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## The Right to Die: A Brief Look at Physician-Assisted Suicide

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THE RIGHT TO DIE:  
A BRIEF LOOK AT  
PHYSICIAN-ASSISTED SUICIDE

by

BROOKE MEREDITH SANDERS PURVES

Thesis submitted in partial fulfillment  
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Recently, there has been some discussion in Congress about writing a Constitutional amendment declaring that every American citizen has the "right to die" if he or she so sees fit. Opponents of this amendment believe that it will be abused - that although the amendment would generally apply to terminally ill patients, depressed teenagers and the like will be able to commit suicide if they feel like it, and mothers with deformed infants may act as guardians and exercise the right for their children, with no protection from the state. Their concern is certainly warranted. It is not the goal of the proposed amendment, however, to tell society that we do not care about your life. The goal is to make legal physician-assisted suicide, or the taking of one's terminal life through the help of a qualified health care professional in the instance of extreme pain and suffering on the part of the competent, informed patient.

The right to die has become a very controversial topic in recent months, possibly due to the trials of Dr. Jack Kevorkian, a Michigan pathologist who has performed several assisted suicides in the past few years. Because the ban on physician-assisted suicide has been lifted in Michigan, Dr. Kevorkian is being tried under common law statute that declares suicide illegal. While Dr. Kevorkian does not exemplify the type of person we necessarily want performing these physician-assisted suicides, he has broken new ground in the fight for the right to die with his efforts.

Most people will admit that it is justifiable to refuse or withdraw medical treatment when the patient's prognosis is poor.<sup>1</sup> The issue has certainly been discussed, because every state has some statute about living wills or medical directives. Many people, however, are not willing to extend that personal liberty with respects to medical treatment to include the right to die by means of voluntary active euthanasia or physician-assisted suicide. We have the right to die, they say, but only by natural means. There are many, however, that feel that to even speak of a

“right” to die is absurd. That right is as basic as the right to life, and is justifiable on the grounds of privacy, autonomy, and accepted medical practices.

### ***Withdrawal of Treatment and Physician-Assisted Suicide***

Although the American medical Association does not endorse mercy killing, it has taken a stand on withdrawal of treatment:

“The cessation of the employment of extraordinary means to prolong the life of the body when there has been irrefutable evidence that biological death is imminent is the decision of the patient and / or his immediate family. The advice and judgement of the physician should be freely available to the patient and / or his immediate family.”<sup>2</sup>

As we have mentioned before, most people, including the United States Supreme Court, feel it is acceptable to withdraw treatment from patient who has no hope of recovering to a recognizably human state, and from those who are so near to death that treatment seems futile. The author fails to see, however, much of a difference between withdrawal of treatment and hastening of inevitable death.

In what many consider to be a landmark essay on the morality of active euthanasia, James Rachels points out that there is a striking similarity between killing and letting die.<sup>3</sup> In *Active and Passive Euthanasia*, Rachels relates a tale of two men, Smith and Jones, who are both at a great financial advantage if their nephews were to die. Both sneak into their respective nephew's bath to drown them. Smith does so and makes it look like an accident. Jones, on the other hand, enters the bath after the child had slipped and hit his head, and refuses to revive the drowning boy.

The essay is not written to infer that physicians who withdraw treatment or hasten a terminal patient's death are in it for some capital gain. Instead, it shows, quite convincingly,

how hastening one's death is the same thing, essentially, as letting one die. If we take another scenario, this time with terminal patients, the meaning may become more clear. There are two terminally ill patients in a hospital room. They are both very close to death and will not make it through the night. They are both in extreme pain, a pain so bad that medication can no longer help them. They are both on ventilators. If the ventilator is removed, the patient will die more quickly, probably within a matter of minutes.

In one case, the ventilator is removed. The patient chokes for a while, his face turning blue. After a few minutes, he flops around on the bed like a fish out of water and eventually dies. His death, although relatively quick, was quite painful and dramatic. In the second case, the ventilator is not removed, but some sort of intense morphine solution is added to the IV. Within a few minutes, the patient gently slips out of consciousness and into the next world. His death was painless and dignified. In both cases, the intention was not necessarily to kill, but the physician had the knowledge that death would occur if either action was taken. As in the case above, often times, hastening one's death is more humane than letting one die. Is it not better to let the patient decide to go out painlessly than to force him to go out in agony?

### ***Privacy and Autonomy***

Most consider the debate on the right to die to be a matter of personal privacy, because privacy and autonomy are absolutely key in the discussion. While neither the Bill of Rights nor the Constitution explicitly talk about the matter of privacy,<sup>4</sup> the Fourteenth Amendment's Due Process Clause has been interpreted to be protective of the rights of the terminally ill to hasten their inevitable death.<sup>5</sup> The United States Supreme Court recognizes the right to personal privacy and that some areas of privacy, such as decisions about one's health care, are protected under the constitution.<sup>6</sup> Through this, the fourteenth amendment guarantees personal autonomy.<sup>7</sup>



When we speak of autonomy, we speak of self governance, the right to control our destinies and make informed decisions about our lives. Used in the context of health care, we are autonomous when we have full control over our decisions as to which health care procedures we will endure and for how long. Without personal autonomy, we cannot be free. One's autonomy can be expressed to the fullest extent by choosing to or not to end one's life. Physician-assisted suicide can be the ultimate exercise of self determination and self governance for it is to take entire control of one's fate<sup>8</sup> It is a decision worthy of respect.<sup>9</sup>

This argument, that the right to die is an issue of privacy and autonomy, is the most revered argument and has been held up in federal cases dealing with the terminally ill. In the case of Karen Quinlan, a landmark case in the right to die debate, her right to die was protected even though she was not competent. Her case was fought not on the premise that because she was comatose her life was not worth living, for that can be a dangerous premiss. It was ruled that she had a personal right to decide if she would like to go on living.<sup>10</sup> In an effort to avoid the destruction of her right to die, her right to privacy was advanced on her behalf by her guardian.<sup>11</sup> If the right to die was upheld in a case where the person was incompetent, then it surely should be upheld for a competent adult on this basis.

### ***Quality of Life***

Maine Superior Court Judge David G. Roberts said,

"At the moment of live birth there does exist a human being entitled to the fullest protection under the law. The most basic right enjoyed by every human being is the right to life itself."<sup>12</sup>

Although many of us can think of certain instances when we would consider a life not worth living, we do not want that to be the basis of the argument for the right to die. Many see a life as

being intrinsically valuable.<sup>13</sup> Life is what allows us the acquisition of all goods, material and spiritual. Without life, we have no freedom<sup>14</sup> and without freedom, we cannot be happy.<sup>15</sup> If we want to be happy, however, we must exercise the freedom given us. When we are not given the choice to end our lives in a competent, dignified manner, we are not able to exercise our freedom.

Many believe that human life is sacred because it is made in the image of the Creator.<sup>16</sup> To destroy it is in essence to destroy God. Life is the absolute good, while death is the absolute evil. Physician-assisted suicide is inconsistent with the view that life is an absolute good. Fortunately, however, we live in a country where the secular and religious are kept separate in legislation. An informed, competent adult, rather than a church, must make the ultimate decision as to the quality of his or her life.

What is more fundamental than the acquisition of goods or freedom is the creation of interpersonal relations. Without these, we cannot enjoy all of the wonderful things in life that many are concerned will be lost by those who choose to die. They are the meaning of one's life. When life moves ahead of all other values, such as liberty and freedom, its value is distorted out of context.<sup>17</sup> While the right to life exists regardless, life is a relative good, not an absolute. We make decisions about the relative quality of lives everyday by choosing charities to whom we give or not give money and by condemning prisoners to death. We are saying to those prisoners, "Your life is of no value to us anymore. You are a burden to society." We are saying to the recipients of the charitable funds, "You are special. We value your life above this other one, so you should eat." In a highly technological society like ours, our lives are being judged for their function in society rather than given intrinsic value.<sup>18</sup>

Social justice is about "maximizing an individual's potential."<sup>19</sup> It is well within the limits

of religion to say that there comes a point when a human lives a life that cannot be defined as having any human potential with regards to relationships.<sup>20</sup> A person may not even be able to thank the creator for the life given to him. That person has reached his potential and may now choose to or not to end his life. This does not imply that this particular life is not worth living, or that it is any less valuable than anyone else's. It is simply the end of any furtherance of the acquisition of anything of value.

### ***State Interest***

The issue of the right to die has been compared with the abortion issue on the basis of privacy and autonomy. Many proponents of the right to die believe that if an act is to be written, it should be modeled after the United States Supreme Court decision on abortion in 1973. The argument should be based on the same premises of personal privacy and autonomy over one's body. It is in the interest of the state for such activities to be regulated rather than to be carried out covertly.<sup>21</sup> As we say in the abortion issue, it is in the interest of public health for these procedures to be performed safely and cleanly, rather in back alleys.

Although we consider health care to be a private issue, for the sake of the state and for the sake of life, the state may step in and order medical procedures to be or not to be performed.<sup>22</sup> There is a compelling state interest to protect the public's health. But is it in the interest of the state to preserve life at all costs? Obviously not. If the state were interested in preserving all life, the health care system would be run much differently than it is today. We would be caring for our elderly rather than cutting their funds. This attitude of the state has been portrayed again in the Karen Quinlan case. Karen's care, along with many terminally ill patients', served a maintenance function only.<sup>23</sup> In a case where we cannot cure, but only prolong death, the United States Supreme Court ruled that the state's interests decrease as the bodily invasion needed to



keep the patient alive increases. In this case, the patient's right to privacy takes precedence over any state interest. Karen's prognosis was poor and her bodily invasion, with the use of respirators, feeding tubes, etc., was quite extensive. These seem to be the qualifications for a person's right to privacy to surpass the state's interest.

We can see how this attitude, however, may lead us to extreme views about the disabled. The New Jersey Supreme Court once ruled that the state has an interest in preserving only cognitive and sapient life, not just biological life.<sup>24</sup> Many of the patients that enter an emergency room are not conscious. By this court's statement, the state and the hospital should have no interest in reviving or otherwise lending medical care to these people, no matter how temporary the state of unconsciousness might be. Again, we need to place the patient's interest at least on the same level as that of the state.

### ***Oregon Death with Dignity Act: A Model***

As we have seen, physician-assisted suicide is incredibly difficult to regulate. In order to avoid these blanket rulings with regards to physician-assisted suicide, some states have been working on statutes that regulate it in order to legalize it. While the Oregon Death With Dignity Act does not legalize physician-assisted suicide (suicide is still illegal under a 1983 Oregon statute,<sup>25</sup>) it does regulate a means by which a terminally ill patient, with the written prescription by a physician, may take an overdose of a lethal drug, thus inducing death, with no party involved suffering legal action.<sup>26</sup> The Act says that if a patient requests a lethal prescription, he is not attempting suicide.<sup>27</sup>

The adult patient must make three requests for the prescription, two oral and one written, within a fifteen day period.<sup>28</sup> In that time, he must acquire the signatures of two witnesses who are not interested in his estate and must undergo psychological examinations in order to ensure

competence. The physician may then write a prescription for some lethal amount of a drug which the patient must take to a pharmacy to have filled, and must take the medication without any help from any health care professional or institution. The patient is only legally able to ask for this prescription if he is suffering from a terminal illness that will ensure his death within six months.

There has been much debate about this act. So much, in fact, that in August, 1995, a federal district judge ruled the act unconstitutional because it did not offer the terminally ill the same protection against suicide as was available to the rest of the population.<sup>29</sup> In essence, the courts were saying that they cannot stop the competent terminally ill from doing something that they want to do and are entitled to. The rest of the population that want to kill themselves for other reasons are quite possibly incompetent, therefore, they are protected.

When discussing this Act with others, one may find opposition on the grounds that if a person desired to kill himself, he should do it himself. One should have the gumption to "pull the trigger" without anyone's buying the gun and loading it for him. The person who says this obviously does not understand the issue. This act and physician-assisted suicide in general is to help those who cannot pull the trigger because of health or other reasons. With this Act, a terminally ill patient may end his life with no consequences for his life insurance policy because suicide is not to be written as the cause of death. While the Act does make it difficult for bedridden patients to take advantage of it, it does allow for a safe and painless death, unlike a gunshot.

### ***Problems with the Death with Dignity Act***

Many of those who are familiar with the Act are also familiar with the problems with the act. Firstly, the Act sets a limit at those patients who are terminal within a six month period.

Many patients who are going to die within six months and are so bad off that they consider assisted suicide are not competent enough to ask for the prescription, drive to the pharmacy to have it filled, then drive home and take it themselves. They may be bedridden or delirious, unable to give informed consent. If the patient is so close to death, then they may not make it through the two week waiting period. It may be argued that the patient can "stick it out" for another six months and avoid the hassle altogether. Even the "terminality" in six months is to be called into question. Six months is an arbitrary point in time and it may be difficult to predict if a person will die in six months. We want to avoid a misdiagnosis if at all possible.

#### ***Physicians' Attitudes Toward Physician-Assisted Suicide***

The goal of the physician should be to practice good medicine by enhancing the quality of life through proper medical care. Some say that the practice of physician-assisted suicide goes against all the principles physicians vow to follow. It is to practice bad medicine.<sup>30</sup> A physician who kills is antithetical and immoral. While public support for physician-assisted suicide is growing,<sup>31</sup> many still feel that physicians are trained to be "enemies of death,"<sup>32</sup> and the role of the healer is compromised if they were to participate in physician-assisted suicide.

The answer to these objections may be to not legalize it or to allow assisted suicide with no member of the health care field participating. It may be sufficient, however, to allow those doctors who do not find it objectionable to perform it within the law. A survey of 2761 Oregon physicians concluded that while 60% thought physician-assisted suicide should be legal in some cases,<sup>33</sup> only 46% of physicians might be willing to write a prescription for a lethal dose of medication if asked by a patient.<sup>34</sup> This percentage seems to be greater than in any previous United States studies on the matter. Those who are not willing to participate are not willing because of religious or other reasons. Generally, in this survey and another done in Michigan,

those with the strongest religious convictions were less likely to participate.<sup>35</sup> In Michigan, only a third of those physicians surveyed might participate if it were legal.<sup>36</sup> Interestingly, those were closest to terminally ill patients were less likely to find the practice unobjectionable.<sup>37</sup>

Although there seems to be quite a number of physicians who are willing to participate, there are some concerns that should not be taken lightly. Nearly half of those surveyed were not confident that they could predict if death would occur in the next six months,<sup>38</sup> as is required by the Oregon Death With Dignity Act. Nearly the same amount of primary care physicians have been found to overlook depression,<sup>39</sup> the analysis of which is one of the many safeguards of the program. In addition to these problems, a physician may not know what to prescribe as a lethal drug. There are a series of barbiturates and anti-depression drugs available, but few would know what to give and in what dose. A dosage that is too light may not kill the patient and only lead to further problems, rendering the patient incompetent and therefore, not able to apply for another prescription.

### ***Consequences of Physician-Assisted Suicide***

Regardless of the acceptance or not of physician-assisted suicide, we will all admit that there are important cautions and consequences of implementing such a practice. We are looking to legalize and regulate this practice in part to avoid the destructive covert suicides that take place everyday. If this practice is regulated and physicians follow the guide lines, then the problems associated with wrongful death lessen. For example, many physicians are hesitant to perform physician-assisted suicide for the fear that the family might sue. If the consent of an informed patient is obtained in the presence of witnesses, as in the Oregon Death With Dignity Act, then the question of wrongful death is thrown out. Yet do we fully understand the ways in which physician-assisted suicide may be taken advantage of? Without the proper safeguards, a



prescription may fall into the wrong hands or may be misused among other things. With the proper safeguards, however, problems such as these are nearly wiped out.

The problems that trouble most people who understand the methods are those of a theoretical nature. If covert suicides are already happening, can we really trust our physicians? Can we trust the health care system to use this to our best advantage? Will physicians take it upon themselves to decide that this is the best course of action? Does this attitude send the wrong message to society? Some may interpret this as a suggestion that the health care community has no interest in the terminally ill. You may continue to live if you wish, but we really do not care.<sup>40</sup> If you do not choose the easy way out, instead of racking up medical bills for your family, you may be seen as selfish. And if this long-term care is seen as elective, we may see no obligation to pay for it.<sup>41</sup> The social acceptance of the killing of "innocents" will endanger the lives of those that want to live.<sup>42</sup>

There is certainly a cause for concern. We have seen physician-assisted suicide abused in other countries. A Dutch doctor, for example, was authorized to give a lethal injection to a quadriplegic woman because her condition was seen as terminal. Because paralyzed patients have a difficulty coordinating their breathing and swallowing, she could have died at any moment from inhaling her food.<sup>43</sup> Some courts see comatose and vegetative patients, no matter how temporary their condition may be, as being terminal, because they must be fed artificially, and if those means were disconnected, they would surely die.

Dr. Lawrence K. Pickett admits that "allowing hopelessly ill patients to die is accepted medical practice."<sup>44</sup> What, then, is a hopelessly, or terminally ill patient? These patients are ones that cannot be saved, that are irretrievably in the dying process.<sup>45</sup> For the sake of discussion, a hopelessly ill patient is one that while nearly terminal, is so racked with pain and



suffering as to make living a burden. (Pain should not be the basis for euthanasia because pain can usually be treated through medication.<sup>46)</sup> Sadly, sometimes the definition of terminally ill can be too broad if discretion is not used. The Uniform Rights of the Terminally Ill Act as proposed by the National Conference of Commissions of Uniform State Laws in 1986 states that a terminal illness is one that causes a patient's death in a relatively short time if no life-preserving treatment is given.<sup>47</sup> This definition would include diabetics who require insulin shots, or infants who, although otherwise healthy, are temporarily too weak to nurse and must be fed through a tube.

Leon R. Kass, in his article, "Suicide Made Easy: The Evil of "Rational" Humaneness," finds the work of "right to die" groups as evil.<sup>48</sup> He writes of a book entitled *Final Exit*, written by the president of the Hemlock Society, Derek Humphry, in which Humphry gives directions on how to "self deliver" one's self from this life. Kass is right in that Humphry's book should never have been written, for it directs anyone in the method of killing and is too readily available to the public. The terminally ill will not be the only ones reading this book, and even if they were, Kass feels that the practice itself is to be abhorred. Kass notes that in countries like Holland, where physician-assisted suicide is legal, euthanasia accounts for 19.4 percent of the deaths. That is a staggering percent. What is even more disturbing, says Kass, is that this includes nearly 1,000 cases of direct active involuntary euthanasia! The author fails to see, however, how making legal physician-assisted suicide will encourage physicians to take part in illegal activities if they were not already doing so.

With the proper legislation, the author sees physician-assisted suicide as a helpful tool in health care in relieving the suffering of competent, yet terminal adults. The right to die is a right

as fundamental as the right to life. Yet it is a right that must be extended with caution. The author sees it in relation to a driver's licence. Assume for the sake of argument that driving is a right and not a privilege. We extend this right to all capable adults. One with a licence is free to drive when and where he likes within the limits of the law. The moment that person becomes intoxicated, or otherwise incompetent, his right to drive is taken away. This is done to protect the driver as well as those around him. He still has his licence, yet he is temporarily suspended from exercising his right to drive. So it is with the right to die. Only a competent adult may make such a decision. The right is denied to children because we, as a society assume that they do not have the life experience to make responsible decisions concerning such matters. The right is denied to incompetents, such as those who are suicidal, because we assume that if they were competent they would want to live. We make such assumptions everyday in emergency rooms.

The right to die is a fundamental right and ought to be protected. With the proper safe guards and at the will only of competent adults, we can exercise this right with little error. In our criminal system, we tolerate the death penalty, even though we have mistakenly executed innocent men, because we see the death penalty as a benefit to society. In physician-assisted suicide, we must proceed carefully and cautiously in order to avoid errors. There are sure to be some errors, yet if we are to err, we must err on the side of life.<sup>49</sup>

In the past few weeks, several courts in the country have made decisions with regards to bans on physician-assisted suicide. On March 6, 1996, the United States Court of Appeals for the Ninth Circuit ruled that the Washington ban on physician-assisted suicide is unconstitutional because it violates a competent, terminally ill patient's constitutionally protected liberty to determine the

time and place of death.<sup>50</sup> It is an intimate choice on the part of the patient. And on April 2, 1996, The United States Court of Appeals for the Second Circuit struck down the Washington ban on physician-assisted suicide because it violates the Equal Protection Clause.<sup>51</sup> The Court stated that it was less active to prescribe a prescription of lethal drugs than to allow a patient to die from asphyxiation, from the removal of a ventilator, or from starvation or dehydration, from the removal of an IV.<sup>52</sup>

- <sup>1</sup> "Euthanasia: Do terminally Ill Patients Have the Right to Die?," Moral Issues: Philosophical and Religious Perspectives, ed. Gabriel Palmer - Fernandez (Prentice Hall, 1996) 115.
- <sup>2</sup> Richard A. McCormick, "To Save or Let Die: The Dilemma of Modern Medicine," Ethics in Medicine, ed. William Curran, Arthur Dyck and Stanley Reiser, MD (MIT Press, 1975) 546.
- <sup>3</sup> James Rachels, "Active and Passive Euthanasia," Biomedical Ethics, ed. Thomas A. Mappes and Jane S. Zembaty (McGraw-Hill, 1991) 369.
- <sup>4</sup> Supreme Court of New Jersey, "In the Matter of Karen Quinlan, an Alleged Incompetent," 70 N.J. 10, 355 A 2d 647, Moral Issues: Philosophical and Religious Perspectives, ed. Gabriel Palmer - Fernandez (Prentice Hall, 1996) 119.
- <sup>5</sup> R. A. Sedler "The Constitution and Hastening Inevitable Death," Hasting's Center Report 23.5 (1993): 20-25.
- <sup>6</sup> Ibid.
- <sup>7</sup> F. Helminski "Assisted Suicide and the Savings Clause," Mayo Clinic Process 70.6 (1995): 593-4.
- <sup>8</sup> Richard Doerflinger, "Assisted Suicide: Pro-Choice or Anti-Life?," Moral Issues: Philosophical and Religious Perspectives, ed. Gabriel Palmer - Fernandez (Prentice Hall, 1996) 122.
- <sup>9</sup> Ibid, 122.
- <sup>10</sup> "Quinlan" 120.
- <sup>11</sup> Ibid.
- <sup>12</sup> McCormick 544.
- <sup>13</sup> "Euthanasia" 116.
- <sup>14</sup> Ibid.
- <sup>15</sup> Doerflinger 122.
- <sup>16</sup> McCormick 547.
- <sup>17</sup> Ibid. 548.
- <sup>18</sup> Doerflinger 121.
- <sup>19</sup> McCormick 547
- <sup>20</sup> Ibid.
- <sup>21</sup> Jerald G. Bachman, PhD., et.al, "Attitudes of Michigan physicians and the Public Toward Legalizing Physician-Assisted Suicide and Voluntary Euthanasia," New England Journal of Medicine 334.5 (1996): 303.
- <sup>22</sup> "Quinlan" 118.
- <sup>23</sup> Ibid. 120.
- <sup>24</sup> Doerflinger 124.
- <sup>25</sup> Courtney Campbell, PhD, Jan Hare, PhD and Carrie Nelson, MD, letter, JAMA 27 December 1995: 1910.
- <sup>26</sup> "Oregon Death With Dignity Act," Ethical Issues in Death and Dying, ed. Tom C. Beauchamp and Robert M Vatch (Georgetown, 1996) 204.
- <sup>27</sup> Campbell, 1910.
- <sup>28</sup> "Oregon" 199-201.
- <sup>29</sup> Melinda A. Lee, MD, et al. "Legalizing Assistd Suicide - Views of Physicians in Pregon," New England Journal of Medicine 334.5 (1996): 310.
- <sup>30</sup> "Euthanasia" 116.

- <sup>31</sup> Bachman 303.
- <sup>32</sup> Doerflinger 125.
- <sup>33</sup> Lee 312.
- <sup>34</sup> Ibid.
- <sup>35</sup> Bachman 307.
- <sup>36</sup> Ibid. 308.
- <sup>37</sup> Ibid.
- <sup>38</sup> Lee 312.
- <sup>39</sup> Lee 313.
- <sup>40</sup> Doerflinger 123.
- <sup>41</sup> Ibid. 124.
- <sup>42</sup> Ibid. 123.
- <sup>43</sup> Ibid. 124.
- <sup>44</sup> McCormick 544.
- <sup>45</sup> Ibid.
- <sup>46</sup> Margaret P. Battin "Euthanasia: The Way We Do It, The Way They Do It," 128.
- <sup>47</sup> Doerflinger 124.
- <sup>48</sup> Leon R. Kass "Suicide Made Easy: The Evil of "Rational" Humaneness," Commentary  
December 1991: 19-24
- <sup>49</sup> McCormick 547.
- <sup>50</sup> "Physician-Assisted Suicide Ban Struck Down on Equal Protection Grounds," The U. S. Law  
Week. Bureau of National Affairs, Inc. 9 April 1996.
- <sup>51</sup> "Ban on Physician-Assisted Suicide Violates Right to Make Intimate Choices," The U. S.  
Law Week. Bureau of National Affairs, Inc. 12 March 1996.
- <sup>52</sup> Ibid.