

NOTE

SUICIDE AND EUTHANASIA: THE INTERNATIONAL PERSPECTIVE ON THE RIGHT TO DIE

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Several countries across the globe have weighed their interests in preserving life, in preventing suicide, and in allowing terminally ill patients to end their lives at their own discretion with, or without, the help of a physician. This Note will highlight the inconsistencies in jurisdictions that treat suicidal ideations both criminally and medically, and ultimately argues for a uniform system of laws that govern mental illness internationally.

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INTRODUCTION

In trying to extract exactly why a government is interested in regulating death and dying, one runs into a complicated cross section of religion, cultural tradition, sociology, medicine, and psychology. Balancing the concerns and implications in all of these areas is a sensitive task that has sparked and continues to cause controversy across the globe, and consequently results in very different governing schemes and attitudes. This Note argues for an international standard to guide medical and legal practitioners when dealing with affected indi-

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viduals, and aims to shed light on the inconsistent answers to the same question from nation to nation: how should governments handle suicidal citizens? Are governments making a distinction between a terminally ill citizen's request for euthanasia and a non-terminal citizen's request, and more significantly, should they?

The United States Supreme Court put to words why exactly governments need to address the issue. They held in both *Washington v. Glucksberg*¹ and *Vacco v. Quill*² that there were specific and legitimate government interests in preventing assisted suicide, and that it is best left up to the states to have "serious, thoughtful examinations of physician-assisted suicide."³ Those interests were to preserve life, to prevent suicide, to avoid the involvement of third parties and their undue influence, to protect the integrity of the medical profession, and to avoid the proverbial slippery slope that could ensue, where more patients request assisted suicide for less severe illnesses.⁴ Striking the right chord between these interests is evidently a subjective test,⁵ and this Note aims to analyze some of the ways that this balancing act has played out internationally.

The Supreme Court did not explicitly ban assisted suicide, but instead declared that the "right to die" is not protected by the Constitution.⁶ In other words, the issue of whether to legalize the practice was left to state governments. The state statutes challenged in the lawsuits, which restricted assisted suicides within their respective jurisdictions, were held constitutional.⁷ It is legal today for doctors to assist in suicide for terminally ill patients in California, Montana, Oregon, Vermont, Hawaii, the District of Columbia, Washington, and Colorado.⁸ Internationally, it is legal in Switzerland, Germany, Canada, and Finland.⁹ Alternatively, human euthanasia is le-

¹ 521 U.S. 702 (1997).

² 521 U.S. 793 (1997).

³ *Washington*, 521 U.S. at 719; *see Vacco*, 521 U.S. at 808–09.

⁴ *See Washington*, 521 U.S. at 728 n.20.

⁵ *Id.* at 722.

⁶ *Id.* at 728.

⁷ *See id.* at 702; *Vacco*, 521 U.S. at 793.

⁸ Felicia Nimue Ackerman, *Current Laws Permitting Assisted Suicide Are Morally Indefensible*, VOX (Dec. 14, 2016, 9:21 AM), <http://www.vox.com/the-big-idea/2016/11/21/13693016/assisted-suicide-referendums-philosophy> [<https://perma.cc/L4VA-PU5U>].

⁹ *See Euthanasia & Physician-Assisted Suicide (PAS) Around the World*, PROCON.ORG (July 20, 2016, 7:31 AM), <https://euthanasia.procon.org/view.resource.php?resourceID=000136> [<https://perma.cc/94MV-7Q78>] [hereinafter *Around the World*].

gal in the Netherlands, Belgium, Colombia, and Luxembourg.¹⁰ The important distinction between the two practices is that in assisted suicide, the *patient* is given the fatal dosage in order to administer it to him or herself.¹¹ Alternatively, human euthanasia allows the *physician* to administer the dosage.¹² This Note aims to add to the pertinent conversation occurring as more states and countries put the issue to a vote of their constituents.

One particular goal of this Note is to color the difference between the suicidal ideations accompanying patients with terminal illnesses and the suicidal ideations of non-terminal patients. Euthanasia statistics, specifically from jurisdictions like Oregon¹³ where euthanasia has been practiced for a considerable amount of time before this Note was written, suggest that the reasons terminally ill patients request euthanasia are not entirely different from the reasons any other non-terminal person might attempt or request suicide. However, there remains the unchallenged assumption that there is something fundamentally different about the legitimacy of these reasons.¹⁴

This Note will further explore how the criminal-law system and the psychiatric community in the United States treat suicidal ideations as a symptom of mental illness, largely treatable with effective psychological and biological medication. Juxtapose this practice with the legal practice of assisted suicide, and it would appear that there is an inherent contradiction between what science suggests about suicidal ideations and the law. It seems that some jurisdictions concede that it is not worth the resources to rid those with terminal illnesses of suicidal ideations, despite at least the possibility of doing so. From perhaps a more common perspective, legitimate quality of life concerns are not treatable suicidal ideations at all; rather, they are the same symptom, but a fundamentally different root. Still yet, this Note will recognize situations where a person without a terminal physical illness, but instead a mental illness, can have legitimate quality of life concerns not

¹⁰ *See id.*

¹¹ *See id.*

¹² *See id.*

¹³ Or. Pub. Health Div., *Oregon Death with Dignity Act: 2015 Data Summary*, OR.GOV (Feb. 4, 2016), <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year18.pdf> [<https://perma.cc/8KFJ-VLDD>].

¹⁴ *Id.*

taken seriously by a majority of the world's physicians.¹⁵ This Note will simultaneously explore whether a rational wish to die based on an impending death can be treatable within the mental health context, and if so, whether it should be required procedure within hospitals.¹⁶ In short, this Note asks why it is that suicidal ideations are categorized as both rational and irrational simultaneously across the globe, and why doctors and lawmakers have not bridged the gap or come to some universal understanding. The ultimate goal of this exploration is to encourage lawmakers to consider the curious implications of some of the contradicting laws that exist globally.

First, this Note will explore the premises on which Justice Rehnquist's opinion in *Glucksberg* rested by evaluating suicide and euthanasia laws internationally.¹⁷ Doctors and patients alike argued that there should be a fundamental right to die protected by the Constitution.¹⁸ This argument, however, tests the notion that suicidal ideations are symptoms of mental illness, and it forces the distinction previously mentioned and so widely accepted. If that right does exist, would principles of medicine and psychology suggest that it is mentally ill to exert it? Are certain people inherently exempt from this psychological status because of their physical illness? The Court's first conclusion was that it is in the government's interest to *preserve* life.¹⁹ This assumes that if mental illnesses *can* be treated biologically, the illnesses *should* be treated despite a contrary, "rational" request.²⁰ Suicidal individuals are almost always quarantined inside hospitals and are directed to mental health professionals for evaluation immediately following any attempt.²¹ As this Note will explore, however, there is an argument that some non-terminal mental illnesses should be considered terminal in the sense that they are incurable, and thus

¹⁵ Ann M. Mitchell et al., *Suicide Assessment in Hospital Emergency Departments: Implications for Patient Satisfaction and Compliance*, 27 TOPICS EMERGENCY MED. 302, 308-09 (2005).

¹⁶ See William Breitbart et al., *Depression, Hopelessness, and Desire for Hastened Death in Terminally Ill Patients with Cancer*, 284 J. AM. MED. ASS'N 2907, 2907 (2000); see also *Suicide Prevention*, NAT'L INST. MENTAL HEALTH (Mar. 2017), https://www.nimh.nih.gov/health/topics/suicide-prevention/index.shtml#part_153179 [<https://perma.cc/M7X4-U89Y>] (providing possible treatments and therapies for individuals with suicidal thoughts).

¹⁷ See *Washington v. Glucksberg*, 521 U.S. 702, 706 (1997).

¹⁸ See *id.* at 702; *Vacco v. Quill*, 521 U.S. 793, 793 (1997).

¹⁹ See *Washington*, 521 U.S. at 728.

²⁰ Jouko K. Lonnqvist, *Psychiatric Aspects of Suicidal Behaviour: Depression*, in THE INTERNATIONAL HANDBOOK OF SUICIDE AND ATTEMPTED SUICIDE 108, 117 (Keith Hawton & Kees van Heeringen eds., 2000).

²¹ See Mitchell et al., *supra* note 15, at 308.

should be eligible for assisted suicide. If no amount of treatment, medical or psychological, alleviates the symptoms of a mental disease or cures the underlying biological issue, this argument asserts that the non-life-threatening ailment is equally intolerable.²² If a government adopted this rationale, requests for euthanasia might dramatically increase for a number of non-terminal ailments. One particular case in New Jersey will illustrate this, and as this Note will additionally highlight, a number of European countries not only find the argument convincing, but also started to allow the practice.²³

In analyzing the next premise, the deterrence of suicide, this Note will explore how several different countries respond to suicidal attempts with criminal punishment. In Rwanda and Uganda, for instance, a person who engages in nonfatal suicidal behavior can be criminally convicted and sentenced to two to five years in prison.²⁴ Section 309 of the Penal Code in Singapore punishes those who attempt suicide with imprisonment of up to one year and/or a fine,²⁵ and in Islamic countries like Pakistan, suicide is punishable with incarceration in addition to the strong negative and religious implications the individual will suffer.²⁶ Suicide, and by extension mental illness, in these particular countries is often underdiagnosed and underreported, which makes analysis of the suicide rates far more difficult.²⁷ The intention of criminalizing suicide might be deterrence, but mental illness is entirely impossible to deter via incarceration when there is a biological obstacle.²⁸ This is the very rationale behind the insanity plea in the United States.²⁹ When a defendant cannot appreciate the wrongfulness of their

²² See Rachel Aviv, *The Death Treatment*, NEW YORKER (June 22, 2015), <http://www.newyorker.com/magazine/2015/06/22/the-death-treatment> [https://perma.cc/M3NT-JHJP].

²³ See Sarah Jorgensen, *Woman with Severe Eating Disorder Wins Right to Refuse Forced Feedings*, CNN (Nov. 23, 2016, 5:22 PM), <http://www.cnn.com/2016/11/23/health/nj-woman-eating-disorder-legal-case/> [https://perma.cc/4VQM-2DPH].

²⁴ See Rajeev Ranjan et al., *(De-) Criminalization of Attempted Suicide in India: A Review*, 23 *INDUS. PSYCHIATRY J.* 4, 5 (2014).

²⁵ See Marian Govin, *Attempting Suicide Is Illegal, but Rare for Person to Be Charged*, STRAITS TIMES (Sept. 18, 2016, 4:24 PM GST), <http://www.straitstimes.com/singapore/attempting-suicide-is-illegal-but-rare-for-person-to-be-charged> [https://perma.cc/PSF4-DUCM].

²⁶ See Murad Moosa Khan, *Suicide and Attempted Suicide in Pakistan*, 19 *J. CRISIS INTERVENTION & SUICIDE PREVENTION* 172, 172–76 (1998).

²⁷ See *id.*

²⁸ See Andrew E. Taslitz, *Mental Health and Criminal Justice*, 22 *CRIM. JUST.* 4, 5 (2007).

²⁹ See Ralph Slovenko, *Pleading Insanity Is Here to Stay, Insanity Plea or Not*, N.Y. TIMES (Feb. 14, 1983), <http://www.nytimes.com/1983/02/14/opinion/1->

conduct in the United States, punishment through incarceration will do little to deter that individual from committing the offensive conduct again, and thus the system will not incarcerate him or her.³⁰ The World Health Organization, in its first global study of suicide prevention in September 2014, concluded that decriminalization does not increase suicide rates.³¹ Interestingly, the study revealed other consequences of decriminalizing suicidal attempts that this Note will discuss.³²

Next, this Note will address two premises together: (1) That it is in the government's best interest to avoid the involvement of third parties to avoid the use of arbitrary, unfair, or undue influence and (2) that it is best to avoid the slippery slope that could follow from legalization. It will do this by exploring procedures and protocols for euthanasia requests in Belgium and the Netherlands, two countries whose acceptance and legalization of euthanasia for a wide array of non-terminal illnesses has received both criticism and support in the international community.³³ It is in both these nations that the slippery slope argument can most easily be illustrated as politicians and citizens push for less restrictive statutes.³⁴ With the concern for undue influence in mind, this Note will argue that the practices in Belgium and the Netherlands demonstrate how severe that influence can be, and will take the position that these countries have taken too extreme of a stance on making euthanasia widely available.

Lastly, this Note will address how the legalization of euthanasia affects, protects, and undermines the integrity of the medical profession. Physicians and mental health professionals stand on both sides of the table in the euthanasia discussion: some adamantly for, and some adamantly against.³⁵ It is

pleading-insanity-is-here-to-stay-insanity-plea-or-not-226082.html [https://perma.cc/BUQ3-YNHD].

³⁰ See Taslitz, *supra* note 28, at 5.

³¹ *First WHO Report on Suicide Prevention*, WORLD HEALTH ORG. (Sept. 4, 2014), <http://www.who.int/mediacentre/news/releases/2014/suicide-prevention-report/en/> [https://perma.cc/GUG7-6EZW].

³² See David Lester, *Decriminalization of Suicide in Seven Nations and Suicide Rates*, 91 PSYCHOL. REP. 898, 898 (2002) (concluding that "decriminalization of suicide may be associated with an increase in the official suicide rate").

³³ See generally Aviv, *supra* note 22.

³⁴ *Id.*

³⁵ See Paula Span, *Physician Aid in Dying Gains Acceptance in the U.S.*, N.Y. TIMES (Jan. 16, 2017), https://www.nytimes.com/2017/01/16/health/physician-aid-in-dying.html?rref=collection%2Ftimestopic%2FEuthanasia&action=click&contentCollection=timestopics®ion=stream&module=stream_unit&version=latest&contentPlacement=1&pgtype=collection&_r=0 [https://perma.cc/373X-YFEZ].

important to note that even if a statute makes it legal to assist in dying, this does not mean it is necessarily easy to find a physician and accompanying pharmacy to help carry out the request.³⁶ Euthanasia procedures require several medical physicians and pharmacists to approve and carry out the request.³⁷ The words of the Hippocratic Oath can also weigh heavily on medical professionals' decision to participate in a practice that is at odds with their training, and it presents yet another hurdle for that patient to overcome in assembling physicians.³⁸ That said, some doctors use the Hippocratic Oath to argue the converse: that the oath in fact encourages the practice of assisted death because the underlying goal of assisted death is to ease the suffering of others.³⁹

The literature on the subject generally conveys a ubiquitous notion that it is unnatural to request or pursue suicide: that a sane and otherwise stable and healthy individual could not be interested.⁴⁰ This is deduced from not only the strict requirements for euthanasia in the United States, but also from the plethora of statutes worldwide that ban the practice outright.⁴¹ In other words, to challenge the assumption that only the mentally unstable request euthanasia is also to say that one's free will, uninhibited by substance or disease, *could* bring them to the thought of suicide. This assumption does not seem to be entirely clear, though, in those parts of the world where attempting suicide does not trigger the system to treat that individual like a patient. On the contrary, some countries view that person criminally, which presents a new and interesting problem.⁴² This alternate triggering of a criminal system, as opposed to a medical intervention, implies that committing suicide in those countries might be considered a sane, albeit illegal, course of action. Just in the way the United States does not view a thief as particularly mentally ill by virtue of his theft, the suicidal are viewed similarly in those countries.

³⁶ *Id.*

³⁷ *See id.*

³⁸ *See Hippocratic Oath*, ENCYCLOPEDIA BRITANNICA, <https://www.britannica.com/topic/Hippocratic-oath> [<https://perma.cc/UH36-MPGX>]. *But see* Peter Tyson, *The Hippocratic Oath Today*, PBS: NOVA (Mar. 27, 2001), <http://www.pbs.org/wgbh/nova/body/hippocratic-oath-today.html> [<https://perma.cc/C8X9-D3J7>] (noting that only 14% of modern Hippocratic oaths prohibit euthanasia).

³⁹ *See* Tyson, *supra* note 38.

⁴⁰ *See* Lonngqvist, *supra* note 20, at 108; Breitbart, *supra* note 16, at 2909; Taslitz, *supra* note 28, at 5; Aviv, *supra* note 22.

⁴¹ *See* Khan, *supra* note 26, at 173; Ackerman, *supra* note 8; Govin, *supra* note 25; Around the World, *supra* note 9.

⁴² *See* Aviv, *supra* note 22.

The governing bodies of countries and states alike are sensitively weighing their goals against what might or might not be a constituent's right to end his or her own life. The issue demands a solution, and it is no wonder that it has become such a challenge to determine the better solution. This Note argues that no matter the outcome, it is equally important that the answer be consistent globally.

I

UNITED STATES AND ITS LANDMARK DECISIONS

In the landmark cases where the United States Supreme Court set the stage for euthanasia laws, the Justices were asked to decide whether or not the Constitution protected a right to die.⁴³ In *Washington v. Glucksberg*, five physicians, three terminally ill patients, and a non-profit organization challenged a Washington statute that made it a felony to assist in the suicide of another.⁴⁴ It was the contention of the plaintiffs that the right to engage in assisted suicide was a liberty interest protected by the Due Process Clause of the Fourteenth Amendment to the Constitution.⁴⁵ However, Chief Justice Rehnquist rejected that notion, saying that liberty interests not "deeply rooted in this Nation's history and tradition" were not protected by that clause.⁴⁶

Then, in *Vacco v. Quill*, plaintiffs challenged a statute in the state of New York that made it a crime for a physician to help end the life of a patient, even if that patient was terminally ill and mentally competent to make the decision.⁴⁷ The plaintiffs argued that the prohibition violated the Equal Protection Clause of the Fourteenth Amendment because while patients were legally able to refuse lifesaving treatment, they could not authorize a physician to perform any life-ending procedure.⁴⁸ The Court expressly rejected the idea that these two rights were the "same thing,"⁴⁹ making the strong distinction between *causing* someone to die and *allowing* someone to die.⁵⁰ This

⁴³ See *Washington v. Glucksberg*, 521 U.S. 702 (1997); *Vacco v. Quill*, 521 U.S. 793 (1997).

⁴⁴ See *Washington*, 521 U.S. at 702.

⁴⁵ See *id.* at 722-23.

⁴⁶ *Id.* at 721 (citation omitted).

⁴⁷ See *Vacco*, 521 U.S. at 797; see also Elsebeth Nylev Stenager & Egon Stenager, *Physical Illness and Suicidal Behavior*, in *THE INTERNATIONAL HANDBOOK OF SUICIDE AND ATTEMPTED SUICIDE*, *supra* note 20, at 405 (discussing increased risk of suicide in individuals with somatic disorders).

⁴⁸ See *Vacco*, 521 U.S. at 793.

⁴⁹ *Id.* at 798.

⁵⁰ See *id.* at 793-94.

very distinction has been recognized internationally, as several countries have legalized one practice, but not the other.⁵¹ Both *Washington* and *Vacco*, in upholding the state prohibitions, made clear that the government interests at stake far outweighed the interests of the individuals challenging the statutes.⁵² To reiterate, those interests were to preserve life, to prevent suicide, to avoid the involvement of third parties and their undue influence, to protect the integrity of the medical profession, and to avoid the proverbial slippery slope that could ensue.⁵³ This discussion⁵⁴ did not include an analysis about the mental health of these patients—a silence this Note interprets as recognition of the legitimate nature of a request for euthanasia under certain medical circumstances.

As a result of these decisions, the states were welcome to decide on their own how to treat euthanasia within their jurisdictions. The Death with Dignity Act of Oregon (DWDA), approved in 1994 but not officially implemented until 1997, was one of the first acts of its kind.⁵⁵ The DWDA allows terminally ill citizens to end their lives through voluntary self-administration of lethal medications.⁵⁶ Under the law, a competent adult who has been diagnosed with a terminal illness may request in writing a prescription for a lethal dose of medication for the purpose of ending his or her life within six months of his or her probable time of death.⁵⁷ The request must be confirmed by two witnesses, at least one of whom is not related to the patient, is not entitled to any portion of the patient's estate, is not the patient's physician, and is not employed by a health care facility caring for the patient.⁵⁸ After the request is made, another physician must examine the patient's medical records

⁵¹ See, e.g., Jose Pereira, *Legalizing Euthanasia or Assisted Suicide: The Illusion of Safeguards and Controls*, 18 CURRENT ONCOLOGY e38, e38 (2011) (noting that assisted suicide is legal in Switzerland, but euthanasia is not); see also text accompanying *supra* notes 9–10.

⁵² See *Washington v. Glucksberg*, 521 U.S. 702, 729–35 (1997) (evaluating the state's interests in prohibiting assisted suicide); *Vacco*, 521 U.S. at 808–09 (considering New York State's reasons for prohibiting assisted suicide).

⁵³ See *Washington*, 521 U.S. at 703–04; *Vacco*, 521 U.S. at 794.

⁵⁴ See generally *Washington*, 521 U.S. 702 (failing to discuss the mental health of patients interested in assisted suicide); 521 U.S. 793 (same).

⁵⁵ See Mark C. Siegel, *Lethal Pity: The Oregon Death with Dignity Act, Its Implications for the Disabled, and the Struggle for Equality in an Able-Bodied World*, 16 LAW & INEQ. 259, 270 (1998) (detailing the history and significance of the Oregon Death with Dignity Act).

⁵⁶ See Death with Dignity Act (DWDA), OR. REV. STAT. § 127.800-955 (1994).

⁵⁷ *Id.*

⁵⁸ *Id.*

and confirm the diagnosis.⁵⁹ If the request is authorized, the patient must wait at least fifteen days and make a second oral request before the prescription may be written.⁶⁰ The patient has a right to rescind the request at any time.⁶¹ Lastly, the patient must be determined to be free of a mental condition impairing judgment, and should either physician have concerns about the patient's ability to make an informed decision, or feel the patient's request may be motivated by depression or coercion, the patient must be referred for a psychological evaluation.⁶² This is the part of the DWDA that is particularly interesting because while the Act aims to exclude patients suffering from mental illness, the patients who were granted euthanasia listed concerns that ordinarily would qualify for psychological treatment.⁶³ The DWDA requires that Oregon run statistics on every person who requests euthanasia,⁶⁴ and those statistics revealed that between 1997 and 2015, primary end of life concerns were loss of autonomy (91.6%), inability to make life enjoyable (89.7%), and loss of dignity (78.7%).⁶⁵ Secondary concerns included being a burden on family and friends and the financial implications of treatment.⁶⁶ These concerns are virtually the same as some of the leading reasons for unassisted suicide attempts and depression generally.⁶⁷ J. Mark G. Williams and Leslie R. Pollock, in *The Psychology of Suicidal Behaviour*, outline the "cry of pain" model of suicidal behavior, describing suicidal behavior as an "attempt to escape from a feeling of entrapment."⁶⁸ It follows that the DWDA contemplates that while the symptoms are the same, the root of the problem is so fundamentally different as to not entitle the individual to the law's benefit.

⁵⁹ *Id.*

⁶⁰ *Id.*

⁶¹ *Id.*

⁶² *Id.*

⁶³ Compare *id.* § 127.833-3.03 (prohibiting medication from being dispensed to patients suffering from a "psychological disorder or depression"), with Mitchell et al., *supra* note 15 (finding that many terminally ill patients experience depression and documenting a correlation between desire for death and depression), and Breitbart et al., *supra* note 16 (same).

⁶⁴ OR. REV. STAT. § 127.833-3.09.

⁶⁵ *Id.* § 127.800-955.

⁶⁶ *Id.*

⁶⁷ See J. Mark G. Williams & Leslie R. Pollock, *The Psychology of Suicidal Behaviour*, in THE INTERNATIONAL HANDBOOK OF SUICIDE AND ATTEMPTED SUICIDE 79 (Keith Hawton & Kees van Heeringen eds., 2000); see also Mitchell et al., *supra* note 15, at 307 (examining factors, including psychiatric illnesses, known to motivate suicide attempts and identifying populations at a high-risk of suicide).

⁶⁸ Williams & Pollock, *supra* note 67, at 79.

Depression is not a valid reason under the DWDA for requesting euthanasia.⁶⁹ However, the reported findings out of the state suggest that terminally ill patients are in fact experiencing symptoms of depression.⁷⁰ Elsebeth Nylev Stenager and Egon Stenager, in *Physical Illness and Suicidal Behaviour*, focus on how somatic diseases and disorders have psychosocial consequences.⁷¹ They conclude that a wide variety of physical disorders are associated with an increased risk of suicide and suicide attempts and that health personnel should be aware of the risk of suicidal behavior in the physically ill.⁷² Their study is most intriguing because it proved, by studying a number of patients with specific physical illnesses, the systematic nature of accompanying suicidal ideations with certain physical illnesses.⁷³ This suggests that doctors and mental health professionals could be equipped and on hand to cooperate in every diagnosis linked to suicidal ideations. If doctors can predict that patients might request euthanasia,⁷⁴ it is curious why they do not aim to lower the number of requests with preventative psychological and/or psychiatric care. Additionally, Stenager and Stenager note that “hopelessness uniquely contributes to the prediction of suicidal ideation when the level of depression is statistically controlled for, not only in the psychiatric disorders but also in the terminally ill.”⁷⁵ This further illustrates the conflict this Note highlights: the differential treatment of patients with these ideations. The governmental interest in preserving the lives of citizens could in theory be just as strong within the hospital walls as it is outside of them. If symptoms of depression can be isolated, then physicians must aim to treat those symptoms in addition to the terminal physical ailment.⁷⁶ If successful, it is then that the fundamental difference might rear its head: the sane and otherwise not depressed individual requests euthanasia. The DWDA and laws like it operate on the conclusion that this is occurring.

⁶⁹ See OR. REV. STAT. § 127.800–955.

⁷⁰ See William Breitbart et al., *supra* note 16, at 2909 (finding a correlation between depression in terminally ill patients and increased desire to hasten death); see also Barry Rosenfeld, *Assisted Suicide, Depression, and the Right to Die*, 6 PSYCHOL. PUB. POLY & L. 467, 474–76 (2000) (collecting studies examining the relationship between terminal illness, depression, and the desire for death).

⁷¹ See Stenager & Stenager, *supra* note 47, at 406.

⁷² See *id.* at 417.

⁷³ See *id.* at 412.

⁷⁴ By looking for physical disorders noted in *supra* note 67.

⁷⁵ Stenager & Stenager, *supra* note 47, at 412.

⁷⁶ See Ackerman, *supra* note 8.

II
PRESERVING LIFE AND DETERRING SUICIDE
INTERNATIONALLY

Historically, the influence of religious institutions on governments has always been significant and instrumental in shaping the positions governments take.⁷⁷ Even in the United States, where the government has taken extraordinary measures to separate church and state, it is not too difficult to see that religious influences can motivate political opinions, and, occasionally, motivate judicial decisions.⁷⁸ A most prominent example is the large demographic of United States citizens who oppose gay marriage because the Bible directly forbids it.⁷⁹ In the realm of death and dying, religion too plays a very strong role. The Catholic Church, for instance, stands behind the commandment that “[t]hou shalt not kill,”⁸⁰ and emphasizes that every human life has equal value regardless of mobility or intellect.⁸¹ This principle challenges those in support of euthanasia, and it is especially problematic in cases where mobility and intellectual capabilities are so minimal as to be the primary reason for the request. The medical community is in severe disagreement over the concept of brain death, and what skills and/or capabilities a person or body needs to have in order to be considered “alive.”⁸² In *The New Yorker*, Rachel Aviv recounts the curious case of Jahi McMath, a teenage girl who was brought across state borders in order to remain on life support because states not only have a different definitions of what it means to be dead, but also different requirements of hospitals in honoring the religious beliefs of its patients.⁸³

It should be noted that Americans do generally support the practice of euthanasia for the terminally ill.⁸⁴ In conducting a

⁷⁷ See Ranjan et al., *supra* note 24, at 4.

⁷⁸ See Nigel Barber, *Why Religion Rules American Politics*, HUFFINGTON POST (July 20, 2012, 3:34 PM EST), https://www.huffingtonpost.com/nigel-barber/why-religion-rules-america_b_1690433.html [<https://perma.cc/8LL9-TFBM>].

⁷⁹ See Katharine Q. Seelye & Janet Elder, *Strong Support Is Found for Ban on Gay Marriage*, N.Y. TIMES (Dec. 21, 2003), <http://www.nytimes.com/2003/12/21/us/strong-support-is-found-for-ban-on-gay-marriage.html> [<https://perma.cc/U7XR-Z3NH>].

⁸⁰ Exodus 20:13 (King James).

⁸¹ *Euthanasia and Assisted Dying*, BBC (Aug. 3, 2009), http://www.bbc.co.uk/religion/religions/christianity/christianethics/euthanasia_1.shtml [<https://perma.cc/9M3Q-L7EX>].

⁸² See Rachel Aviv, *What Does It Mean to Die?*, NEW YORKER (Feb. 5 2018), <https://www.newyorker.com/magazine/2018/02/05/what-does-it-mean-to-die> [<https://perma.cc/6KCP-WAHX>].

⁸³ See *id.*

⁸⁴ See Span, *supra* note 35.

poll for the *General Social Survey*, researchers out of the University of Chicago found that for the last 15 years the proportion of Americans responding positively to the idea stayed between 66 and 69%.⁸⁵ This data suggests that citizens are often sympathetic to those who wish to end their lives, but this contributes to the dilemma regarding differential treatment. Those who attempt suicide on their own in the United States and are unsuccessful are routinely confined and kept for observation for a period of time within a hospital's walls.⁸⁶ Those individuals are subject to psychiatric evaluations by trained medical professionals.⁸⁷ The practice of psychiatry would then require pharmacotherapy combined with classic therapy treatment to effectively treat that patient.⁸⁸ Both the medication and the dialogue with a therapist aim to combat the mental illnesses at work and to help that patient cope with their situation. Large bodies of clinical data prove that there is a genetic susceptibility to suicidal behaviors, often manifesting when an individual is stressed or ill.⁸⁹ In short, depression requires medical treatment.⁹⁰ While any individual who wishes to die but who does not have a terminal diagnosis could be medically treated to alter their chemical imbalance, the legitimate nature of a terminal patient's desire to end their life is not given the same weight, even though that patient could benefit from similar courses of treatment.

In the face of this medical understanding, a number of countries across the globe still do not view suicidal ideations as a form of mental illness, and instead criminalize the behavior and punish attempts with incarceration.⁹¹ One such example is Singapore, where citizens share the notion that criminaliza-

⁸⁵ *Id.*

⁸⁶ See Mitchell et al., *supra* note 15, at 308.

⁸⁷ See *id.*

⁸⁸ See *What Is Psychiatry?*, AM. PSYCHIATRIC ASS'N (2018), <https://www.psychiatry.org/patients-families/what-is-psychiatry> [<https://perma.cc/Z4V4-GFPQ>].

⁸⁹ See Karl Andriessen & Alja Videtic-Paska, *Genetic Vulnerability as a Distal Risk Factor for Suicidal Behaviour: Historical Perspective and Current Knowledge*, 54 SLOVENIAN J. PUB. HEALTH 238, 238 (2015), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4820161/pdf/sjph-54-03-238.pdf> [<https://perma.cc/UT7K-R4TX>]; see also AM. PSYCHIATRIC ASS'N STEERING COMM. ON PRACTICE GUIDELINES, PRACTICE GUIDELINE FOR THE ASSESSMENT AND TREATMENT OF PATIENTS WITH SUICIDAL BEHAVIORS 42 (2013), https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/suicide.pdf [<https://perma.cc/TL9G-E74E>].

⁹⁰ See NAT'L INST. OF MENTAL HEALTH, DEPRESSION: WHAT YOU NEED TO KNOW 3 (2015) ("Most people who experience depression need treatment to get better.").

⁹¹ See Ranjan et al., *supra* note 24, at 6.

tion acts as a useful deterrent.⁹² In an article in *The Straits Times*, an English daily newspaper based out of and printed in Singapore, the prevalent sentiment on suicide was that it impedes on the progress of the city-state.⁹³ Although those who attempt suicide are rarely convicted due to the despondent and delicate emotional nature of the individuals, the law remains unsympathetic.⁹⁴ The implications of a statute like this directly challenge the understanding of mental illness in the United States, while the practice of not convicting recognizes its futility in the law.⁹⁵ Incarceration can only deter those who have the capacity to appreciate the wrongfulness of their act.⁹⁶ For this reason, the criminal law system in the United States generally requires the *mens rea* element, or *guilty mind*.⁹⁷ A mentally incompetent individual is unable to have a guilty mind, which is why the American system allows for their insanity defense.⁹⁸ This discrepancy between the systems suggests that countries like Singapore do not link suicidal ideations with chemical imbalances, despite an overwhelming body of knowledge in the medical community that suggests otherwise.⁹⁹

The alternate insanity defense has to do with the *actus rea*, or *guilty act*.¹⁰⁰ This means that the person lacks the ability to resist the offensive conduct. This is attributed again to a mental or physical condition preventing the individual from exercising reasonable control of his or her body.¹⁰¹ Some states are reluctant to accept an *actus reus* defense because although scientific studies might indicate a chemical inability to control an impulse, a huge proportion of the prison population likely suffers from some degree of this chemical imbalance.

⁹² Cf. Shaffiq Idris Alkhatib, *Death Penalty 'a Powerful Deterrent,'* STRAITS TIMES (Apr. 5, 2017, 5:00 AM SGT), <https://www.straitstimes.com/singapore/death-penalty-a-powerful-deterrent> [https://perma.cc/VV59-WVHN] (typifying the Singaporean view that criminal law is a useful deterrent).

⁹³ See Govin, *supra* note 25.

⁹⁴ *Id.*

⁹⁵ *Id.*

⁹⁶ Michael D. Slodov, *Criminal Responsibility and the Noncompliant Psychiatric Offender: Risking Madness*, 40 CASE W. RES. L. REV. 271, 276 n.32 (1989) (summarizing why punishing the insane fails to advance the deterrence functions of criminal law).

⁹⁷ See Slovenko, *supra* note 29.

⁹⁸ See *id.*

⁹⁹ See Ranjan et al., *supra* note 24, at 6.

¹⁰⁰ See Slovenko, *supra* note 29.

¹⁰¹ See Kenneth B. Chiacchia, *Insanity Defense—Insanity Defense Statistics, Problems with NGRI, Guilty but Mentally Ill*, PSYCHOL. ENCYCLOPEDIA <http://psychology.jrank.org/pages/336/Insanity-Defense.html> [https://perma.cc/8A6Y-RZGR].

ance.¹⁰² Finding them all not guilty by reason of insanity would be very dangerous to society at large, and would lead to the slippery slope judicial bodies are inclined to avoid.¹⁰³ The alternate verdict some states have adopted is *guilty but mentally ill*.¹⁰⁴ This theory recognizes mental illness but simultaneously punishes the defendant for the crime—in essence deciding that the mental defect was not the actual and proximate cause of the crime.¹⁰⁵

III

CULTURAL NORMS, RELIGIOUS INFLUENCES, AND LEGISLATION

In Islamic and Hindu countries like Pakistan and India, respectively, the religious implications of suicide are quite severe.¹⁰⁶ While attempted suicide was decriminalized in India in 2014, a study of 200 attempted suicide victims at a hospital in India showed that only 46.2% of males and 26.6% of females were even aware that it was a criminal act to attempt suicide prior to the new law.¹⁰⁷ The Law Commission in India finally conceded that attempting suicide is the “manifestation of a diseased condition of mind” that needs treatment and care rather than punishment.¹⁰⁸ However, noted criminal lawyer Nitya Ramakrishnan fears that if the truth is manipulated, many deaths will be “camouflaged as suicide.”¹⁰⁹ In response to the World Health Organization listing India as one of the countries with the highest suicide rates in 2012, a Mental Health Care Bill in 2013 was passed that explicitly states that any person who attempts suicide shall be presumed, unless proved otherwise, to be suffering from a mental illness at the time of the bid.¹¹⁰ More dramatically, the bill seeks “to provide

102 *Id.*

103 *See id.*

104 *See* Slovenko, *supra* note 29.

105 *See* Chiacchia, *supra* note 101.

106 *See* Ranjan et al., *supra* note 24, at 4; *see also* Khan, *supra* note 26, at 172, 174.

107 Manan Kumar, *Attempt to Suicide No More a Criminal Defense*, DAILY NEWS & ANALYSIS (Dec. 11, 2014, 7:40 AM IST), <http://www.dnaindia.com/india/report-attempt-to-suicide-no-more-a-criminal-offence-2042938> [<https://perma.cc/6585-M622>].

108 *Id.*

109 *Id.*

110 *See id.*; *see also* PTI, *New Mental Health Bill Decriminalises Suicide*, HINDU (Aug. 21, 2013 19:15 IST), <http://www.thehindu.com/news/national/new-mental-health-bill-decriminalises-suicide/article5045156.ece> [<https://perma.cc/V92A-97D5>] (discussing introduction of Bill) [hereinafter *New Mental Health Bill*].

for mental health care for persons with mental illnesses and to protect, promote and fulfill the rights of such persons during the delivery of mental health care and services.”¹¹¹ The bill also came after India ratified the United Nations Convention on the Rights of Persons with Disabilities, requiring it to protect disabled persons.¹¹² Described as “humane and progressive,” India’s Health Minister J.P. Nadda said the bill will help provide more support to India’s population, 27% of which the World Health Organization says suffer from depression.¹¹³ However, while a progressive bill, the warning from Ramakrishnan suggests again that the statistics coming out of India are likely unreliable.

Indian government officials are additionally concerned with the social stigma attached to mental illness.¹¹⁴ Suicidal death is associated with bringing dishonor to an entire lineage and carries a heavy social burden on surviving family members in both the Hindu and Islamic religions.¹¹⁵ Hinduism excludes those who die via suicide from achieving “salvation,” and those who die from suicide are denied customary funeral rituals.¹¹⁶ Although there is no particular principle of Islam that forbids attempted suicide, scholars suggest that the religion has strong sanctions against it.¹¹⁷ These traditional attitudes inform reporting patterns and ultimately shape the efforts governments are putting into protecting, preserving, and even saving vulnerable lives.

In Pakistan, Section 325 of the Pakistan Penal Code adjudges attempted suicide as a criminal offense punishable with one year of imprisonment and/or a fine.¹¹⁸ One study concluded that 39% of women and 21% of men in Pakistan had

¹¹¹ See *New Mental Health Bill*, *supra* note 110.

¹¹² See *id.*; see also Dep’t of Econ. & Soc. Aff., *Convention on the Rights of Persons with Disabilities (CRPD)*, UNITED NATIONS (Dec. 13, 2006), <https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html> [<https://perma.cc/2RD8-QQ8C>] (showing India’s ratification of the Convention).

¹¹³ See PTI, *Rajya Sabha Passes Mental Healthcare Bill*, INDIAN EXPRESS (Aug. 8, 2016, 7:30 PM), <http://indianexpress.com/article/india/india-news-india/rajya-sabha-mental-healthcare-india-mental-health-parliament-illness-2962059/> [<https://perma.cc/X45G-42Y8>] [hereinafter *Rajya Sabha*].

¹¹⁴ See *id.*

¹¹⁵ See *id.*; see also Ranjan et al., *supra* note 24, at 4.

¹¹⁶ See Ranjan et al., *supra* note 24, at 5.

¹¹⁷ See Khan, *supra* note 26, at 172; see also Michael Rubin, *Does the Koran Condemn or Condone Suicide?*, NEWSWEEK (Jan. 12, 2015, 1:44 PM), <http://www.newsweek.com/does-koran-condemn-or-condone-suicide-298719> [<https://perma.cc/WAU9-HJ47>] (examining the theology of suicide in Islam).

¹¹⁸ See *New Mental Health Bill*, *supra* note 110.

contemplated suicide, and the World Health Organization in 2002 reported almost 16,000 suicide cases in the country.¹¹⁹ At such high rates, it is reported that citizens often bribe law enforcement officials in order to avoid criminal charges when it is believed someone has killed themselves.¹²⁰ It is this very fact that makes the figures in Pakistan again so unreliable—if 16,000 cases were reported, how many additional cases were not reported for fear of repercussions, both criminally and socially?¹²¹ The situation in Pakistan undoubtedly is in need of mental health resources to both educate and help reshape policy and attitudes. It is evident that the concept of euthanasia would be quite inapposite to the cultural norms there, despite the number of citizens who have suicidal ideations.¹²² This lack of recognition for these symptoms of depression and other illnesses likely contributes to these high rates because the citizens are too afraid, and simply unable to, seek out the necessary help. The government interests listed by the Supreme Court of the United States are even more persuasive when superimposed onto Pakistan: governments should aim to preserve the lives of constituents, but without recognizing what modern science has deemed a curable chemical imbalance, lives will be lost.¹²³

Surprisingly, Pakistan simultaneously offers its criminal defendants the insanity defense.¹²⁴ If we accept the assumption that suicidal individuals are suffering from mental illness, then it should appear strange that those individuals are held criminally liable for their actions. In the United States, defendants are permitted to use the insanity defense in order to *excuse* their behavior.¹²⁵ This by definition means that the defendant has been proven guilty or has admitted to the wrongdoing, *but due to their mental state*, cannot be held criminally liable.¹²⁶ Instead, the individual is held for psychiatric evalua-

119 *Id.*

120 *Id.*

121 *See Rajya Sabha, supra* note 113.

122 *See* Muhammad Nasir Afzal et al., *Attitude of Pakistani Doctors Towards Euthanasia and Assisted Suicide*, 60 *Pak. Armed Forces Med. J.* (2010), <http://www.pafmj.org/showdetails.php?id=304&t=O> [<https://perma.cc/L6X5-SJNA>].

123 Rick Nauert, *Depression's Chemical Imbalance Explained*, *PSYCH CENT.*, <https://psychcentral.com/news/2006/11/09/depressions-chemical-imbalance-explained/398.html> [<http://perma.cc/DA3R-DCYB>] (last updated Aug. 8, 2018).

124 Ashraf Ali, "Plea of Insanity" as a Defense in Pakistan (*Analysis of the Celebrated Judgements of Superior Courts*), 4 *INT'L J. HUMAN. & SOC. SCI.*, 270, 273–76 (2014).

125 *See* Chiacchia, *supra* note 101.

126 *See id.*

tion and, if cured or rendered stable, will be released at a date that has no correlation to what his or her prison sentence would have been had they been declared competent at the time of the crime.¹²⁷ In Pakistan, the defense works much the same.¹²⁸ This illustrates a new contradiction: one can be excused of his or her crime by way of mental illness, but will be incarcerated for an act that substantial scientific data has determined is also due to mental illness.¹²⁹ While mental illness does not *always* rise to the level of insanity, it does support the notion that criminalizing the behavior is inconsistent with the goals of criminalization. Suicidal ideations are associated with depression—a medically recognized disease of the mind usually accompanied by a chemical imbalance.¹³⁰ Almost 90% of suicides may be related to depression.¹³¹ Pakistan has remarkably gone under the radar with this conflict in its system; it seems illogical that suicidal persons are not excused via the insanity defense for attempting to take their own lives.¹³²

In their attempt to determine how Islamic physicians view euthanasia, Muhammed Nasir Afzal, Rabia Latif, and Tahir Ahmad Munir found that most physicians rejected the concept.¹³³ A survey of 105 doctors with moderate Islamic teaching showed that 86% were against the idea of legalizing euthanasia, and only 9% believed in the practice for those were suffering from “intractable pain.”¹³⁴ This is consistent with the other findings out of Pakistan that suggest an aversion to the concept of ending a life with intention, with no exception taken for those with terminal illness.¹³⁵ This model is almost at the opposite extreme as some of the other countries this Note will explore, and it begs the question, how far should governments be able to elevate moral religious beliefs over medical science?

The assertion that “suicidal ideations are indicators of depression” has a strong counter in some cultures; namely, the practice of honor suicides in Asian countries like Japan.¹³⁶

¹²⁷ See Taslitz, *supra* note 28, at 5.

¹²⁸ See Ali, *supra* note 124, at 270, 273.

¹²⁹ See Mitchell et al., *supra* note 15, at 305.

¹³⁰ See *id.* at 306; see also Nauert, *supra* note 123.

¹³¹ See *New Mental Health Bill*, *supra* note 110.

¹³² See Lonqvist, *supra* note 20, at 107 (“[S]tudies concluded over the past 40 years suggest that depression is found in 29–88% of all suicides.”).

¹³³ See Afzal et al., *supra* note 122.

¹³⁴ *Id.*

¹³⁵ *Id.*

¹³⁶ See Lissette Padilla, *Why the Japanese See Honor in Suicide*, SEEKER (July 8, 2015, 1:00 AM), <https://www.seeker.com/why-the-japanese-see-honor-in-suicide-1501524382.html> [<https://perma.cc/VZ4J-NZ9H>].

The Japanese culture historically believed that suicide would preserve a family's honor.¹³⁷ By framing suicide as "responsibility-driven," done in hopes of clearing debts and affording beneficiaries any payout from the death, Japanese people find the act to be selfless.¹³⁸ Perhaps then the suicidal Japanese person, in hopes of providing for his family, who suffers no terminal illness and previously had no history of mental illness, is experiencing a legitimate suicidal ideation without biological causes due to Japanese cultural norms. It is difficult to reconcile this position with almost any position that categorizes depression as a "disease," but it further illustrates how cultural conditioning influences both governments and medical professionals in handling affected individuals.¹³⁹

It is this Note's position that the government's interest in preserving life should outweigh an individual's intentions against their own preservation. With proper treatment and care, the mental health community in this country believes that those who wish to end their life early can be persuaded or treated into no longer feeling that way.¹⁴⁰ Those countries who believe that criminalizing this behavior¹⁴¹ is the proper approach are missing the heart of the problem: that mental illness prevents effective deterrence. In countries like Pakistan, where governments recognize what mental illness is but choose to ignore it in the context of suicide, this Note urges policymakers to extend their understanding about why individuals attempt suicide.¹⁴² Although experienced mental health professionals are the most capable of picking up on behavioral patterns that are indicative of suicidal ideations, accurately predicting suicide is not an exact science.¹⁴³ Professionals devoted to the prevention of suicide have had to acknowledge their limitations and focus their efforts on relieving the despair that is more often than not the proximate cause of the ultimate suicide or attempted suicide.¹⁴⁴

¹³⁷ *Id.*

¹³⁸ *Id.*

¹³⁹ See Sara Reardon, *Suicidal Behavior Is a Disease, Psychiatrists Argue*, NEW SCIENTIST (May 17, 2013), <https://www.newscientist.com/article/dn23566-suicidal-behaviour-is-a-disease-psychiatrists-argue/?cmpid=RSSNSNS2012-GLOBALonline-news> [<https://perma.cc/9Y3H-P8A5>].

¹⁴⁰ See Mitchell et al., *supra* note 15, at 306.

¹⁴¹ See Ranjan et al., *supra* note 24, at 6.

¹⁴² See Khan, *supra* note 26, at 172, 174.

¹⁴³ See Robert D. Goldney, *Prediction of Suicide and Attempted Suicide*, in THE INTERNATIONAL HANDBOOK OF SUICIDE AND ATTEMPTED SUICIDE, *supra* note 20, at 585, 593.

¹⁴⁴ See *id.* at 593–94.

Published in 1992, David Lester's instrumental study on suicide legislation examined suicide rates over a period of ten years (five of which were in countries that criminalized suicidal behavior and five of which were post-decriminalization) and revealed an interesting outcome.¹⁴⁵ Canada, New Zealand, and Ireland showed no change at all pre- and post-decriminalization.¹⁴⁶ The Ireland study, however, did show a change of a different kind.¹⁴⁷ The study concluded that the legalization of suicide was not associated with a significant increase in suicide deaths, but did have an effect on the number of *undetermined* death verdicts.¹⁴⁸ This speaks to the implications that the "suicide" classification has on a society at large when the act itself is criminalized. While that study did not address this increase, this Note posits that there is good reason for this.¹⁴⁹ When suicide is illegal, classifying a death as a suicide has legal and financial ramifications.¹⁵⁰ The classification of manner of death is important to their next-of-kin most notably for financial reasons.¹⁵¹ It was in the best interest of families to avoid admitting that suicide had occurred.¹⁵² As a caveat, Lester did also conclude that in countries where the suicide rate went up post decriminalization, the recording methods of those suicide deaths were less efficient and somewhat unreliable, a common issue this Note previously encountered in countries like Pakistan and India.¹⁵³

Deterring suicide and preserving life are persuasive government priorities that foreign countries need to consider against their constituents' requests. While religious and cultural beliefs are evidently strong prevailing counterarguments, this Note asserts that medical science demands a particular response. These countries across the globe might be trying to accomplish the same goals, but as this Note concludes, with no

¹⁴⁵ See Lester, *supra* note 32, at 898; see also Ranjan, *supra* note 24, at 6 (discussing Lester's study in the context of decriminalization arguments).

¹⁴⁶ See Lester, *supra* note 32, at 898; see also Mugtaba Osman et al., "Suicide Shall Cease to be a Crime": Suicide and Undetermined Death Trends 1970–2000 Before and After the Decriminalization of Suicide in Ireland 1993, 186 *Irish J. MED. SCI.* 201, 202–03 (2016) (elaborating upon Ireland's pre- and post-decriminalization trends).

¹⁴⁷ See Osman et al., *supra* note 146.

¹⁴⁸ *Id.* at 203–04.

¹⁴⁹ See P. Lindqvist & L. Gustafsson, *Suicide Classification: Clues and Their Use—A Study of 122 Cases of Suicide and Undetermined Manner of Death*, 128 *FORENSIC SCI. INT'L.* 136, 140 (2002).

¹⁵⁰ See Ranjan et al., *supra* note 24, at 5.

¹⁵¹ See *id.*

¹⁵² See Khan, *supra* note 26, at 172–74.

¹⁵³ See Ranjan et al., *supra* note 24, at 5.

success.¹⁵⁴ In fact, it is the situations elsewhere that bring greater credence to Chief Justice Rehnquist's premises here at home. The question remains whether or not even allowing euthanasia to occur at all in the states that legalize it adds or takes away from the government's ultimate goal.

IV

THIRD PARTIES, UNDUE INFLUENCE, AND THE SLIPPERY SLOPE

In *Washington v. Glucksberg*, The Supreme Court of the United States held that the following government interests were heavy enough to outweigh the interests of the challenging patients and physicians: avoiding the undue influence of third parties on those individuals who might seek euthanasia¹⁵⁵ and avoiding the potential of a slippery slope of increasing euthanasia requests for less severe illnesses.¹⁵⁶ In attempting to prove the value of these premises, the current political and medical professional climate in Belgium and the Netherlands serve as helpful anecdotes.

In the fascinating true story of a Belgian woman named Godelieva De Troyer, Rachel Aviv of *The New Yorker* recounts the story of how De Troyer suffered from severe and incurable depression.¹⁵⁷ De Troyer subsequently sought euthanasia after exhausting her medical options because she was convinced she could not be relieved of her depression.¹⁵⁸ In other words, she considered her depression terminal.¹⁵⁹ Conveniently, Belgium views itself as rather progressive in its laws that legalize assisted suicide.¹⁶⁰ The "right-to-die" movement, as Aviv writes in *The Death Treatment*, has gained popularity in European countries.¹⁶¹ Although most Belgians who are euthanized have terminal diagnoses, people have been euthanized there for autism, anorexia, borderline personality disorder, chronic-fatigue syndrome, partial paralysis, blindness coupled with deafness, manic depression, and transgender status.¹⁶² Wim Distelman, the founder of Life End Information Forum (LEIF), is a strong proponent of allowing

154 See *id.* at 5–6.

155 See *Washington v. Glucksberg*, 521 U.S. 702, 728 n.20 (1997).

156 See *id.* at 702.

157 See Aviv, *supra* note 22.

158 See *id.*

159 *Id.*

160 See *id.*

161 *Id.*

162 See *id.*

those who wish to end their lives to do so.¹⁶³ The right to a dignified death, he writes, is an accomplishment of secular humanism, a belief system recognized by the Belgian government.¹⁶⁴ The laws in Belgium seem to view suicide as a medical treatment “stripped of its tragic dimensions.”¹⁶⁵ To most Americans, however, some of those diagnoses are far from legitimate reasons to request euthanasia.¹⁶⁶ This brings up the concern of undue influence. With such a pervasive practice of euthanasia in Belgium,¹⁶⁷ it forces one to question how influenced De Troyer was to be euthanized. No doubt it was a combination of the teachings and philosophy of humanism and Distelman,¹⁶⁸ combined with the sheer capability of doing so for her non-terminal disorder that influenced her decision.¹⁶⁹

In 2001, the Netherlands became the first country in the world to legalize euthanasia for terminal patients suffering from diseases with no possibility of a cure.¹⁷⁰ Further, Edith Schippers, the Health Minister of the Netherlands, read a letter to the Dutch government in late 2016¹⁷¹ arguing that the laws surrounding euthanasia should be less restrictive in order to accommodate a growing older community of citizens who had “completed life,” a phrase which this Note highlights has no medical significance.¹⁷² In 2015, almost 4% of all deaths in the country were via euthanasia.¹⁷³ Opponents worry that this is the beginning of the slippery slope that the Justices of the Supreme Court were worried about.¹⁷⁴ A populist politician in the Netherlands, Geert Wilders, argued that the country should combat depression instead of enabling those who wish to die.¹⁷⁵ The issue is that although euthanasia is masked as a

¹⁶³ See *id.*

¹⁶⁴ See *id.*

¹⁶⁵ *Id.*

¹⁶⁶ See Scott Hensley, *Americans Support Physician-Assisted Suicide for Terminally Ill*, NPR (Dec. 28, 2012 7:39 AM), <https://www.npr.org/sections/health-shots/2012/12/27/168150886/americans-support-physician-assisted-suicide-for-terminally-ill> [https://perma.cc/M5WZ-QXAX].

¹⁶⁷ See Aviv, *supra* note 82.

¹⁶⁸ *Id.*

¹⁶⁹ *Id.*

¹⁷⁰ Dan Bilefsky & Christopher F. Schuetze, *Dutch Law Would Allow Assisted Suicide for Healthy Older People*, N.Y. TIMES (Oct. 13, 2016), <https://www.nytimes.com/2016/10/14/world/europe/dutch-law-would-allow-euthanasia-for-healthy-elderly-people.html?rref=collection%2Ftimestopic%2FEuthanasia> [https://perma.cc/Q5CK-MM6D].

¹⁷¹ *Id.*

¹⁷² *Id.*

¹⁷³ See *id.*

¹⁷⁴ See *id.*

¹⁷⁵ See *id.*

“purely individual choice,”¹⁷⁶ the reality is that the choice to end one’s life affects everyone around that individual from close family members and friends, to health care providers and the community at large.¹⁷⁷ In a study led by Dr. Scott Y. H. Kim, a psychiatrist and bioethicist at the National Institutes of Health, patients declined treatments that could have helped or all together alleviated their suicidal ideations in more than half of approved doctor assisted deaths in the Netherlands between the years of 2011 and 2014.¹⁷⁸ Depression was the most common diagnosis.¹⁷⁹ This statistic is particularly troublesome and undoubtedly stems from the “progressive” attitudes prevailing there. Despite the very real possibility of treating these patients, the country has opted to grant their wishes. This Note argues that this is a devastating blow to what should be a government’s ultimate goal of preserving the lives of its constituents.

Professor of Psychiatry at Columbia University, Dr. Paul S. Appelbaum, noted that “[t]he criteria in the Netherlands essentially require[s] that the person’s disorder be intractable and untreatable, and this study shows that evaluating each of those elements turns out to be problematic.”¹⁸⁰ According to an article in the *New York Times*, people in the Netherlands were leaving their treating primary physician and going to a clinic funded by euthanasia advocacy organizations that exist solely for the purpose of providing euthanasia assistance.¹⁸¹ These health care providers aim to measure the levels of suffering and disease in each of its patients—a job Dr. Appelbaum argues is best left to the original treating physician.¹⁸² This Note argues that in the Netherlands, the barrier between ordinary citizen and desired death on command are wholly insufficient. The question that is left unanswered is whether any of the individuals requesting euthanasia are *truly* mentally competent enough to do so. In granting requests to individuals suffering from depression, schizophrenia, or just loneliness, this Note argues

¹⁷⁶ *See id.*

¹⁷⁷ *Id.*

¹⁷⁸ *See* Benedict Carey, *Assisted Suicide Study Questions Its Use for Mentally Ill*, N.Y. TIMES (Feb 10, 2016), <https://www.nytimes.com/2016/02/11/health/assisted-suicide-mental-disorders.html> [<https://perma.cc/W4GD-M7DM>]; *see also* Scott Y.H. Kim et al., *Euthanasia and Assisted Suicide of Patients with Psychiatric Disorders in the Netherlands 2011 to 2014*, 73 J. AM. MED. ASS’N. PSYCHIATRY 362, 362–68 (2016) (the study itself).

¹⁷⁹ *See* Carey, *supra* note 178.

¹⁸⁰ *Id.*

¹⁸¹ *Id.*

¹⁸² *Id.*

that countries like the Netherlands and Belgium are euthanizing mentally incompetent persons.

In the United States, the slippery slope may have already started. In November 2016, a New Jersey court granted a woman the right to refuse forced feedings.¹⁸³ The judge announced that the court recognized her right to “live free from medical intervention.”¹⁸⁴ The state argued that the ruling was essentially allowing the woman to die.¹⁸⁵ Although euthanasia is not legal in New Jersey,¹⁸⁶ one cannot help but assess the validity of the state’s argument. There exists a fine line between physician-assisted suicide and allowing someone to inevitably die. This woman was not declining treatment, but was instead declining basic nutrition.¹⁸⁷ This case in New Jersey is quite distinguishable from the typical case the Supreme Court imagined when it initially made the distinction between *allowing* and *causing*.¹⁸⁸ The woman here was suffering from a mental disease, one that could not be considered “terminal” due to its treatable nature.¹⁸⁹ To support this point, the state included in its brief some of this very same woman’s statements.¹⁹⁰ She had stated that she believed that any person over 65 pounds was “obese”—which this Note argues is enough evidence alone for any mental health professional to conclude that she was mentally incompetent to make rational decisions regarding her own health.¹⁹¹ This ruling allowed her to be removed from her feedings, and thus characterized her mental illness as “terminal” given that she immediately entered palliative care.¹⁹² While the decision in New Jersey¹⁹³ by no means implies that this woman was being euthanized, the fact remains that this woman’s mental health disorder led her to have clear suicidal intentions, and she was granted the chance to let that happen.

183 See Jorgensen, *supra* note 23.

184 *Id.*

185 *See id.*

186 *Id.*

187 *Id.*

188 See *Washington v. Glucksberg*, 521 U.S. 702, 750 (1997); *Vacco v. Quill*, 521 U.S. 793, 800–01 (1997).

189 See Aviv, *supra* note 82.

190 See Jorgensen, *supra* note 23.

191 *Id.*

192 *Id.*

193 *Id.*

V

CONTROVERSY WITHIN THE MEDICAL PROFESSION

The Hippocratic Oath taken by those entering the medical practice states the obligations, goals, and proper conduct of doctors.¹⁹⁴ A growing number of physicians, however, feel that the Oath has become inadequate because it does not address the realities of the modern medical world.¹⁹⁵ Physician-assisted suicide, with its growing rates of acceptance and legalization, was explicitly banned in the classic version of the Oath.¹⁹⁶ An earlier Oath read, "I will neither give a deadly drug to anybody who asked for it, nor will I make a suggestion to this effect."¹⁹⁷ A more modern version reads, "[I]t may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty."¹⁹⁸ The mantra of "do no harm" must weigh heavily on physicians, who are told that "[a]bove all, I must not play at God."¹⁹⁹ It is not surprising to learn, then, that it can be difficult for patients to find a physician willing to recommend them for euthanasia.²⁰⁰ The entire practice of euthanasia, it would seem, is antithetical to the medical profession. Physicians who are proponents of the practice suggest that in some cases, providing euthanasia services is truly giving the patient the care he or she needs.²⁰¹ Preserving dignity, they argue, could be the best medical help a physician could provide to a patient in need.²⁰²

Felicia Nimue Ackerman, a professor of philosophy at Brown University, wrote in a piece for *Vox* that a "society that 'pathologizes' suicidal feelings of indignity and degradation . . . while endorsing them in the terminally ill is . . . engaging in a horrifying, odious form of bigotry."²⁰³ What she means is that the discussion should not be between legalizing assisted suicide for terminally ill people or not, but between legalizing it for

194 See Tyson, *supra* note 38.

195 See *id.*

196 See *id.*

197 *Id.*

198 *Id.*

199 *Id.*

200 Haider Javed Warraich, *On Assisted Suicide, Going Beyond 'Do No Harm,'* N.Y. TIMES (Nov. 4, 2016), <https://www.nytimes.com/2016/11/05/opinion/on-assisted-suicide-going-beyond-do-no-harm.html> [<https://perma.cc/3YK9-U5GY>].

201 *Id.*

202 *Id.*

203 Ackerman, *supra* note 8.

all people, or not.²⁰⁴ The difference is subtle, but significant. She aims to say that society is legitimizing the depression faced by those terminally ill patients, but is discounting it for everybody else.²⁰⁵ In legalizing assisted suicide for a subclass of people, society is saying the life it aims to preserve for all other people is intrinsically more valuable.²⁰⁶ She argues that those who suffer from depression or live in undesirable conditions are no more likely to face some drastic change than the terminally ill patient is to die.²⁰⁷ She points out that by not allowing assisted suicide for all competent adults, those patients not terminally ill but suffering from depression or the like will only continue to suffer for longer.²⁰⁸ It seems then that Ackerman is either in full support of either extreme: the seemingly on-demand practices in the Netherlands,²⁰⁹ or the nations like Pakistan that categorically do not recognize the practice.²¹⁰ The United States, in its inconsistent treatment of the subject, is squarely at odds with her theory. Ackerman uses the rape victim as an example of a person who might consider living to be undignified in the same way that a person suffering from a debilitating disease might consider their life undignified.²¹¹ The statistics from Oregon suggest that the reasons the state accepts as legitimate for desiring euthanasia are almost exactly the same as the reasons patients without terminal illnesses request euthanasia.²¹² Ackerman forthrightly rejects the idea that society should try to protect “dignity” for the former class of persons, and not the latter.²¹³ Her ultimate suggestion is that the United States should aim to biologically treat those terminally ill patients for their depression with the same rigor that we try to treat depression in non-terminal patients.²¹⁴ Laws that allow one and not the other for competent adults are placing less value on one person’s life over another—a position she contends is hard to swallow.²¹⁵ Ackerman points out that “[t]he terminally ill are not the only people who may have strong and stable suicidal desires grounded in conditions that are

204 *Id.*

205 *See id.*

206 *See id.*

207 *See id.*

208 *See id.*

209 *See generally* Kim et al., *supra* note 178; Carey, *supra* note 178.

210 *See* Khan, *supra* note 26, at 173–74.

211 *See* Ackerman, *supra* note 8.

212 *See id.*

213 *See id.*

214 *See id.*

215 *See id.*

unlikely to change.”²¹⁶ In short, the reasons we do *not* allow competent adults who are not terminally ill to choose assisted suicide are identical to the reasons we *are* allowing it for the terminally ill,²¹⁷ and this Note finds this argument particularly persuasive.

Although Ackerman refuses to “take a side” on the matter, there are pros and cons to both alternate systems of euthanasia laws.²¹⁸ Ackerman refuses to place a value on life for good reason,²¹⁹ but she fails to address value at all. A physician does not frivolously hand out the diagnosis of terminally ill. The law gives a presumption of competence to medical professionals in their work,²²⁰ and just because one course of treatment does not work for a patient does not make the treating physician liable unless there is evidence of negligence.²²¹ As a result, the characterization of “terminal” has heavy implications, and this Note fears that Ackerman is not giving the word the depth it deserves. If a doctor consents to euthanasia, his or her definitiveness that the patient is close to death is purportedly high.²²² With imminence and inevitability so strong, perhaps the value judgment of whatever life is remaining necessarily results in zero. Additionally, the argument that those with terminal illnesses should be treated for depression with the same vigor as any other individual has implications. Leaving the consideration of financial resources, potential outcomes of a course of treatment, or the hastening effects of a terminal illness to lawmaking bodies or even physicians is asking them to play the role of God forewarned by the Hippocratic Oath. Even in a situation where a terminal illness is present and major depression is effectively treated, the forces at work against the patient are resilient and relentless.²²³ The underlying conclusion just might be that it is pragmatic to accept that a certain and impending death is a legitimate and incurable reason for depression. The alternative effectively denies those who are truly suffering from a dignified end, and it is difficult to take that position in light of the pain and suffering terminally ill

²¹⁶ See *id.*

²¹⁷ See *id.*

²¹⁸ See *id.*

²¹⁹ *Id.*

²²⁰ See *Rivera v. N.Y.C. Health & Hosp. Corp.*, 191 F. Supp. 2d 412, 418 (S.D.N.Y. 2002) (holding that the professional judgment rule means that physicians cannot be held liable for mistakes made in the course of treatment when the treatment has a proper medical foundation).

²²¹ See *id.*

²²² See Warraich, *supra* note 200.

²²³ Breitbart et al., *supra* note 16, at 2909.

patients often face. The states must answer these difficult questions, and as is obvious, some countries were quicker than others to come up with their own conclusions.

Haider Javed Warraich, a fellow in cardiovascular medicine at Duke University Medical Center, penned an opinion piece for the *New York Times* entitled, *On Assisted Suicide, Going Beyond 'Do No Harm,'* where he advocated strongly for euthanasia.²²⁴ His first point is that in some situations, “doing no harm” actually means providing the life-ending service requested by the patient.²²⁵ When a disease has a patient writhing in pain, a doctor could plausibly decide that performing euthanasia was the best course of action.²²⁶ This is even consistent with the conservative physicians of Pakistan.²²⁷ Dr. Warraich’s second concern has to do with the fact that patients with severe depression and suicidal ideations are already permitted to request treatment withdrawal, noting again the distinction drawn by the courts between *causing* someone and *allowing* someone to die.²²⁸ Withdrawal too is a life-ending request, so refusing an otherwise not depressed patient from making a similar request does not quite feel consistent.²²⁹ Next, Dr. Warraich states that doctors and nurses freely push opiate prescriptions on terminal patients, but the government does not seem to realize that these drugs also hasten death because they can slow down breathing to the point of a complete stop.²³⁰ This method of sedation seems to escape all scrutiny, despite its similarities.²³¹

The article continues to rebut the slippery slope argument rather convincingly.²³² Dr. Warraich cites a study for the *Journal of the American Medical Association* revealing that although legalization of euthanasia has increased worldwide, there is no evidence that the percentage of citizens requesting the practice has increased at any alarming rate and in fact continues to be relatively rare.²³³ He also argues the fact that the majority of patients who request and receive euthanasia are older, wealth-

224 See Warraich, *supra* note 200.

225 *Id.*

226 *See id.*

227 See Khan, *supra* note 26, at 173–74.

228 *See id.*

229 *See id.*

230 *See id.*

231 Ezekiel J. Emanuel et al., *Attitudes and Practices of Euthanasia and Physician-Assisted Suicide in the United States, Canada, and Europe*, 316 J. AM. MED. ASS'N 79, 81 (2016).

232 *See id.*

233 See Warraich, *supra* note 200.

ier, and white suggests that the legalization of euthanasia does not expose poor and/or vulnerable populations to the practice in any substantial way, thus combating the undue influence premise of the Supreme Court's opinion.²³⁴ Interestingly, in another study cited by Dr. Warraich in an article, the facts indicate that immediately following the legalization of euthanasia in the Netherlands, there *was* a huge increase in requests.²³⁵ However, the rates eventually stabilized at around 5,000 requests a year.²³⁶ Dr. Warraich used this same study to suggest that the numbers made doctors more comfortable with the idea of euthanasia, and thus more likely to address pre-death comfort needs to avoid ever having to receive the request in the first place.²³⁷ The predictability, then, assisted physicians in keeping those numbers down.

Lastly, Dr. Warraich cites a study that indicated that medical error was the third leading cause of death in the United States.²³⁸ He brings this up to say that the "do no harm" argument fails already right here in the United States. The study conclusively showed that doctors are in fact causing a lot of harm already.²³⁹ Although not as convincing a point, Dr. Warraich aims to conclude that legalizing euthanasia will not increase death rates as we might expect. In short, he argues that euthanasia can be a preferable course of action over experimental surgeries.²⁴⁰ It is likely physicians would support the idea of limited euthanasia due to the nature of pain and suffering, but for each individual the analysis is vastly different. While blanket rules would not serve useful in assessing whether or not a patient can rightfully and competently request assistance in dying, this Note argues that the post-request assessment of competency is of the utmost importance, and thus needs to be consistent and conclusive.

CONCLUSION

In determining that the states have legitimate interests in preserving life, the Supreme Court declined to legalize eutha-

234 *See id.*

235 R.L. Marquet et al., *Twenty Five Years of Requests for Euthanasia and Physician-Assisted Suicide in Dutch General Practice: Trend Analysis*, 327 *BRIT. MED. J.* 201, 201 (2003).

236 *Id.*

237 *See id.*

238 *See Warraich, supra note 200.*

239 *See id.*

240 *See id.*

nesia.²⁴¹ The balancing test that the states now conduct considers and implicates human dignity, state resources, the entire medical profession, and several important government interests.²⁴² In a quest to figure out which governing regime is most effective in curbing suicide rates and preserving life, this Note has seen that governments around the world are at odds. All that is known is that a government's recognition of mental health, its professionals, and the treatability of diseases all play a significant role. While some countries have used their criminal system to carry out their goals, others have exploited their mentally incompetent in order to save themselves the resources. Still yet, other countries allow religious influences to justify their expenditure of resources in incarcerating affected individuals and leaving terminally ill patients in hospitals. This Note concludes that the inconsistency amongst the states and countries globally places very different values on the lives of constituents and provides very different degrees of control over one's own life—and it is this fact that is most troubling.

²⁴¹ See *Washington v. Glucksberg*, 521 U.S. 702, 719 (1997); *Vacco v. Quill*, 521 U.S. 793, 809 (1997).

²⁴² See *Washington*, 521 U.S. at 728.