"WALKING INTO THE SEA"[1] OF LEGAL FICTION: AN EXAMINATION OF THE EUROPEAN COURT OF HUMAN RIGHTS, *PRETTY V. UNITED KINGDOM* AND THE UNIVERSAL RIGHT TO DIE

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I. INTRODUCTION

History has proven that certain realities survive legal prohibitions.[2] Regardless of the law, homosexuals participate in the military,[3] women

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1. Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 296 (1990) (Scalia, J., concurring) (finding that the line drawn between active and passive euthanasia is as "unreasonable" as ruling that "one may not kill oneself by walking into the sea, but may sit on the beach until submerged by the incoming tide; or that one may not intentionally lock oneself into a cold storage locker, but may refrain from coming indoors when the temperature drops below freezing").

2. Chester Bowles, a member of the 1941 wartime Office of Price Administration, opined that approximately 20% of the regulated population will comply with any regulation, 2 or 3% will be inherently dishonest, and the remaining 75% or so will generally comply as long as they think that they are not being had. CHESTER BOWLES, PROMISES TO KEEP: MY YEARS IN PUBLIC LIFE 1941-1969, 25 (1971).

3. In recent years, the European Court of Human Rights has determined that the United Kingdom's dismissal of homosexuals from the military violated the applicants' privacy rights which are guaranteed under the Convention. *See* Lustig-Prean & Beckett v. United Kingdom, 31 Eur. H.R. Rep. 601 (2001); Smith & Grady v. United Kingdom, 31 Eur. H.R. Rep. 620 (2001). *See also* Rich v. Sec'y of the Army, 735 F.2d 1220, 1227 n.7, 1228-29 (10th Cir. 1994) (recognizing a "significant split of authority as to whether some private consensual homosexual behavior may have constitutional protection" but finding the military's "compelling interest" in regulating homosexual conduct sufficient to uphold discharge) (discussing Beller v. Middendorf, 632 F.2d 788 (9th Cir. 1980)).

abort unwanted fetuses,[4] and licensed physicians kill terminally-ill patients.[5] These realities speak to the core of human value[6] and to an individual's right to privacy which is protected explicitly by the Council of Europe's[7] Convention for the Protection of Human Rights and Fundamental Freedoms (the Convention),[8] implicitly by the United States Constitution (the Constitution),[9] and expressly by most state constitutions.[10] Where members of the Council of Europe (Member States or States) have interfered with privacy rights under the Convention, the European Court of Human Rights in Strasbourg (sometimes referred to as the Strasbourg Court or the Court) has engaged in a balancing test to determine if the harm of the interference is outweighed by the State's legitimate need to regulate its interests.[11] Federal and state courts in the United States have employed the same method of analysis. In addition to general notions of fairness, public opinion and the common practices of western democratic nations have influenced the international and U.S. courts' weighing of governmental and individual interests: mainstream perspectives on the morality and legality of homosexuals in the military, abortion, and physician-assisted suicide have found their way into the international, national, and state courts' decision-making processes.[12]

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4. CARL N. DEGLER, AT ODDS: WOMEN AND THE FAMILY IN AMERICA FROM THE REVOLUTION TO THE PRESENT 245 (1980) (explaining that "a study in the 1920s reported that about one out of four pregnancies ended with a criminal abortion").

5. *See generally* ROGER S. MAGNUSSON, ANGELS OF DEATH: EXPLORING THE EUTHANASIA UNDERGROUND (2002) (documenting numerous first-person accounts of health care workers in Australia and the United States who have participated in assisted suicide and euthanasia despite the illegality of their actions) [hereinafter ANGELS OF DEATH].

6. *See* Planned Parenthood of Southeastern Pa. v. Casey, 505 U.S. 833, 851 (1992) ("At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State.").

7. For a complete list of the forty-five Member States of the Council of Europe, see http://www.coe.int/T/E/Communication_and_Research/Contacts_with_the_public/About_Council_of_Europe/CoE_Map_&_Members/ (last visited Sept. 14, 2003).

8. Convention for the Protection of Human Rights and Fundamental Freedoms, Nov. 4, 1950, 213 U.N.T.S. 222 [hereinafter Convention].

9. *See* Griswold v. Connecticut, 381 U.S. 479 (1965) (finding a right to privacy within the "penumbras" of the First, Third, Fourth, and Fifth Amendments). The scope of the right to privacy has been determined on a case-by-case basis. *See, e.g.,* Roe v. Wade, 410 U.S. 113 (1973) (abortion); Eisenstadt v. Baird, 405 U.S. 438 (1972) (contraception); Loving v. Virginia, 388 U.S. 1 (1967) (marriage).

10. *See*, e.g., N.J. CONST., art. I.

11. *See*, e.g., In re Quinlan, 355 A.2d 647, 664 (N.J. 1976), *cert. denied sub nom.* Garger v. New Jersey, 429 U.S. 922 (1976) (balancing the right of privacy against asserted state interests); Dudgeon v. United Kingdom, 4 Eur. H.R. Rep. 149, 165 (1981) (explaining that the aims of government must be particularly serious to outweigh interferences with "a most intimate aspect of private life").

12. *See, e.g.,* Thomas J. Ward & Frederick A. Swarts, *The Mainstreaming of Homosexuality*, WORLD & I, Oct. 1993, at 365; MAGNUSSON, *supra* note 5, at 36-38 (explaining that although restrictions on euthanasia have been a common feature of medical ethics since 400 B.C., the debate has only recently surfaced as a result of today's rising costs of health care, the growing

Consequently, as public opinion evolves toward a more liberal view of individual rights, the more conservative stance of jurisprudence on the right to privacy, and particularly on the prohibition of physician-assisted suicide, is threatened.[13]

The European Court of Human Rights recently weighed in on the subject of assisted suicide in *Pretty v. United Kingdom*,[14] in which the international tribunal provided morsels of modern thought regarding an individual's right to self-determination. The Strasbourg Court took great care not to upset the position taken by a majority of western democracies, but its decision treads on shaky ground. Common law courts — including the House of Lords, the United States Supreme Court, and various state supreme courts — depend on linguistic distinctions to deny an individual's right to self-determination. The European Court of Human Rights relied on these common law jurisdictions for guidance in *Pretty*.[15] Its decision, therefore, rests on carefully constructed fallacies rather than logical legal analysis. While opponents of assisted suicide proffer strong arguments against legalization and express valid concerns for vulnerable individuals, tentative definitions of euthanasia cannot support a government's prohibition on physician-assisted suicide as applied to mentally competent, terminally-ill adults. The European Court of Human Rights should abandon these common law arguments and recognize that the Convention's protection of the right to privacy encompasses an individual's right to die. As long as the Strasbourg Court defers to its Member States, people like Diane Pretty will suffer, and the universality of human rights will be called into question.[16]

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importance of individual rights, "an increasingly educated population losing its awe of the medical profession," and the decline of religious institutions) (citations omitted); Ezekiel J. Emanuel, *Why Now?*, *in* REGULATING HOW WE DIE: THE ETHICAL, MEDICAL, AND LEGAL ISSUES SURROUNDING PHYSICIAN-ASSISTED SUICIDE 175, 175-202 (Linda L. Emanuel ed., 1998) (addressing the reasons that assisted suicide has become a highly debated issue in the 1990s); Margaret M. Funk, Comment, *A Tale of Two Statutes: Development of Euthanasia Legislation in Australia's Northern Territory and the State of Oregon*, 14 TEMP. INT'L & COMP. L.J. 149, 149 (2000) (arguing that the debate over euthanasia "is not new").

13. *See* WESLEY J. SMITH, FORCED EXIT: THE SLIPPERY SLOPE FROM ASSISTED SUICIDE TO LEGALIZED MURDER 224 (1997) ("Euthanasia is on the cutting edge of 1990s social trends.... Few other issues so perfectly reflect the public gestalt of our times: Euthanasia is justified by claims of compassion, appeals to raw emotionalism, and paeans to 'choice.'").

14. 35 Eur. H.R. Rep. 1 (2002).

15. *Id.*

16. It is important to clarify that this paper does not condone involuntary euthanasia, nor does it argue for the legalization of assisted suicide by someone other than a licensed physician as the likelihood of complications is too great. *See* R. v. Hough, [1984] 6 Cr. App. R. 406, 407-08 (explaining how a sixty-year-old woman, who had promised her suicidal, eighty-four-year-old friend that she would not let anyone resuscitate her after an overdose, resorted to tying plastic bags over the elderly woman's head because the drugs had not stopped her breathing); ANGELS OF DEATH, *supra* note 5, at 122-23 (outlining the dangers of "'amateur' suicide").

A. The Story of Diane Pretty and Amyotrophic Lateral Sclerosis

Diane Pretty's fate was ultimately decided by the six men and one woman who sat as a Chamber for the European Court of Human Rights.[17] To appreciate the legal significance of the *Pretty* decision, one must first become acquainted with Diane Pretty's story.[18] Ms. Pretty and her husband Brian met when Diane was only fifteen years old.[19] Photographs from the couple's wedding reveal a young woman's confidence and sense of humor.[20] But after twenty-five years of marriage and the birth of two children and a grandchild, Ms. Pretty's disposition changed.[21]

In November of 1999, a doctor diagnosed Ms. Pretty with Amyotrophic Lateral Sclerosis (ALS),[22] more commonly known as Lou Gehrig's disease or motor neuron disease.[23] Four months later, Ms. Pretty was confined to a wheelchair.[24] ALS attacks motor neurons, the nerve cells located in the brain and along the spinal cord, degenerating the electrical impulses that send signals to an individual's muscles.[25] As a result, ALS patients suffer "progressive muscle paralysis in the face, the tongue, the throat, the respiratory system, the shoulders, hands, and legs. [Once the disease has taken full effect,] the patient cannot swallow, speak, cough, or breath unassisted."[26] But a person with ALS remains mentally alert and his or her senses of smell, touch, taste, hearing, and sight are in no way diminished.[27] Thus, "[t]he final stages of the disease are exceedingly distressing and undignified" as the patient's inability to

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17. *Pretty*, 35 Eur. H.R. Rep. at 1. *But see* Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 293 (1990) (Scalia, J., concurring) (arguing that it is inappropriate for a court to decide the issues in a right to die case because guidelines "are neither set forth in the Constitution nor known to the nine Justices of [the United States Supreme] Court any better than they are known to nine people picked at random from the Kansas City telephone directory").

18. Pictures of Diane and Brian Pretty can be seen on Ms. Pretty's website *at* http://www.justice4diane.org.uk (last visited Sept. 14, 2003) or on the BBC News Online website at http://www.news.bbc.co.uk (last modified Sept.14, 2003). Justice4diane. org.uk is fully funded by the Voluntary Euthanasia Society. *Id.*

19. *Id.*

20. *The Dignity of Diane Pretty*, BBC NEWS ONLINE, *at* http://news.bbc.co.uk/1/low /health/1983781.stm (May 12, 2002).

21. *See id. See also, Diane Pretty: Timeline*, BBC NEWS ONLINE, *at* http://news.bbc.co.uk/1/ low/health/1983562.stm (May 12, 2002) [hereinafter *Timeline*].

22. *Timeline*, *supra* note 21.

23. Penney Lewis, *Rights Discourse & Assisted Suicide*, 27 AM. J.L. & MED. 45, 46 n.4 (2001).

24. *Timeline*, *supra* note 21.

25. *See* Information, *at* www.ucsf.edu/brain/als/diagnosis.htm (last visited Sept. 14, 2003); *Motor Neurone Disease*, BBC NEWS ONLINE, *at* http://news.bbc.co.uk/1/ low/health/ medical_notes/j-m/1500231.stm (Aug. 20, 2001).

26. RAPHAEL COHEN-ALMAGOR, THE RIGHT TO DIE WITH DIGNITY 92-93 (2001) [hereinafter THE RIGHT TO DIE WITH DIGNITY].

27. JOHN KEOWN, EUTHANASIA, ETHICS AND PUBLIC POLICY: AN ARGUMENT AGAINST LEGISLATION 22 (2002). *See also Motor Neurone Disease*, BBC NEWS ONLINE, *at* http://news.bbc.co.uk/1/low /health/ medical_notes/j-m/1500231.stm (Aug. 20, 2001).

control his or her breathing leads to a complete failure of the respiratory system.[28] The average life expectancy of an ALS patient is three to four years.[29]

Photographs revealing Ms. Pretty's clinched fingers and limp wrists document some of the early effects of her disease; her arms are lifeless.[30] By the final months of her life, Ms. Pretty was a quadriplegic who could only communicate through the use of a machine.[31] Despite the loss of her voice, Ms. Pretty's message was clear. In a letter posted on her website, she explained that:

> Motor neurone disease ha[d] left [her] mind as sharp as ever, but it ha[d] gradually destroyed [her] muscles, making it hard for [her] to communicate with [her] family. It…left [her] in a wheelchair, catheterised and fed through a tube. [She] fought against the disease for…two years and had every possible medical treatment.
>
> [She was] fully aware of what the future [held] and ha[d] decided to refuse artificial ventilation. Rather than die by choking or suffocation, [she] want[ed] a doctor to help [her] die when [she was] no longer able to communicate with [her] family and friends…. [She] want[ed] to have a quick death without suffering, at home surrounded by [her] family so that [she could] say good-bye to them.
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> If [she had been] physically able [she] could [have] take[n] [her] own life. That [was] not illegal. But because of the terrible nature of [her] illness [she could not] take [her] own life — to carry out [her] wish [she would have needed] assistance.[32]

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28. Pretty v. United Kingdom, 35 Eur. H.R. Rep. 1, 6 (2002).

29. *Motor Neurone Disease*, BBC NEWS ONLINE, *at* http://news.bbc.co. uk/1/low/health/medical_notes/j-m/1500231.stm (Aug. 20, 2001). *But see* KEOWN, *supra* note 27, at 138 (noting that Professor Stephen Hawking has lived with ALS for twenty-five years and that Professor Hawking's life has been both productive and meaningful).

30. *See Timeline*, *supra* note 21 (photograph included on the website). *But see* Wesley J. Smith, *Assisted Suicide Seduction*, 16(2) INT'L TASK FORCE ON EUTHANASIA AND ASSISTED SUICIDE (2002), *available at* www.internationaltaskforce.org/iua25.htm (last visited Sept. 14, 2003) [hereinafter "Assisted Suicide Seduction] ("The good news is that people with motor neuron disease do not die by choking if they receive proper medical care.").

31. *Pretty*, 35 Eur. H.R. Rep. at 6.

32. Posting of Diane Pretty *at* http://www.justice4diane.org.uk/story.asp (last visited Sept. 28, 2002). For the sake of clarity, both "neurone" and "neuron" are appropriate spellings of the word. The spelling ending in "e" is used in the United Kingdom whereas the spelling without a final "e" is more common in the United States. In this article, "neurone" is used

Through the internet, Ms. Pretty appealed to the international community for support. She turned to international law for a determination of her rights because, unlike the common law of England, the Convention, brought into force in the United Kingdom by the Human Rights Act of 1998, includes an explicit right to privacy.[33] Ms. Pretty's words, her face, and her fight became international symbols for both the euthanasia movement and human rights.[34]

B. The Fundamental Provisions of the Convention and the European Court of Human Rights

Ms. Pretty predicated her claims on the broad language of the Convention, an international treaty drafted in 1950.[35] The fundamental provisions of the Convention — Articles 2, 3, and 8 — pronounce specific rights, rights that persons have by virtue of their being persons, and impose corresponding duties on the Member States.[36] But the scope of these rights and duties is "under-determined"[37] and the words of the Convention are susceptible to a variety of meanings. Article 2, for example, establishes the individual's right to life and the government's obligation to safeguard that right. Under this provision, "[e]veryone's right to life shall be protected by law. No one shall be deprived of his [or her] life intentionally save in the execution of a sentence of a court following his [or her] conviction of a crime for which this penalty is provided by law."[38] Case law has moved beyond a literal translation of

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only in quotes where the original source used this spelling.

33. *Pretty*, 35 Eur. H.R. Rep. *at* 7 (2002) (quoting on the application of Pretty, R. v. DPP, 10 H.R.L.R. 241 (HL 2002)).

34. Pretty's legal battle and her website were financially supported by the Voluntary Euthanasia Society and by Liberty, a human rights organization. *See Timeline*, *supra* note 21; *Case, at* http://www.justice4diane.org.uk/case.asp (last visited Sept. 28, 2002).

35. *Pretty*, 35 Eur. H.R. Rep. at 42-43 (unanimously holding that there has been no violation of Articles 2, 3, 8, 9, or 14). *See also* Mark E. Villiger, *Proceedings of the Ninety-Fifth Annual Meeting of the American Society of International Law and Human Rights and Direct Petition: The European Court of Human Rights*, 95 AM. SOC'Y INT'L L. PROC. 79, 79 (2001). The Convention "entered into force in September 1953." The object of its authors was to take the first steps for the collective enforcement of certain of the rights stated in the Universal Declaration of Human Rights of 1948. HISTORICAL BACKGROUND, ORGANISATIONAL AND PROCEDURE, REGISTRAR OF THE EUROPEAN COURT OF HUMAN RIGHTS, HISTORICAL BACKGROUND, ORGANISATION AND PROCEDURE, *at* http://www.echr.coe.int/Eng/EDocs/HistoricalBackground.htm (last modified July, 2003).

36. *See* Villiger, *supra* note 35, at 79 ("The Convention…enables the individual to bring an application before the Court in order to complain about a breach of one of these rights by a state authority and, if the application is successful, to obtain a binding judgment and damages."). As of January 1, 2001, the Court's docket had a backlog of sixteen thousand cases, and the Court's registry was receiving between eight hundred and one thousand letters a day. *Id.* at 80.

37. Paolo G. Carozza, *Uses and Misuses of Comparative Law in International Human Rights*, 73 NOTRE DAME L. REV. 1217, 1219 (1998).

38. Convention, *supra* note 8, at art. 2 § (1).

Article 2 to impose positive obligations on the state; under certain situations, a state has a duty to actively protect an individual whose life is at risk.[39] Similarly, Article 3 establishes that "[n]o one shall be subjected to torture or to inhuman or degrading treatment or punishment."[40] There are no exceptions to this Article; implicit in its declaration is the government's duty to treat individuals in a humane way, but an exact definition of "inhuman" and "degrading" is left for the Member States and the Strasbourg Court to determine.[41] Finally, Article 8, the provision that speaks most closely to the issues of physician-assisted suicide, states that:

> 1. Everyone has the right to respect for his [or her] private and family life, his [or her] home and his [or her] correspondence.
>
> 2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of…public safety…for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.[42]

This provision seems to create a universal right to privacy, as well as a universal obligation on public authorities not to interfere with that right, but its application is not so clear. Before the Strasbourg Court can decide whether there has been interference in the exercise of the right to privacy and whether that interference is justified as being "necessary in a democratic society,"[43] it must first explore the scope of activities included in the ever-evolving definitions of private and family life.

The European Court of Human Rights employs a method of comparative law to interpret and apply the written provisions of the Convention.[44] In theory, the Council of Europe has authorized the

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39. *See* X v. Germany, App. No. 10565/83, 7 Eur. H.R. Rep. 152 (1984) (requiring the state to force feed a prisoner who had gone on a hunger strike while in custody); Keenan v. United Kingdom 33 Eur. H.R. Rep. 913 (2001) (holding prison authorities liable for the death of a young prisoner who committed suicide while in state custody).

40. Convention, *supra* note 8, at art. 3.

41. *Id. See also* Pretty v. United Kingdom, 35 Eur. H.R. Rep. 1, 13-14 (2002) (quoting on the application of Pretty, R. v. DPP, 10 H.R.L.R. 241 (HL 2002)) (reasoning that "while states may be absolutely forbidden to inflict the proscribed treatment on individuals…the steps appropriate or necessary to discharge a positive obligation will be more judgmental, more prone to variation from state to state").

42. Convention, *supra* note 8, at art. 8 § (1), (2).

43. *Id.* § (2).

44. *Id. See also* Carozza, *supra* note 37, at 1225 ("The only characteristics of the Court's

Strasbourg Court to enforce a list of universal human rights.[45] In practice, the Court maintains its legitimacy by sifting through normative values in search of what may be deemed the least common denominator or the minimum standard shared by a majority of the Member States.[46] When the law is "in a transitional stage," making it difficult to find uniformity throughout democratic societies, the Court will apply a wide "margin of appreciation" and defer to the state's application of the law.[47] This margin of appreciation undercuts the notion of universal rights, and the Court's decisions reveal a tension between "universalist…aspirations and the…relativist tendencies of a comparative approach to international human rights."[48] Nevertheless, if the Convention, like the United States Constitution, is to serve as a living document rather than as a historical record of rights and obligations, and if the European Court of Human Rights must rely on the approval of Member States for its legitimacy, there may be no alternative but to continue the comparative approach.

In analyzing the Strasbourg Court's application of Article 8 to assisted suicide, this paper next explores the Court's decision in *Pretty v. United Kingdom*[49] and the developing jurisprudence on patients' rights in the United States. Part III continues with an examination of the definitions supporting euthanasia cases in the United Kingdom, the United States, and, by application, the European Court of Human Rights. Finally, this paper predicts how the European Court of Human Rights will handle future particularized challenges to a prohibition on physician-assisted suicide.

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comparative 'method' on which virtually all commentators have agreed are its lack of depth, rigor, and transparency.") (citation omitted).

45. *See* Carozza, *supra* note 37, at 1219 (asserting that the articles of the Convention "are sometimes too facilely assumed to be 'universal'").

46. *See id.* at 1232 (arguing that "the Court is at one and the same time caught between the need to uphold a set of normative principles that are outside of the will of the Member States and the need to ground its decisions to some degree in the consent of the Member States"). *See also* Villiger, *supra* note 35, at 80-81 (explaining that the court "is the main tool of European states to protect against human rights violations in Europe" and that "full membership will require strict conformity with human rights norms").

47. Carozza, *supra* note 37, at 1222-23 (citations omitted) (defining margin of appreciation as "the latitude of deference or error which the Strasbourg organs will allow to national bodies before it is prepared to declare a violation of one of the Convention's substantive guarantees"). *See, e.g.,* Goodwin v. United Kingdom, 35 Eur. H.R. Rep. 447, 448 (2002) (Article 8 "requirements will vary considerably from case to case and the margin of appreciation to be accorded to the authorities may be wider than that applied in other areas under the Convention."); Willis v. United Kingdom, 35 Eur. H.R. Rep. 547, 549 (2002) ("The Contracting States enjoy a certain margin of appreciation in assessing whether and to what extent differences in otherwise similar situations justify a different treatment.").

48. *See* Carozza, *supra* note 37, at 1219.

49. *See* Pretty v. United Kingdom, 35 Eur. H.R. Rep. 1, 19-20 (2002); Convention, *supra* note 8, at art. 8.

II. THE RIGHT TO DIE

Ms. Pretty's story continues from her initial diagnosis in 1999 to July 27, 2001 when her attorney wrote a letter to David Calvert Smith, the Director of Public Prosecutions (DPP), asking for assurance that Brian Pretty would not be prosecuted if he was to assist his wife in committing suicide.[50] In a carefully drafted response, the DPP maintained that "[s]uccessive Directors – and Attorneys General – have explained that they will not grant immunities that condone, require, or purport to authorise or permit the future commission of any criminal offense, no matter how exceptional the circumstances."[51] Thus, while Mr. Smith may have felt personal sympathy for Ms. Pretty's case, his hands were tied by precedent.[52]

A. The British Response

In August, Ms. Pretty sought declaratory and injunctive relief from the British courts on several grounds.[53] Apart from her belief that the DPP had the authority to grant her husband immunity from prosecution,[54] Ms. Pretty argued that Section 2 of the 1961 Suicide Act[55] and its criminalizing of assisted suicide "was incompatible with Articles 2 [Right to Life], 3 [Prohibition of Torture], 8 [Right to Privacy], 9 [Freedom of Thought, Conscience and Religion], and 14 [Prohibition of Discrimination] of the Convention."[56] Her case reached the United Kingdom's Supreme Court of Appeal in less than three months.[57] Lord Bingham of Cornhill, writing on behalf of the House of Lords, conceded that "no one of ordinary sensitivity could be unmoved by the frightening

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50. *See* Pretty, 35 Eur. H.R. Rep. at 6. It is unclear why Ms. Pretty petitioned the court to allow her husband, who is not a physician, to assist her in suicide when she had expressed a desire to have a doctor "help [her] die when [she was] no longer able to communicate with [her] family and friends." Posting of Diane Pretty *at* http://www. justice4diane.org.uk /story.asp (last visited Sept. 28, 2002).

51. *Pretty*, 35 Eur. H.R. Rep. at 6.

52. *But see* Suicide Act, 1961, 9 & 10 Eliz., c. 60, § 2 (4) (Eng.) ("[N]o proceedings shall be instituted for an offence under this section except by or with the consent of the Director of Public Prosecutions.").

53. *Pretty*, 35 Eur. H.R. Rep. at 6-7.

54. *See* Suicide Act, 1961, 9 & 10 Eliz. c. 60, § 2 (4) (Eng.).

55. According to the Suicide Act ,1961, 9 & 10 Eliz. c. 60, § 2 (1)-(2) (Eng.):

> (1) A person who aids, abets, counsels or procures the suicide of another, or an attempt by another to commit suicide, shall be liable on conviction on indictment to imprisonment for a term not exceeding fourteen years.
> (2) If on the trial of an indictment for murder or manslaughter it is proved that the accused aided, abetted, counselled or procured the suicide of the person in question, the jury may find him guilty of that offence.

Id.

56. *Pretty*, 35 Eur. H.R. Rep. at 7.

57. R.(on the application of Pretty) v. DPP, 10 H.R.L.R. 241 (HL 2002). Ms. Pretty's case had been "fast-tracked" as the courts recognized that her death was imminent.

ordeal which face[d] Mrs. Dianne [sic] Pretty."[58] Then he affirmed the Divisional Court's denial of Ms. Pretty's claims.[59]

B. A Response from the European Court of Human Rights

Having exhausted all available remedies within the United Kingdom, Ms. Pretty turned to the European Court of Human Rights where she reasserted her argument that the United Kingdom's Suicide Act of 1961 violated Articles 2, 3, 8, 9, and 14 of the Convention.[60] Article 8 provides the greatest opportunity for a favorable outcome because it establishes an individual's "right to respect for his [or her] private…life" and restricts public authorities from interfering with that right.[61] But this restriction is not absolute. Recall that the second section of the Article justifies governmental interferences that are both "in accordance with the law and…necessary in a democratic society in the interests of…public safety…the prevention of disorder or crime…the protection of health or morals, or…the protection of the rights and freedoms of others."[62] Thus, to successfully argue her claim, Ms. Pretty had to prove: (1) that her decision to commit suicide with the help of her husband or, more preferably, a physician, fell within the protected scope of her private life; (2) that the United Kingdom's proscription on assisted suicide had interfered with her right to privacy; and (3) that the interference was not "necessary in a democratic society" to achieve a legitimate aim under the Convention.[63]

Accordingly, the Court began its analysis with a discussion on the scope of rights protected under Article 8.[64] The judges recognized that "the concept of 'private life' is a broad term not susceptible to exhaustive definition" and that the boundaries of an individual's privacy are therefore constructed on a case-by-case basis.[65] Although prior case law had not directly addressed the issue of whether the right to self-determination fell within the scope of Article 8,[66] a number of cases stood

58. *Id.* at 244.

59. *Id.*

60. Pretty applied to the European Court of Human Rights on the basis of Convention Articles 2, 3, 8, 9, and 14. Each claim was eventually dismissed on its merits. *Pretty*, 35 Eur. H.R. Rep. at 27. This Section only focuses on the Court's analysis under Article 8.

61. Convention, *supra* note 8, at art. 8(1)-(2).

62. *Id.* at art. 8(2).

63. *Id.* at art. 8(1)-(2).

64. *Pretty*, 35 Eur. H.R. Rep. at 35-36.

65. *Id.* at *35. See generally* B. v. France, 16 Eur. H.R. Rep. 1 (1992) (discussing the rights of transsexuals); X and Y v. Netherlands, 8 Eur. H.R. Rep. 235 (1985) (addressing the rights of a mentally disabled youth); Dudgeon v. United Kingdom, 4 Eur. H.R. Rep. 149 (1981) (outlining the privacy rights of homosexuals).

66. The facts of *Sanles v. Spain,* EUR. H.R.L. REV. 348 (2001), were similar to Pretty's, but in *Sanles* the applicant did not base her claims on Article 8. Moreover, the applicant died and the European Court of Human Rights never issued a decision on the merits.

for the proposition that "the ability to conduct one's life in a manner of one's own choosing may also include the opportunity to pursue activities perceived to be of a physically or morally harmful or dangerous nature for the individual concerned."[67] By extension, explained the Court, Article 8 "included the right to choose when and how to die."[68] Despite the government's arguments to the contrary, Ms. Pretty's Article 8 rights were engaged.

Next, without a developed body of precedent, the Court conducted a somewhat random search for guidance on whether the United Kingdom had interfered with Ms. Pretty's right to privacy.[69] The Court first looked for persuasive authority in the House of Lords. In his dissenting opinion, Lord Hope had argued that "the closing moments of [Ms. Pretty's] life [were] part of the act of living, and [that] she [had] a right to ask that [these moments] must be respected."[70] The Court agreed with Lord Hope and observed that "notions of the quality of life" have great value under Article 8; the DPP's refusal to grant Mr. Pretty immunity diminished, or interfered with, Ms. Pretty's ability to control her quality of life.[71] The Court also noted that "[i]n an era of growing medical sophistication combined with longer life expectancies, many people are concerned that they should not be forced to linger on in old age or in states of advanced physical or mental decrepitude which conflict with strongly held ideas of self and personal identity."[72]

As a living document, the Convention is designed to ameliorate modern concerns.[73] Finally, the Court referenced *Rodriquez v. Attorney General of Canada*, where the Supreme Court of Canada applied the Canadian Charter to similar facts and concluded that a prohibition on assisted suicide "required justification under principles of fundamental justice."[74] Relying on a hodgepodge of authority — Lord Hope's dissent,

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67. *Pretty*, 35 Eur. H.R. Rep. at 36. *See, e.g.,* Laskey, Jaggard & Brown v. United Kingdom, 24 Eur. H.R. Rep. 39 (1997) (concerning prosecution and conviction for sado-masochistic practices within the home); Valasinas v. Lithuania, App. No. 44558/98(2001) (concerning refusal of medical treatment for a prisoner), *available at* http://hudoc.echr.coe.int (last visited Sept. 14, 2003).

68. *Pretty*, 35 Eur. H.R. Rep. at 35.

69. *Id.* at 37 (Ms. Pretty "is prevented by law from exercising her choice to avoid what she considers will be an undignified and distressing end to her life. The Court is not prepared to exclude that this constitutes an interference….").

70. *Id.* at 22 (quoting R. v. DPP, 10 H.R.L.R. 241 (HL 2002) (Hope, L., dissenting) on the application of Pretty).

71. *Id.* at 37.

72. *Id., at* 37.

73. *See* Marckx v. Belgium, 5 Eur. H.R. Rep. 330, 353 (1979) (recalling that the Convention must be interpreted "in light of present-day conditions").

74. *Pretty*, 35 Eur. H.R. Rep. at 37 (citing Rodriguez v. Attorney Gen. of Canada, [1994] 2 L.R.C. 136). *See generally* Caroline Richmond, *British Case Mimics* Rodriguez *Case*, 166 CANADIAN MED. ASS'N J. 232 (2002), *available at* www.cma.ca/cmaj/cmaj_today/2001/12_03.htm (Dec. 3, 2001).

public opinion, and Canadian law — the Strasbourg Court determined that the United Kingdom's law, and not Ms. Pretty's illness, prevented her from exercising her privacy rights under the Convention.

In concluding its analysis, the Court addressed the final piece of the Article 8 puzzle: whether the United Kingdom's interference with Ms. Pretty's right to privacy was justified; in other words, whether the interference was "in accordance with the law," had legitimate aims, and was "necessary in a democratic society."[75] Ms. Pretty agreed that the prohibition on assisted suicide was imposed by law and that the 1961 Suicide Act legitimately aimed to protect life and the rights of others.[76] Her concessions enabled the Court to focus on the necessity of the interference.[77] As the Court explained, "the notion of necessity implies that the interference corresponds to a pressing social need and, in particular, that it is proportionate to the legitimate aim pursued."[78] Moreover, "in determining whether an interference is 'necessary in a democratic society', the Court will take into account that a margin of appreciation is left to the national authorities."[79] This margin of appreciation expands and contracts; and here, the court abruptly ruled that unlike interferences with an individual's sex life that require particularly compelling reasons under a narrow margin of appreciation,[80] interferences with an individual's right to self-determination call for a wide margin of appreciation.[81] The Court visualized universal rights on a continuum and recognized one's freedom of sexual identity as more universal than the right to self-determination.[82] In this light, the Court turned to the question of proportionality.

The proportionality test examines the relationship between the interference—a general ban on all methods of assisted suicide as applied to a "mentally competent adult who knows her own mind, who is free from pressure and who has made a fully informed and voluntary decision" — and the purpose of the interference — to protect the vulnerable.[83] While the Court recognized a lack of proportionality in this relationship, it also noted that states are free to protect public health and safety through the application of general criminal law and that the states'

75. *Pretty*, 35 Eur. H.R. Rep. at 37 (quoting Dudgeon v. United Kingdom, 4 Eur. H.R. Rep. 149, 162 (1982)).
76. *Id.*
77. *See id.*
78. *Id.* at 38.
79. *Id.*
80. *See* Smith & Grady v. United Kingdom, 31 Eur. H.R. Rep. 620, (2000) ("A margin of appreciation is left open to Contracting States [and] varies according to the nature of the activities restricted and of the aims pursued by the restrictions.") (citing Dudgeon v. United Kingdom, 4 Eur. H.R. Rep. 149 (1982)).
81. *Pretty*, 35 Eur. H.R. Rep. at 42.
82. *See id.* at 38.
83. *Id.*

interests had to be balanced against the interference with an individual's personal autonomy or liberty.[84] Personal autonomy sat on one side of the scale and an entire class of vulnerable individuals, plus the United Kingdom's assessment of the risk of abuse, piled onto the other side.[85] "[N]otwithstanding arguments as to the possibility of safeguards and protective procedures," public health and safety interests outweighed personal autonomy.[86] The interference was justified; the United Kingdom's prohibition on assisted suicide did not violate Article 8 of the Convention. Six months after the European Court of Human Rights announced its decision and declined to give Ms. Pretty the right to authorize active euthanasia, Ms. Pretty died in the manner "she had foreseen and was afraid of," at the Pasque Hospice and not at home.[87]

Tension in the Strasbourg Court's universalist aspirations and relativist tendencies clearly shaped its analysis of what is "necessary in a democratic society."[88] The Court's use of the balancing test may have been an attempt to formulate universal standards through objective measures, but its application of a wide margin of appreciation dictated a predetermined outcome. Common law courts have held that state interests — "(1) preserving life; (2) preventing suicide; (3) avoiding the involvement of third parties and use of arbitrary, unfair, or undue influence; (4) protecting family members and loved ones; (5) protecting the integrity of the medical profession; and (6) avoiding future movement toward euthanasia and other abuses [a slippery slope]"[89] — outweigh the right to privacy if the patient wants to die by lethal injection, but the same state interests do not outweigh the right to privacy if the patient wants to die by terminating life-sustaining treatment.[90] Despite this

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84. This was the position held by both the House of Lords and the Supreme Court of Canada in *Rodriguez*, but the Court seems to be applying a hybrid of the United States Supreme Court's First Amendment analysis — neutral law of general application — and its analysis under the Equal Protection clause of the Fourteenth Amendment. *See generally* R. v. DPP (on the application of Pretty), 10 H.R.L.R. 241 (HL 2002); Rodriguez v. Attorney Gen. of Canada [1993] 3 S.C.R. 519, 523.

85. *See Pretty*, 35 Eur. H.R. Rep. at 39.

86. *Id.* The Court harbored a belief that the Suicide Act of 1961 provided flexibility in the law in requiring the consent of the DPP prior to prosecution and in its allowance of minimal sentences. The Court fails to recognize that these elements do not provide flexibility for law-abiding citizens.

87. *Diane Pretty Dies*, BBC NEWS ONLINE, *at* http://news.bbc.co.uk/1/low/health/1983457.stm (quoting Brian Pretty)(May 12, 2002).

88. Convention, *supra* note 8, at art. 8(2).

89. Washington v. Glucksberg, 521 U.S. 702, 728 n.20 (1997). *See generally* Linda L. Emanuel, *A Question of Balance, in* REGULATING HOW WE DIE: THE ETHICAL, MEDICAL, AND LEGAL ISSUES SURROUNDING PHYSICIAN-ASSISTED SUICIDE 234, 235 (Linda L. Emanuel ed., 1998) (including a chart of the arguments for and against physician-assisted suicide and active euthanasia).

90. *See* Lewis, *supra* note 23, at 57 ("When a competent terminal patient chooses to die, the state interests balanced against that patient's right to privacy are virtually the same regardless of the means chosen." (quoting Steven J. Wolhandler, *Voluntary Active Euthanasia*

inconsistency, the Strasbourg Court deferred to the law of the United Kingdom and the House of Lords.

The House of Lords was influenced by the United States Supreme Court's decision in *Cruzan v. Director, Missouri Department of Health*.[91] In *Cruzan*, Nancy Beth Cruzan spent seven years in a persistent vegetative state (PVS)[92] as a result of injuries she sustained in a tragic car accident; her parents petitioned the Missouri courts for permission to terminate all life-sustaining treatment.[93] The Supreme Court of Missouri held that Ms. Cruzan's parents lacked the authority to withdraw their daughter's artificial feeding and hydration tubes because they could not produce the statutorily required "clear and convincing" evidence of Ms. Cruzan's directives for treatment under such circumstances.[94] The Supreme Court granted certiorari and held in a 5-4 decision that the United States Constitution allowed Missouri to require clear and convincing evidence of an incompetent patient's consent to terminate life-sustaining treatment.[95]

The majority opinion in *Cruzan* by Chief Justice Rehnquist was similar to the Strasbourg Court's decision in *Pretty* in that it first surveyed the law of its "member states," in this case Missouri, Massachusetts, New York, New Jersey, California, and Illinois.[96] Although the Supreme Court never had held that a generalized right to privacy included a right to refuse treatment, many state court decisions were grounded on an individual's constitutional right to privacy.[97] Justice

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for the Terminally-ill and the Constitutional Right to Privacy, 69 CORNELL L. REV. 363, 375 (1984)).

91. *See* Airedale N.H.S. Trust v. Bland, [1993] A.C. 789, 803-04, 859 (outlining the Court's analysis in Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261 (1990).

92. According to Dr. Fred Plum, creator of the term "persistent vegetative state," PVS refers to:

> a body which is functioning entirely in terms of its internal controls. It maintains temperature. It maintains heart beat and pulmonary ventilation. It maintains digestive activity. It maintains reflex activity of muscles and nerves for low level conditioned responses. But there is no behavioral evidence of either self-awareness or awareness of the surroundings in a learned manner.

In re Jobes, 108 N.J. 394, 403 (1987).

93. *See Cruzan*, 497 U.S. 261, 265-66.

94. *Id.* at 265.

95. *Id.* at 266. After this case, a lower court heard further evidence and decided that the clear and convincing standard had been met. Nancy Cruzan died 12 days later on December 26, 1990. RONALD D. ROTUNDA, MODERN CONSTITUTIONAL LAW 870 (2000).

96. *See Cruzan*, 497 U.S. at 269-78. *See also* Pretty v. United Kingdom, 35 Eur. H.R. Rep. 1, 22-24 (2002).

97. *Cruzan*, 497 U.S. at 279 n.7. *See, e.g., In re* Quinlan, 355 A.2d 647, 662-64 (N.J. 1976), *cert. denied sub nom;* Garger v. New Jersey, 429 U.S. 922 (1976) (finding that the patient had a right to privacy grounded in the Federal Constitution to terminate treatment); Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417 (Mass. 1977) (relying on the right to privacy to permit the withholding of chemotherapy from a profoundly retarded patient); Conservatorship of Drabick, 245 Cal. Rptr. 840 (App. 6 Dist. 1988), *cert. denied*, 488

O'Connor, however, noted in her concurring opinion that "no national consensus has yet emerged on the best solution for this difficult and sensitive problem."[98] The Supreme Court did not decide the issue in *Cruzan* because it did not face a particularized claim like the one presented by Diane Pretty.

Privacy-based arguments for the right to die still rely on *Cruzan* and on the Supreme Court's sole recognition that competent adults have a constitutional right to direct life-sustaining treatment to be withheld.[99] If patients have the right to *refuse* medical treatment, the argument proceeds, then they have the right to *choose* medical treatment.[100] Moreover, if patients have a right to die naturally, then they have a right to die under the care and supervision of a physician.[101] For now, just as the European Court of Human Rights has instituted a wide margin of appreciation in assisted suicide cases, the U.S. Supreme Court has deferred to the states and to their respective legislatures to make sense of these issues.[102] Recent cases, however, suggest that five out of nine Supreme Court justices stand ready to acknowledge a constitutional right

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U.S. 958 (1988) (authorizing removal of a nasogastric feeding tube based on a constitutional right to privacy). Rehnquist suggested that the individual right involved may best fit within the scope of the Fourteenth Amendment's liberty interest, but the Court did not answer this question; the only issue presented was whether Missouri's law was constitutional. *See Cruzan*, 497 U.S. at 279. *See also* Lewis, *supra* note 23, at 56 ("Arguments in favor of a right to suicide or assisted suicide derived from the right to privacy are closely related to those derived from the rights to autonomy and liberty.").

98. *Cruzan*, 497 U.S. at 292.

99. *See* RONALD DWORKIN, LIFE'S DOMINION 188 (1993) ("Several states revised their laws after the *Cruzan* decision, and every state has now made provision for honoring living wills, health-care proxies, or, in most states, both. In 1990, Congress adopted a law requiring all hospitals supported by federal funds to inform [patients]…about advance directives.").

100. *But see* Nat'l Legal Ctr. for the Medically Dependent & Disabled, Inc., *Whether Physician-Assisted Suicide Serves A "Legitimate Medical Purpose" Under the Drug Enforcement Administration's Regulations Implementing the Controlled Substances Act*, 17 ISSUES LAW & MED. 269, 292 (2002) (concluding that physician-assisted suicide does not serve a legitimate medical purpose); Wesley J. Smith, *Killing Isn't Medicine*, NAT'L REV. ONLINE (May 1, 2002), *at* www.nationalreview.com/comment-smith050102.asp (arguing that if assisted suicide was a medical procedure, the European Court of Human Rights would not have heard Pretty's case because it would have been clear that she was asking the Court to allow her husband to practice medicine without a license).

101. *See* Lewis, *supra* note 23, at 56-57; Compassion in Dying v. Washington, 49 F.3d 586, 595-96 (9th Cir. 1995) (Wright, J., dissenting) (asserting that terminally-ill, mentally competent adults have a fundamental privacy right to physician-assisted suicide), *rev'd* 850 F. Supp. 1454 (W.D. Wash. 1994), *rev'd en banc,* 79 F.3d 790 (9th Cir. 1997), *aff'd*, Washington v. Glucksberg, 521 U.S. 702, 743 (1997).

102. Unlike its influence on the European Court of Human Rights, national consensus is not determinative of the Supreme Court's decision; the Supreme Court's legitimacy does not rest in a margin of appreciation and the Court is free to overrule even a unanimous position held by the collective states. *See* Margaret P. Battin, *Is a Physician Ever Obligated to Help a Patient Die?, in* REGULATING HOW WE DIE: THE ETHICAL, MEDICAL, AND LEGAL ISSUES SURROUNDING PHYSICIAN-ASSISTED SUICIDE 21, 21 (Linda L. Emanuel ed., 1998) ("Physician-assisted suicide will probably soon become legal on a state-by-state basis, culturally tolerated, and openly practiced.").

to physician-assisted suicide for competent, terminally ill adults.[103] Recognition of a universal right to die therefore looms in the future, tipping national, and perhaps international, balances in the direction of individual rights. But before the courts can recognize a universal right to die, they must first abandon the judicial device that enables them to differentiate between active euthanasia, passive euthanasia, and palliative care.

III. DEFINING DEATH

Beyond the Strasbourg and United States Supreme Courts' analyses of guaranteed, fundamental rights, the international body of right-to-die-jurisprudence rests on carefully crafted language and technical distinctions between active and passive euthanasia and between active euthanasia and palliative care. As a result, language has meant the difference between life and death. For purposes of this paper, the terms "physician-assisted suicide" and "euthanasia," meaning the intended termination of a patient's life, have been used interchangeably; Ms. Pretty would have been satisfied with either one. But the euthanasia movement has a lexicon of its own, and a person contributing to the discourse must be aware of the subtle distinctions assigned to the terms "physician-assisted suicide" and "euthanasia." Physician-assisted suicide occurs when — in response to a request from a mentally competent, terminally-ill[104] adult — "a doctor knowingly and intentionally gives a patient the means [to commit suicide], or otherwise assists a patient who takes his or her own life."[105] In these cases, the physician most often prescribes a lethal dosage of medication for either the patient or someone

103. In Washington v. Glucksberg, 521 U.S. 702 (1997), the Court applied the Fourteenth Amendment's Due Process Clause to Washington's ban on assisted suicide and found that the statute was rationally related to legitimate governmental interests. On the same day, the Court decided Vacco v. Quill, 521 U.S. 793 (1997) and held that New York's prohibition did not violate the Fourteenth Amendment's Equal Protection Clause. Justices O'Connor, Ginsberg, Breyer, Souter, and Stevens filed concurring opinions which left open the possibility that a ban on assisted suicide could be unconstitutional as applied to a competent, terminally-ill adult. For further discussion on the majority and concurring opinions in these cases, see Neil M. Gorsuch, *The Right to Assisted Suicide and Euthanasia*, 23 HARV. J.L. & PUB. POL'Y 599, 613-21 (2000).

104. The characterization of a patient as "terminally-ill" refers to "an incurable or irreversible condition that has a high probability of causing death within a relatively short time with or without treatment." Margaret A. Drickamer et al., *Practical Issues in Physician-Assisted Suicide*, ANNALS OF INTERNAL MED. (Jan. 15, 1997), *at* http://www.acponline.org /shell-cgi/printhappy.pl/ journals/annals/15jan97/pipas.htm. A patient may be considered terminal if he or she has acquired a "terminal disease," meaning "an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months." *Id.*

105. Roger S. Magnusson, *The Sanctity of Life and the Right to Die: Social and Jurisprudential Aspects of the Euthanasia Debate in Australia and the United States*, 6 PAC. RIM. L. & POL'Y J. 1, 4 (1997).

other than the physician to administer.[106] Euthanasia, on the other hand, literally means "easy death;" in common parlance, the word refers to "an act or practice of painlessly putting to death persons suffering from incurable conditions or diseases."[107] When used in the discourse of the "right to die" movement, however, euthanasia escapes universal definition.[108]

In *Euthanasia, Ethics, and Public Policy*, John Keown identifies three definitions of euthanasia; "all three…concur that 'euthanasia' involves *doctors* making decisions *which have the effect of shortening a patient's life* and that these decisions are *based on the belief that the patient would be better off dead.*"[109] The scope of activities covered by each of the definitions varies greatly, but the end result is the same for the patient. In contrast, the physician must face consequences of a drastically different nature.

A. Active Euthanasia

Keown's first definition of euthanasia, most often referred to as "active euthanasia,"[110] addresses "the *active, intentional* termination of a patient's life by a doctor."[111] Unlike physician-assisted suicide, where the doctor prescribes a lethal dosage of medication for self-administration, active euthanasia depends on the doctor to administer the drug.[112] Most jurisdictions, including the United Kingdom and the United States, define euthanasia under this narrow definition.[113] But instead of distinguishing active euthanasia from physician-assisted suicide, they lump the two together and offer another label, namely murder.[114]

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106. Lara L. Manzione, *Is There a Right to Die?: A Comparative Study of Three Societies (Australia, Netherlands, United States)*, 30 GA. J. INT'L & COMP. L. 443, 446 (2002).

107. WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY 786 (2002) (noting that the etymology is Greek).

108. *See* KEOWN, *supra* note 27, at 10.

109. *Id.*

110. BLACK'S LAW DICTIONARY, *supra* note 111, at 575.

111. KEOWN, *supra* note 27, at 10.

112. *See* BLACK'S LAW DICTIONARY, *supra* note 111, at 575.

113. KEOWN, *supra* note 27, at 11. The House of Lords Select Committee on Medical Ethics defined euthanasia in 1994 as "a deliberate intervention undertaken with the express intention of ending a life to relieve intractable suffering." *Id.* (quoting *Report of the Select Committee on Medical Ethics* (HL Paper 21-I of 1993-4)). In that same year, the New York State Task Force on Life and the Law defined Euthanasia as "direct measures, such as a lethal injection, by one person to end another person's life for benevolent motives." *Id.* (quoting N.Y. STATE TASK FORCE ON LIFE & THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT (1994)).

114. *See* Suicide Act, 1961, 9 & 10 Eliz. c. 60, § 2 (1) (Eng.) (criminalizing assisted suicide in the United Kingdom); R. v. United Kingdom 33 D.R. 270 (1983) (finding that the applicant's conviction for aiding and abetting suicide did not violate the Convention). For a comprehensive state survey of laws criminalizing assisted suicide in the United States, see Vacco v. Quill, 521 U.S. 793, 805 n.9 (1997). Oregon is currently the only jurisdiction in the United States that legalizes physician-assisted suicide. *See* The Oregon Death With Dignity Act, OR.

The case of *People v. Kevorkian* is widely recognized for its conviction of Dr. Jack Kevorkian, a seventy-one year old physician sentenced to concurrent prison terms of seven years for delivering a controlled substance and ten to twenty-five years for the second-degree murder of former racecar driver Thomas Youk.[115] Like Ms. Pretty, Mr. Youk suffered from ALS, but similarities between the two cases end there.[116] Most notably, Mr. Youk expressed his desire to die with seemingly less conviction.[117] Notwithstanding the gravity of Mr. Youk's decision, Dr. Kevorkian, "perhaps the most notorious proponent of assisted suicide and euthanasia,"[118] met with Mr. Youk for the first time on September 15, 1998; the meeting lasted twenty minutes.[119] On the following night, Dr. Kevorkian returned to perform, in his words, "a mercy killing."[120] In less than five minutes, Mr. Youk was dead.[121] Although Dr. Kevorkian had assisted in over 130 suicides,[122] Mr. Youk's death was the first to be recorded and aired on national television.[123]

In the course of its decision, the Michigan Court of Appeals remarked that "[b]ut for defendant's self-described zealotry, Thomas

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REV. STAT. ch. 127.800 § 1.01 (1994). Attorney General Ashcroft has challenged Oregon's Death With Dignity Act as a violation of the federal Controlled Substances Act. *See generally* Oregon v. Ashcroft, 192 F. Supp. 2d 1077 (2002); Memorandum from Sheldon Bradshaw, Deputy Assistant Attorney General, and Robert J. Delahunty, Special Counsel, to the Attorney General (June 27, 2001), *reprinted in Whether Physician-Assisted Suicide Serves a "Legitimate Medical Purpose" Under the Drug Enforcement Administration's Regulations Implementing the Controlled Substances Act*, 17 Issues L. & Med. 269 (2002).

115. 639 N.W.2d 291, 296 (Mich. Ct. App. 2001), *appeal denied*, 642 N.W.2d 681 (Mich. 2002), *and cert. denied*, 2002 WL 1575134 (U.S. Oct. 7, 2002). *See also* ANGELS OF DEATH, *supra* note 5, at 32-34 (describing the exploits of Australia's answer to Kevorkian, Dr. Philip Nitschke, "who presided over all four of the legal euthanasia deaths under the Territory legislation" before it was repealed).

116. *See Kevorkian*, 639 N.W.2d at 298.

117. Dr. Kevorkian allegedly had Mr. Youk sign a consent form and read a prepared statement before being injected with potassium chloride:

> I, Thomas Youk, the undersigned, entirely voluntarily, without any reservation, external persuasion, pressure, or duress, and after prolonged and thorough deliberation, hereby consent to the following medical procedure of my own choosing, and that you have chosen direct injection, or what they call active euthanasia, to be administered by a competent medical professional, in order to end with certainty my intolerable and hopelessly incurable suffering.

Id.

118. Gorsuch, *supra* note 103, at 601.

119. *See Kevorkian,* 639 N.W.2d at 298.

120. *Id.* at 296.

121. *Id.* at 298.

122. Gorsuch, *supra* note 103, at 601. Despite his notoriety, Dr. Kevorkian is "hardly without allies. Derek Humphry, founder of The Hemlock Society, a group devoted to the legalization of euthanasia, has praised Dr. Kevorkian for 'breaking the medical taboo on euthanasia.' The [ACLU] has taken up his legal defense." *Id. But see Kevorkian*, 639 N.W.2d at 312-14 (discussing Kevorkian's decision to represent himself).

123. For a discussion on Dr. Kevorkian's interview with Mike Wallace of *60 Minutes*, see *Kevorkian*, 639 N.W.2d at 299-300.

Youk's death would, in all probability, not have been the subject of national attention, much less a murder trial."[124] In reality, a majority of common law jurisdictions have not prosecuted individuals under assisted suicide statutes since the early 1900s, and this common practice of willful blindness may have left Mr. Youk's death as little more than a number on Dr. Kevorkian's ghoulish résumé.[125] Instead, Dr. Kevorkian repeatedly challenged the courts to judge his actions, which he genuinely believed "could never be a crime in any society which deems itself enlightened," in its purest form.[126] Dr. Kevorkian embodies many of society's rightly-held fears regarding the legalization of physician-assisted suicide; in terms of human rights role models, he is no Diane Pretty. But the strength of Dr. Kevorkian's convictions is seen in his unwavering refusal to characterize his actions under more acceptable definitions of euthanasia, namely passive euthanasia or palliative care.[127]

B. Termination of Life by Act or Omission

Keown's second definition, which he titles "the intentional termination of life by act or by omission," includes the intentional killing of a patient by removal of an artificial breathing device or through the termination of an artificial means of sustenance.[128] Acts such as these are commonly referred to as "passive euthanasia."[129] Under the notion that switching off a patient's ventilator, for example, is an omission rather than an action,[130] the United Kingdom and the United States have exempted physicians and other health care providers from criminal prosecution for the death of a competent patient who either refuses or

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124. *Id.* at 297.

125. *See* Compassion in Dying v. Washington, 79 F.3d 790, 808-10 (9th Cir. 1996) (en banc). Despite laws prohibiting assisted suicide, courts and medical associations in the United Kingdom and the United States have been lenient in dealing with doctors who have admitted prescribing legal dosages of medication to patient with whom they had shared a long, professional relationship. For anecdotal stories of cases in Canada, the United Kingdom, and the United States, see DWORKIN, *supra* note 99, at 185-87.

126. *Kevorkian*, 639 N.W.2d at 299 (quoting Kevorkian's interview on *60 minutes*).

127. *See* Barry A. Bostrom, *In the Michigan Court of Appeals:* People vs. Jack Kevorkian, 18 ISSUES L. & MED. 57, 59 (2002) (noting that Kevorkian did not claim that his actions were covered by the right to refuse life-sustaining treatment or to relieve pain).

128. KEOWN, *supra* note 27, at 12.

129. *See* BARRON'S LAW DICTIONARY 178 (4th ed. 1996). *See also* CAROL KROHM, M.D. & SCOTT SUMMERS, ADVANCE HEALTH CARE DIRECTIVES 140 (2002) [hereinafter ADVANCE HEALTH CARE DIRECTIVES](reporting that "some medical practitioners unilaterally…resort to approaches that come right up to the line of passive euthanasia: 'slow codes' (also known as 'Hollywood Codes' or 'Light Blue,' among other euphemisms), where health care providers go through the motions of heroic interventions").

130. *But see* Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 296-97 (1990) (Scalia, J., concurring) (quoting Blackstone, "[T]he cause of death in both cases is the suicide's conscious decision to pu[t] an end to his own existence.").

wishes to terminate life-sustaining treatment.[131] In fact, even if the patient is incompetent, health care law has evolved in both jurisdictions such that advance directives, particularly living wills and the durable powers of attorney, are recognized as the patient's voice "on how medical choices are to be made in the event of decisional or communicative incapacity."[132] Thus, while competent adults like Ms. Diane Pretty are refused the right to self-determination, passive euthanasia extends the right to die to competent *and* incompetent patients who depend on life-sustaining medical treatment.

The House of Lords relied on this unconvincing logic to distinguish passive euthanasia from active euthanasia in *Airedale NHS Trust v. Bland*.[133] Anthony Bland suffered a crushing blow to his chest as a result of the 1989 Hillsborough disaster,[134] which left him in a persistent vegetative state at the young age of seventeen.[135] A team of doctors agreed "that there was absolutely no hope of any improvement" and sought judicial declarations from the High Court of Justice allowing them to remove Mr. Bland's artificial feeding tube and to cease antibiotic treatment.[136] The High Court acknowledged that within two weeks, "the lack of sustenance would bring an end to the physical functioning of the body of Anthony Bland[,] and he would in terms 'die.' The process would be that of 'starvation.'"[137] All euphemisms aside, the "process" would be that of a mercy killing, a court-sanctioned death by starvation. Had Mr. Bland been able to consent to the withdrawal of the nasogastric tube, or had he prepared advance directives, the doctors would have been able to proceed without the threat of prosecution.[138] Unfortunately, the only

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131. *See* Ms. B v. An NHS Hospital Trust, 2 Eng. Rep. 449 (Fam. 2002) (declaring that Ms. B's right to refuse artificial ventilation is well-established); *In re* Quinlan, 355 A.2d 647, 662-64 *cert. denied sub nom.* Garger v. New Jersey, 429 U.S. 922 (1976) (holding that Ms. Quinlan had a privacy right to terminate treatment).

132. ADVANCE HEALTH CARE DIRECTIVES, *supra* note 129, at 9. *See also* Brendan A. Thompson, *Final Exit: Should the Double Effect Rule Regarding the Legality of Euthanasia in the United Kingdom be Laid to Rest?*, 33 VAND. J. TRANSNAT'L L. 1035, 1038 (2000) ("Under English law, doctors may honor a patient's request for passive euthanasia if [the request is] either made to the doctor personally or by an advance directive."). For a discussion on advance directives and other health care alternatives in the United States, see generally ADVANCE HEALTH CARE DIRECTIVES, *supra* note 129.

133. [1993] A.C. 789, 865 ("[T]he law draws a crucial distinction between cases in which a doctor decides not to provide, or to continue to provide…treatment or care which could…prolong his life, and those in which he decides…to bring his patient's life to an end…. [T]he former may be lawful….").

134. For more information on the Hillsborough disaster, see http://www.contrast.org/hillsborough/history/index.shtm (last visited Sept. 14, 2003).

135. *See Airedale N.H.S. Trust*, [1993] A.C. at 795.

136. *Id.* at 796. The trial court noted that the hospital was not financially motivated to seek such a declaration. *See id.*

137. *Id.*

138. *See id.* at 809. The court explained that:

> if, presciently, Mr. Bland had given instructions that he should not be

evidence of Anthony Bland's wishes was his father's feelings that his son "wouldn't want to be left like he is."[139] The judges agreed.

In a unanimous decision, the House of Lords dismissed the official solicitor's appeal and held that the hospital could lawfully terminate Mr. Bland's treatment because he no longer benefited from it.[140] Despite Lord Mustill's admonition that "[e]mollient expressions such as 'letting nature take its course' and 'easing the passing'…[were] out of place,"[141] the Lords glossed over the reality of death and dedicated much of their attention to distinguishing passive euthanasia from active euthanasia. Their arguments are weak. Lord Goff conceded that:

> the drawing of this distinction may lead to a charge of hypocrisy; because it can be asked why, if the doctor, by discontinuing treatment, is entitled in consequence to let his patient die, it should not be lawful to put him out of his misery straight away, in a more humane manner, by a lethal injection, rather than let him linger on in pain until he dies.[142]

Lord Goff's answer to the charge? The law cannot recognize active euthanasia as lawful because it will become "difficult to see any logical basis for excluding it."[143] The "slippery slope" argument, as discussed in greater detail in Part IV of this Article, does not advance a rational basis for distinguishing starvation from lethal injection. Lord Keith's reasoning is equally unconvincing. He opines that "the principle of the sanctity of life…forbids the taking of active measures to cut short the life of a terminally ill patient," but it does not prohibit the cessation of "medical treatment and care to a [PVS] patient who has been in that state for over three years, considering that to do so involves invasive manipulation of the patient's body to which he has not consented and which confers no benefit upon him."[144] Rather than serving as an exhibition of critical analysis, Lord Keith's words reveal a value judgment based on medical testimony that Mr. Bland's life was not worth living.

> artificially fed or treated with antibiotics if he should become a P.V.S. patient, his doctors would not act unlawfully in complying with those instructions but would act unlawfully if they did not comply, even though the patient's death would inevitably follow.

Id.

139. *Id.* at 797.
140. *See id.* at 856-99.
141. *Airedale N.H.S. Trust*, [1993], A.C.. at 886-87.
142. *Id.* at 865.
143. *Id.*
144. *Id.* at 859.

Interestingly, Lord Keith took "comfort to observe that in other common law jurisdictions, particularly in the United States,…the courts have with near unanimity concluded that it is not unlawful to discontinue medical treatment and care…of [PVS] patients."[145] Common law jurisdictions like the United Kingdom and the United States have differentiated between active and passive euthanasia by crafting legal distinctions out of Anglo-American traditions.[146] Lord Browne-Wilkinson explained in *Airedale N.H.S. Trust* that a patient must consent to medical treatment because touching a patient's body without consent "constitutes the [common law] crime of battery and the tort of trespass to the person."[147] The right to the withdrawal of life support, Lord Browne-Wilkinson explained, is justified by laws against battery.[148] The common law courts have focused on the definition of battery rather than the mercy killing performed when active steps are taken to withdraw life support. The United States Supreme Court is no exception. While it may be true that the United States judiciary is a bastion of rational thought, the bi-polar regulation of active and passive euthanasia is not its finest example.[149]

The medical, ethical, and legal issues presented by *In re Quinlan* are remarkably similar to *Bland.*[150] Karen Ann Quinlan, a twenty-two year old New Jersey resident, had inexplicably lapsed into a "chronic and persistent vegetative state."[151] For more than a year, Ms. Quinlan assumed a "fetal-like and grotesque" position in a hospital's intensive care unit.[152] Although she required a ventilator and an artificial means of sustenance, "[u]nder any legal standard recognized by the State of New Jersey and also under standard medical practice, Karen Ann Quinlan [was] alive."[153] Like Mr. Bland, Ms. Quinlan did not have advanced directives and could not consent to the termination of treatment, yet her father sensed from prior conversations that she would not have wanted to continue living in a vegetative state.[154] He therefore sought guardian-

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145. *Id.*

146. *But see* Compassion in Dying v. Washington, 79 F.3d 790, 808-10 (9th Cir. 1996) (en banc) (explaining that although assisted suicide was unlawful under English and American common law, a majority of the states had not prosecuted individuals under attempted suicide statutes since the early 1900s).

147. *Airedale N.H.S. Trust*, [1993] A.C. at 882-83 ("The doctor cannot owe to the patient any duty to maintain his life where that life can only be sustained by intrusive medical care to which the patient will not consent".).

148. *See id.*

149. Many American courts have recognized the distinction between passive and active euthanasia. *See* Vacco v. Quill, 521 U.S. 793, 804 n.8 (1997) (compiling cases).

150. *In re* Quinlan, 355 A.2d 647 (N.J.), (1976) *cert. denied sub nom.* Garger v. New Jersey, 429 U.S. 922 (1976).

151. *See id.* at 655.

152. *Id.*

153. *Id.* at 652.

154. *See id.* at 653.

ship over his daughter and petitioned the court to terminate her treatment.[155]

After an initial finding that hearsay evidence of Ms. Quinlan's aversion to life-sustaining medical treatment lacked significant probative weight, the New Jersey Supreme Court aimed to accord the withdrawal of life support with the state's medical standards and ethics;[156] its conclusions rested "upon definitional and constitutional bases."[157] In defining passive euthanasia, the court made an incredulous leap by likening a physician's withdrawal of life support for PVS patients to the hospital's treatment of terminal patients who die naturally.[158] Doctors testified to an "unwritten and unspoken standard of medical practice implied in the foreboding initials DNR," which prevents health care workers from taking extraordinary measures to resuscitate terminally-ill patients.[159] The generally accepted practice of failing to revive terminally-ill patients, in the court's reasoning, was similar to the informal doctrine of "judicious neglect" where a physician decides that "it does not serve either the patient, the family, or society in any meaningful way to continue treatment with [the] patient" and accordingly suspends or terminates the patient's care.[160] While the court admitted that its "thread of logic…may be elusive," it found that the withdrawal of life support, like DNR orders, comported with New Jersey's medical standards of acting in the best interests of the patient.[161]

The court's "thread of logic," like the threads of the emperor's new clothes, was "make believe."[162] Of course passive euthanasia is *not* a DNR order; the former invites death, the latter prevents defeating it. Unlike a DNR order, passive euthanasia is not passive; it requires action such as the turning off of a ventilator or the removal of a nasogastric tube. Moreover, from the competent patient's perspective, passive euthanasia leads to an array of activities: "[r]emoving a respirator produces suffocation; terminating dialysis produces the symptoms of uremia; refusing feedings produces the symptoms of dehydration or starvation."[163]

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155. *See id.*

156. *In re Quinlan*. 355 A.2d at 657.

157. *Id.* at 670. The court's decision is supported by a right to privacy in the federal and state constitutions. *See id.* at 664 (finding that the termination of treatment is protected by her right to privacy). The Court's analysis under the right to privacy is discussed in greater detail in Part IV of this article.

158. *Id.* at 657.

159. *Id.* DNR stands for "do not resuscitate." *Id.*

160. *Id.*

161. *Id.*

162. *See generally* H.C. ANDERSON, THE EMPEROR'S NEW CLOTHES: AN ALL-STAR RETELLING OF THE CLASSIC FAIRY TALE (1998).

163. Marcia Angell, *Helping Desperately Ill People to Die*, *in* REGULATING HOW WE DIE: THE ETHICAL, MEDICAL, AND LEGAL ISSUES SURROUNDING PHYSICIAN-ASSISTED SUICIDE 3, 13 (Linda L. Emanuel ed., 1998).

In fact, passive euthanasia is more akin to active euthanasia; if passive euthanasia is legal, active euthanasia must be lawful as well.[164] But the New Jersey Supreme Court, like the House of Lords, distinguished passive euthanasia from active euthanasia. The court found that Ms. Quinlan's "ensuing death would not be homicide but rather expiration from existing natural causes [and that] if it were to be regarded as homicide, it would not be unlawful" because Ms. Quinlan had a right to refuse treatment.[165] Here again, semantics played an important role in the court's decision.

Airedale N.H.S. Trust and *Quinlan* clearly influenced the Strasbourg Court's decision in *Pretty* as it adopted the linguistic distinctions proffered by each of these cases.[166] In deciding whether the United Kingdom had interfered with Ms. Pretty's right to privacy, the Court noted that:

> the refusal to accept a particular treatment might, inevitably, lead to a fatal outcome, yet the imposition of medical treatment, without the consent of a mentally competent adult patient, would interfere with a person's physical integrity in a manner capable of engaging the rights protected under Article 8(1) of the Convention.[167]

The Court recognized that "in domestic case law, a person may claim to exercise a choice to die by declining to consent to treatment."[168] Then, with a slight of hand, the Court declared that "medical treatment [was] not an issue" in Ms. Pretty's case.[169] This statement enabled the Court to justify the United Kingdom's interference with Ms. Pretty's rights under Article 8(2), whereas the same actions would not have been justified had the court viewed active euthanasia in the same light as passive euthanasia.

In general, these decisions address distinctions between active and passive euthanasia based on causation, act-omission, and intent;[170] but

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164. *See* Robert L. Burgdorf Jr., *Assisted Suicide: A Disability Perspective*, *at* http://www.ncd.gov/newsroom/publications/suicide. html (Mar. 24, 1997) (Although he opposed the legalization of active euthanasia, Professor Burgdorf, writing on behalf of the National Council on Disability, conceded "that current laws and legal principles regarding treatment, nontreatment, and assisted suicide need refinement" to correct the ironies of the passive-active euthanasia dichotomy).

165. *In re Quinlan*, 355 A.2d at 669-70. *See also* Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 424-428 (1977) (concluding that the individual patient's interests in refusing treatment outweigh those of the state).

166. *See* Pretty v. United Kingdom, 35 Eur. H.R. Rep. 1, 36-37 (2002).

167. *Id.* at 36.

168. *Id.*

169. *Id.*

170. Gorsuch, *supra* note 103, at 643.

these distinctions cannot stand. The causation argument is that, unlike active euthanasia, with passive euthanasia the disease or "nature" is responsible for the patient's death when life-sustaining treatment is discontinued.[171] This is simply untrue. If the physician's actions are not the cause of the individual's death, then the causation argument prevents a state from prosecuting anyone who decides to terminate life support or refuse life-sustaining treatment against the patient's wishes. Moreover, "[w]hen patients decide to forgo or withdraw basic care such as food and water, the claim that death is 'caused' as much by that human choice as any death by lethal injection has some undeniable appeal."[172] The act-omission distinction is equally manipulable as "the writing of a prescription to hasten death…involves a far less active role for the physician than is required in bringing about death through asphyxiation, starvation and/or dehydration."[173] In fact, passive euthanasia contradicts Anglo-American notions of a physician's duty to his or her patient where "a physician's 'omission' of readily available treatment is the textbook definition of professional malpractice."[174] Yet the courts sanction passive euthanasia and disapprove of active euthanasia.[175] Influenced by bioethicists, the courts also focus on intent. According to the United States Supreme Court, a physician who terminates or forgoes life support "purposefully intends, or may so intend, only to respect his patient's wishes" while a doctor assisting suicide "must, necessarily and indubitably, intend primarily that the patient be made dead."[176] Diane Pretty's struggle is but one example of why this argument is preposterously false; a doctor who prescribes a lethal dosage of medication need not have any more of an intent to kill his or her patient than the doctor who withdraws the patient's life support.[177] The arguments are further weakened by the courts' treatment of palliative care that often includes the foreseeable consequence of death.

C. Foreseeable Consequences

Keown's third and final definition, adopted by many advocates of voluntary active euthanasia (VAE),[178] "embraces not only the intentional termination of life by act or omission, but also acts and omissions which

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171. *Id.* at 644.
172. *Id.* at 645.
173. Quill v. Vacco, 80 F.3d 716, 729 (2d Cir. 1996).
174. Gorsuch, *supra* note 103, at 646.
175. *See* Vacco v. Quill, 521 U.S. 793, 802 (1997).
176. *Id.* at 801-02.
177. Washington v. Glucksberg, 521 U.S. 702, 750 (1997) (Stevens, J., concurring).
178. Distinctions have been made between voluntary euthanasia (patient-initiated) and involuntary euthanasia (without the consent of the patient as a result of the patient's incompetency). *See, e.g.,* Thompson, *supra* note 132, at 1038-39; Manzione, *supra* note 106, at 446; Funk, *supra* note 12, at 151.

have the *foreseen* consequence of shortening life."[179] This final definition is the most broad; it includes the administration of large doses of palliative drugs, such as morphine, which have a known side-effect of depressing a patient's respiration.[180] Prescribing large doses of morphine does not fall under the first two definitions of euthanasia if the doctor does not intend to kill his or her patient but palliative care *is* included in the third definition, independent of the physician's motivation, because the patient's death is foreseeable.[181]

The inclusion of foreseen consequences in defining "euthanasia" challenges the well-established "double effect" doctrine which allows for the administration of pain-killers, despite their secondary effects, if the treatment is proportional to the illness and intended to ease suffering.[182] The United Kingdom, the United States, and presumably the European Court of Human Rights subscribe to this doctrine which has served to remove ethical and legal concerns from palliative care:

> Doctors prescribe large doses of medication knowing that, as a result, suffering will be lessened and also that life will be shortened. They feel comfortable with what they are doing: They are not breaking the law; they are acting in accordance with their medical understanding and perceive themselves as providing solace to suffering patients.[183]

Because the legality of palliative care rests on the physician's subjective state of mind, it is difficult to determine whether a decision to prescribe morphine, for example, rests on a genuine intention to ease a patient's pain or the physician's conviction that "enough is enough." Palliative care, in some ways, may be the "don't ask, don't tell" policy[184] of physician-assisted suicide. VAE advocates have attempted to redefine euthanasia to include generally accepted methods of palliative care, thereby winning the support of a broader segment of the population.

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179. KEOWN, *supra* note 27, at 15.
180. *Id.*
181. *See* KEOWN, *supra* note 27, at 15-16.
182. *See* THE RIGHT TO DIE WITH DIGNITY, *supra* note 26, at 27 (noting that the double effect doctrine was "developed by Roman Catholic moral theologians in the Middle Ages as a response to situations requiring actions in which it is impossible to avoid all harmful consequences."); *See generally* Thompson, *supra* note 132 (discussing the United Kingdom's utilization of the double effect doctrine).
183. THE RIGHT TO DIE WITH DIGNITY, supra note 26, at 27.
184. *See* Associated Press, *Bisexual Soldier Discharged* (Oct. 18, 2002), *available at* http://www.gaymilitary.ucsb.edu/PressClips/ 02_1018_AssociatedPress.htm (last visited Sept. 14, 2003) ("The Pentagon's 'don't ask, don't tell' policy allows gay men and lesbians to serve if they keep their sexual orientation private and do not engage in homosexual acts.").

But the global community has not adopted this comprehensive definition and opponents of assisted suicide continue to distinguish palliative care. For example, Wesley J. Smith, an attorney for the International Task Force on Euthanasia and Assisted Suicide, insists that "[a]lthough the use of pain-control drugs such as morphine, like surgery or most other medical treatments, can have serious side effects, including death, pain control, if *properly applied*, rarely hastens death [and]…is in no way akin to intentional killing."[185] Neil Gorsuch, author of *The Right to Assisted Suicide and Euthanasia*, quoting the Attorney General's brief from *Washington v. Glucksberg,* maintains that "[a]nalytically and medically, acceptance of palliative treatment that may result in death is no different from the knowing acceptance of the risk of death that accompanies many medical treatments, such as the risk of death attendant on a quadruple bypass."[186] Smith and Gorsuch too easily dismiss the reality of palliative care as applied to terminally-ill patients; unlike medical treatments that pose a risk of death, the high dosages necessary to relieve the pain of a terminal illness make death a foreseeable consequence rather than a mere possibility.[187] Nevertheless, the American Medical Association has endorsed palliative care even when death is foreseeable.[188] Until a patient's right to active euthanasia is treated in the same respect as his or her right to passive euthanasia or palliative care, courts will continue to tip the scales in favor of state interests.

IV. CONCLUSION

Sincerely held arguments against physician-assisted suicide and active euthanasia exist, and the two strongest points concern the "slippery slope" and the role that finances will play in the decision-making process if assisted suicide is legalized.[189] First, the law of entropy teaches that legal doctrine, like everything else, expands, rather than contracts; and the Dutch experience has given rise to fears of a slippery slope.[190] Statistical studies of the effect of legalization in the Netherlands are most often cited as support for the slippery slope; "[t]he extension of euthanasia to more patients has been associated with the inability to regulate the

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185. SMITH, *supra* note 13, at 222.
186. Gorsuch, *supra* note 103, at 707.
187. Council on Ethical and Judicial Affairs, American Medical Association, *Decisions Near the End of Life*, 267 JAMA 2229, 2232 (1992).
188. *Id.*
189. *See Assisted Suicide Seduction*, *supra* note 30.
190. *Id.* ("During the past 30 years, the Dutch have slid quickly down the slippery slope. Doctors have gone from killing terminally ill people who ask to be killed, to chronically ill persons who ask to be killed, to infants born with defects who by definition cannot ask to be killed.").

process within established rules."[191] But it is difficult to draw conclusions from these statistical studies because they cannot be likened to an objective norm and because various factors contribute to a physician's willingness to report cases of euthanasia; thus, a scholar's comparison of the number of cases of physician-assisted suicide post-legalization to the actual number of cases pre-legalization is misleading.[192] Second, opponents of active euthanasia worry that "assisted suicide inevitably will be about money. Once fully established in the bedrock of medical practice, it would be less about 'choice' than about profits in the health care system or cutting the costs of government-funded health care."[193] The financial argument gravely underestimates the ability of physicians and government officials to make medical, ethical, and moral decisions; moreover, it ignores the fact that the real decision makers are the competent adults who are terminally-ill. No matter their strength, the slippery slope and financial contentions do not outweigh an individual's right to self-determination.

The European Court of Human Rights, the House of Lords, the United States Supreme Court, and the many state supreme courts that have issued judgments on physician-assisted suicide share at least one common element in their decisions: each has crafted a legal fiction to deny the existence of a universal right to die. Of all the institutions, the European Court of Human Rights may be the least culpable. The Preamble of the Convention offers a primary defense; the treaty is characterized as an agreement between "the Governments of European countries which are like-minded and have a common heritage of political traditions, ideals, freedom and the rule of law."[194] As Professor Paolo G. Carozza explains by quoting Eva Brems, the Convention "is not considered to be a superstructure imposed on the contracting states from above, but a system of rules which are part of the common European heritage."[195] To extract and enforce rules from this common heritage, the Court must engage in a comparative analysis of national legal systems. If the Court departs from the common rule of law, Member States, at least theoretically, may ignore judgments, or the Convention may even be denounced.[196] Thus, the Court's opinions may reflect the Judges' concern for maintaining legitimacy.

Although the vast majority of Member States and other western democracies continue to criminalize active euthanasia and physician-assisted suicide, there is increasing movement toward legalization. Since

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191. *See* Herbert Hendin, *The Dutch Experience*, 17 ISSUES L. & MED. 223, 229 (2002).
192. *See generally* Gorsuch, *supra* note 103, at 679-683.
193. *Assisted Suicide Seduction*, *supra* note 30.
194. Convention, *supra* note 8, preamble at 222-24.
195. Carozza, *supra* note 37, at 1226 (citation omitted).
196. *See id.* at 1229.

the early 1990s, "serious political and legal actions taken by euthanasia advocates and their lawyers have brought assisted suicide to the brink of legal acceptance."[197] Measure 16, Oregon's Death with Dignity Act, was passed on November 10, 1994.[198] Australia's Northern Territory legalized euthanasia in its Rights of the Terminally-ill Act of 1995, effective July 1, 1996; the Federal Parliament, however, invalidated the law less than a year after it became effective.[199] On April 10, 2001, the Netherlands became "the first and at [that] time only country in the world to legalize euthanasia."[200] Belgium passed similar legislation a year later.[201] And, as discussed in Part II of this paper, the United States Supreme Court may be prepared to recognize, under certain circumstances, the right to self-determination.[202] The stage is being set for an international, dare say universal, right to die.

Although the Netherlands, Belgium, and Oregon currently stand in the minority, "[t]he history of the human rights movement makes it lamentably obvious that even large groups of states might share similar internal norms that all violate some basic aspect of human dignity."[203] Indeed, the majority's prohibition of physician-assisted suicide is an egregious violation of human dignity; for proof, look no further than the case of Diane Pretty. In *Pretty*, the Strasbourg Court's deference to Member States weakened the effectiveness of the Convention, forcing Ms. Pretty to face the death that she most feared. But for its application of a wide margin of appreciation, the Court would have held that the ban on assisted suicide violated Article 8.[204] If Article 8 includes "the right to choose when and how to die,"[205] and if the United Kingdom's interference with Ms. Pretty's right lacked proportionality,[206] then a wide margin of appreciation does not rectify the wrong. Moreover, Article 8 mandates, rather than merely permits, recognition of a competent, terminally-ill

197. SMITH, *supra* note 13, at 115.

198. *See* The Oregon Death With Dignity Act, OR. REV. STAT. 127.800 (2002).

199. *See* Funk, *supra* note 12, at 163-64.

200. Raphael Cohen-Almagor, *Why the Netherlands?*, 30 J.L. MED. & ETHICS 95, 97 (2002). The Dutch treatment of physician-assisted suicide has been the topic of much debate and a prolific source of scholarly writing. *See, e.g.,* Hendin, *supra* note 191, at 229; Manzione, *supra* note 106, at 444; Raphael Cohen-Almagor, *"Culture of Death" in the Netherlands: Dutch Perspectives*, 17 ISSUES L. & MED. 167 (2001).

201. *See International News,* DEATH WITH DIGNITY NATIONAL CENTER, *at* www.deathwithdignity.org/resources/ international.htm (last visited May 12, 2003).

202. Washington v. Glucksberg, 521 U.S. 702 (1997).

203. Carozza, *supra* note 37, at 1228.

204. In the end, the Court found that the right to privacy encompasses the right to die, the prohibition on assisted suicide interfered with Ms. Pretty's right to privacy, and the ban lacked proportionality. *See* Pretty v. United Kingdom, 35 Eur. H.R. Rep. 1, 35-38 (2002).

205. *Id.* at 35.

206. *See id.* at 38 ("[A]lthough the Government argued that [Ms. Pretty]… must be regarded as vulnerable, this assertion is not supported by the evidence before the…House of Lords which, while emphasizing that the law in the United Kingdom was there to protect the vulnerable, did not find that the applicant was in [this] category.").

patient's right to die because a prophylactic rule is not "necessary in a democratic society" that condones passive euthanasia and palliative care.[207]

The next inevitable step in the recognition of fundamental human rights is for the European Court of Human Rights to find that competent, terminally-ill adults have an inviolable right to decide not only what medical treatment they will *not* receive but to choose the medical treatment that they will receive. Given their historical deference to majority rule, this is, for now, unlikely. The Strasbourg Court was given the authority to decide Ms. Diane Pretty's fate; they must not waste the opportunity to build her legacy.

207. Convention, *supra* note 8, at art. 8.