Direct Democracy and Bioethical Choices: Voting Life and Death at the Ballot Box

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Direct democracy, the political process that enables citizens to draft, circulate, and enact laws, has become the refuge for grassroots organizations seeking statutory validation in a legislative arena perceived to be unresponsive or unfriendly to their concerns. One group of citizens, advocates for physician-aid-in-dying, has recently emerged on the national scene, sponsoring state ballot initiatives in three states and pledging to continue their quest for legalization of physician-assisted death throughout the country. In this Article, Professor Daar examines the interplay between direct democracy and regulation of end-of-life decision making. This examination reveals that lawmaking by initiative, as seen through the campaigns to gain legalization of physician-aid-in-dying, is no less susceptible to the ravages of political wrangling than is representative democracy. Professor Daar argues that direct democracy is best utilized as a spur to legislative action rather than as a replacement for the study and compromise unique to legislating through representative democracy. In addition, the author advocates recognition of a constitutionally protected liberty interest in choices surrounding death, thus providing a threshold level of protection to all citizens, not just those whose lawmakers or citizens are motivated to codify this fundamental right.

Introduction

On election day in November 1992, voters across the country went to the polls to cast their votes on a variety of political inquiries, ranging from who should serve as the next president of the United States to whether members of Congress should be limited in the number of terms they serve. In several

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states, ballots also included questions that are more correctly characterized as social, or perhaps personal, in nature: Should physicians be permitted to render aid-in-dying to terminally ill patients? Should women be protected from state interference with their right to choose abortion prior to fetal viability? Should the state be required to condemn homosexuality as abnormal and to actively discourage its practice?

Each of the foregoing arguably apolitical questions was presented to voters in the form of a ballot initiative. An initiative allows citizens to draft their own proposed laws, circulate petitions to raise a required number of signatures, and then place the proposed law on the ballot. If the initiative receives a simple majority vote, the measure becomes law. By empowering citizens to formulate, circulate, and vote on their own notions of what the law should be, the initiative serves as a

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2. For example, Proposition 161, entitled the “Death with Dignity Act,” posed this question to voters in California; the proposition was defeated by a vote of 54% to 46%. Michael Miller, Doctor-Assisted Suicide Measure Loses in California, Reuters, Nov. 4, 1992, available in LEXIS, News Library, Wires File. For a more elaborate discussion of circumstances surrounding the defeat of Proposition 161, see infra text accompanying notes 241-46.

3. Two states’ ballots contained questions regarding abortion rights. See Reinhold, supra note 1, at 88. In Maryland, voters approved Initiative 6, which prohibits the state from interfering with a woman’s decision to abort a pregnancy prior to fetal viability. Id. In Arizona, voters rejected Initiative 110, which would have eliminated public funding of abortion except when the mother’s life is threatened. Id.

4. This was one of two questions pertaining to homosexual rights put to voters in the November 1992 general election. See Reinhold, supra note 1, at 88. Oregon Initiative 9, defeated by a vote of 57% to 43%, would have amended the state constitution to require that the government discourage homosexuality. Id. In Colorado, voters approved Amendment 2 by a margin of 53% to 47%. Id. The initiative amended the Colorado Constitution to bar state and local governments from prohibiting discrimination claims based on sexual orientation. See COLO. CONST. art. II, § 30b; Ned Zeman et al., No “Special Rights” for Gays, NEWSWEEK, Nov. 23, 1992, at 32. On October 11, 1994, the Colorado Supreme Court upheld a trial court’s entry of a permanent injunction barring enforcement of Amendment 2, holding that the State had no compelling interest in amending the constitution to infringe on fundamental federal rights. Evans v. Romer, 882 P.2d 1335, 1350 (Colo. 1994), cert. granted, 115 S. Ct. 1092 (1995).

5. Reinhold, supra note 1, at 88.


7. See DEMOCRACY BY INITIATIVE, supra note 6, at 173. Most states with initiatives also allow voters to amend their state constitutions through the initiative process, but some impose higher voting requirements, such as a super-majority vote. Id.
form of direct democracy. Direct democracy, in contrast to representative democracy, allows citizens to vote directly on whether they want a particular proposal to become law. By circumventing the legislative process, voters can create law by initiative without the same scrutiny and mechanisms that accompany enacted legislation.

This legislative bypass, no doubt, produces several ramifications that sharpen the distinction between representative and voter-made law. Perhaps the most notable of these distinctions is found in the subject matter covered by ballot initiatives. In many instances, initiatives have raised issues that elected representatives had previously shunned because the issues are

8. Three forms of direct democracy exist in the United States today; they are initiative, referendum, and recall. CRONIN, supra note 6, at 2. The initiative allows voters to place on the ballot a statutory measure or constitutional amendment "by filing a petition bearing a required number of valid citizen signatures." Id. The referendum submits a proposed or existing law to the electorate for approval or rejection. Id. The recall enables voters "to remove or discharge a public official from office by filing a petition bearing a specified number of valid signatures demanding a vote on the official's continued tenure in office." Id.; see also Julian N. Eule, Judicial Review of Direct Democracy, 99 YALE L.J. 1503, 1510-13 (1990) (discussing the initiative and referendum forms of direct democracy).

The focus of this Article is voter lawmaking through initiative because it alone allows voters to both write and pass laws. Therefore, any references to direct democracy hereafter will be to the initiative only, unless otherwise indicated.

9. By "representative democracy" I am referring to a system of government in which groups of citizens elect individuals to a political body to represent them in making and deciding law.

10. For example, in California the initiative can neither be amended once it has qualified for the ballot nor be subjected to public hearings; thus, the initiative lacks the legislative "benefits" of both amendment through compromise and information-gathering through hearing. DEMOCRACY BY INITIATIVE, supra note 6, at 79–80. For a critique of the initiative process and suggestions for reform, see id. at 20–29.

11. A wide array of literature addresses the distinctions and similarities between direct and representative democracy. Some works criticize direct democracy as a form of lawmaking, while others recognize its shortcomings but advocate it over the legislative process as a means of serving the public interest. Compare DAVID B. MAGLEBY, DIRECT LEGISLATION: VOTING ON BALLOT PROPOSITIONS IN THE UNITED STATES 188-90 (1984) (arguing that the use of initiative has harmed the political process by weakening political parties and legislatures, accelerating growth of single-issue politics, and enhancing special interest group power) and Derrick A. Bell, Jr., The Referendum: Democracy's Barrier to Racial Equality, 54 WASH. L. REV. 1, 2 (1978) (arguing that reliance on referenda and initiatives "poses a threat to individual rights" and "creates a crisis for the rights of racial and other discrete minorities") with Richard Briffault, Distrust of Democracy, 63 TEX. L. REV. 1347, 1367–71 (1985) (reviewing MAGLEBY, supra, and arguing that direct democracy is valuable for increasing representativeness of government and that it should coexist with the legislative process) and Clayton P. Gillette, Plebiscites, Participation, and Collective Action in Local Government Law, 86 MICH. L. REV. 930, 931–37 (1988) (suggesting that representative democracy is more likely to produce results that deviate from optimal outcomes than are plebiscites).
divisive within the legislature or controversial within the electorate.\textsuperscript{12} Not surprisingly, voter initiatives have become the refuge for citizens who believe that local and state legislators are simply unresponsive to their fundamental concerns.\textsuperscript{13}

One such group of voters is the Americans Against Human Suffering (AAHS), formed in 1986 to promote the legalization of physician-aid-in-dying.\textsuperscript{14} Frustrated in their efforts to attract legislative attention to the plight of terminally ill patients who wish to hasten their death through medical means, AAHS mounted a successful campaign to place the issue of voluntary active euthanasia on the California state ballot in November 1992.\textsuperscript{15} While the initiative itself was defeated by a margin of

\textsuperscript{12} One study reveals that the most common topics of initiative activity are governmental and political process reform, civil liberties, and environmental protection. \textit{See} \textit{Democracy by Initiative, supra} note 6, at 58–69. Citizen lawmaking in the political process arena is logically linked to topics of legislative divisiveness, if not utter conflict of interest. Term limits serve as a recent example. By the end of 1994, 22 states had enacted some form of congressional term limits; in 21 of these states, the measures were enacted by a direct vote of the people. United States Term Limits, Inc. v. Thornton, 115 S. Ct. 1842, 1909 n.39 (1995).

Regarding influence of constituent approval on proposed legislation, it is likely that any bill will have its supporters and detractors who will align themselves with individual legislators to advocate passage or defeat of a particular measure. Competing business and special interest agendas, for example, can lead to legislative deadlock, preventing lawmakers from effectively dealing with controversial topics. In this instance, the ballot box seems a viable solution, whereby advocates and opponents can bypass legislative wrangling and appeal directly to the public for a vote on the merits. Yet, some would argue that the initiative's ability to help settle controversial issues is highly questionable. \textit{See}, e.g., \textit{Democracy by Initiative, supra} note 6, at 61–62 (describing the 1990 California ballot which hosted four initiatives dealing with environmental reform; two were proposed by environmental groups, while two were business-backed counter initiatives, but all were rejected by voters).

\textsuperscript{13} \textit{See} \textit{Democracy by Initiative, supra} note 6, at 59–64 (outlining various political developments that have spurred the growth of initiatives, including legislative inaction on issues of importance to voters).

\textsuperscript{14} \textit{See} Katherine Bishop, \textit{Backers Fail to Get Lethal Injection Bid on California Ballot}, \textit{N.Y. Times}, May 18, 1988, at A23. After its formation, AAHS worked to place an initiative on the 1988 California ballot that would have legalized physician-assisted death for terminally ill patients, but the group failed to secure the required number of signatures. \textit{Id}.

fifty-four percent to forty-six percent, the lobby group has already announced its intention to place a similar measure on the California state ballot in 1996. Moreover, AAHS was not the first group to place a euthanasia initiative on a state ballot. In 1991, the Washington Citizens for Death with Dignity gathered the requisite signatures to place Initiative 119, providing for legalization of physician-aid-in-dying, on that state's ballot. Finally, in the most recent attempt to gain statutory authority for physician-aid-in-dying, on November 8, 1994, voters in Oregon approved Measure 16, the

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16. See George de Lama, States Take Pulse on Morality: Oregon Anti-Gay Measure Fails; Abortion-Rights Issues Gain, CHI. TRIB., Nov. 5, 1992, at 18. The California initiative, Proposition 161, would have permitted mentally competent adults who had been diagnosed as terminally ill to write a revocable directive authorizing their doctors to terminate their lives in a "painless, humane and dignified manner." The California Death with Dignity Act § 2525.1 (voter initiative rejected 1992) (on file with the University of Michigan Journal of Law Reform) [hereinafter Death with Dignity Act]. The measure also would have provided immunity for doctors and healthcare professionals and facilities from civil or criminal liability after following the provisions of a patient directive. Id. § 2525.9. Some political observers believe that the initiative was defeated chiefly because voters feared the measure "lacked sufficient safeguards against abuse." de Lama, supra, at 18.

17. Americans for Death with Dignity Targets Law Reform in 1996, PR Newswire, May 14, 1993, available in LEXIS, News Library, Arcnw File. The lobby group changed its name to "Americans for Death with Dignity" and reportedly strengthened its supporter base by adding the following people to its board of directors: Betty Rollin, television reporter and author of Last Wish; Charlotte Ross, founder and, for 25 years, director of the Suicide Prevention and Crisis Center of San Mateo County, California; and two physicians. Id. The group's mission statement is as follows:

To create a legal right in the USA so that every mentally competent adult has the choice of a physician-assisted humane and dignified death when he or she becomes terminally ill.

Id.


19. See U.S. Judge Keeps Oregon's New Suicide Law in Limbo, L.A. TIMES, Dec. 28, 1994, at A5 (reporting that Measure 16 was approved by Oregon voters by a 51% to 49% margin).
nation's first law authorizing physicians to assist in the suicide of terminally ill patients.\textsuperscript{20}

What is interesting about the public debate over euthanasia\textsuperscript{21} is not so much that it is going on, but rather \textit{where} the debate is taking place. Euthanasia, like other bioethical legal issues\textsuperscript{22}

\textsuperscript{20} See The Oregon Death with Dignity Act, ch. 3, 1995 Or. Laws 12 [hereinafter Measure 16]. Unlike the prior California and Washington initiatives, Measure 16 is limited to a physician assisting in the suicide of a terminally ill patient by prescribing a lethal dose of medication. \textit{See id.} § 3.01, 1995 Or. Laws at 13. The physician is not authorized to administer the drugs, \textit{id.} § 3.14, 1995 Or. Laws at 14, as contemplated in the other two states' measures. \textit{See} Timothy Egan, \textit{Suicide Law Placing Oregon on Several Uncharted Paths}, \textit{N.Y. TIMES}, Nov. 25, 1994, at A1, B14.

Almost immediately after its passage, Measure 16 was challenged in federal court by several plaintiffs, including two physicians and four terminally ill patients, on the grounds that the law violates the United States Constitution as well as other federal law. Lee v. Oregon, 869 F. Supp. 1491, 1493 (D. Or. 1994). On December 27, 1994, the court granted a preliminary injunction blocking implementation of the law "until the constitutional concerns are fully heard and analyzed." \textit{Id.} On August 3, 1995, Judge Michael Hogan ruled that Measure 16 violates the Equal Protection Clause of the United States Constitution and therefore permanently enjoined the voter-approved practice of physician-assisted suicide. Lee v. Oregon, 891 F. Supp. 1439, 1439 (D. Or. 1995).

21. The public and academic debate surrounding the concept of physicians actively and knowingly participating in their patients' deaths encompasses a host of issues, including questions about terminology and semantics. Those who enter the "euthanasia" debate generally set forth their preference for terms and the behavior attached thereto. For example, over 20 years ago, medical ethicist Joseph Fletcher proposed a typology of forms of euthanasia, suggesting that the practice of a "good death" could be: (1) voluntary and direct, (2) voluntary but indirect, (3) direct but involuntary, and (4) both indirect and involuntary. Joseph Fletcher, \textit{Ethics and Euthanasia, in To LIVE AND TO DIE: WHEN, WHY, AND HOW} 113, 117-18 (Robert H. Williams ed., 1973). Another theme in the debate over terminology focuses on whether the practice of physician-assisted dying should be categorized as either "passive" or "active" euthanasia. \textit{Compare} James Rachels, \textit{Active and Passive Euthanasia}, 292 \textit{NEW ENG. J. MED.} 78, 79 (1975) (suggesting that there is no moral difference between a physician actively helping a patient to die or agreeing to withhold treatment) \textit{with} Tom L. Beauchamp, \textit{A Reply to Rachels on Active and Passive Euthanasia, in ETHICAL ISSUES IN DEATH AND DYING} 246, 247 (Tom L. Beauchamp & Seymour Perlin eds., 1978) (defending the occasional importance of the active/passive distinction). To further complicate the debate about proper euthanasia terminology, George Lundberg, editor of the Journal of the American Medical Association, has identified six major types of euthanasia: (1) passive, (2) semipassive, (3) semiactive, (4) accidental, (5) suicidal, and (6) active. George D. Lundberg, "It's Over, Debbie" and the Euthanasia Debate, 259 \textit{JAMA} 2142, 2143 (1988). For a discussion of the differences in the moral, factual, and interpretive premises of euthanasia, see \textit{Eike-Henner W. Kluge, THE ETHICS OF DELIBERATE DEATH} 9-29 (1981).

I consider the practice of physician-assisted death as breaking into two categories: (1) assisted suicide, where the physician provides the means of death but is not the final agent in the patient's death, and (2) voluntary active euthanasia, where the physician provides the means of death and is the final agent in the patient's death. These two practices—physician-assisted suicide and voluntary active euthanasia—comprise what I refer to as "physician-aid-in-dying." This latter term connotes the ways in which a physician can help his terminally ill patients achieve a less painful, more accelerated death.

22. The term "bioethics" is defined as "[t]he study of the ethical and moral questions involved in the application of new biological and medical findings, as in the fields of genetic engineering, neurobiology, and drug research." \textit{AMERICAN HERITAGE
that have preceded it, including abortion and the rights of patients to withhold or withdraw life-sustaining treatment, involves a wide variety of legal issues ranging from criminality to constitutionality. Unlike previous bioethical issues, however, euthanasia seems to be unique in its evasion of the judicial and legislative processes that have produced a rich jurisprudence of patient self-determination. In other words, while the law surrounding the rights of patients to seek abortions or withdrawal of medical treatment has been defined by enacted legislation and court opinions, the battle over euthanasia is being staged at a grass-roots, populist level that evades, perhaps intentionally, the involvement of established political processes.

This Article explores the practice and wisdom of regulating bioethical choices through direct democracy. The intersection between personal decision making and voter-generated law has grown increasingly pronounced over the past several years. Given that the trend toward direct voter lawmaking in this area is likely to continue, it is essential to examine the history, present practices, and future of direct democracy and its impact on bioethical choices. Using the euthanasia movement as a paradigm case, this Article examines the benefits and disadvantages of pursuing the legislation of self-determination through the electoral process. Efforts toward the legalization of euthanasia serve as an excellent model for this discussion because these efforts have been aimed at every level of government, revealing much about the way citizens and policymakers approach the regulation of personal decision making. Part I explores the reasons why citizens and interest groups have turned to direct democracy as a way of garnering support for euthanasia, thereby turning away from more
traditional methods of obtaining legal rights. By comparing the legislative and judicial successes of the so-called "right-to-die" movement of the 1970s and 1980s with the relative failure of euthanasia advocates to gain legalization, one begins to understand the movement's current strategies.

Part II examines the history and practice of direct democracy. After briefly reviewing the impetus for instituting direct democracy in our states in the early years of the twentieth century, Part II discusses current criticisms of citizen lawmaking. In particular, concerns about voter competency, the tyranny of the majority, and special interest domination are discussed in the context of the euthanasia campaigns in Washington and California. What emerges from this analysis is the realization that lawmaking at the ballot box is no more immune from the ravages of political wrangling than is legislating through representative democracy. Part II therefore concludes that direct democracy is best utilized as a spur to legislative action rather than as a replacement for the study and compromise unique to our legislative process.

Finally, Part III explores the question of whether democratic lawmaking is an appropriate means for protecting bioethical choices, particularly choices about the end of life. This question is first tackled in the context of direct democracy as practiced through ballot initiatives. Analysis of this question reveals that lawmaking through the initiative process is particularly problematic because it is available in less than half the states in our nation, rendering universal access to reform impossible at present. Part III then questions whether personal decisions, particularly decisions about death, should ever be the subject of legislation. Given that citizens in our nation have long resisted legal interference with private preference, it is no surprise that we would treat regulation of choice in death with some degree of suspicion and hostility. Perhaps the optimal outcome for the debate surrounding euthanasia would be for supporters to turn away from the initiative process and advocate for a constitutionally protected right to choose aid-in-dying. Legal regulation of choice-in-dying would then be governed by a threshold level of protection available to all citizens, not just to those who go to the ballot box.
I. JUDICIAL, STATUTORY, AND CONSTITUTIONAL RESPONSES TO BIOETHICAL CHOICES: THE CASE OF EUTHANASIA

The term "bioethical choices" eludes precise definition but nonetheless conjures up a vague concept that likely includes decision making about one's mental and physical well-being. Throughout this century, and particularly throughout the past twenty years, the concept of bioethical choices has filtered into our legal system, causing judges, legislators, and even voters to consider how our laws can best respond to individual needs and preferences. Since the 1970s, we have witnessed increasing legal activity regarding bioethical choices, notably in the areas of abortion and patient decision making.

In both of these bioethical areas, the legal response has been comprehensive in that it has come from judicial, legislative, and constitutional sources. Currently, every state has enacted law regulating abortion, and within almost every state a court has ruled on the applicability or advisability of such law.25 Likewise, every state has passed legislation speaking to the rights of patients to control their medical treatment,26 and courts in thirty-eight jurisdictions have discussed the issue of patient self-determination.27 Additionally, federal lawmakers and judges have become involved in these bioethical areas.

25. See generally 1 ABORTION IN THE UNITED STATES: A COMPILATION OF STATE LEGISLATION (Howard A. Hood et al. eds., 1991) (setting forth the text of each state's abortion statute and summarizing court opinions on abortion in each state). No court decisions on abortion exist in Hawaii, Idaho, New Hampshire, or Vermont. Id. at 121, 127-36, 387-88, 583.

26. Every state except Massachusetts and Michigan have enacted a living will statute, which allows patients to direct their physicians to withhold or withdraw life-sustaining treatment in the event of terminal illness. 2 ALAN MEISEL, THE RIGHT TO DIE §§ 11.1, 11.22 tbl. 11-1 (2d ed. 1995). Every state except Alabama has enacted a health care power-of-attorney statute, which enables patients to appoint another person to make health care decisions on their behalf when they are unable to do so for themselves. Id. §§ 12.1, 12.52 tbl. 12-1.

27. 2 MEISEL, supra note 26, § 1.7 tbl. 1-1 (listing by state all right-to-die cases). The appellate courts that have decided right-to-die cases can be found in Arizona, California, Colorado, Connecticut, Delaware, the District of Columbia, Florida, Georgia, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Nevada, New Jersey, New Mexico, New York, Ohio, Pennsylvania, Tennessee, Virginia, Washington, West Virginia, and Wisconsin. Id. The states whose trial courts have decided right-to-die cases are Alabama, Hawaii, Nebraska, North Carolina, North Dakota, Oregon, Rhode Island, and Texas. Id.
Congress has enacted abortion\textsuperscript{28} and patients' rights legislation.\textsuperscript{29} The Supreme Court has grappled with both issues, ultimately looking to the Constitution as a source for its rights-based analysis.\textsuperscript{30}

In contrast to the substantial legal activity surrounding individual decision making regarding pregnancy and withdrawal of treatment, until very recently, scant formal legal attention has been paid to the issue of euthanasia.\textsuperscript{31} Despite

\textsuperscript{28} While regulation of abortion has rested primarily with the states, Congress has enacted legislation relating to abortion funding. See Laurence H. Tribe, Abortion: The Clash of Absolutes 151, 197–228 (1990). Since 1976, Congress has prohibited the use of any federal funds to reimburse the cost of abortions under the Medicaid program, except in special cases. Id. at 151–52. Congress regularly enacts this restriction as a “Hyde Amendment,” named after its original congressional sponsor, Representative Henry Hyde, a Republican from Illinois. Id. at 151, 153. For a discussion of the constitutionality of the “Hyde Amendment,” see Harris v. McRae, 448 U.S. 297, 306–27 (1980).

\textsuperscript{29} In 1990, Congress enacted the Patient Self-Determination Act (PSDA), Pub. L. No. 101-508, §§ 4206, 4751, 104 Stat. 1388-115, 1388-204 (1990) (codified at 42 U.S.C. §§ 1395cc(f)(1), 1396a(w) (Supp. V 1993)). The PSDA requires hospitals, long-term care facilities, hospices, home health care agencies, and health maintenance organizations receiving Medicare or Medicaid reimbursement to provide adult patients with written information about their legal rights to accept or refuse medical or surgical treatment and the right to formulate advance directives, such as living wills. 42 U.S.C. §§ 1395cc(f)(1), 1396a(w) (Supp. V 1993).

\textsuperscript{30} See, e.g., Planned Parenthood v. Casey, 112 S. Ct. 2791, 2833 (1992) (affirming the essential holding of Roe v. Wade that the Constitution protects a woman's decision to terminate her pregnancy before fetal viability without undue interference from the state); Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261, 278 (1990) (holding that a competent adult has a constitutionally protected liberty interest in refusing unwanted medical treatment).

\textsuperscript{31} This statement may seem surprising in light of the barrage of news coverage afforded Dr. Jack Kevorkian, the retired Michigan pathologist who, since 1990, has "assisted" in the deaths of more than 20 people. See Top Michigan Court Reinstates Assisted-Suicide Ban, for Now, N.Y. Times, June 8, 1994, at A21 [hereinafter Top Michigan Court]. Further indication of the extensive media coverage of Kevorkian is that a search in LEXIS, News Library, Curnws and Arcnws Files, of the term "Kevorkian" revealed 8745 stories in its data bank as of August 14, 1995. Another physician whose actions and writings brought attention to the question of physician-aid-in-dying is Dr. Timothy Quill, a New York doctor who publicly detailed his role in assisting a 45-year-old leukemia victim to end her life. See Timothy E. Quill, Death and Dignity: A Case of Individualized Decision Making, 324 New Eng. J. Med. 691, 693 (1991) (describing how the doctor prescribed barbiturates for a long-term patient, suspecting that she would use them to end her life). The 1991 Washington, 1992 California, and 1994 Oregon ballot initiatives asking voters to endorse physician-aid-in-dying also raised public consciousness and debate about euthanasia. See supra text accompanying notes 15–20 and accompanying text.

Yet, despite this attention in the news, the subject of physician-aid-in-dying has been the focus of only two appellate court opinions, one in Michigan, People v. Kevorkian, 527 N.W.2d 714, 739 (Mich. 1994) (finding constitutional the State's effort to ban physician-assisted suicide), cert. denied, 115 S. Ct. 1795 (1995), and the other in the Court of Appeals for the Ninth Circuit, Compassion in Dying v.
the apparent intensity of current public interest in physician-
aid-in-dying, few legislators or appellate court judges have
given the practice the kind of high-profile, thoughtful review
 accorded other bioethical issues. There are at least two possi-
bile explanations for this lack of official attention. First, and
particularly in the case of legislators, it may be that, despite
a significant degree of public support,32 lawmakers do not
wish to endorse the cause of voluntary active euthanasia
because they believe that it is not an issue for which a consen-
sus can be negotiated at this time. Second, despite longstand-
ing support and concern for the issue, the modern euthanasia
movement may be perceived to be at a nascent stage where
headway into legislative and judicial changes is still a long
way off.33 In either case, frustration with the lack of progress
in advancing their agenda has caused euthanasia supporters
to take a grass-roots approach to legalizing physician-aid-in-
dying, asking voters to help legalize the practice state by
state. A comparison of the current euthanasia movement with
the development of laws surrounding the rights of patients to
control administration of life-support treatment reveals that
the physician-aid-in-dying movement is unlikely to follow the
same path to state and federal lawmaking that defined the
“right-to-die” movement.

Washington, 49 F.3d 586, 594 (9th Cir.) (reversing a district court opinion holding
such a ban unconstitutional), reh'g granted, 62 F.3d 299 (9th Cir. 1995). In addition,
two trial courts have issued notable opinions concerning physician-assisted suicide.
See Lee v. Oregon, 891 F. Supp. 1439 (D. Or. 1994) (permanently enjoining voter-
approved law allowing physician-assisted suicide); Quill v. Koppell, 870 F. Supp. 78,
85 (S.D.N.Y. 1994) (finding the New York assisted-suicide ban constitutional as
applied to physicians aiding competent, terminally ill adults). As to lawmakers, those
few state legislative bodies that have grappled with the issue have done so only by
way of prohibiting or disfavoring the practice, usually through the state’s patients’
rights laws. See infra note 77.
32. See infra note 111.
33. Currently the most visible organization promoting physician-aid-in-dying is
the National Hemlock Society, formed in 1980. See DEREK HUMPHRY, FINAL EXIT: THE
of 1990, it had a membership of 38,000 in 70 chapters across the country. Id. For a
thorough discussion of the euthanasia movement in the United States, including the
major individual and organizational players, see generally DEREK HUMPHRY & ANN
In his book *The Right to Die*, Henry Glick details the growth of the right to die as a social and political issue. Throughout his book, Professor Glick focuses primarily on the laws and high court opinions that address the rights of patients and their surrogate decisionmakers to make decisions about withholding or withdrawing life-sustaining treatment. This right, which Professor Glick calls the "right to die," has now worked its way into our medicolegal culture, but its entrance into the legal world was probably as much due to the efforts of individuals with a personal stake in the matter as it was due to genuine political interest.

Professor Glick details the path of right-to-die bills in three states: California, Florida, and Massachusetts. The sponsor of each bill was moved by some personal experience to create law giving patients more control over their health care. For example, in California, the first state in the nation to enact a living will law, the state senator who championed the cause did so because he had met the issue several times in his personal life before entering politics. Before he became a California State senator in 1974, Barry Keene had been asked by a neighbor to search for a way to end the neighbor's wife's medical treatment for cancer. Keene tried but was ultimately unable to help his neighbors avoid the nasogastric tube and ventilator support that they wanted withdrawn. Later, in 1972, Keene faced this same dilemma when his mother-in-law developed cancer and faced a similar life-prolonging medical

35. *Id.* at ix.
36. *Id.*
37. Professor Glick explains at the outset of his book that the term, "right to die," can relate to a range of activities, including assisted suicide and active euthanasia. *Id.* at 8. His research, however, focuses primarily on the right to withdraw or withhold treatment. See *id.* at 8–12.
38. *Id.* at 92–132.
40. See *Glick, supra* note 34, at 93–94.
41. *Id.* at 94.
42. *Id.* at 93.
43. *Id.* at 93–94.
regimen.\textsuperscript{44} Although she had signed a medical directive to limit treatment, nothing required her physician or hospital to honor such a request.\textsuperscript{45}

When Keene was elected in 1974, he was appointed to chair the Committee on Health.\textsuperscript{46} Shortly thereafter, he introduced a bill that simply stated that "every person has the right to die without prolongation of life by medical means."\textsuperscript{47} The California Pro-Life Council and the California Catholic Conference immediately opposed the bill, and it was easily defeated.\textsuperscript{48} Over the next two years, Senator Keene worked to build a consensus among supporters and opponents of treatment limitation, ultimately winning the tempered support of the Catholic lobby and the California Medical Association.\textsuperscript{49}

In 1976, Keene introduced a new proposal, this one more modest and specific than the 1974 version.\textsuperscript{50} As the bill was being debated and amended in Sacramento,\textsuperscript{51} an event occurred

\begin{itemize}
\item Id. at 94.
\item Id.
\item Id. Professor Glick describes Senator Keene's meteoric rise to power in California's two-party competitive legislature as follows:

Keene was no ordinary freshman senator. Very early in his legislative career, he and four other newcomers had cast the deciding votes to elect the speaker of the assembly who repaid the favor by appointing the five to chair various legislative committees. Keene chose the Committee on Health and the speaker assured him that Keene's new living will bill would be referred to Keene's committee, and that the issue would receive a hearing and leadership support.

\item Id.
\item Id.
\item See id.
\item Id. at 95. Despite the support of certain religious groups, Senator Keene did not win the support of the California Pro-Life Council. Id. In its view, any government policy that suggested limitations on life-sustaining medical treatment was the "first step on a slippery slope" to active euthanasia and extermination of undesirables. Id. Members of the group demonstrated near Keene's office, hanged him in effigy, and likened him to Adolf Hitler on handbills. Id. According to Glick, "At a committee hearing opponents placed a copy of William Shirer's \textit{Rise and Fall of the Third Reich} on the witness table." Id.
\item See id. at 94-96.
\item The Keene Bill was amended nine times before it was enacted into law. See id. at 97. Professor Glick states that Keene accepted many amendments offered by the California Catholic Conference in exchange for dropping its opposition. See id. at 96-97. These amendments included: making living wills inapplicable to pregnant women; requiring extensive provisions for witnesses; requiring a denunciation of active euthanasia; requiring the certification of two physicians for a diagnosis of terminal illness; establishing the validity of a living will for only five years from the date of signature; and requiring a diagnosed terminally ill person to wait 14 days before making a living will. Id. at 96.
\end{itemize}
that did more than any single bill could do to focus the nation's attention on the rights of patients to withdraw medical treatment. On March 31, 1976, the New Jersey Supreme Court declared that the parents of Karen Quinlan had the right, grounded in both constitutional and common law, to authorize removal of their comatose daughter's respirator. The Quinlan case created a "window of opportunity" for the pending Keene bill to gain easy passage later that year.

A story of personal interest and public focus on the issue of treatment withdrawal also explains Florida's enactment of right-to-die legislation. In 1967, novice state house representative Dr. Walter Sackett, a family physician for several decades before running for office, introduced the first right-to-die measure ever to be placed on any governmental agenda in the United States. The measure would have amended the Florida constitution to include the phrase "the right to die with dignity." Like Senator Keene, Representative Sackett's interest in the issue developed from his personal interactions with patients who were just beginning to experience the downside of modern medical advances. Unlike Keene, however, Sackett did not meet with the same popularity, and his proposal was debated in the Florida House for just one hour before it was voted down. As in California, Florida right-to-die proponents attracted extreme opposition from right-to-life organizations and the Florida Catholic Conference. Despite this intense opposition, Sackett continued to introduce right-to-die bills into the legislature, but none was enacted during his tenure, which ended in 1976.

Various liberal Democratic legislators from southern Florida carried on the Florida legislative drive for right-to-die

53. See Glick, supra note 34, at 98.
54. See id. at 104.
55. Id. at 105.
56. See id.
57. Id.
58. Id. at 106.
59. Id. at 105–09. Representative Sackett was depicted as a "one-issue legislator with photographs in local newspapers showing him napping during legislative sessions." Id. at 109. Nevertheless, his persistence in this unpopular arena kept the right-to-die issue before the Florida government. Professor Glick writes that, "[e]ven though [Sackett's] controversial bills were defeated, and he was the only person in the state visibly supporting legislation, his tenacity attracted media and public attention and kept the issue on the decisional agenda, and, in time, the right to die became official policy." Id.
legislation after Sackett's defeat. The final impetus for enactment of such a law came not from an out-of-state court decision but rather from a series of pronouncements from the Florida appellate courts. In 1980, the Florida Supreme Court became the fourth state supreme court in the nation to hand down a decision involving the right to die. In *Satz v. Perlmutter,* the court held that a competent, terminally ill patient had the right to refuse continued medical treatment. In its opinion, the court demanded that the Legislature act, stating that "[i]t is the type [of] issue which is more suitably addressed in the legislative forum, where fact finding can be less confined and the viewpoints of all interested institutions and disciplines can be presented and synthesized."

Despite this stern judicial warning, it was not until 1984, following another well-publicized court opinion, that the Florida Legislature finally passed its first right-to-die bill. Prior to 1984, sixteen other states had enacted some type of legislation addressing the rights of terminally ill patients to be free of unwanted medical treatment. In 1984 and 1985, an additional nineteen states enacted some type of living will law. This legislative surge in the mid-1980s is most likely

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60. See id.
61. Id.
62. See id. at 110.
63. 379 So. 2d 359 (Fla. 1980).
64. Id. at 360.
65. Id.
66. In 1983, a Florida appellate court held that a legal guardian of an incompetent, comatose, terminally ill patient who has executed a living will could be authorized to remove life-sustaining treatment only after applying to a trial court for authorization and presenting evidence of the patient's intent. John F. Kennedy Memorial Hosp., Inc. v. Bludworth, 432 So. 2d 611, 620 (Fla. Dist. Ct. App. 1983). On May 24, 1984, the Florida Supreme Court reversed the lower court ruling, finding that judicial authorization is not necessary for a patient's custodian to make decisions on behalf of an incompetent patient, regardless of whether the patient had executed a living will. John F. Kennedy Memorial Hosp., Inc. v. Bludworth, 452 So. 2d 921, 926 (Fla. 1984).
67. GLICK, supra note 34, at 112–14; see FLA. STAT. ANN. ch. 765.302–310 (Harrison 1994 & Supp. 1995) (entitled the Life-Prolonging Procedure Act of Florida). Like the first California law, see supra note 39 and accompanying text, the Florida bill reflected compromise provisions intended to win the support, or at least to avoid the opposition, of the Catholic Church. See GLICK, supra note 34, at 112. The Florida Catholic Conference found important "a statement of intent supporting life; a requirement that sustenance (food and hydration) be provided to all patients; application of the law to terminal patients only; language against mercy killing; and nullification of a living will in the case of pregnancy." Id. at 113.
68. See GLICK, supra note 34, at 170.
69. Id. By the mid-1980s another type of right-to-die statute, one creating a durable power of attorney for health care, was beginning to appear in state legislatures.
attributable to the new position taken by the Catholic Church with respect to patients' rights.\footnote{70} In 1984, the National Conference of Catholic Bishops softened its approach to right-to-die legislation,\footnote{71} perhaps in response to numerous state court opinions favoring patients' rights in this area.\footnote{72} As a result of this change on the national level, several state Catholic conferences began drafting legislation instead of opposing it.\footnote{73} What this meant for the right-to-die movement was that its chief opponent was now an ally, albeit a somewhat reluctant and watchful one.\footnote{74}

Given the history and ultimate success of those seeking to give patients more control over the provision and withdrawal of life-sustaining treatment, can euthanasia proponents hope for the same slow but steady progress toward legislative

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\footnote{70}{See GLICK, supra note 34, at 171.}
\footnote{71}{See id. at 171–72.}
\footnote{72}{See, e.g., Bartling v. Superior Court, 209 Cal. Rptr. 220 (Cal. Ct. App. 1984); Barber v. Superior Court, 195 Cal. Rptr. 484 (Cal. Ct. App. 1983); Severns v. Wilmington Medical Ctr., Inc., 421 A.2d 1334 (Del. 1980); John F. Kennedy Memorial Hosp., Inc. v. Bludworth, 452 So. 2d 921 (Fla. 1984); In re L.H.R., 321 S.E.2d 716 (Ga. 1984); In re Spring, 405 N.E.2d 115 (Mass. 1980); In re Torres, 357 N.W.2d 332 (Minn. 1984); In re Storar, 420 N.E.2d 64 (N.Y.), cert. denied, 454 U.S. 858 (1981); Estate of Leach v. Shapiro, 469 N.E.2d 1047 (Ohio Ct. App. 1984); In re Colyer, 660 P.2d 738 (Wash. 1983).}
\footnote{73}{See GLICK, supra note 34, at 171.}
\footnote{74}{The story of the right-to-die movement in Massachusetts, the third jurisdiction Professor Glick discusses, is similar to that observed in Florida. See id. at 120–28. Professor Glick writes:}

One of the early sponsors [of legislation] was motivated by a 1977 court case in his own district involving a brain dead teenager injured in an automobile accident who was being maintained on life-support systems. The county medical examiner had refused to permit [the machines'] removal due to concern for the legal rights of the motorist who had caused the accident.

\footnote{Id. at 120. At the same time, a state supreme court decision, Superintendent of Belchertown State School v. Saikewicz, 370 N.E.2d 417 (Mass. 1977), allowing a state hospital to withhold leukemia treatment from an elderly and severely retarded patient, spurred public interest. See GLICK, supra note 34, at 121. Thereafter, patient rights legislation was introduced during every legislative session, but, because of the Massachusetts Catholic Conference's opposition efforts, it was not until 1990 that Massachusetts had its first right-to-die law, a health care proxy statute. See id. at 120, 126.}
legitimization? In my estimation, the answer is no, not at this time. While it is highly possible that several legislators across the country will encounter a loved one, friend, or constituent who futilely seeks physician-aid-in-dying, it is unlikely that such an experience will spur those lawmakers into fighting for legislative action. Perhaps, in the legislative mind, empowering patients to end their lives is perceived as different from empowering patients to authorize their physicians to end their lives. Transferring instrumentality from patient to physician, seen as logical and practical by some, may cause a reaction in legislators unseen when living will laws were being debated.

For this reason, perhaps euthanasia advocates view patience and persistence with the legislative process as a poor use of their resources and thus have turned to the voters themselves to carry the legalization banner. A review of legislative forays in the euthanasia arena reveals a smattering of bills but no perceptible degree of legislative support. In fact, many state legislatures have enacted legislation banning or disfavoring the practice. It is this legislative unfriendliness

75. A glimpse into the legislative mindset on euthanasia is revealed in the events following the 1985 conviction of Roswell Gilbert, a 76-year-old Florida man who shot his wife to end her suffering from Alzheimer’s Disease and osteoporosis. See Michael Moline, Senator Predicts Legislative Silence on Mercy Killing, UPI, Nov. 5, 1985, available in LEXIS, News Library, Wires File. Shortly after Gilbert’s conviction, Florida State Senator Peter Weinstein, chair of the Senate Judiciary Committee, predicted that despite widespread sympathy for the “mercy killer,” the legislature “will remain silent on euthanasia rather than risk giving any impression it condones the practice.” Id. For a more extensive discussion of the case of Roswell Gilbert, see infra text accompanying notes 128-30.

76. See infra note 105 and accompanying text.

that differentiates the right-to-die movement from the current public caucus supporting voluntary active euthanasia.

B. Legislative Efforts Toward Voluntary Active Euthanasia: A Cause Non-Célèbre

1. A History of Euthanasia Legislation Throughout the Century—Although proposals for laws permitting physicians to withdraw treatment did not reach state legislatures until 1968, the first bill to seek legalization of voluntary euthanasia was introduced in the Ohio legislature in 1906. The bill was to apply to adults of sound mind who were fatally hurt, terminally ill, or suffering from extreme pain without hope of recovery. In such cases, a physician would be permitted to ask the patient in the presence of three witnesses if she wished to die. If the answer was yes, three other physicians would be required to confirm the original prognosis before the patient could be put to death. Although the bill did not emerge from committee, it did begin an uphill, unpopular, and as yet unsuccessful battle for the legalization of physician-aid-dying.

The next effort to legalize euthanasia in the United States came in 1937 with the introduction of a bill in the Nebraska Legislature. The bill was given to a committee, where it

78. See Glick, supra note 34, at 62.
80. Russell, supra note 79, at 61.
81. Id.
82. Id.
83. Messinger, supra note 79, at 189 (citing Russell, supra note 79, at 60–61). A New York Times editorial condemned the bill, calling it "something considerably worse than ignorant folly—something that verges close upon, if not into, the criminal." Id. at 189 n.148 (internal quotation marks omitted).
84. For a discussion of euthanasia legalization efforts in Great Britain, see id. at 190–91.
85. See id. at 191. This bill was modeled after a 1936 British bill called the Voluntary Euthanasia Bill, which permitted adult patients suffering from incurable and
remained.86 One year later, in 1938, the Euthanasia Society of America was formed in New York;87 at the same time, a bill to legalize euthanasia was introduced in the New York Legislature, and it was defeated in 1939.88 New York euthanasia advocates tried again in 1947 with a similar bill, but it too was rejected.89 At that point in our nation’s history, reports of the Nazi practice of euthanasia had a chilling effect on efforts to legalize physician-assisted dying in the United States.90 No further legislative efforts were made until the late 1960s, about the same time that the treatment withdrawal movement began. In 1969, the Voluntary Euthanasia Bill was introduced in the Idaho House of Representatives, seeking legalization of voluntary euthanasia when the patient suffered from an “irremediable condition.”91 This bill was defeated despite its safeguards against abuses.92

Beginning in the early 1970s and continuing until the early 1990s, legislative attempts to legalize euthanasia were overshadowed by the significant effort to pass laws relating to treatment withdrawal.93 In fact, it was not until the mid-1980s, when the Hemlock Society and its founder, Derek Humphry, began working to bolster national support,94 that the legislative...
euthanasia efforts became perceptible. 95 Those efforts took a slightly different turn from previous attempts. Instead of approaching individual legislators, who seemed hostile to the idea of physicians as "agents" of death 96 and who had rarely agreed to present the issue to their legislative colleagues, supporters turned to those believed to be in the best position to enact laws legalizing euthanasia: the voters themselves. 97

Armed with public opinion polls that showed growing support for the right to voluntary active euthanasia, 98 leaders in the national Hemlock Society and individual state organizations in Washington and California sought to harness this public approval in these direct democracy states. The Hemlock Society and its sister organizations worked to place the issue of doctor aid-in-dying on those states' electoral agendas. Although they were successful in placing the issue before the voters in Washington in 1991 and in California in 1992, neither initiative received enough votes to become law. 99 To date, no state has successfully passed a law legalizing voluntary active euthanasia. 100

In comparing the path traveled by proponents of euthanasia with that of living-will advocates, what emerges is not so much a picture of divergence but an image of a single purpose in which success in the latter arena was propelled by attention to the former. Withdrawal of treatment legislation is a by-product of euthanasia legislation efforts developed in the context of a dramatically enhanced technological era. The fact that the first euthanasia bill appeared in this country some

95. See supra text accompanying notes 14–20.
96. The negative image of a physician as an agent of death (as opposed to a positive image of a physician using learned skills to end a patient's suffering) has often been invoked by euthanasia opponents. See, e.g., Daniel Callahan, Can We Return Death to Disease?, HASTINGS CENTER REP. (Supp.), Jan.–Feb. 1989, at 4, 6 (arguing that a physician's historical and social role has been to cure and comfort patients, never to end life).
98. See infra note 111.
99. See supra notes 16, 18.
100. As noted previously, on November 8, 1994, Oregon voters approved Initiative Measure 16, the Oregon Death with Dignity Act, a ballot proposition authorizing physician-assisted suicide. See supra notes 19–20 and accompanying text. The Oregon measure, unlike the Washington and California initiatives, did not authorize physicians to administer a lethal dose of medication to a dying patient, i.e. to euthanize the patient. See Egan, supra note 20, at B14. Instead, Measure 16 merely authorized physicians to prescribe medication for their terminally ill patients to self-administer. Id. Although this law passed, it has been permanently enjoined. Lee v. Oregon, 891 F. Supp. 1439 (D. Or. 1995).
thirty years before the first treatment withdrawal bill illustrates that, until the 1960s, our society had no need for retreat from life-sustaining treatment because virtually none was available. Treatment that seems so common today, such as respirators and the provision of nutrition and hydration through artificial tubes, simply was not standard care until well into the 1970s. It was not until patients began to linger in what Justice Brennan called the “twilight zone” that the need for treatment withdrawal legislation became apparent.

This analysis of the legislative activity surrounding euthanasia as a long-term movement with recent derivative success raises questions about the future of legislative activity in this area. Will euthanasia supporters be encouraged by the successes of the right-to-die movement, or will those successes highlight the legislative failings of the current movement? My own observations lead me to conclude that proponents will move away from state legislatures for changes in the law and will look increasingly toward two other groups: voters who can enact physician-aid-in-dying legislation and judges who can rule on the legality of statutes currently making the practice of euthanasia unlawful. To support this conclusion, I offer the following evidence of recent legislative and judicial activity in the euthanasia arena.

2. Recent Legislative Activity Surrounding Euthanasia
Since Jack Kevorkian and Timothy Quill raised the practice of physician-aid-in-dying to the level of a national controversy, surprisingly little formal legislative debate has focused on the

101. See supra notes 78–79 and accompanying text.
102. See Office of Technology Assessment, U.S. Congress, Life-Sustaining Technologies and the Elderly 209, 275 (1987). The impact that these two types of medical advances have had on medical jurisprudence is evidenced by the fact that almost every “right-to-die” case brought before an appellate court in this country has involved withdrawal of a respirator or artificial food and hydration. See Glick, supra note 34, at 143–45. Interestingly, only a few of the early patients’ rights cases involved withholding of treatment, see, e.g., Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 435 (Mass. 1977) (withholding chemotherapy from retarded adult patient), but in the past several years a majority of treatment-related cases have focused on withdrawal of life-sustaining treatment, see, e.g., Cruzan v. Director, Mo. Dep’t of Health, 497 U.S. 261, 270–78 (1990) (discussing state cases dealing with termination of life-sustaining treatment). What this legal landscape may show is that, as more patients, physicians, and hospitals learn about the right to refuse treatment, less conflict arises over this issue. Proponents of the right to refuse life-sustaining treatment can only hope that the substantial litigation surrounding withdrawal of treatment will more firmly establish it as an unquestioned patient right.
103. Cruzan, 497 U.S. at 301 (Brennan, J., dissenting).
104. See supra note 31.
As of June 1994, seven states had introduced bills to legalize some form of physician-aid-in-dying. None of the bills has become law. In contrast, several states have recently enacted laws to ensure that any physician's attempt to aid dying patients in achieving an earlier death will be considered a violation of law.

Lackluster legislative support for voluntary euthanasia, particularly apparent when compared with the flurry of activity in state houses across the country following the decision of In re Quinlan, likely can be attributed to legislative ambivalence or timidity in this area. Anecdotal evidence suggests

105. The seven states are Hawaii, Iowa, Maine, Michigan, New Hampshire, Oregon, and Vermont. See S.F. 2066, 74th Leg., 2d Sess. (Iowa 1992) (introduced by Senator Sturgeon in early 1992 and allowing a physician to provide voluntary assistance in dying if a patient is mentally competent and suffering a terminal condition); S.P. 453, 116th Leg., 1st Reg. Sess. (Me. 1993) (introduced by Senator Cahill in 1992 and 1993 and providing for medically assisted death for terminal competent adult patients likely to die within a short period of time); H.R. 5415, 86th Leg., Reg. Sess. (Mich. 1991) (introduced by Representative Wallace in 1991 and providing a process for requesting and authorizing, or refusing, aid-in-dying); H.B. 395, 153d Leg., Reg. Sess. (N.H. 1993) (introduced by Representative Guest in 1993 and permitting a terminally ill patient with an irreversible illness to request from his doctor medication which the patient would self-administer); S.B. 1141, 66th Leg., Reg. Sess. (Or. 1991) (introduced by Senator Roberts and allowing a competent adult to request physician assistance in ending her life if she is suffering an illness that would cause death in six months); H. 470, 62d Leg., 1st Sess. (Vt. 1993) (introduced by Representative Corren and others and allowing physicians to assist patients in committing suicide). Apparently, Hawaii Assemblywoman Joan Hayes has introduced a bill that would amend the Hawaii living will act to permit people to agree in advance to aid-in-dying if they are terminally ill. See Parachini, supra note 15, pt. V, at 1.

106. See, e.g., ILL. ANN. STAT. ch. 720, para. 5/12–31 (Smith-Hurd Supp. 1995) (amending the crime of "inducement to commit suicide" to include assisted suicide when a person either intentionally offers and provides the means or commits a physical act that enables another to commit suicide); IND. CODE ANN. § 35-42-1-2.5 (West Supp. 1995) (creating the felony of assisting suicide); MICH. COMP. LAWS ANN. § 752.1027 (West Supp. 1995) (creating the offense of assisting suicide and amending related provisions). By its own terms, the Michigan law was to expire six months after the State Commission on Death and Dying made a recommendation to the Legislature. Id. § 752.1027(5). The Commission was originally slated to issue its report in May 1994. See Top Michigan Court, supra note 31, at A21. Although the Commission failed to reach a consensus on the topic of physician-assisted suicide, see Michigan Senate Moves to Ban Assisted Suicides, WASH. POST, Dec. 8, 1994, at A12, the Michigan Supreme Court declared assisted suicide a crime even in the absence of a specific statute banning the act. People v. Kevorkian, 527 N.W.2d 714, 738–39 (Mich. 1994), cert. denied, 115 S. Ct. 1795 (1995).

107. 355 A.2d 647 (N.J.), cert. denied, 429 U.S. 922 (1976). As noted previously, in the first three years following the activities of Dr. Kevorkian and Dr. Quill, no legislature successfully passed a law legalizing or decriminalizing physician-assisted suicide. See supra note 31. In contrast, in the three years following Quinlan, ten states enacted some type of treatment withdrawal legislation. See GLICK, supra note 34, at 170.
that, even when legislators favor legalizing voluntary euthanasia, they are unlikely to introduce such a bill. For example, during 1992 hearings before the Iowa Legislature, Dr. John G. Westover, President of the National Hemlock Society, testified as follows: “Several years ago, Mr. Willie Brown, Speaker of the California Assembly, admonished an audience against seeking a Humane and Dignified Death Act through a ballot initiative instead of through the Assembly. Still, while he favored personal autonomy, he would not introduce a medical aid-in-dying bill.”108

Speaker Brown’s reluctance is shared by lawmakers across the country for a variety of possible reasons, ranging from concern about constituent reaction to influence by organized opposition groups. In fact, the same groups that once opposed living will legislation have redoubled their efforts to fight physician-aid-in-dying.109 In addition, the pro-life groups that once focused exclusively on opposing abortion rights have

108. Prepared testimony of Dr. John G. Westover, President, National Hemlock Society, Iowa Legislative Hearing on Senate Bill 2066, at 2 (Feb. 25, 1992) (on file with the University of Michigan Journal of Law Reform). Other supporters of right-to-die legislation have been unwilling to sponsor bills relating to physician-aid-in-dying. Senator Barry Keene, noted for having pursued the first living will statute in the nation, declined to include aid-in-dying language to a 1986 bill aimed at amending the 1976 California Natural Death Act. See GLICK, supra note 34, at 103. Reportedly, Keene felt that any proposal that called for physician-aid-in-dying was “too controversial and politically risky to stand any chance of getting through the Legislature.” Parachini, supra note 15, at 10; see also supra note 75 (describing the Florida Legislature’s unwillingness to sponsor euthanasia legislation, despite its sympathy for those involved in a recent mercy killing situation).

mobilized a campaign against euthanasia.¹¹⁰ No doubt these powerful interest groups have been successful in discouraging lawmakers from supporting the controversial practice of euthanasia, much as they initially discouraged support for patients' rights to withdraw life-sustaining treatment.

Even in light of visible opposition to physician-aid-in-dying, legislative inaction is still somewhat surprising given that public opinion favors giving patients the right to choose an accelerated death. Polls taken within the past several years consistently show at least sixty percent of those responding favor allowing physicians to assist their dying patients who choose to control the timing of their deaths.¹¹¹ For example, a 1992 article appearing in the Journal of the American Medical Association stated that, based on polling, sixty-four percent of Americans believed that physicians should be allowed by law to respond to a patient's request for lethal drugs or injections to aid dying if the patient is terminally ill, conscious, and in pain.¹¹² Perhaps this swell of public support has convinced euthanasia advocates that the place to make real change is in

¹¹⁰. See, e.g., Roger Mahony, Ending Pain Shouldn't Mean Ending Lives, L.A. TIMES, May 9, 1994, at B7 (opposing physician-aid-in-dying and writing that “Christians, in particular, believe that loving acceptance of suffering can lead to enormous personal growth”). Cardinal Roger Mahony, the writer of this editorial, is archbishop of Los Angeles and chairman of the United States Catholic Bishops' Committee for Pro-Life Activities. Id.

¹¹¹. For example, a 1990 Gallup Poll asked: “When a person has a disease that cannot be cured, do you think doctors should be allowed by law to end the patient’s life by some painless means if the patient and his family request it?” GLICK, supra note 34, at 83. Sixty-nine percent of respondents answered affirmatively. Id. at 84. A 1990 Roper Poll asked: “When a person has a painful and distressing terminal disease, do you think doctors should or should not be allowed by law to end the patient’s life if there is no hope of recovery and the patient requests it?” Don C. Shaw, Reflection, in CHOOSING DEATH: ACTIVE EUTHANASIA, RELIGION, AND THE PUBLIC DEBATE 128, 129 (Ron P. Hamel ed., 1991). Sixty-four percent of the respondents said “yes,” 24% said “no,” and 13% did not know. Id.

Polls taken during the statewide campaigns in Washington in 1991 and in California in 1992 also showed strong support for the concept (and presumably the practice) of voluntary euthanasia, at least until the final days before the election. See infra notes 182–84 and accompanying text; see also Schanker, supra note 79, at 980 (reporting that California voters favored Proposition 161 until just before the election); Peter Steinfels, Beliefs, N.Y. TIMES, Nov. 9, 1991, at L11 (analyzing Washington voters' shift in views from favoring to opposing the initiative).

¹¹². Robert J. Blendon et al., Should Physicians Aid Their Patients in Dying?, 267 JAMA 2658, 2659 (1992). In addition to general polling, a group of researchers recently conducted a poll of Washington state physicians' attitudes toward physician-aid-in-dying. See Cohen et al., supra note 18, at 89. The researchers found that 53% of those physicians responding to a written survey thought that euthanasia should be legal in some circumstances. Id. at 90.
the voting booth and not through traditional legislative channels. In other words, even where public opinion would support legislative efforts to legalize euthanasia, few such efforts have gone forward. When efforts toward legalization have gone forward, they generally have been met with opposing efforts. In Michigan, for example, a state at the center of the euthanasia debate because of the actions of Dr. Kevorkian, legislation has been introduced both favoring and banning physician-assisted aid-in-dying.\footnote{See supra notes 105-06 and accompanying text.} Despite, or perhaps because of, this legislative activity, in 1994 euthanasia supporters in Michigan began gathering voter signatures to place a physician-assisted suicide constitutional amendment referendum on the November ballot.\footnote{See Top Michigan Court, supra note 31, at A21. The Michigan effort needed 256,741 signatures by July 11, 1994; as of June 8, 1994, more than half that number had been collected. Id. In the end, however, supporters were unable to gather the requisite signatures. See Kevorkian Referendum Drive Fails, Closes, CHI. TRIB., July 12, 1994, available in LEXIS, News Library, Curnws File (reporting that Dr. Kevorkian's lawyer, Geoffrey Fieger, plans to finance personally the petition drive for the 1996 ballot).} In Colorado, a group called Colorado Citizens for Peaceful Death is seeking passage of a law similar to Oregon's Measure 16.\footnote{See Clifford D. May, Doctor-Assisted Death: Is Assisted Suicide a Right That Should Be Available to Dying Individuals?, ROCKY MTN. NEWS, Jan. 15, 1995, at 91A. For a description of the California efforts, see supra notes 15-17 and accompanying text.}

The recent flurry of grass-roots activity is likely a signal that supporters of voluntary active euthanasia have resorted to making positive law voter-by-voter, state-by-state.\footnote{One major shortcoming of this strategy is that voter lawmaking is available in less than half of the states in this country, meaning that supporters must look to the legislatures in the remaining states. For a more detailed discussion of this issue, see infra Part III.A.} Both positive and negative forces have influenced the move toward voter-made law. The principal negative force is the fact that supporters have been essentially shunned by representative lawmakers who sense opposition from constituents or influential lobby groups.\footnote{See supra text accompanying notes 75, 109.} But supporters also have been motivated by a sense that death choices, like life choices, are intensely personal and should be made on an individual basis.\footnote{See, e.g., Letter from Michael H. White, President, Death with Dignity, to the author (Dec. 26, 1994) (soliciting funds for his group and emphasizing right to make personal, individual choice in dying) (on file with the University of Michigan Journal of Law Reform).} The
movement itself has survived because of the efforts of individual members who have strived to establish choice-in-dying for themselves and others.\textsuperscript{119} This quest for personal choice is evident in both the practice and legalization of physician-aid-in-dying; in each instance, there is a perceived need for individual participation.

In predicting the future strategies of euthanasia supporters, one must analyze the recent events surrounding the enactment of the nation’s first law authorizing physician-assisted suicide. Although Oregon voters were able to pass, by a bare majority, a statute assuring some choice in dying, a federal court in that state has enjoined the statute’s implementation.\textsuperscript{120} This judicial block certainly will give pause to supporters in other states who may perceive their organizing efforts to be in vain if citizen approval does not assure a change in current law. Perhaps the Oregon experience is best viewed as a testing ground for voter-made law in this area. If the law ultimately fails to pass constitutional muster, then direct democracy becomes a toothless tiger in this respect. Under those circumstances, supporters will likely shift their efforts to gain judicial approval of some form of physician-aid-in-dying under current law.\textsuperscript{121}

\textbf{C. Euthanasia and the Courts: A Model of Erraticism and Ambivalence}

Voluntary active euthanasia is illegal in every state in this country.\textsuperscript{122} Thus, doctors who cause the death of a patient, even at the patient’s request, can be prosecuted for homicide.\textsuperscript{123}

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\textsuperscript{119} The principal founder of the National Hemlock Society, Derek Humphry, describes the group’s mission as follows: “Hemlock publishes newsletters and books, holds conferences, conducts research, makes educational videos, and calls public meetings, all with the intention of raising consciousness about the right of terminally ill persons to choose to die in a manner of their choice.” Humphry, supra note 33, at 180.
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\textsuperscript{120} See supra note 20.
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\textsuperscript{121} To some extent, this shift has already occurred as courts in three states have considered constitutional challenges to bans on assisted suicide as they apply to physicians and terminally ill patients. See infra note 135.
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\textsuperscript{123} Generally, consent by the victim is not a defense in a criminal prosecution. 1 Wayne R. Lafave & Austin W. Scott, Jr., Substantive Criminal Law § 5.11(a) (2d ed. 1986).
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Moreover, physicians who assist in a patient’s self-inflicted death can be prosecuted for assisting in a suicide, a criminal offense in thirty-one states. Despite the apparent clarity of the criminal law, in this century individuals who have engaged in “mercy killing” have seen our judicial system respond in an erratic and ambivalent manner.

A review of “mercy killing” cases reveals that juries and sentencing judges tend to be more lenient on defendants who are physicians, regardless of whether they participated in the death of a patient or a member of their own family. To date, eleven physicians have faced criminal charges in connection with the killing of a patient or family member, but none has been imprisoned. In contrast, several nonphysicians who

124. For a list of the state statutes that prohibit assisted suicide, see Schanker, supra note 79, at 983 n.31.

125. The term “mercy killing” is often used interchangeably with the word “euthanasia.” See, e.g., BLACK’S LAW DICTIONARY 988 (6th ed. 1990) (defining “mercy killing” as “euthanasia [or] the affirmative act of bringing about immediate death allegedly in a painless way and generally administered by one who thinks that the dying person wishes to die because of a terminal or hopeless disease or condition”).

126. By the term “imprisoned,” I am referring to serving time in prison following conviction or plea in a matter relating to the killing of a patient or relative. Imprisonment can be contrasted with incarceration, in which a defendant will spend time in jail awaiting the disposition of his case. Defendant physicians facing mercy killing charges have been incarcerated. For example, Dr. Jack Kevorkian was twice jailed on charges of violating Michigan’s newly enacted assisted-suicide law. Judy Pasternak, Kevorkian’s Assisted-Suicide Trial Opens, L.A. TIMES, Apr. 20, 1994, at A20. In both instances, Dr. Kevorkian staged hunger strikes in protest of the ban on assisted suicide. Id. In November 1993, during one of Dr. Kevorkian’s hunger strikes in jail, Jack DeMoss, a Michigan attorney, posted a $2000 bond to release the physician and end Kevorkian’s supposedly “faked hunger strike.” Kevorkian Faces Hearing, ATLANTA J. & CONST., Apr. 1, 1994, at A7. In April 1994, DeMoss filed a motion seeking to revoke Kevorkian’s bond, saying, “I want to see him back in jail because I think he is a menace to society.” Id.

For a discussion of the 11 cases of physician prosecution, see Schanker, supra note 79, at 986 n.41. In his article, Schanker describes the scenarios surrounding the various physician mercy killing cases, including the first widely publicized case involving Dr. Herman Sander, a New Hampshire general practitioner who injected air into the vein of a comatose cancer patient sometime in 1949. Id. at 986. The jury acquitted Dr. Sander after an outpouring of public support and denouncement from religious groups. Id. Other cases include a 1973 case in which Dr. Vincent Montemarano, chief surgical resident at the Nassau County Medical Center in New York, gave a 57-year-old throat cancer victim a fatal injection of potassium chloride and was subsequently indicted for murder. Id. The jury deliberated for only 55 minutes before returning a not guilty verdict. Id. Dr. Donald Caraccio, a Michigan physician, lethally injected a comatose 74-year-old woman; he pleaded guilty to the murder and received only five years probation with community service. Id. at 986 n.41. Cases that involve physicians’ family members include Dr. Harold Blazer, who killed his daughter, a victim of cerebral spinal meningitis, in 1935 and was later acquitted at trial. Id. Another physician/family member case involved Dr. Peter Rosier of Florida, who was
participated in the death of a loved one have served time in prison. One such defendant, Roswell Gilbert, received national attention in 1985 when he shot his wife of fifty-one years, who suffered from Alzheimer's disease and osteoporosis. Mr. Gilbert was convicted of premeditated murder and sentenced to life imprisonment. On August 2, 1990, Florida Governor Bob Martinez pardoned Gilbert, who was then eighty-one and in failing health.

In searching for a rationale to explain why physicians and not family members who euthanize their loved ones are more often acquitted by juries or treated leniently by judges, one might look to the public perception of physicians in our society. Judges as well as juries may perceive that a physician's participation in killing a suffering patient, whether family member or stranger, is merely an extension of the doctor's ability to abate suffering. Clearly doctors are trained to treat illness for the purpose of ending suffering; when illness can no longer be treated and yet suffering persists, some may find it logical for doctors to be the appropriate agents in ending a person's suffering, even if that means ending her life. Family members, on the other hand, possess no specialized training in medicine or caring for the dying; juries may be more comfortable with their roles as participants in the bedside vigil than in the death of their loved one.

acquitted after a failed attempt to end the life of his cancer-stricken wife. See STANLEY M. ROSENBLATT, MURDER OF MERCY: EUTHANASIA ON TRIAL 7-9 (1992) (Dr. Rosier's lawyer's account of the events surrounding the physician's prosecution).

Between 1920 and 1985, 51 "mercy killing" cases were brought to trial in criminal courts; out of those 51, 10 defendants were found guilty of criminal homicide and imprisoned. HUMPHRY & WICKETT, supra note 33, at 219.

Poll on Mercy-Killing Supports Full Pardon, CHI. TRIB., Aug. 15, 1985, at C30 (reporting the results of statewide poll in Florida, favoring a pardon for Gilbert); Poll: 63% Favor Gilbert Pardon, MIAMI HERALD, Aug. 12, 1985, at 1A.

See Gilbert v. State, 487 So. 2d 1185, 1187 (Fla. Dist. Ct. App. 1986). Under Florida law, Gilbert's conviction carried a mandatory minimum sentence of 25 years, meaning that he would be 100 years old before being eligible for release. Id. The appellate court affirmed Gilbert's conviction and, while showing sympathy for the elderly prisoner, noted that Florida law allowed no distinctions in the sentencing of different kinds of wrongdoers, whether they are hired gangsters or kill for love or mercy. Id. at 1192. Any such distinctions, the court concluded, "must be decided by the legislature and not by the judicial branch." Id.


But see Norman J. Finkel et al., Right to Die, Euthanasia, and Community Sentiment: Crossing the Public/Private Boundary, 17 LAW & HUM. BEHAV. 487, 495 (1993) (describing a study that found juries in mock euthanasia trials willing to convict a defendant husband of first degree murder of his terminally ill wife only
While it may be difficult to discern jury or even community sentiment surrounding euthanasia, it is not difficult to see that even the most compelling scenarios have failed to rally the courts around the issue of voluntary euthanasia the way that *In re Quinlan*\(^\text{132}\) prompted court after court to consider withdrawal of treatment cases. In the ten years following *Quinlan*, appellate courts in seventeen states issued decisions relating to a patient's right to refuse or withdraw treatment, and since then courts in thirteen other states have added to the jurisprudence of treatment withdrawal.\(^\text{133}\) Moreover, in 1990, the United States Supreme Court decided its first right-to-die case.\(^\text{134}\)

In contrast, little jurisprudence exists on the issue of euthanasia, despite public interest over the issue and the individuals whose cases have come to the attention of judges.\(^\text{135}\) Perhaps the most obvious explanation for the lack of euthanasia jurisprudence comes from the court that upheld Roswell Gilbert's first degree murder conviction. In affirming the trial court's decision not to instruct the jury on euthanasia, the appellate court explained that "[t]he judge denied this

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35.9% of the time); *infra* note 139 (discussing Dr. Quill's dismissal from all charges by a jury in Rochester, New York).


133. For a list of all right-to-die cases, see 1 MEISEL, *supra* note 26, § 1.7 tbl. 1-1.


135. To date, courts in three states have ruled on the constitutionality of state laws banning assisted suicide. In 1994, a federal judge in Washington held unconstitutional the state's ban on assisting a mentally competent adult to commit suicide. *Compassion in Dying v. Washington*, 850 F. Supp. 1454, 1467 (W.D. Wash. 1994). The United States Court of Appeals for the Ninth Circuit reversed Judge Rothstein's ruling, thereby upholding the validity of the Washington statute as applied to terminally ill patients and their physicians. *Compassion in Dying v. Washington*, 49 F.3d 586, 594 (9th Cir.), *reh'g granted*, 62 F.3d 299 (9th Cir. 1995). In Michigan, the state supreme court held that the United States Constitution does not prohibit the state from imposing criminal penalties on an individual who assists another in committing suicide. *People v. Kevorkian*, 527 N.W.2d 714, 739 (Mich. 1994), *cert. denied*, 115 S. Ct. 1795 (1995). Finally, a federal judge in New York ruled that the state's assisted suicide ban is constitutional insofar as the statute bars physicians from assisting in their terminally ill patients' suicides. *Quill v. Koppell*, 870 F. Supp. 78, 85 (S.D.N.Y. 1994). Although these cases may serve as the springboard for further judicial focus on the issue of assisted suicide, they cannot be said to signal judicial interest in voluntary active euthanasia that includes physician participation, beyond mere prescription, in a patient's death. For further discussion of *Compassion in Dying v. Washington*, see *infra* text accompanying notes 200–18.
instruction because there was no supporting evidence.”136 At trial, however, Gilbert did testify as to his motive for killing his wife,137 evidence that reasonably could be considered supportive of a defense based on euthanasia.

What Gilbert teaches is that, at present, courts are simply unwilling—or perhaps, as the case suggests, unable—to consider killing to end suffering as anything but murder. With this message reverberating across the country, doctors are wise to heed the court's stern warning that any action taken to accelerate138 a patient's death, even if taken at the patient's request, will be met with the full force of the law.139 What this message says to euthanasia advocates is that changes in the law will likely not come from the courts, which in the past have been activists for patients' rights.140 A strong indication of the lack of judicial support came when the Supreme Court of Michigan held that Dr. Kevorkian could be prosecuted for a common-law felony for assisting two women in committing suicide.141 In People v. Kevorkian, the court held that, even absent a specific statutory prohibition of assisted suicide, one who participates in a suicide but has not done the final act causing death may be prosecuted under the felony savings

136. Gilbert v. State, 487 So. 2d 1185, 1190 (Fla. Dist. Ct. App.), review denied, 494 So. 2d 1150 (Fla. 1986). The defendant's requested instruction was to advise the jury that euthanasia is defined as “[t]he act or practice of painlessly putting to death persons suffering from incurable and distressing disease as an act of mercy.” Id.

137. Id. at 1187 (reporting that at trial Gilbert testified on direct examination: “I've got to end her suffering, this can't go on.”).


139. See Gilbert, 487 So. 2d at 1192. But cf. infra text accompanying notes 273–75 (discussing the percentage of physicians who have admitted to helping a terminal patient die). Furthermore, in a ruling that could signal a modern trend, a grand jury in Rochester, New York, declined to indict Dr. Timothy Quill for his role in helping a leukemia patient commit suicide by drug overdose. See Lawrence K. Altman, Jury Declines to Indict a Doctor Who Said He Aided in a Suicide, N.Y. TIMES, July 27, 1991, at 1. At a later hearing by the New York Board for Professional Medical Conduct, convened to assess whether Dr. Quill’s actions amounted to misconduct, the board cleared the doctor of all charges, saying that his actions were “legal and ethically appropriate.” Doctor Who Aided Suicide Cleared of Misconduct, L.A. TIMES, Aug. 18, 1991, at A32 (internal quotation marks omitted).

140. See supra text accompanying notes 62–68 (describing how the Florida appellate courts prompted the Legislature to act in the patients' rights arena).

141. People v. Kevorkian, 527 N.W.2d 714, 733 (Mich. 1994) (holding that the conduct was prohibited despite the fact that the deaths occurred before the enactment of Michigan's ban on assisted suicide), cert. denied, 115 S. Ct. 1795 (1995).
Proponents of euthanasia have only to look at the events in Michigan to see that their strength lies in the individuals who support their cause, not in government institutions unwilling to begin a dialogue on this topic.

Having met with disinterest, suspicion, and hostility, euthanasia supporters are beginning to turn away from traditional paths to legal legitimization and are looking instead to convert grass-roots support into state-by-state legalization. Whether these efforts will be successful remains to be seen, but some predictive value can be placed in a comparison of citizen attempts to institute physician-aid-in-dying through direct and representative democratic channels. A review of the goals and realities of direct democracy reveals that initiatives may not serve proponents of choice-in-dying any better than traditional methods.

II. TRANSLATING POPULAR SUPPORT INTO LAW:
THE IMPERFECTIONS OF DIRECT DEMOCRACY

Proponents of controversial causes face substantial challenges as they fight to convert an idea into enacted law. Certainly advocates for legalized euthanasia have encountered the reality of legislative roadblocks, despite popular support for the notion of freedom of choice in dying. As noted earlier, euthanasia proponents in two states, Washington and California, have turned their uphill legislative battle into a campaign waged as a voter initiative in a statewide election. Although both Washington Initiative 119, in 1991, and California Proposition 161, in 1992, failed to win a majority of voter support, backers will likely continue to seek legalization at the voter level. There are a variety of reasons for this strategy.

142. Id. at 739. The Michigan felony savings clause provides that "[a]ny person who shall commit any indictable offense at the common law, for the punishment of which no provision is expressly made by any statute of this state, shall be guilty of a felony." MICH. COMP. LAWS ANN. § 750.505 (West 1991). The court held that assisting in a suicide would have been an indictable offense at common law. *Kevorkian*, 527 N.W.2d at 738. On May 2, 1994, Dr. Kevorkian was tried and acquitted of assisting in the suicide of Thomas Hyde. See Judy Pasternak, *Kevorkian Is Acquitted for Role in Suicide*, L.A. TIMES, May 3, 1994, at A1, A17. The charges in the Hyde case were brought under Michigan's assisted-suicide ban, enacted in February 1993. *Id.* at A1.

143. *See supra* note 111.

144. *See supra* text accompanying notes 15–18.
The most likely and logical explanation for continued focus on the ballot process is the perceived voter support, and concomitant legislative nonsupport, for the concept of voluntary euthanasia. Euthanasia advocates might also subscribe to the claim of other champions of populist democracy that voter-made lawmaking is inherently more beneficial to a reform movement than its representative counterpart. The espoused benefits of direct democracy include the following: (1) direct legislation promotes government responsiveness and accountability—the people will have an alternative path to lawmaking if lawmakers refuse to follow their wishes; (2) the initiative process is less dominated by special interest groups; (3) voter lawmaking produces open, educational debate on critical issues; (4) direct democracy interests voters, thereby increasing election day turnout; and (5) voter initiatives are needed because legislators often evade difficult issues, instead opting for a low-risk, status quo position that helps them stay in office.145

These perceived benefits of direct democracy are best understood in a historical light. A brief look at the history and development of the voter initiative reveals that the lofty goals set out by turn-of-the-century reformers may not be realistic today.146 Moreover, contemporary legal and political scholars are divided on whether direct legislation offers any advantages over legislative lawmaking.147 Once the interworkings of our current initiative process are examined, one can better analyze the role that direct democracy has and can play in the bioethics arena.

145. See CRONIN, supra note 6, at 10-11. Professor Cronin also summarizes the criticism of direct democracy. Id. at 11. He writes that direct democracy opponents have less faith in the ordinary citizen, thinking that she is not capable of making sound judgments about complex matters and that, instead, she will be influenced by television advertisements and bumper sticker messages, thus playing into the hands of high-spending special interests. Id. For a thorough analysis of the benefits and burdens of direct democracy, see generally MAGLEY, supra note 11, at 181-88 (contrasting the different ends and values of direct and indirect forms of democracy).
146. See infra Part II.A.
147. See infra Part II.B.
A. The History of Direct Democracy: Liberating Government from Internal and External Corruption

The debate over the role of citizen lawmaking in the United States traces its roots back to the founding of the nation. Americans of the Revolutionary era faced myriad challenges in translating an array of strongly held beliefs about the role and power of government into a workable design that would win approval from a majority of citizens. James Madison was a central participant in this exercise. In his writings, Madison showed a strong preference for limiting direct public participation in national politics, writing in *The Federalist No. 10* that “the public voice, pronounced by the representatives of the people, will be more consonant to the public good than if pronounced by the people themselves, convened for the purpose.” Concerned about overriding or ignoring those outside the mainstream, Madison warned that, “[i]f a majority be united by a common interest, the rights of the minority will be insecure.”

Despite Madison’s reservations about direct democracy, citizen lawmaking, albeit in limited form, persisted in the United States throughout the late eighteenth and nineteenth centuries. Though the Constitution did not provide for direct...
voter lawmaking, individual states adopted mechanisms for citizen participation in the enactment of state law. For example, Massachusetts allowed its citizens to vote on a new state constitution in 1778, 153 and by 1831 nearly every state entering the union submitted their constitutions to popular vote. 154 In the latter part of the nineteenth century, however, states increasingly abandoned methods of direct citizen lawmaking and relied on more representative forms of government. 155

Interest in direct democracy resurfaced with the Progressive movement of the early twentieth century. 156 At that time, the country was experiencing massive industrialization, urbanization, and immigration. Citizen distrust of representative democracy was on the rise as special corporate interest groups and political party bosses began to wield increasing influence in government. 157 The Progressives promoted direct democracy as a way of neutralizing these corrupting forces while at the same time restoring more power to the people. 158 They touted the initiative, referendum, and recall as ways of liberating the legislative process from internal and external corruption by bringing the people directly into lawmaking. 159 Moreover, Progressives believed that direct democracy would serve an

153. See DEMOCRACY BY INITIATIVE, supra note 6, at 35.
154. See id.; see also CRONIN, supra note 6, at 41 (noting that, by the end of the nineteenth century, all but a handful of states had constitutions that had been approved by popular referendum).
155. See DEMOCRACY BY INITIATIVE, supra note 6, at 35.
156. Id.
157. In California, for example, the Southern Pacific Railroad entered the 1900s with its economic and political power unchallenged. See id. at 37. The corporation had developed a strong affiliation with the state's ruling Republican Party and was labeled the "octopus" in Frank Norris's book of the same name. See id. at 37 & n.17. Norris described the Southern Pacific Railroad as controlling even the ballot box. Id.
158. See CRONIN, supra note 6, at 54-56 ("Progressives were . . . concerned that state legislatures were not functioning as they should. Their proceedings involved too much secrecy, too little discussion, too much automatic passage of what legislative committees proposed.").
159. Id. at 56. One scholar analogizes the political reforms of the early twentieth century to coinciding economic reforms as follows:

Much as antitrust law was designed to break the economic power of these combinations and restore free competition, the initiative, with the allied reforms of the direct primary, the popular election of Senators, the referendum, and the recall, was intended to break the stranglehold these combinations had on the political process by bringing the people directly into lawmaking.

Briffault, supra note 11, at 1348 (citing RICHARD HOFSTADTER, THE AGE OF REFORM: FROM BRYAN TO F.D.R. 254-69 (1961)). For distinctions between initiative, referendum, and recall, see CRONIN, supra note 6, at 2.
educational and social function, prompting discussion and debate among citizen lawmakers.\textsuperscript{160}

In 1898, South Dakota became the first state to adopt direct democracy in the form of the initiative and referendum.\textsuperscript{161} Over the next twenty years, twenty-one additional states joined in adopting some form of direct voter lawmaking.\textsuperscript{162} To date, twenty-six states authorize voters to initiate legislation or to demand the referral of legislative enactments for approval or rejection.\textsuperscript{163} Of these twenty-six, twenty-one states have initiative provisions, allowing citizens to circulate and enact ordinary legislation by placing an initiative on the ballot.\textsuperscript{164}

\begin{itemize}
\item \textsuperscript{160} Briffault, \textit{supra} note 11, at 1348. Professor Briffault points out that “[e]ven today, proponents of the initiative, who range across the ideological spectrum from Jack Kemp to Ralph Nader, assert that direct democracy can liberate politics from special interest groups, reduce voter malaise, and energize the electorate.” Id. at 1348–49.
\item \textsuperscript{161} See \textit{Cronin}, \textit{supra} note 6, at 51 tbl. 3.1.
\item \textsuperscript{162} Id. Between 1898 and 1918, the 22 states adopting either both initiative and referendum or just referendum were (in order of adoption): South Dakota (1898); Utah (1900); Oregon (1902); Nevada (referendum only, 1904; adopted initiative lawmaking in 1912); Montana (1906); Oklahoma (1907); Maine, Missouri (1908); Arkansas, Colorado (1910); Arizona, California (1911); New Mexico (referendum only, 1911); Idaho, Nebraska, Ohio, Washington (1912); Michigan (1913); North Dakota (1914); Kentucky (referendum only, 1915), Maryland (referendum only, 1915); and Massachusetts (1918). Id.
\item \textsuperscript{163} See id. In addition to the 22 states cited in \textit{supra} note 162, the four states that have authorized direct democracy since 1918 are Alaska (1959); Florida (initiation of state constitutional amendments only, 1968); Wyoming (1968); and Illinois (initiation of state constitutional amendments only, 1970). Id. In 1970, the District of Columbia adopted lawmaking through voter initiative and popular referendum. Id.
\item \textsuperscript{164} See Eule, \textit{supra} note 8, at 1509 n.22. The 21 states that permit citizens to initiate and enact legislation are: Alaska, Arizona, Arkansas, California, Colorado, Idaho, Maine, Massachusetts, Michigan, Missouri, Montana, Nebraska, Nevada, North Dakota, Ohio, Oklahoma, Oregon, South Dakota, Utah, Washington, and Wyoming. Id. The five remaining states that permit some form of direct democracy are Kentucky, Maryland, and New Mexico (referendum only); and Florida and Illinois (constitutional initiative only). Id.
\end{itemize}

In general, a direct initiative “may be placed on the ballot by securing a specified number of signatures—usually set at some percentage of the votes cast in the preceding general election.” Id. at 1510. Thereafter, the measure is enacted if it attracts a majority of votes. Id. For a listing of the specific requirements for qualification and approval of statewide statutory initiatives, see \textit{Magleyb}, \textit{supra} note 11, at 38 tbl. 3.1. See also \textit{Democracy by Initiative}, \textit{supra} note 6, at 130 tbl. 4.1 (providing state-by-state initiative qualification requirements). In California, for example, as of 1992, initiative proponents must obtain 384,971 valid signatures (five percent of the vote in the preceding gubernatorial election) to place a statutory initiative on the ballot and 615,953 signatures (eight percent of the vote in the preceding gubernatorial election) to place a constitutional initiative on the ballot. Id. at 6.
Until the 1970s, voter use of the initiative varied among states, but overall initiative activity was relatively insignificant. Yet, perhaps because of the influences of the Vietnam War, Watergate, urban rioting, or a general distrust of government, the 1970s ushered in a new era of voter activism in the form of ballot initiatives. In California, for example, the number of initiatives qualifying for the ballot rose from nine in the 1960s, to twenty-two in the 1970s, to forty-six in the 1980s; the number is estimated to reach approximately seventy-five to one hundred in the 1990s. In the general election of 1990, initiative proponents across the country succeeded in putting at least sixty-seven proposals on statewide ballots, the largest number since 1932.

With the increased use of the initiative came increased concerns about its use. Scholars, politicians, and voters themselves began to question whether the initiative process was truly an antidote to corrupt government or simply another route for special interest groups to curry favor with uninformed and gullible decision makers. Additionally, concerns surfaced about the problem of "the tyranny of the majority," in which majoritarian voters exclude or discriminate against those with

165. See DEMOCRACY BY INITIATIVE, supra note 6, at 54. In California, between 1912 (the first year initiative voting was permitted) and 1968, voters qualified 138 measures for the ballot, with only 10 and 9 qualifying during the 1950s and 1960s, respectively. Id.

166. Id. at 55 tbl. 2.1.

167. Robert Pear, Number of Ballot Initiatives Is the Greatest Since 1932, N.Y. TIMES, Nov. 5, 1990, at B10. David Magleby, professor of political science at Brigham Young University has postulated that

[t]he initiative process was rediscovered by single-issue groups in the mid-1970's, and its use has been growing since then. People found it was a very effective way to set the political agenda, regardless of whether they won or lost on Election Day. The initiative process is among the most powerful agenda-setting tools in our democracy.

Id. Magleby is the author of Direct Legislation: Voting on Ballot Propositions in the United States, cited earlier in this Article. See MAGLEBY, supra note 11.

168. See, e.g., John Garamendi, California's Ballot Industry, N.Y. TIMES, May 7, 1990, at A15 (criticizing the state's initiative process, which Garamendi claims "renders [California] citizens especially susceptible to the electronic and computerized campaign tactics of those in the business of promoting initiatives, which allows the special interests to profit"); Herb Robinson, Some Problems with Voter Initiatives, SEATTLE TIMES, Sept. 28, 1990, at A12 (complaining that initiative campaigns are about "big bucks being raised, influential endorsements on each side, and posturing by political incumbents"). For a summary of scholarly criticism of direct democracy, see infra notes 170-72.
minority views. These criticisms, as well as the empirical data gathered in their support, help to set the stage for an analysis of citizen lawmaking as it relates to a specific focus of this Article: physician-aid-in-dying.

B. Ballot Initiatives: Lawmaking by the People, for the People, or Through the People?

Contemporary scholars have identified several aspects of direct democracy that arguably reveal that the lofty goals of increased voter participation in government and decreased special interest influence have not been met. Areas of critique include the following: (1) the question of voter competency—critics argue that voters are not informed or thoughtful enough to vote on complicated public policy issues; (2) concerns about subordination or destruction of minority rights—scholars worry that direct democracy fosters a tyranny of the majority, diminishing the rights and liberties of the politically powerless; and (3) the role of money in direct democracy campaigns—empirical studies of initiatives arguably show that spending patterns on ballot initiatives correspond to the success of the bigger spender, raising questions about the impact that special interest groups continue to have on the political process.

169. See, e.g., Bell, supra note 11, at 28 (arguing that referenda demonstrate discrimination and prejudice when "the issue submitted to the voters suggests, even subtly, that majority interests can be furthered by the sacrifice of minority rights.")

170. One author summarizes her criticisms as follows: "Direct democracy is plagued by voter ignorance, voter apathy, and procedural defects, results in laws which impede minority rights, is inefficient, and has a deleterious effect on the branches of government." Cynthia L. Fountaine, Note, Lousy Lawmaking: Questioning the Desirability and Constitutionality of Legislating by Initiative, 61 S. CAL. L. REV. 733, 737 (1988).

171. This criticism actually speaks to two concerns about voter competency: the problem of voters' understanding of the issues and the statutory responses contained in the initiative and the problem of "drop-off," or diminished voter participation in ballot questions compared to voting for candidates on the same ballot.

172. I believe these to be the major criticisms of direct democracy. Numerous other criticisms have been expressed, many of which are derivative of these central concerns. They include: (1) the complexity of ballot measures prevents assessment of an issue's intricacies; (2) there is a lack of informative communication and a surplus of slanted political advertising in the process; (3) the process suffers from numerous procedural defects, including: a lack of pre-enactment review to detect internal inconsistencies, conflicts with existing law, or questionable policy bases; and a lack of signature gathering integrity, through which signatures are obtained through
In addition to concerns about the vitality and malleability of voters, critics highlight the structural shortcomings of the initiative process. For example, once a ballot proposition has been authorized for signature gathering, it only rarely can be amended. This often leaves voters with the choice of accepting or rejecting the proposed language with no opportunity to suggest improvements or clarification. The initiative process in most states also does not provide for public hearings prior to the circulations of the petitions. Moreover, the process is subject to misrepresentation of the substance of the ballot measure; (4) direct democracy discourages compromise by setting up barriers to amending ballot proposals, leaving no place for negotiation and bargaining; (5) ballot initiatives result in inefficiency by encouraging lavish spending on campaigns, forcing state governments to incur substantial costs to verify signatures and conduct elections, and often leading to expensive litigation over the constitutionality of newly enacted measures; (6) direct democracy diminishes legislative responsibility because legislators are tempted to leave controversial issues to a popular vote; and (7) voter-generated statutes place a greater burden on the judiciary, who may be asked to interpret such laws without the benefit of legislative history. See Fountaine, supra note 170, at 739, 741, 742–47, 751–58. For other critiques of direct democracy, see generally DEMOCRACY BY INITIATIVE, supra note 6, at 64–70 (listing 11 criticisms of the California initiative process, including charges that it "[e]ncourages single-issue politics" and "[u]ndermines political parties"); MAGLEBY, supra note 11, at 196–99 (summarizing key issues in any discussion of the initiative process); Goetz, supra note 151, at 814–22 (discussing four "major deficiencies" of the initiative).

In addition to the specific indictments against the workings of the initiative process, numerous scholars have questioned the constitutionality of direct democracy, arguing that direct democracy violates the United States Constitution’s guarantee of a republican form of government. See, e.g., Hans A. Linde, When Initiative Lawmaking Is Not "Republican Government": The Campaign Against Homosexuality, 72 OR. L. REV. 19, 25–30 (1993); Fountaine, supra note 170, at 759–65; Douglas H. Hsiao, Note, Invisible Cities: The Constitutional Status of Direct Democracy in a Democratic Republic, 41 DUKE L.J. 1267, 1290–1310 (1992). The Constitution provides that "[t]he United States shall guarantee to every State in this Union a Republican Form of Government." U.S. CONST. art. IV, § 4. This clause, known as the Guaranty Clause, obligates each state to govern itself by republican institutions. See THE FEDERALIST No. 43 (James Madison). By delegating the power to enact law to the people, states may have abdicated their responsibility to provide a republican, or representative, form of government. The details and debate surrounding this argument are highly important to the vitality of direct democracy but are beyond the scope of this Article, which assumes, per state and federal high court decisions, the constitutionality of the initiative process. See, e.g., City of Eastlake v. Forest City Enter., Inc., 426 U.S. 668, 679 (1976) (upholding a mandatory referendum ordinance and holding that power of initiative and referendum is reserved by the people, not redelegated by the legislature).

173. See DEMOCRACY BY INITIATIVE, supra note 6, at 79–80. Pre-circulation amendability varies from state to state. Some states require review of all initiatives prior to circulation for compliance with the single-subject rule (limiting the content of an initiative to a single subject); others require review by specified election officers to make recommendations concerning the form and substance of the proposal. Id. at 99–109. Post-enactment amendability is also problematic in some states; in California, for example, a law enacted by initiative can only be amended by another ballot measure, unless the law itself allows for subsequent legislative amendments. Id. at 80.
to petition circulation.\textsuperscript{174} This lack of opportunity for public input seems contrary to the notion of direct democracy as a vehicle for popular lawmaking. Taken together, the problems with lack of amendability and opportunity for pre-circulation public debate stand in stark contrast to legislative lawmaking which, at least theoretically, invites public oversight at nearly every turn.

These concerns, among others, leave many doubting that direct democracy provides any advantages over its representative counterpart in terms of voter independence and empowerment.\textsuperscript{175} An examination of these concerns, both generally and as they affected the campaigns surrounding the euthanasia initiatives in Washington and California, shows that the shortcomings of lawmaking through direct democracy are no fewer than those surrounding representative lawmaking. In the end, the initiative process is probably better suited to serve as an impetus for legislative lawmaking rather than as a replacement of it.

1. The Question of Voter Competency: Concerns About Information, Understanding, and Deliberation—Questions about what voters think, hear, and process have captivated political strategists for generations.\textsuperscript{176} Many have expressed skepticism over an ordinary citizen's ability to comprehend intricate statutory language compared to the comprehension level of a "trained" legislator.\textsuperscript{177} After all, voters are not engaged in the business of lawmaking as are full-time legislators who, ideally, spend their working lives analyzing and debating political questions. To this end, I would argue that two phenomena play a role in diminishing this perceived inequality between voters and legislators. First, every state with an initiative system provides for the distribution of voter information, 

\textsuperscript{174} See id. at 102. One state, Colorado, allows for a public hearing on an initiative before signatures are collected. Id. Initiative proponents thereby receive criticisms and advice from the public and not merely from governmental sources. Id. As a result, roughly 70\% to 80\% of original initiative drafts are revised by the proponents. Id.

\textsuperscript{175} See supra note 172.

\textsuperscript{176} See, e.g., ANGUS CAMPBELL ET AL., THE AMERICAN VOTER 4-17 (1960) (outlining the first presidential election voting behavior survey, conducted from 1948 to 1956).

\textsuperscript{177} See, e.g., Fountaine, supra note 170, at 740 (describing a study that found that the level of education required to understand California ballot pamphlets varied from two years of college to two years of graduate school but that the average voter had completed only 13 years of school); see also MAGLEBY, supra note 11, at 118–19 (discussing the readability of ballot titles and descriptions).
including a caption and summary of all proposed measures. 178 Information disseminated to voters through such mechanisms as ballot pamphlets and newspaper descriptions offers voters an objective, simplified discussion of the proposed law. 179 In a recent study on the issue of voter ability to understand ballot measures, one author came to the following conclusion: "Experience in the states suggests that on most issues, especially well-publicized ones, voters do grasp the meaning of the issue on which they are asked to vote, and that they act competently." 180

Second, perhaps as a counterbalance, I would argue that our elected lawmakers are often not well-versed in the details of much legislation, particularly when they must vote on large numbers of bills in order to meet an impending deadline. 181 I do not mean to argue that voters are better or even equally informed about the particulars of legislation compared to elected lawmakers: my conclusion is that, on a given election day, voters may be as informed about one or several ballot propositions that have been the subject of written and verbal debate as a legislator is on any given voting session day.

How do these assessments fare in the context of the euthanasia campaigns in California and Washington? Perhaps the best indication of voter information intake and understanding can be found in the exit polls that asked voters why they voted as they did. In California, where Proposition 161 was defeated despite early polls indicating relatively high levels of support, 182 voters indicated that the major reason they opposed

178. See DEMOCRACY BY INITIATIVE, supra note 6, at 228; see also id. at 231 tbl. 7.2 (setting out a chart of state provisions for official ballot captions and summaries).

179. See id. at 235–36. "Fourteen states, including California, distribute a ballot pamphlet to voters. Fourteen states purchase pages in major newspapers to print official descriptions of initiatives. Five states use both methods." Id. at 235. It is important to note that the responsibility for drafting ballot captions, summaries, and descriptions generally rests with a state official, such as the Attorney General or Secretary of State. See id. at 230. For a list of each state's official responsible for drafting ballot captions and summaries, see id. at 231.

180. CRONIN, supra note 6, at 87.

181. See, e.g., Daniel M. Weintraub, Legislators Throw out the Textbook in Last-Minute Frenzy, L.A. TIMES, Sept. 15, 1989, pt. I, at 3 ("Meeting late into the night, the Senate and Assembly pass bills by the bushel, most of which are never read by the members.").

182. Alexander M. Capron, Even in Defeat, Proposition 161 Sounds a Warning, HASTINGS CENTER REP., Jan.–Feb. 1993, at 32, 32 ("Surveys taken in March and April [of 1992] showed that 75 percent of California voters favored the basic concept of physician-aid-in-dying, 54 percent strongly so."). According to a Los Angeles Times poll conducted approximately a week before the November 3, 1992 election, 49% of
this particular initiative was because it lacked sufficient safeguards against abuse. In Washington, Initiative 119 suffered a similar experience. This uniform response indicates either that voters were swayed by negative campaigning focusing on the "inadequate safeguards" argument or that voters were informed enough about the issue to make a reasoned judgment as to their personal preference for this piece of legislation, or both. In other words, Proposition 161 and Initiative 119 garnered voter response that showed a relatively high level of voter comprehension: voters seemed to be informed about the substance, and to some extent the specifics, of the proposed legislation.

The political experience surrounding the euthanasia initiatives, at least with respect to voter competency, stands out as a positive tally for combining direct democracy and bioethical choices. If voters perceive that they will be given the opportunity to express their own personal, moral beliefs about a practice that may very well touch their own lives, they are likely to become informed about the choices they are asked to make. Bioethical choices, such as decisions about abortion and the right to die—unlike choices often posed in initiatives such as taxation, environmental controls, or land use planning—call upon voters to consider issues that they likely have contemplated already in their lives. I would surmise that few voters contemplated their response to physician-aid-in-dying for the California voters favored Proposition 161, 45% opposed it, and 6% were undecided. George Skelton, Voters Evenly Split Over Proposal to Cut Welfare, L.A. TIMES, Oct. 27, 1992, at A1, A18.

183. See Capron, supra note 182, at 32 ("Among those who voted against [Proposition 161], 43 percent told exit-pollsters that inadequate safeguards was the primary reason for their opposition."). Proposition 161 provided that a patient could make a written request to a doctor to end her life, followed by an oral request at the time the patient decided she wanted to die. Death with Dignity Act, supra note 16, §§ 2525.3, 2525.7. One of the allegedly inadequate safeguards was that an independent witness did not have to sign a patient's written request for aid-in-dying or be present during an oral request. See Miller, supra note 2.

184. Polls preceding the November 5, 1991 vote showed that 61% of Washington residents favored Initiative 119. Andrew M. Jacobs, The Right to Die Movement in Washington: Rhetoric and the Creation of Rights, 36 HOW. L.J. 187, 209 (1993). Opponents asserted that Initiative 119 had no safeguards and could, for example, lead to euthanizing of the depressed. Id. Apparently the "no safeguards" tactic worked, as both the Seattle Times and Initiative 119 campaign chair Karen Cooper credited this argument for the defeat of Initiative 119. Id. at 205.

185. See DEMOCRACY BY INITIATIVE, supra note 6, at 60 tbl. 2.5 (setting out the subject matters of California initiatives from 1912 to 1990).
first time on or just before election day.\(^{186}\) Unlike intricate tax schemes or complicated plans to regulate toxic emissions, ballot questions about personal medical decisions are generally quite simple, asking the voter: "Do you want the government to regulate your decision making in this area in this way?"\(^{187}\) One's response to this question necessarily invokes long-standing and deeply held beliefs and values that guide one's personal decision making on a day-to-day basis.

Accepting, arguendo, this high level of voter interest and knowledge about bioethical ballot measures, one might also expect a high amount of voter discussion and deliberation about these particular measures. Such a result would be exactly what the proponents of direct democracy envisioned—an informed, participatory electorate debating the pros and cons of various statutory suggestions.\(^{188}\) Critics of direct democracy suggest that inter-voter deliberation of ballot propositions is low, even nonexistent at times.\(^{189}\) Newspaper accounts of the activity surrounding both Proposition 161 and Initiative 119, however, show a fairly high level of community debate and citizen deliberation.\(^{190}\) For example, both initiatives were the subject of sermons and group discussion in churches across the states;\(^{191}\) they were also the focus of numerous radio, television, and newspaper advertisements and commentaries.\(^{192}\)

\(^{186}\) One poll reported that, in Washington, 63% of voters said that they made up their minds on aid-in-dying at least a month before casting their ballots, when public debate began to intensify. Jack Broom & Susan Gilmore, Morality, Freedom of Choice Clash in Decisions on 119, 120, SEATTLE TIMES, Nov. 6, 1991, at D1.

\(^{187}\) Admittedly this is a gross oversimplification of the substance of previous initiatives, but it serves to illustrate the distinction between ballot bioethical choices and choices about other social and economic issues, which tend not to implicate directly an individual's bodily integrity or personal autonomy.

\(^{188}\) See supra text accompanying notes 158–60.

\(^{189}\) See CRONIN, supra note 6, at 70–77.

\(^{190}\) See, e.g., Susan Gilmore, Will Foes' Efforts Doom California's Euthanasia Bill?, SEATTLE TIMES, Oct. 24, 1992, at A14 (reporting that 135 groups joined to oppose Proposition 161, which, like Initiative 119, had touched off much debate); Paul Jacobs, Initiative Fuels Debate Over Morality of Euthanasia, L.A. TIMES, Oct. 31, 1992, at A20 (detailing that university bioethicists were in high demand to speak on Proposition 161).

\(^{191}\) Seattle's Archbishop Thomas Murphy argued against Initiative 119 during a Catholic mass. Charles E. Brown, Initiatives 119, 120 Denounced in Mass by Archbishop Murphy, SEATTLE TIMES, Oct. 7, 1991, at E1. In California, Cardinal Roger Mahony expressed opposition to Proposition 161 by writing a letter to be read at all masses in Los Angeles, Ventura, and Santa Barbara counties on the Sunday before election day. Jacobs, supra note 190, at A20.

\(^{192}\) For example, Proposition 161 and Initiative 119 were the subject of over 180 newspaper editorials during and after the campaigns. Search of LEXIS, News Library, Curnws & Arcnws Files (Aug. 18, 1995).
Although this kind of media and popular attention may not be completely unique to the euthanasia initiatives, what was unique about the campaigns surrounding Initiative 119 and Proposition 161 was the personal nature of the material disseminated and discussed. The issue caused voters to reflect on their own experiences, desires, and expectations surrounding the deeply personal issue of death. It was this self-reflection, this high degree of intimacy, that separated the bioethical ballot measures from their traditional counterparts. At the same time, lawmaking by citizens alone allows a majority of the voting public to dictate the range of personal choices available to all citizens. In Washington and California, a bare majority of voters were essentially able to deny to all residents the right to choose physician-aid-in-dying.

This example of majoritarian rule is quite problematic with regard to laws affecting personal decision making. By definition, decisions about self-determination should be made on an individual, not a collective, basis. While this critique could be applied to lawmaking in this area in general, it is particularly troubling to realize that friends, neighbors, and strangers can impose their values on an entire jurisdiction simply by voting their preference. Unlike legislators, who can be held accountable for their decisions by their constituents, voters are not motivated to learn and consider the variety of views held on a ballot subject. Thus, despite an apparently high level of voter interest and comprehension surrounding the euthanasia initiatives, the problem of the tyranny of the majority, discussed below, may militate against pursuing bioethical choices through direct democracy.

2. Euthanasia and the Tyranny of the Majority—Initiatives and referenda have been criticized for jeopardizing and subordinating minority rights by empowering a majority block of

193. The amount of money spent to support and oppose Proposition 161, see infra note 241, pales in comparison with the monies spent in connection with numerous other initiatives, including the 1988 California insurance initiative, Proposition 104 ($37.5 million), and the 1990 California alcohol tax initiative, Proposition 134 ($24.2 million), DEMOCRACY BY INITIATIVE, supra note 6, at 266. Despite this spending gap, the California euthanasia measure seemed to garner more newspaper attention, though other initiatives have also attracted attention. Nearly 60 editorials focusing on Proposition 161 appeared in newspapers across the country, compared to just over 20 for Proposition 104, the insurance initiative. Search of LEXIS, News Library, Curnws & Arcnws Files (Aug. 18, 1995).

voters to ignore or trample the rights of those holding fewer votes. Tyranny of the majority in the voting booth, then, is a concept that can be viewed in at least two ways. First, majoritarian domination means that groups constituting a majority in society, such as whites or heterosexuals, can pool their supernumerary votes and enact legislation adversely affecting those in the minority, such as blacks or gays. Alternatively, one can view majoritarian voting as simply the result of a democratic process in which the candidate or ballot measure with the most votes prevails. In either case, voting in our society inevitably pits some type of majority against a nonprevailing minority.

Voter lawmaking about bioethical choices tends to invoke concerns over the latter view of majoritarianism. With respect to the euthanasia ballot initiatives, it does not appear that the substance of the proposals themselves are aimed at, or even disparately impact, any particular minority group. The population most affected by the legislation would be the terminally ill and their families, a group that is as representative of our nation's population as any. Illness and death are human conditions, irrelevant to a person's race, ethnicity, or sexual orientation. Unlike initiatives that single out distinct minorities, explicitly or implicitly, the aid-in-dying measures would not discriminate against any discrete minority group.

195. See Bell, supra note 11, at 14-15. ("Ironically, because it enables the voters' racial beliefs and fears to be recorded and tabulated in their pure form, the referendum has been a most effective facilitator of that bias, discrimination, and prejudice which has marred American democracy from its earliest day."). As an example, Professor Bell points out that, between 1963 and 1968, 10 cities and the State of California conducted open housing referenda, all initiated by fair housing opponents. Id. at 15 n.54. All but one were enacted. Id.

With respect to gay rights, one need only glance at the political scene today to see attempts by majoritarian heterosexuals to limit or destroy civil rights for homosexuals. For example, citizens in 10 states attempted to place on the November 1994 ballots initiatives that would ban civil rights protection for homosexuals. Brad Knickerbocker, Gay-Rights Advocates Step Up Campaign, CHRISTIAN SCI. MONITOR, Aug. 12, 1994, at 3. The petition drives were successful in two states, Oregon and Idaho. Id.

196. An example of a constitutional proposition that explicitly singled out a minority group was Amendment 2, the Colorado measure approved by voters that bars local governments from prohibiting discrimination based on sexual orientation. See supra note 4. An example of an initiative that had an adverse impact on a minority group but did not explicitly mention the group's distinguishing characteristic was Proposition 14, in which California voters repealed the state's fair housing laws with a constitutional amendment that barred any restriction on a property owner's discretion to sell or lease to any person. See Reitman v. Mulkey, 387 U.S. 369, 370-71 (1967). The Supreme Court struck down the amendment, finding that through it the state authorized and encouraged illegal racial discrimination in violation of the Equal Protection Clause. Id. at 381.

197. I realize that there are those who disagree with this position and argue that voluntary active euthanasia would be a discriminatory practice in that it would be
The second view of majoritarianism described above, as a means whereby a majority of voters can impose their views upon a smaller group of voters, is, I believe, highly problematic when the ballot issue is one involving medical decision making. When voters are asked to enact a scheme that limits or enhances government regulation of a bodily function, their collective decision may have an enormous impact on the way their fellow citizens lead their lives. Sensitive to this important dynamic relationship between regulation and personal decision making, courts traditionally have been solicitous of the right to control one's physical destiny.

The hallmark of our medicolegal jurisprudence has been the centrality of personal autonomy and self-determination. The Supreme Court confirmed these principles when it stated that "a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment." This liberty interest, according to the Court, derives from the notion of bodily integrity, which gives every adult the right to direct what shall or shall not be done with his own body.

A similar interpretation of constitutionally protected liberty interests informed the decision of Judge Rothstein in *Compassion in Dying v. Washington*, in which three terminally

used disproportionately "on" (as opposed to "by") those who are weak—physically, socially, politically—such as the elderly, women, and racial or ethnic minorities. For example, in *Compassion in Dying v. Washington*, 49 F.3d 586, 592 (9th Cir.), *reh'g granted*, 62 F.3d 299 (9th Cir. 1995), Judge Noonan, writing for the majority, outlined the state's interests in outlawing physician-assisted suicide, which included not subjecting the elderly and the infirm to "psychological pressure to consent to their own deaths" as well as protecting the poor and minorities from exploitation based on a desire to reduce the cost of public assistance. *Id.* One commentator has argued that certain groups do perceive themselves to be at disparate risk if euthanasia is legalized, citing results from the vote on Proposition 161 in which females opposed the measure 56%-44%, while males were split 50%-50%; whites opposed the measure 52%-48%, while black and Hispanic voters opposed it 60%-40%. Capron, *supra* note 182, at 32.


199. *Id.* at 278, 272–73. Chief Justice Rehnquist, writing for the majority, spoke of the notion of bodily integrity as an integral part of the common law doctrine of informed consent, quoting the famous words of Justice Cardozo that “[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body.” *Id.* at 269 (quoting Schloendorff v. Society of N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914)). "The logical corollary of the doctrine of informed consent," Justice Rehnquist wrote, "is that the patient generally possesses the right not to consent, that is, to refuse treatment." *Id.* at 270. This same right to refuse medical treatment is assumed to be a constitutionally protected liberty interest later in the opinion. *See id.* at 279.

200. 850 F. Supp. 1454 (W.D. Wash. 1994), *rev'd*, 49 F.3d 586 (9th Cir.), *reh'g granted*, 62 F.3d 299 (9th Cir. 1995). Despite its current lack of precedential value, I discuss the substance of Judge Rothstein's opinion because I believe that it provides a logical and sensible framework for analyzing the legality of physician-aid-in-dying.
ill patients and several physicians challenged the constitutionality of a Washington statute that makes it a felony to aid knowingly another person in committing suicide. Judge Rothstein held that the Fourteenth Amendment liberty interest extends to a personal choice by a mentally competent, terminally ill adult to commit physician-assisted suicide. Relying on Planned Parenthood v. Casey, Judge Rothstein reiterated long-standing Supreme Court jurisprudence that personal decision making involving intimate choices is a constitutionally protected liberty interest. According to the Court in Casey, “at the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life.” Although the Court in Casey used this language with regard to one's concept of how life begins, Judge Rothstein found it applicable to decisions about the end of life as well. Likening the decision of a terminally ill person to commit suicide to that of a pregnant woman choosing to have an abortion, Judge Rothstein held that both “involv[e] the most intimate and personal choices a person may make in a lifetime’ and constitut[e] a ‘choice[] central to personal dignity and autonomy’” and are thereby embodied within the liberty interest. Thereafter Judge Rothstein adopted the same standard of review applicable in Casey: in order to demonstrate the unconstitutionality of a state statute, plaintiffs had to show that it would “operate as a substantial obstacle” to the exercise of a constitutional right and would therefore constitute an “undue burden.” Here, the court concluded that the Washington statute “not only places a substantial obstacle in the path of a terminally ill, mentally competent person wishing to commit physician-assisted suicide, but entirely prohibits it.” The court held that such a total

201. 850 F. Supp. at 1156–59; see WASH. REV. CODE § 9A.36.060 (1994) (“A person is guilty of promoting a suicide attempt when he knowingly causes or aids another person to attempt suicide.”). The plaintiffs challenged the statute only insofar as it bans physician-assisted suicide by mentally competent, terminally ill adults who knowingly and voluntarily choose to hasten their deaths. 850 F. Supp. at 1459.
202. 850 F. Supp. at 1467.
204. Compassion in Dying, 850 F. Supp. at 1459.
205. Id. (quoting 112 S. Ct. at 2807).
206. Id. at 1460 (quoting 112 S. Ct. at 2807).
207. Id. at 1462 (citing 112 S. Ct. at 2830).
208. Id. at 1465.
ban unquestionably places an undue burden on the exercise of a constitutionally protected liberty interest.\textsuperscript{209}

On appeal, a three-judge panel of the United States Court of Appeals for the Ninth Circuit reversed Judge Rothstein's decision, with one judge dissenting; it thereby upheld the validity of the state's assisted-suicide ban.\textsuperscript{210} In short, the court found that the lower court's reliance on \textit{Casey} was "an unwarranted extension of abortion jurisprudence" which should be limited to the reproductive context in which it was decided.\textsuperscript{211} Moreover, the court held that the liberty interest in \textit{Casey} did not include the right to physician-assisted suicide because, if it did, it could not legitimately be limited to terminally ill persons.\textsuperscript{212} Finally, the court spelled out several state interests that outweigh any "alleged liberty of suicide,"\textsuperscript{213} including protecting the integrity of the medical profession and guarding against coercion of vulnerable populations such as the elderly and handicapped.\textsuperscript{214}

In his dissenting opinion, Judge Wright agreed with Judge Rothstein that our nation's liberty jurisprudence includes the right to choose physician-hastened death, just as it encompasses the right to refuse life-sustaining treatment.\textsuperscript{215} Judge Wright found that no constitutional distinction could be drawn between a patient who seeks death via termination of a medical modality, such as a respirator, and one who seeks to end unwanted agony but is not dependent on any artificial life support.\textsuperscript{216} Addressing the majority's concern about the limitlessness of the right to physician-assisted suicide if the statute were held unconstitutional, Judge Wright stressed that the statute was invalid only as it is applied to terminally ill,

\textsuperscript{209} \textit{Id.} The court also relied on the principles set out in \textit{Cruzan v. Director, Missouri Department of Health}. See \textit{id.} at 1461. Noting that, in \textit{Cruzan}, the Court found that competent, terminally ill adults enjoy a constitutionally protected liberty interest in refusing life-sustaining treatment, Judge Rothstein concluded that no distinction could be drawn between refusing medical treatment to hasten death, and seeking physician assistance for the same purpose. \textit{Id.}

\textsuperscript{210} Compassion in Dying v. Washington, 49 F.3d 586, 594 (9th Cir.), \textit{reh'g granted}, 62 F.3d 299 (9th Cir. 1995).

\textsuperscript{211} \textit{Id.} at 591.

\textsuperscript{212} \textit{Id.}

\textsuperscript{213} \textit{Id.}

\textsuperscript{214} \textit{Id.} at 592–93.

\textsuperscript{215} \textit{Id.} at 597.

\textsuperscript{216} \textit{Id.} at 595–96.
mentally competent adults.\textsuperscript{217} The Ninth Circuit has since granted a rehearing \textit{en banc} of this case.\textsuperscript{218}

The Rothstein/Wright approach to physician-aid-in-dying legislation is both socially sensible and constitutionally sound. Our medicolegal jurisprudence recognizes the right of every adult patient to refuse medical care, even when such refusal will lead to certain death.\textsuperscript{219} Death is therefore among the range of options available to patients whose lives are sustained by mechanical means, such as respirators. But for those who are not acutely dependent on machines to support their life functions, the ability to choose death is severely circumscribed. Likely the only treatment refusal that these patients can choose is starvation. To force patients who choose death to endure additional days or weeks of suffering\textsuperscript{220} seems inconsistent with the otherwise acknowledged right to choose death by refusing treatment.\textsuperscript{221}

\begin{footnotesize}
\begin{enumerate}
\item\textsuperscript{217} \textit{Id.} at 595–97.
\item\textsuperscript{218} Compassion in Dying v. Washington, 62 F.3d 299 (9th Cir. 1995).
\item\textsuperscript{219} Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261, 281 (1990).
\item\textsuperscript{220} For example, Nancy Cruzan lived for 12 days after her feeding tube was removed; her cause of death was listed as "shock, due to dehydration, due to severe head injury." Robert Steinbrook, \textit{Comatose Woman Dies 12 Days After Life Support Is Halted}, L.A. TIMES, Dec. 27, 1990, at A17 (internal quotation marks omitted).
\item\textsuperscript{221} The unfortunate scenario in which certain terminally ill patients are not able to choose a swift and painless death through the exercise of a fundamental liberty right raises the specter of unequal protection for similarly situated populations. In her opinion, Judge Rothstein addressed the equal protection concerns of the plaintiffs. \textit{Compassion in Dying}, 850 F. Supp. at 1466–67. Specifically, Judge Rothstein considered the contention of the plaintiffs that the statute denied them equal protection of the law because it distinguishes between two similarly situated groups of mentally competent, terminally ill adults: those terminally ill patients attached to life-sustaining equipment who, under current state law, could lawfully obtain medical assistance in terminating such treatment and thus hasten death; and those terminally ill patients who need no life-support systems, and who are therefore denied the option of hastening death with medical assistance. \textit{Id.} at 1466. The court found that these two groups of patients were similarly situated and held that, by denying the latter group of patients the equivalent option of exercising their rights to hasten their own deaths with medical assistance, the statute violated the equal protection guarantee of the Fourteenth Amendment. \textit{Id.} at 1467.

The Ninth Circuit rejected the lower court's equal protection rationale, finding that the two groups of patients were not similarly situated because one group required that action be taken to end life while the other depended on "actions by which life is not supported or ceases to be supported." \textit{Compassion in Dying}, 49 F.3d at 593. I fail to see the difference between authorizing removal of a respirator and prescribing a lethal dose of medication. Both involve action; both result in swift and painless death; and both are done at the request of the patient or appropriate surrogate. Perhaps the court worried that accepting the equal protection analysis in this instance would leave little opportunity to deny its applicability to voluntary active euthanasia. If states were to permit competent, terminally ill adults to hasten their death by ingesting a lawfully prescribed overdose of medication, but did not permit competent, terminally ill adults who lack the physical capacity to ingest medications to hasten their deaths with
Although courts have, for now, rejected physician-assisted suicide as a protected liberty interest,\(^{222}\) none has rejected the Supreme Court's pronouncement that some patients have a fundamental right to choose death.\(^ {223}\) This right, like other fundamental rights, cannot be abridged by state action absent exceptional circumstances.\(^ {224}\) Given that the state, through its legislature, cannot create laws that violate the liberty interests of its citizens, neither can voters draft and enact such laws. Although legal scholars have debated the standard of judicial review that should be accorded citizen-made law,\(^ {225}\) courts indisputably have the power to strike down popular laws that violate our Constitution. In the words of Chief Justice Burger, "it is irrelevant that the voters rather than a legislative body [enact a law], because the voters may no more violate the Constitution by enacting a ballot measure than a legislative body may do so by enacting legislation."\(^ {226}\)

Assuming that individuals have a liberty interest in their choices about death and that citizens may not enact legislation violating constitutional parameters, one can see how direct democracy, as a way of setting policy about medical decision making, can result in a majority of voters restricting the liberties of a minority of voters, and perhaps of a majority of citizens in the state. In California and Washington, when voters rejected proposals for physician-aid-in-dying, they

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medical assistance, then they would be creating a situation in which similarly situated groups are receiving different treatment. Moreover, one's physical limitations, such as muscle atrophy due to ametropic lateral sclerosis, should not be the barrier between a lawful physician-assisted suicide, by drug ingestion, and an unlawful physician-assisted suicide, by drug injection. If, under a proposed assisted-suicide law, there were no substantial differences between terminally ill patients who depend on mechanical support to live and those who do not, then likewise there should not be a distinction made between terminally ill patients who wish to end their lives through prescription and those who require injection. Both require medical assistance; both involve an intimate, personal decision arguably embodied in our constitutionally protected liberty interest.

222. See supra note 31 (discussing the four decisions that have ruled on the issue).

223. See Cruzan, 497 U.S. at 281.

224. According to our constitutional jurisprudence, once a fundamental right is involved, a statute that limits that right can be justified only by a compelling state interest and must be narrowly drawn to serve only that interest. See Compassion in Dying, 49 F.3d at 596 (Wright, J., dissenting).

225. See, e.g., Eule, supra note 8, at 1508 (arguing that courts should bring more scrutiny to voter-made law); Hsiao, supra note 172, at 1271 (disagreeing with Eule and arguing that courts should declare voter-made law unconstitutional).

imposed on the citizens of those states a regimen of nonchoice in a most intimate part of their lives: death. This imposition of the majority of the voters’ will is no less tyrannical under these circumstances than it is when voters decide to repeal civil rights laws enacted for minority groups such as blacks or gays. In either case, larger voting pools are empowered to withdraw or deny protected rights to some or all citizens within the jurisdiction.

Of course, these two situations are not identical. In one instance citizens vote to repeal existing rights, while in the other voters refuse to enact legislation that would protect certain rights. One may question how the refusal to enact legislation can be considered tyranny of the majority. In the euthanasia campaigns, where the right of patients to exercise their self-determination by enlisting the voluntary assistance of their physicians was at stake, the populace’s actions stayed, for now, a fledgling right that many predict will ultimately be incorporated into our medical jurisprudence. Voters, therefore, are currently withholding a valued right from their fellow citizens—a right that time will likely help to mature into a legislated, protected choice.

227. See, e.g., supra note 196 (describing California Proposition 14, in which voters repealed the state’s fair housing laws, and Colorado’s Amendment 2, which barred local governments from prohibiting discrimination based on sexual orientation).

228. This argument assumes that the right to choose physician-aid-in-dying is a protected right under our constitutional principles. See supra text accompanying notes 219–21.

229. Even the most vocal opponents of physician-aid-in-dying admit that the current movement is likely to succeed in bringing legislative choices to dying patients. For example, Professor Alexander Capron, who opposes voluntary active euthanasia, writes:

Unless the health care providers who opposed Proposition 161 realize that its showing at the polls is a clear public cry for help, akin to an individual’s suicide attempt, and unless they change those aspects of the system that make a quick death such an attractive alternative, support for legalizing euthanasia is sure to build and eventually to prevail.

Capron, supra note 182, at 33. For an indication of Professor Capron’s views on euthanasia, see Jacobs, supra note 190, at A20 (quoting Capron describing active euthanasia as “a statement of medical power, a clean medical solution to a problem, a statement of medical omnipotence and omniscience,” while “[w]ithdrawal of treatment is [merely] a recognition of the limits to medicine”).

230. There are other examples of rights being withheld by a majority of voters at first, only later to be recognized as an important part of our constitutional jurisprudence. Prior to 1920, several states placed the question of female suffrage on the ballot. Cronin, supra note 6, at 97. Citizens in Missouri, Nebraska, and Ohio voted against the measures. Id. In contrast, after several failed attempts in Colorado and
and dying under the current system certainly have reason to feel the oppression of majoritarianism.

Thus the question of the tyranny of the majority is not about whether certain insular and protected groups will be adversely affected by election outcomes but rather about whether an emerging right will be denied to all because of the actions of a majority of voters. When making bioethical choices, citizens have enjoyed fairly broad protections from both legislatures and courts. But in the area of physician-aid-in-dying, legislative and judicial assistance has been slight, and proponents have tried to turn generalized support into a statutory choice. That statutory choice, proponents would argue, will allow each individual to decide what is right for herself, so that no majority group of voters can veto or oblige an individual’s choice-in-dying.

3. Lobbying at the Ballot Box: Direct Democracy and Campaign Spending—The grass-roots effort to attain statutory validation for physician-aid-in-dying has been expensive for proponents and opponents alike. Achieving change through direct democracy requires expenditures that equal or exceed those poured into lobbying efforts at the legislative level. This is probably not what the pioneers of direct democracy envisioned. In the early 1900s, when Progressives sought to dilute the influence of well-financed special interests, they likely envisioned a political process where voluntary and grass-roots groups simply would circulate petitions, obtain the requisite signatures, and inform potential voters about the merits of proposed ballot measures. This vision has proven to be highly unrealistic. Numerous studies conducted over the past two decades show that money plays a significant, if not decisive, role in direct democracy. Money is used both to gain

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Oregon, and relatively quickly in Arizona, voters granted the vote to women through initiative petitions years before the United States Constitution was amended to permit women’s suffrage. See id.

232. See infra notes 240–41 and accompanying text.
233. See DEMOCRACY BY INITIATIVE, supra note 6, at 263.
234. See, e.g., id. (arguing that money dominates the initiative process in California even more than it does the legislative process); BETTY H. ZISK, MONEY, MEDIA, AND THE GRASS ROOTS: STATE BALLOT ISSUES AND THE ELECTORAL PROCESS 90–110 (1987) (examining 50 ballot questions in four states from 1976 to 1982 and concluding that campaign spending is the “single most powerful predictor” of the outcome); Daniel H. Lowenstein, Campaign Spending and Ballot Propositions: Recent Experience, Public Choice Theory and the First Amendment, 29 UCLA L. REV. 505, 517–47 (1982) (examining 25 California ballot campaigns between 1968 and 1980 and finding that
the initial signatures for placing a measure on the ballot and to shape voters’ perceptions and ultimate choices in the voting booth. Many argue that spending by special interest concerns has dominated direct democracy to the point where it is as vulnerable and responsive to financial influence as the state legislature. Empirical research is persuasive in this regard. One California study shows that, until 1988, the money spent lobbying state government always exceeded the amount spent lobbying the public on state initiatives. In 1988, the relative amounts spent to influence state law shifted, with more spent to persuade voters in ballot measure contests than to lobby the state legislature. While scholars concede that it is often difficult to gauge the degree of influence that campaign spending has on the outcome of a particular election, they do seem one-sided spending in opposition to a measure is highly effective). Total spending on voter initiatives has increased dramatically over the past decades. For example, in California in 1976, total spending on the four initiatives on the ballot was approximately $9 million. DEMOCRACY BY INITIATIVE, supra note 6, at 283 tbl. 8.9. By 1988, total campaign costs for the initiatives that qualified for the ballot were over $127 million—a 1400% increase over 1976. See id. Increased spending may be due in part to the increase in initiatives to reach the ballot. See id. at 55 tbl. 2.1 (showing that 22 initiatives in the 1970s and 46 initiatives in the 1980s qualified for the California ballot).

235. There are now professional signature-gathering firms. See DEMOCRACY BY INITIATIVE, supra note 6, at 265. In addition, the California Commission on Campaign Financing found that any individual, corporation, or organization with approximately $1 million could place an issue on the ballot and have a chance of enacting a state law. Id.

236. See id. at 283–84 (noting that campaign groups are increasingly utilizing more expensive campaign methods than were previously used). In the 1950s, campaign voter contact strategies were fairly evenly divided among newspaper advertising, broadcast advertising, and campaign pamphletting. Id. at 284 tbl. 8.10. By 1990, voter outreach strategies rested almost entirely on expensive broadcast advertising (76% of overall spending). Id.

237. Id. at 264 tbl. 8.1 (comparing money spent lobbying state government and money spent lobbying the public on initiatives).

238. Id. The study conducted by the California Fair Political Practices Commission shows that, from 1976 through 1986, the total amount of money spent to influence California legislation through the lobbying process was roughly twice that spent to influence voters through the initiative process, ranging from approximately $10 million (initiatives) compared to $20 million (lobbying) in 1976, to $35 million (initiatives) compared to $65 million (lobbying) in 1986. Id. In 1988, dollars spent on initiatives totaled approximately $125 million compared to $85 million for lobbying. Id.

239. See, e.g., Lowenstein, supra note 234, at 513. Lowenstein writes:

There can be no certain answer to the question of whether big spending “bought” a victory for or against any particular ballot proposition. To attempt to ascertain the effects of spending on the election result, one must make judgments
to agree on one proposition: one-sided or substantially greater spending in opposition to a ballot initiative is highly effective in gaining defeat of the measure.240

This proposition certainly proved to be true in the campaigns surrounding voluntary euthanasia. In California, opponents of physician-aid-in-dying outspent supporters by more than double.241 This spending differential may have contributed to the successful efforts to lure voters into the “No” camps, but that conclusion would be difficult, if not impossible, to prove. While early polls showed that the support for Initiative 119 and Proposition 161 was greater than the opposition to it,242 there are any number of factors that could have contributed to the measures’ defeat. Intense negative advertising is a likely suspect, but not the only one. Another explanation may be that the voters’ early response to pollsters reflected their general approval of euthanasia.243 Thereafter, voters began to examine the particulars of a proposal, all the while being lobbied by a powerful influence, the Catholic Church.244 Early enthusiasm turned into a traditional preference for the status quo.245

regarding what influenced the decisions of millions of individual voters, based upon fragmentary evidence of the communications that took place during the campaign and, to the extent such information can be gleaned from public opinion polls, what voters were thinking.

Id. 240. See id. at 511. In his study, Lowenstein looked at initiative campaigns between 1968 and 1980 in which spending by either the affirmative or negative side exceeded $250,000 and was at least twice as high as spending on the opposite side. Id. Of the 25 initiatives analyzed, the big-spending side won in 16 cases (64%) and lost in nine (36%). Id. at 518. Breaking down the analysis further into campaigns of support and opposition, Lowenstein found that, among the 10 measures opposed by big money, 90% (nine) were defeated, compared to a success rate of 46% for campaigns in which big money supported a proposition. Id. at 518–19.

241. Reports of the precise amount of money raised in connection with the two initiatives varies, but it is clear that opponents raised far more than supporters. See, e.g., Gilmore, supra note 190, at A14 (reporting that, less than two weeks before the 1992 California election, opponents of Proposition 161 had raised $1.7 million from 135 groups, more than twice that raised by the initiative’s sponsors); Miller, supra note 2 (reporting that opponents of Proposition 161 raised $2.8 million, while backers raised just $215,000).

242. See supra notes 182, 184.

243. See supra text accompanying note 111 (showing general support for the concept of physician-aid-in-dying).

244. In both California and Washington, the Catholic Church was a major sponsor of the campaigns against Proposition 161 and Initiative 119. See Jacobs, supra note 190, at A20; Lori Olziewski, Right-to-Die Law Apparently a Loser, S.F. CHRON., Nov. 4, 1992, at A12.

245. See CRONIN, supra note 6, at 85. (“Support for the ‘cautious voter’ theory is provided by findings that about two-thirds of the citizen-initiated measures appearing on statewide ballots have been rejected.”).
According to this theory, voters are more likely to vote against a measure that seems radical or extreme, opting for no change at all. It was not difficult for voters to construe the euthanasia measures as extreme when opponents argued that they amounted to murder, often reminding voters of the biblical commandment, "Thou shall not kill." 246

The demise of the euthanasia initiatives may be attributable to a host of factors, including resource differentials and voter preference for the status quo, but their appearance in the electoral process revealed how political the issue of personal decision making has become. Initiative 119 and Proposition 161 were not spared campaign efforts to lead and mislead voters about the ramifications of enacting aid-in-dying legislation. Special interest influence also played a role in the campaigns. Thus, the euthanasia ballot initiatives were subjected to the same political forces that the Progressives sought to evade. 247

In the end, decisions about self-determination and autonomy were made amid political forces, hardly an ideal setting for choices of this magnitude.

Turning to the alternative lawmaking body, the legislature, one hardly sees a political process devoid of special interest influence and filled with pure, substantive debate. But in the area of personal decision making about death, any legislation is better if framed, debated, and enacted in the legislative bodies of our country rather than by initiative. Recall that every legislature in our nation, including Congress, has debated the merits of "right-to-die" issues. 248 Legislators are familiar with the arguments raised by the primary opponent of such laws, the Catholic Church. 249 Much of the early "right-to-die" legislation was a product of church influence, which changed its approach as popular support grew stronger. 250 The mechanisms of compromise that legislators routinely employ simply are not available to citizens deciding ballot measures; initiatives are not subject to public hearings, which can be useful for information gathering, and initiatives can rarely be amended once signature-gathering commences. 251 Without these opportunities

246. See Jacobs, supra note 184, at 198 (describing the role of religious rhetoric in the debate over Initiative 119).
247. See supra notes 157-59 and accompanying text.
248. See supra notes 26, 29.
249. See supra note 244.
250. See supra text accompanying notes 71-74.
251. DEMOCRACY BY INITIATIVE, supra note 6, at 21-23.
for self-education and compromise, the initiative process becomes a less desirable mechanism for creating personal choice regulation.

III. DEMOCRACY AS A MEANS OF PROTECTING BIOETHICAL CHOICES

In Part II of this Article, I criticized the use of direct democracy to enact legislation protective of certain bioethical choices, namely the right to voluntary euthanasia. My critique was based in part on the argument that majoritarian voting has led to a denial of fundamental rights, a problem for which the remedy lies with an unwilling legislature or with the efforts of another voter initiative. In either case, those in search of physician-aid-in-dying are unlikely to see legalization through the democratic process in the near future. Supporters might wonder whether democracy in any form is an appropriate vehicle for generating and protecting bioethical choices. After all, one could argue, if a choice is truly personal, it should not be the subject of governmental regulation. This proposition is explored below in the context of both direct and representative democracy.

A. Direct Democracy and Laws Affecting Personal Autonomy

At first blush, empowering citizens to draft and enact laws affecting their private lives seems reasonable in a society that has historically deemed such legislation appropriate. But relying on the initiative process to develop a comprehensive jurisprudence surrounding euthanasia, or any bioethical issue, is unwise and unfair for at least one major reason: lawmaking by initiative is only available in twenty-one states in our nation. Citizens in the remaining twenty-nine states must look to their state representatives to act in an area they may not wish to enter.

252. For example, abortion legislation has existed in this country since 1821, when Connecticut enacted legislation prohibiting the inducement of abortion through the use of dangerous poisons. See Tribe, supra note 28, at 28–29.
253. See supra note 164.
The inequitable availability of direct democracy to citizens in our country has implications beyond the mere opportunity to enact voter-made law. That is, even if citizens in the initiative states are unsuccessful in getting ballot propositions passed, their efforts may serve to alert legislators to the interest in or need for legislation in particular areas. In fact, the experience in Washington following the 1991 defeat of Initiative 119 is a good example of a legislature motivated by the electorate. In 1992, the Washington Legislature amended the state's living will law to allow physicians to withhold nutrition and hydration from terminally ill patients. This change was included as part of Initiative 119; the Legislature apparently was moved to consider some of the issues raised in the measure after its defeat. Euthanasia supporters in states without an initiative mechanism, however, must rely on traditional lobbying efforts to spur the legislature into action, a tool that has proved to be unsuccessful to date.

The limited availability of the initiative process also could lead to a divergence in the laws across our country. If euthanasia supporters are eventually able to pass legislation at the ballot box while legislators generally remain uninspired, we could see a hodge-podge of laws defining our medicolegal jurisprudence. This may mean that citizens from non-initiative states will travel to states recognizing a person's right to receive aid-in-dying. Forcing terminally ill patients to travel any distance is burdensome and ultimately discriminatory against those who lack the resources to make such a journey.

Checkerboard jurisprudence already does exist in our country in at least one area involving personal decision making: abortion. In that arena, however, the Supreme Court has

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254. See WASH. REV. CODE § 70.122.020(5) (1994) (expanding the definition of "life-sustaining treatment," which may be withheld under § 70.122.030).
255. Colen, supra note 18, at 122.
256. Such was the case for at least the first person who sought the assistance of Dr. Kevorkian. See Diane M. Gianelli, Murder Charge Filed Against Dr. Kevorkian May Spur Further Euthanasia Debate, AM. MED. NEWS, Dec. 14, 1990, at 3. For example, his first "patient," Janet Adkins, traveled from Oregon, which prohibits assisted suicide, to Michigan, where the law at that time did not proscribe Dr. Kevorkian's actions. Id.
257. The abortion law in our country is made up of a network of state laws regulating the practice in each state. See generally 1 ABORTION IN THE UNITED STATES, supra note 25 (listing the relevant abortion statutes in each state). Statutes in some states impose a 24-hour waiting period on women who seek abortion, see, e.g., MISS. CODE ANN. § 41-41-33 (1993), while others require parental consent for minors, see, e.g., 18 PA. CONS. STAT. ANN. § 3206 (1983). Congress has entertained a bill that would create a federal law protecting the right to choose abortion, but no such law has been enacted. See S. 25, 103d Cong., 1st Sess. (1993) (entitled the Freedom of Choice Act).
stepped in to protect a minimal right to reproductive freedom. In Planned Parenthood v. Casey,258 the Supreme Court held that the Constitution protects "the right of the woman to choose to have an abortion before [fetal] viability and to obtain it without undue interference from the State."259 This right, the Court said, derives from the liberty interest contained in the Due Process Clause of the Fourteenth Amendment.260 What this means from a practical standpoint is that states (or citizen lawmakers) may not enact legislation that would prohibit or impose a substantial obstacle to a woman's right to elect early abortion. To date, no protection exists for a right to choose physician-aid-in-dying,261 and this could result in a euthanasia checkerboard that is far more pronounced than that of abortion. Some states, for example, may permit and regulate choice-in-dying, while others may prohibit all physician aid. Ultimately this creates inequities among the rights of terminally ill patients nationally, which is hardly a desired result in a democratic society.

B. Representative Democracy and Laws Affecting Personal Autonomy

In our democratic society, we have come to expect that personal decisions invoking private preferences will be met with government regulation only under limited circumstances, such as when our actions pose harm to others. The jurisprudence surrounding bioethical choices, such as abortion and the right to refuse medical treatment, are examples of governmental deference coupled with limited regulation aimed at protecting third parties.262 In the euthanasia arena,

259. Id. at 2804.
260. Id.
261. See supra note 135 (citing cases in which courts have held that there is no constitutional right to physician-aid-in-dying).
262. I recognize that public debate surrounding these two issues, particularly abortion, continues to rage; what I am referring to by "governmental deference" are the constitutional protections afforded both practices. In Casey, the Supreme Court affirmed the pronouncement, first made in Roe v. Wade, that a woman's right to seek an abortion during the first trimester of pregnancy is fundamental and permits no undue governmental interference. Casey, 112 S. Ct. at 2804. Likewise, in Cruzan v. Director, Missouri Department of Health, the Court held that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment, including nutrition and hydration. 497 U.S. 261, 278-80 (1990).
supporters are now questioning whether choice-in-dying can be achieved through state regulation and whether a broader, constitutional approach would best achieve the desired personal autonomy. A brief discussion of the legal theory surrounding regulation of personal choice may shed light on the particular dilemma facing euthanasia advocates.

In his article, *Legal Interference with Private Preferences*, Professor Sunstein writes that "American law generally treats private preferences as the appropriate basis for social choice." Thus, in our society legal interference with private preferences can be objected to as paternalistic and even tyrannical. According to Professor Sunstein, the bases for objections to legal interference with private preferences are the concepts of liberty and futility. The objection based on liberty principles argues that the government has no purpose in evaluating whether a person's choice will serve her interests, except when that choice causes harm to others. The futility objection is that interference with private preferences will be ineffectual, because preferences will surface outside of regulation in a way that counteracts its intended effects. Applying this theoretical framework on potential regulation of euthanasia, any such regulation could be found objectionable on both liberty and futility grounds.

The objection to legal interference with private preferences for physician-assisted suicide based on liberty concerns has been previously set out. In the words of Judge Rothstein, "[t]here is no more profoundly personal decision, nor one which is closer to the heart of personal liberty, than the choice which a terminally ill person makes to end his or her suffering and hasten an inevitable death." This liberty interest, broadly

263. E.g., Interview with Michael White, Co-Founder of Californians Against Human Suffering, Santa Monica, Cal. (Apr. 20, 1994) (speculating that physician-aid-in-dying supporters would turn to the federal courts to gain constitutional protection rather than continuing to seek legislation, an effort proving futile and expensive).
265. Id. at 1129.
266. Id. at 1130.
267. Id. at 1131-32.
268. Id. at 1132.
269. Id.
270. See supra text accompanying notes 200–21.
construed, would include all forms of physician-aid-in-dying, because to deny any terminally ill patient such a right would infringe on that person's liberty interest in choosing death.

As to the argument that interference with private preference will be ineffectual, Professor Sunstein posits that such regulation will be futile because people will act in a way that expresses their private choice, thereby negating the intended effect of the law.\textsuperscript{272} Empirical data surrounding physicians' practices with respect to their terminally ill patients, though sparse, indicates that regulation barring doctors from rendering aid-in-dying to those patients would be ineffectual. Even though voluntary active euthanasia is illegal in every state in the nation, some physicians have admitted to helping patients die. For example, according to a survey of physicians conducted in 1991, "one in ten doctors said they had deliberately taken action to cause a patient's death."\textsuperscript{273} In that same year, a survey of internists who were members of the American Society of Internal Medicine reported that "one in five respondents had at some point taken 'deliberate action' to end a patient's life."\textsuperscript{274} The same study found that one in four of the physicians surveyed revealed that "patients had asked them to assist in committing suicide."\textsuperscript{275} These figures reveal that, despite the current laws prohibiting physicians from actively participating in a patient's death, such practices do occur, perhaps by as many as ten to twenty percent of all physicians.

Definitions of what constitutes legal futility may vary, but if we are cognizant of the apparent desire of both patients and physicians for more freedom to choose death, then we can predict that laws denying the full range of choices will likely be futile. If physicians and patients have already shown their unwillingness to abide by regulation limiting these freedoms, any further attempts to circumscribe choice will be met with either outright defiance or a move toward systematic, covert practices.

The dilemma for euthanasia advocates who are working toward legalization is to select a route that will produce the broadest protections for the most individuals. As noted in Part III.A, the method of enacting legislation through the initiative

\textsuperscript{272} Sunstein, supra note 264, at 1132.

\textsuperscript{273} Richard A. Knox, 1 in 5 Doctors Say They Assisted a Patient's Death, Survey Finds, BOSTON GLOBE, Feb. 28, 1992, at 5 (referring to a survey conducted by Physicians Management).

\textsuperscript{274} Joyce Price, 1 in 5 Doctors Helped Take Life, WASH. TIMES, Mar. 28, 1992, at A6; see also Knox, supra note 273, at 5 (citing the same survey).

\textsuperscript{275} Knox, supra note 273, at 5; Price, supra note 274, at A6.
process is of limited value as it is available in fewer than half of our states.276 Using more traditional lobbying efforts at state legislatures has proven ineffective to date, but the grass-roots efforts within selected states may help spur legislative action. The problem with relying on regulation on a state-by-state basis is that the law will undoubtedly be uneven, with some states allowing some highly regulated physician-aid-in-dying, while others will continue to ban the practice altogether.

Perhaps the best solution lies in combining efforts at the federal court and state legislative levels. If, for example, the Supreme Court were to recognize the right to physician-aid-in-dying as a part of the liberty interest described in *Cruzan v. Director, Missouri Department of Health*,277 then any state regulation would have to respect this fundamental right of its citizens. Thereafter, state regulation would have to meet a minimum constitutional threshold that would include protection of every citizen's right to exercise choice in dying. Although regulation could still be uneven, as it remains in the case of abortion,278 it could not operate to deny individuals the right to exercise their fundamental right to choose a dignified, accelerated death.

**CONCLUSION**

The popularity of the ballot initiative as a way to air politically and socially controversial topics was certainly evident in November 1992, when voters cast their ballots on measures relating to euthanasia, abortion, and gay rights. Direct democracy in the form of ballot initiatives enables citizens to gain access to lawmaking in the face of a disinterested or hostile legislature. In the case of physician-aid-in-dying, direct democracy presented an opportunity for grass roots supporters to convert a perceived bioethical choice into law. Yet despite its potential for inspiring widespread citizen discussion and debate about euthanasia as a bioethical choice, citizen lawmaking will likely never produce the concentrated, often forced, compromise-oriented debate that can be achieved in the legislative process. It is this flaw—the lack

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276. See supra note 164.
278. See supra note 257.
of opportunity for citizen bargaining and compromise—that ultimately indicates that bioethical lawmaking is best placed in legislative hands. If legal protection of euthanasia is one day achieved,\(^{279}\) it should be through a process that enables lawmakers to study a variety of choices, pick each of them apart, and piece together a consensus plan accommodating a majority interest while still protecting personal autonomy. This was the history of the right-to-die movement in the 1970s and 1980s; euthanasia proponents can strive for this same treatment in the years to come.

By this conclusion, I do not intend to suggest that direct democracy and bioethical choices are completely incompatible; to the contrary, I believe that the initiative process has and will play an important role in the fight for physician-aid-in-dying by triggering public debate about the issue, inevitably alerting legislators to the need for reasoned debate.\(^{280}\) Certainly the experience in Washington following the defeat of Initiative 119 is an excellent example of the role that citizen lawmaking can play in motivating legislative action.\(^{281}\) This joint citizen/legislative effort may be a preferred political model for designing and enacting legislation which so profoundly affects individual decision making.

\(^{279}\) As noted in Part III.B, I would advocate that euthanasia regulation be enacted amid constitutional protection recognizing the right to physician-aid-in-dying as a fundamental liberty interest accorded all citizens.

\(^{280}\) This view is certainly not unique among those who have commented on the initiative process. For example, in his review of Professor Magleby's book on direct legislation, Professor Richard Briffault concludes that, despite its shortcomings, direct democracy serves an important role in ensuring that certain proposals not ordinarily high on the legislative agenda are given consideration. Briffault, \textit{supra} note 11, at 1372 ("So long as enough initiatives succeed periodically to demonstrate the electorate's potential lawmaking power, it is probably better that most laws emerge from the legislative process, with its greater capacity for rationality, compromise, care, and deliberation."); \textit{see also} Eule, \textit{supra} note 8, at 1555 ("Considered judgments, sensitive to the interests of all, require time, debate, deliberation, information, and shared power. Substitutive plebiscites shortchange the decision-maker on all these accounts.").

\(^{281}\) \textit{See supra} text accompanying notes 254–55.