

STETSON LAW REVIEW

VOLUME XXVI

WINTER 1996

NUMBER 2

ARTICLES

LAST RIGHTS? CONFRONTING PHYSICIAN-ASSISTED SUICIDE IN LAW AND SOCIETY: LEGAL LITURGIES ON PHYSICIAN-ASSISTED SUICIDE

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One of the most emotionally charged and politically thorny dilemmas facing modern society is the question of whether to legalize physician-aided dying.¹ Due to the amount of litigation and public

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1. The term of art for this has been dubbed by the popular press as physician-assisted suicide (PAS). However, describing the requested act as a suicide has added confusion to the debate over PAS, given traditional views about suicide held in our society. Suicide has traditionally referred to someone who, because of depression or a mental condition, desires to end their life. If this individual is involuntarily committed to a mental facility and receives counseling and drug therapy, the presumption exists that the individual, after receiving help, will come back to his or her "right" mind and will no longer be a "suicide risk." With PAS, however, the individual has a condition from which there can be no recovery, and therefore seeks the ultimate exercise of autonomy: the timing, method, and moment of death. The individual chooses control over the moment and method of death, dying in a chosen setting and with more dignity than the "normal" dying process. Recently, PAS issues have stimulated renewed consideration of the concept of suicide as a rational choice. *See infra* note 5.

Even the Court of Appeals for the Ninth Circuit has noted the questionable ap-

pressure, legalization of physician-assisted suicide (PAS) may be likely to occur in the near future in the United States.² The high profile actions of Dr. Jack Kevorkian in providing assistance to forty-six people in ending their own lives and three failed prosecutions has catapulted public attention toward PAS.³ There is concern that a conviction against Kevorkian cannot be obtained.⁴ People from other states now go to Michigan with frequency to have him help them end their lives.

propriateness of the label "assisted suicide." *Compassion in Dying v. Washington*, 79 F.3d 790, 802 (9th Cir.), *stay granted sub nom. Washington v. Glucksberg*, 116 S. Ct. 2494, *and cert. granted*, 117 S. Ct. 37 (1996).

Accordingly, we believe that the broader terms — "the right to die," "controlling the time and manner of one's death," and "hastening one's death" — more accurately describe the liberty interest at issue here. Moreover, as we discuss later, we have serious doubts that the terms "suicide" and "assisted suicide" are appropriate legal descriptions of the specific conduct at issue here.

Id. The court went on to state:

There is one further definitional matter we should emphasize Throughout that examination, we use the term "physician-assisted suicide," a term that does not appear in the Washington statute but is frequently employed in legal and medical discussions involving the type of question before us. For purposes of this opinion, we use physician-assisted suicide as it is used by the parties and district court and as it is most frequently used: the prescribing of medication by a physician for the purpose of enabling a patient to end his life.

Compassion in Dying, 79 F.3d at 802 (footnote omitted) (referencing Sarah Henry, *A Time to Die: The Battle Over Assisted-Suicide*, CAL. LAW., Jan. 1996, at 34 (defining physician-assisted death as "providing or prescribing medication to someone, knowing that that person intends to take a lethal dose of the medication")). The court further stated that, "We use the terms 'assisted suicide' and 'physician-assisted suicide' interchangeably throughout this opinion, although as we have noted, we have serious doubts as to the correctness or propriety of the terms, as they are generally used." *Compassion in Dying*, 79 F.3d at 802 n.15.

2. The United States Supreme Court heard oral arguments on the Ninth and Second Circuit cases on January 8, 1997. A decision will be rendered by the end of the Court's current term. At this writing, a trial court in West Palm Beach, Florida became the first in the nation to support PAS. See Raju Chebium, *Judge Says Dying Man, Doctor Can Choose Suicide*, TAMPA TRIB., Feb. 1, 1997, at 1. Euthanasia became legal in the Northern Territory of Australia as of July 1, 1996, and the law was upheld by the Northern Territory Supreme Court later that month. See *DeathNET: Advancing the Art & Science of Dying Well* (visited Nov. 21, 1996) <<http://www.islandnet.com/death-net/Wnews3.html>>. See also *How the First Euthanasia Law Was Passed*, WORLD RIGHT TO DIE NEWSL., Nov. 1996, at 3, 5.

3. The issue is a subject for discussion within state medical journals. See, e.g., Symposium, *Ethical Issues in Assisted Dying: Exploring the Valley of the Shadow of Death*, 92 J. S.C. MED. ASS'N 43 (1996).

4. Dr. Kevorkian was indicted in three suicides. See *Kevorkian Charged in 3 Suicides*, DAILY NEWS L.A., Nov. 1, 1996, at N28. However, the new prosecuting attorney dismissed the charges. See *Prosecutor Drops Charges*, WASH. POST, Jan. 11, 1997, at A7.

Kevorkian's actions are only the tip of the iceberg, and in many ways represent the most visible part of a multi-level evolution of public policy. There are other doctors who assist their patients in ending their lives, only much more circumspectly than Kevorkian. The fact remains that PAS happens in society today, and likely more often than anyone knows.⁵ And it happens despite the very real threat of prosecution or professional discipline.

The movement toward legalization is also happening faster than anyone thought. Arthur Caplan, the University of Pennsylvania's Center of Bioethics Director, puts it most aptly, "I have always thought that society would move toward some sort of legalization of assisted suicide, but I thought it would take the better part of a decade, not the better part of a year You're talking about a sea change — overnight — in public policy on this issue."⁶ Despite these swift changes, the American Medical Association (AMA) has steadfastly refused to revise its position on physician-aided dying. On June 25, 1996, the AMA reaffirmed its opposition to the practice.⁷ The AMA declined to revise its position because, "[p]atients need to know that our goal in providing care will always be to relieve suffering and never to eliminate the sufferer."⁸ Instead, the AMA leaders decided to better educate doctors on alleviating the pain and suffering of their dying patients.⁹ The alleviation of pain and suffering of the dying patient is a lofty ideal, but one not likely to meet many of the underlying reasons for which the patient seeks assistance in

5. See, e.g., Anthony L. Back et al., *Physician-Assisted Suicide and Euthanasia in Washington State*, 275 JAMA 919 (Mar. 1996) (reporting a survey of physicians in Washington State, which found that physicians occasionally provide PAS); *Doctors Admit Helping AIDS Patients Die*, BOSTON GLOBE, July 11, 1996, at 8.

6. Frank Bruni, *Court Overturns Ban in New York on Aided Suicides*, N.Y. TIMES, Apr. 3, 1996, at A1.

7. See Edward Walsh, *AMA Delegates Assail Assistance in Suicides*, WASH. POST, June 26, 1996, at A3. The AMA filed an Amicus Brief with the Court. See Amicus Brief of the American Medical Association, *Washington v. Glucksberg*, No. 96-110, 1996 WL 656263 (U.S. Nov. 12, 1996). Previously, after both the Ninth Circuit and Second Circuit decisions, the AMA issued statements that, despite the decisions, "assisted suicide is against the Code of Medical Ethics and incompatible with the physician's role as healer and care giver. It is not a Constitutional right," and that "[t]he AMA will do everything in its power to protect and care for our patients so they don't perceive assisted suicide as a valid alternative." Thomas Reardon, M.D., *AMA Releases on 2nd and 9th U.S. Circuit Courts Decisions* (visited Jan. 28, 1997) <<http://www.ama-assn.org/ad-com/releases-1996/tr329.html>>.

8. Walsh, *supra* note 7, at A3.

9. See *id.*

dying. Although the fear of pain and suffering is one of the reasons patients seek PAS, it is not the sole reason, and although the AMA can be lauded for their intentions, their actions will little affect those seeking PAS.

The reason for the "sea change" described by Caplan is the historic judicial actions that occurred on both coasts of the United States. Within a two-month period, the United States Courts of Appeals for the Ninth Circuit and for the Second Circuit (March 6, 1996 and April 2, 1996 respectively)¹⁰ overturned lower court decisions that upheld specific statutes banning PAS. Ruling to allow physicians to prescribe lethal dosages of drugs for terminally-ill patients in certain circumstances, these two decisions have brought to the forefront what, until now, has been a simmering social debate about the limits on terminally-ill people to choose the circumstances of their own deaths. The Supreme Court, on January 8, 1997, heard oral arguments in a consolidated review of these two cases and is expected to rule by the end of the term on whether there is a constitutional right to physician-assisted suicide.¹¹

At the center of this debate is the ethical concept of autonomy or self-determination. In recent years, people, especially people who are older, have become more vocal about their rights to determine and control their deaths. As a result, the legal prerogatives of competent patients to refuse or withdraw medical life-sustaining treatment have been clearly defined in society through litigation and legislation.¹² Many people, again with a strong constituency amongst those who are older, are now asserting that their control over their dying should extend to active means of hastening death.¹³

10. See *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir.), *stay granted sub nom. Washington v. Glucksberg*, 116 S. Ct. 2494, and *cert. granted*, 117 S. Ct. 37 (1996); see also *Quill v. Vacco*, 80 F.3d 716 (2d Cir.), *cert. granted*, 117 S. Ct. 36 (1996). Oral arguments in the two cases took place before the United States Supreme Court on January 8, 1997.

11. *Supreme Court Calendar*, WASH. POST, Jan. 8, 1997, at A6.

12. See UNIF. RIGHTS OF THE TERMINALLY ILL ACT §§ 2, 3, 9, 9B U.L.A. (1989); AMERICAN COLLEGE OF PHYSICIANS ETHICS MANUAL (3d ed. 1992), reprinted in CODE OF PROFESSIONAL RESPONSIBILITY 239, 248-53 (Rena A. Gorlin ed., 3d ed. 1994); AMERICAN MEDICAL ASSOCIATION CODE OF MEDICAL ETHICS AND CURRENT OPINIONS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS §§ 2.20 to .211, in CODE OF PROFESSIONAL RESPONSIBILITY, *supra*, at 265, 290-91; George J. Annas & Leonard H. Glantz, *The Right of Elderly Patients to Refuse Life-Sustaining Treatment*, 64 MILBANK Q. 95 (Supp. 2 1986).

13. See H. Taylor, *Doctor-Assisted Suicide: Support for Dr. Kevorkian Remains Strong and 2-to-1 Majority Approves Oregon-Style Assisted Suicide Bill* (The Harris Poll

The current legal and ethical debates about PAS revolve around an American struggle with autonomy. How shall society construe its collective understanding of a person's "last rights" — choices about ending one's life prematurely? Furthermore, do such rights extend to the involvement of others, specifically physicians, who, when it comes to death and dying, hold the public trust in their hands?

This Article will survey and assess three distinct models that have surfaced in society for constructing a public policy of PAS. Within each model are differing ideas and assumptions about the nature of autonomy or self-determination. The different understanding about autonomy reflected in each model produces its own peculiar set of ethical questions, as well as solutions. The issue becomes more complicated because it is not solely a question of law, but instead a bundle of issues based on law, religion, ethics, morality, and more. It involves the very fabric of our identity as persons and as a society.

THE LAW AND AUTONOMY

The law regarding an individual's right to control medical treatment and personal autonomy has been evolving for over 100 years. Clearly articulated by the United States Supreme Court in the case of *Union Pacific Railway v. Botsford*,¹⁴ an individual's autonomy was considered paramount when the defendant sought an order requiring the plaintiff to demonstrate her injuries. The court, in denying the request, held:

The single question presented by this record is whether, in a civil action for an injury to the person, the court, on application of the defendant, and in advance of the trial, may order the plaintiff, without his or her consent, to submit to a surgical examination as to the extent of the injury sued for. We concur with the circuit court in holding that it had no legal right or power to make and enforce such an order. No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable

No. 9, 1995); Timothy E. Quill et al., *Care of the Hopelessly Ill — Proposed Clinical Criteria for Physician-Assisted Suicide*, 327 NEW ENG. J. MED. 1380 (1992).

14. 141 U.S. 250 (1891).

authority of law. As well said by Judge Cooley: "The right to one's person may be said to be a right of complete immunity: to be let alone."¹⁵

Justice, then Judge, Cardozo, in the oft-quoted case of *Schloendorff v. Society of New York Hospital*¹⁶ followed up and expanded on the concept by ruling that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body: and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages."¹⁷

The concept of personal autonomy as applied to end-of-life decisionmaking began to be defined by the courts in 1976.¹⁸ Until that time, no one had really considered when and under what circumstances, the removal of life-prolonging procedures was appropriate, thus allowing a person to die. With medical advances far surpassing the evolution of law,¹⁹ however, technology allows doctors to keep a patient "alive"²⁰ indefinitely. Prior to such advances, ter

15. *Id.* at 251 (quoting THOMAS M. COOLEY, COOLEY ON TORTS, 29 (1880)).

16. 105 N.E. 92 (N.Y. 1914).

17. *Id.* at 93. The *Schloendorff* court noted that such is true absent the application of the emergency doctrine, "where the patient is unconscious, and where it is necessary to operate before consent can be obtained." *Id.*

18. In 1976, the New Jersey Supreme Court decided the seminal decision of *In re Quinlan*, 355 A.2d 647 (N.J. 1976).

19. To visualize the intersection of law and medical developments, we must here use a Star Trek analogy. Medicine began to make technological advances at a speed far surpassing that of the changes in the law. Thus, changes in medicine were occurring at warp speed while those in law were occurring at 65-miles-per-hour. The Ninth Circuit also noted the changes wrought by technology:

The now recognized right to refuse or terminate treatment and the emergent right to receive medical assistance in hastening one's death are inevitable consequences of changes in the causes of death, advances in medical science, and the development of new technologies. Both the need and the capability to assist individuals end their lives in peace and dignity have increased exponentially. Compassion in Dying v. Washington, 79 F.3d 790, 812 (9th Cir.), *stay granted sub nom.* Washington v. Glucksberg, 116 S. Ct. 2494, *and cert. granted*, 117 S. Ct. 37 (1996) (footnote omitted).

20. "Alive" is contained in quotes because describing a person maintained on life support as being alive may not be in keeping with the traditional definition of life. The person's body may not be dead, and their brain may have partial activity, but the patient usually has no hope of recovery. See Linda L. Emanuel, *Reexamining Death: The Asymptotic Model and a Bounded Zone Definition*, HASTINGS CENTER REP., July-Aug. 1995, at 27-35 (calling for a conceptual shift in the traditional medical definition of death); see also Robert M. Veatch, *The Impending Collapse of the Whole-Brain Definition*

mination of life-prolonging procedures was not an issue; instead, the patient was sent home to die.²¹

A whole new set of questions has arisen in the wake of these medical technological advancements. The most central are: When and under what circumstances can life-supportive medical treatment be removed once it has been started? What would be the cause of death for removal of life-supportive medical treatment? What is considered life-supportive medical treatment? Who is the appropriate decisionmaker? When should a court be involved in the decision to terminate life-supportive medical treatment? If there is a right of the patient to have life-prolonging procedures removed, what is the basis of that right? When, and under what circumstances, can that right be exercised?²²

Beginning in 1976 with the landmark New Jersey case of *In re Quinlan*²³ and continuing today, courts have defined and refined the limits of an individual's right to control medical treatment. The majority of the cases have dealt with individuals who have conditions from which there is no recovery.²⁴ The early cases predictably were limited, however, to those patients classified as terminally ill.²⁵

of Death, HASTINGS CENTER REP., July–Aug. 1993, at 18–24 (mounting significant evidence for a revision of status quo criteria for death (and thus what constitutes being “alive”).

21. See Cathaleen A. Roach, *Paradox and Pandora's Box: The Tragedy of Current Right-to-Die Jurisprudence*, 25 U. MICH. J.L. REFORM 133 (1991) (stating that more people today do not die at home, but in facilities such as hospitals or nursing homes); see also *Compassion in Dying*, 79 F.3d at 812 n.61 (noting that currently 80–85% of persons die in a facility while in 1939 only 37% did so).

22. These questions and others have been posed to and answered by courts in the line of cases (over 100 opinions) decided since *In re Quinlan*, 355 A.2d 647 (N.J. 1976). See, e.g., *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261 (1990); *State v. Herbert (In re Guardianship of Browning)*, 568 So. 2d 4 (Fla. 1990); *John F. Kennedy Mem'l Hosp. v. Bludworth*, 452 So. 2d 921 (Fla. 1984); *Satz v. Perlmutter*, 379 So. 2d 359 (Fla. 1980).

23. 355 A.2d 647 (N.J. 1976).

24. See, e.g., *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261 (1990) (coma-tose); *In re Tavel*, 661 A.2d 1061 (Del. 1995) (persistent vegetative state); *State v. Herbert (In re Guardianship of Browning)*, 568 So. 2d 4 (Fla. 1990) (persistent vegetative state); *Satz v. Perlmutter*, 379 So. 2d 359 (Fla. 1980) (Lou Gehrig's disease — amyotrophic lateral sclerosis); *Brophy v. New England Sinai Hosp., Inc.*, 497 N.E.2d 626 (Mass. 1986) (persistent vegetative state); *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417 (Mass. 1977) (cancer); *In re Quinlan*, 355 A.2d 647 (N.J. 1976) (persistent vegetative state).

25. This expansion has caused great difficulty for the courts. The line of early cases such as *In re Quinlan* and *Satz* clearly dealt with individuals who were not going

Limiting autonomy with the requirement of terminal illness leaves a person with hollow rights. Today, too many of the afflictions striking people who are older, such as Alzheimer's disease, are not afflictions that are considered "terminal."

In a short span of time, a series of "early" cases defined an individual's right to control medical treatment as a right based in privacy²⁶ or based in the common law right of self-determination. The distinctions regarding the type of medical treatment quickly fell by the wayside.²⁷ Underlying motivations of petitioners such as finan-

to get better. Possibly because it helped minimize the impact of the decision, courts gave credence to the fact that the individual was near the end of life, thus removing the life-prolonging procedure would not in fact be the cause of the individual's death, but instead would no longer interfere with the natural process of dying. This distinction was first made in *Brophy*. In balancing the individual's right to terminate treatment against the state's interest in preservation of life, the proximity of the patient's death outweighs the state's interest in preserving that life. See *In re Quinlan*, 355 A.2d at 664.

The balancing test used by the courts was adopted in many of the early statutes dealing with advance directives (these statutes were variously known as "living will" statutes, "Natural Death" acts or "Life-Prolonging Procedures" acts). The problem for the courts, in both the case law and statutory law, was determining whether the individual in question was in fact terminally ill. The amount of time remaining before the individual's death became a paramount question for the courts to answer. Yet, how exact could the experts be? How long would the person survive if treatment were stopped or if treatment were continued? If the procedure were stopped, was death occurring within three days close enough; was nine days too long? What if death would occur in six months with the procedure in place? For an illustration of the problems caused by the determination of imminent death, see *State v. Herbert (In re Guardianship of Browning)*, 568 So. 2d 4 (Fla. 1990).

26. Note that the state decisions founded an individual's right to remove treatment, among other things, upon the individual's Fourteenth Amendment right of privacy. In *Cruzan*, the United States Supreme Court's first case on this issue, the Court noted that the right was founded in liberty rather than privacy. *Cruzan*, 497 U.S. at 277-78.

27. See, e.g., *State v. Herbert (In re Guardianship of Browning)*, 568 So. 2d 4 (Fla. 1990). "Recognizing that one has the inherent right to make choices about medical treatment, we necessarily conclude that this right encompasses all medical choices." *Id.* at 10.

"We conclude that a competent person has the constitutional right to choose or refuse medical treatment, and that right extends to all relevant decisions concerning one's health." *Id.* at 11 (footnote omitted). The court went on to state:

We see no reason to qualify that right on the basis of the denomination of a medical procedure as major or minor, ordinary or extraordinary, life-prolonging, life-maintaining, life-sustaining, or otherwise. Although research disclosed no cases that sought to distinguish these terms in the context of the rights of a competent patient, as opposed to an incompetent patient, courts generally are agreed that the terms are legally indistinguishable. See, e.g., *Cruzan ex rel. Cruzan v. Director, Mo. Dep't of Health*, — U.S. —, 110 S.Ct. 2841, 2853, 111 L.Ed.2d 224 (1990) (addressing the issue as the refusal of "life-sustaining medical treatment"); *Corbett v. D'Alessandro*, 487 So.2d 368, 371 (Fla. 2d DCA) ("We are unable to distinguish on a legal, scientific, or a moral basis between those

cial incentives, were quickly reviewed and discounted, with the focus placed instead, and rightly so, on the wishes and desires of the patient. Financial concerns, usually taboo in considering such matters, were addressed recently by the Ninth Circuit in its *Compassion in Dying* opinion.²⁸ It found that concerns for the financial burden placed on the patient and his or her family might be an appropriate basis for a request for aid in dying:

We also realize that terminally-ill patients may well feel pressured to hasten their deaths, not because of improper conduct by their loved ones, but rather for an opposite reason — out of concern for the economic welfare of their loved ones. Faced with the prospect of astronomical medical bills, terminally-ill patients might decide that it is better for them to die before their health care expenses consume the life savings they planned to leave for their families, or, worse yet, burden their families with debts they may never be able to satisfy. While state regulations can help ensure that patients do

artificial measures that sustain life—whether by means of `forced' sustenance or `forced' continuance of vital functions—of the vegetative, comatose patient who would soon expire without use of those artificial means.”), *review denied*, 492 So.2d 1331 (Fla.1986); *Brophy v. New England Sinai Hosp., Inc.*, 398 Mass. 417, 437, 497 N.E.2d 626, 637 (1986) (“[w]hile we believe that the distinction between extraordinary and ordinary care is a factor to be considered, the use of such a distinction as the sole, or major, factor of decision tends, in a case such as this, [is] to create a distinction without meaning”); *In re Hier*, 18 Mass.App.Ct. 200, 207, 464 N.E.2d 959, 964, *review denied*, 392 Mass. 1102, 465 N.E.2d 261 (1984) (rejecting distinction between nutrition and treatment); *In re Gardner*, 534 A.2d 947, 954 (Me.1987) (nutrition and hydration indistinguishable from other life-sustaining procedures); *In re Conroy*, 98 N.J. 321, 367–70, 486 A.2d 1209, 1233–34 (1985) (“[W]e reject the distinction . . . between actively hastening death by terminating treatment and passively allowing a person to die of a disease . . . [and] also reject any distinction between withholding and withdrawing life-sustaining treatment.”); *In re Guardianship of Grant*, 109 Wash.2d 545, 563, 747 P.2d 445, 454 (1987) (the right to withhold life-sustaining procedures extends to “all artificial procedures which serve only to prolong the life of a terminally-ill patient”); *Gray ex rel. Gray v. Romeo*, 697 F.Supp. 580, 588 n. 4 (D.R.I. 1988) (no analytical difference between withholding and withdrawing medical treatment). [sic]

Id. at 11 n.6.

“Courts overwhelmingly have held that a person may refuse or remove artificial life-support, whether supplying oxygen by a mechanical respirator or supplying food and water through a feeding tube. We agree and find no significant legal distinction between these artificial means of life-support.” *Id.* at 11–12 (footnotes omitted).

28. *Compassion in Dying v. Washington*, 79 F.3d 790, 826 (9th Cir.), *stay granted sub nom.* *Washington v. Glucksberg*, 116 S. Ct. 2494, *and cert. granted*, 117 S. Ct. 37 (1996).

not make rash, uninformed, or ill considered decisions, we are reluctant to say that, in a society in which the costs of protracted health care can be so exorbitant, it is improper for competent, terminally-ill adults to take the economic welfare of their families and loved ones into consideration.²⁹

What has been constant throughout the evolution of “right to die” cases is the fact that an individual's right to control medical treatment, including the right to consent to and the right to refuse life-prolonging medical procedures, is not an absolute right. Instead, the individual's right is balanced against the state's interests. The state interests most commonly applied in these cases are: the preservation of life, the prevention of suicide, the protection of innocent third parties, and the protection of the ethical integrity of the medical profession.³⁰

The most significant of the state interests is preservation of life. However, the sicker the individual is, with death imminent and the likelihood of recovery slight, the less the state's interest in the preservation of life would weigh against the individual's right to die.³¹

Prevention of suicide was not an issue in the termination of treatment cases, and when dealt with at all, usually the courts acknowledged that the individual did not want to die, but wanted to live free of the medical device in question.³² Protection of innocent third parties was generally only a concern when these cases involved minor children who were dependent on the patient. However, if the patient had a condition from which there could be no recovery, the interest of the minors would not weigh heavily, especially when continuation of treatment would not restore health to the patient nor the patient to the family.³³

29. *Id.*

30. *See, e.g.*, Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 425 (Mass. 1977); State v. Herbert (*In re* Guardianship of Browning), 568 So. 2d 4, 14 (Fla. 1990).

31. *See In re* Quinlan, 355 A.2d 647, 664 (N.J. 1976) (stating that the state's interest weakens as the chance of death increases).

32. *See, e.g.*, Satz v. Perlmutter, 362 So. 2d 160, 162 (Fla. 4th Dist. Ct. App. 1978), *aff'd*, 379 So. 2d 359 (Fla. 1980); *see also Compassion in Dying*, 79 F.3d at 820–23 (noting that the label of suicide, defined as the senseless and premature ending of life, does not apply to the situation of a terminally-ill patient terminating treatment).

33. Again these cases must be distinguished from those where the individual has a high probability of regaining a functional life if treatment is utilized. Here — no matter what — the person will *not* get better. *See In re* Dubreuil, 629 So. 2d 819 (Fla. 1993)

The protection of the ethical integrity of the medical profession was a true dilemma for the courts in early cases.³⁴ But once the AMA enacted an ethical rule providing that in certain cases cessation of treatment would be appropriate, the interest no longer had significant weight against the individual's rights.³⁵ Although these four state interests are not exclusive,³⁶ they are the interests implicated over and over again by the courts in ruling in treatment termination cases.³⁷

The clear majority of states with case law have determined that

(involving a blood transfusion refused on religious grounds). In that decision, the Florida Supreme Court declined to eliminate the policy that in some cases, protection of innocent third parties from abandonment might outweigh the patient's right to refuse the treatment. *See id.* at 827. The court also noted the possibility that the innocent third party might be someone other than a child. *See id.* at 826 & n.9.

34. *See, e.g., supra* note 30 and accompanying text.

35. *See* AMERICAN COLLEGE OF PHYSICIANS ETHICS MANUAL (3d ed. 1992), reprinted in CODE OF PROFESSIONAL RESPONSIBILITY 239, 248–53 (Rena A. Gorlin ed., 3d ed. 1994).

36. *See* State v. Herbert (*In re* Guardianship of Browning), 543 So. 2d at 258 n.11.

37. The Ninth Circuit identified six relevant state interests to weigh when analyzing these cases:

- 1) the state's general interest in preserving life;
- 2) the state's more specific interest in preventing suicide;
- 3) the state's interest in avoiding the involvement of third parties and in precluding the use of arbitrary, unfair, or undue influence;
- 4) the state's interest in protecting family members and loved ones;
- 5) the state's interest in protecting the integrity of the medical profession; and,
- 6) the state's interest in avoiding adverse consequences that might ensue if the statutory provision at issue is declared unconstitutional.

Compassion in Dying v. Washington, 79 F.3d 790, 816–17 (9th Cir.), stay granted *sub nom.* *Washington v. Glucksberg*, 116 S. Ct. 2494, and cert. granted, 117 S. Ct. 37 (1996) (footnote omitted).

As noted by the Ninth Circuit in *Compassion in Dying*, the three-judge panel that first considered the case identified five state interests:

The majority of the three-judge panel identified five state interests. First, “[t]he interest in not having physicians in the role of killers of their patients.” Second, “[t]he interest in not subjecting the elderly and even the not-elderly but infirm to psychological pressure to consent to their own deaths.” Third, “[t]he interest in protecting the poor and minorities from exploitation.” Fourth, “[t]he interest in protecting all of the handicapped from societal indifference and apathy.” Fifth, “[a]n interest in preventing abuse similar to what has occurred in the Netherlands where, since 1984, legal guidelines have tacitly allowed assisted suicide or euthanasia in response to a repeated request from a suffering, competent patient.”

Id. at 817 n.71 (citation omitted).

The Ninth Circuit noted that the trial court judge identified only two: “The district court, by contrast, employing more dispassionate and traditional terms, identified two somewhat broader state interests: preventing suicide and preventing undue influence and abuse.” *Id.* (citing *Compassion in Dying*, 850 F. Supp. 1454, 1464–65 (W.D. Wash. 1994)).

an individual with a terminal condition (or in some states, one who is in a persistent vegetative state) has the right to have life-supportive treatment terminated when there is clear and convincing evidence of the individual's wish to do so.³⁸ The fact that the individual no longer has the ability to make the decision does not strip the individual of the right to have the treatment terminated.³⁹ Instead,

38. See discussion in *Compassion in Dying*, 79 F.3d at 818–19. “More than 40 other states have adopted living will statutes that permit competent adults to declare by advance directive that they do not wish to be kept alive by medical treatment in the latter stages of a terminal illness.” *Id.* at 818 (footnote omitted). The court, citing to ALAN MEISEL, *THE RIGHT TO DIE* § 11.12 (1989 & 1994 Supp. No. 2), lists the states which have enacted such laws:

Ala.Code § 22-8A-3(6) (1984); Alaska Stat. § 18.12.100(7) (1986); Ark.Stat. Ann. § 20-17-201(9)(Supp.1987); Cal.Health & Safety Code § 7186(j) (West Supp.1992); Colo.Rev.Stat. § 15-18-103(10) (1987 & Supp.1992); Conn.Gen.Stat. Ann. § 19a-570(3)(West Supp.1993); Del.Code Ann. tit. 16, § 2501(e) (1983); D.C.Code Ann. § 6-2421(6) (Supp.1987); Fla.Stat. Ann. § 765.101(17) (West Supp.1993); Ga.Code Ann. § 31-32-2(13) (1991 & Supp.1992); Haw.Rev.Stat. Ann. § 327D-2 (1991); Ill. Ann. Stat. ch. 110, para. 702(h) (Smith-Hurd Supp.1988); Ind.Code Ann. § 16-8-11-9 (Burns Supp.1988); Iowa Code Ann. § 144A.2(8)(West 1989 & Supp.); La.Rev.Stat. Ann. § 40:1299.58.2(9)(West 1992); Me.Rev.Stat. Ann. tit. 18-A, § 5-701(b)(9) (West Supp.1991); Md.Health-Gen.Code Ann. § 5-601(g) (1990); Minn.Stat. Ann. § 145B.02(8) (West Supp.1993); Miss.Code Ann. § 41-41-113 (Supp.1987); Mo. Ann. Stat. § 459.010(6) (Vernon Supp.1993); Mont.Stat. Ann. § 50-9-102(14) (1991); Neb.Rev.Stat. § 20-403(11) (Supp.1992); Nev.Rev.Stat. Ann. § 449.590 (Michie Supp.1991); N.H.Rev.Stat. Ann. § 137-H:2(VI)(Supp.1992); N.J.Stat. [sic] Ann. § 26:2H-55 (West Supp.1992) (“A determination of a specific life expectancy is not required as a precondition for a diagnosis of a ‘terminal condition,’ but a prognosis of a life expectancy of six months or less, with or without the provision of life-sustaining treatment, based upon reasonable medical certainty, shall be deemed to constitute a terminal condition.”); N.M.Stat. Ann. § 24-7-2(f) (1986); N.D.Cent. Code § 23-06.4-02.7 (Supp.1989); Ohio Rev. Code Ann. § 2133.01(AA) (Anderson 1991); Okla.Stat. Ann. tit. 63, § 3101.3(12) (West Supp.1993); Or.Rev.Stat. Ann. § 127.605(6) (1990); 20 Pa.Cons.Stat. Ann. § 5403 (Supp.); R.I.Gen.Laws § 23-4.11-2(h) (Supp.1992); S.C.Code Ann. § 44-77-20(4) (Law.Co-op.Supp.1988); Tenn.Code Ann. § 32-11-103(9) (Supp.1991); Tex. Health & Safety Code Ann. § 672.003(9) (West 1992); Utah Code Ann. § 75-2(10) (Michie Supp.1993); Vt.Stat. Ann. tit. 18, § 5252(5) (1987); Va.Code Ann. § 54.1-2982 (Michie Supp.1992); Wash.Rev. Code Ann. § 70.122.020(9) (West Supp.); W.Va.Code § 16-30-2(6)(1985); Wis.Stat. Ann. § 154.01(8) (West 1989 & Supp.1992); Wyo. Stat. § 35-22-101(a)(ix) (1988 & Supp.1992); see also Uniform Rights of the Terminally Ill Act, § 1(9), 9B U.L.A. 96, 98 (Supp.1992). [sic]

Compassion in Dying, 79 F.3d at 818–19 n.77.

39. As noted by the Ninth Circuit, “many states also permit competent adults to determine in advance that they do not wish any medical treatment should they become permanently and irreversibly unconscious.” *Compassion in Dying*, 79 F.3d at 818–19 (footnote omitted). The court cites to MEISEL, *supra* note 38, and notes that:

the Uniform Rights of the Terminally Ill Act permits the foregoing of treatment

it requires a surrogate decisionmaker, using the substituted judgment standard, to make the decision the patient would make, if the patient were competent and able to do so.⁴⁰

when the patient is in a persistent vegetative state.

Meisel also states:

An increasing number of states now define *terminal condition* to include permanent or persistent vegetative state and/or irreversible coma. *See, e.g.*, Conn.Gen.Stat. Ann. § 19a-570(3) (West Supp.1993); Fla.Stat. Ann. § 765.101(17)(b) (West Supp.1993); Iowa Code Ann. § 144A/2(8) (West 1989 & Supp.) (state of permanent unconsciousness); La.Rev.Stat. Ann. § 40:1299.58.2(7) (West 1992); Neb.Rev.Stat. § 20-403(11) (Supp.1992); Nev.Rev.Stat. Ann. § 449.590 (Michie 1991); Ohio Rev. Code Ann. § 2133.01(U) (Anderson Supp.1991); R.I.Gen.Laws § 23.411-2(h) (Supp.1992); Tenn.Code Ann. § 32-11-103(9) (Supp.1991); Va.Code Ann. § 54.1-2982 (Michie Supp.1992). Other statutes reach the same result by defining *qualified patient* as one who is in a terminal condition or a persistent vegetative state. *See, e.g.*, Cal.Health & Safety Code § 7186(h) (West Supp.1992); Colo.Rev.Stat. § 15-18-103(9) (1987 & Supp.1992); Iowa Code Ann. § 144A.2(7) (West 1989 & Supp.); Me.Rev.Stat. Ann. titl. 18A, § 5 701(b)(7) (West Supp.1991); Neb.Rev.Stat. § 20-403(9) (Supp.1992); Nev.Rev.Stat. Ann. § 449.585 (Michie Supp.1991); N.H.Rev.Stat. Ann. § 137-H:2(V) (Supp.1992); Ohio Rev.Code Ann. § 2133.01(Z) (Anderson Supp.1991); Okla.Stat. Ann. titl. 63, § 3101.3(10) (West Supp.1993); Or.Rev.Stat. Ann. § 127.605(5) (1990); 20 Pa.Cons.Stat. Ann. § 5403 (Supp.); Tex. Health & Safety Code Ann. § 672.002(8) (West 1992); Wash.Rev. Code Ann. § 70.122.020(8) (West Supp.); Wis.Stat. Ann. § 154.01(6) (West 1989 & 1992 Supp.). The amended Hawaii statute, however, achieves this result by deleting the definition of “qualified patient” and adding a definition of “permanent loss of the ability to communicate concerning medical treatment decisions” which includes being in a persistent vegetative state or a deep coma or having a permanent loss of the capacity to participate in medical treatment decisions. *See* Haw.Rev.Stat. Ann. § 327D-2 (1991). Still other statutes reach the same result by including a separate definition of *persistent vegetative state* or *permanent unconsciousness*. *See, e.g.*, Conn.Gen.Stat. Ann. § 19a-570(4) (West Supp.1993); Ga.Code Ann. § 31-32-2(9) (1991 & Supp.1992); Me.Rev.Stat. Ann. titl. 18A, § 5-701(b)(10) (West Supp.1991); Md.Health-Gen. code Ann. § 5-601(0); Neb.Rev.Stat. § 20-403(6) (Supp.1992); N.H.Rev.Stat. Ann. § 137-H:2(VII) (Supp.1992); N.J.Stat. Ann. § 26:2H-55 (West Supp.1992); Okla.Stat. Ann. tit. 63, § 3101.3(7) (West Supp.1993) (defines *persistently unconscious*); 20 Pa.Cons.Stat. Ann. § 5403 (Supp.); S.C.Code Ann. § 44-77-20(7) (Law.Co-op Supp.1991); Utah Code Ann. § 75-2-1103(8) (Michie Supp.1993); Va. Code Ann. § 54.1-2982 (Michie Supp.1992); Wash.Rev.Code Ann. § 70.122.020(6) (West Supp.) (permanent unconscious condition); Wis.Stat. Ann. § 154.01(5m) (West 1989 & Supp.1992); Wyo.Stat. § 35-22-101(a)(v) (1988 & Supp.1992) (“irreversible coma”). [sic]

Compassion in Dying, 79 F.3d at 818–19 n.78.

40. The Ninth Circuit noted that “many states allow patients to delegate decision-making power to a surrogate through a durable power of attorney, health care proxy, or similar device, or permit courts to appoint surrogate decision-makers.” *Compassion in Dying*, 79 F.3d at 819 & n.79 (citing MEISEL, *supra* note 38, at §§ 10A.1–10A.2 (Cumulative Supp. 1994)).

PATIENT CLASSIFICATIONS

In termination of life-support cases, it is important to recognize the classification of the patient. Patients usually fall into three categories. One, the patient is competent and able to consent to or refuse treatment. Two, the patient was once competent but is currently incompetent. Three, the patient has never been competent, and is severely developmentally disabled.

The classification of the patient is relevant to the law because the ability of the patient to direct or consent to termination of treatment is directly implicated by the patient's competency or lack thereof. A person who is competent can say whether treatment should be refused or terminated and, in theory, should be able to have treatment instructions followed without the necessity of seeking a court order to enforce them.⁴¹ The once-competent patients who are currently incompetent may have left a directive regarding their wishes on termination of life-prolonging medical procedures while competent, or may, at least by lifestyle and oral statement, have left evidence of their wishes. The never-competent individual presents a more difficult question for the court. Since this patient never had the legal ability to consent to treatment, there would not be a directive and, although there may be lifestyle evidence, meeting the clear and convincing evidence standard would be more difficult, and perhaps impossible.⁴²

41. *But see* Bouvia v. Superior Court, 225 Cal. Rptr. 297 (Ct. App. 1986); Satz v. Perlmutter, 379 So. 2d 359 (Fla. 1980); State v. McAfee, 385 S.E.2d 651 (Ga. 1989). In *McAfee*, the court was cognizant of the doctor's role in removing the respirator from Mr. McAfee and administering pain medication to him.

We further hold that Mr. McAfee's right to be free from pain at the time the ventilator is disconnected is inseparable from his right to refuse medical treatment. The record shows that Mr. McAfee has attempted to disconnect his ventilator in the past, but has been unable to do so due to the severe pain he suffers when deprived of oxygen. His right to have a sedative (a medication that in no way causes or accelerates death) administered before the ventilator is disconnected is a part of his right to control his medical treatment. *McAfee*, 385 S.E.2d at 652.

42. That, however, has not dissuaded the Massachusetts Supreme Court from applying the substituted judgment standard in several cases. *See, e.g.*, Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417 (Mass. 1979) (deciding the fate of a patient who was profoundly mentally retarded); *see also In re Doe*, 583 N.E.2d 1263 (Mass. 1992) (determining the rights of a profoundly mentally retarded patient in a persistent vegetative state). How can the substituted judgment standard be applied to

And yet, patients do not fall neatly into these three pigeonholes. Recently, the Michigan Supreme Court wrestled with the question of whether life-supportive medical treatment, in this case a feeding tube, could be removed from a questionably competent individual.⁴³ The *Martin*⁴⁴ case had been moving through the judicial process for an extended period of time and graphically illustrates what can happen when involved family members disagree on whether treatment should be stopped.⁴⁵ The issue in question was whether a feeding tube should be removed from Mr. Martin.⁴⁶ Although he had never made a directive, there was testimony by his wife and friends about prior statements he made while competent.⁴⁷ Most troubling for the court was his mental status.⁴⁸ Evidence was presented, and the court ultimately found, that Mr. Martin could answer simple yes and no questions (although sometimes incorrectly).⁴⁹ Mr. Martin was clearly not competent, but not clearly incompetent. The court ruled that treatment would continue.⁵⁰

With this history of case law and evolving medical technology, it was inevitable that a court would be asked to find that a person had a right to physician-aid-in-dying and that "assisted suicide" cases would find their way to the courts. Perhaps most surprising is not that it has occurred, but that it has occurred so quickly, with the large number of cases being litigated, surveys supporting the practice,⁵¹ and a number of people seeking PAS.

SOCIAL STEREOTYPING OF SUICIDE AND PAS

someone who has never had the ability to make the decision? In the case of a profoundly mentally retarded individual who never had the ability to make a decision, how can a surrogate decisionmaker make the decision that patient would make if competent?

43. *In re Martin*, 538 N.W.2d 399 (Mich. 1995), *cert. denied*, 116 S. Ct. 912 (1996).

44. *Id.*

45. The procedural history illustrates how long a case can last: *In re Martin*, 504 N.W.2d 917 (Mich. Ct. App. 1993), *remanded*; *In re Martin*, 517 N.W.2d 749 (Mich. Ct. App. 1994) (continuing the appeal after remand), *appeal granted by In re Martin*, 525 N.W.2d 451 (Mich. 1994); *In re Martin*, 517 N.W.2d 749 (Mich. Ct. App. 1994); *rev'd*, *In re Martin*, 538 N.W.2d 399 (Mich. 1995), *cert. denied*, *Martin v. Martin*, 116 S. Ct. 912 (1996).

46. *See In re Martin*, 538 N.W.2d at 402.

47. *See id.* at 411-14.

48. *See id.* at 406-13.

49. *See id.* at 403-04.

50. *See id.* at 413.

51. *See sources cited supra* note 5.

Inevitably, PAS issues have been linked to social perceptions about suicide. This is unfortunate, since the particular context of PAS cases are radically different from the contexts typically associated with suicidal individuals. Our society has traditionally linked suicide to a failed mental condition, or perhaps a triggering event in a person's life (breakdown of the marriage, loss of a job or loved one, or some sort of despairing event). Thus, society has associated suicide with irrational behavior. If individuals contemplating suicide made their wishes known, they would likely be involuntarily committed to a mental institution for treatment, medication, and therapy to help them manage their mental condition or to get beyond the triggering event in their lives and to ultimately return to society as a happy and functioning member. Society usually takes the position that only someone who is not in their right mental state would want to end their life and, with treatment, the individual would want to live.

Recent studies dispute this mistaken stereotype.⁵² Likewise, recent court rulings have begun to recognize qualitative differences between PAS cases and other types of suicide.⁵³ This is because indi-

52. See JAMES L. WERTH, JR., PH.D., *RATIONAL SUICIDE? IMPLICATIONS FOR MENTAL HEALTH PROFESSIONALS* (1996), for a fine, recent assessment and reappraisal of the changing roles of suicide over the centuries, from being an acceptable option, to a sin and a sign of mental illness. For an understandable and penetrating study from the field of philosophy, see MARGARET BATTIN, *ETHICAL ISSUES IN SUICIDE* (1995). See especially chapter four titled "The Concept of Rational Suicide." The authors do not intend any offense or stereotyping in the description of societal perceptions of individuals seeking suicide.

53. The Ninth Circuit took a firm stance in distinguishing PAS from other types of suicide:

While the state's general commitment to the preservation of life clearly encompasses the prevention of suicide, the state has an even more particular interest in deterring the taking of one's own life. The fact that neither Washington nor any other state currently bans suicide, or attempted suicide, does not mean that the state does not have a valid and important interest in preventing or discouraging that act. . . . [T]he state has a clear interest in preventing anyone, no matter what age, from taking his own life in a fit of desperation, depression, or loneliness or as a result of any other problem, physical or psychological, which can be significantly ameliorated. Studies show that many suicides are committed by people who are suffering from treatable mental disorders. Most if not all states provide for the involuntary commitment of such persons if they are likely to physically harm themselves. . . . While the state has a legitimate interest in preventing suicides in general, that interest, like the state's interest in preserving life, is substantially diminished in the case of terminally-ill, competent adults who wish to die. One of the heartaches of suicide is the

viduals seeking PAS are understood to be in a different category from “traditional” suicide cases. These individuals, all of whom appear to have the requisite competency,⁵⁴ have conditions that are either terminal or, in their views, render their quality of life diminished to the point that death is preferable to continued living. Involuntarily committing them to mental facilities, giving them psychotropic drugs and counseling will not change their dire physical conditions. Instead, these individuals choose to control their lives and their destinies through the ultimate exercise of autonomy — choosing the moment and method of their deaths.

Historically, society has strongly discouraged suicide under any conditions.⁵⁵ Although the act of suicide itself is no longer a crime⁵⁶ (really, how does one punish a successful suicide?), the majority of states have statutes criminalizing *assisting* a suicide.⁵⁷ Although there have been few successful prosecutions,⁵⁸ the fact remains that

senseless loss of a life ended prematurely. In the case of a terminally-ill adult who ends his life in the final stages of an incurable and painful degenerative disease, in order to avoid debilitating pain and a humiliating death, the decision to commit suicide is not senseless, and death does not come too early. Unlike “the depressed twenty-one year old, the romantically devastated twenty-eight year old, the alcoholic forty-year old,” *Compassion in Dying*, 49 F.3d at 590-91, or many others who may be inclined to commit suicide, a terminally-ill competent adult cannot be cured. While some people who contemplate suicide can be restored to a state of physical and mental well-being, terminally-ill adults who wish to die can only be maintained in a debilitated and deteriorating state, unable to enjoy the presence of family or friends. Not only is the state's interest in preventing such individuals from hastening their deaths of comparatively little weight, but its insistence on frustrating their wishes seems cruel indeed.

Compassion in Dying v. Washington, 79 F.3d 790, 820–21 (9th Cir.), *stay granted sub nom. Washington v. Glucksberg*, 116 S. Ct. 2494, and *cert. granted*, 117 S. Ct. 37 (1996) (footnotes omitted).

54. There are those, however, who would dispute an individual's competency based on the fact that the individual seeks death — no one in his or her “right” mind would want to “kill” his or herself, according to this logic.

55. See *Compassion in Dying*, 79 F.3d at 806–12 (discussing the historical and current attitudes towards suicide); see also Rebecca C. Morgan et al., *The Issue of Personal Choice: The Competent Incurable Patient and the Right to Commit Suicide?*, 57 MO. L. REV. 1 (1992) (discussing historical and cultural views on suicide and an individual's right to make choices dealing with his or her own body).

56. See *Compassion in Dying*, 79 F.3d at 809.

57. See *id.* at 810 (citing Julia Pugliese, *Don't Ask — Don't Tell: The Secret Practice of Physician-Assisted Suicide*, 44 HASTINGS L.J. 1291, 1295 (1993)).

58. Although at this writing Dr. Kevorkian has been acquitted three times, the threat of prosecution for doctors still exists. See *Kevorkian Charged in 3 Suicides*, DAILY NEWS L.A., Nov. 1, 1996, at N28.

assisting an individual to commit a suicide is a crime and the threat of prosecution is real, as is the possibility of professional discipline.⁵⁹

People seek PAS for a number of reasons. Some fear the unknown. For others, the fear of dying in pain is a real and major concern. Even though the AMA thinks that educating doctors on pain management will solve the problem, in some cases it simply will not. Jane Doe, a plaintiff in a Second Circuit case, noted in her affidavit that the amount of medication needed to control her pain would simply put her in a drug-induced state of unawareness, a life without quality that she chose to reject as an unacceptable state in which to spend her final days.⁶⁰

Another fear is the exhaustion of financial resources. People have worked hard all their lives to accumulate a nest egg that they intend to leave to their children (or other devisees), only to see it eaten away paying for health care that simply postpones the inevitable.⁶¹ People do not want to be a burden to their family or their loved ones. Further, they fear loss of control and independence, as well as a general lack of dignity. These individuals would rather choose the moment and means that they regard as proper for culmi-

59. See *Compassion in Dying*, 79 F.3d at 810–11 & nn.50–59 for a discussion of the potential for prosecution of doctors assisting patients in dying; the court recites cases where prosecutions were pursued without success.

60. In her personal declaration, Jane Doe passionately stated her reasons for seeking assistance in expediting her own death.

I have a large cancerous tumor which is wrapped around the right carotid artery in my neck and is collapsing my esophagus and invading my voice box. The tumor has significantly reduced my ability to swallow and prevents me from eating anything but very thin liquids in extremely small amounts. The cancer has metastasized to my plural [sic] cavity and it is painful to yawn or cough In early July 1994 I had the [feeding] tube implanted and have suffered serious problems as a result I take a variety of medications to manage the pain It is not possible for me to reduce my pain to an acceptable level of comfort and to retain an alert state At this time, it is clear to me, based on the advice of my doctors, that I am in the terminal phase of this disease At the point at which I can no longer endure the pain and suffering associated with my cancer, I want to have drugs available for the purpose of hastening my death in a humane and certain manner. I want to be able to discuss freely with my treating physician my intention of hastening my death through the consumption of drugs prescribed for that purpose.

Quill v. Vacco, 80 F.3d 716, 720 (2d Cir. 1996), cert. granted, 117 S. Ct. 36 (Oct. 1, 1996).

61. The Ninth Circuit has indicated that this would be an acceptable motivation for a person seeking aid in dying who meets all other criteria. See *Compassion in Dying*, 79 F.3d at 826.

nating their life, albeit prematurely. Because of fears about the process and the technology, and because society has lost sight of the fact that dying has a place in living, patients seek PAS as the only answer to their situation.

Before the advances of medicine, people were sent home to die. The patient was surrounded by familiar objects in a comfortable setting, with their family and other loved ones. Today, death has become clinical. People die in hospitals or other institutions, surrounded by strangers in a cold, sterile environment, filled with tubes and machines that beep and whirr, and lit in the digital glow of technological readouts. In our attempt, unsuccessfully, to conquer death and to cure all, we have created a climate in which we have forgotten the place of death in life, and the role the community has in the dying process. Physician-assisted suicide has awakened our social memories, and caused us to reassess the relative role that medical technology plays in the way we die.⁶²

What will be the social policy on PAS? What are the limits on autonomy? Are we heading down a slippery slope? How will the law deal with the challenge of physician-assisted suicide? Thus far, three distinct models have evolved in the United States for dealing with PAS. All three are closely linked to a particular understanding of autonomy. We now turn to consider these models.

PAS AND AUTONOMY: THREE MODELS

Today, social policy is being debated on three legal fronts: (1) litigation, as illustrated by the Supreme Court's review of decisions from the United States Court of Appeals for the Ninth Circuit and the United States Court of Appeals for the Second Circuit,⁶³ (2) legislation, as illustrated by the Measure 16 Referendum in Oregon, and (3) the direct participation of doctors in PAS. These three

62. A deep sense of dissatisfaction is echoed by a recent rash of articles in the popular press. See Jack D. McCue, *The Naturalness of Dying*, 273 JAMA 1039 (1995); Susan Brink, *The American Way of Dying*, U.S. NEWS & WORLD REP., Dec. 4, 1995, at 70; Leon Jaroff, *Knowing When to Stop*, TIME, Dec. 4, 1995, at 76; Keith H. Hammonds, *The Hospital*, BUS. WK., Jan. 17, 1994, at 48-61.

63. The Supreme Court heard oral arguments on *Compassion in Dying v. Washington* and *Quill v. Vacco* on January 8, 1997. See *Compassion in Dying v. Washington*, 79 F.3d 790, 820-21 (9th Cir.), *stay granted sub nom. Washington v. Glucksberg*, 116 S. Ct. 2494, *and cert. granted*, 117 S. Ct. 37 (1996); *Quill v. Vacco*, 80 F.3d 716 (2d Cir.), *cert. granted*, 117 S. Ct. 36 (1996).

models provide the most dramatic expressions of the radical soul-searching now evident in our society regarding the definition and exercise of autonomy.⁶⁴ Each model is distinct, thus providing three different frameworks within which the issue of PAS could be worked out. Yet each affects the development of the others, and all three reflect a society searching not just for a legal solution, but also for an ethic for PAS.

Litigation

The Ninth Circuit

On May 3, 1994, Judge Barbara Rothstein held that the 140-year-old law banning assisted suicide was unconstitutional.⁶⁵ The legal basis for the decision was the Fourteenth Amendment, which protects individuals from infringement by the state on their basic personal freedoms. The judge linked the issue of assisted suicide to that of a woman's choice to obtain an abortion.⁶⁶ Applying the language and analysis of *Planned Parenthood v. Casey*,⁶⁷ the judge saw the issues as analogous, ruling that the Fourteenth Amendment protects an individual's liberty to decide when to end one's life. "[T]he decision of a terminally-ill person to end his or her life 'involv[es] the most intimate and personal choices a person may make in a lifetime' and constitutes a 'choice[] central to personal dignity and autonomy.'"⁶⁸

Judge Rothstein also relied on *Cruzan v. Director, Missouri Department of Health*,⁶⁹ where the United States Supreme Court found that an individual has a liberty interest in deciding to forego medical treatment.⁷⁰ Connecting these two arguments, the judge concluded that Washington's ban on PAS also violated the Constitution's guarantee of equal protection. It discriminated against terminally-ill patients in that they, unlike those receiving life-supportive medical treatment who may choose to forego or with-

64. See *supra* text accompanying note 18; see also *supra* note 19.

65. See *Compassion in Dying v. Washington*, 850 F. Supp. 1454, 1467 (W.D. Wash. 1994).

66. See *id.* at 1459–60.

67. 505 U.S. 833 (1992).

68. *Compassion in Dying*, 850 F. Supp. at 1459–60 (quoting Judge Rothstein).

69. 497 U.S. 261 (1990).

70. See *id.* at 278.

draw treatment, had no such means to bring about their identical wish.⁷¹ Thus, a person could cause their death by refusing kidney dialysis, but a physician could not lawfully engage in any *positive* assistance to that same person to accomplish the same outcome.

In March, 1995, the Ninth Circuit Court of Appeals, in a two-to-one decision, reversed the lower court opinion.⁷² Writing for the majority, Judge Noonan maintained that, historically, Constitutional protection focused on the right to be free of unwanted treatment, (i.e., the right to be left alone), but this did not translate into a right to PAS. A subsequent motion for rehearing *en banc* was granted, and the arguments were heard by the eleven-judge panel of the Ninth Circuit on October 26, 1995.⁷³

On March 6, 1996, the United States Court of Appeals for the Ninth Circuit reversed the panel decision and upheld, by a nine-to-two margin, the district court's decision, stating that the judge was correct in her analogies of *Casey* and *Cruzan*, and that such decisions were best left in the hands of individuals.⁷⁴ Judge Reinhardt, writing for the majority, concluded:

The Constitution and the courts stand as a bulwark between individual freedom and arbitrary and intrusive governmental power. Under our constitutional system, neither the state nor the majority of the people in a state can impose its will upon the individual in a matter so highly "central to personal dignity and autonomy."⁷⁵

Significantly, the court concluded that little difference exists between what is already happening — that is, a doctor prescribing drugs for a patient that carries a double effect (controlling pain and hastening death), versus providing the patient with a drug for a single purpose (ending the patient's life).⁷⁶ There is little difference between what is currently acceptable and occurring regularly — the doctor's role in removing artificial life support from the patient —

71. See *Compassion in Dying*, 850 F. Supp. at 1466–67.

72. See *Compassion in Dying v. Washington*, 49 F.3d 586 (9th Cir. 1995) (holding that the Washington statute did not deprive people of their liberty interests protected by the Constitution).

73. See *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir.), *stay granted sub nom.* *Washington v. Glucksberg*, 116 S. Ct. 2494, *cert. granted*, 117 S. Ct. 37 (1996).

74. See *id.* at 838–39.

75. *Id.* at 839 (quoting *Planned Parenthood v. Casey*, 505 U.S. 833, 851 (1992)).

76. See *id.* at 828.

versus providing the patient with a prescription for drugs that will allow the patient to end their life.⁷⁷ The court concluded that a slight (but almost insignificant) difference exists from either an ethical or a constitutional perspective between what is currently permissible and what these patients are requesting.⁷⁸

Although the “early” cases were concerned about financial motives of the families seeking to terminate life support from the patient, the Ninth Circuit recognized that the financial drain on the patient's family due to medical bills incurred by the patient's continued existence was an appropriate consideration for the patient seeking PAS. Thus, seeking PAS to avoid being a financial burden to their families could be appropriate.⁷⁹

The Second Circuit

At the same time *Compassion in Dying* made its way to the Ninth Circuit, a concurrent legal battle occurred in the United States Court of Appeals for the Second Circuit. The trial court decision in *Quill v. Koppel*,⁸⁰ was similar to that of the first Ninth Circuit opinion. Although the district court affirmed New York's law against PAS — in April, 1996, Judge Miner of the Second Circuit Court reversed the district court, and found that the New York statute in question was unconstitutional.⁸¹ In contrast to the Ninth Circuit, the Second Circuit followed a somewhat different path forged by the Fourteenth Amendment. Not only does this amendment protect the “liberty interest” of a person, it also provides that no person within a state's jurisdiction may be denied “equal protection of the laws.”⁸² The Second Circuit reasoned that the equal protection clause is violated when there is one law for the dying patient on life support, and another law for the dying patient not dependent on life support. The first patient can hasten her death by having life

77. *See id.* at 826 (stating that concern in either situation deserves serious attention).

78. *See Compassion in Dying*, 79 F.3d at 823.

79. *See id.* at 826 (stating that while states regulate attempts to protect against “rash, uninformed, or ill-considered decisions,” a patient will normally consider the economic welfare of loved ones).

80. 870 F. Supp. 78 (S.D.N.Y. 1994) (holding that physician-assisted suicide is not a protected fundamental right).

81. *See Quill v. Vacco*, 80 F.3d 716, 743 (2d Cir. 1996).

82. *Id.* at 726–27.

support terminated, while the second cannot. The court concluded: "Withdrawal of life support requires physicians or those acting at their direction physically to remove equipment and, often, to administer palliative drugs which may themselves contribute to death. The ending of life by these means is nothing more nor less than assisted suicide."⁸³

This follows the pattern of the Ninth Circuit's opinion in refusing to distinguish between what is currently authorized — removing life support, and what is being requested — a prescription for medication that would allow a terminally-ill, competent individual to end his or her life. Although based on different constitutional concepts, both courts end up with the same result: that a ban against PAS deprives an individual of the right to autonomy, and that this choice should be left to the private relationship of patient and doctor.⁸⁴

The Supreme Court

On January 8, 1997, the Supreme Court heard oral arguments in the consolidated review of these two cases.⁸⁵ A near record number of amicus briefs were filed, illustrating the wide-ranging interest in the issue. In the forthcoming ruling,⁸⁶ the Supreme Court is expected to answer the question of whether there is a constitutional right to PAS, but in reality will most likely review whether the statutes in question are constitutional. The Supreme Court will have to address the equal protection argument that is the thrust of the Second Circuit's opinion. Absent a declaration that the right to PAS exists, the Supreme Court's ruling will neither stop the debate nor the actions of doctors such as Dr. Quill or Dr. Kevorkian.

Philosophical Autonomy

83. *Id.* at 729.

84. See *supra* text accompanying notes 74, 81 for holdings. Compare *supra* text accompanying notes 75, 78 with *supra* text accompanying note 81–83 for different constitutional concepts.

85. See *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir.), *stay granted sub nom. Washington v. Glucksberg*, 117 S. Ct. 37, and *cert. granted*, 117 S. Ct. 36 (1996); *Quill v. Vacco*, 80 F.3d 716 (2d Cir.), and *cert. granted*, *Vacco v. Quill*, 117 S. Ct. 36 (1996).

86. At the risk of making an erroneous prediction, *in writing no less*, the authors believe that the Court will *not* find a constitutional right to PAS, but might leave it up to the states whether to decriminalize and regulate limited-application PAS.

The foundation for these significant holdings can be seen as a “pure” moral concept of autonomy. The implication of such an approach is that if individuals wish to end their lives, the state should not prohibit them. The clash of the appellate courts with the lower courts centers on the appellate courts' willingness to broaden the issue beyond the narrow confines of “the right to be left alone” to the philosophical level of the right of an individual to make decisions about one's own body on *any* level.⁸⁷

The principle of autonomy holds great sway in the American public psyche. It forms the basis of our legal rights for withdrawal or withholding life-sustaining medical treatment. Its power has already been shown in the decisions allowing incompetent patients the right to refuse or withdraw medical treatment by way of surrogacy. Case law is clear.⁸⁸ A person who was once competent but currently incompetent, or a person who has never been competent, has the same constitutional and common law rights to refuse medical treatment, including that of refusal or termination of life-prolonging procedures. The difference lies not in the right, but in how the right is exercised and the evidence of the individual's wishes.⁸⁹

This position continues to be affirmed by state court opinions. The most recent case is from Pennsylvania. On April 2, 1996 that state's supreme court ruled in *In re Fiori*,⁹⁰ that a close family member of a patient in a “permanent vegetative state” can, with the approval of two doctors, withdraw life-sustaining medical treatment without court approval and without an advance health care directive

87. The first appellate decision of *Compassion in Dying*, a three-judge panel, voted two-to-one to reverse the district court (and to uphold the statute). Only in a rehearing *en banc* did the Ninth Circuit reach the same conclusion as the Second Circuit, although the Second Circuit opinion came one month later. On June 12, 1996, the Ninth Circuit issued an order rejecting a request from an active judge of the circuit that the full court rehear the case *en banc*. See *Compassion in Dying v. Washington*, 85 F.3d 1440 (9th Cir. 1996).

88. See, e.g., *State v. Herbert (In re Guardianship of Browning)*, 568 So. 2d 4 (Fla. 1990) (discussing the right to consent or refuse medical treatment and how the right is not lost by virtue of incompetency).

89. See, e.g., *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261 (1990) (once competent, currently incompetent); *State v. Herbert (In re Guardianship of Browning)*, 568 So. 2d 4 (Fla. 1990) (once competent, currently incompetent); *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417 (Mass. 1977) (never competent).

90. 673 A.2d 905, 912–13 (Pa. 1996).

(living will).⁹¹

With the Second and Ninth Circuit Court decisions, however, the power of autonomy flows both ways. If incompetent patients have such clear rights to end their lives by passive means of withdrawal or refusal of treatment, how much more should the right apply to people who can articulate their desires? Furthermore, when linked to that other authentically American principle, equal protection, the power of autonomy takes a quantum leap. The rights of a person wishing to end his or her life because medical treatment is futile should be protected equally as those of a patient who seeks withdrawal of a life-prolonging procedure. The difference is only the *mode* — one is by means of withdrawal of treatment, the other by actively taking a prescribed drug to end life. In each circumstance, the same goal and purpose is accomplished, and the same desires are met.

Currently, the legal decisions on PAS draw the line with competency. No effort has yet been made to analogize PAS decision-making to PAS for *incompetent* people. The two Courts of Appeals' decisions are clear in limiting application to competent, terminally-ill individuals. All proposed legislation also applies only to competent individuals.

Opponents of PAS raise this issue as a real and fearful example of the potential for abuse if PAS were to be legalized. To cross this line would take us out of the realm of PAS and into an even newer frontier of active euthanasia, giving lethal injections to *incompetent* patients through proxy of a surrogate, or even on a doctor's own initiative. If this would occur, they argue, the result would be that society would have moved too far down the slippery slope, making quality-of-life decisions for those unable to make such decisions themselves, and likely basing the decision upon a societal perspective of that individual's value (or burden) to society, not upon the individual's wishes.⁹² Although this possibility is real, it is just as real whether PAS is legal in a closely regulated statutory scheme or under the status quo.

91. *Id.* Still in question in some jurisdictions, however, are issues of whether a guardian must first be appointed by the court, of whether a need exists for court oversight of, or authority for, the surrogate's actions. See *Belchertown*, 370 N.E.2d at 417.

92. A succinct summary of the main arguments against PAS is found in Paul Wilkes, *The Next Pro-Lifers*, N.Y. TIMES MAG., July 21, 1996, § 6, col. 1, at 22.

But the groundwork is laid, and framing the issue under philosophical autonomy forestalls argument against such an extension. Both the Ninth and Second Circuits concluded that no real difference exists between what is currently allowed and what is requested in these cases. Prior opinions have supported the basic axiom that an individual's incompetency does not strip one of the right to refuse, or to request withdrawal of, life support. How effectively can one argue, then, that if PAS is legally allowable for a competent, terminally-ill patient, it is not for a once-competent, currently incompetent, terminally-ill patient?⁹³

Following the case law and statutory developments for the right to refuse life-prolonging medical procedures, one can assume PAS would evolve along those same lines, resulting in a conclusion that no basis exists for refusing to deny an incompetent individual PAS. This would especially apply to patients who, while competent, had previously expressed the desire for PAS. Philosophically, there is no logical barrier.⁹⁴

Thus, under this model, PAS raises its own particular set of ethical challenges. For example:

- What are the practical parameters for this freedom of self-determination? While the decisions of the Courts of Appeals were limited to decisions about the rights of a terminally-ill, competent adult under a specific statute, the demand for a decision on the constitutionality of PAS results in language that would leave unclear why autonomy should be limited to the *competent terminally ill* only. Early opinions granted the right to terminate treatment based on the individual's condition, noting that the sicker and closer to death the person was, the less the state's interest in preserving life would weigh against the individual's right to refuse the treatment in question.⁹⁵ Yet, later decisions refused to balance the existence of the right

93. See generally *Compassion in Dying*, 79 F. Supp. at 822-24; *Quill*, 80 F.3d at 729.

94. See Joram Graf Haber, *Should Physicians Assist the Reaper?*, 5 CAMBRIDGE Q. HEALTHCARE ETHICS 44, 49 (1996).

95. See generally *In re Quinlan*, 355 A.2d 647 (N.J. 1976) (holding that termination of life support upon guardian's approval was permissible, as long as there was no legitimate chance of the person ever coming off life support or coming out of a vegetative state).

against how sick the patient was.⁹⁶ Neither has pain and suffering been used as a barometer.

- Why should this medically defined group be allowed PAS as a medical treatment exclusive of all other people? What about someone suffering from an incurable disease such as diabetes, which is usually not considered “terminal?” What about a person who is diagnosed with Alzheimer's disease? Why should that person not have equal access to a physician's help in obtaining a lethal dosage, if the person is convinced that life is not worth living? Following the rationale of the Second Circuit, a significant argument can be made that the requirement of terminal illness should be struck down and a more appropriate limitation substituted, such as “a condition from which there can be no recovery.”⁹⁷
- Certain limitations are suggested by the rulings. But why are these limitations in terms of time lines only? Why measure the closeness to death exclusively by chronological means? Should the courts also consider levels of physical and non-physical pain and suffering? If so, how should this best be done?
- What about depression over personal issues? If seeking PAS because of concerns about financial burdens is an appropriate basis, then surely so is a desire not to live any longer with an incurable condition, and depression can be a normal part of such a condition.
- What about medical opinions concerning a disease's progression? How many, if any, opinions should be required? Within what degree of medical certainty? How soon is death to be expected — imminently, within a week, a month, six months? Is the prognosis for death with or without consideration of medical intervention?

The Ninth and Second Circuits' opinions take seriously autonomy as a philosophical concept. It is held as the ultimate value over any other competing values or responsibilities. As stated in the Ninth Circuit court's conclusion: “We hold that a liberty interest

96. See *State v. Herbert (In re Guardianship of Browning)*, 568 So. 2d 4 (Fla. 1990) (noting, however, that *Browning* based the right on a state constitutional right to privacy).

97. See generally *Quill v. Vacco*, 80 F.3d 716, 730–31 (2d Cir.), cert. granted, 117 S. Ct. 36 (1996). In arguments, the Supreme Court inquired into how such a line could be drawn, providing a constitutional right only to competent persons.

exists in the choice of how and when one dies”⁹⁸ This raises questions directly related to social concerns reaching beyond the individual:

- To what degree is the state responsible for protecting the individual? If autonomy is maintained purely and ultimately, does this make for a “better society” in which to live?
- At what point, if any, does the individual's responsibility to the larger community transcend the principle of autonomy? Should all ethical “rights” and choices ultimately come down to the individual? Is there anything that should exceed the individual's rights?
- What about the doctor who might be involved? Physicians are unaccustomed to *causing* death. Most understand that their mission is to do everything to save life. What about the effects of such responsibility on the doctor?⁹⁹
- When and under what circumstances will the interests of the state outweigh those of the individual? In PAS, what are the appropriate state interests? How much does the state's interest in preserving life weigh when the patient has a condition from which there can be no recovery?
- How can PAS parameters be set when there are so many considerations that vary from patient to patient?

Measure 16 in Oregon

Legislation is an alternative to the judicial model for PAS. Measure 16 in Oregon establishes a successful legislative model.¹⁰⁰ In November 1994, Oregon voters approved a ballot initiative for PAS (51% to 49%; 32,000 votes).¹⁰¹ The measure answers many of the questions posed above and carefully defines who may choose such assistance. The patient must:

- be a resident of Oregon.
- be judged competent.

98. *Compassion in Dying*, 79 F.3d at 838.

99. *See supra* note 7.

100. We judge this legislation successful not because of its merit, but because it was approved by voters while in other states. Proposed legislation failed to get necessary voter approval.

101. *See* Derek Humphrey, *Assisted Suicide Law Passes in Oregon: Now Make It Work!*, ERGO! (Euthanasia Res. & Guidance Org.), Nov. 1994, at 1.

- be at least eighteen years old.
- make the request orally twice and once in writing; two witnesses are required, one not a relative or heir.
- secure the opinion of two doctors.
- have less than six months to live.
- make the request voluntarily, without coercion.

The doctor:

- must be licensed to practice in Oregon.
- may refuse.
- must document that all requirements are met in patient's medical record.
- must verify upon writing the prescription the patient wishes.

The constitutionality of the new law has been challenged in federal court, and an injunction prohibits its application.¹⁰² Converse to the *Compassion in Dying* and *Quill* cases that used constitutional arguments to support statutes preventing PAS, the plaintiffs in *Lee v. State*¹⁰³ used the Constitution to *block* PAS as provided by Measure 16. The district court judge, sitting in Oregon, concluded that Measure 16 violates the Equal Protection Clause of the Fourteenth Amendment because it discriminates against terminally-ill persons and deprives them protection of Oregon laws that the majority enjoys.¹⁰⁴ This opinion is likely headed for reversal by the Ninth Circuit, since the majority opinion in *Compassion in Dying* criticized the district court's analysis, stating that the district court judge clearly was wrong.¹⁰⁵ The Ninth Circuit's view of the district court's opinion in *Lee* is that the district court got things backwards:¹⁰⁶ "*Lee* treats a *burden* as a *benefit* and a *benefit* as a *burden*."¹⁰⁷

Political Autonomy

102. See *Washington v. Glucksberg*, 116 S. Ct. 2494 (1996).

103. 891 F. Supp. 1429 (D. Or. 1995).

104. See *id.* at 1438.

105. *Compassion in Dying*, 79 F.3d at 837–38.

106. See *id.* at 838.

107. *Id.* See the critique of *Lee v. State* in Charles H. Baron et al., *A Model State Act to Authorize and Regulate Physician-Assisted Suicide*, 33 HARV. J. ON LEGIS. 1, 14–16 (1996) (suggesting that the *Lee* decision was incorrect and thus will be reversed by the Ninth Circuit).

PAS legalization legislation proceeds out of a grass roots movement led primarily by terminally-ill patients (or by families on behalf of patients) who wish to control the timing and circumstances of their own deaths. The Hemlock Society¹⁰⁸ was a moving force behind the Oregon initiative and those in California and Washington.

Measure 16, called the "Death with Dignity Act," attempted to resolve the most frequently expressed concerns about legalization of PAS. Previous defeats of voter initiatives in Washington in 1991 and in California in 1992 led proponents to strengthen safeguards against abuse. The doctor's role is both defined and limited. The circumstances for PAS are carefully delineated, putting the patient in charge. The doctor has a more passive role, acting more as a facilitator who makes sure that the request is legitimate.¹⁰⁹ Measure 16 also specifically protects the physician from criminal or civil penalties. No doctor who participates in or demurs from such action should be penalized by institutions with which the doctor is related in any way (such as employment).¹¹⁰

Like the Appellate Courts' decisions, assumptions about autonomy undergird Measure 16. The Oregon legislation conceives of autonomy, however, in much narrower terms. Assistance in dying is restricted only to those people who meet the conditions described above. Thus, the moral concept of autonomy is political. In an effort to make a referendum as attractive as possible to voters, autonomy took on very specific characteristics.

While this approach is politically wise — it avoids the same speculations that philosophical autonomy encourages — other ethical challenges still arise.

- Why does the ethical concept of autonomy apply at eighteen years of age, but not sixteen or twenty-one years of age? What about infants born with incurable and torturous conditions?

108. The Hemlock Society is an organization dedicated to legalizing voluntary euthanasia and PAS. See their website at <<http://www2.privatel.com/hemlock/>> (visited Nov. 21, 1996).

109. Recent revisions to the Netherlands process also puts the doctor in a less active role, now providing that the patient should be the one to administer the lethal dosage whenever possible. See *Quill*, 80 F.3d at 731 (citing to Marlise Simons, *Dutch Doctors to Tighten Rules on Mercy Killings*, N.Y. TIMES, Sept. 11, 1995, at A3).

110. See Derek Humphry, *Law Reform*, 20 OHIO N.U. L. REV. 729 (1994) (providing an insightful summary of the legislative initiatives, and adjustments concerning physicians in writing Measure 16). Included in this Article is a uniform model Death with Dignity Act that encompasses PAS and active voluntary euthanasia. See *infra* note 118.

Why not allow for the consent of parents for children who might meet satisfactory criteria? Since suffering is no respecter of age, should not children be shown the same compassion we say we want for adults?

- Why draw the diagnostic time line for death of terminally-ill patients at six months? Why is this date a magic point in human existence? This designation seems ethically arbitrary regarding the credibility of doctor-assisted suicide. If pain and suffering are at the heart of physician-assisted suicide measures, why should life expectancy time lines play such an important role?
- Many people are diagnosed with illnesses that mean only a progression of debilitation and suffering for the patient. Why should these people be deprived of the freedom to exercise their autonomous right of the choice to die when they wish?

In short, should the limits of autonomy — so crucial to such a serious matter — be prescribed by politics? What happens if legislation goes forward and is found to not cover all situations? Once the line is drawn, can not compelling arguments be made by those excluded from the statute's application? How long will it be before challenges occur seeking inclusion under the statute?

Doctors' Participation

Most public awareness about physician-assisted dying has been stimulated by Dr. Kevorkian's challenge to Michigan's lack of a specific law against PAS. His persistence led to the state legislature quickly passing a law against it.¹¹¹ Nevertheless, Kevorkian continues what he terms as “medicide.” Attempts to prosecute him have failed, and the ban was ruled unconstitutional.¹¹² As already mentioned, attempts to prosecute physicians for assisting patients to die

111. See MICH. COMP. LAWS ANN. § 752.1027 (West Supp. 1996). The statute states in pertinent part: “A person who has knowledge that another person intends to commit or attempt to commit suicide and who intentionally does either of the following is guilty of criminal assistance to suicide . . . (a) [p]rovides the physical means by which the other person attempts or commits suicide.” *Id.*

112. See Sandra Sanchez, *Assisted Suicide Ban Ruled Illegal*, USA TODAY, Dec. 14, 1993, at 1A; see also *People v. Kevorkian*, 527 N.W. 2d 714, 759 (Mich. 1994) (holding that patients suffering from great pain have a constitutional right to “physician-assisted suicide”). Even after the law was stricken, Kevorkian was prosecuted (unsuccessfully) for a common law felony. He was indicted for three suicides in late 1996, but the newly elected prosecutor dropped those charges.

have been very unsuccessful,¹¹³ but still exist as a real possibility.

Consumer Autonomy

Autonomy is at the core of Kevorkian's views. In contrast to the other models, his understanding of autonomy can be understood as "consumer" autonomy. In other words, Kevorkian views PAS entirely as a matter to be dealt with between patient and physician. He scoffs at critics and has been quoted as saying that: "[e]veryone is a phony", doctors are "socially criminal", legislators are "barbarians", and church officials are "religious fanatics."¹¹⁴

From such a perspective, the issue is entirely private. There are no legal, ethical, religious, or social questions to be considered. Philosophical discussions about Fourteenth Amendment liberties are (from Kevorkian's viewpoint) beside the point. PAS is purely a medical procedure. The only role of the law is to assure that qualified medical personnel are the only people who are allowed to carry out the procedure.

What distinguishes this model from the other two can be seen by looking at those Kevorkian has helped to die so far. One of his patients was forty-eight years old and suffered from a deteriorating case of multiple sclerosis. Under Measure 16 in Oregon, the patient would *not* have qualified for assistance in dying. The decisions of the Ninth and Second Circuits would have, in principle, been more supportive. The constitutional weight they give to a person's autonomous right to choose the conditions of his or her own death would make it difficult to draw the line exclusive of the patient's wishes. But remember the confines of the court decisions: The courts of appeals limited themselves to *terminally-ill* patients, which this patient was *not*. The ambiguity of what is to be included under the category of "terminally ill," and the very logic of philosophical autonomy undergirding their decisions makes the courts of appeal amenable to allowing PAS for this patient.

Kevorkian's first patient, Janet Adkins, pushed the limits even further. At the time of her death, she suffered from early stages of

113. See *supra* notes 57–58 and accompanying text; see also Maria T. Celoz Cruz, *Aid-in-Dying: Should We Decriminalize Physician-Assisted Suicide and Physician-Committed Euthanasia?* 18 AM. J.L. & MED. 369 (1992).

114. Carol J. Castaneda & Robert Davis, *House at the End of Life's Road*, USA TODAY, Feb. 22, 1993, at 1A.

Alzheimer's disease and was neither terminally-ill, nor suffering physically. She was still playing tennis, albeit deeply frustrated that her memory loss had sometimes prevented her from remembering the score.¹¹⁵

Although the Kevorkian and the courts of appeals models are close in their stances, there are distinctions, and these distinctions are important. The appellate decisions consist of constitutional challenges of long-standing statutes. The judicial process is searching for legal and ethical limits of autonomy in dying based on the procedural posture of specific cases. Oregon is attempting to find the same limits for a more limited segment of our society, the population of one state, via legislative means.

The demand for a consumer-based autonomy, however appealing, is too reductionistic. It assumes that an individual lives in a vacuum, without relationships and responsibilities beyond one's own life — or even beyond one's death. The implication is that medicine's sole purpose is to serve the desires of the patient. The danger exists that the physician is reduced to a role of a technician. Also, how would the authority of the doctor be balanced with the authority of the patient? What safeguards would assure that “medicide” does not become an easy solution for people who feel unwanted or mentally depressed? Using the abortion analogy, this model promotes “PAS on demand,” removed from any social context. It becomes a market-based industry.

PAS in the Public Square

The models outlined above represent the most “official” and public efforts to integrate PAS into our society, i.e., they function within the more formal structures of our society for making such broad policy decisions. Other very important dynamics also influence the direction of social perceptions about PAS. Deeper within the structures of society, PAS is already recognized as a fundamental human right. As Jordan Paust concludes, while human rights norms provide interrelated but sometimes conflicting guidance, in general, sufficient evidence exists of a human right to die with dignity, “implicating also a general right to choose the time of one's

115. See Bonnie Johnson et al., *A Vital Woman Chooses Death*, PEOPLE WKLY., June 25, 1990, at 40.

death and a right to medical and other assistance sufficient to assure a humane, dignified process of dying.”¹¹⁶ He states bluntly: “[d]omestic laws flatly prohibiting or punishing suicide, assisted-suicide, or assisted-death are irreconcilably at odds with a general right to die with dignity and should be changed or abandoned.”¹¹⁷

As a result of this general understanding, a consortium of professors of law and philosophy, a patient advocate and public policy economist, attorneys who represent patients, physicians and hospitals, as well as doctors with clinical experience, met for two years to draft a model statute to authorize PAS.¹¹⁸ The proposed statute offers an alternative to the “in-progress” models studied above. It not only focuses on terminally-ill patients, but also *includes people who wish to hasten their death because of intractable and unbearable suffering*. Disorders specifically mentioned are “AIDS, advanced emphysema, some forms of cancer, amyotrophic lateral sclerosis, and multiple sclerosis.”¹¹⁹ The authors of the model act think that the best way of integrating PAS into society is through legislative bills in each of the fifty states.¹²⁰

Not only is PAS regarded as a human right within our society, it is generally seen as conceptually acceptable. Objections to legalizing PAS are largely institutional objections and thus practical. Conceptual objections such as “PAS is killing a person” and therefore something we ought not to do, or other sanctity of life arguments, are seen as unconvincing. Most members of our society are not against killing another person in any and every case. Rather, unless a person is a pacifist, the ethical mandate is to never kill without a compelling reason. Self-defense, capital punishment, and war have commonly been acceptable contexts for killing another human being.¹²¹

The crux of the conceptual debate lies in whether or not society should include PAS in this small circle of acceptable contexts for

116. Jordan J. Paust, *The Human Right to Die with Dignity: A Policy-Oriented Essay*, 17 HUM. RTS. Q. 463, 483 (1995).

117. *Id.* (footnote omitted). See also George C. Garbesi, *The Law of Assisted Suicide*, 3 ISSUES L. & MED. 93 (1987).

118. See Baron et al., *supra* note 107, at 25–34. The Model Statute is also available at <<http://www1.pbs.org/newshour/bb/health/die.html>>. See *infra* Appendix A (containing a complete copy of the Model Statute).

119. Baron et al., *supra* note 107, at 11.

120. See *id.* at 7–9.

121. See, e.g., Haber, *supra* note 94; see generally David C. Maguire, DEATH BY CHOICE (1974).

killing another person. At the center of this debate is the physician. Traditionally, the doctor has functioned as caregiver, and as such has carried the obligation to relieve the suffering of patients. Medical tradition dating back to Hippocrates has drawn the line of acceptable treatment at the point of actively killing the patient.¹²² No law specifies how far physicians can go to relieve suffering and pain, short of intentionally killing the patient.

This difference in intention is why most of the objections to PAS center not on patient's human rights but on why physicians should not assist actively in causing a person's death.¹²³ A distinction between killing and allowing to die has almost become cliché. Those arguing to keep PAS outside the circle remind us of possible abuses. Most of these possibilities lie in the realm of the doctor's power: doctors could unconsciously recommend PAS out of their own biases, likes and dislikes; too much power could be put in the hands of doctors; societal perceptions of physicians as promoting health and wellness could be weakened; patient trust in the doctor would be diminished; patients could feel pressured into PAS because of extensive medical costs.

Yet, it seems clear now that given today's medical technology, distinctions between killing and allowing to die have faded. As the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research concluded in their report, *Deciding to Forego Life-Sustaining Treatment*,¹²⁴ "the distinction between the decisionmakers' 'intending' a patient's death and their 'merely foreseeing' that death will occur does not help in separating unacceptable from acceptable actions that lead to death."¹²⁵ As noted in the Ninth Circuit opinion, there is really little, if any, distinction between what is allowed and what is sought to be allowed. In the end, the acceptable medical practices of withholding

122. *But see* Morgan et al., *supra* note 55, at 46 (noting that Greek and Roman physicians, including Hippocratic physicians, often supplied patients with means to commit suicide).

123. *See Doctors Must Not Kill*, 259 JAMA 2139 (1988); Peter A. Singer & Mark Siegler, *Euthanasia — A Critique*, 322 NEW ENG. J. MED. 1881–83 (1990).

124. PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MED. & BIOMED. & BEHAVIORAL RESEARCH, *DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT: ETHICAL, MEDICAL AND LEGAL ISSUES IN TREATMENT DECISIONS* (1983).

125. *Id.* at 81–82. *See generally* Margaret Pabst Battin, *THE LEAST WORST DEATH* (1994); J. Rachels, *THE END OF LIFE: EUTHANASIA AND MORALITY* (Oxford University Press 1986); Peter Singer, *RETHINKING LIFE & DEATH* (1994).

and withdrawing treatment are not any more “passive” than the “active” writing of a prescription for a lethal drug.

In the public square, such fine-haired distinctions matter little. A climate of frustration about the road we have traveled until now is shared by doctors and patients alike. A recent study revealed that patient requests for PAS are not rare. Neither is the physician's positive response. Of 156 patients who made such a request, twenty-four percent received prescriptions.¹²⁶ Patient concerns that led to the requests were perceived by physicians to be non-physical. They included loss of dignity, being a burden, loss of control, and being dependent on others for personal care.

DECRIMINALIZATION OF PHYSICIAN-AIDED DYING IN FLORIDA

Can PAS be made “legal”? Absolutely. The question is not *can it*, but *should it*? *Can it* is an easy question to answer. Yes, it can, by changing a statute. But *can it* is not the issue. In the end, such a change would not be a test of what is best for society, but of legal endurance, money, and technical manipulation of case law. *Should* PAS be decriminalized? This is the real question, and obviously the most thorny. Countless articles, debates, and meetings have been held to discuss this issue. This question raises deeper concerns about our society as a whole. The *should* involves ethical concerns not only about individual autonomy, but also of how a society views an individual's place in the community in direct relation to their control over their death and the role of society (specifically the medical community) in that choice.

There is a certain and true finality to the issue. If a person commits PAS successfully, there is no turning back. The person has died. Once the act is done, any mistakes cannot be undone.

A great amount of legal argument has focused on showing that the United States Constitution provides the basis for a “right” for requesting PAS. The Supreme Court itself has expressed concerns about lower courts creating rights extrapolated from the Constitution that were not contemplated by the framers.¹²⁷ Whether the Supreme Court will rule that there is such a right will be known

126. See Back et al., *supra* note 5, at 919–25.

127. See, e.g., Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261 (1990).

shortly. Even in the Ninth Circuit, there is a great debate between the majority and the dissent about the existence of such a right. Writing a dissent to the Ninth Circuit's denial of the request that the full court rehear the *Compassion in Dying*¹²⁸ case *en banc*, Judge Trott, with whom Judges O'Scannlain and Kleinfeld concurred, wrote

No magician — not David Copperfield, not even Harry Houdini — can produce a rabbit from a hat unless the rabbit is in the hat to begin with. Moreover, if a hat does not contain such an animal, a magician cannot claim that anything he is able to produce from it is in fact a rabbit, no matter how sincere he may be or how great his forensic skills. All of this has something to do with basic physics.

But law may not be physics, as Judge Reinhardt's opinion . . . demonstrates, because, with all respect, he has in fact succeeded in pulling a nonexistent liberty interest out of thin constitutional air, a liberty interest that certainly does not exist in the document itself Maybe some of us or even many of us would like to see this rabbit in the hat because we believe it's a nice rabbit — hope is an ever-present temptress in a world of woe — but *we* do not get to change the Constitution anymore that we get to change physics.¹²⁹

In Florida, the question of whether PAS will remain a crime rests with the Florida Supreme Court and on the state constitutional right of privacy. A trial court in Palm Beach County Florida held that a competent terminally ill adult has a constitutional right under the state constitutional privacy provision “to decide to terminate his suffering and determine the time and manner of his death, and the right to seek and obtain the assistance of his physician. . .” in ending his life.¹³⁰ The trial court also found that the Florida statute criminalizing assistance in suicide denied the plaintiff his Fourteenth Amendment right to equal protection.¹³¹ The court entered a permanent injunction prohibiting prosecution by the state attorney of anyone who is present or who assists the plaintiff, as long as the plaintiff makes the final action of administering the lethal dosage, as well as a declaratory judgment that Florida's statute prohibiting

128. *Compassion in Dying v. Washington*, 85 F.3d 1440 (9th Cir. 1996).

129. *Id.* at 1446–47 (Trott, J., dissenting).

130. *McIver, Castonguay, Cron & Hall v. Krischer*, No. CL-96-15-04-AF, 23–24 (Fla. 15th Cir. Jan. 31, 1997).

131. *See id.* at 24.

PAS denied the plaintiff equal protection.¹³² The judge specifically limited the opinion to the plaintiffs.¹³³ The state immediately appealed the January 31, 1997 judgment, which stayed the proceeding for thirty days. However, another trial judge in Palm Beach County lifted the stay on February 6, 1997.¹³⁴ The intermediate appellate court declined the appeal and passed the case on to the Florida Supreme Court. An emergency motion to reinstate the stay was filed with the Florida Supreme Court on February 7, 1997.¹³⁵

If indeed the right to PAS is found to exist in Florida by the Florida Supreme Court, will the legislature then act to develop a statute to regulate it? Thinking that a statute could regulate PAS is folly. Although one statute has been approved in Oregon (yet implementation is stayed pending litigation), there will always be issues not resolved by statute. One only has to look at the number of cases dealing with termination of life support in states having advance directive legislation to realize that for as many questions the legislation answers, there are an equal number not answered. Simply put, the law, while providing the limits and constraints within which we operate, is not the best forum for the normal management of this issue. Can the law adequately control it? Many who are closely involved in the debate believe not.¹³⁶ Will PAS truly be an exercise of autonomy if the patient is making the decision because

132. *See id.* at 10–11. The basis of the equal protection ruling was that terminally ill individuals on life support have a right to and in fact do exercise their choice to terminate treatment with the assistance of involved medical personnel. *See id.* at 11. The court found that in both scenarios — affirmatively acting to end life (in the case of the administration of a fatal dosage) and in removing life-supportive procedures — the primary reason for acting is to cause the patient's death, with the only distinction the time it takes the patient to die. *See id.* at 21.

133. *See id.* at 18–19 n.6.

134. *See* Jeanne Malmgren, *Assisted Suicide Ruled Okay*, ST. PETERSBURG TIMES, Feb. 7, 1997, at B1.

135. *See* Jeanne Malmgren, *Assisted-Suicide Case Sits with State Supreme Court*, ST. PETERSBURG TIMES, Feb. 8, 1997, at B6. By the time this Article is published, the Florida Supreme Court will have acted. Although the trial court acknowledged that the United States Supreme Court will be ruling on a similar issue this term (in fact, in a matter of months), the judge found the Second Circuit opinion in *Quill v. Vacco* to be persuasive. *See McIver, supra* note 130, at 21–22.

136. *See The Next Pro-Lifers*, N.Y. TIMES MAG., July 21, 1996, at 22. In that article, Dr. Carlos Gomez of the University of Virginia's hospital in Charlottesville, opposes the legalization: "There are always compelling cases, but we can't allow sweeping public policy to be made out of individual, compelling cases." *Id.* at 24. Further, Dr. Gomez stated, "[i]t cannot be legalized, because it can never be adequately controlled." *Id.*

the patient does not want to be a burden to the family or a financial drain? Will it truly be an exercise of autonomy if it devolves into the doctor's choice?¹³⁷ Will less money for palliative care become available, increasing the pressure on patients to choose suicide or constricting the options available to the patient?¹³⁸ The very real possibility that the old and the disabled will be looked upon by society in a different way¹³⁹ cannot be casually discarded, and the fact that a law would fail to protect against such a possibility is quite likely.

CONCLUSION

PAS is playing an important role in the American social psyche, primarily among the elders of society. They have witnessed the rise of respirators, feeding tubes, and have read about cases such as Karen Ann Quinlan and Nancy Cruzan. This generation of Americans have been part of the "institutionalization of dying," living during the transition from a time when almost everyone died at home, to our current status with eighty percent of all Americans dying in hospitals. While conducive to the technology that dominates their rooms, hospitals also symbolize the loss of control. The environment is alien. The rules change. Patients are no longer in control of their dress, eating, or sleeping habits. They are told what to do and where to go. The normal symbols of control and autonomy are missing.¹⁴⁰

This may explain why the ailing elderly are taking matters into their own hands. The suicide rates for the elderly fell throughout most of this century. During the 1980s, however, they started to climb. In 1980, Florida's elderly accounted for about seventeen percent of the population, and twenty-two percent of the suicides. In

137. The Oregon State Board of Medical Examiners recently accused Dr. Gallant of active euthanasia in the death of Clarietta Day. Dr. Gallant is accused of ordering a lethal injection for Mrs. Day against her wishes, although it is reported that the family supported Dr. Gallant's decision. See *Physician Faces Euthanasia Charge*, L.A. TIMES, July 21, 1996, at A18.

138. See *The Next Pro-Lifers*, *supra* note 136, at 26.

139. There are those who would argue that some view the elderly and the disabled as having little worth to society, and would take the argument down the slippery slope and point to the Nazi experience as a very real possibility of occurring here — select "suicides" of those with less value to society.

140. See David C. Thomasma, *Beyond Autonomy to the Person Coping with Illness*, 4 CAMBRIDGE Q. HEALTHCARE ETHICS 72 (1995). For a fuller discussion, see JURRIT BERGSMAN & DAVID C. THOMASMA, *HEALTH CARE: ITS PSYCHOSOCIAL DIMENSIONS* (Duchesne University Press 1982).

1992, representing eighteen percent of the population, the elderly accounted for twenty-nine percent of suicides in Florida. Nationally, they are killing themselves at a rate nearly twice the average.¹⁴¹

The elderly are not waiting on society or the United States Supreme Court to decide the debate on PAS. Neither are some physicians. Given extraordinary circumstances, their compassion for suffering patients supersedes professional guidelines. As Justice Oliver Wendell Holmes once wrote, “[t]he first requirement of a sound body of law is that it should correspond with the actual feelings and demands of the community, whether right or wrong.”¹⁴² The credibility of his statement is surely debatable, but it echoes the current situation. We live in a society in which grand juries will not indict, district attorneys will not prosecute, and jurors are unwilling to convict a doctor of PAS.¹⁴³ The curve of separation between statutory mandate and actual practice is becoming wider and wider.¹⁴⁴

The social psyche in the United States elevates an autonomy-centered view of human existence coupled with a highly individualized notion of ownership of one's own body.¹⁴⁵ These views fortify ideas about privacy rights of citizens who perceive conventions and laws, as well as ancient religious values, as repressive.¹⁴⁶ Society's challenge is to find a way beyond the power struggles represented by the fight over rights in the courts, and go beyond the defensive postures of the medical profession that claim “we know best.” In the end, we will not find certitude for every case. Unless compassionate concern for the patient prevails, arguments on any side of this issue will be to no avail. Our task is to create a society in which all of us can die without disintegrating into something less than a person, and to find a framework that suitably answers all the questions

141. See Scott Montgomery, *The Unquiet Exit*, PALM BEACH POST, Feb. 6, 1994, at 1D, 4D.

142. James A. Tulsky, et al., *A Middle Ground on Physician-Assisted Suicide*, 5 CAMBRIDGE Q. HEALTHCARE ETHICS 33, 36 (1996) (quoting OLIVER WENDELL HOLMES, *THE COMMON LAW* (Little, Brown & Co. 1881)).

143. See *supra* notes 112–13 and accompanying text.

144. See Norman J. Finkel et al., *Right to Die, Euthanasia, and Community Sentiment: Crossing the Public/Private Boundary*, 17 LAW & HUM. BEHAV. 487 (1993).

145. See generally Thomasma, *supra* note 140, at 12.

146. Many religious communities are finding it necessary to study PAS and reconsider the issue in light of medical technology. For instance, the Episcopal Diocese of Newark, New Jersey recently voted in favor of PAS. See TASK FORCE ON ASSISTED SUICIDE, EPISCOPAL DIOCESE OF NEWARK, *Report to the 122nd Convention of the Episcopal Diocese of Newark* (1996).

raised by the role of death in life and the law. The goal to create the best possible society includes the ultimate challenge of a good death for its individual members, without impoverishing the community as a whole. A deeper question than the Supreme Court's decision can answer is whether or not legalizing PAS will accomplish this goal. It is clear that the present situation most definitely does not.

APPENDIX A

The following document is a Model State Act drafted over two years by a team of lawyers, physicians, academics, and Hemlock Society members in Boston. It closely resembles their Model Act published in the Winter, 1996 issue of the Harvard Journal on Legislation. This special version is an adaptation of the Act designed to fit it squarely within the constitutional protections for physician-assisted suicide afforded by the U.S. Court of Appeals for the Ninth Circuit's March 6, 1996, decision in *Compassion in Dying v. Washington*. There it was decided that the Due Process clause of the Fourteenth Amendment is violated by any categorical ban on assisted suicide which does not make exceptions for physician-assistance in suicide to terminally ill patients who competently request it.

Political groups and legislators are invited to make use of the following Model State Act, but are advised not to alter the wording of the Act without consultation with its authors. This Model Act is NOT copyrighted and may be downloaded and photocopied as necessary.

A MODEL STATE ACT TO AUTHORIZE AND REGULATE PHYSICIAN-ASSISTED SUICIDE

Section 1. Statement of Purpose

The principal purpose of this Act is to enable an individual who requests it to receive assistance from a physician in obtaining the medical means for that individual to end his or her life when he or she suffers from a terminal illness and is otherwise qualified under the terms of the Act. Its further purposes are (a) to ensure that the request for such assistance is complied with only when it is fully informed, reasoned, free of undue influence from any person, and not the result of a distortion of judgment due to clinical depression or any other mental illness, and (b) to establish mechanisms for continuing oversight and regulation of the process for providing such assistance. The provisions of this Act should be liberally construed to further these purposes.

Section 2. Definitions

As used in this Act,

- (a) “Commissioner” means the Commissioner of the Department.
- (b) “Department” means the Department of Public Health [or similar state agency].
- (c) “Health care facility” means a hospital, hospice, nursing home, long-term residential care facility, or other institution providing medical services and licensed or operated in accordance with the law of this state or the United States.
- (d) “Medical means of suicide” means medical substances or devices that the responsible physician prescribes for or supplies to a patient for the purpose of enabling the patient to end his or her own life. “Providing medical means of suicide” includes providing a prescription therefor.
- (e) “Patient’s medical record” means (1) in the case of a patient

who is in a health care facility, the record of the patient's medical care that such facility is required by law or professional standards to compile and maintain, and (2) in the case of a patient who is not in such a facility, the record of the patient's medical care that the responsible physician is required by law or professional standards to compile and maintain.

▪ (f) "Person" includes any individual, corporation, professional corporation, partnership, unincorporated association, government, government agency, or any other legal or commercial entity.

▪ (g) "Responsible physician" means the physician, licensed to practice medicine in this state, who (1) has full or partial responsibility for treatment of a patient who is terminally ill, and (2) takes responsibility for providing medical means of suicide to the patient.

▪ (h) "Terminal illness" means a bodily disorder that is likely to cause a patient's death within six months.

Section 3. Authorization to Provide Assistance

(a) It is lawful for a responsible physician who complies in all material respects with Sections 4, 5, and 6 of this Act to provide a patient with medical means of suicide, provided that the responsible physician acts on the basis of an honest belief that

1. the patient is eighteen years of age or older;
2. the patient has a terminal illness; and
3. the patient has made a request of the responsible physician to provide medical means of suicide, which request

▪ (a) is not the result of a distortion of the patient's judgment due to clinical depression or any other mental illness;

▪ (b) represents the patient's reasoned choice based on an understanding of the information that the responsible physician has provided to the patient pursuant to Section 4(d) of this Act concerning the patient's medical condition and medical options;

▪ (c) has been made free of undue influence by any person; and

▪ (c) has been repeated without self-contradiction by the patient on two separate occasions at least fourteen days apart, the last of which is no more than seventy-two hours before the responsible physician provides the patient with the medical means of suicide.

(b) A responsible physician who has provided a patient with medical means of suicide in accordance with the provisions of this

Act may, if the patient so requests, be present and assist the patient at the time that the patient makes use of such means, provided that the actual use of such means is the knowing, intentional, and voluntary physical act of the patient.

Section 4. Discussion with Patient and Documentation

Before providing medical means of suicide to a patient pursuant to Section 3 of this Act, the responsible physician shall

(a) offer to the patient all medical care, including hospice care if available, that is consistent with accepted clinical practice and that can practicably be made available to the patient for the purpose of curing or palliating the patient's illness or alleviating symptoms, including pain and other discomfort;

(b) offer the patient the opportunity to consult with a social worker or other individual trained and experienced in providing social services to determine whether services are available to the patient that could improve the patient's circumstances sufficiently to cause the patient to reconsider his or her request for medical means of suicide;

(c) counsel the patient to inform the patient's family of the request if the patient has not already done so and the responsible physician believes that doing so would be in the patient's interest; and

(d) supply to and discuss with the patient all available medical information that is necessary to provide the basis for a reasoned decision concerning a request for medical means of suicide, including all such information regarding the patient's diagnosis and prognosis, the medical treatment options and the medical means of suicide that can be made available to the patient, and their benefits and burdens, all in accordance with the following procedures:

1. at least two adult individuals must witness the discussion required by this paragraph (d), at least one of whom (a) is not affiliated with any person that is involved in the care of the patient, and (b) does not stand to benefit personally in any way from the patient's death;

2. the responsible physician shall inform each witness that he or she may question the responsible physician and the patient to ascertain that the patient has, in fact, heard and understood all of the material information discussed pursuant to this paragraph (d); and

3. the responsible physician shall document the discussion with the patient held pursuant to this paragraph (d), using one of the following methods:

- (a) an audio tape or a video tape of the discussion, during which the witnesses acknowledge their presence; or
- (b) a written summary of the discussion which the patient reads and signs and which the witnesses attest in writing to be accurate.

The documentation required by this subparagraph (3) must be included and retained with the patient's medical record, and access to and disclosure of such records and copies of them are governed by the provisions of Section 10 of this Act.

Section 5. Professional Consultation and Documentation

Before providing medical means of suicide to a patient pursuant to Section 3 of this Act, the responsible physician shall

(a) secure a written opinion from a consulting physician who has examined the patient and is qualified to make such an assessment that the patient is suffering from a terminal illness;

(b) secure a written opinion from a licensed psychiatrist, clinical psychologist, or psychiatric social worker who has examined the patient and is qualified to make such an assessment that the patient has requested medical means of suicide and that the patient's request meets the criteria set forth in Sections 3(a)(3)(A), 3(a)(3)(B), and 3(a)(3)(C) of this Act to the effect that the request is not the result of a distortion of the patient's judgment due to clinical depression or any other mental illness, is reasoned, is fully informed, and is free of undue influence by any person; and

(c) place the written opinions described in paragraphs (a) and (b) of this section in the patient's medical record.

Section 6. Recording and Reporting by the Responsible Physician

Promptly after providing medical means of suicide to a patient, the responsible physician shall (a) record the provision of such means in the patient's medical record, (b) submit a report to the Commissioner on such form as the Commissioner may require pursuant to Section 8(a) of this Act, and (c) place a copy of such report in the patient's medical record.

Section 7. Actions by Persons Other than the Responsible Physician

(a) An individual who acts on the basis of an honest belief that the requirements of this Act have been or are being met may, if the patient so requests, be present and assist at the time that the patient makes use of medical means of suicide, provided that the actual use of such means is the knowing, intentional, and voluntary physical act of the patient.

(b) A licensed pharmacist, acting in accordance with the laws and regulations of this state and the United States that govern the dispensing of prescription drugs and devices and controlled substances, may dispense medical means of suicide to a person who the pharmacist reasonably believes presents a valid prescription for such means.

(c) An individual who acts on the basis of an honest belief that the requirements of this Act have been or are being met may counsel or assist the responsible physician in providing medical means of suicide to a patient.

Section 8. Record Keeping by the Department

(a) The Commissioner shall by regulation specify a form of report to be submitted by physicians pursuant to Section 6(b) of this Act in order to provide the Department with such data regarding the provision of medical means of suicide as the Commissioner determines to be necessary or appropriate to enable effective oversight and regulation of the operation of this Act. Such report shall include, at a minimum, the following information:

1. the patient's diagnosis, prognosis, and the alternative medical treatments, consistent with accepted clinical practice, that the responsible physician advised the patient were practicably available;

2. the date on which and the name of the health care facility or other place where the responsible physician complied with the patient's request for medical means of suicide, the medical means of suicide that were prescribed or otherwise provided, and the method of recording the discussion required by Section 4(d) of this Act;

3. the patient's vital statistics, including county of residence, age, sex, race, and marital status;

4. the type of medical insurance and name of insurer of the patient, if any;

5. the names of the responsible physician, the medical and mental health consultants who delivered opinions pursuant to Section 5 of this Act, and the witnesses required by Section 4(d) of this Act; and

6. the location of the patient's medical record.

(b) The Commissioner shall require that the report described in paragraph (a) of this section not include the name of the patient but shall provide by regulation for an anonymous coding or reference system that enables the Commissioner or the responsible physician to associate such report with the patient's medical record.

Section 9. Enforcement and Reporting by the Department

(a) The Commissioner shall enforce the provisions of this Act and shall report to the Attorney General and the appropriate board of registration [or similar state agency] any violation of its provisions.

(b) The Commissioner shall promulgate such rules and regulations as the Commissioner determines to be necessary or appropriate to implement and achieve the purposes of this Act and shall, at least ninety days prior to adopting any rule or regulation affecting the conduct of a physician acting under the provisions of this Act, submit such proposed rule or regulation to the Board of Registration in Medicine [or similar state agency] for such Board's review and advice.

(c) The Board of Registration in Medicine [or similar state agency] may promulgate no rule or regulation inconsistent with the provisions of this Act or with the rules and regulations of the Department promulgated under it and shall, at least ninety days prior to adopting any rule or regulation affecting the conduct of a physician acting under the provisions of this act, submit such proposed rule or regulation to the Commissioner for the Commissioner's review and advice.

(d) The Commissioner shall report to the Legislature annually concerning the operation of this Act and the achievement of its stated purposes. The report of the Commissioner shall be made available to the public upon its submission to the Legislature. In order to facilitate such annual reporting, the Commissioner may collect and review such information as the Commissioner determines to be helpful to the Department, the Board of Registration in Medicine [or similar state agency], or the Legislature and

may by regulation require the submission of such information to the Department.

Section 10. Confidentiality of Records and Reports

(a) The information that a person acting under this Act obtains from or about a patient is confidential and may not be disclosed to any other person without the patient's consent or the consent of a person with lawful authority to act on the patient's behalf, except as this Act or any other provision of law may otherwise require.

(b) The report that a responsible physician files with the Department pursuant to Section 6(b) of this Act is confidential, is not a public record, and is not subject to the provisions of [the state public records statute or freedom of information act].

Section 11. Provider's Freedom of Conscience

(a) No individual who is conscientiously opposed to providing a patient with medical means of suicide may be required to do so or to assist a responsible physician in doing so.

(b) A health care facility that has adopted a policy opposed to providing patients with medical means of suicide and has given reasonable notice of such policy to its staff members may prohibit such staff members from providing such means to a patient who is within its facilities or under its care.

Section 12. Patient's Freedom from Discrimination

(a) No physician, health care facility, health care service plan, provider of health or disability insurance, self-insured employee health care benefit plan, or hospital service plan may require any individual to request medical means of suicide as a condition of eligibility for service, benefits, or insurance. No such physician or entity may refuse to provide medical services or medical benefits to an individual because such individual has requested medical means of suicide, except as Section 11 of this Act permits.

(b) A patient's use of medical means of suicide to end such patient's life in compliance with the applicable provisions of this Act shall not be considered suicide for the purpose of voiding a policy of insurance on the life of such patient.

Section 13. Liability

(a) No person who has acted in compliance with the applicable provisions of this Act in providing medical means of suicide to an

individual shall be subject to civil or criminal liability therefor.

(b) No individual who has acted in compliance with the applicable provisions of this Act in providing medical means of suicide to a patient shall be subject therefor to professional sanction, loss of employment, or loss of privileges, provided that such action does not violate a policy of a health care facility which complies with Section 11(b) of this Act.

(c) Except as provided in paragraphs (a) and (b) of this section, this Act does not limit the civil, criminal, or disciplinary liability of any person for intentional or negligent misconduct.

Section 14. Criminal Penalties

In addition to any other civil, criminal, or disciplinary liability which he or she may otherwise incur thereby, an individual who willfully violates Section 3, 4, 5, 6, or 7 of this Act is guilty of a [specify grade of offense].