Book Review

WESLEY J. SMITH, FORCED EXIT: THE SLIPPERY SLOPE FROM ASSISTED SUICIDE TO LEGALIZED MURDER

JULIE A. FINEGAN

During the fall of 1998, one of the top news stories in the Baltimore-Washington metropolitan area was that of Hugh Finn, who was left in a permanent vegetative state after a car accident, and his family's struggle to decide upon his fate.[1] Finn's wife and sisters sought to have his feeding tube removed and intravenous fluids discontinued.[2] However, his brothers and parents argued that Finn, because of his religious beliefs,[3] would not have wanted to end his life.[4] Prince William Circuit Judge Frank A. Hoss, Jr. determined that the testimony of Finn's wife and attorney provided sufficient evidence that he would not want to be kept alive under such conditions; therefore, artificial nutrition could be withdrawn.[5] Despite an appeal to the Virginia Supreme Court by Governor James Gilmore[6] and efforts by a state legislator to prevent the removal of the feeding tube,[7] Finn's wife prevailed.[8] The feeding tube was removed and intravenous fluids were discontinued.[9] Eight days later, on October 9, 1998, Finn died.[10]

The saga of Hugh Finn and his family sparked much debate.[11] Reporters discussed how different religious denominations viewed

---

1. *See* Brooke A. Masters, *Conscious of a Life in the Balance: Brain Injured Man's Divided Family Caught in Legal, Medical Netherworld*, WASH. POST, Sept. 27, 1998, at B1 [hereinafter *Conscious of a Life in the Balance*].

2. *See id.*

3. Finn was a practicing Roman Catholic. *See* Brooke A. Masters, *Family Reunites as Hundreds Mourn Finn; Pastor Calls for Forgiveness*, WASH. POST, Oct. 13, 1998, at B4.

4. *See Conscious of a Life in the Balance*, *supra* note 1.

5. *See* Brooke A. Masters, *The Battle Outlives Hugh Finn: Medical Examiner Tries to Take Body*, WASH. POST, Oct. 10, 1998, at A1.

6. *See* R. H. Melton & Brooke A. Masters, *Court Rejects Gilmore's Bid to Overturn Finn Ruling: Family Decision Stands to Let Newscaster Die*, WASH. POST, Oct. 3, 1998, at B1. Gilmore argued that a 1992 Virginia law that allowed the removal of feeding tubes from vegetative patients should not apply to Finn. *See id.* Gilmore contended that Finn was not dying and that the removal of the feeding tube was euthanasia, which is illegal. *See id.*

7. *See id.*

8. *See Judge Rejects Legislator's Suit in Finn Case*, WASH. POST, Oct. 9, 1998, at B3.

9. *See Conscious of a Life in the Balance*, *supra* note 1.

10. *See id.*

11. *See infra* notes 12-16 and accompanying text.

end-of-life issues.[12] Newspaper articles debated whether the removal of a feeding tube was tantamount to euthanasia.[13] Interest in living wills and advance directives increased.[14] The question of whether a living will was a suicide wish was raised.[15] Writers examined the shift from heart cessation to brain death as the determining factor of death.[16] Although none of these issues can be easily resolved, in *Forced Exit*,[17] Wesley J. Smith explores end of life decision-making issues and expresses his opinion that legalized assisted suicide will lead us down "the slippery slope from assisted suicide to legalized murder."[18]

Smith insinuates that we have already started down a slippery slope by allowing the removal not only of artificial ventilation but also of feeding tubes (artificial nutrition).[19] Smith builds his slippery slope argument by creating doubt in the reader's mind as to how and where a line could be drawn or a regulation could be devised to ensure that assisted suicide is available only to those with a hopeless illness or unbearable pain.[20] His argument is presented not only through a discussion of legal decisions and the structure of the health care delivery system, but also through family testimonials and anecdotal evidence.[21] In his book, he includes several case studies, which provide a name, a biography, and a family behind the statistics.[22] He offers the viewpoints of nurses who care for people who are terminally ill or in a permanent vegetative state.[23]

As evidenced by the title, Smith seeks to convince the reader that allowing assisted suicide in any circumstance will begin a dangerous slide ending in the devaluation of the lives of the elderly, children

---

12. *See, e.g.*, Caryle Murphy, *When is it Time to Die? Faiths, Families Weigh End-of-Life Issues*, WASH. POST, Nov. 2, 1998, at C1.

13. *See, e.g., id.*

14. *See, e.g.*, Don Colburn, *Facing Death With a Plan; 'Five Wishes' Living Will Aims to Help Families Prepare for the End of Life*, WASH. POST, Oct. 27, 1998, at Z7; Jennifer Lenhart and Justin Blum, *Living-Will Inquiries Increase in Wake of Case*, WASH. POST, Oct. 11, 1998, at B1; Murphy, *supra* note 12.

15. *See, e.g.*, Murphy, *supra* note 12.

16. *See, e.g.*, Guy McKhann, *The Modern Meaning of Death; And Why the Brain Is at the Heart of It*, WASH. POST, Oct. 25, 1998, at C1.

17. WESLEY J. SMITH, FORCED EXIT: THE SLIPPERY SLOPE FROM ASSISTED SUICIDE TO LEGALIZED MURDER (1997).

18. *Id.*

19. *See id.* at 43.

20. *See id.* at 50, 100, 122-23.

21. *See id.* at 155-57, 159-60, 173-78, 188-91, 194-99.

22. *See id.* at 39-42 (discussing Robert Wendland), 48-49 (discussing Christine Busalacchi), 52-60 (discussing Ronald Comeau), 60-64 (discussing Michael Martin).

23. *See id.* at 39, 48.

with birth defects, and the disabled.[24] His story is a compelling one, skillfully crafted to unfold in a manner that will convince many readers of the danger of the slippery slope. This book review consists of two parts. Section I summarizes some of *Forced Exit*'s major topics including the removal of feeding tubes, euthanasia in Nazi Germany and the Netherlands, legislation and lower court decisions leading to the 1997 landmark United States Supreme Court cases, and the predicted impact of legalized euthanasia in the United States. In addition, Section I includes an update on key United States Supreme Court decisions announced after *Forced Exit* was published.[25]

An examination of the strengths and weaknesses of Smith's arguments follows in Section II. Readers may question Smith's presumption that terminally ill individuals are at higher risk for suicide.[26] Nonetheless, this assertion appears to be well-founded.[27] However, his distinction between the removal of life support and artificial nutrition may not be satisfactory to all. Further, the implementation and effectiveness of some of Smith's suggested alternatives may prove daunting.[28] Many of Smith's arguments could have greater impact if he included any available statistics to support his theories.[29] Additionally, a more in-depth analysis of *In re Quinlan*,[30] a landmark case on this subject, would give his theories greater strength.[31]

I. SMITH'S ARGUMENTS

A. *The Discontinuation of Artificial Nutrition*

In chapter two, "Creating a Caste of Disposable People," Smith examines the removal of feeding tubes, or "artificial nutrition," from non-terminal patients.[32] Smith explains that the use of "artificial nutrition" and fluids was once considered humane care, a category of care that includes warmth, shelter, and cleanliness.[33] In contrast to

---

24. *See id.* at 166-67 (discussing the elderly), 106-08 (discussing children with birth defects), 181-193 (discussing the disabled).

25. *See* Washington v. Glucksberg, 521 U.S. 702 (1997); Vacco v. Quill, 521 U.S. 793 (1997). *See also infra* notes 135-51 and accompanying text.

26. *See* SMITH, *supra* note 17, at 29-30.

27. *See, e.g., id.* at 29-30, 124-25. *See also infra* notes 168-75 and accompanying text.

28. *See infra* notes 212-26 and accompanying text.

29. *See generally, e.g.*, SMITH, *supra* note 17, at 97-101. *See also infra* notes 202-11 and accompanying text.

30. 355 A.2d 647 (N.J. 1976).

31. *See, e.g.*, SMITH, *supra* note 17, at 42-43, 134-35. *See also infra* notes 191-95 and accompanying text.

32. SMITH, *supra* note 17, at 36-89.

33. *Id.* at 42-43.

humane care, medical care includes interventions such as surgery, medications, and tests.[34] He takes the view that the term "artificial nutrition" was coined to create the appearance that food and water, or humane care, are not what is really being withdrawn.[35] Instead, what is being withdrawn is "artificial nutrition," or medical treatment.[36] The use of the term "artificial nutrition" was the first step in a "deliberate campaign" to desensitize the public to the withdrawal of food and fluids from the permanently unconscious.[37]

Smith notes that in 1986 the American Medical Association Council on Ethical and Judicial Affairs issued a statement that treatment, including artificial nutrition and hydration, may be discontinued for individuals who are undoubtedly permanently unconscious.[38] He discusses how such cases initially applied only to permanently unconscious individuals who had previously expressed that they would want such treatment discontinued.[39] Smith begins with the landmark case *Cruzan v. Director, Missouri Department of Health*.[40] As the result of a 1983 car accident, Nancy Cruzan was left severely disabled. Although she was able to swallow small amounts of food, Cruzan was unable to swallow enough to meet her daily needs.[41] She was placed on a feeding tube, and, one year after the American Medical Association opinion, Cruzan's parents sued the Missouri Department of Health to remove her nutrition and fluids.[42] The Circuit Court ordered the hospital to comply with Cruzan's request, but the Missouri Supreme Court reversed.[43] The United States Supreme Court, agreeing that artificial nutrition is a form of medical treatment that can be ethically withdrawn, held that Missouri law allowed life support to be withdrawn from an incompetent patient if there was clear and convincing evidence that the person would so desire.[44]

Smith illustrates how decisions have strayed from initially removing feeding tubes from completely unconscious individuals to removing artificial nutrition from those who may be conscious at some level.[45] He describes the cases of several individuals who were con-

---

34. *See id.* at 43.
35. *Id.*
36. *Id.*
37. *Id.* at 42-45.
38. *See id.* at 44-45.
39. *See id.* at 44-47.
40. *See id.* at 45-46 (discussing 497 U.S. 261 (1990)).
41. *See* Cruzan v. Director Mo. Dep't of Health, 497 U.S. 261, 266 n.1 (1990).
42. *See* SMITH, *supra* note 17, at 45-46 (citing *Cruzan*, 497 U.S. at 268).
43. *See id.* at 46 (citing *Cruzan*, 497 U.S. at 268).
44. *See id.* at 46-47 (citing *Cruzan*, 497 U.S. at 280).
45. *See id.* at 63-64.

scious, although severely brain-damaged, whose families or guardians sought to discontinue artificial nutrition.[46] One such story is that of Michael Martin, who was seriously injured when his car was struck by a train.[47] Prior to his accident, Martin had allegedly expressed to his wife that if he ever suffered a devastating injury, he would not want to live at a low-functioning level.[48] After the accident by using a letter board, Martin expressed that he was afraid for himself and that he was afraid he would have to leave the facility where he was living.[49] Even though he was conscious, the Michigan Court of Appeals gave deference to his decision before the injury and not to his desire to continue living expressed after the injury.[50] Ultimately, the Michigan Supreme Court ruled that the uncorroborated testimony of Martin's wife was insufficient to meet the standard of clear and convincing evidence[51] required to withdraw treatment.[52] Mrs. Martin's appeal to the United States Supreme Court was denied, and Mr. Martin's feeding tube was not removed.[53]

By describing the physical realities of dehydration, Smith bolsters his argument that dehydrating conscious individuals is a dangerous step.[54] He notes that when conscious individuals are dehydrated, they may be able to feel the pain associated with this ten-to-fourteen-day death.[55] Further, Smith describes how the patient's skin, lips, and tongue crack, the drying of the mucus membranes and stomach lining, and the other physical realities of death by dehydration.[56] Additionally, he notes that doctors are uncertain about how much pain medication is required to minimize the discomfort that conscious individuals may experience.[57]

---

46. *See id.* at 48-64.

47. *See id.* at 62.

48. *See id.* at 63.

49. *See id.* at 60.

50. *See id.* at 63.

51. *See id.* Clear and convincing evidence requires that the truth of the facts asserted be highly probable. *See* BLACK'S LAW DICTIONARY 251 (6th ed. 1991).

52. *See* SMITH, *supra* note 17, at 64 (citing *In re* Michael Martin, 538 N.W. 2d 399, 413 (Mich. 1995)).

53. *See id.* at 64.

54. *See id.* at 50.

55. *See id.*

56. *See id.* (citing interview with Dr. William Burke).

57. *See id.* (citing *In re* Conservatorship of Robert Wendland No. 65669 Cal. Sup. Ct. San Jouquin County, filed 1995, deposition of Dr. Ronald Cranford, at 48).

B. Euthanasia in Nazi Germany and the Modern-Day Netherlands

Smith next shifts from examining issues surrounding the withdrawal of treatment to actual euthanasia.[58] For the purposes of this book, Smith defines euthanasia as the killing of one person by another because the person to be killed has a serious disease, injury, disability, emotional or mental disturbance, or is elderly.[59] He defines assisted suicide as occurring when an individual who is seriously ill, disabled, or elderly kills himself or herself with another person assisting in or facilitating the termination of life.[60] Smith uses the examples of Nazi Germany and the modern-day Netherlands to show how quickly a society can go from accepting euthanasia in limited circumstances to accepting its use for children with birth defects and elderly individuals with non-terminal illnesses.[61]

The philosophical foundation for euthanasia in Germany began with scholarly writings of the late nineteenth and early twentieth centuries supporting the practice.[62] By 1938, relatives of dying persons and severely disabled children were requesting permission from the government to end the lives of their dying and disabled relatives.[63] German medical personnel first began killing children with birth defects when parents turned them over despite suspecting their children would be killed.[64] Hitler gradually expanded euthanasia to include severely mentally ill and retarded adults, criminally insane persons, and individuals with conditions such as epilepsy, schizophrenia, and paralysis.[65] Although Hitler ordered that the German euthanasia program be discontinued in 1941, many doctors continued to participate.[66] While his examination of euthanasia in Nazi Germany is largely based on historical accounts, Smith incorporates statistics from a recent survey of medical doctors in the Netherlands to emphasize how ineffective guidelines can be in preventing abuses.[67]

In 1973, the Netherlands permitted euthanasia under limited circumstances for cases where no other medical means would alleviate a

---

58. *See, e.g., id.* at 68-114.
59. *See id.* at xxv.
60. *See id.*
61. *See, e.g., id.* at 68-114.
62. *See id.* at 72-73 (citing ADOLF JOST, RIGHT TO DEATH (1895); ROLAND GERKAN, EUTHANISE (1913); KARL BINDING & ALFRED HOCHE, PERMITTING THE DESTRUCTION OF LIFE NOT WORTHY OF LIFE: ITS EXTENT AND FORM (1920), *in* 8 L. & MED., 231-65 (1992)).
63. *See id.* at 77.
64. *See id.* at 77-78.
65. *See id.* at 79.
66. *See id.* at 80-81.
67. *See id.* at 97-100.

patient's suffering.[68] Euthanasia has not been formally legalized in the Netherlands, but it is not prosecuted if the doctors follow official guidelines.[69] The requirements include the following:

- The request must be of the patient's free will and not result from pressure by others;
- The request must be made repeatedly over a period of time;
- The patient's suffering must be unbearable;
- The patient must be told about and have time to consider alternatives to euthanasia;
- There must be no reasonable alternatives to relieve the patient's suffering;
- Doctors must consult a colleague who has experience in euthanasia;
- Only a doctor may euthanize; and
- A report must be filed with the coroner.[70]

Smith cites the 1990 Remmelink Report on the practice of euthanasia in the Netherlands to demonstrate the ineffectiveness of these guidelines.[71] This report showed that 90,000 deaths involved end-of-life decision making.[72] Of those deaths, 2,300 people were euthanized upon request and 400 died by physician-assisted suicide.[73] There were 1,040 cases of involuntary euthanasia or lethal injections given without request or consent.[74] Of the involuntary euthanasia cases, 145 were individuals who were still competent in making their own medical decisions.[75] Finally, 8,100 patients were given an intentional overdose of pain-control medication with the intention of ending their lives.[76] Although he provides two examples of involuntary euthanasia, Smith does not provide a complete explanation of the doctors' reasoning behind these 1,040 cases.[77]

---

68. *See id.* at 93.

69. *See id.*

70. *Id.* at 96 (citing CARLOS GOMEZ, REGULATING DEATH 62 (1991)).

71. *See id.* at 98 (citing J. REMMELINK ET AL., MEDICAL DECISIONS ABOUT THE END OF LIFE (1991)). The Remmelink report surveyed over 400 physicians retrospectively on their position and practice of euthanasia. *See id.* For six months, the same physicians recorded their actions in cases with a fatal outcome. *See id.* Finally, a sampling of deaths were taken, and the physicians asked for information about the cases. *See id.*

72. *See id.* at 99 (citing J. REMMELINK ET AL., MEDICAL DECISIONS ABOUT THE END OF LIFE (1991)).

73. *See id.*

74. *See id.*

75. *See id.*

76. *See id.*

77. *See id.* at 100-01. In one case, Smith explains that a patient was euthanized against the patient's will and without the treating doctor's knowledge. *See id.* The euthanizing

Smith also cites a more recent study that indicates that the Remmelink Report may actually underestimate the incidence of euthanasia deaths.[78] Based upon the results of this report, Smith suggests that preventive guidelines and protections are ineffective in restricting euthanasia.[79] Contrasting the Netherlands's socialized medical system, which provides virtually every citizen with medical care, with the American for-profit health care system and level of uninsurance,[80] he warns that the American experience could be far worse.[81]

C. *American Legal History*

Smith also examines legislation and landmark legal battles in the United States leading up to the time of publication.[82] For example, beginning in the early 1990s, voters in Washington and California rejected two initiatives that would have legalized euthanasia.[83] Washington's Initiative 119, which would have allowed doctors to lethally inject patients under some circumstances, lost fifty-four percent to forty-six percent of the vote in the 1991 election.[84] The following year, fifty-four percent of California voters also rejected euthanasia by voting down Proposition 161.[85]

Oregon's Measure 16, also known as the Oregon Death with Dignity Act, was successful.[86] This 1994 measure allowing suicide for the terminally ill who request medication for ending their lives[87] was narrowly approved, earning fifty-one percent of the vote.[88] The Death with Dignity Act's provisions define a terminal illness as an incurable disease that will result in death in less than six months.[89] However,

---

doctor stated that the patient's bed was needed for another case. *See id.* (citing Interview with Dr. K.F. Gunning). In another case, a nun was euthanized against her will because her doctor felt she was in too much pain. *See id.* at 101 (citing Herbert Hendin, *Assisted Suicide, Euthanasia, and Suicide Prevention: The Implications of the Dutch Experience*, 21 SUICIDE & LIFE THREATENING BEHAV., Spring 1995, at 201-02).

78. *See id.* at 100. (citing Paul J. van der Maas et al., *Euthanasia and Other Medical Practices Concerning the End of Life*, 22 HEALTH POL'Y MONOGRAPHS 49 (1992)).

79. *See id.*

80. *See id.* at 93.

81. *See id.* at 109. *See also infra* notes 152-64 and accompanying text.

82. *See id.* at 115-41.

83. *See id.* at 116.

84. *See id.*

85. *See id.*

86. *See id.* at 121 (citing OR. REV. STAT. ch. 127.800 (1996)).

87. *See id.* at 116-17 (citing OR. REV. STAT. ch. 127.800 (1996)).

88. *See id.* at 116-17, 121.

89. *See id.* at 122 (citing OR. REV. STAT. ch. 127.800, §1.01(12) (1996)). The statute requires that the attending physician make an initial determination that the patient has a terminal disease. *See id.* The attending physician must then refer the patient to another physician for a confirmation of the diagnosis. *See id.*

Smith points to an Oregon Medical Association Poll showing that fifty percent of doctors reported they did not feel competent to predict when a patient had less than six months to live.[90] Smith also criticizes the law for not adequately providing for effective depression screening since the law does not require a formal psychiatric evaluation.[91] A formal psychiatric evaluation is essential to diagnose depression, as many medical doctors are not adequately trained to identify depression in their dying patients.[92]

Shortly after it passed, Dr. Gary Lee and several other plaintiffs brought a lawsuit against Measure 16 in the United States District Court.[93] Dr. Lee and the other plaintiffs, including a man dying of AIDS and a diabetic, claimed that the basis of the law was the belief that the lives of the terminally ill and disabled are less worthy of protection.[94] Judge Hogan of the United States District Court ruled that Measure 16 was unconstitutional because it excluded terminally ill individuals from protections against suicide that Oregon laws provide to others.[95] Judge Hogan also noted that Oregon law provided residents protection against suicide if they are found to be a danger to themselves.[96] The court found that the law provided a means to commit suicide to terminally ill individuals who may be incompetent, abused, or unduly influenced prior to their decisions.[97] At the time *Forced Exit* was written, the case was awaiting appeal with the United States Court of Appeals for the Ninth Circuit.[98] In early 1997, after *Forced Exit* went to press, the United States Court of Appeals for the Ninth Circuit overturned Judge Hogan's ruling by holding that the plaintiffs did not have standing[99] to challenge the law.[100] In other words, the plaintiffs,

---

90. *See id.* at 123 (citing Patrick O'Neill, *Suicide Aid Worries Oregon Doctors*, PORTLAND OREGONIAN, Feb. 1, 1996).

91. *See id.* at 124 (discussing OR. REV. STAT. ch. 127.800 *et seq.* (1996)).

92. *See id.*

93. *See id.* at 125 (citing Lee v. Oregon, 891 F. Supp. 1421, 1438 (D. Or. 1995)).

94. *See id.* at 126 (citing Lee v. Harcleroad, Case No. 94-6467-TC, U.S. District Court, District of Oregon, 1994, Complaint for Declaratory and Injunctive Relief, civil rights).

95. *See id.* (citing *Lee*, 891 F. Supp. at 1438).

96. *See id.* (citing *Lee*, 891 F. Supp. at 1438).

97. *See id.* at 127 (citing *Lee*, 891 F. Supp. at 1439).

98. *See id.*

99. In a lawsuit, the parties must have standing, meaning that they must have a legally protectable and tangible interest at stake in the litigation. *See* BLACK'S LAW DICTIONARY, *supra* note 51, at 978. The issue of standing involves whether the litigant is the proper party to fight the lawsuit, not whether the issue itself is appropriate for the court's review. *See id.*

100. *See* Ashbel S. Green & Erin Hoover, *Judge Gives Suicide Foes Another Try at Suit*, PORTLAND OREGONIAN, Nov. 26, 1997, at A1. *See also* Lee v. Oregon, 107 F.3d 1382 (9th Cir. 1997).

a woman with muscular dystrophy and two of her doctors, were not personally harmed by the assisted suicide law.[101] The United States Supreme Court refused to hear the appeal.[102]

In the November, 1997 elections, Oregon voters defeated a measure to repeal the Death with Dignity Act by sixty percent to forty percent.[103] However, the legal wrangling did not end there, as the United States Senate and the House of Representatives considered bills that would invalidate the law.[104] In June, 1998, Senator Don Nickles of Oklahoma introduced a bill that would have amended the Controlled Substances Act[105] to prohibit doctors from prescribing lethal doses of pain-killers for terminally-ill patients.[106] This amendment would have therefore rendered the Oregon measure practically inoperative.[107] Although Senator Nickles was unsuccessful with his bill, he plans to introduce it again when the 106th Congress convenes in January, 1999.[108] A companion bill, introduced in the House of Representatives, "stalled before a floor vote" in September, 1998.[109] However, Oregon was not the only state where such legal battles were raging.[110]

Smith next analyzes *Compassion in Dying v. Washington*,[111] in which the group Compassion in Dying[112] and three terminally ill patients challenged Washington's law banning assisted suicide.[113] Smith notes that the plaintiffs won in United States District Court, but he does not discuss the District Court's reasoning.[114] The United States District

---

101. *See* Green & Hoover, *supra* note 100.

102. *See* Lee v. Harcleroad, 891 F. Supp. 1421 (D. Or. 1995), *cert. denied sub. nom.*, 118 S. Ct. 328 (1997).

103. *See* Gail Kinsey Hill, *Lawmakers Might Halt Suicide Law Efforts*, PORTLAND OREGONIAN, Dec. 11, 1997, at D1.

104. *See* Jim Barnett & Dave Hogan, *Senator Drops Effort to Block Suicide Law*, PORTLAND OREGONIAN, Oct. 15, 1998, at A1.

105. The Controlled Substances Act is part of the Comprehensive Drug Abuse Prevention and Control Act. *See* 21 U.S.C. § 841 *et seq.* (1981).

106. *See* Barnett & Hogan, *supra* note 104.

107. *See id.*

108. *See id.* Nickles "dropped his effort" to pass the bill after it appeared that he could not insert the bill's language into the Omnibus Budget Bill. *Id.*

109. *Id.*

110. *See infra* notes 111-50 and accompanying text.

111. 850 F. Supp. 1454 (W.D. Wash. 1994), *rev'd* 49 F.3d 586 (9th Cir. 1995), *aff'd en banc* 79 F.3d 790 (9th Cir. 1996), *rev'd sub nom.* Washington v. Glucksberg, 521 U.S. 702 (1997). The names of the parties changed on appeal after *Forced Exit* went to press.

112. Compassion in Dying, an offshoot of the Hemlock Society, provides counseling for individuals contemplating suicide and assistance in committing suicide. *See* SMITH, *supra* note 17, at 128.

113. *See id.* (discussing *Glucksberg*, 521 U.S. at 707).

114. *See id.*

Court held that the Fourteenth Amendment protected the liberty interests of terminally ill adults to choose physician-assisted suicide and that the statute unconstitutionally burdened this liberty interest.[115] The District Court also found that the Washington statute banning assisted suicide violated the Equal Protection clause of the Fourteenth Amendment[116] by banning assisted suicide while allowing terminally ill patients to refuse life support.[117]

Next, a three-judge panel of the United States Court of Appeals for the Ninth Circuit reversed the district court and held that Washington's law was constitutional.[118] An eleven-judge panel of the same court reheard the case and, in an 8-3 decision, found the law against assisted suicide unconstitutional as it applied to the terminally ill.[119] Smith criticizes the outcome of the eleven-judge panel as creating new constitutional rights while ignoring the words of the Constitution itself, ignoring judicial precedent,[120] and disregarding the results of the election defeating Washington's Initiative 119.[121] Smith also states that this decision created a liberty interest that does not apply to all people; instead, *Compassion in Dying* created a sliding scale in which the state has a greater interest in preventing the suicide of young, healthy people than of the terminally ill.[122]

Finally, Smith examines *Quill v. Vacco*[123] in which the plaintiffs sought to have New York's law banning assisted suicide declared unconstitutional.[124] The trial court dismissed Quill's suit, and he appealed to the United States Court of Appeals for the Second Circuit.[125] Just weeks after the Ninth Circuit's ruling in *Washington v. Glucksberg*[126] upholding the right to die, the United States Court of

---

115. *See Compassion in Dying*, 850 F. Supp. at 1467.

116. Section 1, Clause 2 of the Fourteenth Amendment states, "No state shall . . . deny to any person within its jurisdiction the equal protection of the laws." U.S. CONST. amend XIV, § 1.

117. *See Compassion in Dying*, 850 F. Supp. at 1467.

118. *See* SMITH, *supra* note 17, at 128 (discussing Compassion in Dying v. Washington, 49 F.3d 586 (9th Cir. 1995)).

119. *See id.* (discussing Compassion in Dying v. Washington, 79 F.3d 790 (9th Cir. 1996) (en banc)).

120. Precedent is "[a]n adjudged case or decision of a court, considered as furnishing an example or authority for an identical or similar case afterwards arising or a similar question of law." BLACK'S LAW DICTIONARY, *supra* note 51, at 814.

121. *See* SMITH, *supra* note 17, at 129.

122. *See id.* at 130.

123. 850 F. Supp. 78 (S.D.N.Y. 1994), *rev'd* 80 F.3d 716 (2d. Cir. 1996), *rev'd* 521 U.S. 723 (1997).

124. *See* SMITH, *supra* note 17, at 132 (discussing *Quill*, 80 F.3d at 718).

125. *See id.* (discussing *Quill*, 80 F.3d at 722).

126. 521 U.S. 702 (1997).

Appeals for the Second Circuit countered that ruling and held that assisted suicide is not a fundamental liberty interest stemming from the Constitution.[127] Rather, the United States Court of Appeals for the Second Circuit used the Equal Protection clause of the Constitution[128] to permit assisted suicide.[129] Under the Equal Protection clause, citizens who are similarly situated must be treated alike under the law.[130] Therefore, the court concluded that terminally ill patients who require life support and those who do not require life support are similarly situated; those who do not require life support and cannot die by refusing treatment should have the right to assisted suicide.[131]

Smith counters the Court of Appeals' reasoning by arguing that dying a natural death, as would happen when life support is removed, is not the same as being killed.[132] When a respirator is removed, doctors cannot be certain that the patient will die; Karen Quinlan lived for ten years after her respirator was removed.[133] In assisted suicide, the patient is certain to die after the doctor injects the necessary medication.[134]

In June, 1997, after *Forced Exit* went to press, the United States Supreme Court upheld both the Washington and New York statutes.[135] In *Washington v. Glucksberg*, the Court held that assisted suicide is not a fundamental liberty interest protected by the Due Process Clause.[136] The Court noted that the Due Process Clause protects rights and liberties that are "'deeply rooted in this Nation's history and tradition.'"[137] The Court distinguished the asserted right to die from previous cases, such as *Cruzan v. Director, Missouri Department of Health*,[138] which allowed patients to refuse medical treatment.[139] The Court also noted society's consistent rejection of a right to die, from

---

127. *See* SMITH, *supra* note 17, at 132 (discussing *Quill*, 80 F.3d at 724-25).
128. *See supra* note 116.
129. *See* SMITH, *supra* note 17, at 133 (discussing *Quill*, 80 F.3d at 725-31).
130. *See id.*
131. *See id.* at 134 (discussing *Quill*, 80 F.3d at 729).
132. *See id.*
133. *See id.*
134. *See id.*
135. *See* Roberto Suro, *States to Become Forum for Fight Over Assisted Suicide: In Wake of Justices' Ruling, Legislatures Will Play Key Role in Rights of the Terminally Ill.*, WASH. POST, June 27, 1997, at A19.
136. Washington v. Glucksberg, 521 U.S. 702, 728 (1997), *rev'g* 79 F.3d 790 (9th Cir. 1996), *aff'g en banc* 49 F.3d 586 (9th Cir. 1995), *rev'g* 850 F. Supp. 1454 (W.D. Wash. 1994).
137. *Glucksberg*, 521 U.S. at 721 (quoting Moore v. City of E. Cleveland, 431 U.S. 494, 503 (1977) (plurality opinion)).
138. 497 U.S. 261 (1990).
139. *See Glucksberg*, 521 U.S. at 722-28.

the common law punishment of suicide and assisted suicide in England and the American colonies to the voters' rejection of Washington's and California's assisted suicide initiatives.[140] Additionally, the Court noted that Washington had a legitimate state interest in banning assisted suicide.[141] In reaching this conclusion, the Court compared the ban on assisted suicide to other homicide statues, noted that certain groups, such as adolescents, the elderly, and depressed individuals, are particularly at risk for suicide, and stated that Washington had an interest in protecting the medical profession's ethical standards.[142] Finally, the Court noted the risk of involuntary euthanasia, citing statistics on involuntary euthanasia in the Netherlands.[143]

In *Vacco v. Quill*, the United States Supreme Court held that New York's law banning assisted suicide did not violate the Equal Protection clause of the Fourteenth Amendment.[144] The Court noted that the Equal Protection Clause requires the states to treat similar cases alike but does not impose such a requirement on differing cases.[145] The Court noted several differences between the refusal of life-sustaining treatment and assisted suicide.[146] First, when life-sustaining treatment is removed, the patient dies from the underlying condition itself; whereas with lethal medication, the medication causes the death.[147] The Court noted that a physician's intent varies with each situation.[148] In withdrawing life support, the intent is to cease futile treatment; in assisting suicide, the intent is to kill the patient.[149] Finally, the Court noted that lower courts and state legislatures had consistently distinguished between the withdrawal of treatment and assisted suicide.[150]

The *Glucksberg* and *Vacco* decisions were handed down after *Forced Exit* went to press, so one can only speculate on Smith's reaction to the decisions. It is likely that he would be pleased that the Court found that there is no fundamental liberty interest in assisted suicide and that the state has a legitimate interest in banning assisted suicide. The Supreme Court's reasoning paralleled many of Smith's argu-

140. *See id.* at 711-19.
141. *See id.* at 728.
142. *See id.* at 728-33.
143. *See id.* at 734-35.
144. Vacco v. Quill, 521 U.S. 793, 799 (1997).
145. *See id.* at 799.
146. *See id.* at 801-03.
147. *See id.* at 801.
148. *See id.*
149. *See id.* at 801-04.
150. *See id.* at 803-04.

ments. However, the Court refused to hear an appeal of *Lee v. Oregon*, thus allowing Oregon's assisted suicide statute to remain in effect. The net result of the Court's rulings in *Glucksberg* and *Vacco*, combined with its refusal to hear *Lee*, allows each state to make its own decisions about assisted suicide.[151] Whether this net result will lead to more assisted suicide statutes, which would support Smith's slippery slope argument, remains to be seen.

D. Forecast of the American Experience

Smith argues that the legalization of euthanasia in the United States would be much more dangerous than in the Netherlands.[152] This is due in part to the differences between each country's health care delivery systems.[153] While the Netherlands provides free medical care to almost all citizens, the United States has a profit-driven health-care delivery system.[154] For-profit health maintenance organizations place financial pressures on doctors who provide too much care.[155] Additional issues of concern in the United States include the limited access for all citizens to hospice care, the lack of support for caregivers, and the inadequate provision of pain control medications.[156] Therefore, the financial pressures on doctors to hasten death may be much greater in the United States than in the Netherlands.[157]

Smith cites research showing that pain and depression in severely ill patients are significantly undertreated and that minority, female, elderly, or child patients are more likely to be undertreated for their pain.[158] Hospice care, as well as treatment for depression and pain, is generally inaccessible to the uninsured American.[159] However, Smith's greatest concern is the implementation of euthanasia and assisted suicide under the for-profit American health care delivery system.[160]

Smith predicts that by the year 2000, fifty percent of all health-insured Americans, as well as Medicare and Medicaid recipients, will receive their health coverage through for-profit health maintenance

151. *See* Suro, *supra* note 135.
152. *See* SMITH, *supra* note 17, at 109.
153. *See id.*
154. *See id.*
155. *See id.* at 109-10.
156. *See id.* at 149.
157. *See id.* at 110.
158. *See id.* at 146-47.
159. *See id.* at 149.
160. *See id.* at 150.

organizations (HMOs).[161] Smith hypothesizes that since HMO profits increase as costs decrease there could be a financial incentive behind the decision to euthanize a patient, as the patient's death will end the costs of continued care.[162] Smith also notes that managed care physicians are often personally financially responsible for treatments, tests, and specialists they recommend; moreover, these financial pressures are already impacting doctors' medical decisions.[163] Smith insinuates that if these financial pressures are attached to end-of-life decision-making, doctors may be even more likely to euthanize a patient than if such financial pressures do not exist.[164]

II. ANALYSIS

Some of Smith's arguments may trouble the reader, while others appear to rest on a solid foundation and could even be strengthened. First, one may be initially concerned by Smith's presumption that terminally ill individuals are at higher risk for suicide.[165] His distinction between the removal of life support and artificial nutrition may not be satisfactory to all readers.[166] Smith could strengthen his argument concerning the pain associated with removal of artificial nutrition or intravenous fluids.[167] Many of Smith's points could have greater impact if he included any available statistics and studies to support his theories. Finally, Smith needs to provide more realistic alternatives to euthanasia than those he provides.

A. *Are Terminally Ill Individuals at Higher Risk for Suicide?*

A component of *Forced Exit* that initially appears troubling is Smith's claim that individuals who are terminally ill are at higher risk for suicide.[168] It seems incongruous that people who are facing a shortened life would choose to end their lives even sooner. However, suicide rates are higher among individuals with terminal illnesses than in the population as a whole, and more than one third of dying patients may be depressed.[169] A recent study, surveying nearly 1,000 patients whose doctors expected them to die within six to twelve

161. *See id.*
162. *See id.* at 153.
163. *See id.* at 155.
164. *See id.* at 157-58.
165. *See id.* at 124.
166. *See id.* at 134-35.
167. *See id.* at 34-39.
168. *See id.* at 124.
169. *See, e.g.*, Ezekiel J. Emanuel & Linda L. Emanuel, *The Promise of a Good Death*, 351 LANCET 21, 23 (1998).

months, found that ten and one-half percent reported seriously contemplating suicide.[170] Among those patients surveyed who reported feeling depressed all or part of the time, twenty percent reported that they had considered suicide.[171] Surprisingly, according to this study, patients in pain were no more likely to consider suicide than those who were not in pain.[172] Depression and dependence on others, not pain, were the leading reasons the dying patients contemplated physician assisted suicide.[173]

This study weakens Smith's argument that inadequate medication for pain control is a contributing factor to the likelihood of suicide among the terminally ill. It also brings into question his argument that those most likely to be undertreated for pain, women, minorities, elderly individuals, and children,[174] will be more at risk with legalized euthanasia. However, the fact that dependence on others is a reason terminally ill individuals consider suicide strengthens Smith's thesis that greater access to hospice care and other support, especially for the uninsured,[175] will be key in preventing abuses.

These surveys also strengthen Smith's arguments that provisions in statutes such as Oregon's are not sufficient to ensure patients are adequately screened for depression. Depression is under-recognized and underestimated among the terminally ill,[176] as assessment instruments are ill-equipped to address the needs and concerns of dying patients.[177] Many doctors dismiss depression as the patient's natural reaction to impending death rather than as a condition that may have existed prior to the illness.[178]

B. Smith's Distinction between the Removal of Artificial Respiration and the Removal of Feeding Tubes

Smith's contention that removing a respirator is acceptable while discontinuing artificial nutrition is not may not prove satisfactory to many readers. Smith discusses the difference between medical and

---

170. *See, e.g.*, Richard A. Knox, *Pain is Found to Trail in Considering Suicide*, BOSTON GLOBE, May 20, 1998, at A13.

171. *See id.*

172. *See id.*

173. *See id.*

174. *See* SMITH, *supra* note 17, at 146-47 (citing DEP'T CONSUMER AFF., STATE OF CAL., SUMMIT ON EFFECTIVE PAIN MANAGEMENT: REVOKING IMPEDIMENTS TO APPROPRIATE PRESCRIBING 3 (1994)).

175. *See id.* at 149.

176. *See, e.g.*, Emanuel & Emanuel, *supra* note 169, at 23.

177. *See id.*

178. *See* Linda Emanuel, *Facing Requests for Physician Assisted Suicide*, 280 JAMA 643, 644 (1998).

humane care[179] and notes that removing artificial ventilation protects the patient from unwanted physical intrusions, but he does not explain why the feeding tube is not also an unwanted intrusion.[180] Moreover, Smith barely discusses the case of Karen Ann Quinlin, where the parents of a comatose woman were permitted to remove their daughter from a respirator.[181] Finally, Smith criticizes the removal of feeding tubes as a cruel and painful way of ending the lives of these individuals.[182]

1. Medical Versus Humane Care

Recall that Smith defines humane care as a category of care that includes warmth, shelter, and cleanliness[183] and describes medical care as including interventions such as surgery, medications, and tests.[184] Smith argues that we would not deprive patients of humane care by sending them out into a blizzard to freeze to death, even if they requested it; therefore, we should not withdraw food and allow those same patients to starve to death.[185] Smith's moral argument is strongly supported. For example, social and some religious values tell us that it is only reasonable to feed individuals who are unable to care for themselves.[186] Therefore, feeding should be viewed as humane care and not as treatment which a patient has the right to refuse.[187]

On the other hand, artificial nutrition may seem very much like medical treatment. If artificial nutrition is required on a long-term basis, a tube is surgically inserted into the stomach,[188] thus the provision of artificial nutrition is physically invasive. Artificial nutrition replaces the bodily functions of chewing and swallowing for a patient who has a functional digestive tract but can no longer take food by mouth.[189] Finally, as with other medical procedures, complications, such as tube displacement into the respiratory tract or migration into the esophagus, may result following the insertion of a feeding tube.[190]

---

179. *See* SMITH, *supra* note 17, at 42-43.

180. *See id.* at 134-35.

181. *See In re* Quinlan, 355 A.2d 647 (N.J. 1976).

182. *See* SMITH, *supra* note 17, at 50.

183. *See id.* at 42-43. *See also supra* note 33 and accompanying text.

184. *See* SMITH, *supra* note 17, at 43. *See also supra* note 34 and accompanying text.

185. *See, e.g.*, SMITH, *supra* note 17, at 42-43.

186. *See, e.g.*, Jacquelyn A. Beatty, *Artificial Nutrition and the Terminally Ill: How Should Washington Decide?*, 61 WASH. LAW REV. 419, 419 (1986); Paula McCormack, *Quality of Life and the Right to Die: An Ethical Dilemma*, 28 J. ADVANCED NURSING 63, 65 (1998).

187. *See* McCormack, *supra* note 186, at 65.

188. *See* THE LIPPONCOTT MANUAL OF NURSING PRACTICE 566 (Lisa Stead ed., 6th ed. 1996).

189. *See id.*

190. *See id.* at 569.

From this perspective, one could understand why courts treat the removal of life support and artificial nutrition similarly.

2. Smith's Analysis of In re Quinlan

Smith barely touches upon *In re Quinlan*.[191] This is a key omission. When Karen Quinlan remained in a persistent vegetative state after a drug overdose, her father sought to have her respirator removed.[192] Ruling in her father's favor, the Supreme Court of New Jersey noted the United States Supreme Court's recognition that although the Constitution does not explicitly mention privacy, certain privacy rights exist,[193] especially in the areas of family life decisions.[194] The *Quinlan* court concluded that the privacy right found in *Roe v. Wade* for a woman to terminate her pregnancy could also include the right to refuse medical treatment under certain circumstances.[195] Since Smith bases his argument on his assertion that artificial nutrition is a form of humane care, and not medical treatment, he could have included a summary of the legal reasoning behind allowing patients to refuse treatment. Even though Smith plays the role of an advocate, an understanding of *Quinlan* would greatly assist the reader in reaching his or her own conclusion.

3. Does the Removal of Artificial Nutrition Cause a Painful Death?

Smith describes dehydration as a cruel and painful way to allow a patient to die, focusing upon conscious patients who are severely disabled but not in a persistent vegetative state.[196] He describes the physical effects of dehydration, notes that doctors are uncertain about how much discomfort these individuals may feel, and suggests that doctors cannot be certain pain medication will ease the symptoms.[197] However, other doctors report that even if the patient were conscious he or she would experience discomfort for only a day or two, at which time the body would begin to produce ketones that suppress hunger and thirst.[198]

---

191. 355 A.2d 647 (1976).

192. *See* SMITH, *supra note* 17, at 134 (citing *Quinlan*, 355 A.2d at 651).

193. *See Quinlan*, 355 A.2d at 663 (citing Eisenstadt v. Baird, 405 U.S. 438, 453-54 (1972); Stanley v. Georgia, 394 U.S. 557, 566 (1969)).

194. *See id.* (citing Griswold v. Connecticut, 381 U.S. 479, 484 (1965); Roe v. Wade, 410 U.S. 113, 152-56 (1973)).

195. *See id.*

196. *See id.* at 50.

197. *See id.*

198. *See* Brook A. Masters & Bill Broadway, *Changes Will Be Slow, Painless As Newscaster Drifts to Death*, WASH. POST, Oct. 3, 1998, at B6.

Smith does not express whether he believes persons in a persistent vegetative state can feel the pain associated with dehydration. Many doctors contend that patients in a persistent vegetative state do not experience hunger, thirst, or pain.[199] Although the patient's body may exhibit the physical signs of stress, the patient is unable to identify the discomfort as hunger or to remember pain.[200] However, a survey of over three hundred physicians, approximately half of which were neurologists, showed that thirty percent of the physicians believed that patients in a persistent vegetative state can experience pain and thirteen percent believed they could feel hunger and thirst.[201] While these beliefs may be representative of a minority of doctors, they certainly would provide additional support for Smith's position if he had cited them.

C. Smith Fails to Use Statistics to Support His Arguments

Another difficulty for the reader may be the lack of statistical support for Smith's arguments. One of the few times Smith provides statistics to back his arguments is when he uses the results of the Remmelink report to demonstrate the extent to which euthanasia is practiced and abused in the Netherlands.[202] In some instances, study results support Smith's contentions; in other instances, statistics weaken his arguments.

For example, recent research supports Smith's argument that the persistent vegetative state is often misdiagnosed and that patients who have some levels of consciousness may be having their artificial nutrition discontinued.[203] It is estimated that between 14,000 to 35,000 Americans have been labeled as being in a persistent vegetative state by their physicians.[204] Alarmingly, between twenty-seven to forty-three percent of patients labeled as vegetative actually show some minimal signs of consciousness.[205] It is possible that some of the individuals included in Smith's case studies, such as Michael Martin,[206] may fall into this category.

As a matter of fact, specialists have been working for the past four years to define another category of brain injury for people who are

---

199. *See, e.g., id.*

200. *See id.*

201. *See* Kirk Payne, *Physicians' Attitudes About the Care of Patients in the Persistent Vegetative State: A National Survey*, 125 ANNALS INTERNAL MED. 104, 104 (1996).

202. *See* SMITH, *supra* note 17, at 97-101.

203. *See, e.g., Conscious of a Life in the Balance, supra* note 1.

204. *See id.*

205. *See id.*

206. *See supra* notes 47-53 and accompanying text.

severely disabled but whose disability is less serious than a vegetative patient.[207] These patients could be described as being in a minimally conscious state, which is defined as "a condition of severely altered consciousness in which the person demonstrates minimal but definite behavioral evidence of self or environmental awareness."[208] Such patients are similar in appearance to vegetative patients but may respond to stimuli, feel pain, communicate through gestures, and track visitors with their eyes.[209] This minimally conscious state may be a temporary step on the path from a vegetative state to a higher level of consciousness, or it may be permanent.[210] Patients in a permanent minimally conscious state, despite their slightly higher level of functioning, have no better prognosis for recovery.[211]

While the personal stories throughout the book are what make it so compelling, the reader is unsure whether Smith has merely found the one-in-a-million situation or whether the problems he addresses are widespread. Providing information about the number of people in a persistent vegetative state and the number of patients whose families seek to have artificial nutrition removed would assist the reader in understanding the depth of the problem and in future decision-making. Also, if Smith had provided the reader with information about minimally conscious state, rather than labeling the people in his stories as conscious, the reader could have understood how difficult and delicate these ethical questions are. A reader's decision to cast his or her vote either for or against physician assisted suicide may depend on knowing how many individuals are faced with an assisted suicide decision. Since Smith does not offer such statistics, the reader is unable to determine whether such situations occur frequently or whether Smith has cited the very emotional but very rare cases.

D. Are Smith's Solutions Feasible?

Smith offers a variety of alternatives to euthanasia, including better training for doctors in pain management, increased accessibility of hospice care, and education for all members of society about the dying process.[212] Smith's suggestion to improve pain management training is well-founded; however, researchers are not certain what an

---

207. *See Conscious of a Life in the Balance, supra* note 1.

208. Ronald E. Cranford, *The Vegetative and Minimally Conscious States: Ethical Implications*, 53 GERIATRICS 70, 71 (1998).

209. *See Conscious of a Life in the Balance, supra* note 1.

210. *See* Cranford, *supra* note 208, at 71.

211. *See Conscious of a Life in the Balance, supra* note 1.

212. *See* SMITH, *supra* note 17, at 226-35, 246-49.

ideal rate of pain relief is. Surveys of terminally ill patients and their families indicate that pain is under-treated in the last days of life. One study found that twenty-five percent of dying cancer patients experienced severe pain and another forty to fifty percent described their pain as moderate to severe.[213] In another study, interviews with 3357 surrogates of dying patients showed that forty percent of conscious patients reported severe pain during the last three days of life.[214] Barriers to effective pain relief cited by the researchers include inadequate training and dysfunctional organization within the delivery system.[215] The authors of this study admit that no one knows what rate of pain relief could be achieved with optimal care.[216] Other pain research shows that pain can readily be relieved in seventy to ninety percent of cancer patients and that much of the remaining ten to thirty percent of patients can receive pain relief without complete sedation.[217]

However, providing sufficient pain relief may not be as simple as it first appears. One would think that if the patient or the patient's family members notified the hospital staff that the patient was in pain, dosage could be increased; however, patients are reluctant to complain about pain.[218] But doctors may also be afraid to provide the amounts of medication needed to adequately relieve a patient's pain.[219] Drug-prescribing laws may either be outdated or misinterpreted by state licensing boards.[220] Licensing boards carefully monitor a physician's actions, and a doctor who provides more pain medication than is believed to be reasonably prudent may have her/his license to practice medicine restricted.[221]

---

213. *See* APPROACHING DEATH: IMPROVING CARE AT THE END OF LIFE 132 (Institute of Medicine ed. 1997) [hereinafter APPROACHING DEATH].

214. *See* Joanne Lynn et al., *Perceptions by Family Members of the Dying Experience of Older and Seriously Ill Patients*, 126 ANNALS INTERNAL MED. 97, 100 (1997).

215. *See id.* at 104.

216. *See id.* at 104-05.

217. *See* APPROACHING DEATH, *supra* note 213, at 132.

218. *See* Janice Lynch Schuster, *Addressing Patients' Pain: Veterans Health Administration's Addition of Fifth Vital Sign May Have Far-Reaching Effects*, WASH. POST, Feb. 2, 1999, at Z28.

219. *See U.S. Patients Do Not Always Get the Best End-of-Life Care*, 349 LANCET 1747, 1747 (1997).

220. *See id.*

221. *See, e.g.*, Hoover v. Agency for Health Care Admin., 676 So.2d 1380 (Fla. Dist. Ct. App. 1996). The Board of Medicine penalized Dr. Hoover and restricted her license to practice. *See id.* at 1380. The Board claimed that Dr. Hoover excessively prescribed controlled substances to seven of her patients who were in intractable pain, thus falling below the standard of care of a reasonable physician under similar conditions or circumstances. *See id.*

Adequate hospice care is out of reach for many Americans. Only one percent of all Medicare spending currently goes to providing hospice care, despite the fact that one-third of the $210 billion Medicare budget is used to treat patients during the last year of their lives.[222] The reason for this is unclear. Medicare requires patients to have a life expectancy of less than six months to qualify for hospice care, yet the median stay in hospice care for Medicare patients is only thirty-six days.[223] Smith argued that doctors are unable to predict with certainty when a patient has six months or less to live.[224] This uncertainty may contribute to the under-utilization of hospice care. Doctors may need additional education about the hospice alternatives available to patients.

Changing cultural attitudes toward dying in our society will prove difficult. While a century ago family members cared for dying relatives, today dying persons are cared for in hospitals and nursing homes; thus many Americans have never had a close personal experience with death.[225] The American culture has been described as "death denying," viewing death as an accident that could be prevented with further research or improvements in technology.[226] Although well-intended, the implementation of many of Smith's ideals into practice may be unrealistic, given the finite resources of medical schools, hospitals, and the government.

III. CONCLUSION

Although Smith's use of individual stories to present his argument has its drawbacks, it is this narrative style that makes the book such an easy and interesting read. Smith's storytelling style and explanations of legal and medical terminology make the information in *Forced Exit* accessible to all individuals, not just to medical and legal professionals. Despite the fact that Supreme Court decisions, elections, and legislative activity have dated Smith's legal analysis, *Forced Exit* provides the reader with food for thought and offers a key perspective on end-of-life decision making.

---

222. *See* Joseph A. Califano, Jr., *Physician Assisted Living*, WASH. POST, Dec. 31, 1998, at A27.

223. *See* APPROACHING DEATH, *supra* note 213, at 40.

224. *See* SMITH, *supra* note 17, at 122-23.

225. *See id.* at 33.

226. *Id.* at 48.