involve patients with cancer*. Existing data do not indicate widespread abuse of these practices.[181]

A decade ago researchers found that the willingness of physicians in Europe and Australia to grant requests for terminal treatments varied according to who made the request (patient, family, or on the doctor's own initiative), the decisional capacity of the patient, his or her life expectancy and pain management, and cultural/social influences. The authors of the JAMA report concluded "that cultural and legal factors influence the frequencies of different ELDs [end-of-life decisions] and the strength of the different

179. Robert Jay Lifton, *German Doctors and the Final Solution,* NY TIMES MAG. (Sept. 21, 1986), http://www.nytimes.com/1986/09/21/magazine/german-doctors-and-the-final-solution.html.

180. *See* Simon Caldwell, *Most Euthanasia Deaths Linked to Loneliness, Says Dutch Study,* CATH. HERALD (Feb. 18, 2016), http://www.catholicherald.co.uk/news/2016/02/18/most-euthanasia-deaths-linked-to-loneliness-says-dutch-study/. A majority of people killed by euthanasia in the Netherlands for so-called psychiatric reasons had complained of loneliness, a new study has found. Researchers in the U.S. found that loneliness, or "social isolation," was a key motivation behind the euthanasia requests of 37 of 66 cases reviewed, a figure representing 56 percent of the total. *Id*. Most had personality disorders and were described as socially isolated or lonely. Depressive disorders were the primary psychiatric issue in 55% (n = 36) of cases. *Id.*

181. Emanuel, et al., *supra* note 40, at 79 (emphasis added).

determinants of these decisions but that they do not change the essence of the decision making."[182]

Suicide, of course, is just one form of self-abuse, albeit the most lethal.

> The National Center for Health Statistics (NCHS) states that each year, one in five females and one in seven males engage in self-injury. According to the statistics released by the NCHS, approximately two million cases of self-harm are reported annually in the United States. This number only reflects cases reported and documented by medical facilities. That means there are more.[183]

So if it should be legal to assist someone to commit suicide, should it also be legal to assist persons in other forms of self-abuse, such as "cutting" or "blading" or bulimia? Is there not a slippery slope to all kinds of other serious abuses?

IV. THE IMPACTS UPON FAMILIES OF LEGALIZING ASSISTED SUICIDE

Suicide has profound effects upon family members. The family of a person who commits suicide "may feel rejected or abandoned by the deceased because they see the deceased as choosing to give up and leave their loved ones behind. They are often left feeling bewildered, wondering why their relationship with the person was not enough to keep them from taking their lives."[184] Surviving family members often face stigmas, and it can be hard for them to talk to others about their loss because they are not comfortable talking about the suicide. Survivors may feel isolated. People facing challenges often turn to religion for help, but

> [S]everal religions impose shameful restrictions on the grief rituals for those who have been bereaved by suicide. Suicide survivors face additional logistical barriers when handling the deceased's business after a suicide, as most insurance policies even have clauses with built-

182. Bregje D. Onwuteaka-Philipsen et al., *End-of-Life Decision Making in Europe and Australia,* 166 ARCHIVES OF INTERNAL MED. 921, 927 (Apr. 24, 2006), available at http://jamanetwork.com/journals/jamainternalmedicine/fullarticle/410172.

183. Kimberly Whitten, *Understanding and helping those who self-harm*, THE ETHICS & RELIGIOUS LIBERTY COMM'N OF THE S. BAPTIST CONVENTION (Oct. 14, 2016), http://erlc.com/resource-library/articles/understanding-and-helping-those-who-self-harm (footnote omitted).

184. Young, et al., *supra* note 23, at 180 (footnote omitted).

> in stigma . . . . For many people, talking about their loved ones is vital for their recovery from their loss. [So, the] stigma of suicide poses a barrier to the healing process.[185]

Losing a family member to suicide is one of the most painful experiences a person may have. The feelings of grief, loss, and loneliness that are experienced after the death of a loved one may be magnified for suicide survivors by feelings of guilt, confusion, rejection, shame, anger, and stigma.

> [S]urvivors of suicide loss are at higher risk of developing major depression, post-traumatic stress disorder, and suicidal behaviors, as well as a prolonged form of grief called complicated grief. Added to the burden is the substantial stigma, which can keep survivors away from much needed support and healing resources. Thus, survivors may require unique supportive measures and targeted treatment to cope with their loss. After a brief description of the epidemiology and circumstances of suicide, we review the current state of research on suicide bereavement, complicated grief in suicide survivors, and grief treatment for survivors of suicide.[186]

Numerous studies have confirmed that there is an "increased risk of death by suicide among people who have lost an immediate family member to suicide."[187] For spouses who lose a spouse to suicide there is an elevated risk of suicide "as much as a 46-fold increase for men losing a spouse to suicide . . . ."[188]

> Parents who have lost a child to suicide report more guilt, shame, and shock than spouses and children. They often think "If only I had not lost my temper" or "If only I had been around more." The death of [a] child is arguably the most difficult type of loss a person can experience, particularly when the death is by suicide.[189]

Tragically, some surviving family members:

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185. *Id.* at 181 (footnotes omitted).

186. *Id.* at 177.

187. John R. Jordan & John L. McIntosh, *Suicide Bereavement: Why Study Survivors of Suicide Loss?*, in GRIEF AFTER SUICIDE: UNDERSTANDING THE CONSEQUENCES AND CARING FOR THE SURVIVORS 11, (John R. Jordan & John L. McIntosh, eds. 2011).

188. *Id.*

189. Young, et al., *supra* note 23, at 180 (footnote omitted).

> [m]ay feel closer to their loved one by taking their life in the same way. Indeed, a survivor told us of how her mother's death by suicide was so difficult to bear for her sister who, like her father, also struggled with bipolar disorder, that her sister completed suicide in the exact same way the following year, on the same date, at the same time.[190]

Family members of the suicide victim profoundly influence and are profoundly influenced by assisted suicide.

> Parents of child suicides and suicide-bereaved spouses were more often blamed and held more responsible or accountable for the death than those of the same kinship relations who had lost someone by another mode of death. Attitudes suggested a belief that spouses had the opportunity to prevent their spouse's suicide and were more ashamed than survivors of other causes of death. Parents of children who died by suicide were not only more often blamed and held accountable, but they were also disliked more than other surviving parents. They were also seen as more emotionally disturbed.[191]

Family support or opposition can greatly influence the decision for or against assisted suicide. "Hospice nurses reported that family opposition was the most important predictor of requesting patients failing to receive a lethal prescription."[192] However at least one study concluded that:

> pursuit of aid in dying does not have negative effects on surviving family members and may be associated with greater preparation and acceptance of death.
> . . .
> [Moreover,] [c]ompared with other family members of decedent Oregonians who did or did not request aid in dying, there appeared to be little impact on mental health outcomes, including prolonged grief symptoms and diagnosis, depressive symptoms or diagnosis, or mental health care use. However, as compared with control families, families in which aid in dying was requested felt, on average, more prepared for the death, felt more accepting of the loved one's death,

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190. *Id.* at 181.

191. John R. Jordan & John L. McIntosh, *The Impact of Suicide on Adults*, GRIEF AFTER SUICIDE: UNDERSTANDING THE CONSEQUENCES AND CARING FOR THE SURVIVORS, *supra* note 187, at 44.

192. Linda Ganzini et al., *Mental Health Outcomes of Family Members of Oregonians Who Request Physician Aid in Dying*, 38 J. OF PAIN & SYMPTOM MGMT. 807, 808 (2009).

and were less likely to endorse that they wanted more opportunities to care for the loved one.[193]

Of course, the fact that assisted suicide is a premeditated act sometimes may allow those who are close to and informed by the life-taker the time to get "more prepared for the death" and to become "more accepting" of it.[194]

A. The Positive Message and Meaning Attributed to Legalizing Assisted Suicide: Why and How Families and Communities Legalize and Practice Assisted Suicide

Opposition to assisted suicide may rest in part on a theory of rights that emphasizes the relational context necessary for the notion of rights. Most "rights" exist in a social context, and are, by their very nature, relational—defining the scope, extent, boundaries, and limits of our legitimate actions and interactions.[195]

Because relationships are critical to our understanding of rights it seems curious to describe some actions which destroy all relationships as "rights."[196] Thus, taking one's own (or another's) life—by suicide, assisted suicide, murder, or enslavement—are beyond the scope of legitimate "rights." Viewed in isolation, a person may have a "claim" to control their body as they choose,[197] including to commit suicide. In philosophy, "[t]he principal moral issue surrounding suicide has been -- 1. Are there conditions under which suicide is morally justified, and if so, which conditions?"[198] It is clear that "[i]n any event, the interrelationships among suicide's moral permissibility, its rationality, and the duties of others and of society as a whole is complex . . . ."[199]

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193. *Id.* at 807, 813. This article noted that: "Comparing family members of those who requested aid in dying to those who did not revealed no differences in primary mental health outcomes of depression, grief, or mental health services use. Family members of Oregonians who requested aid in dying felt more prepared and accepting of the death than comparison family members." *Id*. at 807.

194. *Id.* at 813.

195. *See, e.g.*, *Summary of Constitutional Rights, Powers and Duties,* CONST. SOC'Y, http://www.constitution.org/powright.htm (last visited Oct. 27, 2016). For a different concept of relational rights, *see* Hallie Ludsin, *Relational Rights Masquerading as Individual Rights,* 15 DUKE J. GENDER L. & POL'Y 195, 197 (2008).

196. Leif Wener, *Rights*, STAN. ENCYCLOPEDIA OF PHIL., (Sept. 9, 2015), http://plato.stanford.edu/entries/rights/.

197. *Id.* "Bodily and property rights are paradigmatic rights with claim-rights at their core." *Id*.

198. Cholbi*, supra* note 21.

199. *Id.*

Perhaps, the most popular justifications for suicide in contemporary society are libertarian.

> For libertarians, suicide is morally permissible because individuals enjoy a *right* to suicide.
>
> . . .
>
> Libertarianism typically asserts that the right to suicide is a *right of noninterference*, to wit, that others are morally barred from interfering with suicidal behavior. Some assert the stronger claim that the right to suicide is a *liberty right*, such that individuals have no duty to forego suicide (i.e., that suicide violates no moral duties), or a *claim right*, according to which other individuals may be morally obliged not only not to interfere with a person's suicidal behavior but to assist in that behavior . . . . Our having a claim right to suicide implies that we also have rights of noninterference and of liberty and is a central worry about physician-assisted suicide . . . . [W]hether we have a liberty right to suicide concerns whether it violates other moral obligations, including obligations to other people.
>
> . . .
>
> A popular basis supporting a right to suicide is the idea that we own our bodies and hence are morally permitted to dispose of them as we wish.
>
> . . .
>
> Another rationale for a right of noninterference is the claim that we have a general right to decide those matters that are most intimately connected to our well-being, including the duration of our lives and the circumstances of our deaths. On this view, the right to suicide follows from a deeper right to self-determination, a right to shape the circumstances of our lives so long as we do not harm or imperil others . . . .[200]

One of the prominent messages of legalizing assisted suicide is that persons living with disabilities have inferior worth as human beings. The disabled and their families and advocates know (and all mature adults should know) that there is no shame in needing help. There is no loss of dignity in admitting the need for, and in accepting, assistance to live. Many persons who

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200. *Id.* However, it does not seem to follow from having a right to life that a person has a right to death, i.e., a right to take her own life. Because others are morally prohibited from killing me, it does not follow that anyone else, including myself, is permitted to kill me. This conclusion is made stronger if the right to life is inalienable, since in order for me to kill myself, I must first renounce my inalienable right to life, which I cannot do . . . .

would be considered candidates for assisted suicide because of their illnesses or disabilities, and who might be pressured into ending their lives, have full, abundant, contributing lives. They are of value to their families, friends, and communities. Yet legalizing assisted suicide demeans and degrades the value of the lives of the disabled. The availability of assisted suicide provides not just another option but may create some pressure to choose it. It may be perceived to suggest that society views the life of the vulnerable person to be an undue burden. Thus, the disability community recognizes that legalizing assisted suicide may help a few but will harm many; it will increase and exacerbate prejudice against the disabled and damage their families and impoverish society.[201]

The "lack of family support" is one factor that "contribute[s] to the wish for death."[202] Doctors Hendin and Foley describe one case in which they suggest that "[t]he eagerness of her daughter and son-in-law [were] likely to have influenced" an older woman's decision to take suicide pills.[203] Even "in the best of circumstances[,] frail, elderly patients can feel coerced to die."[204]

Assisted suicide is especially popular among white elites.

> The Oregon Department of Human Services compared those who died by PAD to all other Oregon decedents through 2005; those who die by PAD are less likely to be very old, less likely to be married, and more likely to have cancer. In addition PAD deaths occur in persons with much higher levels of education — PAD decedents are 8 times more likely to have completed college education.[205]

"Persons in Oregon who choose aid in dying are almost seven times more likely to be college educated than other decedents . . . ."[206] So, legalized assisted suicide is heavily laden with cultural baggage that appears to be elitist—favoring the lifestyle preferences of the advantaged and creating risks and new dangers for the disadvantaged.

The impact of assisted suicide upon family members is not entirely negative. Some studies have shown that "[t]he bereaved family and friends of cancer patients who died by euthanasia coped better with respect to grief

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201. *Why Assisted Suicide Must Not Be Legalized*, *supra* note 154.

202. Hendin & Foley, *Physician-Assisted Suicide in Oregon*, *supra* note 135, at 1622.

203. *Id.* at 1627.

204. *Id.*

205. Linda Ganzini, *Legalised Physician-Assisted Death in Oregon*, 16 QUT L. REV. 76, 78 (2016) (footnote omitted).

206. Ganzini, et al., *supra* note 192, at 814.

symptoms and post-traumatic stress reactions than the bereaved of comparable cancer patients who died a natural death."[207]

B. The Negative Message and Meaning of Legalizing Assisted Suicide: Why and How Families and Communities Reject, Restrict, and Discourage Assisted Suicide

One set of significant problems with legalizing assisted suicide is definitional. For example, do the lawmakers mean to allow the practice of letting "a *physician* provide[] or administer[] medication that intentionally brings about the patient's death, at the request of the patient,"[208] as the Supreme Court of Canada put it? Or do they mean to permit "*medical* assistance in dying" which broadens the class of persons eligible to provide suicide assistance to include other medical professionals such as nurses, and/or perhaps medical technicians?[209]

Concerns about abuses, if assisted suicide is legalized, are significant. The case of Tom Mortier's mother's death is one example cited by Paul Kelly, an Australian commentator.

> Kelly quotes Mortier when responding to Distelmans' claim that giving a lethal injection is an act of "unconditional love":
>
> I loved my Mother for more than 30 years and I wanted her to live; Dr Distelmans loved her so much - 'unconditionally' - that after a few brief consultations over six months he gave her a lethal injection.[210]

Kelly also doubts the ability (or will) of governments to enforce boundaries and restrictions on assisted suicide. He noted that "[a] 2012 report by the European Institute of Bioethics said: 'Initially legalised under very strict conditions, euthanasia has gradually become a very normal and even ordinary

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207. Nikkie B. Swarte et al., *Effects of Euthanasia on the Bereaved Family and Friends: A Cross Sectional Study*, 327 BRIT. MED. J. 1, 1 (2003), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC166123/pdf/el-ppr189.pdf.

208. Carter v. Canada (Attorney General), [2015] 1 S.C.R. at para. 40.

209. *See generally* Konstantin Tretyakov & Glenn Cohen, *Medical Assistance in Dying and "Suicide Tourism" to Canada: Bill C-14 from a Comparative Perspective,* J. OF ETHICS IN MENTAL HEALTH (July 31, 2016).

210. Paul Russell, *Leading Australian journalist decries push for euthanasia,* MERCATORNET (Oct. 3 2015), http://www.mercatornet.com/careful/view/leading-australian-journalist-decries-push-for-euthanasia/18766 (emphasis omitted).

act to which patients are deemed to have a right."[211] Mr. Kelly further noted: "It is surely extraordinary that people skeptical of the ability of governments to get trains running on time fool themselves into thinking they can confidently manage a regime that sanctions the termination of human life."[212] This critic also expressed concerns about the harmful collateral effects of legalizing euthanasia.

> If we proceed then life will change, there will be a "slippery slope," your relationship with your doctor will be different, the vulnerable will have a reason to feel uneasy, the push to make euthanasia a right will be inevitable, the frail will feel obliged to volunteer and our values as a community will shift more quickly than you appreciate.[213]

Professor Leon Kass has argued that the legalization of assisted suicide will have a "destructive impact . . . on the intrinsic trust that must underlie the relationships between doctor and patient."[214] Likewise, Dr. Edmund Pellegrino asserts that "compassion can be misdirected" leading a physician (especially one who is unable to relieve a patient's suffering) to "inappropriately agree to end the patient's life."[215]

The loss of patients' trust in doctors is one of the grave risks of legalizing assisted suicide.[216] A visual example of this came recently in the article written by an elderly Canadian woman who explained: "For years, I warned my children to steer clear of tattoo parlors, and now at 81 years old, I have had to resort to one myself."[217] She had the message "Don't euthanize me" tattooed on her upper left arm.[218] As one palliative care physician has written: "[p]hysician-assisted suicide and euthanasia go against the very core of the palliative care approach and have no place within palliative care."[219]

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211. *Id.*

212. *Id.*

213. *Id.*

214. Foley & Hendin, *supra* note 1, at 8.

215. *Id.* at 9.

216. *Id.* at 28.

217. Christine Nagel, *Elderly Canadians Fear Euthanasia,* MERCATORNET (Sept. 16, 2016), http://www.mercatornet.com/careful/view/18670.

218. *Id.*

219. Herx, *supra* note 12, at 83.

In fact, it is revealing and noteworthy that "[s]ome of the most powerfully moving opposition to assisted suicide has come from patients with disabilities. They are acutely aware of the dangers of misguided compassion."[220]

Assisted suicide obviously implicates some very profound and fundamental values, including, but clearly not limited to, religious beliefs. The International Task Force on Euthanasia and Assisted Suicide reports:

> Right-to-die leaders have attempted for a long time to make it seem that anyone against euthanasia or assisted suicide is trying to impose his or her religion on others. But that's not the case.
>
> People on both sides of the euthanasia and assisted suicide controversies claim membership in religious denominations. There are also individuals on both sides who claim no religious affiliation at all. But it's even more important to realize that these are not religious issues, nor should this be a religious debate.
>
> The debate over euthanasia and assisted suicide is about public policy and the law . . . .
>
> In Washington state, where an attempt to legalize euthanasia and assisted suicide by voter initiative in 1991 failed, polls taken within days of the vote indicated that fewer than ten percent of those who opposed the measure had done so for religious reasons.[221]

One risk of assisted suicide was expressed by a veteran with terminal brain cancer who spoke in opposition to the assisted suicide bill being proposed in the District of Columbia. He noted: "If I'd had those drugs, I would have had them right [there on] my nightstand, there would have been no doctor checking in on me, there would have been no proper control . . . . I needed counseling . . . not assisted suicide pills."[222] Thus, legalizing assisted suicide is a poor substitute for adequate medical and mental health provision. We need to signal our commitment to care, not our abandonment. Inclusion, compassion, and adequate care are better alternatives than assisted suicide.

Another problem with assisted suicide is the inability to accommodate one of the most prominent human qualities—the penchant of human beings to change their mind. In 2015, a Belgian woman known as Emily fought for two years to obtain the right to die, won approval from Belgian authorities, made

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220. Foley & Hendin, *supra* note 1, at 13*; see also* NOT DEAD YET*, supra* note 149.

221. ProCon.org*, supra* note 156 (quoting Rita L. Marker, *Frequently Asked Questions: Euthanasia and Assisted Suicide,* PATIENTS RIGHTS COUNCIL, (Oct. 27, 2006), http://www.patientsrightscouncil.org/sit/frequently-asked-questions/).

222. Harkness, *supra* note 129 (video).

a popular video "in which she confessed: 'I've had enough of all this, nothing gets to me anymore, I don't want to live a lie.'"[223] But then, at the last minute she changed her mind.[224]

I recall a case that I followed as a young law professor beginning to learn and teach Biomedical Ethics in law school. A distressed, paralyzed woman in California named Elizabeth Bouvia was engaged in a highly publicized battle to disconnect the hospital feeding tube that kept her from dying. She finally won the legal battle in 1986, then changed her mind and declined to terminate the feeding tube. The battle to win the right to decide for herself had rekindled her sense of purpose and her desire to live.[225] The *L.A. Times* reported that she was still alive more than twenty years later.[226]

Further, legalizing assisted suicide may contribute to our society becoming more obsessed with personal convenience and comfort. "As one Dutch ethics professor has said, '[t]he risk now is that people no longer search for a way to endure their suffering.'"[227]

V. THE NEGLECTED ALTERNATIVES OF PALLIATIVE CARE AND LIVING ASSISTANCE

If adequate palliative care and living assistance were provided, there would be little or no need or rational demand for assisted suicide. As a BBC report noted: "Palliative care is physical, emotional and spiritual care for a dying person when cure is not possible. It includes compassion and support for family and friends. Competent palliative care may well be enough to prevent a person feeling any need to contemplate euthanasia."[228] Official reports in the assisted suicide "poster-child" state of Oregon have shown the legalization of assisted suicide has led to a reduction in palliative care to the

223. Steve Myall, *Woman aged 24 granted right to die posts farewell message on YouTube – but changes mind at last minute,* MIRROR (UK) (Nov. 13, 2015, 2:13 PM), http://www.mirror.co.uk/news/real-life-stories/woman-aged-24-granted-right-6819594.

224. *Id.*

225. Harold Bursztajn, et al., *Depression, Self-love, Time, and the "Right" to Suicide*, 8 GEN. HOSPITAL PSYCHIATRY 91, 91–93 (1986).

226. Elaine Woo, *USC professor advocated civil rights, access for disabled*, LOS ANGELES TIMES (May 10, 2008), http:articles.latimes.com/print/2008/may010/local/me-hahn10.

227. Lerner & Caplan, *supra* note 89, at 1641.

228. *Would Legalizing Euthanasia or Physician-Assisted Suicide Undermine the Quality of Palliative Care that Patients Receive?,* ProCon.Org (Mar. 11, 2009, 9:27 AM), http://euthanasia.procon.org/view.answers.php?questionID=000182#answer-id-001209.

point that the state Board of Medical Examiners officially reported that the "palliative care was a problem in the state."[229]

Professor Margaret Somerville points out that truly informed consent to assisted suicide requires that:

> all reasonable alternatives to the proposed "treatment" [assisted suicide] are offered. This means that fully adequate palliative care must be available . . . . We know, however, that only 16 to 30 percent of Canadians who need palliative care have access to it, which is appalling. We also know that many patients who ask for euthanasia change their minds when given good palliative care.[230]

Underlying the assisted suicide controversy is a troubling flaw in our health care and social security systems. Thus, Bob Kafka of ADAPT, a national organization for protecting the human rights of people with disabilities,[231] has written:

> Seniors and people with disabilities who need assistance to do everyday tasks like dressing and bathing want the choice to get those services at home and to have control over how the services are delivered. They do not want to be forced into a nursing facility, nor see themselves and their spouse, and sometimes their children, forced to live in poverty to qualify for help with such basics. Unfortunately, that choice is not a reality for most. In states which have legalized assisted suicide, according to data from Oregon, over a third of those who request assistance to die do so because of "feelings of being a burden" and over 90% cite "loss of autonomy" as a factor. If the only alternative to death that those in power offer people who require assistance is poverty and segregation in nursing facilities, then it makes no sense to talk about assisted suicide as a "choice."[232]

Marilyn Golden, Senior Policy Analyst at the Disability Rights Education & Defense Fund agrees. She writes:

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229. *See* Hendin & Foley, *Physician-Assisted Suicide in Oregon*, *supra* note 135, at 1621 (footnote omitted).

230. *Evolution or Revolution, supra* note 3, at 758.

231. NOT DEAD YET, *supra* note 149; *see also* ADAPT: FREE OUR PEOPLE, http://www.adapt.org (last visited Oct. 11, 2016).

232. NOT DEAD YET, *supra* note 149.

> Contrary to the claims of its supporters, it [assisted suicide] would radically decrease, not increase, individual self-determination, due to the significant risk of abuse. It poses substantial danger to people with disabilities and many other people in vulnerable circumstances. For example, people with psychiatric disabilities and depression are given lethal drugs in Oregon, despite the claims of proponents that these conditions disqualify a person. Elder abuse is a growing but still largely unreported reality that threatens to pressure seniors toward an early death. Moreover, the supposed safeguards in the Oregon and Washington State laws don't really protect patients. If one's doctor refuses lethal drugs, the patient or family can—and do—simply shop for another doctor. And nothing in the law can protect patients when family pressures, financial or emotional, distort patient choice.[233]

Suicide by a family member raises the risks of suicide for other families. For example, many studies have confirmed that "suicide may have a 'ripple effect,' touching the lives of many people with whom the surviving family may not even be very familiar . . . ."[234] Following the suicide of a family member, "survivors often experience more guilt, shame, rejection, resentment, isolation, issues with social stigma, and anger . . . ."[235] Children, in particular, are vulnerable to feeling rejected. "Surviving offspring may feel a profound sense of abandonment while surviving parents may question their own parenting and become overprotective of surviving children . . . ."[236] While there is need for more research, among the psycho-social "outcomes in family members after a suicide, long-term difficulties with social functioning at school, work, among friends and within marriage have been reported."[237] Specifically, "[d]elinquency and aggressive behavior have been noted among child and adolescent survivors of parental suicide."[238] While families of suicide survivors apparently "do not have greater psychiatric morbidity than survivors of other types of unexpected or violent death (AFSP, 2007) but [they] do experience more psychiatric morbidity than nonbereaved community

233. *Id.*

234. Holly C. Wilcox, et al., *The Impact of Suicide on Surviving Family Members*, in SUICIDE FROM A GLOBAL PERSPECTIVE: PUBLIC HEALTH APPROACHES 145 (citation omitted).

235. *Id.* (citation omitted).

236. *Id.* (citation omitted).

237. *Id.* at 146 (citation omitted).

238. *Id.* (citation omitted).

controls."[239] Overall, there is a greater risk of suicide for family members of persons who commit suicide.

> Family studies have consistently reported a four to six-fold increased risk for suicide among relatives of suicide decedents compared to the relatives of controls . . . . This increased familial risk for suicide is also independent of family history of psychiatric disorder or mental illness (which also increases the risk of suicide) . . . . A family history of suicide has been associated with suicidal behavior at all stages of the life cycle . . . , although Roy [1983 study] showed that the risk for suicide attempt among offspring is higher if a parent died from suicide during childhood as compared to adulthood.[240]

Mourning after a death from suicide is different from and more difficult than grief and mourning other types of death.[241] Additionally, the spouse of a suicide victim is at greater risk of dying. "Suicide has been associated with a greater risk of death in the spouse, especially by suicide (20-fold greater risk) which was not attributable to selective mating . . . ."[242] Surviving family members "often struggle to make sense of the motives and frame of mind of the deceased. [Also], survivors show higher levels of feelings of guilt, blame, and responsibility for the death than other mourners . . . ."[243] "[T]here is considerable evidence that survivors feel more isolated and stigmatized than other mourners and may in fact be viewed more negatively by others in their social network."[244] Moreover, surviving family members are prone to self-stigmatization, assuming that "others are judging them negatively and therefore withdraw or otherwise act in ways that inhibit social support efforts from others."[245]

Suicide may have harmful impact upon family in many other diverse ways, including:

- An increase in "disturbed family interactional styles and increased disruptions of attachments when compared with families without a

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239. *Id.* at 147.

240. *Id.* at 148 (citations omitted).

241. John R. Jordan, *Is Suicide Bereavement Different? A Reassessment of the Literature*, 31 SUICIDE & LIFE-THREATENING BEHAVIOR 91, 93 (2001).

242. WILCOX ET AL.,*supra* note 234, at 148 (citation omitted).

243. Jordan, *supra* note 241, at 92.

244. *Id.* at 93.

245. *Id.*

suicidal member" particularly with "suicidal adolescents or children.[246]

- "[A] dysfunctional family environment can operate as both a predisposing element in the early psychosocial development of suicidal persons and as a precipitating factor in a suicide death."[247]
- Higher rates of depression in surviving siblings and mothers at six-months after the suicide; continued elevated depression for mothers at one-year after the incident; and elevated level of depression in siblings (especially younger ones) at 12-37 months post suicide.[248]
- "In an uncontrolled qualitative study . . . [they] found that twice as many survivors in their small sample reported that relationships with family members (and friends) became more distant after the suicide than reported an increase in closeness."[249]
- Surviving children commonly hide information about the suicide and distort what happened.
- Researchers "have also identified several aspects of family interactions that may be affected by the death of a member, including the shut- down of open communication, disruption of role functioning of family members, development of conflict around differences in bereavement coping styles, destabilization of family coalitions and intergenerational boundaries, and disruption of relationships between the family and its larger social network."[250]
- "Suicide bereavement is an unusual form of mourning experience, because losing a loved one to suicide may elevate the mourner's own risk for suicidal behavior and completion."[251]
- A likely reason for increased suicide for survivors is because of the "interpersonal loss and disruption of attachments . . . ."[252]
- Children who lose their parents at a young age to suicide have an increase in suicidal behavior.[253]

246. *Id.* at 94 (citation omitted).
247. *Id.*
248. *Id.* at 94–95.
249. *Id.* at 95 (citation omitted).
250. *Id.* (citation omitted).
251. *Id.* (citation omitted).
252. *Id.*
253. *Id.*

- "Loss has also been linked to increased vulnerability to the psychiatric disorders that may be highly associated with suicidality, such as major depression and anxiety disorder in adults."[254]
- Familial factors which influence depression (drug abuse, genetics, psychiatric disorders, disorganization, break up, intrafamilial violence, sexual abuse, family environment) may increase the risk of suicide for survivors.[255]
- "[E]xposure to suicide, [especially] for young people, may increase the chances of suicidality" for that individual.[256]

Compared to families in which there was a non-suicide automobile death, families in which there was a suicide experienced significantly higher levels depression, anxiety disorders, and divorce in two years after the suicide of a child as compared to the two years before.[257] Likewise, "children who experience parental suicide are at [an] increased risk of committing suicide themselves."[258] The age of the child when the parents committed suicide influence the risk of suicide. Children who are zero to twelve when they lost a parent are at a greater risk for attempted suicide than if a child lost a parent when they were thirteen to twenty-four years old. "The greatest risk [of] suicide . . . is within 1 to 2 years after a parent's suicide, with the risk declining over time."[259]

Thus, it is no surprise that a palliative care nurse has reported "that nearly all of her patients were more concerned with the relationships they had built with others and being truly happy than they were with money, fame or success . . . . 'It all comes down to love and relationships in the end.'"[260] She reported that "[e]very male patient . . . felt they had spent less quality time with their families - missing their children growing up, and not spending enough time with their partners."[261]

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254. *Id.* (citation omitted).

255. *Id.* at 96.

256. *Id*.

257. Megan Brooks, *Suicide Takes a Heavy Toll on Family Members' Mental Health*, MEDSCAPE MEDICAL NEWS (Dec. 11, 2012), http://www.medscape.com/viewarticle/776044.

258. *Id.*

259. *Id.*

260. Elsa Vulliamy, *The Most Common Regrets of the Dying, According to a Palliative Care Nurse*, INDEPENDENT (UK) (Feb. 3, 2016), http://www.independent.co.uk/life-style/palliative-nurse-shares-the-most-common-regrets-of-her-patients-a6821061.html.

261. *Id.*

VI. RECOMMENDATIONS FOR LEGAL REFORMS REGARDING ASSISTED SUICIDE

Many policy and programmatic reforms are needed to protect the vulnerable aged, sick, and dying from neglect and exploitation. Legalizing assisted suicide, however, would increase those risks, not reduce them.

All of society and the quality of our medical system will suffer in and to the extent that assisted suicide is legalized. As one doctor wrote in the JAMA:

> In sum, physician-assisted suicide is never justifiable. It is never justifiable because it always violates the injunction not to kill. It is never justifiable because it unjustly patronizes the desires of the few who request physician-assisted suicide over the needs of the much larger number who have already endured, or expect to endure, the debility and dependence that advocates for physician-assisted suicide desire to avoid. Physician-assisted suicide contradicts the physician's professional role and undermines the distinctive solidarity with those whose health is diminished that makes the practice of medicine possible.[262]

The loss of confidence in the medical profession attendant to legalizing physician-assisted suicide harms all members of society. For example, in the Netherlands, many persons have added provisions to their wills stating that they do not consent to non-voluntary euthanasia.[263] In the United States, it is not surprising that minorities are especially concerned about their vulnerability if assisted suicide is legalized.[264] So, laws protecting the vulnerable from pressures to end their lives are needed.

One practical and achievable objection would be to protect vulnerable patients from aggressive, pro-euthanasia health care providers. Lawmakers should enact laws "to make certain that a patient's right to receive care and compassion is not replaced by a doctor's right to prescribe poison or administer a lethal injection."[265]

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262. Yang & Curlin, *supra* note 112, at 248.

263. Neil M. Gorsuch, THE FUTURE OF ASSISTED SUICIDE AND EUTHANASIA 125-26 (Robert P. George ed., 2006).

264. *Id.* at 126. However, as Emanuel points out, "The demographic profile of patients in the United States who have received [physician-assisted suicide] is white, well-educated, and well-insured." Emanuel, *supra* note 40, at 87.

265. *International Task Force on Euthanasia and Assisted Suicide,* PROCON.ORG (June 4, 2008), http://euthanasia.procon.org/view.source.php?sourceID=000658.

Additionally, the financial dimension of assisted suicide poses additional risks. Is it not likely that it "create[s] disincentives to the development and dissemination of other, more expensive end-of-life options?"[266] Suicide, of course, is cheaper than paying for medicine for dying patients.

In part, the debate over assisted suicide turns on information. For example, Doctors Foley and Hendin cited studies showing that "the less physicians know about palliative care, the more they favor legalization [of assisted suicide]; the more they know, the less they favor legalization."[267] So, legislation insuring adequate disclosure of all relevant information about alternatives to assisted suicide is essential.

September is "Suicide Prevention Awareness Month."[268] The National Alliance on Mental Illness ("NAMI"), noted that:

> Suicidal thoughts can affect anyone regardless of age, gender or background. Suicide is the third leading cause . . . of death among young people and is often the result of mental health conditions that effect people when they are most vulnerable . . . . In many cases the individuals, friends and families affected by suicide are left in dark, feeling shame or stigma that prevents talking openly about issues dealing with suicide.[269]

As an attorney in America's capital city wrote: "[T]he lives of *all* persons are worth protecting, including the lives of those suffering from debilitating and terminal illnesses who, rather than lethal drugs, need effective pain management, psychological counseling and community support. Life, in any stage, is too great a gift to be thrown away."[270]

The issue of assisted suicide is a timely one as the large baby-boom (post-World War II) generation is reaching the "golden" years. "Assisted suicide is an issue about which the public needs to be informed, one whose importance will only increase with the increasing percentage of elderly people in the population."[271]

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266. Gorsuch, *supra* note 263, at 128.

267. Foley & Hendin, *supra* note 1, at 3.

268. *Suicide Prevention Awareness Month*, NAT'L ALLIANCE ON MENTAL ILLNESS, https://www.nami.org/suicideawarenessmonth/hp (last visited Oct. 3, 2016).

269. *Id.*

270. Smith, *supra* note 126 (emphasis added).

271. Foley & Hendin, *supra* note 1, at 1.

VII. CONCLUSION: TOWARDS FAMILIES AND COMMUNITIES THAT RESPECT AND PROTECT THE EQUAL WORTH OF ALL HUMAN LIVES

Forty years ago Colorado Governor Richard Lamm infamously opined that the elderly, especially the incurably ill, have a "duty to die and get out of the way."[272] He cited economic considerations to justify his comment. "The Governor said . . . that the costs of treatment that allows some terminally ill people to live longer was ruining the nation's economic health."[273] The legalization of assisted suicide is the leading edge of growing social and governmental acceptance of Governor Lamm's controversial proposal. (Interestingly, Colorado is not one of the six American states that has legalized assisted suicide).

"'There is little hope for democracy if the hearts of men and women in democratic societies cannot be touched by a call to something greater than themselves.'"[274] There is a moral order in society reflecting the dominant public morality that undergirds our culture. There also is a moral content to the law. Both change over time and according to circumstances. "When there is a gap between the moral order of society and the law, some movement to close the gap is likely."[275] The questions about assisted suicide suggest either an effort to close an emerging gap between the law and moral order, or an effort to move the law in order to create such a gap and to push or pull moral order in the direction of supporting assisted suicide.

Our lives, our family, our friends, our neighbors, our communities, and our country deserve higher and better ideals than assisted suicide offers. Prohibiting assisted suicide will not prevent all assisted suicides, but it conveys a message of valuing life that is worthy of our best nature and of the greatest nations. Legalizing assisted suicide may (but might not) cause a substantial increase in the number of suicides, but that is not the most important effect. Rather, more fundamentally, it will do tremendous damage to the principles upon which our nations (and Western civilization) were

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272. *Gov. Lamm Asserts Elderly, If Very Ill, Have 'Duty to Die',* N.Y. TIMES (Mar. 29, 1984), http://www.nytimes.com/1984/03/29/us/gov-lamm-asserts-elderly-if-very-ill-have-duty-to-die.html. ("Elderly people who are terminally ill have a 'duty to die and get out of the way' instead of trying to prolong their lives by artificial means, Gov. Richard D. Lamm of Colorado said Tuesday.").

273. *Id.*

274. M. Russell Ballard, *Address at the BYU Annual University Conference: A Light on a Hill* (Aug. 27, 1996) (quoting Margaret Thatcher).

275. Lynn D. Wardle, *The Gap Between Law and Moral Order: An Examination of the Legitimacy of the Supreme Court Abortion Decisions,* 1980 B.Y.U. L. REV. 811, 813 (1980) (footnote omitted).

founded. Most tragically, legalizing assisted suicide will convey a message of public disinterest and of lack of care and support to those who are most vulnerable. In that sense, in its abandonment of those who are most in need of society's caring support and encouragement to live, *to legalize assisted suicide is to commit assisted suicide*. So, legalizing assisted suicide makes all of us, our societies, and our legal systems, guilty of abandoning the most vulnerable among us by authorizing their deaths. Great nations deserve greater ideals than those embodied in the legalization of assisted suicide, and, ultimately, nations that legalize assisted suicide cannot remain great for very long.

The title of this paper echoes the title of James Agee's great, semi-autobiographical novel, which explores the traumatic impact which the automobile accident death of a young husband-father had upon his young family, especially on his six-year old son, Rufus.[276] The moving portrayal of family life, loss, and grief in *A Death in the Family* earned Agee the Pulitzer Prize for Fiction in 1958, three years after the author died.[277] One clear message of the poignant novel is that despite the loss and sorrow, "[s]omehow, for some reason, life must and should go on."[278] Legalizing assisted suicide repudiates that message and, instead, conveys a message that the patient is an unwelcome burden, whom family and society want to neglect and abandon.

Hope, endurance, persistence, and perseverance are among the most beautiful and essential qualities of the human spirit. Legalizing assisted suicide mocks those profound qualities and mocks the meaning of life. Ultimately, that is why legalizing assisted suicide is a very bad, very dangerous idea. It embodies the ethics and messages of abandonment, desertion, despair, defeat, and giving up.

There is much more to human value, human character, and human dignity than merely doing whatever one wants to do. Indeed, doing things one does *not* want to do but which need to be done is the first test of morality. Moral men and women accept unwanted duties for the sake of benefiting others, for the good of our families, communities, and nations. Commitment to any worthy cause usually requires the sacrifice of selfish desires upon the altar of service to others and to the causes that benefit others, even generations unborn and unseen. Perhaps, part of that commitment should continue to include social and legal rejection of assisted suicide.

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276. *See* John H. Fincher, *James Agee's 'A Death in the Family' Tells a Story of Love and Loneliness,* THE HARVARD CRIMSON (Dec. 5, 1957), http://www.thecrimson.com/article/1957/12/5/james-agees-a-death-in-the/.

277. *James Agee*, WIKIPEDIA, https://en.wikipedia.org/wiki/James_Agee (last visited April 5, 2017).

278. Fincher, *supra* note 276.