THE RIGHT TO DIE

JOSE P. CRISOSTOMO, JR.
CESAR H. DAVID
DENNIS G. MESINA
ALFREDO Z. PIO DE RODA III
SYLVETTE Y. TANKIANG

INTRODUCTION AND HISTORICAL ASPECTS

The fascinating subject of death is multi-faceted perhaps along the same vein with the Eastern idea that death manifests itself in innumerable forms, that death wears many masks. Consequently, there have been countless and varied approaches used in answering questions concerning death; questions such as what exactly is the condition of death, what are its effects, and what are its determinants, have been answered differently by philosophers, artists, doctors, lawyers, and laymen, each providing different views and insights. One undeniable implication that can be drawn from any question concerning death is that the answer would necessarily involve the notion or subject of life. Like death, the problems encountered, with a discussion about what life consists of are similar to the problems found in a discourse about death and yet death and life may be said to be located at opposite ends. Perhaps there is such a thing as the unity of opposites here; that the nature of the relationship between life and death is paradoxical yet complementary as the Eastern mystics have propounded. Nonetheless, death and life should be distinguished; their respective patterns or underlying form must be identified and delineated. This paper however is not focused on such a delineation. Rather it is focused on a question which directly deals with the one true philosophical problem and that is suicide.

The problem of suicide, according to Albert Camus, is the one true philosophical problem which should be answered first before any other philosophical problem.[1] The fundamental question to be answered therefore is whether or not life is worth living. If it is not worth living, with the assumption that our thoughts determine our actions, then suicide is proper. If it is worth living, then suicide is not proper. The question which this paper will attempt to focus on is — granting that life is not worth living, whatever the reasons behind such judgment — can an individual avail of a right, speci-

[1] CAMUS, THE MYTH OF SISYPHUS AND OTHER ESSAYS 3 (1955).

fically the right to die? Rather, is there such a right and if so, is it recognized to be one? It may be argued that such a right exists from the mere fact that suicides occur and, in effect, that suicides illustrate the exercise of such a right, and therefore such a right exists. This argument may be countered however with the question — does the occurrence of suicide necessarily involve a right to die? Likewise it is important to note that, assuming that such a right must be viewed not only from an individual's viewpoint, but also from society's viewpoint i.e., the social context since the granting of a right implies that there is a grantor, the grantor in this case, being the state/society. There are, therefore, legal and social factors that should also be taken into consideration. The norms of a society are based on ethical and moral considerations and these merit consideration also. This paper will attempt to explore these various areas and hopefully provide answers or if not, definitely insights into a topic which is dying to be shed light into.

Before directly dealing with the problem of the right to die, it would be proper if a historical background be presented in order to see how the idea of suicide developed.

There is no single consistent attitude or view to which primitive peoples adhered to with regards to the deed of suicide. Some thought of it with superstititious horror while others like the Germanic tribes before the Christian era, accepted it calmly. One must bear in mind however that there is that basic human impulse of self-preservation and this was most probably taken into note when suicide was not looked upon favorably by a particular society.[2]

In the Greco-Roman world, there are traces of revulsion and condemnation of suicide, as inferred from the Athenian and Thebian practice of denying funeral rights to suicides. Similarly, in Attic law, the hand that committed the suicide was cut off and buried part from the rest of the body, which was also denied the usual solemnities. These laws, however, probably fell into disuse, since the balance of Greek intellectual thought was not against suicide. Socrates condemned suicide but when there was a judgment rendered against him, he complied with the order seeing the "visible necessity of dying." Plato recorded these views in the ninth book of his *Laws* and likewise condemned suicide in general, admitting however, exceptions. His condemnation of suicide is questionable when we take into account that suicide is justifiable when suicide was committed because of intolerable stress, or because of a major disgrace or by virtue of a judgment of the state. Aristotle condemned suicide as an act of cowardice and as an act against the State arguing that

[2] WILLIAMS, THE SANCTITY OF LIFE AND CRIMINAL LAW 249 (1957).

because the law never commands a person to kill himself and what the law does not command, it forbids; it follows therefore that suicide is wrong. The argument is obviously untenable for there are liberties which the law neither commands nor forbids.[3]

It was the Epicureans and the Stoics who gave general approval to suicide as a reasonable exercise of human freedom. Epicurus arrived at this conclusion with the premise that man lives for pleasure alone, denying the interference of gods in human affairs.[4] Man was therefore the arbiter of his own life and death and if life ceased to be a pleasure, he had every right to end it. The Stoics, although professing themselves to be indifferent to pain, believed that suicide is proper when the circumstances warrant it, as in the case of pain or disease. To the Stoics, the right to die was necessarily part of human freedom.[5]

Roman philosophy adopted the Stoic view that suicide was justifiable by circumstances and in effect, Roman law contains no general prohibition against suicide. Seneca contended that suicide is the last defense against intolerate suffering. "Human affairs," according to Seneca, "are in such a happy situation, that no one need be wretched but by choice. Do you like to be wretched? Live. Do you like it not? It is in your power to return from whence you came." In particular, Seneca argued for suicide in old age age when the body could not discharge its offices, but in the same breath, Seneca also recognized the duty to live for others, such as parent or wife. Pliny maintained that the exercise of the right to die was God's best gift to man amidst the sufferings of life.[6]

Partly as a result of these views, suicide was a frequent practice under the Roman Empire. Persons who fell ill, starved themselves; and when a noble family was suspected of treason, in order to avoid forfeiture of their property and denial of customary burial rites, which were penalties accorded to persons found guilty of treason, suicide was committed to forestall condemnation. Roman law later adjusted to this practice by providing that forfeiture of property could still be carried out despite the event of suicide, but this could only be done if the guilt of the deceased was proven. Ironically it was only in one case where suicide was actually discouraged and this was with regards to soldiers who were to be punished by death if found guilty of attempted suicide. Romans reasoned that the act of committing suicide by a soldier as tantamount to a kind of desertion from his post, which was of value to the State.[7] How-

[3] *Ibid.* at 249-250.
[4] *Ibid.*, at 252.
[5] ST. JOHN-STEVAS, LIFE, DEATH, AND THE LAW 247 (1961).
[6] *Ibid*, at 253-254.
[7] *Ibid.*

ever this means, in either case, a soldier who failed at suicide would still get his wish.

Completely contrary to the Roman view was the Christian view which condemned the practice of suicide. Although in the Bible, there is no express condemnation of suicide, the Christian doctrine on suicide was formulated mainly by St. Augustine in *The City of God.* Three arguments were given, namely: 1) that it violated the commandment "Thou shalt not kill", which applied to all innocent lives; 2) that it precluded any opportunity for repentance; and that 3) it was a cowardly act. The only exception he allowed was to those who took their lives under divine inspiration. Eventualy, these views found expression in Church Law. These views were further fortified by St. Thomas Aquinas during the Middle Ages. Aquinas based his condemnation on its opposition to nature and to proper self-love. According to him God alone had control over life and death, and in deciding the moment of one's death, a suicide was usurping God's power. To this day, the Augustinian-Thomist position remains as the position of Christianity in general.[8]

The Renaissance brought about a re-evaluation of the ancient world and consequently, intellectual thought leaned more to the allowance of suicide. Thomas More in *Utopia* suggested that in his imaginary community, those suffering from incurable and painful diseases be allowed to take their own lives provided they did so with the consent of priests and magistrates. John Donne wrote his *Biathanatos* which consisted of a comprehensive defence of suicide, with the thesis that suicide was not incompatible with reason nor with the law of God.[9]

The views of suicide expressed in the later centuries up to the present do not reflect a consistent view of suicide. Voltaire showed a tolerant attitude towards suicide, and Montesquieu attacked the law penalizing it. Consequently, in 1790, France repealed the sanction against suicides.[10] William Henry rejected suicide on pragmatic grounds whereas Schopenhauer became the apostle of suicide, portraying life as an unpleasant dream, the sooner ended the better.[11] One effect, however, can be discerned from the rejection of the Christian doctrine, and that has been the demand for the change of the law to suit today's world.

---

[8] *Ibid.*, at 248-249.
[9] *Ibid.*, at 251-252.
[10] *Ibid.*, at 250.
[11] GURNHILL, THE MORALS OF SUICIDE 173 (1900).

SUICIDE AND THE CRIMINAL LAW

Introduction

Suicide is "self-destruction, the deliberate termination of one's existence, while in the possession and enjoyment of his mental faculties."[12]

Four aspects of the problem of suicide shall be dealt with: suicide; attempted suicide; aiding, abetting, and advising; and suicide pacts.

Does the the State have an interest in punishing the person who commits or attempts suicide as well as the person who aides, abets or induces another in committing suicide? Central to this issue is the question of why any given act should be made criminal and its perpetration punished. H.L.A. Hart reasons that punishment is to "announce to society that these actions are not to be done and to secure that fewer are to be done".[13] H. Packer's enumeration of the justifications of criminal punishment should be also considered in determining whether any positive effect is being reaped from the State's laws regarding suicide (attempted suicide specifically).[14]

Suicide

After twenty centuries of discussion, the question of the "right" to commit suicide still ranks as one of the most controversial subjects in the history of mankind, the question "still being posed in the same terms as ever".[15]

There are several cultures in which suicide is a matter of indifference or an act to be admired.[16] As early as January 21, 1790, France had legalized suicide under the principle of *nullum crimen siene poene legi* when upon motion of Docteur Guillotin, the National Assembly repealed all sanctions against the body and the

---

[12] BLACK'S LAW DICTIONARY, 1602 (Rev. 4th Ed. 1968).

[13] HART, PUNISHMENT AND RESPONSIBILITY 6 (1968).

[14] PACKER, THE LIMITS OF THE CRIMINAL SANCTION 35-61 (1968). Packer divides the justification for criminal punishment into five groups: 1) Retribution; 2) Utilitarian Prevention; Deterrence—more good is likely to result from inflicting punishment than from withholding it; 3) Special Deterrence: Intimidation—future crimes of the person are eliminated; 4) Behavioral Prevention: Incapacitation—physical restraint results in the loss of the ability to commit future crimes; 5) Behavioral Prevention: Rehabilitation—the personality of the offender will be changed so that the will conform to the dictates of the law.

[15] Silving, *Euthanasia: A Study in Comparative Criminal Law*, 103 U. PA. L. REV. 350-369 (1954).

[16] Markson, *The Punishment of Suicide—A Need for Change*, 14 VILL. L. REV. 463, 464 (1969).

property of the suicide.[17] Other European countries followed suit and today immunity of suicide is a generally accepted principle of continental European law.

Earlier Western civilization (during the Greek, Roman and early Christian eras) regarded suicide as a horrendous deed.[18]

Suicide appeared first in England, not as a crime *per se* but as a confession of some other crime.[19] Early English law provided for escheat of a criminal's property to the lord (later rule provided escheat to the king), whenever he was convicted of or confessed a crime. If he died before conviction, the property would descend to his heirs. However, if before he was convicted he killed himself, the self-destruction was presumed a confession of his guilt, thus his property would still be the subject of forfeiture.[19a]

Mr. Justice Brown, in *Hales v. Petit* (1562),[20] considered suicide as criminal. It was an offense against nature, against God and against the king. It was an offense against nature because it is contrary to the rule of self-preservation, which is the principle of nature and because to destroy oneself is contrary to nature, and a thing most horrible. It was an offense against God because to kill oneself is a breach of a commandment, and against the king in that he had lost a subject.

Blackstone[20a] reasons that "the suicide is guilty of double offense; one spiritual, in evading the prerogative of the Almighty, and rushing into his immediate presence uncalled for; the other temporal, against the king, who hath an interest in the preservation of all his subjects".

Early common law punished a person who committed suicide by ignominous burial on the highway with a stake impaling the body and forfeiture of the suicide's goods and chattels to the king. The Forfeiture Act of 1870 ended the practice of escheat of the suicide's property to the king. Since the English Suicide Act of 1961, it is no longer a crime for a person to commit suicide.

In the United States, the early English common law on suicide was never accepted with all its implications. Suicide is generally accepted in the United States as unpunishable but there is question as to whether suicide is criminal or unlawful. This distinction is

---

[17] Silring, *Euthanasia: A Study in Comparative Criminal Law*, 103 U. PA. L. REV. 370 (1954).

[18] For a general historical discussion, see WILLIAMS, THE SANCTITY OF LIFE AND THE CRIMINAL LAW (1957).

[19] As quoted in W. Mikell, *Is Suicide Murder?*, 3 COL. L. REV. 379 (1903).

[19a] See discussion on Roman Law, *supra*.

[20] As quoted in WILLIAMS, *op. cit. supra* note at 274.

[20-a] *Ibid.*

inconsequential in the case of the accomplished suicide but is determinative of criminality in the cases of attempted suicide and of suicidal acts involving another party.

In the Philippines, the law does not punish suicide by forfeiture or escheat of the gods. It is believed that the person who committed suicide should be pitied more than punished.

III. *Attempted Suicide*

Since early common law treated suicide as a felony, attempted suicide was considered as a misdemeanor. The English Suicide Act of 1961 has abolished the crime of attempted suicide as well as the crime of suicide.

In the United States where vestiges of common law remain in some states, the criminality of attempted suicide was treated in different ways. One approach holds that unless repealed by a statute, suicide remains a felony and attempted suicide a misdemeanor. The New Jersay Supreme Court, in *State v. Carney*,[21] affirmed a conviction for attempted suicide relying on a statute which provided that all offenses indictable at common law and not provided by statutes are treated as misdemeanors.

Some states approach the indictability of attempted suicide by either adopting specific legislation regarding it or their courts have reached their conclusion on some relevant statutory language.[22] Thus in Massachusetts, the Court in *Commonwealth v. Dennis*,[23] held that attempted suicide was not a crime on the basis that the entire subject of criminal attempt had been revised by a statute[24] which provided that punishment for an attempted crime be calculated by reference to the length of imprisonment for the completed crime. Since there could be no imprisonment for the completed act of suicide, there could be no punishment for an attempt. Employing the rules on statutory construction, the court reasoned that attempted suicide, a crime at common law, had been repealed by implication.

Some states like Nevada, Oklahoma, Washington, Dakota and New Jersey have enacted statutes affixing criminal liability for attempted suicide. Such statutes typically provide that attempted suicide is punishable by imprisonment in the state penitentiary for a period of up to two years, a fine of up to $1,000.00 or both.[25]

---

[21] 55 Atl. 44 (1903).
[22] Markson, *op. cit. supra*, note 16 at 467.
[23] 105 Mass. 162 (1870).
[24] Mass. Ann Laws ch. 274 sec. 6, (1968).
[25] Markson, *op. cit. supra*, note 16 at 468.

The proper formulation of a law regarding attempted suicide necessitates an analysis of who attempts suicide, what kind of person he is, and what drives him to self-destruction. Considering all these factors and the goals of criminal law, the Philippines was correct in not making suicide and attempted suicide the proper subjects of criminal law and in not imposing any punishment at all on such acts.

There are basically two approaches to the question as to what drives a person to commit suicide: the sociological and the psychoanalytic. The classical sociological investigation was made by Durkheim[26] when he classified the three basic types of suicide. The egoistic suicide occurs in individuals who are poorly integrated into society and are forced to depend largely on themselves. Altruistic suicide occurs in individuals who are highly integrated into a society which strongly dictates habits and customs. The anomic suicide occurs in individuals whose needs are governed by society but who fail to adapt when society changes.

The psycho-analytic approach to suicide as presented by Freud[27] suggested that the cause of suicide is an inherent death instinct.

The current psychiatric view is that attempted suicide is a symptom of mental illness and, as such, it makes no more sense to affix criminal liability to it than any other symptom of any other illness[28] unless there is some overriding justification to punish or incarcerate this particular type of symptom.[29]

Since suicide and attempted suicide are symptoms of illness and are not criminal manifestations, the person who commits or attempts suicide should be treated and not punished.

Thus, Wilbur Larremore[30] contends that punishing an attempt would not deter others from making similar attempts; it would not even discourage a second attempt by the same person. A person who is bent on taking his life would scarcely pause to consider his liability to fine or imprisonment should his plan fail.

Suicide and attempted suicide should not be punished since there is an absence of justification for the application of punishment.[31] The theory of retribution, based on man being responsible for his actions and thereby deserving punishment, is inapplicable

---

[26] DURKHEIM, SUICIDE (1951).
[27] FREUD, BEYOND THE PLEASURE PRINCIPLE (1959).
[28] Markson, *op. cit. supra*, note 16, at 469, citing, East, *Suicide From The Medico-Legal Aspect*, Brit. Med. J.
[29] Protection of society is necessary justification for incapacitation when the psychopathic murderer has no control over his anti-social tendencies.
[30] Larremore, *Suicide and the Law*, 17 HARV. LAW REV. 331, 340 (1974).
[31] Markson, *op. cit. supra*, note 16 at 471-472.

since the very fact of the attempt negates the idea of responsibility. The goal of utilitarian prevention through deterrence is not served since others deserving death would not be deterred by the loss of freedom. If any deterrence would exist, this would only result in the attempter adopting a more foolproof method of committing his suicide in order to avoid failure.

The potential suicide *generally* presents a risk only to himself and beyond the goal of behavioral reformation. There is no need to isolate him from the community for protection of society from anti-social acts.[32]

Imprisonment of a suicidal person would fail to achieve the justification of behavioral prevention through rehabilitation until adequate psychiatric therapy is readily available in penal institutions.

The application of utilitarian principles would not allow punishment for suicide. Under the utilitarian principles, society suffers from the act of the suicide only to the extent of the good the suicide's future acts could have produced. This reasoning is leaving too much to chance. Furthermore, the fact that the victim is suffering from mental illness reduces the possibility of his potential productivity.

Since suicide is generally accepted as a result of mental disease,[33] the act itself is a patent evidence of the inability of the individual to conform his conduct to the requirements of law. If one is to treat suicide and attempted suicide as crimes, one must allow psychiatric evidence to provide a defense of insanity which would negate criminal responsibility.

Norman St. John Stevas summarizes the reasons for abolishing the treatment of attempted suicide as a crime:

> All modern research points to one conclusion about the problem of suicide — the irrelevance of the criminal law to its solution. Whether it is hoped to reduce the suicide rate by changing the social structure or providing psychiatric help for potential suicides, the criminal law can do nothing to help.[34]

---

[32] "The danger to the community from manic-depressive psychotics is secondary. Murder does occur in severe depressions but it is rare." M. FUTTMACHER & H. WEIHOFEN, PSYCHIATRY AND THE LAW, 66 (1952).

[33] Markson, *op. cit., supra,* note 11 at 472 citing: OVERHOLSER, THE PSYCHIATRIST AND THE LAW 46-47 (1953), who stated "...it is pretty generally recognized by the law, as it is of course by psychiatrists and by the general public that the presumption in the case of a suicide or attempted suicide is that a person is suffering from a serious mental disturbance."

A. Brill in *Fundamental Conception of Psychoanalysis* (1721), has stated categorically that all suicides are committed by psychotics, for only those afflicted with a mental disease lack attachment to an individual or object strong enough to negate the compulsive drive for self-destruction and embody the utter rejection of the basic law of self-preservation.

[34] ST. JOHN-STEVAS, *op. cit. supra,* note 5 at 75.

Perhaps Mr. St. John-Stevas was too general when he dismisses the help of providing psychiatric help for potential suicides. Suicide is usually the result of a fit of depression or the result of an irresistible impulse. Mr. Larremore is more specific when he says that although the suicide should not be treated as a criminal, he must be given, by a state who has an interest in his welfare, a chance to be rehabilitated. Rehabilitation may either be in a psychiatric ward in a hospital or in prison. Rehabilitation in a psychiatric ward in prison need not necessarily be of less help than a ward in a hospital as long as facilities and staff are efficient and adequate.

The law should allow some means of interposition to prevent a suicide specially believed to be the result of a passing impulse or temporary depression. Criminal law, however, need not be the only solution to providing deterrence to attempted suicides.

Aiding, Abetting, and Advising Suicide

Under common law one who advised another to commit a crime and who was actually present at the time and place of the crime was considered a principal in the second degree.[35] Where the adviser was not present at the time of the crime, he was considered an accessory before the fact, and under artifical common law rule could not be punished until the principal had been tried.[36] Thus in suicide cases under common law, a principal in the second degree was guilty of murder, while an accessory before the fact could be freed from criminal liability if the person who committed suicide was never tried in court. Today, however, the distinction between a principal in the second degree and an accessory before the fact has been abolished in most jurisdictions.

The law with respect to the instigator, abettor and aider of suicide varies in the different legal systems. Where punishment of accessories depend upon the criminality of the act of the principal, the instigator, abettor and aider of suicide enjoy immunity if the act of the principal is not considered a crime.[37]

The majority of jurisdictions in the United States affix specific criminal liability to aiding, abetting or advising suicides provided that the causal connection between the inducement and the act of suicide can be proven.[38] This view is based on the premise that mur-

[35] Markson, *op. cit. supra*, note 16 at 473.
[36] 13 A.L.R. 1259 (1921).
[37] Immunity of the accessory to suicide on the ground that suicide itself is not a crime defined by statute is particularly striking in Germany, where, in all other respects there is a tendency to judge the act of each individual independently, in accordance with his own guilt.
[38] Grieshober, *Suicide-Criminal Aspects*, 1 VILL. L. REV. 317, 320 (1956).

der may occur though the victim desires death. The defendant is as guilty as if he alone desired death.

Other jurisdictions hold that the aider and abettor is a murderer on his own right. In *People v. Roberts*[39] the court affirmed a conviction for murder by poison against an individual who mixed the poison and placed it within reach of the suicide. The Court in *Blackburn v. State*[40] went further by stating that even if defendant had not actually furnished the poison but was present at the time it was taken and urged the deceased to commit suicide, this would also constitute murder.

Texas courts have held that suicide is not criminal and if one merely advises or encourages suicide or indirectly aids by furnishing poison he is guilty of no crime. But, if the defendant actually administers the lethal dose he is guilty of murder.[41] The Texas court decisions represent the minority.

Some jurisdictions punish the aider and abettor as a party to the suicide. In *Commonwealth v. Hicks*,[42] an accessory before the fact was held guilty of murder inasmuch as suicide was a felony and all accessories to felonies are subject to the same punishment as the principal. The Court explained that although suicide is not punishable, the act involved the killing of another and hence, the accessory should be treated as an accessory to murder.

To summarize, the secondary party to suicide may be treated as either one not guilty of a crime; as one guilty of a special offense; as one guilty of murder; or one party to a suicide.

The rule of treating inducing, aiding and abetting suicide as a crime *sui generis* has been adopted in New York, Norway, India, Pakistan, Ceylon, Austria,[43] Switzerland, Italy and other countries.

The Swiss Penal Code provides that whoever instigates another to the commission of suicide or assists him therein is punishable provided that his action is caused by selfish motives.[44] Intent is dis-

[39] 178 N. W. 690 (1920).
[40] 23 Ohio St. 146 (1872), cited in Markson, *op. cit. supra*, note 16 at 474.
[41] Grieshober, *op. cit. supra*, note 38 at 320.
[42] 82 S. W. 265 (1904).
[43] In Austria punishment of suicide was first expressly abolished by Art. 16 of the Imperial Decree of 1850. Questions arose as to the legality of accompliceship in suicide. In several cases, the Supreme Court held that accompliceship is subject to punishment as a "minor crime against society", that although suicide was not punishable, it was ethically reprehensible. On June 19, 1934, the Code was amended and accompliceship in suicides was made separately punishable along with homicide upon request.
[44] Swiss Penal Code, Art. 115 provides "Whoever from selfish motives, induces another to commit suicide or assists him therein shall be punished in a penitentiary for not more than five years or by imprisonment".

tinguished from motive, hence, if the motives are altruistic, punishment will not lie.

While suicide is generally accepted to have been committed by one suffering from mental disease or infirmity, there is no such evidence as to the general state of an aider, abettor or instigator of suicide.[45] It would even appear that the instigator, abettor or aider to suicide could be prompted by the same state of mind as any other criminal. Aiding, abetting, and instigating suicide may be punished since the principles of justification of punishment are applicable.[46]

However, statutes on the matter of those instigating, aiding and abetting suicide are too general and usually fail to take into account the varying degrees of culpability and the light of the factual situations. The punishment imposed must correlate directly with the culpability of the offender.

Consider the following example:

S, the son of T, knows T is suffering from psychoses and has been known to have suffered nervous breakdowns. S want to take over his father's business but T refuses to retire. S informs T that the business is not doing well and constantly urges T to commit suicide since he is a failure in his life.

The following are situations which may arise:

Situation A — While S is on a vacation, T purchases a gun and kills himself.

Situation B — While S is on a vacation, T reads in the newspaper a report that S is leaving T's business to set up his own, since S reports that he is tired of working for a failure. T purchases a gun and kills himself.

Situation C — S buys a gun and leaves it on T's dressing table and then departs for work. T kills himself in S's absence.

Situation D — S buys a gun and gives it to T and leaves. In S's absence, T kills himself.

Situation E — S buys a gun, gives it to T and stands and watches T kill himself.

Situation F — S buys a gun, gives it to T and encourages T to kill himself.

Situation G — S buys a gun, and with T's acquiescence, puts it to his head and fires.

---

[45] The case of suicide pacts not covered by the present discussion but shall be discussed later.

[46] See note 31, *supra*.

Under Situation G, most jurisdictions would consider this as murder since the victim's consent does not justify the crime. There are of course qualifications. Note that under the Philippine Revised Penal Code, a person who assists another to commit suicide to the extent of doing the killing himself is guilty only of the crime of giving assistance to suicide.[47] Although homicide upon request is treated as a crime in most legal systems, homicide upon request is treated less severely than ordinary homicide. It is generally accepted that while killing is a reprehensible act, killing is less reprehensible when performed with the consent of the victim than when performed against his will. Such a reasoning has given rise to a separate crime of "homicide upon request", which is punishable less severely than ordinary homicide. In Italy, reduction of penalty in the case of homicide upon request has been justified on the ground of the "lesser intrinsic graveness of the act and the lesser social dangerousness of the actor".[48] If a legal system, however, treats assistance to suicide as not a criminal act, then homicide upon request should not be punishable since these actions are hardly distinguishable from each other. In Germany, homicide upon request is no longer a crime *sui generis* but rather a special instance of the general law on homicide wherein express provisions are made for reduction of penalty in the case of mitigating circumstances and for the punishment of attempt.[49] In Switzerland, homicide upon request is treated as an exceptional instance of intentional homicide.[50]

There are qualifications as to what constitutes 'consent' or 'request'. The request must be "express and earnest" (Germany) or "earnest and urgent" (Switzerland.)[51] In Germany, killing with the mere consent of the victim is considered as common homicide.[52] The express consent must be unequivocal. Earnest consent is not one given in the heat of passion. An urgent consent is one repeatedly expressed. In Italy, however, mere consent is sufficient to classify an act as "homicide with consent".[53]

The request or consent must be made by one in possession of mental capacity but this requisite does not exclude a mentally ill

---

[47] Article 253. This will be discussed fully later.

[48] Silving, *op. cit. supra,* note 15 at 379.

[49] *Ibid* at 382-383.

[50] Swiss Penal Code Art. 114, defines homicide upon request as follows: "Whoever kills another upon the latter's earnest and urgent request is punishable by imprisonment."

[51] Silving, *op. cit. supra,* note 15 at 384.

[52] *Ibid.*

[53] Silving citing Saltelli & Romano—Di Falco . . . . "proof of an express request of the victim would be exceedingly difficult to adduce and that it would be almost impossible to prove an insistence overcoming, beyond doubt, the hesitation and uncertainty of the guilty person".

person who has the required capacity of judgment. In Switzerland it is sufficient that the person is capable of grasping the import of the request and be aware of its consequences.

In Situations E and F, the aider and abettor presents, instigates the suicide and furnishes the instrumentality of death. In both situations, duress is present though at different points in time relative to the act. In Situation E, the duress has taken place constantly before but not directly immediate to the suicide. Not every prior encouragement may be classified as duress. Duress which makes aider, abettor, instigator liable is when the suicide's will has been reduced to nothing so as to allow substitution of the former's will. The act of the suicide in killing himself could be regarded as the act of the instigator, aider or abettor. Duress to constitute murder must occur at the time and place of the suicidal act.

Situation D differs from E on the factor of presence or absence of the advisor. Statutes do not make any difference in culpability of the aider and abettor on the basis of the presence or absence of the advisor. In the case of *State v. Webb*,[54] it was held that an aider and abettor, after procuring the fatal instrumentality could escape criminal responsibility by renouncing his solicitation and fleeing the scene. Such an approach is highly questionable. Presence at the time of suicide is not conclusive proof of a significant causal connection between the advising and the act is not an indication of the degree of *mens rea* present. By providing for such a distinction, the law merely is opening itself to evasion of punishment of the guilty party.

Situations C and D involve a distinction between the probative weight of the intent of S that T will find the gun and use it in suicide.

Situation B and C are distinguished from each other on the basis of the procurement of the instrumentality. One who provides the instrumentality of the crime is of far greater danger to society than one who merely encourages another to commit suicide. The one who procures the instrument for suicide exhibits a greater degree of moral turpitude than one who encourages another to commit suicide and also points to the degree of seriousness of the aider's intent.

Situations A and B may be involved in a point of irony. At first glance, Situation B would seem to involve a greater degree of criminal responsibility. But in fact, it is Situation A which involves the greater degree of responsibility. In Situation B, the inducing

[54] 115 S.W. 998 (1909), cited in Silving *op. cit. supra*, note 15 at 385.

cause of suicide was the reading of the newspaper report and this is not punishable by law. In Situation A, the constant advising of S was the contributing cause of T's suicide.

The possible situations considered above reflect the many fine distinctions which a general law regarding the aiding, abetting and instigating of suicide may tend to overlook. The degree of culpability of the aider and abettor is a prime factor in achieving the objectives of the law regarding the matter.

The Revised Penal Code[55] of the Philippines may be considered highly inadequate insofar as the punishment of the aider, abettor and instigator of suicide is concerned. Article 253 of the Revised Penal Code only punishes the giving of assistance to suicide. The giving of assistance to suicide, as provided, even covers homicide upon request.

The law here has opened itself to difficulty in its application. What does one need in order to prove that consent of the deceased or suicide attempter was given? What standard of consent would be considered as acceptable? Would an assistant to a suicide who does the killing himself be relieved of the charge of murder if aside from the free and voluntary request of the deceased, he himself desired and intended the death of the deceased? Would it be sufficient to merely present proof of express consent in order to relieve the assistant in such a case of the charge of murder?

While the Revised Penal Code punishes the assistant to suicide, it fails to punish the instigator of the suicide. If a person encourages another to commit suicide he is encouraging the commission of an act involving moral turpitude although said act is admittedly not punishable. Is not one encouraging suicide a menace to society, one of whom society has the right to punish? Even if the Revised Penal Code fails to punish an instigator of suicide, the instigator may still be liable under certain cases wherein the suicide was merely a person who was a passive tool of the instigator's evil intent. The criminal liability of such a murderer cannot be diminished by the actions of a non-responsible agent.

The instigator of suicide may also be held liable civilly under the principles of tort liability.[56]

---

[55] Art. 253. *Giving Assistance to Suicide.* — Any person who shall assist another to commit suicide shall suffer the penalty of *prision mayor;* if such person lends his assistance to another to the extent of doing the killing himself, he shall suffer the penalty of *reclusion temporal.* However, if the suicide is not consummated, the penalty of *arresto mayor* in its medium and maximum periods shall be imposed.

[56] See Schwartz, *Civil Liability for Causing Suicide: A Synthesis of Law and Psychiary,* 24 VILL. L. REV. 217 (1971).

Tort law[57] can serve as an auxiliary arm of criminal law to deter wrongful conduct. When claims have been brought on the ground that an individual has "caused" the suicide of another, courts tend to focus on the state of mind of the suicide at the very second he terminates his life. The concept of "proximate cause" comes into play in considering defendant's liability.

If the defendant used duress or fraud to bring about the victim's apparent consent, there is no true consent and the defendant would still be liable.

Careful psychiatric study has made it clear that although a person who might commit suicide is a medical problem and cannot be deterred by criminal or civil sanctions, the individual who assists him can be deterred.[58]

Suicide Pacts

Generally in the United States, a person who survives a mutual suicide pact is guilty of murder when the other dies.[59] Texas represents the minority rule that the survivor is guilty of no crime unless he actually killed the victim or forced him to commit suicide.[60] In *State v. Webb, supra,* the court even interpreted the aiding and abetting suicide statute to include a suicide pact. This approach fails to consider that the survivor of a suicide pact is not necessarily the one who encouraged the other to commit suicide. It is possible that the survivor was actually the passive partner, that the deceased was the active partner who encouraged suicide. The suicide pact partner necessarily differs from the non-suicide pact aider and abettor in the sense that the suicide pact partner is a potential victim. The suicide pact partner is more of one who attempts suicide rather than an aider and abettor. Reasons for not punishing one who attempts suicide appear to apply with equal force to the survivor of a suicide pact.

However, one cannot merely transpose the law on attempted suicide to the survivor of a suicide pact without considering factors such as control of the instrumentality and the intent of the actor. The law should be modified to apply to the circumstances peculiar to a suicide pact survivor.

Consider the factor of the control of the fatal instrument. Different situations arise depending as to the use of instrument in car-

[57] CIVIL CODE, arts. 20, 21; 2176.
[58] Schwartz, *op. cit. supra,* note 56 at 479 citing McMahon v. State, 168 Ala. 70 (1910).
[59] Grieshober, *op. cit. supra,* note 38 at 320.
[60] Markson, *op. cit. supra,* note 16, at 479, citing McMahon v. State, 168, Ala. 70 (1910).

rying out the pact. If the instrument employed was in the control solely of the survivor, he cannot escape criminal liability by reasoning that he had originally intended to kill himself. Intent to kill oneself is not an exempting circumstance for the murder of another. Thus if one uses a gun to kill his suicide partner and then decides against commiting suicide, then he is liable for murder. If the fatal instrumentality is not directly employed, as in carbon monoxide asphyxiation or where both are in equal control, as in a poisoning case where one purchased the poison and the other mixed it, a problem would arise in determining culpability.[61]

The factor of actual intent of the survivor of the suicide pact must be considered. Three different situations may arise.

Situation A — A and R decided to commit suicide by shooting themselves. R shoots herself but A could not shoot himself because the police arrived to stop him.

Situation B — A and R desire to commit suicide. R shoots herself but A changes his mind after he sees R's corpse.

Situation C — A has no desire to commit suicide but he feigns the desire in order to induce R to commit suicide. R kills herself.

Under Situation C, the case falls squarely under murder. The suicide pact is merely a deception. Under Situation A, the potential suicide victim was under an aberrated mental state and thus his actions were not criminal. Under Situation B, the potential suicide victim underwent a change of mental condition. The potential suicide victim in this case is more like one who aids and abets in committing suicide.

EUTHANASIA

Along with suicide, euthanasia is the other expression of the right to die. The concept of euthanasia is closely related to suicide. The practice of such acts is influenced largely by the value placed upon individual human life as compared to the good of the total community. In addition, attitudes toward death are important determinants of behavior of the dying persons and those around him.

The Medical Aspects

The problem of a person's right to die is a most crucial issue in the medical field. Practitioners in the medical profession since its earliest stages have probably been confronted with the problem of facing a situation where a patient suffering from a painful, usual-

[61] Markson, *op. cit. supra*, note 16, at 480.

ly terminal illness would be better off if his existence were cut off instead of letting him drift to an inevitable—and agonizing—death. Thus arose the solution presented by euthanasia. Its more popularly known form is the *active* euthanasia, or mercy killing, where there is a deliberate act of taking a human being's life; an intervention which shortens the life of a patient who is suffering from a painful, incurable disease. The other form, *passive* euthanasia, has gained increased attention over the past years as a result of the great advances achieved in medical technology, particularly in life-sustaining machines.[62] Passive euthanasia refers to a failure to utilize heroic or extreme measures to prolong life in cases of incurable and painful illness. It refers to allowing death to occur by omitting an act (to forestall death) and permitting nature to take its course. As differentiated from active euthanasia, it does not directly cause life to end by an overt act.[63]

Notwithstanding its ancient beginnings, euthanasia, as an aspect of medical thought, did not really gain prominence until fairly recently. The term euthanasia is derived from a Greek word which is literally translated to "easy death". The Oxford English Dictionary cites 1646 as the date of the first use of the term. An early medical definition of the word is "a soft easy passage out of the world, without convulsions or pain".[64] However, for the first two hundred years of its use in literature and medical writing the term did not imply a shortening of life but a state of mind at the time of death. The dying person was supposed to be tranquil and the means by which this was to be achieved included primary physical support and moral support, thus, "spiritual" euthanasia. However, euthanasia, in its modern connotation was believed to have been practiced since antiquity. Throughout history, the moral acceptability and practice of certain acts relating to life and death have been intimately related. The concept of "active" euthanasia is closely associated philosophically with suicide, infanticide, and murder. The practice of such acts is influenced largely by the value placed upon an individual human life as compared to the good of the total community. In addition, attitudes toward death are important determinants of behavior of the dying person and those around him.

> Throughout antiquity, many people preferred voluntary death to endless agony. This form of euthanasia was an everyday reality and many physicians actually gave their patients the poisons for which they asked.[65]

---

[62] W. Bruce Fye, *Active Euthanasia, An Historical Survey Of Its Conceptual Origins and Introduction into Medical Thought*, BULL. HIST. MED., 492, (1978).

[63] Manto, *Readings in Medical Jurisprudence* 65.

[64] Blanchard, *The Physical Dictionary* 126.

[65] Gourevitch, *Suicide Among the Sick in Classical Antiquity*, Bull. Med. Hist. 315 (1969).

The practice of suicide among the sick becomes unusual after about the second century A.D. Largely responsible for the change in philosophy toward suicide and its occurence in this period was the importance palced upon individual life by Judaeo-Christian teachings. This influence was especially important and went largely unquestioned until the middle of the nineteenth century. It accounts for the uniformity of Western opinion toward the prolongation of human life and acceptance of human suffering at the time of death.

The first half of the nineteenth century witnessed a spectacular growth of sophistication in the diagnosis and prognosis of diseases as a result of advance in physical diagnosis, the introduction of statistical methods into medicine and emphasis on pathological correlations of clinical conditions. With these modalities, physicians in the second half of the nineteenth century were equipped to prognosticate more accurately than ever before, providing information which a physician could rely upon in making diagnostic and prognostic decisions. Only when a patient's condition could be judged incurable with reasonable accuracy would be feasible to propose a concept as radical as "active" euthanasia. There were significant developments in the administration of morphine and the discovery of anesthesia. Subsequently, physicians are to advocate the use of these drugs, as well as opium and chloroform for the alleviation of pain and suffering in the dying patient. But noting the dangers of excessive doses, physicians were soon to advocate these agents of spiritual euthanasia for use in active euthanasia.

It was at about this period when the subject of "active" euthanasia became the topic of discussion and articles, both medical and legal. The major arguments in favor and against the practice of "active" euthanasia had been articulated by the early writers on the subject. The incidence of the practices of active euthanasia was impossible to estimate. It is clear, however, that it did occur. There was concern that the issue would not be settled in light of the legal and moral aspects. In this atmosphere was "passive" euthanasia articulated as a practice which may be considered a compromise. But even the advocates of "passive" euthanasia admit that it is perhaps logically difficult to justify a passive more than an active attempt at euthanasia. But they considered it less abhorrent to their feelings. The interest in euthanasia continued sporadically throughout the closing years of the nineteenth century, with emphasis continuing to shift to its legal aspects. Today, the controversy over euthanasia which was initiated over a century ago continues today with little likelihood of resolution in the foreseeable future.[66]

[66] W. Bruce Fye, *op. cit. supra*, note 62 at 493-502.

Evidence of the continuing controversy covering euthanasia is the lack of adequate legislation on the subject. There have been attempts in some countries to introduce legislation legalizing euthanasia. Most have failed. Three important reasons for the failure are: 1) non-acceptance of the idea of euthanasia by a majority of the community; 2) the unwillingness of doctors to become involved; and 3) the difficulty of formulating legislative provisions. Behind these three reasons is the blunt fact that euthanasia means the active and deliberate ending of a life—that is, killing. By conventional community standards and by law as it is, euthanasia is murder and therefore, it is not acceptable to the community. While it may not be morally repugnant to them, physicians are wary of measures legalizing euthanasia. Their traditional professional role is to promote and to safeguard life, and they have no wish to jeopardize this. This difficulty of formulating precise provisions for hard, practical implications, i.e., delicate human situation, deep emotional overtones, etc., is a real problem.[67]

The following discussion seeks to explore the problems concerning the impact of euthanasia on professional ethics, as well as the difficulties posed on doctor's professional standing and the inadequacy of reliable standards concerning the practice of euthanasia.

> Sec. 3 Article 1 of the Code of Medical Ethics provides "In his relation to his patients, he shall serve their interest with greatest solicitude, giving them always his best talent and skill."

The physician has a contract with the patient to prevent or cure his disease, or to slow its progress or to relieve its symptoms and this is a contract in trust and guaranteed only by that trust. The physician does not have a contract out on the life of the patient.[68]

In addition, Sec. 1, Article II, on duties of physicians to their patients provides:

> A physician should attend to his patients faithfully and conscientiously. He should secure for them all possible benefits that may depend upon his professional skills and care. As the sole tribunal to adjudge the physician's failure to fulfill his obligations to his patients is, in most cases, his own conscience, any violation of this rule on his part is discreditable and inexcusable.

Whenever a physician-patient relationship is established, there is that duty of the physician to abide by the obligations imposed by such contract. He is obliged by law to comply with the duties imposed by the agreement with proper diligence of a good father of

---

[67] *Thhe Problems of Legalizing Euthanasia—and the Alternative,* THE MEDICAL JOURNAL OF AUSTRALIA, 2:667, 6 (1976).

[68] *Medicine, Terminal Illness, and the Law,* CANADIAN MEDICAL ASSOC. JOURNAL, 3 Sept. 1977.

a family, unless there is a stipulation to the contrary.[69] From a theologian's point of view, this relationship is seen as a "covenant" to maintain the "sanctity of life" and that "caring or respect for Human life" is the basic moral obligation binding individual medical decisions and the rules of medical practice.[70] In the performance of this contract, the physician is allowed a wide range in the exercise of his judgment. The best judgment is dependent on the circumstances of every case, although generally, he is duty bound to apply judgment commonly used by physicians in the community when confronted by a similar case. The problem is whether such discretion includes the decision to terminate life.

But when the physician is confronted with a "hopeless" case, the problem reaches a different magnitude as extra-medical considerations become significant, even decisive (assuming that there was a diagnosis that the condition was indeed terminal). The difficulties of the physician are compounded by the fact that his training has been emphasized on the preservation and protection of life but with little import directed on caring for the dying.[71] When the outcome is recognized as inevitable and imminent, then it is incumbent upon the physician to determine his course of action by carefully considering all the facts of the individual case — the patient's age, family and personal obligations, financial resources, and the seriousnes of the pain, the likelihood of success, and the cost of proposed therapy.[72] There are many conditions in which the patient is not only unconscious but in which he would die if some of his bodily functions were not taken over by the appropriate apparatus. There is no nice rule of thumb or legal aphorism which can replace the ultimate responsibility of the physician. The use of such apparatus makes sense only so long as there is some reasonable hope of returning the patient to a personal existence — in other words, so long as his disease will respond to treatment. When to stop the medical treatment, when to pull the plug, is the crux of the practical problem. It is a very critical judgment and it is underwritten only by the mutual trust and understanding between patient and physician before that stage is reached.[73] But there are other difficulties under the present law, the individual physician is quite uncertain about his legal position with regards to terminating treatment though it is deemed to have become medically ineffective. In addition, peer

---

[69] Manto, *op. cit. supra*, note 63 at 17.

[70] Redlich, et. al.; *Overview: Ethical issues in Contemporary Psychiatry*, AM. J. PSY., 229, (1976).

[71] Campos, *The Hopeless Case*, MED. FORUM July-Sept. 65 (1962).

[72] Ayd, *The Hopeless Case: Medico-Legal Considerations*, MED. FORUM, July-Sept. 46 (1962).

[73] *Medicine, Terminal Illness and The Law*, LAW MED. ASSOC. J. 57 (3 Sept. 77).

pressure, real or imagined, prevents the physician from terminating useless treatment.[74] Doctors could hardly be expected to accept the role of public executioners. In line with earlier discussion as to the role played by the value placed by society on human life, it should be noted that the trend in society has been to reject killing as a form of punishment. It would follow that society will hesitate before it would sanction an act to take a life or the refusal to act to save one. The individual physician is left quite uncertain about his legal position with regards to terminating treatment that has become medically ineffective.

While there are divergent views as to the duties of a doctor when a patient is critically ill, as a result of questions regarding ethics and legal implications, the more basic problem is the difficulty in the determination as to when a person is truly dying. Not a few practitioners contend that no one really knows when death is inevitable.[75] The term "hopeless case" is not one which covers a definite entity. Doctors are not infallible in their diagnosis. Errors of judgment must occur in the practice of an art which consist largely in the balancing of probabilities. Even if diagnosis is correct, doctors can never be certain of the prognosis. Two reasons account for this. One is progress in medicine which may render curable tomorrow that which is incurable today. The last few decades have seen many such developments. The other fact is still a mystery to medicine. Some illness that, according to experience, should take a quickly progressive course come to a standstill for reasons unknown. Thus, there has been a case where a patient suffering from cancer deemed to be a terminal case and as such, sent home only with some palliative drugs, returned 20 years later in substantially the same condition. The cancer had simply stopped growing.[76]

Until very recent times the physician and layman alike used the same criteria for determining when a person crossed the seemingly clear-cut border between life and death. When a person's heart stopped beating and he stopped breathing, he was dead; this phenomenon is usually termed clinical death or medical death. The standard is based on the medical fact that respiration, heart action, and brain function are closely related to each other, and the cessation of any one of them will bring the other two to a halt within a few minutes. Indeed, this standard has been so persuasive that one looks in vain for any legal definition of death.

---

[74] *See* note 72.
[75] Ayd, *op. cit. supra*, note 72 at 60.
[76] Pole, *The Hopeless Case*, MED. FORUM July-Sept. 1962.

In recent years, however, a whole group of life-supporting devices and techniques have become available. These machines have modified the earlier unconditional interplay of circulation, respiration and brain activity. It is now possible to compensate for deficiencies in heart action or respiration in some situations. These machines were designed to meet situations involving temporary interference with the patient's own physiologic prowess. As they came into use, however, physicians found themselves faced with an ethical, moral, and perhaps legal problem of the first magnitude. The accepted standard of death was that of clinical death; the criterion of brain activity had been left out in the equation. This omission was no doubt due to the fact that until very recently there was no way of diagnosing brain death. But with the present technology, it was found that there is still some brain activity for a certain period following the cessation of respiration and of the beating of the heart. Now the physician is faced with a situation which until this time had been moot. It must be noted that when a person dies, his brain cells are almost immediately affected by the lack of oxygen. Within 3 to 6 minutes, the most complex cells in the brain start to die out. These are the cells which provide the thinking or conscious element of man's activities. At the point where sufficient brain damage has occurred to preclude the possibility of psychic functioning, the patient has become "brain dead".

After this stage, the patient cannot regain consciousness, thus rendering further treatment useless. However, the physician finds himself maintaining with machines the patient's respiration or heartbeat or both — the very functions the absence of which were the basis for distinguishing and certifying death. However, the fundamental concept of death has not undergone a change. One medical dictionary defines death as "the apparent extinction of life as manifested by absences of heartbeat and respiration". Thus, in the absence of brain activity, would he then be permitted to turn off the machine? Would he be considered to have killed the patient by his own acts? Presently, medicine's operational concept of death is the absence of heartbeat and respiration for three to five minutes. Within this time limit the failure to institute resuscitative measures would constitute malpractice. The only logical reason for this time factor is that within this time limit, the brain has not suffered irreversible damage and, consequently, consciousness can be restored The heart can often be started well beyond this period, as in the case of breathing, but conscious brain function cannot.[77] Even where there has been consultation with the relatives of the patient, a physician who removes the life support system exposes himself to

[77] Wasmuth, *The Concept of Death*, 30 OHIO STATE LAW J. (1969).

legal liability for malpractice, breach of warranty, and homicide. The law makes no distinction regarding the duties and liabilities of doctors where a case is deemed hopeless or where there has been the onset of brain death.

Apparently, the solution lies in the formulation of appropriate legislative measures. The law should recognize the existence of euthanasia, a practice which has long been a reality. Rather than letting a doctor's conscience be the sole guide in his actions, the law should set adequate standards to regulate the practice, prevent or at least minimize the probability of errors of judgment and abuse. The law should set requirements for the exercise of such a drastic act. There are, however, conspicuous constitutional and statutory circumstances which have had a broad impact on the legal development of the right to die.

On the night of April 15, 1975, a patient was rushed to Newton Memorial Hospital by some of her friends and the local police. Upon admission she was immediately put on a respirator. The precise events leading to her admission to Newton Memorial Hospital are unclear, but it was determined that she ceased breathing for at least two fifteen-minute periods.

When she was transferred to the Intensive Care Unit of St. Clare's Hospital, she was still unconscious and still on a respirator. Her condition was such that she required 24-hour nursing care, and the application of a host of antibiotics to ward off infection that would cause her death. She was found to have suffered irreversible brain damage that caused loss of cognitive or cerebral functioning. From then on, she could only blink her eyes, cry, react to noxious stimuli by grimacing — activities controlled by that function of the brain relative to control of the body temperature, breathing, blood pressure, heart rate, chewing, swallowing and sleeping and waking. There was no life in that other functions of the brain which controlled her relation to the outside world, her capacity to talk, to see, to feel, to sing, to think. Her attending physician described her condition as a chronic or "persistent vegetative state", a phrase used to describe severe cases of comatose. The doctors have determined that for all the sophistication of present medical technology, she can never be restored to cognitive or sapient life.[78]

Her name was Karen Ann Quinlan, a comatose patient whose case has embarrassed existing knowledge on medical science, the central figure in the subsequent legal controversy that for a time held the attention of the world especially the Church, the legal, and the medical professions.

[78] In the Matter of Quinlan, 355 A. 2d 671 (1976).

By a petition to the court, her father, Joseph Quinlan, after agonizing over the question, sought court permission to unplug the respirator that sustained her life. He asked the court to grant him the express power of authorizing the discontinuance of all extraordinary means of sustaining the vital processes of his daughter. He asserted that Karen and her family have, by virtue of the constitutional right of privacy, a right of self-determination which extends to the decision to terminate "futile use of extraordinary medical measures". He prayed that Karen be alowed "to die with dignity".

Thus was thrust to the court the question that to this day still engages the interest of the philosopher, the lawyer, the doctor, the clergyman, a question laden with philosophical, legal, medical, moral, and social considerations — has an individual the right to die?

Constitutional Issues

There is no express provision in the United States Constitution or in any statute granting a terminally-ill patient, or another person on his behalf, the right to choose euthanasia as an alternative to medical treatment. Every civilized legal system usually considers euthanasia a crime. Some consider it a form of manslaughter, while others, notably the Common Law system, regard euthanasia as a form of homicide.[79] The basic philosophy of the Common Law that life is sacred and inalienable precludes any individual from licensing his own destruction. So pervasive and absolute is this belief that it even protects those who are dying.[80]

The Common Law concern for life, however, is not as severe under an individualistic legal system, such as that prevailing in the United States. This system believes that man is endowed with an innate personal dignity, and that he is an end in himself and not mere means serving extraneous social ends, such as those of the State, or even those of follow human beings.[81]

In theory, this concern for life is recognized in the Fourteenth Amendment to the U.S. Constitution which safeguards it against taking by the State without due process of law.[82] By virtue of this constitutional mandate, the law reflected a judgment that the in-

---

[79] Baughman, Bruha & Gould, *Survey, Euthanasia: Criminal, Tort, Constitutional, and Legislative Considerations*, 48 NOTRE DAME L. REV. 1203, 1203-1204 (1973). (Hereinafter referred to as Survey.

[80] *Ibid*, at 1205.

[81] Silving *op. cit. supra*, note 15 at 354.

[82] The Philippine Constitution has a similar provision embodied in Article IV, Section 1, which states that "no person shall be deprived of life, liberty, or property without due process of law, nor shall any person be denied the equal protection of the law."

dividual's legal prerogative to employ life-terminating practices should be significantly limited, and to penalize those who terminate the lives of others for humanitarian purposes, as well as those who assist terminal patients in taking their own lives.[83]

This "sanctity of life" rule has been applied in a number of situations wherein individuals have deliberately put their lives in danger or who have apparently no concern for their own lives, such as in snake-handling,[84] or helmet-less motorcycling,[85] and other forms of voluntary risk-taking. The concern for life has extended to compulsory-treatment cases generally involving patients who refused life-saving blood transfusions on religious grounds, despite the promise of fully restored, good health.[86] Thus, although the common law rights to control one's body and to consent to or refuse medical treatment are "basic, deeply-rooted values", the right to choose a medical course of action resulting in or hastening death is not.[87]

The idea that no individual may compromise his existence by the performance of certain acts, whether voluntary or involuntary, was of little consolation to persons afflicted with terminal or incurable illness seeking to forego further bodily pain and futile life-prolonging treatments. In theory, the State limited the individual's prerogative to employ life-terminating practices, and States homicide laws generally purported to penalize those assisting others to terminate their lives, though done for humanitarian purposes.[88] But in practice, the State seldom prosecuted such individuals to the fullest extent of the law. Most cases involving euthanasia deaths concluded in the failure of the grand jury to indict, convictions upon a lesser charge, acquittal upon a defense of insanity, or refusal by

---

[83] Survey, *op. cit., supra,* note 79 at 1227.

[84] In the cases involving snake-handling as a form of religious faith, the Courts ruled that the State may act to prevent the individual from consenting to his own death. Harden v. State, S.W. 2d 708 (1948); Dunn v. North Carolina, 336 U.S. 942 (1949); State v. Massey, 51 S.E. 2d 179 (1949); Lawson v. Commonwealth, 164 S.W. 2d 972 (1942); Hill v. State, 88 So. 2d 880 (1956).

[85] Though with mixed views. See generally, Annot., 32 A.L.R. 3d 1270 (1970).

[86] The leading case is *Application of President and Directors of Georgetown College,* 331 F. 2d 1000 (1964); cert. denied, 377 U.S. 978 (1964). Also, U.S. v. George, 239 F. supp. 752 (1964); Jehovah's Witnesses v. King County Hospital, 278 F. Supp. 488 (1967). It seems that the "compelling state interest in the sanctity of life would, in appropriate cases, override the freedom of religion guaranteed by the first amendment (Art. IV, Sec. 8, Philippine Constitution). The Courts have denied total immunity to religiously motivated behavior.

[87] Davis, *Notes. The Refusal of Life-Saving Medical Treatment v. the State's Interest in the Preservation of Life: A Clarification of the Interests at Stake,* 58 WASH. U.L.Q. 85 (1980).

[88] To shorten a life, even of a dying person, is to commit homicide: State v. Mally, 366 P. 2d 868, 873 (1961); State v. Francis, 149 S.E. 348 (1929). The rule is applicable even though the victim knowingly consents to die; Turner v. State, 108 S.W. 1139 (1908); People v. Roberts, 178 N.W. 690 (1920); JFK Memorial Hospital v. Heston, 279 A. 2d 670 (1971).

the jury to bring in a verdict of guilt.[89] Nullification of the offense of mercy-killing either by prosecutorial discretion, acquittal, or judicial leniency was a predictable result. Such nullification served a useful function since it provided a safety valve of mercy while at the same time maintaining the deterrent of criminal law, thereby limiting the instances of euthanasia.[90] Such an unofficial compromise, however, is insufficient for two reasons:

First, the lack of a safeguard against State-imposed measures to prolong life. The spectre of a prosecution for mercy-killing is still always present. A person assisting in euthanasia is never sure that the judge, jury, or the prosecutor will be lenient with him. Besides, he may be subjected to the unwanted expense and publicity of a trial, even though he may escape the burden of a murder conviction.

Second, this dichotomy between theory and practice creates a constitutional dilemma. By failing to treat the perpetrators as murderers, the State may be denying the victims of euthanasia both due process and equal protection of the law. This is especially true where the terminally-ill are unconscious, or though conscious, may not actually want their lives terminated, either on grounds of religious belief, hope for a miraculous recovery, or fear of death. By convicting euthanasia perpetrators as murderers, however, the State may be exacting an excessively cruel and unusual punishment in violation of the Eighth Amendment guarantee.[91]

Gradually, the theory that terminally-ill or incurably-ill patients, seeking to forego further bodily pain, may have some constitutional protection from state interference under a fundamental right to privacy, began to be considered. In *Griswold vs. Connecticut*[92] the United States Supreme Court recognized the right to privacy as a fundamental constitutional guarantee. In that case, the Court invalidated a Connecticut statute prohibiting the use of contraceptives by married couples and the distribution of birth-control information to them as violative of this right of privacy. The textual locus of the right is the word "liberty" in the due process clause of the

---

[89] Survey, *op. cit. supra*, note 79 at 1228.

[90] Collester, *Death, Dying, and the Law: A Prosecutorial View of the Quinlan Case*, 30 RUTGERS L.R. 304, 313 (1977). A rare instance of a prosecution and conviction for a "mercy-killing" is the case of Commonwealth v. Noxon, 66 N.E. 2d 814 (1946), involving the killing of a six-year old mongoloid son, by wrapping him in an electric cord and electrocuting him. The circumstances that the defendant was a lawyer and the grotesque manner of the killing influenced the decision. Nevertheless, the sentence of the defendant was commuted from life to a maximum of six years, and he was paroled before the expiration of that term.

[91] Survey, *op. cit. supra*, note 79 at 1229. In the Philippine Constitution, the injunction against cruel and unusual punishment is found in Article IV, Section 21.

[92] 381 U.S. 479 (1965).

Fourteenth Amendment. Fundamental aspects of personal privacy as part of that liberty interest are evidenced by, and emanate from, the specific guarantees of privacy in the First, Third, Fourth, and Fifth Amendment.[93] The Courts reasoned that, though the Constitution nowhere specifically mentions a right to privacy, such rights come within the penumbra of the said specific guarantees in the Bill of Rights, "emanating" from these same guarantees.[94]

The concept of the right of privacy was further developed in the case of *Eisenstadt v. Baird*[95] (relating to procreation and marriage), and the abortion cases of *Roe v. Wade*[96] and *Doe v. Bolton*[97] (reaffirming privacy's protection of individual autonomy in intimate and momentous matters). However, the Courts have also held that the right of privacy is not absolute, that a "compelling state interest" may overcome this right. Thus in certain cases involving a patient's refusal to receive medical treatment,[98] the Courts allowed the State to intervene. To compel treatment, therefore, the State must have to assert an *interest* that outweighs the individual's constitutional or common law right to refuse.[99]

Physically or Mentally Defective Persons

If the patient is not mentally competent, whether because he is semi-conscious, psychotic, a minor, or under court-created guardianship, the established machinery will be set in motion for appointing some competent person to decide the treatment question.[100]

This was adequately explained in *Superintendent of Belchestown State School v. Saikewicz*,[101] a case which involved a 67-year old retardate suffering from incurable leukemia. The case was primarily concerned with the patient's right to refuse treatment and the manner in which the exercise of that right may be secured to persons unable to make the decision for themselves. After determining that the patient has the right to decide whether to decline further treatment or submit to therapy, the Court held that by reason of the

---

[93] Cantor, *Quinlan, Privacy, and the Handling of Incompetent Dying Patients*, 30 RUTGERS L. REV. 243, 245 (1977).

[94] Criswold v. Connecticut, *supra*, note 92 at 438.

[95] 405 U.S. 438 (1972).

[96] 410 U.S. 113 (1973).

[97] 410 U.S. 179 (1973).

[98] Notably, the leading case of Georgetown, *supra*, note 86.

[99] The Courts have identified the protection of the patient's dependent children, the protection of the interests of the medical profession, and the preservation of life, as valid state interests favoring compulsory life-saving medicar treatment. For a discussion of these interests, see Davis, *op. cit. supra*, note 87 at 101-110.

[100] Sharpe & Hargest III, *Life Treatment For Unwilling Patients*, 36 FORDHAM L. REV. 695 (1968).

[101] 370 N.E. 2d 417 (1977).

incompetence of Saikewicz to make the choice himself, such choice could be made for him by a probate judge placing himself as best as he could in the position of Saikewicz, attempting to approximate subjectively the decision Saikewicz make for himself.

Refusal of Life-Saving Treatment

A formidable argument against allowing a patient to decline life-saving treatment is the compelling state interest in favor of preserving human life. According to one extensive research on the subject, judicial intervention to secure lifesaving medical treatment was justified by resorting to the State's traditional *parens patriae* authority, overriding religious objections put forward by parents in cases involving minors who need blood transfusions or operations.[102]

The State's *parens patriae* authority was recognized in *John F. Kennedy Memorial Hospital v. Heston,*[103] where blood transfusion was ordered by the Court to save the life of a patient despite religious reasons advanced against the transfusion. The case concerned a member of the Jehovah's Witnesses by the name of Delores Heston who was severely injured in an automobile accident. She was taken to the plaintiff's hospital where it was determined that she would die unless operated on for a ruptured spleen and it was imperative that a blood transfusion be administered for the operation. A tenet of Delores Heston's religion forbids blood transfusion, and her mother opposed it. Death being imminent, the hospital applied to a judge of the Superior Court for the appointment of a guardian for Miss Heston with directions to consent to transfusions as needed to save her life. The Court granted the application and blood transfusion was administered.

In upholding the decision of the judge of the Superior Court, the Supreme Court of New Jersey cited two sufficient interests that justified the judicial intervention—the State's interest in preserving life and the hospital's interest in pursuing its functions without the threat of liability.

In the *Quinlan* case, *supra,* all the defendants relied on this argument aside from the assertion that no constitutional right to die exists. The outcome of the case therefore hinged on the superiority of the right of privacy weighed against the countervailing interest of the State in the preservation of human life. In upholding the

---

[102] Cantor, Norman, *A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity v. The Preservation of Life,* 26 RUTGERS L. REV. 230 (1973).

[103] 279 A. 2d 670 (1971).

former against the latter, the Court placed great reliance on the testimony of Karen Quinlan's attending physician as well as testimonies of expert neurologists who examined her. The doctors testified that Quinlan will not return to a level of cognitive functions and that there is no available or known course of treatment that can reverse her condition.

The Court then adverted to the claimed State interests which are essentially the preservation and sanctity of human life, and defense of the right of physician to administer medical treatment according to his best judgment. In dismissing the argument of State interest the court noted that the nature of Quinlan's case and the realistic chances of her recovery are quite unlike those of the patients discussed in the many cases where treatments were ordered. In many of those cases the medical procedure required constituted a minimal bodily invasion and the chances of recovery and return to functioning life were very good. It held that State's interest weakens and the right to privacy grows as the degree of bodily invasion increases, and the prognosis dims. "Ultimately", the court held, "there comes a point at which the individual's right overcome the State interest."

The Court distinguished *Quinlan* from *Heston* in the sense that in the latter the patient was apparently salvable to long life and vibrant health, a situation not at all similar to the *Quinlan* case.

A fundamental distinction between the two cases, is that in the *Heston* case, the Court found that Delores Heston did not wish to die, that she wanted to live but her mother opposed the transfusion on religious grounds. However, in the *Quinlan* case, the Court made a putative decision for Karen in favor of death. Thus the Court said:

> We have no doubt, in these unhappy circumstances that if Karen were herself miraculously lucid for an interval and perceptive of her irreversible condition, she could effectively decide upon discontinuance of the life-support apparatus even if it meant the prospect of natural death.

This distinction is essential because the argument of State interest is premised on the assumption that an individual under normal circumstances would opt for life. Thus in those cases where lifesaving treatment was ordered the court invariably found that the patient wanted to live but for religious grounds are compelled to refuse medical treatment. Naturally the Court in those cases felt justified in upholding the State interest in the preservation of life. This fact readily discernible in the *Heston* case is similarly apparent in the previous case of *Application of the President*

and Directors of Georgetown College, Inc.,[104] a case which also involved a Jehovah's Witness who needed blood transfusion to save her life. The husband of the patient objected to the projected blood transfusion and the patient herself expressed her feeling that a blood transfusion would be against her will. When asked by the judge, however, whether she would oppose the transfusion if the court allowed it, she indicated that in such a case it would not be chargeable to her responsibility. The Court therefore made the conclusion that the patient did not wish to die, that on the contrary she wanted to live and her voluntary presence in the hospital seeking medical help attested to this fact.

Under like circumstances, an order for lifesaving treatment pursuant to State interest is indeed proper and legally defensible. There is in these cases a life to be protected because a patient desires to live and it is incumbent upon the State, through the courts, to afford protection to life.

Where, however, a competent individual chooses to decline lifesaving treatment and chooses to die, made either personally or through a putative judgment, the normal congruency of interests between individual welfare and state protection against death is disrupted. An entirely different situation is presented and the constitutional right of privacy lies against State interest.

This refusal may be based on religious grounds recognized in some States like Illinois as sufficient to defeat State interest. In the case of *In Re Brooks' Estate*[105] the Supreme Court in a unanimous decision upheld the patient's right to determine her own fate. Although the hospital's representative asserted an overriding social interest in protecting life, the Court perceived no immediate threat to the public health, safety or welfare sufficient to outweigh the patient's interest in religious freedom. The Court said in that case:

> Even though we may consider Mrs. Brook's beliefs unwise, foolish, or ridiculous, in the absence of an overriding danger to society, we may not permit interference therewith for the purpose of compelling her to accept medical treatment forbidden by her religious principles and previously refused by her with full knowledge of the probable consequences.

Another cogent argument for allowing patients to decline lifesaving treatment is the right of privacy and of self-determination, conceded to be recognized by the Constitution. This right has been the basis of the doctrine of informed consent under which doctrine, no medical procedure may be performed without a patient's con-

[104] 331 F. 2d 1000 (1964).
[105] 32 Ill. 2d 361 (1965), 205 N.E. 2d 435 (1965).

sent obtained after explanation of the nature of the treatment, substantial risks and alternative therapies. The doctrine recognizes that the consequence of physician's explanation and consultation may be a patient's refusal of treatment and that the exercise of the right of self-determination may mean the spurning of life-saving assistance.[106]

Judicial respect for personal decision pursuant to the right of privacy was affirmed in *In Re Quackenbush,*[107] a post-Quinlan case decided on January 13, 1978. Interestingly enough, the judge who penned the decision, Justice Muir, was the same judge in the lower court who denied the petition of Joseph Quinlan. In that case, the hospital where Quackenbush was confined petitioned the Court to amputate the legs of the patient and to consent to other medical treatment necessary due to gangrenous condition in both legs. The treating physician's affidavit indicated the probability of death within three weeks unless amputation was resorted to and treatment administered. The probability of recovery from the amputation was good and the risks involved were limited. Quackenbush, after having been made to appreciate the nature of the illness, the nature of the surgery, the risks involved in the operation and the risks involved if there is no operation decided not to submit to it.

The hospital equated the refusal to suicide and asserted a compelling State interest in preventing Quackenbush from refusing medical care and treatment, relying on *John F. Kennedy Memorial Hospital v. Heston.* Quackenbush asserted a constitutional irght of privacy and right of self-determination, relying on *In Re: Quinlan.*

The Court in deciding the case in favor of the right of self-determination, went further than *Quinlan* which suggested a combination of significant bodily invasion and a dim prognosis before the individual's right of privacy overcomes the State interest in preserving life. Under the circumstances, the State interest in the preservation of life gave way to Quackenbush's right of privacy to decide his own future, regardless of the absence of a dim prognosis. The Court therefore held that Quackenbush as a mentally competent individual has the right to make his informed choice concerning the operation and the court will not interfere with that choice.

Who Decides

The question of who decides whether further treatment should be administered or not was answered by the Courts in various cases.

---

[106] Landsverk, *Informed Consent as a Theory of Medical Liability,* 1970 WIS. L. REV. 879 (1970).

[107] 383 A. 2d 785 (1978).

The case of *In the Matter of Shirley Dinnersten*[108] recognizes the authority of the attending physician to decide whether treatment should be continued in the case of a terminally-ill patient. The issue involved was, whether a physician attending an incompetent, terminally-ill patient may lawfully direct that resuscitation measures be withheld in the event of cardiac or respiratory arrest where such a direction has not been approved in advance by the Probate Court.

The patient's family in that case concurred in the doctor's recommendation that resuscitation should not be attempted in the event of cardiac or respiratory arrest. The Court held that that question is not one for judicial decision, but one for the attending physician and that the law does not prohibit a course of medical treatment which excludes attempts at resuscitation in the event of cardiac or respiratory arrest and the validity of an order to that effect does not depend on prior judicial approval.

In the *Quinlan* case, the Court noted the fact that many hospitals have established an Ethics Committee composed of physicians, social workers, attorneys, and theologians which serves to review the individual circumstances of ethical dilemna. The Court in that case held that upon the concurrence of the guardian and family of Karen, should the attending physicians conclude that there is no possibility of Karen's ever emerging from her comatose condition and that the lifesaving apparatus being administered to Karen should be discontinued, they shall consult with the Ethics Committee and if that body agrees that there is no reasonable possibility of Karen's emerging from her comatose condition, the support system may be withdrawn.

Of course if the patient is competent to make the decision, the *Quackenbush* case recognizes the right of the patient to make the decision for himself.

REASON FOR AND AGAINST THE RIGHT TO DIE

Among the interests often asserted in opposition to the right to die are: 1) that the State has a duty to protect the lives of persons; 2) that since death is an irreversible process, the risks to both the patient and his physician of a hasty or ill-informed decision are unacceptable; 3) that permitting individuals to die who are under medical treatment violates the physician's ethical code, his right to practice his profession, and the Hippocratic oath; 4) that permitting individuals to choose the moment of their deaths will undermine respect for the sanctity of life by usurping a deci-

[108] 380 N.E. 2d 134 (1978).

sion only God should make; 5) that recognition of such a right will serve as an "entering wedge" for compulsory elimination of the aged, the unproductive, and the genetically defective; 6) that society depends on the productivity and hence, the continued existence of its members; and 7) that the death of some will leave dependents destitute and unable to care for themselves.[109]

As mentioned, the argument for the duty to protect life comes within the purview of the Fourteenth Amendment. American law has long acknowledged the pre-eminence of the right to life and, through the process of case law evolution, has recognized the right to choose death.[110] When, by electing euthanasia, the individual has expressly renounced his right to life, the State cannot reasonably assert an interest in protecting that right as a basis for overriding the individual's private decision to die. To hold otherwise makes little more sense than urging a prohibition against destroying or giving away one's private property simply because the Constitution protects property as well as life. Although the Constitution recognizes that human life is of inestimable value to most persons, and protects against its taking without due process of law, nothing in that document compels a person to continue living who does not desire to do so.[111]

Protecting the individual from the irrevocable consequences of a hasty and ill-considered act is the State's most compelling interest in preventing suicide and is equally significant in cases in which patients refuse life-saving medical treatment.[112] This risk of error is sometimes said to occur when a patient selects death in circumstances where others would consider such a decision mistaken or unreasonable. Determining whether a given decision has been made is, of course, a much simpler task than determining whether or not it has been *wisely* made. Traditional legal notions of autonomy and self-determination favor the protection of a *competent* and *informed* decision, no matter how foolish or tragic.[113] The Court in *Lane v. Candura*[114] stated it in this wise:

> The irrationality of (a patient's) decision does not justify a conclusion that (the patient) is incompetent in the legal sense. The law protects (his) right to make his own decision to accept or reject treatment, whether that decision is wise or unwise.

---

[109] Delgado, *Euthanasia Reconsidered—The Choice of Death as an Aspect of the Right of Privacy*, 17 ARIZ. L. REV. 474, 481-482 (1975). *See also* Kamisar, *Some Non-Religious Views Against Proposed Mercy-Killing Legislation*, 42 MINN. L. REV. 969 (1958).

[110] See Survey, *op. cit. supra*, note 79 at 1252.

[111] Delgado, *supra*, at 483.

[112] Davis, *op. cit. supra*, note 87 at 109.

[113] Delgado, *op. cit. supra*, note 109 at 484.

[114] 376 N.E. 2d 1232, at 1235-1236 (1978).

Then there is the possibility of decisions coerced by pain and the stress of illness. To avoid the possibility of such coercion would not justify the State's enacting a blanket prohibition that would have the effect of removing all free choice. Rather, the effort should center around a search for ways to ensure that only those patients who are uncoerced are permitted to elect death and that the decision is made with the patient's full understanding of his condition.[115]

RECOMMENDED SOLUTIONS ON EUTHANASIA

Apparently, the solution lies in the formulation of appropriate legislative measures. The law must recognize the existence of euthanasia, a practice which has long been a reality. Rather than letting a doctor's conscience be the sole guide in his actions, the law must set adequate standards to regulate the practice, prevent or at least minimize the probability of errors of judgment and abuse. The law must set requirements for the exercise of such a drastic act: this could be in the form of consent from the patient himself or from other interested parties; concurrence from a panel of recognized medical authorities that the case is terminal and that euthanasia would be the proper step to take; adequate documentation of the facts regarding the history of the case, the methods of treatment applied, and the reaction to such treatment and that such records shall be made available to the panel of authorities. Most important, the law must recognize death from the disease and not at the hand of the physician.

However, difficulties are easy to foresee. If the law were to attempt to regulate the definition of death, it would encounter an area in which it is not equipped to operate, institutionally or professionally. Indeed, the legal system might be unable to enforce its own orders. Ultimately, only the physician can treat the patient. If the members of the medical profession found a court's rejection of the medical standard of brain death as a legal standard unbearable, they could easily circumvent it. To maintain a patient in his twilight state requires a continuing observation of the patient to the end that the proper biochemical balances are maintained. It would be virtually impossible to prove a violation of the court's order if one of the more critical balances were allowed to go out of control. There also arises the question of public confidence in our hospitals and the medical profession itself. Even the basic principles of medicine are not well understood by the average person—the future patient. He has been brought up to believe that heartbeat and respiration are synonymous with life and their absence with death. Now he is to be told that a person can have a heartbeat and respira-

115 Delgado, *op. cit. supra,* note 109 at 486.

tion and be dead, and this on the basis of principles with which he is not conversant. Whether the average layman will accept this proposition, even after an appropriate educational effort, cannot be answered here. In any case, one may consider whether the legal system could be useful in legitimating the concept of brain death.[116]

The consideration to be taken in deciding whether to perform euthanasia involve more than scientific knowledge. The injection of human nature, high emotions, and personal affections render this a unique situation, totally unsuited to the universalities of law. Hard cases make hard laws, and these are all hard cases.[117] It has been said that the bureaucrat is too taken with his macroeconomic human engineering and his statistical social planning to be much concerned about the plights of the individual patient or the physician.[118]

Notwithstanding these difficulties, a positive legislative policy on euthanasia would be an important step in enlightening the medical profession, as well as the general public as to its legal implications. The law should guarantee the right of the physician to practice medicine *secundum artam* and not to take it upon itself to extend the practice of medicine beyond its scientifically supportable limits.[119] When realistic hope of recovery has evaporated, it is the right of the patient to choose only ordinary means to sustain his life and the duty of the doctor to provide palliative care. Otherwise, life preserving treatment ceases to be a gift, becoming, instead, a scientific weapon for the prolongation of agony.[120]

The "sanctity of life" argument is often couched in terms of a religious imperative: only God may decide when a human life is to end. The interest sought to be preserved is avoidance of the cheapening and depreciation of the value of life that could result from permitting individuals to take their own lives. But the fact is, for the dying patient, the alternatives are not living or dying: they are, rather, a protracted death or one that comes more quickly. When dying is protracted, it is often accompanied by fear, indignity, loss of control of bodily functions, and incessant pain that is uncontrollable by drugs. In such cases, permitting death with dignity is surely a more humane solution than a focus on life in purely vegetative or quantitative terms.[121]

Although religions may condemn refusal of life-saving medical treatment, the Constitution specifically prohibits the State from

---

[116] Wasmuth, *op. cit., supra,* note 77 at 35-57.
[117] See note 114, *op. cit., supra.*
[118] Morris & Schiumatcher, *Medical Heroics and the Good Health,* Can. Med. Assoc. J (3 September 1977).
[119] See note 114, *op. cit. supra.*
[120] Ayd, *op. cit. supra,* note 72 at 62.
[121] *Ibid.,* at 488.

enforcing religious beliefs. Any attacks upon euthanasia must point to primarily secular foundations for the State's interest. Nonetheless, that refusing extraordinary treatment does not endanger the sanctity of life can be shown by looking at the pronouncements of the Roman Catholic church. Pope Pius XII, addressing a group of physicians in 1957, remarked that Christian ethics do not require the administration of extraordinary treatment to patients where life is ebbing hopeless. He declared that this statement referred to terminating extraordinary procedures already begun as well as refusing those not yet undertaken.[122]

Many proponents of the right to life argue that to permit willing patients to die will inevitably lead to forcing death upon unwilling ones.[123] This "entering wedge" theory of State efforts toward compulsory elimination of undesirables, draws its parallel from the Nazi experience with genocide during the last war.[124] But the Nazi experience of genocide existed in a social atmosphere which rationally cannot serve as an analogy to any other period of time. Moreover, a government capable of such machinations would undoubtedly have more efficacious and direct means of accomplishing its purposes.[125]

Two closely related objections to permissive euthanasia are the State's interest in the productive capacity of its citizens and its interest in avoiding the destitution of surviving dependents. This "economic interest" of the State is clearly inapplicable to seriously or terminally-ill patients who have no productive capacity to offer the State. Moreover, even if the patient could contribute to the economy, the State can claim no compelling interest in productivity.[126] The opinion that one's productivity determines the value the State attaches to one's life, contradicts the emphasis on the value of all life, runs counter to the liberal tradition and respect for the individual cherished in our society, and is in derogation of the Constitution's protection of the lives of all persons.[127] Only the presence of minor dependents may outweigh an individual's interest in dying, so long as he is still able to perform his wage-earning or parental duties.[128]

---

[122] Survey, *op. cit. supra*, note 79 at 1242.
[123] Davis, *op. cit. supra*, note 87 at 106.
[124] See Kamisar, *op. cit. supra*, note 109 at 1031-1041.
[125] Delgado, *op. cit. supra*, note 109 at 491. One commentator, after an analysis of the judicial handling of the issues, opined that a utilitarian view of the value of human life was developing—with dangerous implications. See Davis, *supra* at 115.
[126] Davis, *supra*, at 108.
[127] *Ibid.*, at 114.
[128] Delgado, *supra*, at 493.

The right to control one's own body now enjoys some constitutional protection as an offshoot of the right to privacy. Nevertheless, the State still has a proper role as protector of life in medical treatment cases. That role is not to insist on preserving life until the last possible moment at great human cost and with no benefit to the patient. Rather, it is to ensure the clarification of facts and the purification of the decision-making process. The challenge facing the courts is to decide the cases in a way that leaves no doubt that the State's interest in protecting lives extends to all citizens, but with the aim of enhancing, not diminishing, human dignity and autonomy.[129]

THE SPECIAL QUESTION OF SUICIDE

In discussing the problem of suicide, one must necessarily take into account ethical and moral considerations before a definite answer can be arrived at. It is in this area where the strongest objections against suicide lie, but in the same token, it is in this area where the existence of the right to die could be established. But before this can be established, if at all it is to be established, it would be most appropriate to involve ourselves with a preliminary discussion on the nature of moral philosophy. Everybody seems to have a fair notion as to what morality is all about, but it would indeed be illuminating if we acquaint ourselves briefly as to its nature and as to the various moral or ethical systems. After this, a discussion as to how the right to die would fare in such systems would be proper before a definite position can be arrived at.

There are certain standards of right and wrong which we acquired in our childhohod when our parents told us what we ought to do and what we ought not to do. Despite this training, until today, we do not really have definite answers to questions such as: What is my duty to others and to myself? What kinds of actions are right and what kinds of actions are wrong? How should I live? These questions are the type of questions which involve moral philosophy and at this point it is important that we make definitions so as to delineate the areas of moral philosophy. What then is a moral question? Or rather how are they distinguished? Moral questions are those which are answered by citing moral rules, moral ideals, or moral standards. But what are moral rules, moral ideals, or moral standards? (When one is engaged in defining things, definitions upon definitions are arrived at.) Moral rules are rules which we expect every human being to follow, simply because he is a human being, whereas a moral ideal is an ideal which all men ought to try to live up to. Similarly, moral standards are standards by

[129] Davis, *supra*, at 115-116.

which we decide the goodness and badness of a person's character or the rightness and wrongness of his actions, again simply with respect to his being a human being among other human beings, and not with respect to any special role which he has in practical life.[130] The common ground upon which these definitions stand on as clearly shown is the claim to universal applicability, that is, its claim to all human beings everywhere at all times.

A very serious problem arises with regards to moral philosophy and this occurs when we investigate the possibility of justifying the claim to universality. When there is a claim to universality, there must be a basis for such a claim but the question is is there such a basis? Ethical relativism contends that there can never be any basis for justifying moral claims, that there are no rules, ideals, or standards of human conduct that can be applied justifiably apply to individuals living outside of society. The main argument of the ethical relativist is that they maintain this belief because of certain findings of history, psychology, and the social sciences and these are: 1) There exists great variation in the rules, ideals, and standards, accepted by different societies at different times in history. 2) Most human beings are ethnocentric in that they believe that the rules, ideals, and standards of their own society are the only true ones. 3) The conscience and moral beliefs of every person came from his social environment.[131]

If we are to accept ethical relativism as a model explaining or describing morality what would be the status of the right to die? The answer would indeed depend on the social context, rather, if a certain society believed that the right to die was necessarily included with the idea of freedom or that there existed such a right, then there would be no doubt that any member of that society could validly exercise that right and commit suicide, and would incur no punishment if he failed. On the other hand if a certain society frowned upon suicide, and did not recognize such a right, then any person who commits suicide would be dealt with a certain type of punishment, whatever punishment could be possible. The same would hold true if he failed in his attempt to commit suicide. The question arises however, as to how these rules would affect an individual living outside society. A hermit perhaps would not be bound by such rules since such rules are socially based and as such, he would be free to do anything with himself as long as it took place outside of society. The existence of the right to die, however, under this model, would not be absolute. But the peculiar character of this school of

[130] SPRAGUE & TAYLOR, KNOWLEDGE AND VALUE 484-485 (1967).
[131] FLUGEL, MAN, MORALS AND SOCIETY 35 (1945).

thought is that it questions the very nature of morals itself, i.e., are there really universal rules inherent in every man?

Another school, ethical absolutism, proposes an opposite view. The ethical absolutist claims that there is one true set of moral rules, ideals, and standards which apply to all men in all societies. According to this view, people can be correct or mistaken not only in their moral judgments, but also in their rules, ideals, and standards, since one moral code may be superior to another. Because of this, ethical absolutism enters into quite a few difficulties. It is maintained that there are moral truths but without certainty as to what they are. Moreover, if the ethical absolutist adheres to certain sets of moral truths, there is the danger of his becoming ethnocentric, dogmatic, or intolerant. In order to establish an accepted set of rules, ideals, and standards as universally binding on all men, the ethical absolutist must state as to how this can be done; rather, it must be shown how it is possible to obtain genuine moral knowledge, so that it can be determined in any given case whether what one thinks is right or wrong is really right or wrong.[132]

There have been quite a number of attempts to do this in the history of philosophy. In each case, the moral philosopher examined the grounds on which moral knowledge stood upon and tried to show how these grounds justify the acceptance of a certain rule of conduct, ideal of life, or a certain set of such rules, and if we are at all to establish the existence of the right to die, then these grounds must be examined, that is, if we do accept the ethical absolutist's position. Furthermore, the existence of the right to die would be dependent on a particular model of the ethical absolutist, (and there are quite a few), and therefore, the existence of such a right would likewise be relative in the same manner as that of the ethical relativist's view. At any rate, it would be worthwhile to review the several systems propounded by ethical absolutists.

David Hume in his book, *An Inquiry Concerning the Principles of Morals,* believed that we obtained moral knowledge through what he calls the "moral sense". What is this "moral sense"? According to Hume, neither our reason itself nor knowledge which we gain by the use of our reason can directly determine our actions. Only "passion" which we now call emotions, attitudes, desires, wishes, and needs, can act as a motivating force on our behavior. Reason can only tell us what the probable consequences of our actions will be, and thus indirectly cause us to act one way rather than another, depending on whether we like or dislike the consequences of which it inform us. Applied to the right to die, suicide is possible when our "passion" mo-

[132] SPRAGUE, *supra,* at 487-488.

tivates us to do such a deed. Our moral sense tells us what to do, and since "moral sense" is determined by "passion" and not reason, the right to die could easily be justifiable in view of the situation where an individual will decide to commit suicide because of emotional problems or because of a certain wish or desire to die. However, one logical consequence of Hume's theory, which by itself would be an objection, is that when a dispute as to a moral question arises, it could very well be settled by collecting statistics of how people in fact feel. Such an answer indeed seems irrelevant to this kind of question.

Emmanuel Kant, in his *Fundamental Principles of the Metaphysics of Morals,* proposes the theory that moral knowledge is *a priori,* that is, it is knowledge which rests solely on pure reason. He claims that we should act in accordance with our moral duty, our moral duty consisting in obeying a moral law, a law which by definition would be a law which commands nothing but obedience to law as such. To act in accordance with moral law is to act in accordance with a universal rule or principle which applies impartially to all beings. Kant therefore offers the so-called categorical imperative—that each person is to act in the way that he would be willing as a rational being to have everyone else act. It follows that what is right or wrong for one person is right and wrong for everyone—indeed, for all rational beings—in all places and at all times. The question may be asked, can we assume that all men are rational beings? At any rate, under Kant's view, the act of suicide would be wrong, for if an individual committed suicide, can it be said that such deed would be proper for everybody? Such a deed cannot be true for everybody and can not form a universal law, and although reason may be used to justify a suicide, it most likely will be used to refuse suicide. (The argument crops up, however—why prolong life when we're going to die anyway?)

John Stuart Mill was a proponent of utilitarianism, the school of thought which regards pain as an absolute evil and pleasure as good. According to Mill, actions are right or good in proportion to their usefulness or as they tend to promote happiness; wrong as they tend to produce the reverse of happiness. By happiness is meant the intended pleasure and the absence of pain; by unhappiness, pain and the privation of pleasure. The end and criterion of public action is therefore the greatest happiness of the greatest number.[133] Under the Utilitarian view, there is a right to die, but only under certain conditions; that is, when the individual who wishes to die does so due to an incurable suffering. Euthanasia, which means peaceful death, should be mandatory in such a situa-

[133] J. S. Mill 9 UTILITARIANISM (1962).

tion when there is intolerable physical suffering. It may be argued, however, that suffering need not only be physical but also emotional or mental. And if we bring utilitarianism to its logical conclusion, suicide or the exercise of the right to die would likewise be proper when an individual experiences pain, whether it may be mental, emotional, or physical.

In conclusion, although there have been other numerous moral theories which have not been presented, we believe that there is a lack of any convincing argument that the right to die does exist. The authors maintain that there exists such a right to die on the basis of the very occurrence of suicide. The answering of the question of whether such right should be allowed or not, or whether such right should be granted or not, becomes moot when a suicide occurs. Perhaps with regards to this particular issue, the existence of this right is made possible in an "extra-ethical" sense. It cannot be denied, however, that there are ethical considerations to be taken into account but as pointed out by ethical relativism, if we accept this, and we do, morals are relative. Ethical considerations may indeed be supportive of a certain action but in the main, one objection in relying on them is that they might not reflect the reality of the situation. Again we are faced with the particular nature of morality, with the difference between "ought" and "is". An ethical absolutist believing that suicide is wrong may assert that there ought not to be a right to die, our arguments would be moot, since there really is a right to die, as evidenced by its exercise. We maintain therefore that there is a right to die, and rightly so because the individual has the freedom to do so.

Granting that we make an assertion that there ought to be a right to die, making such an assertion on the basis of an absolute moral truth, the ethical considerations that are taken into account in making a decision, as whether or not to commit suicide, are seen from the point of view of the individual. There is therefore, an emphasis on the individual's point of view; it is his life that is at hand here and his freedom of choice should be upheld. It is important to note however that in such a situation, the decision to commit suicide is made usually more on the basis of the individual's feeling. A question inevitably arises: Does society have every right to control the behavior of an individual and deprive him of his freedom of choice? We think not, and in such a situation, human freedom must be upheld.

There is the argument, however, that if we apply this existence of a right inferred from the occurrence of an event, one may similarly argue that along these same lines, we could arrive at the existence

right to murder since murder occurs, or for that matter, there exists a right to steal since robberies occur. The difference with this situation, however, is that society provides concrete sanctions against such behavior which are effective. Such behavior, because of a society's effective sanctions, cannot be invoked as a right without including the possible sanctions that might befall any offender. Here, there is a clear prohibition by society whereas in suicide there is none. Societies which do condemn suicide however, do provide sanctions only to those who fail at suicide. If they punish suicide with the penalty of death, the result would be the same and no doubt such a policy would appear absurd. Other societies view suicides as mentally aberrant individuals who need treatment not punishment. At any rate, there are numerous cases which report of suicides by people who have undergone treatment. It therefore stands that from the view of society, there are no really effective measures to prohibit the exercise of the right to die. If they ignore it they are blind to reality, and because such a phenomenon occurs constantly in society, perhaps has developed into, or fit into, the definition of a "right"; something inherent in the individual which can be availed of at any time, with no qualification.

At this point, it must not be lost sight of that upon establishing the existence of the right to die, the individual should not only be permitted to commit suicide but also to have euthanasia performed on him dependent, of course, on his choice to do so, or not. Although it may be true that there are different considerations involved in euthanasia, the main issue must not be lost track of — that a patient, because he has a right to die unqualifiedly, with more reason should be able to exercise this right under special circumstances.

Suicide may be a manifestation of the newly realized freedom, the freedom of the individual. It may be done to defy society, or even express himself or even an idea. Be it right or wrong, depending on whose point of view one takes (but we submit that the only view that matters should be the individual's), each successful suicide necessarily implies the final exercise of death in the same manner that we are able to exercise the right to bear life. Be that as it may, even if society disapproves of it, even if the law provides penalties for it, every act of suicide proves the contrary, that there exists a right to die. Values may be indeed relative, but we cannot deny reality.

We had originally aspired to determine whether the act of suicide was within the sphere of the law, considering that a man had the right to die as inferred from the constitutional right to

privacy. The answer was supposed to have been arrived at through the channels of ethical, legal, social, and medical considerations.

After undertaking this multi-disciplinary approach we feel that morality, ethics and legal considerations *per se* do not provide an adequate basis for criminal sanctions imposed by State in the perpetuation of its alleged interest to prevent suicide. Ethical considerations cannot form the basis of laws punishing suicide. The ethics of a social group should not be imposed on a whole society. While some may view suicide as a horrendous deed against society, there are some who logically rationalize that suicide benefits society since it is a process by which society rids itself of elements of misery and dissatisfaction. Suicide is harmful to a certain section of society — friends, relatives, and those who may be unintentionaly harmed in the process of suicide. But suicide is an act of the solitary man who seeks only to relieve himself of a burden he can not bear.

The strongest argument for the condemnation of suicide is that it strengthens the will to live. It is accepted by authorities that suicide is generaly the act of a person suffering from a mental aberration. It is of public as well as of personal advantage for society to regard suicide as cowardly, immoral and disgraceful.

However, such an argument leaves much to be desired with regard to practical effects. Suicidal attempts do not seem to have lessened due to popular sentiment against the act. Considering the reasons for and desire of one to commit suicide, it is doubtful whether the opinion of society regarding suicide would be of much moment to him.

The potential suicide is driven by motives beyond the power of criminal sanctions to change. Suicide is more of a medical rather than a legal problem. Penal laws are not effective deterrents to suicide and its intrusion in such tragedies (specifically suicide and attempted suicide), is more of an abuse than anything else.

Those who instigate, aid or abet a suicide is a different matter. The fact that these persons are accomplices merely to a principal not guilty of a crime should not be a basis for their non-culpability.

Philippine penal law has adopted the right approach when it does not treat suicide or attempted suicide as a crime. However, the Revised Penal Code considers the giving of assistance to suicide as a crime. There is a gap with regard to the criminal liability of one who instigates or encourages another to commit suicide. Those

who instigate or encourage suicide are a nuisance to order in society and should be subject to a penalty. Instigators, abettors and aiders can not be considered as having no *means rea* simply because suicide is not treated as a crime in the Philippines. To allow the instigator of suicide to go unpunished is an invitation to murder by way of suicide.