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Euthanasia: Is It Murder or Mercy Killing? A Comparison of the Criminal Laws in the United States, the Netherlands and Switzerland

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I. INTRODUCTION

With the advent of modern medical technology and progressive medical treatments, such as "miracle drugs," life support systems, artificial organs and organ transplants, the human race now has the novel ability to prolong life and to postpone death.[1] However, prolonged suffering is often a negative consequence of this improved ability to prolong life,[2] as evidenced by the many Americans who are held hostage by the excruciating and intolerable pain that accompanies death from degenerative and incurable diseases.[3] This severe pain has caused many people to plead with their doctors, families and loved ones to release them from their suffering in any manner possible, including death.[4] Because of the frequency of patients' requests for an end to their suffering, and because many such requests have been granted by doctors, friends and loved ones, the courts are now struggling with the difficult issue of whether or not a person has the right to die, with assistance if necessary.

The purpose of this Comment is to examine the current status of the right to die in the United States, focusing particularly on active

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1. Hitts, *Life Expectancy Rises 3 Years to 74 for Men, 86 for Women*, Wash. Post, May 31, 1983, at A2, col. 1, *cited in* O'Brien, *Facilitating Euthanatic, Rational Suicide: Help Me Go Gentle into That Good Night*, 31 ST. LOUIS U.L.J. 655, 655 (1987).

2. *In re* Farrell, 108 N.J. 335, 340, 529 A.2d 404, 406 (1987). The court stated:

> While medical advances have made it possible to forestall and cure certain illnesses previously considered fatal, they also have prolonged the slow deterioration and death of some patients. Sophisticated life-sustaining medical technology has made it possible to hold some people on the threshold of death for an indeterminate period of time.

Id.

3. *See* D. HUMPHREY & A. WICKETT, THE RIGHT TO DIE (1986). The authors state that "[i]nfectious diseases, once life-threatening, have become reversible, while degenerative and chronic diseases have become the predominant cause of death." *Id.* at 189.

4. *Merciless Jury; Pressures for Commutation*, TIME, May 27, 1985, at 66. This article concerned a recent case in Florida where a 75-year-old man, Roswell Gilbert, was convicted of first-degree murder for shooting his wife. Gilbert asserted that his wife had repeatedly asked him to kill her to relieve her suffering. *Id.*

voluntary euthanasia. This Comment will compare the legality of euthanasia in the United States, the Netherlands and Switzerland by examining the criminal laws of each of these countries. Next, the future of United States law will be analyzed to determine the likelihood of legalized euthanasia in the United States. Finally, some suggestions for legal reform will be proffered.

II. DEFINITIONS AND DISTINCTIONS

Before analyzing the current status of the law, it is first necessary to explain the meaning and implications of euthanasia and clarify some important distinctions that arise when the right to die is considered. The word "euthanasia" is derived from the Greek words *eu*, which means good, and *thantos*, which means death.[5] However, from this etymology, the term has acquired a broader, more complex meaning. Today, "euthanasia" encompasses any action that helps one achieve a painless death.[6]

The *Medical Dictionary for Lawyers* defines euthanasia as "[a]n act or practice, which is advocated by many, of putting persons to death painlessly who are suffering from incurable and malignant diseases, as an act of mercy."[7] While most commentators suggest that euthanasia is motivated by kindness and a desire to end the intense suffering of another,[8] not all individuals view euthanasia in such a positive manner. For example, some commentators think euthanasia is a euphemism for murder,[9] while others object to euthanasia because it is contrary to the Hippocratic Oath,[10] or because it violates

5. M. HEIFETZ, THE RIGHT TO DIE 99 (1975).

6. D. Humphrey, *The Case for Rational Suicide*, 17 SUICIDE AND LIFE-THREATENING BEHAVIOR 355 (1987).

7. MEDICAL DICTIONARY FOR LAWYERS 287 (3d ed. 1960).

8. *See, e.g.*, Kohl, *Voluntary Beneficent Euthanasia*, in BENEFICENT EUTHANASIA 130-40 (M. Kohl ed. 1975). Kohl argues that the dominant motive of a person performing euthanasia is a desire to help the intended recipient. He defines euthanasia as "the inducement of a relatively painless and quick death, the intention and actual consequences of which are the *kindest possible treatment* of an unfortunate individual in the actual circumstances." *Id.* at 134.

9. D. HORAN, EUTHANASIA AND BRAIN DEATH: ETHICAL AND LEGAL CONSIDERATIONS 11 (1977). The author quotes Percy Foreman who states that "euthanasia is a highfalutin word for murder." *Id.*

10. The Hippocratic Oath, taken by all doctors, provides in pertinent part: "I will give no deadly medicine to anyone if asked, nor suggest any such counsel." *Reprinted in* Levisohn, *Voluntary Mercy Deaths: Socio-Legal Aspects of Euthanasia*, 8 J. FORENSIC MED. 57, 60 (1961).

their religious and moral beliefs.[11]

There are differences between the terms involuntary and voluntary euthanasia and active and passive euthanasia. The courts have taken these distinctions into account when assessing the criminal liability of the actor engaging in euthanasia. The rationale for recognizing these distinctions becomes evident upon an examination of the definitions of these terms. Involuntary euthanasia occurs when an individual, other than the patient, decides to discontinue treatment or to terminate an incompetent or a competent unconsenting person's life.[12] In contrast, voluntary euthanasia occurs when the patient himself decides to terminate treatment or to end his life.[13] Thus, involuntary euthanasia and voluntary euthanasia differ in that the former occurs without the patient's consent, while the latter occurs with the patient's consent.

It is the nature of the third party's actions that distinguishes active euthanasia from passive euthanasia.[14] With active euthanasia, a physician administers treatment which induces a painless death,[15] while with passive euthanasia,[16] the physician withdraws or withholds treatment or nourishment.[17] Thus, involuntary and voluntary eutha-

11. In Judeo-Christian religions, man is specifically prohibited from taking the life of another, regardless of the circumstances. The command is "thou shalt not kill." Exodus 20:13. Members of these religions believe that the right over life and death belongs exclusively to God and that society has no right to intervene. For a discussion of religious views of euthanasia, see Sherwin, *Jewish Views of Euthanasia*, in BENEFICENT EUTHANASIA 3-10 (M. Kohl ed. 1975); Maguire, *A Catholic View of Mercy Killing*, in BENEFICENT EUTHANASIA 34-42 (M. Kohl ed. 1975).

12. Comment, *Voluntary Active Euthanasia for the Terminally Ill and the Constitutional Right to Privacy*, 69 CORNELL L. REV. 363, 365-66 (1984).

13. *Id.* at 366.

14. *See* Sherlock, *For Everything There Is a Season: The Right to Die in the United States*, 1982 B.Y.U. L. REV. 545, 550.

15. In most instances, doctors induce a painless death with a lethal injection of drugs or an injection of air into the patient's bloodstream. For a discussion of the methods and drug doses used in performing euthanasia and auto-euthanasia, see generally D. HUMPHREY, LET ME DIE BEFORE I WAKE (1988).

16. Sherlock, *supra* note 14, at 550.

17. *See generally* Admiraal, *Euthanasia in the Netherlands—Justifiable Euthanasia*, 3 ISSUES L. & MED. 361 (1988). Passive euthanasia is defined as "the discontinuance of life sustaining means or treatment as a result of which the patient dies after a shorter or longer period." *Id.* at 368-69. Examples of passive euthanasia include "[s]topping existing [life support] medications such as antibiotics, cytotoxins, antiarrythmia's [heart regulating medications], medications for increasing blood pressure, diuretics, cortico-steroids, or insulin." *Id.* at 369. Other examples include "[s]topping existing nonmedication treatments such as kidney dialysis, blood transfusions, intravenous or tube feeding, reanimation, physiotherapy, or antidecubitis treatment." *Id.*

nasia may either be active or passive.

Although this Comment will briefly discuss all four types of euthanasia, it will focus mainly on active voluntary euthanasia. This form of euthanasia is commonly called "mercy killing" because the person administering the fatal treatment is motivated by an altruistic desire to alleviate the patient's suffering and to fulfill the patient's last, and perhaps most personal, wish. Thus, for the purposes of this Comment, the terms voluntary active euthanasia and "mercy killing" will be used synonymously.

III. THE CURRENT STATE OF THE LAW IN THE UNITED STATES

A. Active and Passive Involuntary Euthanasia

With involuntary euthanasia, the active/passive distinction is immaterial in assessing the actor's criminal liability. Since involuntary euthanasia is the taking of a person's life against his will or without his express consent, it constitutes homicide, regardless of whether it is active or passive.[18]

The legal prohibition against involuntary euthanasia stems from the theory of informed consent and the right of self-determination. Under these two doctrines, "[e]very human being of adult years and sound mind has a right to determine what should be done with his own body."[19] Therefore, without the patient's consent, or the consent of a relative or guardian, a physician may not engage in involuntary euthanasia.[20] Involuntary euthanasia involves a doctor acting without such requisite consent, thereby violating a patient's right of self-determination, privacy and life.[21] Thus, the courts do not, and should never, sanction involuntary euthanasia.

B. Passive Voluntary Euthanasia

As previously mentioned, in cases involving involuntary euthanasia, the active/passive distinction is immaterial when assessing criminal liability, since both active and passive involuntary euthanasia are illegal in the United States. In contrast, in cases involving voluntary

18. Comment, *The Right to Die—A Current Look*, 30 LOY. L. REV. 139, 142 n.18 (1984).

19. *See* Schloendorff v. Soc'y of N.Y. Hosp., 211 N.Y. 125, 105 N.E.2d 92 (1914), *rev'd on other grounds*, 2 N.Y.2d 656, 163 N.Y.S.2d 3, 143 N.E.2d 3 (1957). The court stated that "[t]he patient's right to an informed consent makes no sense without a right to an informed refusal." *Id.* at 129, 105 N.E.2d at 114.

20. Comment, *Euthanasia: A Comparison of the Criminal Laws of Germany, Switzerland and the United States*, 4 B. C. INT'L & COMP. L. REV. 533, 538-39 (1983).

21. Comment, *supra* note 18, at 142.

euthanasia, the active/passive distinction is crucial when assessing the criminal liability of the actor. Most jurisdictions in the United States permit voluntary passive euthanasia, which is commonly characterized as the right to withdraw or refuse medical treatment.[22] However,

22. The following states have held that a patient has the right to withdraw or refuse medical treatment: Arizona, *see* Rasmussen v. Fleming, 154 Ariz. 200, 741 P.2d 667 (1987) (holding that there is a constitutional and common-law right to refuse treatment which may be exercised on an incompetent patient's behalf); California, *see* Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986) (holding that a mentally competent patient has a right to refuse medical treatment); Connecticut, *see* Foody v. Manchester Memorial Hosp., 40 Conn. Supp. 127, 482 A.2d 713 (Super. Ct. 1984) (holding that parents of a comatose patient had the right to discontinue the use of life-sustaining systems and that compliance with this right would not subject the physicians or the hospital to civil or criminal liability); Delaware, *see In re* Severns, 425 A.2d 156 (Del. 1980) (holding that an individual's right, expressed through a guardian, to decline to be kept alive as a veritable vegetable overcomes the interest of the state in the preservation of life); District of Columbia, *see* Tune v. Walter Reed Army Hosp., 602 F. Supp. 1452 (D.D.C. 1985) (holding that a competent adult has the right to determine whether his life should be prolonged by artificial means, such as life support systems); Florida, *see* Satz v. Perlmutter, 362 So. 2d 160 (Fla. Dist. Ct. App. 1978), *aff'd*, 379 So. 2d 359 (Fla. 1980) (holding that a competent individual has the right to refuse medical treatment); Georgia, *see In re* L. H. R., 253 Ga. 439, 321 S.E.2d 716 (1984) (holding that in the case of an incompetent patient who is terminally ill, in a chronic vegetative state, and with no reasonable possibility of regaining cognitive function, a family member or legal guardian may decide, on the patient's behalf, to terminate life-support systems without prior judicial approval); Illinois, *see In re* Estate of Longeway, 133 Ill. 2d 33, 549 N.E.2d 292, *reh'g denied*, 58 U.S.L.W. 2306 (1989) (holding that the common-law right to refuse medical treatment includes the right to withdraw artificial nutrition and hydration); Indiana, *see* Kumple v. Bloomington Hosp., 422 N.E.2d 1309 (Ind. 1981) (holding that the constitutional right of privacy includes a patient's right to refuse medical treatment); Maine, *see In re* Gardner, 534 A.2d 947 (Me. 1987) (holding that an individual's personal right to refuse life-sustaining treatment is firmly anchored in the common-law doctrine of informed consent, which requires the patient's informed consent to the administration of any medical care); Maryland, *see* Mercy Hosp., Inc. v. Jackson, 62 Md. App. 409, 488 A.2d 1130 (Ct. Spec. App. 1985) (holding that an individual has a right of informed consent to medical treatment and the corollary right to refuse medical treatment); Massachusetts, *see* Superintendent of Belchertown v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977) (holding that a terminally ill person has a general right to refuse medical treatment and such general right extends to the case of a mentally incompetent patient); Minnesota, *see In re* Torres, 357 N.W.2d 332 (Minn. 1984) (holding that if an incompetent patient's best interests are no longer served by continuance of life-support systems, the court may empower the guardian to order their removal); Mississippi, *see* Brown v. Mississippi, 478 So. 2d 1033 (Miss. 1985) (holding that an individual's rights to free exercise of religion and privacy were broad enough to allow him to refuse medical treatment, such as a blood transfusion); New Jersey, *see In re* Farrell, 108 N.J. 335, 529 A.2d 404 (1987) (holding that any person who, in good faith reliance on procedures established by the state supreme court, withdrew life-sustaining treatment at the request of informed and competent patient who had undergone a required independent medical examination would incur no civil or criminal liability); *In re* Conroy, 188 N.J. Super. 523, 457 A.2d 1232 (1983) (holding that the nasogastric tube should be removed from an 84-year-old patient who is suffering from severe organic brain syndrome and a variety of other ailments, even though removal will almost certainly lead to the patient's death by starvation and dehydration); *In re* Quinlan, 70 N.J. 10, 355 A.2d 647,

voluntary active euthanasia has not received the same treatment by the courts.[23]

With voluntary euthanasia, the actor's liability will depend upon whether the action taken was "active" or "passive." However, this is an artificial distinction. There is little, if any, difference between killing someone through suffocation or starvation (which are considered "passive" acts because they involve "pulling the plug" or disengaging a nasogastric tube) and killing someone with a fatal injection (which is considered "active"). To stop or withdraw treatment, with the intention of relieving the patient's suffering through death, is no different than giving a fatal injection, since both actions ultimately achieve the same result—the patient's death.[24]

The distinction between active and passive euthanasia is illusory. For example, many commentators and legal scholars assert that this distinction simply does not make sense.[25] It is merely an artificial line that the courts have drawn for their own administrative convenience. As a prominent oncologist stated, "the difference between [voluntary active] euthanasia [that is killing or participating in a suicide] and letting the patient die by omitting life-sustaining treatment is a moral quibble."[26] In other words, it is logically inconsistent to impose no legal penalty on a doctor who removes life support equipment, but to

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cert. denied, 429 U.S. 922 (1976) (holding that the right to refuse medical treatment may be asserted by a guardian on the patient's behalf and that life-support systems may be withdrawn without civil or criminal liability on the part of any participant, whether guardian, physician, hospital or others); New York, *see* Delio v. Westchester County Medical Center, 129 A.D.2d 1, 516 N.Y.S.2d 677 (N.Y. App. Div. 1987) (holding that a patient has a common-law right to refuse medical treatment in the form of nutrition and hydration by artificial means); Ohio, *see* Leach v. Shapiro, 13 Ohio App. 3d 393, 469 N.E.2d 1047 (1984) (holding that a patient has the right to refuse medical treatment, and that this refusal may not be overcome by the doctrine of implied consent); Pennsylvania, *see In re* Jane Doe, 16 Phila. 229 (Pa. Ct. Com. Pl. 1987) (holding that life-sustaining medical treatment may be withdrawn at the request of a competent person); Washington, *see In re* Guardianship of Hamlin, 102 Wash. 2d 810, 689 P.2d 1372 (1984) (holding that in the case of an incompetent patient, life-support systems may be withdrawn without prior judicial approval, if the members of the patient's immediate family (guardian if no family), treating physician and the prognosis committee all agree that the patient's best interests would be served by the withdrawal of life-sustaining treatment).

23. Active euthanasia is universally classified as murder, even when performed at the victim's request or with the victim's consent. Sherlock, *supra* note 14, at 553.

24. Potts, *Looking for the Exit Door: Killing and Caring in Modern Medicine*, HOUS. L. REV. 493, 500 (1988).

25. For a general discussion of the irrelevancy of the active/passive distinction, see O'Brien, *supra* note 1, at 663; Sherlock, *supra* note 14, at 550; Comment, *supra* note 12 at 368.

26. O'Brien, *supra* note 1, at 663.

impose legal penalties on one who helps implement a patient's decision to end his life.[27]

1. Sources of the Right To Refuse or Withdraw Medical Treatment

The right to refuse or withdraw medical treatment is based upon three sources—the constitutional right of religious freedom, the common-law right of bodily self-determination, and the constitutional right to privacy.[28]

Most courts have held that a person has a right to refuse medical treatment, based upon his or her religious convictions, where the individual's right of religious freedom outweighs the state's interest in preserving life.[29] For example, in the case of *In re Brooks' Estate*,[30] the Illinois Supreme Court held that the patient, a Jehovah's Witness, could not be forced to have a blood transfusion contrary to her religious beliefs. The court stated that the U.S. Constitution protects an individual's absolute right to exercise his or her religious beliefs. The government may only limit this right where the exercise of the right presents a clear and present danger to the public health, welfare or morals.[31] Since there was no clear and present danger in *In re Brooks' Estate*, the court held that the transfusions should not be administered against the patient's will.[32]

However, in *Application of President & Directors of Georgetown College, Inc.*,[33] the District of Columbia Circuit Court ordered that the patient, a Jehovah's Witness, be administered blood transfusions, despite her objections to the treatment. The court held that the compelling state interests present in this case—the possibility that the patient's seven year old daughter would become a ward of the state as well as the state's interest in preserving life—and the potential civil

27. Comment, *supra* note 12, at 369.

28. Comment, *supra* note 18, at 145.

29. In determining whether a person may refuse medical treatment based upon his or her religious convictions, a court will balance the individual's right to religious freedom against the state's interest. *See generally* D. MEYERS, MEDICO-LEGAL IMPLICATIONS OF DEATH & DYING (1981); Sullivan, *The Dying Person—His Plight and His Right*, 8 NEW ENG. L. REV. 197, 205-209 (1973).

30. *In re* Brooks' Estate, 32 Ill. 2d 361, 205 N.E.2d 435 (1965).

31. *Id.* at 372, 205 N.E.2d at 441.

32. *Id.* at 373, 205 N.E.2d at 441-42. The court stated that "[n]o overt or affirmative act of appellants offers any clear and present danger to society—we have only a governmental agency compelling conduct offensive to appellant's religious principles." *Id.*

33. Application of President & Directors of Georgetown College, Inc., 331 F.2d 1000 (D.C. Cir. 1964).

and criminal liability of the physician and hospital outweighed the patient's constitutional right of religious freedom.[34]

A second proposition upon which the refusal or withdrawal of medical treatment is justified is the common-law right of bodily self-determination and the doctrine of informed consent. Self-determination means that an individual has a right to control what is done with his or her body. The United States Supreme Court has stated that "no right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law."[35]

The doctrine of informed consent was developed to protect the right of self-determination.[36] Under this doctrine, "no medical procedure may be performed without a patient's consent, obtained after explanation of the nature of the treatment, substantial risks, and alternative therapies."[37] Taken together, the right of bodily self-determination and the doctrine of informed consent require that a patient must consent before he or she is subjected to invasive medical treatments.

A patient's right to bodily self-determination only has meaning if a patient's right to informed refusal is also recognized.[38] Thus, one may not be forced to submit to medical treatment to which he or she does not consent. This concept was recognized by the California appellate court in the case of *Bouvia v. Superior Court*:[39]

> a person of adult years and in sound mind has the right, in the exercise of control over his own body, to determine whether or not to submit to lawful medical treatment. It follows that such patient has the right to refuse *any* medical treatment, even that which may save or prolong her life.[40]

The court incorporated the right of bodily self-determination into the constitutional right of privacy developed in *Griswold v. Con-*

34. *Id.* at 1008-09. By contrast, these interests were not present in the *Brooks'* case, as the patient had no minor children and had executed documents releasing both the doctor and hospital from any civil liability which might result from a failure on the part of either to administer the transfusions. *In re* Brooks' Estate, 32 Ill. 2d at 372, 205 N.E.2d at 442.

35. *In re* Conroy, 98 N.J. 321, 346, 486 A.2d 1209, 1221 (1985).

36. Cantor, *A Patient's Decision To Decline Life-Saving Medical Treatment: Bodily Integrity Versus the Preservation of Life*, 26 RUTGERS L. REV. 228, 237 (1973).

37. *In re* Conroy, 98 N.J. at 346, 486 A.2d at 1222.

38. *Id.* at 347, 486 A.2d at 1222.

39. Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986).

40. *Id.* at 1137, 225 Cal. Rptr. at 300 (citation omitted).

necticut.[41] The defendants in *Griswold* had disseminated information, instruction, and medical advice to married couples regarding contraception.[42] Subsequently, they were convicted under a Connecticut statute which prohibited the aiding or counseling of others regarding the use of contraceptives.[43] On appeal to the United States Supreme Court, the defendants challenged the constitutionality of both the Connecticut statute and another statute which prohibited the use of contraceptives.[44] The Court held that "the First Amendment has a penumbra where privacy is protected from governmental intrusion."[45] Based on this finding, the Court concluded that a married person's right to use contraceptives fell within this penumbra.[46] Accordingly, the two challenged statutes were struck down as unconstitutional.[47]

In *Roe v. Wade*, the Court expanded the right to privacy which it had recognized in *Griswold*.[48] In *Roe*, the Court held that a Texas law prohibiting all abortions, except those necessary to save the life of the mother, violated the due process clause of the fourteenth amendment.[49] The Court stated, "th[e] right of privacy . . . is broad enough to encompass a woman's decision whether or not to terminate her pregnancy."[50]

The right to privacy is also broad enough to encompass a patient's decision to be free from unwanted medical care. Several recent court opinions have recognized that the right to refuse or withdraw medical treatment is also a fundamental and unabridgable component of the right to privacy.[51] For example, in *Bouvia v. Superior Court*,

41. Griswold v. Connecticut, 381 U.S. 479 (1965).
42. *Id.* at 480.
43. *Id.*
44. *Id.*
45. *Id.* at 483.
46. Griswold v. Connecticut, 381 U.S. 479, 485 (1965).
47. *Id.*
48. Roe v. Wade, 410 U.S. 113 (1973).
49. *Id.* at 163-64.
50. *Id.* at 153-54. Although the Court stated that a woman has a right to an abortion, the Court held that this right is not absolute:

> [M]ost of these courts have agreed that the right of privacy, however based, is broad enough to cover the abortion decision; that the right, nonetheless, is not absolute and is subject to some limitations; and that at some point the state interests as to the protection of health, medical standards, and prenatal life, become dominant. We agree with this approach.

Id. at 155.
51. Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 1137, 225 Cal. Rptr. 297, 301 (1986). In *Bouvia*, the court stated that "[t]he right of a competent adult patient to refuse medical treatment is a constitutionally guaranteed right which must not be abridged." *Id.* at 1141, 225 Cal. Rptr. at 304.

the California Court of Appeals ordered that Elizabeth Bouvia's nasogastric tube be removed.[52] The doctors had inserted the tube in Bouvia's stomach without her consent, thereby keeping her alive through involuntary, forced feeding. In reaching its conclusion, the court stated that "[t]he right to refuse medical treatment is basic and fundamental. It is recognized as a part of the right of privacy protected by both the state and federal constitution."[53] Furthermore, in *In re Farrell*, the New Jersey Supreme Court stated that, "[w]hile we held that a patient's right to refuse medical treatment even at the risk of personal injury or death is primarily protected by the common law, we recognized that it is also protected by the federal and state constitutional right of privacy."[54] Therefore, most courts recognize that the right to refuse or withdraw medical treatment is firmly grounded in the constitutional right to freedom of religion, the common law right of self-determination and the right to privacy.

2. Consent in the Case of the Incompetent Patient

When a patient is incompetent, a surrogate decision-maker may exercise the patient's right to refuse medical treatment.[55] In the case of an incompetent patient, the courts use three tests to determine whether medical treatment will be withdrawn: (1) the subjective test; (2) the limited-objective test; and (3) the pure-objective test.[56]

Under the subjective test, the decision-maker determines what the particular patient would have chosen to do, had he or she been competent.[57] This is not an objective standard; the question is not what a reasonable person would have done under these circum-

52. *Id.* at 1146, 225 Cal. Rptr. at 307.

53. *Id.* at 1137, 225 Cal. Rptr. at 301. The right to refuse medical treatment was also recognized as being basic and fundamental by the courts in Bartling v. Superior Court, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (1984); Barber v. Superior Court, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983); *In re* Quinlan, 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976).

54. *In re* Farrell, 108 N.J. 335, 341, 529 A.2d 404, 410 (1987).

55. *See In re* Quinlan, 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976). The right of an incompetent to decide whether to discontinue the use of the mechanical respirator which maintained her vital processes was a valuable incident to her right to privacy and may be asserted on her behalf by her guardian) *Id.* at 20-21, 355 A.2d at 664; *In re* Conroy, 98 N.J. 321, 486 A.2d 1209 (1985) (a surrogate decision-maker has the right to direct the withdrawal or withholding of life-sustaining treatment for an incompetent patient under certain circumstances if certain procedures are followed) *Id.* at 342, 486 A.2d at 1231.

56. *Conroy*, 98 N.J. at 360-67, 486 A.2d at 1229-32.

57. *Id.* at 360, 486 A.2d at 1229.

stances, but what this particular patient would have done.[58] The following evidence may be used in discerning whether the patient would have chosen to withdraw or withhold treatment, if he or she had been competent to make the decision: evidence of oral directives previously given by the patient to family members or friends; evidence of proxies or powers of attorney authorizing a particular person to make the decision on the patient's behalf; evidence of religious beliefs; and evidence of the patient's pattern of conduct with respect to prior decisions about his or her medical care.[59] Thus, under this test, treatment may only be withdrawn or withheld if there is clear evidence that the patient would have chosen this course of action had he or she been competent to make the decision.

Under the limited-objective test, a guardian may refuse treatment on a patient's behalf when there is "some trustworthy evidence that the patient would have refused treatment, and the decision-maker is satisfied . . . that the burdens of the patient's continued life with the treatment outweigh the benefits of that life for him."[60] Medical evidence is essential in order to establish that the burdens of treatment (i.e. the pain and suffering) outweigh the benefits of treatment.[61] Thus, this test allows termination of an incompetent patient's treatment if two conditions are met. First, it must be clear that the treatment in question would merely prolong the patient's suffering. Second, there must be some "trustworthy" evidence that the patient would have wanted the treatment terminated, had he or she been competent to make the decision. Facts capable of satisfying the second part of this test include all evidence that is acceptable to satisfy the subjective test. However, the "some trustworthy evidence" standard is a lower standard of proof than that required under the subjective test.[62] Thus, evidence that is too tenuous to satisfy the subjective test might nevertheless be sufficient to satisfy this part of the limited-objective test.[63]

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58. *Id.*

59. *Id.* at 361-65, 486 A.2d at 1229-31.

60. *In re* Conroy, 98 N.J. 321, 365, 486 A.2d 1209, 1232 (1985).

61. *Id.*

62. Silving, *Euthanasia: A Study in Comparative Criminal Law*, 103 U. PA. L. REV. 350, 378 (1954).

63. *Conroy*, 98 N.J. at 366, 486 A.2d at 1232. The court stated, "[e]vidence that, taken as a whole, would be too vague, casual, or remote to constitute the clear proof of the patient's subjective intent that is necessary to satisfy the subjective test—for example, informally expressed reactions to other people's medical conditions and treatment—might be sufficient to satisfy this prong of the limited-objective test." *Id.*

In the absence of any evidence regarding what the patient would have done had he or she been competent to make the decision, treatment may still be withdrawn or withheld from an incompetent patient if the pure-objective test is satisfied.[64] The pure-objective test provides that:

> the net burdens of the patient's life with the treatment should clearly and markedly outweigh the benefits that the patient derives from life. Further, the recurring, unavoidable and severe pain of the patient's life with the treatment should be such that the effect of administering life-sustaining treatment would be inhumane.[65]

However, the treatment may not be withheld if there is any evidence suggesting that the patient would have chosen to accept the treatment, had he or she been competent to make the decision.[66]

In summary, the right to refuse or withdraw medical treatment has been explicitly recognized by most state courts.[67] Additionally, many state legislatures have passed Natural Death Acts that facilitate the exercise of this right.[68] For instance, Section 7186 of the California Health and Safety Code provides that "adult persons have the

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64. *Id.* at 366, 486 A.2d at 1232.

65. *In re* Conroy, 98 N.J. 321, 366, 486 A.2d 1209, 1232 (1985).

66. *Id.*

67. *See supra* note 22.

68. Currently, thirty-eight states, including the District of Columbia, have enacted some type of living will statute. *See* ALA. CODE §§ 22-8A-1 to -10 (1975); ALASKA STAT. §§ 18.12.010-12.100 (1986); ARIZ. REV. STAT. ANN. §§ 36-3201 to -3210 (1986); ARK. STAT. ANN. §§ 20-17-201 to -218 (Supp. 1989); CAL. HEALTH & SAFETY CODE §§ 7185-7195 (West Supp. 1990); COLO. REV. STAT. §§ 15-18-101 to -113 (1987 & Supp. 1989); CONN. GEN. STAT. ANN. §§ 19a-570 to -575 (West Supp. 1989); DEL. CODE. ANN. tit. 16, §§ 2501-2508 (1983); D.C. CODE. ANN. §§ 6-2401 to -2430 (1982); FLA. STAT. ANN. §§ 765.01-.15 (West 1986); GA. CODE ANN. §§ 31-32-1 to -12 (Harrison 1985); HAW. REV. STAT. §§ 327 D-1 to -27 (Supp. 1987); IDAHO CODE §§ 39-4501 to -4509 (1985 & Supp. 1989); ILL. ANN. STAT. ch. 110½, paras. 701-710 (Smith-Hurd Supp. 1989); IND. CODE ANN. §§ 16-8-11-1 to -22 (Burns 1990); IOWA CODE ANN. §§ 144A.1 to .11 (West 1989); KAN. STAT. ANN. §§ 65-28,101 to 28,122 (1985); LA. REV. STAT. ANN. §§ 40:1299.58.1 to .10 (West Supp. 1990); ME. REV. STAT. ANN. tit. 22, §§ 2921-2931 (Supp. 1988); MD. HEALTH-GEN. CODE ANN. §§ 5-601 to -614 (1990); MISS. CODE ANN. §§ 41-41-101 to -121 (Supp. 1989); MO. ANN. STAT. §§ 459.010 to .055 (Vernon Supp. 1990); N.H. REV. STAT. ANN. §§ 137-H:1 to H:16 (Supp. 1990); N.J. STAT. ANN. §§ 52:9Y-1 to -6 (West 1986); N.M. STAT. ANN. §§ 24-7-1 to -10 (1986); N.C. GEN. STAT. §§ 90-320 to -323 (1985); OKLA. STAT. ANN. tit. 63, §§ 3101-3111 (West Supp. 1990); OR. REV. STAT. §§ 97.050 to .090 (1987); S.C. CODE ANN. §§ 44-77-10 to -160 (Law. Co-op. Supp. 1989); TENN. CODE ANN. §§ 32-11-101 to -110 (Supp. 1986); TEX. HEALTH & SAFETY CODE ANN. § 4590h-1 (Vernon Supp. 1990); UTAH CODE ANN. §§ 75-2-1101 to -1118 (Supp. 1989); VT. STAT. ANN. tit. 18, §§ 5251-5262 (1987); VA. CODE ANN. §§ 541-2981 to -2992 (1988 & Supp. 1989); WASH. REV. CODE ANN. §§ 70.122.010 to .905 (Supp. 1989); W. VA. CODE §§ 16-30-1 to -10 (1985); WIS. STAT. ANN. §§ 154.01 to .15 (West 1989); WYO. STAT. §§ 35-22-101 to -109 (1988).

fundamental right to control the decisions relating to the rendering of their own medical care, including the decision to have life-sustaining procedures withheld or withdrawn in instances of a terminal condition."[69]

C. Active Voluntary Euthanasia

Currently, United States criminal law classifies mercy killing as murder.[70] For example, the California Penal Code provides that "murder is the unlawful killing of a human being with malice aforethought."[71] It is first degree murder if the killing is "willful, deliberate, and premeditated."[72] The consent of the victim does not vitiate the crime.[73] Similarly, the fact that the patient is in a terminal condition[74] or that the actor was motivated to act out of mercy or compassion will not excuse or lessen the crime.[75]

In *People v. Conley*,[76] the court stated that "one who commits euthanasia bears no ill will toward his victim and believes his act is morally justified, but he nonetheless acts with malice if he is able to comprehend that society prohibits his act regardless of his personal belief."[77] Thus, when a person ends the life of another person, regardless of whether the victim is a loved one or a consenting patient, the

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69. CAL. HEALTH & SAFETY CODE § 7186 (West Supp. 1988).

70. *See* F. WHARTON, WHARTON'S CRIMINAL LAW §§ 137-170 (14th ed. 1979); Foreman, *The Physician's Criminal Liability for the Practice of Euthanasia*, 27 BAYLOR L. REV. 54, 54 (1975).

71. CAL. PENAL CODE § 187(a) (West Supp. 1988).

72. *Id.* § 189.

73. R. PERKINS, CRIMINAL LAW 1075 (3d ed. 1982). *See also* Turner v. State, 119 Tenn. 663, 671, 108 S.W. 1139, 1141 (1908). The court held that "[m]urder is no less murder because the homicide is committed at the desire of the victim. He who kills another upon his desire or command is, in the judgment of the law, as much a murderer as if he had done it merely of his own head." *Id.*

74. Garbesi, *The Law of Assisted Suicide*, 3 ISSUES L. & MED. 93, 94 (1987). Professor Garbesi states that "[t]he fact that death may have been imminent at any rate is immaterial. The crime lies in causing death to occur earlier than otherwise would have been the case." *Id.*

75. People v. Conley, 64 Cal. 2d 310, 411 P.2d 911, 49 Cal. Rptr. 815 (1966); People v. Mangano, 375 Ill. 72, 30 N.E.2d 428 (1940); State v. Ehlers, 98 N.J.L. 236, 119 A. 15 (1922); Turner v. State, 119 Tenn. 663, 108 S.W. 1139 (1908). For example, in State v. Ehlers, the court stated,

> the state has a deep interest and concern in the preservation of the life of each of its citizens, and . . . does not either commit or permit any individual, no matter how kindly the motive, either the right or the privilege of destroying such a life, except in punishment for a crime and in the manner prescribed by law.

98 N.J.L. at 241, 119 A. at 17.

76. People v. Conley, 64 Cal. 2d 310, 411 P.2d 911, 49 Cal. Rptr. 815 (1966).

77. *Id.* at 322, 411 P.2d at 918, 49 Cal. Rptr. at 822.

act is done intentionally and, therefore, constitutes first degree murder.[78]

Despite the statutory prohibitions against active voluntary euthanasia, the courts have not been consistent when deciding cases involving mercy killings. The defendants are usually charged with some type of homicide, but the actual verdicts range from first degree murder to outright acquittal.[79] Two cases exemplify the disparate outcomes in euthanasia cases. First is the case of *People v. Roberts*.[80] In this case, the victim had multiple sclerosis and was suffering from excruciating pain. She had unsuccessfully attempted suicide by ingesting carbolic acid. Following this attempt, her husband succumbed to her urgent and repeated requests and placed poisoned water on a chair within her reach. The woman drank the poisoned water and subsequently died.[81] The husband was convicted of first degree murder, despite his altruistic motives.[82]

The outcome in *Roberts* is in sharp contrast with the result in the case of Dr. Hermann Sander. Dr. Sander was acquitted in the death of his terminally ill, cancer-stricken patient, despite evidence that clearly indicated that he had injected a lethal dose of air into his pa-

78. Silving, *supra* note 62, at 352.

79. Note, *The Right of the Terminally Ill to Die, with Assistance If Necessary*, 8 CRIM. JUST. J. 403, 414 n.74 (1986). According to Gilbreath, an analysis of the verdicts in the 48 reported mercy killings between 1930 and 1960 reveals the following disparate resolutions:

Type of sentence/final outcome of case	# of people
Mercy killer committed suicide	17
Manslaughter/second-degree murder	11
First-degree murder	
life sentence	4
death sentence	1
Temporarily insane	
Acquitted and freed	6
Not indicted	1
Committed to mental institution	3
Acquitted outright	3
Dismissed by judge	1
Died while under indictment	1

Id. at 416.

80. People v. Roberts, 211 Mich. 187, 178 N.W. 690 (1920).

81. *Id.* at 192, 178 N.W. at 691.

82. *Id.* at 199, 178 N.W. at 694. The court stated that,

> We are of the opinion that, when defendant mixed the paris green with water and placed it within reach of his wife to enable her to put an end to her suffering by putting an end to her life, he was guilty of murder by means of poison within the meaning of the statute, even though she requested him to do so.

Id. at 197, 178 N.W. at 693.

tient's veins.[83] Thus, these two divergent cases demonstrate the desperate need for either a federal statute or a Supreme Court ruling to remedy the lack of uniform adjudication by the courts in this area.

Generally, the actual practice of criminal law does not coincide with strict legal theory.[84] Cases such as *People v. Roberts*[85] are the exception, rather than the rule. It is more common for persons performing euthanasia to not be prosecuted.[86] The reasons for this are two-fold. First, the decedent's relatives ordinarily do not cooperate with the prosecutor since they consented to the euthanasia.[87] Second, juries are often unwilling to return guilty verdicts against defendants who killed out of mercy or kindness.[88] It is time that legal theory changed to comport with actual societal practice. The Netherlands and Switzerland may serve as useful models for implementing changes in the United States' euthanasia law.

IV. THE CURRENT STATE OF THE LAW IN THE NETHERLANDS

Holland has come close to legalizing the practice of euthanasia.[89] Although Article 293 of the Dutch Criminal Code expressly provides for a twelve-year prison sentence for any person who "takes the life of another at his or her explicit and serious request,"[90] thousands of cases of euthanasia occur annually in the Netherlands without criminal prosecutions.[91] The doctors who practice euthanasia are rarely, if ever, prosecuted.[92] For example, Dr. Pieter V. Admiraal, an anesthesiologist at a hospital in Delft, has openly performed euthanasia over

83. N.Y. Times, Feb. 8, 1950, at 1, col. 2. For other examples of the inconsistent court rulings in mercy killing cases, see Note, *supra* note 79, at 414 n.74.

84. Levin & Levin, *DNR: An Objectionable Form of Euthanasia*, 49 U. CIN. L. REV. 567, 575 (1980).

85. People v. Roberts, 211 Mich. 187, 178 N.W. 690 (1920).

86. For example, in March 1988, Marty James appeared on national television announcing that he had assisted two people, who were suffering from AIDS, in ending their lives. While the television revelation sparked a criminal investigation, no charges were ever filed. Braun, *Deliver Them from Death*, L.A. Times, Aug. 28, 1988, at 1, col. 1.

87. Levin & Levin, *supra* note 84.

88. *Id.*

89. Potts, *supra* note 24, at 495.

90. Clines, *Dutch Quietly in Lead in Euthanasia Requests*, N.Y. Times, Oct. 31, 1986, at 4, col. 3.

91. Estimates of the number of euthanasia cases per year in the Netherlands vary considerably. One source suggests that between 6 and 12 thousand cases of euthanasia occur annually in the Netherlands. Dessaur & Rutenfrans, *The Present Day Practice of Euthanasia*, 3 ISSUES L. & MED. 399, 402 (1988). Other sources suggest that the number may be as high as 20 thousand. *60 Minutes: The Last Right?* (CBS television broadcast, Aug. 21, 1988).

92. Potts, *supra* note 24, at 495.

one hundred times in the past ten years; however, he has been prosecuted only once.[93] Furthermore, he was acquitted of the charges even though he admitted to giving his patient a fatal injection.[94]

Additionally, in 1984, the Supreme Court of the Netherlands decided a case in which it held that mercy killing was privileged conduct in certain circumstances.[95] The case involved a ninety-four-year-old woman, named Maria, who had poor eyesight, poor hearing, suffered from dizzy spells and had difficulty moving. Although she had urged her doctor to end her life, he had not granted her request. Several months later Maria fell and broke her hip. By this time, her hearing and sight had rapidly deteriorated and she was barely able to speak. She was totally dependent on the nursing staff with regard to bathing and personal hygiene. She could no longer eat or drink and had lost consciousness for a period of time. After several urgent requests from Maria and her family members, the doctor finally relented and agreed to end Maria's suffering. She died in her sleep from an injection administered by her doctor. The doctor was later prosecuted but was acquitted at the trial court level. However, the intermediate appellate court overturned the acquittal and found the doctor guilty. The intermediate appellate court's decision was then overturned by the Supreme Court which held that mercy killing is not punishable if it is carried out in the context of an emergency situation and results from the physician's careful consideration of his conflicting duties and responsibilities.[96]

Since 1973, Dutch courts have ruled that active voluntary euthanasia is not a punishable offense under certain conditions.[97] These conditions are:

(1) euthanasia may be practiced only by a doctor;

(2) there must be evidence of a verbal or written decision by the deceased that he wanted his life terminated;

(3) that decision must have been made without coercion and must have been of a lasting, settled nature;

(4) alternatives must have been considered, with the deceased having been informed of the particulars of his situation and the

93. *60 Minutes: The Last Right?* (CBS television broadcast, Aug. 21, 1988).

94. *Id.*

95. Garbesi, *supra* note 74, at 108.

96. Vervoorn, *Voluntary Euthanasia in the Netherlands: Recent Developments*, 6 BIOETHICS NEWS 19, 20 (1987).

97. *Id.* at 19.

> alternatives open to him while he was still in a state to consider those alternatives and actually did so;
> (5) the case must have involved severe or unbearable physical or mental suffering of a lasting nature, for the relief of which there was no reasonable alternative available;
> (6) there must be evidence that careful decision-making took place, including consultation with another medical practitioner.[98]

Therefore, as long as doctors follow the guidelines delineated above, they will not be punished for performing euthanasia.

Several groups within the Netherlands' government have actively campaigned to change the penal laws, which criminalize euthanasia, to coincide with current case law, which allows euthanasia to be performed if certain conditions exist.[99] For example, in 1984, Mrs. Wessel-Tunistra introduced a bill to legalize the practice of euthanasia. Although the bill did not pass, it was not the end of the euthanasia debate in the Netherlands.[100] In 1985, a State Commission on Euthanasia presented its findings to the Queen and stated its position that a doctor who takes the life of a patient, at the patient's request, should not be punished, provided that certain conditions have been met.[101] On January 20, 1986, a draft bill on euthanasia was sent by L.C. Brinkman, Minister of Well-Being, Public Health and Culture, to the President of the Lower Chamber.[102] Additionally, in March 1987, the Royal Netherlands Society for the Promotion of Medicine and the Dutch Nurses' Union issued a joint statement which advocated euthanasia and set forth what the "normal" conduct of nurses and doctors should be at the bedside of a patient desiring to end his suffering.[103] Furthermore, in January 1987, the Royal Netherlands Society for the Promotion of Pharmacy issued a pamphlet which contained a list of the drugs and the appropriate mixtures that could be used by a doctor

98. *Id.* The last requirement, that there must be evidence that careful decision-making took place, was set aside in a 1985 case in which the court ruled that consultation with a second doctor was not necessary. The court reasoned that it was unnecessary to consult a second doctor before performing euthanasia, because a second doctor would not be as well informed as the treating doctor about the circumstances of the particular patient. *Id.*

99. *Id.*

100. Schepens, *Euthanasia: Our Own Future?*, 3 ISSUES L. & MED. 371, 375 (1988).

101. Driesse, Van der Kolk, Van Nunen-Forger & de Marees van Swinderen, *Euthanasia and the Law in the Netherlands*, 3 ISSUES L. & MED. 385, 395 (1988). These conditions are: the patient must be in a hopeless condition with no hope of recovery; the request for euthanasia must be voluntary; and the termination of life must take place within the framework of careful medical practice. *Id.*

102. Schepens, *supra* note 100, at 375.

103. *Id.* at 378.

to perform euthanasia.[104] Finally, a member of the Dutch Parliament proposed a bill to amend the Criminal Code to make it consistent with the current case law. However, no action has been taken on this bill as of the writing of this Comment.[105]

Therefore, even though the penal statutes remain on the books, the Netherlands' courts have in effect made euthanasia a non-punishable offense.[106] Euthanasia in the Netherlands is a common practice, accepted by the general public,[107] physicians, nurses, hospital boards, politicians and the courts.[108] It is merely a matter of time before euthanasia will also be accepted by the Netherlands' legislature.

V. THE LAW IN SWITZERLAND

A. The Element of Motive

In the United States, an actor's motive is immaterial in assessing his culpability for a crime.[109] A compassionate motive will not exonerate one who commits murder[110] and will not alter the fact that an intent to end a human life existed. "If the proved facts established that the defendant in fact did the killing willfully, that is with intent to kill . . . and as the result of premeditation and deliberation . . . there is murder in the first degree, no matter what the defendant's motive may have been."[111] Hence, an individual who kills another out of empathy or compassion will be accorded the same treatment as one who commits a cold-blooded murder.[112]

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104. *Id.*

105. Garbesi, *supra* note 74, at 111. I have spoken with Professor Garbesi, General Counsel for the Hemlock Society, and the Dutch Embassy who have confirmed that no action has been taken on the bill to amend the criminal code to remove euthanasia from the category of first-degree murder.

106. *Id.* at 109-10.

107. Vervoorn, *supra* note 96, at 20.

108. Schepens, *supra* note 100, at 378.

109. Comment, *supra* note 20, at 547.

110. *See supra* note 75. *See also* W. LA FAVE & A. SCOTT, CRIMINAL LAW 204 (1972). The authors state that motive is immaterial in determining the culpability of the actor. "The most laudable motive is no defense [to a criminal act]." *Id.*

111. State v. Ehlers, 98 N.J.L. 236, 238, 119 A. 15, 17 (1922).

112. The fact that euthanasia is not accorded a more lenient treatment than murder is illustrated by the following two cases. Ronald Fisher Elam brutally murdered Debbie Ann Scott by shooting her in the head as he drove by her car on the freeway. Elam was convicted of first-degree murder and sentenced to 27 years. Ramos, *Man Sentenced for Killing Woman in Passing Truck*, L.A. Times, May 10, 1988, at 1, col. 1. He will be eligible for parole in 13½ years. *Id.* at 4, col. 2. *See also* Gilbert v. State, 487 So. 2d 1185 (Fla. Dist. Ct. App. 1986). Roswell and Emily Gilbert had been married for 51 years. They had a wonderful relationship and were in the habit of lunching together every day. Emily suffered from osteoporosis and

By contrast, under the Swiss Penal Code, the actor's motive is the essential factor in determining the actor's culpability.[113] The motive which caused the actor to commit the crime is relevant in determining the actor's dangerousness and in predicting whether or not he will repeat the crime.[114] The theory is that one who kills to gain a reward or a financial benefit will do so again, while one who kills out of mercy or compassion is unlikely to repeat the act.[115]

A Swiss judge will also consider a defendant's motive in the grading and the sentencing of an offense.[116] Article 63 of the Swiss Penal Code provides that, "[t]he judge will determine the penalty according to the culpability of the offense, taking into account *the motives*, prior offenses and the personal circumstances surrounding the latter."[117] Accordingly, a defendant who has a highly reprehensible motive will be guilty of murder, while a defendant who has a more benign motive will be guilty of a lesser crime. Furthermore, if the actor is motivated by a desire to comply with a patient's request to be relieved from his suffering through death, the actor will be guilty of a completely separate crime, called "homicide upon request."[118]

In Switzerland, the actor's motive is relevant in determining the length and severity of the criminal sentence.[119] This is reflected in article 64 of the Swiss Penal Code which provides that "[t]he judge will be able to lighten the sentence . . . when the offender [has] acted, by yielding to *honorable motives*."[120] Thus, one who kills another out of compassion—an "honorable" motive—will receive a lighter sentence than one who kills out of anger or greed.

The Swiss Penal Code mandates that the judge consider motive

Alzheimer's Disease. She was suffering from intense pain and was often confused. On March 3, Emily was hospitalized. Emily did not want to stay at the hospital, so Roswell took her home. On March 4, Emily was in intense pain. Roswell gave her four pain pills, which had been prescribed by Emily's doctor. When these were ineffective she said, "Please, somebody help me. Please, somebody help me." *Id.* at 1187. In an effort to relieve Emily's suffering and respond to her pleas, Roswell shot Emily. She died instantaneously. *Id.* at 1188. Despite Roswell's compassionate motive, he was convicted of first-degree murder and sentenced to serve a minimum of 25 years in prison. *Id.* at 1187. Thus, it is possible that Mr. Elam, a vicious criminal, acting with an evil motive, will be released 11 1/2 years before Mr. Gilbert, a peaceful citizen, acting with an altruistic motive.

113. Comment, *supra* note 20, at 547.
114. Silving, *supra* note 62, at 361.
115. *Id.* at 362.
116. Sw. StGB art. 63 (1982).
117. *Id.* (emphasis added).
118. *Id.* art. 114.
119. *Id.* art. 64.
120. *Id.* (emphasis added).

when determining a defendant's sentence.[121] Thus, a Swiss judge must reduce the sentence if a defendant has a compassionate motive.[122] By contrast, a judge in the United States need not consider motive when determining a defendant's sentence. Therefore, it is conceivable that a mercy killer, who acted out of compassion and love, could receive a harsher sentence than one who committed a cold-blooded murder.[123] It is flagrantly unfair to treat one who acts with a benevolent motive the same as, or more severely than, someone who acts with a malignant and sinister motive. Therefore, it is time to change the laws of the United States to remedy this gross injustice.

Under the Swiss system, a defendant will be guilty of one crime with a given punishment if his motive is altruistic, while he will be guilty of an entirely different crime, with a greater punishment, if his motive is malevolent.[124] Thus, one who commits euthanasia and, thereby, acts with an "honorable motive," will either be acquitted or will receive a reduced sentence.[125]

B. Homicide Upon Request

In the United States, one who kills another in response to the decedent's request is guilty of murder.[126] The fact that the victim desired to be killed or asked to be killed is not a defense and, therefore, will not mitigate the defendant's sentence.[127] By contrast, in Switzerland, one who commits a homicide at the decedent's request will receive a mitigated sentence.[128]

The governing belief in Switzerland is that although killing is always reprehensible, it is less reprehensible when performed at the decedent's request.[129] Therefore, the Swiss legislature has created a separate crime called "homicide upon request" which is punished less

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121. Comment, *supra* note 20, at 548.

122. *Id.*

123. For an example of a judge imposing a harsh sentence on a defendant who acted with an altruistic motive, see Gilbert v. State, 487 So. 2d 1185 (1986), discussed *supra* note 114.

124. Comment, *supra* note 20, at 548.

125. *Id.* at 553. The author states that

> [i]n some cases, the motives may be so benevolent that total exculpation of the actor is warranted. A physician who has acted with a benevolent motive in terminating the life of an individual lacks the malice which is a major element in the exigency to punish a person for homicide.

Id.

126. CAL. PENAL CODE § 187(a) (West Supp. 1988).

127. *See* Garbesi, *supra* note 74.

128. *Id.*

129. Silving, *supra* note 62, at 378.

severely than murder.[130] Article 114 of the Swiss Penal Code provides that "[h]e who kills another upon the latter's earnest and urgent request will be punished by imprisonment."[131] Although the statute mandates imprisonment, a benevolent motive will mitigate this punishment considerably.[132] Thus, the statute incorporates the equitable principle that "justice requires that killing a consenting person . . . should not be punished as severely as killing a person against his will."[133]

In order to qualify as a "homicide upon request," the victim's request must be both "earnest and urgent."[134] An earnest request is one that is serious and sincere, not one that is made in jest. Also, for a request to be considered "earnest," the victim must understand the nature and the consequences of the type of request he is making. Thus, someone who has a diminished capacity, because he is mentally ill, drunk or in the heat of passion, may not be capable of making an "earnest" request.[135] A request will be deemed "urgent" if it is repeated several times by the victim.[136]

Thus, the Swiss legislature has ameliorated the problem of euthanasia in two ways. First, a defendant's motive will be taken into account when determining a defendant's sentence.[137] Hence, one who kills with a benevolent motive will receive a mitigated sentence. Second, "homicide upon request" is a separate crime, carrying a lighter sentence than murder.[138]

VI. CONCLUSION

While both the Dutch parliament and the Swiss legislature have attempted to deal with the growing problem of euthanasia in creative ways, the United States legislature has not. Instead, the United States has chosen to ignore the problem. As a result, euthanasia occurs covertly, subject to the dangers of abuse.[139] Furthermore, neither the

130. SW. STGB art. 114 (1982).
131. *Id.*
132. Comment, *supra* note 20, at 554.
133. Silving, *supra* note 62, at 378.
134. SW. STGB art. 114 (1982).
135. Silving, *supra* note 62, at 384.
136. Comment, *supra* note 20, at 555.
137. SW. STGB arts. 63-64 (1982).
138. *Id.* art. 114.
139. For example, in an euthanasia survey conducted in California by the Hemlock Society, a national group that advocates euthanasia, 79 physicians claimed that they deliberately took the lives of terminal patients who asked to die. Of the 79 physicians who said they had

Supreme Court[140] nor Congress has considered the legality of euthanasia. Hence, the area is left to the states which results in inconsistent and conflicting decisions.[141] Therefore, it is time that either Congress or the Supreme Court dealt with the issue so that euthanasia can be practiced overtly, subject to both governmental control and proper safeguards. Federal action will also ensure that euthanasia cases are uniformly decided from state to state.

The distinction between active and passive euthanasia is artificial and without merit. It is illogical to permit a doctor to withdraw life support systems without incurring a penalty, while imposing a penalty on a doctor who helps implement a patient's desire to end his suffering. An individual has a right to determine what is done to his or her body. Accordingly, an individual has a right to choose death over a life of pain and suffering, as long as the decision to die is competent, well-informed and made after careful thought and deliberation.

> To require that a person be kept alive against his will and to deny his pleas for a merciful release after the dignity, beauty, promise and meaning of life have vanished, when he can only linger on in stages of agony or decay, is cruel and barbarous. The imposition of

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performed active euthanasia, 15 had done so once, 35 had done so two or three times, and 29 had done so on more than three occassions. Derek Humphrey, the Hemlock Society's director, states that the study is significant because "it's an indicator that active euthanasia is going on covertly in hospitals now." Parchini, *Euthanasia: New Findings in the Hemlock Poll*, L.A. Times, Feb. 25, 1988, at 1, col. 3.

140. Currently, in the case of Cruzan v. Missouri Dept. of Health, the Supreme Court is considering whether a person has a right to refuse unwanted medical care. Cruzan v. Harmon, 760 S.W.2d 408 (1988), *cert. granted*, 109 S. Ct. 3240 (1989). Since a severe car crash in 1983, Nancy Beth Cuza has remained in a vegetative state, with no chance of recovery. She is unconscious and being fed through a tube. Her parents wish to remove the tube, but are being blocked by the state of Missouri. Thus, they have appealed to the Supreme Court.

It is unclear how the Court will rule on this issue. The Court's conservative members expressed doubts that the Constitution expressly gives an individual a right to be free from unwanted medical care. Thus, a broadly written decision could overturn those state court rulings, such as the *Quinlan* case and the *Bouvia* case, which have found such a right. On the other hand, Justice Sandra Day O'Connor, the fifth and pivotal vote of the conservative majority, seems to be leaning towards a more narrow ruling which would balance the state's interest in preserving life against the wishes of the individual or the individual's guardian. The Supreme Court will most likely issue its opinion in the spring of 1990. Savage, *Justices Grapple with 1st "Right-to-Die" Case*, L.A. Times, Dec. 7, 1989, at 32, col. 1. However, even if the Supreme Court does issue a broad ruling regarding whether a person has the right to die through passive measures (i.e. whether one has a right to terminate or refuse medical treatment), the question of whether one has a right to die through active measures remains unanswered.

141. *See supra* note 79 and accompanying text.

> unnecessary suffering is an evil that should be avoided by civilized society.[142]

The Dutch and Swiss approaches may serve as useful models to the United States for implementing changes in the United States euthanasia laws. Specifically, the United States should follow Switzerland's example and consider the actor's motive and the victim's wishes when determining the penalty for one who commits euthanasia.[143] An individual who helps implement a patient's decision to die should be accorded more lenient treatment than one who performs premeditated murder. Thus, the harsh rule on murder should be modified so that courts may consider the compassionate motives of one who commits euthanasia. However, in formulating any laws regarding euthanasia, the legislature must be careful to impose sufficient safeguards so that a euthanasia defense will not be abused. "Specifically, there is a danger that homicidal charlatans will perform euthanasia on demurring subjects and later elude prosecutions by falsely claiming that they merely facilitated a rational suicide."[144] The time is ripe for Congress to promulgate laws regarding the right to die or for the Supreme Court to rule on the legality of active euthanasia.

Dana Elizabeth Hirsch

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142. Comment, *A Right to Choose Death*, 13 CUMB. L. REV. 117, 135 (1982).

143. This attitude is best exemplified by Judge Letts' opinion in *Gilbert v. State* where he stated:

> Finally, this court notices that this aged defendant has been a peaceful, law-abiding and respected citizen up until this time. No one has suggested that he will again kill someone or enter upon a criminal career. However, the absolute rigidity of the statutory mandatory minimum sentences do not take into account any mitigating circumstances. Whether such sentences should somehow be moderated so as to allow . . . distinctions to be made in sentencing between different kinds of wrongdoers . . . are all questions which, under our system, must be decided by the legislature.

Gilbert v. State, 487 So. 2d 1185, 1192 (1986).

144. O'Brien, *supra* note 1, at 665.