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ARTICLES

THE LEGALIZATION OF PHYSICIAN-ASSISTED SUICIDE: CREATING A REGULATORY POTEMKIN VILLAGE

*Daniel Callahan**

*Margot White***

I. INTRODUCTION

Over the past two decades, both professional and lay opinion have shown a markedly favorable shift toward the legalization of euthanasia and physician-assisted suicide (PAS).¹ Yet the translation of that support into legislation has come more slowly. Only in 1994, after the failure in some states to enact legislation and the defeat of ballot initiatives in California in 1991 and Washington in 1992, did an initiative finally succeed in Oregon. Although a court injunction has prevented it from taking effect, the fact of its passage marks an historical milestone. Among Western countries, euthanasia and PAS are legally available only in the Netherlands and the Northern Territory of

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1. Robert J. Blendon et al., *Should Physicians Aid Their Patients in Dying?*, 267 JAMA 2658, 2662 (1992); cf. David P. Caddell & Rae R. Newton, *Euthanasia: American Attitudes Toward the Physician's Role*, 40 SOC. SCI. & MED. 1671, 1671-1687 (1995); NATIONAL OPINION RESEARCH CENTER: CHICAGO SOCIAL SURVEY TRENDS TAPE MARGINALS, 1972-1989 (1990).

Australia. The latter recently passed a "Rights of the Terminally Ill" bill allowing euthanasia (though it will not immediately go into effect).² Elsewhere, the debate remains primarily academic—with the obvious exception of the twelve states in the United States where bills were pending in 1995.

Why did the ballot initiative succeed in Oregon after it had failed in two other states?³ There are two likely reasons. The first reason is that the Oregon initiative was more carefully formulated than the initiatives in California and Washington; in particular it tried to take into account worries about abuse that were said to have contributed to the defeat of the earlier initiatives. The second reason is an important change of emphasis, from a focus on euthanasia in California and Washington to one exclusively on physician-assisted suicide in Oregon. The formulators of the Oregon initiative believed, probably correctly, that PAS would arouse less apprehension because it made patients, rather than physicians, the final agents of their own deaths.

Despite the changed formulation in Oregon and other legal formulations to be found in various proposed state laws and relevant literature, it is the contention of this article that it is impossible in principle and in practice to regulate either euthanasia or PAS successfully. This is not to deny that carefully crafted laws and regulations might be written, although the fact that this has not been done in practice suggests that this goal may be unattainable. Yet, however careful the language, the nature of the doctor-patient relationship and of the medical procedures themselves renders them resistant to the standards asked for by one article: "clear criteria, rigorous procedures, and adequate safeguards."⁴ We liken the effort to devise suitable legal standards to that of erecting Potemkin villages,⁵ an elabo-

2. *Rights of the Terminally Ill Act 1995*, 108 BULL. MED. ETHICS 8-1 (1995).

3. See Peter M. McGough, *Washington State Initiative 119: The First Public Vote on Legalizing Physician-Assisted Death*, 2 CAMBRIDGE Q. HEALTH CARE ETHICS 63-67 (1993) (discussing the failure of the initiative in Washington); Allan Parachini, *The California Humane and Dignified Death Initiative*, 19 HASTINGS CENTER REP., Jan. 1989 at 10, 10-12 (addressing the failure of the California legislation).

4. Franklin G. Miller et al., *Regulating Physician-Assisted Death*, 331 NEW ENG. J. MED. 119, 120 (1994).

5. The term "Potemkin Village" originally referred to sham villages created in 18th century Russia to impress Empress Catherine II on her tours of the country.

rate regulatory facade concealing a poverty of potential for actual enforcement.

In developing this argument, we should make clear at the outset that we morally oppose euthanasia and PAS. We would continue that opposition even if adequate legal safeguards could be developed, which we believe they cannot for the reasons we discuss in this article. The impossibility of devising effective safeguards simply adds one more reason to oppose euthanasia and PAS, but by no means is it the only reason. Since the legislative emphasis has of late seen a tactical shift from euthanasia to PAS, our analysis will focus primarily on the latter. We believe, however, that much of what we say would apply with at least as much force to euthanasia and that the practice cannot be restricted to PAS. We will begin with an examination of the logical and practical problems of writing meaningful laws in this domain, discussing some of the more prominent articles in the literature proposing model guidelines. We will then take a brief look at the Dutch experience of regulating euthanasia, analyze the strategy and language of some proposed statutes and of the successful Oregon ballot initiative, and conclude with some general reflections on the problem of developing regulatory safeguards.

II. THE LOGIC OF REGULATION

Although there has been a variety of moral and medical objections over the years to euthanasia and PAS, among the most prominent have been worries about the potential for abuse. Even many of those who might morally accept euthanasia and PAS, under some circumstances, have doubted that their legalization could avoid the danger of coercion or manipulation.⁶ Nonetheless, it is not difficult for most people to imagine circumstances—or personally to have observed them—where even the best medical and palliative care appears unable to relieve pain or suffering, and where death is marked by misery and despair. Thus, the pull toward legalization of PAS is

6. See THE NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT xii, 102, 119-120, 140 (1994) [hereinafter NEW YORK STATE TASK FORCE].

strong, and even those firmly opposed on moral grounds can partially understand, and even sympathize with, the motivations of its proponents—however much they conclude (as we do) that its legalization would be a medical, social, and moral disaster.

Proponents of PAS have had to discharge a heavy double burden. They have had to show, first, that there are good moral and medical reasons to accept PAS, which they have most commonly attempted to do by arguing the rights to self-determination and to mercy in the relief of suffering. These have been discussed amply elsewhere and will not be summarized here.⁷ Second, the proponents have had to show that laws and regulations can be formulated which provide clear criteria and sound procedures, and most importantly, obviate or radically minimize the possibility of abuse. Since there appears to be a considerable reservoir of public sympathy for PAS, meeting this second requirement has been of special importance, perhaps the key to legislative success.

Two arguments have been deployed to take on the worry about abuse. On the one hand, there is the contention that careful and effective rules precluding or minimizing abuse can be written;⁸ and on the other hand, that the current situation of widespread violation of the present legal prohibitions and a secret, unregulated underground practice of PAS is itself a dangerous legal corruption, crying out for rectification.⁹ It is alleged that many doctors, at considerable professional and legal risk, are complying with their patients' pleas for relief,

7. See DON V. BAILEY, *THE CHALLENGE OF EUTHANASIA: AN ANNOTATED BIBLIOGRAPHY ON EUTHANASIA AND RELATED TOPICS* (1990); Margaret P. Battin, *Euthanasia*, in *HEALTH CARE ETHICS* 58 (Tom Regan & Donald Van Der Veer eds., 1987); HELGA KUHSE, *THE SANCTITY-OF-LIFE DOCTRINE IN MEDICINE* (1987); JAMES RACHELS, *THE END OF LIFE: EUTHANASIA & MORALITY* (1986); Howard Brody, *Assisted Death—A Compassionate Response to a Medical Failure*, 327 *NEW ENG. J. MED.* 1384, 1384-87 (1992); Franklin G. Miller & Howard Brody, *Professional Integrity and Physician-Assisted Death*, 25 *HASTINGS CENTER REP.*, May 1995 at 8, 8-17; Franklin G. Miller & John C. Fletcher, *The Case for Legalized Euthanasia*, 36 *PERSP. BIOLOGY & MED.* 159, 159-76 (1993).

8. Timothy E. Quill et al., *Care of the Hopelessly Ill: Proposed Clinical Criteria for Physician-Assisted Suicide*, 327 *NEW ENG. J. MED.* 1380, 1383 (1992); Miller et al., *supra* note 4, at 122; see also Dan Brock, *Voluntary Active Euthanasia*, *HASTINGS CENTER REP.*, Mar.-Apr. 1992, at 20.

9. Quill et al., *supra* note 8, at 1383; Miller et al., *supra* note 4, at 119.

but with no oversight or regulation, or consultation with colleagues.¹⁰ That state of affairs, it is argued, cannot fail to be a worse situation than one where the practice is brought out into the open and clear standards are formulated and implemented. The covert practice of PAS "compromises the professional integrity of physicians and undermines respect for the law."¹¹ In the same vein, Lawrence O. Gostin has written that "[e]stablishing clear rules for the practice rather than benignly ignoring it will relieve physicians of the secrecy and isolation imposed by current criminal prohibitions."¹²

Yet there is at least one problem with this contention. If it is truly the case that the present statutes forbidding euthanasia and PAS are widely ignored by physicians, why should we expect new statutes to be taken with greater moral and legal seriousness? There is no available survey or other evidence to indicate that new laws will bring any increased commitment to following the law.

However, that is not the only problem. "Reviews of the legal literature have not identified a single case in which a physician has been convicted for helping a suffering patient die at the patient's request."¹³ But then why should we expect that there will be any more convictions under the new laws for violations than under the present laws? Nor are there any surveys or other available evidence to suggest that prosecutors will show more zeal with new laws than with the old ones, or that juries will display less sympathy for violation of the new rules than they have for those who transgressed the old rules.¹⁴ It is, in short, very odd to claim that physicians who now do as they please, with complete de facto immunity from prosecution, will

10. Miller et al., *supra* note 4, at 120.

11. *Id.* at 119.

12. Lawrence O. Gostin, *Drawing a Line Between Killing and Letting Die: The Law, and Law Reform, on Medically Assisted Dying*, 21 J. L. MED. & ETHICS 94, 98 (1993).

13. Miller et al., *supra* note 4, at 119.

14. Yale Kamisar has discussed the high incidence of jury nullification during the 1940s and 1950s in the case of "mercy-killers," which refers to those family members committing euthanasia and assisting in suicide. Yale Kamisar, *Some Non-Religious Views Against Proposed 'Mercy-Killing' Legislation*, 42 MINN. L. REV. 969, 971-73 (1958).

act differently with new laws, and that the new laws will be more stringently enforced.

Could it not, however, be said in any case that laws that lead to few prosecutions or convictions ought to be removed from the books? Not necessarily. As the New York State Task Force on Life and Law noted in its report on euthanasia and PAS, the legal prohibition carries intense symbolic and practical significance,¹⁵ and "shores up the notion of limits in human relationships."¹⁶ Even laws that are not enforced can have an important place, particularly for physicians when they have the additional support of the traditional Hippocratic prohibition of PAS.

The legal and moral reasons given in favor of PAS over euthanasia seem no less poorly based. Consider one prominent line of reasoning in favor of PAS: "[in] assisted suicide, the final act is solely the patient's, and the risk of subtle coercion from doctors, family members, institutions, or other social forces is greatly reduced. The balance of power between doctor and patient is more nearly equal in physician-assisted suicide than in euthanasia."¹⁷ Notably, arguments of this kind do not cite any empirical studies to show there is less coercion and a greater balance of power. There are no such studies. The claim is pure assertion, and not a very plausible one at that. To insinuate the idea of suicide into the mind of someone already grievously suffering can surely be no more difficult than insinuating the idea of euthanasia. Indeed, it could be all the more manipulative if the insinuated hint was combined with a tacit flattery of someone's capacity to act on his or her own.

As for the power of doctors, their general prestige as professionals, who with training and experience are widely thought to understand better matters of life and death than the rest of us, and their capacity to give or withhold lethal drugs, already establishes the power differential between themselves and their patients. The fact that most of Dr. Kevorkian's patients, if that is the right word, were perfectly physically capable of committing suicide by themselves, including most obviously the one

15. See NEW YORK STATE TASK FORCE, *supra* note 6, at 140.

16. *Id.* at 131.

17. Quill et al., *supra* note 8, at 1381.

physician he helped to die, suggests that the desire to medicalize PAS already bespeaks the power and legitimation conferred by medical approval of it.¹⁸

In any event, as Dr. Herbert Hendin has shown, it is perfectly easy for families and physicians to subtly guide someone toward a PAS choice.¹⁹ In a prominent *New York Times Magazine* article and a PBS documentary, he contended that there is easily available public evidence to show exactly how it can be, and has been, done.²⁰ While strong-willed sick and suffering people may be able to resist patent and gross coercion, they may have far more difficulty contending with well-meaning manipulation and gentle, discreet suggestion. The most successful form of manipulation is to lead a person to think that someone else's idea is actually his or her own, or to nudge that person's already existing ambivalence one way or the other.

There is an additional consideration about PAS that needs reflection. In the case of euthanasia, where a physician would commonly give a lethal injection or radically increase a dose of morphine fully and directly intending death, the equivalent of a paper trail exists, at least in the hospital. The use of the lethal pharmaceutical agents will have to be recorded somewhere, and that can be traced. In the instance of PAS, however, the physician can more easily cover his or her tracks; the necessary pills, to be consumed all at once, can be prescribed in typical doses over a long period of time, and no one would be the wiser. This possibility, we surmise, is no doubt one explanation why the alleged common practice of PAS is so difficult to detect and prosecute, even if the authorities are willing to do so.

We can hardly fail to note, moreover, that the perfect formula for combining legal obfuscation and patient seduction is when a doctor says something like the following to a patient:

I perfectly understand how much you would like to be relieved of your terrible pain and suffering, which seems so meaningless. Like other patients of mine, you may have

18. Herbert Hendin, *Seduced by Death: Doctors, Patients, and the Dutch Cure*, 10 ISSUES L. & MED. 123, 131 (1994).

19. Herbert Hendin, *Selling Death and Dignity*, 25 HASTINGS CENTER REP., May-June 1995, at 19.

20. *Id.*

considered suicide as a peaceful way out. I am sorry I cannot help you if you have had such thoughts. But I want to warn you that if you take more than twenty of the pills I have been prescribing to help you with your pain, you are going to die quietly and quickly in your sleep. So please be careful, doing what you know is best.

III. REGULATING THE UNREGULATABLE

We have stressed two objections to PAS—that there is no reason to believe that new laws or regulations will bring more honesty and oversight into the practice, and that PAS is no less subject to coercion and a doctor-patient power imbalance than euthanasia. Both of those issues, however, touch on a still deeper problem, revealing the most fundamental flaw in regulatory proposals. If it is true, as it indubitably is, that “decisions about medical treatment are normally made in the privacy of the doctor-patient relationship,”²¹ then an obvious question must be asked: how is it possible, or could it *ever* be possible, to monitor and regulate those decisions regarding PAS that occur within the ambit of that privacy? How can there be oversight of those discussions, decisions, and transactions which must remain secret, and the confidentiality of which is protected by state statutes prohibiting unauthorized access to medical records? Is that not the legal equivalent of squaring the circle—regulating the unregulatable? If it is true that “[p]hysicians and patients have a unity of interest in defending and promoting the right of privacy that protects decisionmaking in the doctor-patient relationship from irruptive interference by the state,”²² then where does that leave the regulation of PAS?

There are two possible ways to proceed here: either we can station a policeman in every doctor’s office and next to every sickbed to monitor all conversations, or we can depend upon the individual physician to voluntarily reveal that he or she has been part of an agreement to pursue PAS. Since the former course would both violate doctor-patient confidentiality and be

21. Miller et al., *supra* note 4 at 119.

22. George J. Annas et al., *The Right of Privacy Protects the Doctor-Patient Relationship*, 263 JAMA 858, 861 (1990).

utterly impractical, only the latter option is available. But that course means, in effect, that any PAS regulation must, in the end, be physician self-regulated; no one hears, or can hear, what goes on between doctors and patients. Physicians, then, must be willing to come forward to say that they are contemplating PAS and are willing to abide by whatever the controlling statutes determine. Only if the physicians take that step can the law be followed, and only then is outside regulation and monitoring meaningful.

We submit that maintaining the privacy of the physician-patient relationship and the confidentiality of these deliberations is fundamentally incompatible with meaningful oversight and adherence to any statutory regulations. What if a physician decides not to come forward? A patient might want to keep his suicide private. Or the doctor may decide that the regulatory specifications have not been met, but nonetheless be sympathetic to the patient's request. It is not difficult to imagine many circumstances in which either the physician or the patient, or both, would prefer to keep the agreement secret. How can that situation be monitored or regulated? How could abuses be detected if a physician wrongly decided to induce someone to consider, and then use, PAS? Of course, there could be risk on the physician's part: a patient might decide to tell someone else after all, and that person could blow the whistle. Otherwise, the possibility of public regulation is simply nonexistent. No one could have known what Dr. Timothy Quill did with and for his patient, Diane, had he not chosen to make it public.²³ No new laws will or can change that situation. Precisely the principle that allows doctors and patients to reach private agreements—doctor-patient confidentiality—no less assures them that PAS decisions can continue to be effectively hidden.

The contention that PAS should be treated as a "nonstandard medical practice reserved for extraordinary circumstances"²⁴ cuts both ways: extraordinary circumstances for non-disclosure of PAS agreements can easily exist, particularly when the circumstances are such that the legal criteria are almost, but not

23. Timothy E. Quill, *Death and Dignity: A Case of Individualized Decision Making*, 324 NEW ENG. J. MED. 691, 693 (1991).

24. Miller et al., *supra* note 4, at 119.

quite, met. If we concede that extraordinary circumstances can justify PAS, it is only a short step to using the same argument to justify concealing PAS. The trouble lies in invoking extraordinary conditions for just about any action.

Consider once again the claim that legalizing PAS would end the secrecy that now marks its present practice. Why would that necessarily happen? Why would the impunity with which doctors now covertly practice it be lessened by the requirement that they follow new guidelines? In what respect would new guidelines give patients protection they do not already have? In what ways would subtle manipulation of suffering patients be less possible with new laws than with present laws?

Yet the fact that, in the end, all regulation of PAS must, of necessity, be tantamount to physician self-regulation precludes any satisfactory answer to such questions. The behavior of physicians would still be screened from public scrutiny by doctor-patient confidentiality. Yet if new, more permissive laws would do nothing to change the privacy of doctor-patient agreements, then the cloaked circumstances that make abuse now possible would have a more overt effect. They would, for instance, morally and legally legitimate the practice and, no doubt, increase its prevalence. That effect, and not the protection of vulnerable patients, would probably be the real significance of more permissive laws.

IV. SOME PROPOSED GUIDELINES: FINE TOUCHES ON THE POTEMKIN FACADE

We have laid the emphasis here on the *intrinsic* obstacles to effective regulation of PAS. Regardless of how carefully crafted and nicely drawn PAS regulations can be on paper, that is all beside the point if doctors alone, or doctors and patients together, secretly decide to ignore them altogether or to evade one or more of their requirements. Nonetheless, it is worth looking at some efforts in the literature to draft guidelines with the purpose of precluding or minimizing abuse. Even in their own terms, the actual details of the Potemkin village facade are riddled with problems.

In the nature of the case, it can never be easy, legally, to specify acts justifiable only in extraordinary circumstances.²⁵ A well-drawn statute must ordinarily work with familiar and perspicuous standards of a kind that can be treated uniformly and that do not require, or open the way to, systematically ambiguous interpretation. Most of us could probably imagine some extraordinary circumstances that would justify theft and intentional killing, and in such situations prosecutors, juries, and judges often temper justice with mercy. But it is difficult for laws to be written that can carefully specify those conditions in advance; so they must be left to *ex post facto* judgment and resolution in the courts.

In any event, consider one prominent set of proposed criteria and the difficulty of interpretation posed by most of its features: severe, unrelenting suffering, not being the result of inadequate comfort care; repeated request; non-distorted judgment; good doctor-patient relationship; consultation with another physician; and clear documentation.²⁶ Of that list, only the requirements of a repeated request, consultation with another physician, and clear documentation are objectively ascertainable. The other conditions require difficult interpretations of verbal and physical behavior, uncertainty as to what is truly going on in a patient's mind, and an almost certain impossibility of falsifying otherwise unverifiable claims. No evidence could establish that a patient is not suffering the severe and unrelenting suffering he claims, or which the doctor subsequently claims the patient claimed.

Moreover, ordinary medical practice and human experience make clear that there is no obvious correlation between expressions of suffering and actual degree of suffering, and no way of verifying the latter. Nor is there a correlation between medical conditions and unbearable suffering, as considerable individual variation could and does exist.²⁷ Repeated requests for PAS do not prove suffering so much as they prove determination. Exactly this kind of determination would make *prima facie* plausible

25. *Id.*

26. Quill et al., *supra* note 8, at 1381-82.

27. DANIEL CALLAHAN, THE TROUBLED DREAM OF LIFE: IN SEARCH OF A PEACEFUL DEATH 102 (1993).

claims that comfort care has failed, and there would be no way, in the face of a patient's insistence that comfort care had failed, to prove that it had not. All the cards, so to speak, are in the hands of the determined patient.

Just how easy this will become for such a patient is made even clearer in the 1994 proposed set of guidelines.²⁸ Three features of those guidelines deserve special attention. First, despite the insistence on the need for special procedures and independent monitoring, the patient's evaluation of his or her suffering is the ultimate criterion: "physician-assisted death becomes a legitimate option only after standard measures for comfort care have been found unsatisfactory by competent patients *in the context of their own situation and values.*"²⁹ There is an obvious tension between the radical subjectivity of this standard and the emphasis on the otherwise extraordinary circumstances for which the same guidelines call. Patients, not doctors, appear to be the ones who will determine what counts as extraordinary. The patient's views, moreover, may be colored by unduly pessimistic advice by doctors untrained in palliative care or unduly influenced by the doctor's own values on pain and suffering.

Second, the proposed guidelines directly confront two difficult questions: what about those suffering patients physically unable to end their own lives, and those who have "unremitting suffering" but are not terminally ill? The response of the authors is to opt for a "liberal, inclusive policy with respect to these issues."³⁰ In short, in the former case, it would be acceptable for the physician to perform direct euthanasia (the only way to effect a liberal policy), even though it would contradict the stand taken against euthanasia and in favor of PAS in the document. In the latter case, it will, once again, not be some reasonably objective standard, but the standards of the patient that will be determinative. By definition, an individually determined standard is not a standard.

Third, the proposed guidelines state that "[t]reating physicians would be prohibited from providing lethal treatment with-

28. Miller et al., *supra* note 4, at 119.

29. *Id.* (emphasis added).

30. *Id.* at 120.

out prior consultation and review by an independent, certified palliative-care consultant."³¹ These consultants are to be backed up by palliative-care committees that would review "difficult or disputed cases."³² The problem with this strategy is that, in the nature of the case, the independent consultant would have to be someone who has already accepted the morality of PAS, as would members of the review committees. Thus from the outset, the deck would be stacked in a direction favorable to PAS by eliminating as committee or consultant candidates those on the wrong side of the ethical fence.

In the end, the standards and procedures proposed by these guidelines accomplish a number of undesirable results: (1) they open the door very widely to expanded indications for PAS by including those who are suffering but not terminally ill; (2) they bring euthanasia in through the back door by apparently permitting it for those patients physically unable to commit suicide; (3) they not only make the system one of physician self-regulation since they must voluntarily come forward, but also of patient self-regulation by saying that, in the end, it is the patient's situation and values, which define last resort and which are determinative; and (4) while the intent of a palliative-care consultant and committee might be to avoid rubber-stamp decisions, the committees themselves are unlikely to include moral opponents of PAS. In short, the criteria and methods of these guidelines fail on all counts proposed by the authors themselves. The guidelines will not necessarily protect vulnerable patients, preserve physician integrity, assure the public that PAS will only occur as a last resort, or provide for the possibility of independent monitoring and regulation (which will apply only to those physicians who do not choose to keep their intentions secret).

V. LESSONS FROM THE NETHERLANDS

In this context, it is useful to examine the Dutch situation, as the Netherlands is the one country in the world that has had experience in attempting to regulate euthanasia and PAS.

31. *Id.* at 121.

32. *Id.*

Although the Netherlands has yet to enact legislation to decriminalize euthanasia and PAS, court decisions and legislative developments since 1973 have established that doctors may lawfully perform them in certain circumstances.³³ These developments were fueled, to a considerable degree, by the support of public opinion and of the main representative group of Dutch physicians, The Royal Dutch Medical Association (KNMG).³⁴

In 1984, the KNMG was the first to set forth the criteria that, until recently, were taken to be clearly determinative by the courts and the Parliament.³⁵ The criteria are (1) voluntariness, which is a patient's free-will choice; (2) a well-considered request, which is a request made by a patient who has carefully thought about his or her request; (3) a durable death wish, which is a persistent request; (4) unacceptable suffering, which is suffering that is persistent, unbearable, and hopeless; and (5) consultation and reporting, which is a consultation with a colleague and another doctor and accurate reporting on the cause of death.³⁶

Although often reiterated by the Dutch courts, the criteria are subject to one general exception and are open in principle to being set aside altogether. The general condition results from the acceptability of the defense of necessity or *force majeure*. By that principle, a doctor who can claim an exception to the criteria on the basis of "irresistible compulsion or necessity" [overmacht] is not criminally liable.³⁷ Necessity means that in the doctor's judgment, the situation is one where euthanasia or PAS is called for because of a "conflict of interests" in the "light of medical ethics."³⁸ The doctor's duty to alleviate suffering outweighs his or her duty not to kill. Until recently, the medi-

33. See John Keown, *The Law and Practice of Euthanasia in the Netherlands*, 108 LAW Q. REV. 51 (1992); H.J.J. Leenen, *Euthanasia, Assistance to Suicide and the Law: Developments in the Netherlands*, 8 HEALTH POL'Y 197, 200-02 (1987).

34. Leenen, *supra* note 33, at 198-216.

35. *Id.* at 198-99 (relating the circumstances leading up to the publication of the guidelines).

36. *Guidelines for Euthanasia*, 3 ISSUES L. & MED. 429, 431-33 (Walker Lagerweg trans., 1988).

37. John Keown, *Some Reflections on Euthanasia in the Netherlands*, in EUTHANASIA, CLINICAL PRACTICE AND THE LAW 193, 195 (Luke Gormally ed., 1994); see also J.K.M. Gevers, *Legal Developments Concerning Active Euthanasia on Request in the Netherlands*, 1 BIOETHICS 156, 159 (1987).

38. Keown, *supra* note 37, at 195-96.

cal profession and the courts had emphasized that this defense was available only in cases where the patient had freely requested death.³⁹

Two recent cases, however, exceeded even that defense. In the first case, the Supreme Court of Holland held that the patient need not even be suffering physical, let alone terminal, illness and that it could be lawful to assist a mother, who was depressed over losing two sons, to kill herself.⁴⁰ Then, in April 1995, a district court exonerated a physician who had euthanized a newborn with spina bifida at the request of its parents.⁴¹ Moreover, it is a highly idiosyncratic understanding of "the norms of medical ethics" to claim that a duty to alleviate suffering outweighs a duty not to kill. There is no basis in the traditions of medical ethics to sustain such a claim.

It is not our intention here to examine either the necessity principle or the two recent court cases. We simply note that although the Dutch have supposedly established criteria, they seem perfectly willing to set the criteria aside in the name of necessity. The criteria become, in effect, dispensable guidelines rather than essential requirements. This situation is reminiscent of the kind of strategic and systematic vagueness of the proposed American statute,⁴² which would set aside its criteria for those physically unable to commit suicide and for those who, though not terminal, are judged to be suffering unbearably. The only point we would make is that with such criteria, it is hard to know just where a line could be drawn in theory or in practice.

For our purposes here, the more salient information about the Dutch situation is how the judicially legitimated practice of euthanasia and PAS have been implemented. What can we learn about the success of regulation? The best information on this subject comes from a survey commissioned by the Dutch Government's Commission on Euthanasia appointed in January of 1990.⁴³ The survey, directed by Professor P.J. van der Maas,

39. See, e.g., *id.* at 199 (discussing the requirement of "voluntariness").

40. *Doctor Unpunished for Dutch Suicide*, N.Y. TIMES, June 22, 1994, at A10.

41. *Dutch Doctor Free After Prosecution Proves Murder Case*, AM. MED. NEWS, Dec. 4, 1995, at 4.

42. Miller et al., *supra* note 4.

43. John Keown, *Further Reflections on Euthanasia in the Netherlands in the*

encompassed a sample of 406 physicians, who were guaranteed anonymity in providing information to the researchers.⁴⁴

Based on the physicians sampled, the official results showed that out of a total of 129,000 deaths, there were 2300 cases of euthanasia⁴⁵ and 400 cases of assisted suicide.⁴⁶ Additionally, and most strikingly, there were 1000 cases of intentional termination of life without explicit request (nonvoluntary euthanasia).⁴⁷

Remarking that the narrow Dutch definition of euthanasia excludes both intentional life-shortening by omission and termination without the patient's request, one commentator concludes that the van der Maas survey reveals 10,558 cases in which it was the doctor's explicit purpose to shorten life, by act or by omission.⁴⁸ This commentator points out, moreover, that the majority of the cases were about nonvoluntary euthanasia; in 5450 cases the patient made no explicit request for euthanasia.⁴⁹ If cases in which doctors said it was partly their purpose to shorten life are included, the number of cases swells to 26,350 and 15,158 respectively.⁵⁰

This is a disturbing set of figures in its own right, rendered all the more distressing by the gloss put on them by the commission that had initiated the survey. While the commission deplored the act of euthanasia without the explicit request of competent patients, the commission was not nearly so hard on those acts carried out on the incompetent:

The ultimate justification for the intervention is in both cases the patient's unbearable suffering. So, medically speaking, there is little difference between these situations

Light of the Rimmelink Report and the Van Der Maas Survey, in EUTHANASIA CLINICAL PRACTICE AND THE LAW 219, 219-20 (Luke Gormally ed., 1994).

44. *Id.* at 221-22.

45. Euthanasia is defined as the "intentional action to terminate a person's life, performed by someone other than the person concerned upon request of the latter."

46. Keown, *supra* note 43, at 224-25.

47. See H.J.J. LEENEN, TIJDSCHRIFT VOOR GEZONDHEIDSRECHT 48 (1994); P.J. van der Maas et al., *Euthanasia and Other Medical Decisions Concerning the End of Life*, 338 THE LANCET 669-74 (1991).

48. Keown, *supra* note 37, at 227, 232.

49. *Id.* at 232.

50. Keown, *supra* note 43, at 224.

and euthanasia, because in both cases patients are involved who suffer terribly. . . . The degrading situation the patient is in confronts the doctor with a case of *force majeure*.⁵¹

Therefore, the criteria set by the KMNG and the courts were not only ignored by the physicians who acted without a request, but also regarded as dispensable by the commission, which attempted to justify the physicians' actions.⁵² Even in those cases where the criteria were supposedly met, many cases lacked the quality of intolerable suffering, and there were many others in which euthanasia was not the last resort.⁵³ The avoidance of suffering appears to have been as much a consideration for many physicians as the relief of suffering.

What did the physicians actually report? The majority of cases were, and are still, unreported and illegally certified as deaths from "natural causes."⁵⁴ In 1990, the year covered by the van der Maas survey, only 454 cases were reported.⁵⁵ Therefore, even if the survey's low estimate of 2700 cases of voluntary euthanasia and PAS is accepted as accurate, over seventy percent of cases went unreported. The officially reported figures of late have, however, improved considerably—1303 cases were reported in 1993 and 1417 in 1994.⁵⁶ Even so, that number is still barely more than half the Rummelink estimated euthanasia total, and does not include the unreported, nonvoluntary cases. Given such figures, it would appear that euthanasia is not at all effectively regulated in The Netherlands.⁵⁷ As

51. *Medische beslissingen rond het levenseinde. Rapport van de Commissie onderzoek medische praktijk inzake euthanasie*, Sdu Uitgeverij Plantijnstraat, 's-Gravenhage (1991) (quoting Keown, *supra* note 33, at 229). "Force majeure" is synonymous in Dutch usage with "necessity."

52. Keown, *supra* note 43, at 239.

53. *Id.* at 232-33.

54. *Id.* at 235.

55. *Id.*

56. JOHN KEOWN, *EUTHANASIA IN THE NETHERLANDS* 296 (1995) (citing *Jaaverslaag Openbaar Ministerie 1994*, Ministerie van Justitie, Den Haag, 1995).

57. See also HERBERT HENDIN, *SEDUCED BY DEATH: DOCTORS, PATIENTS AND THE DUTCH CURE* (forthcoming 1996); Alexander M. Capron, *Euthanasia in the Netherlands: American Observations*, 22 HASTINGS CENTER REP., Mar. 1992 at 30, 30-33; J.K.M. Gevers, *Legislation on Euthanasia: Recent Developments in The Netherlands*, 18 J. MED. ETHICS 138 (1992); Henk A.M.J. ten Have & Jos V.M. Welie, *Euthanasia: Normal Medical Practice?*, 22 HASTINGS CENTER REP., Mar. 1992 at 34, 34-38; Hendin, *supra* note 18; H. Jochemsen, *Euthanasia in Holland: An Ethical Critique of the New Law*, 20 J. MED. ETHICS 212 (1994); Maurice A.M. de Wachter, *Euthanasia*

with the laws proposed in the United States, the Dutch guidelines depend upon the willingness of doctors voluntarily to report what they do. It is evident that most doctors do not; certainly not those substantial numbers who engage in nonvoluntary euthanasia. As we turn to a closer look at the wording of the Oregon statute,⁵⁸ keep the Dutch figures in mind. The Dutch have failed to monitor and regulate euthanasia and physician-assisted suicide. Can we expect to do any better?

VI. WHAT ARE WE DOING IN THE UNITED STATES?

We examined the provisions of bills pending as of June 1995 in twelve state legislatures: California,⁵⁹ Colorado,⁶⁰ Connecticut,⁶¹ Maine,⁶² Massachusetts,⁶³ Michigan,⁶⁴ New Hampshire,⁶⁵ New York,⁶⁶ Oregon,⁶⁷ Vermont,⁶⁸ Washington,⁶⁹ and Wisconsin.⁷⁰ Three additional bills which failed during 1994-95 in their state legislatures (Maryland, New Mexico, and Virginia) were not examined. The Oregon statute was passed by a fifty-one to forty-nine percent margin in November of 1994,⁷¹ and will be discussed at length. It has been the almost verbatim model for bills pending in six other states: California, Colorado, Maine, Massachusetts, New Hampshire, and Vermont. In discussing the Oregon statute, therefore, we will be describing seven bills which may be referred to as "the Oregon model" to simplify comparisons. Within this group, Vermont's bill has some unique features which we will note only in passing.⁷²

in the Netherlands, 22 HASTINGS CENTER REP., Mar. 1992 at 23, 23-30.

58. Or. Laws ch. 3 (I.M. 116) (1995).

59. Cal. A.B. 1080 (1995).

60. Colo. H.B. 95-1308 (1995).

61. Conn. H.B. 1308 (1995).

62. Me. H.P. 552 (1995).

63. Mass. H.B. 3173 (1995).

64. Mich. H.B. 4134, 88th Leg., Reg. Sess. (1995).

65. N.H. H.B. 339 (1995).

66. N.Y. S.B. 5024 (1995).

67. Or. S.B. 907 (1995).

68. Vt. H.B. 335 (1995).

69. Wash. S.B. 5596, 55th Leg., Reg. Sess. (1995).

70. Wis. S.B. 90, 92d Leg., Reg. Sess. (1995).

71. Yale Kamisar, *Physician-Assisted Suicide: The Last Bridge to Active Voluntary Euthanasia*, in EUTHANASIA EXAMINED 245 (John Keown ed., 1995).

72. Vt. H.B. 335 (1995).

The legislation pending in Michigan deserves special attention not only because of its authorization of euthanasia and PAS, but also because it has extremely broad criteria for eligibility.⁷³ The status of challenges to Michigan's prohibition of assisted suicide and the legal status of Dr. Jack Kevorkian are beyond the scope of this article and are analyzed in depth elsewhere.⁷⁴ Connecticut's bill is noteworthy for its extreme brevity because it is set forth in its entirety in a footnote.⁷⁵ Connecticut is, at least, to be commended for its intellectual honesty in acknowledging that the purpose of legalization is the protection of physicians, not patients.⁷⁶

Wisconsin's bill resembles the Oregon model in many respects, but it also includes some unique witnessing requirements that further demonstrate the illusory nature of supposed safeguards.⁷⁷ Washington state has constructed a convoluted and bewildering piece of legislation that illustrates, among other things, the danger of assuming that physicians, hospital administrators, lay people—indeed anyone—can be absolutely certain of what the legislation requires.⁷⁸

To make matters worse, there is an astonishing level of ambiguity, if not outright obfuscation, created by the terminology used not only in the body of the various pieces of proposed legislation, but in many of the titles by which the bills are introduced and would, presumably, be known. Before turning to

73. Mich. H.B. 4134, 88th Leg., Reg. Sess. (1995).

74. See Kamisar, *supra* note 71, at 240-248.

75. "An Act Concerning Physician Assisted Suicide":

Be it enacted by the Senate and House of Representatives in General Assembly convened:

That section 53a\56 of the general statutes be amended to provide an affirmative defense to manslaughter in the second degree for physician assisted suicide if (1) the physician is licensed in this state, (2) the victim made a written request to the physician for the medication which was self-administered, (3) the victim was eighteen years of age or older and able to understand the nature and consequences of such medication and (4) the victim was deemed to be in terminal condition.

STATEMENT OF PURPOSE: To provide an affirmative defense to manslaughter in the second degree for physician assisted suicide.

Conn. S.B. 334, Reg. Sess. (1995).

76. See *id.*

77. Wis. S.B. 90, 92nd Leg., Reg. Sess. (1995).

78. Wash. S.B. 5596, 55th Leg., Reg. Sess. (1995).

the bodies of those pieces of legislation, a comment is in order on their titles.

VII. IS THERE A DICTIONARY IN THE HOUSE?

The importance of using clearly defined terms and of forthright acknowledgment of the nature of the acts being contemplated would seem axiomatic and self-evident. Regrettably, the campaign to legalize PAS and euthanasia has been marked not only by a proliferation of confusing terminology, but also by a kind of Orwellian doublespeak that has been acknowledged by at least one proponent as deliberate and politically motivated. "Aid-in-dying" is one of the euphemistic and perhaps deliberately misleading phrases employed in both public opinion polls and in proposed state statutes. Derek Humphry, former president of the pro-euthanasia Hemlock Society and author of *Final Exit*,⁷⁹ admitted that use of the precise terms suicide and euthanasia, instead of aid-in-dying, helped defeat the first attempts to legalize these practices in Washington.⁸⁰ Humphry acknowledged that aid in dying can mean "anything from a physician's lethal injection all the way to holding hands with a dying patient and saying, 'I love you.'"⁸¹ This semantic ambiguity seems to have been used to exploit widespread fears of abandonment at the end of life and to garner public support for legalization.

The phrase more widely used now than aid-in-dying to refer to physician-assisted suicide is "death with dignity," which is no improvement. This phrase is borrowed directly from living will legislation, and therefore risks confusion in the minds of voters as to what acts are covered. In Michigan, "death with dignity" covers the physician's prescription of lethal doses of medication for the patient to commit suicide as well as the physician's direct administration of lethal drugs to the patient.⁸² Apparently abandoning the vagueness of "aid-in-dying," Washington has chosen instead to call its statute the "Terminally Ill Patient

79. DEREK HUMPHRY, *FINAL EXIT* (1991).

80. John Leo, *Stop Murdering the Language!*, U.S. NEWS & WORLD REP., Apr. 12, 1993, at 23.

81. *Id.*

82. Mich. H.B. 4134, 88th Leg., Reg. Sess. (1995).

Act of 1995,"⁸³ a title that would seem indistinguishable from a living will statute. Elsewhere, "death with dignity" refers, for the time being at least, to physician-assisted suicide, and also to withdrawal of life support.⁸⁴

The persistent use of euphemisms may be intended to soften the political landscape and lower the temperature of the debate, but it can also suggest a degree of intellectual dishonesty and potential abuse of public trust that renders promises of regulation and good faith adherence to guidelines difficult to believe. The confusion is obvious to a casual observer—the use of a single phrase to cover acts which for some time have been legal, as well as acts which have traditionally been prohibited, raises concerns regarding motive and intent.⁸⁵

83. Wash. S.B. 5596, 55th Leg., Reg. Sess. (1995).

84. The variety of titles used to designate state living will statutes, or those permitting a variety of advance directives for authorizing the withdrawal or withholding of life-sustaining treatment, gives some idea of the extraordinary melange of terminology and the lack of consistency already prevalent in this area of state law: Hawaii's "Medical Treatment Decisions Act," Idaho's "Natural Death Act," Indiana's "Living Wills and Life-Prolonging Procedures Act," Iowa's "Life-Sustaining Procedures Act," Kansas's "Natural Death Act," Maine's "Uniform Rights of the Terminally Ill Act," Minnesota's "Adult Health Care Decisions Act," Mississippi's "Withdrawal of Life-Saving Mechanisms Act," New Hampshire's "Terminal Care Document Act," North Dakota's "Rights of the Terminally Ill Act," Oklahoma's "Hydration & Nutrition for Incompetent Patients Act," South Carolina's "Death With Dignity Act," Utah's "Personal Choice and Living Will Act," and so on.

To illustrate the confusion, the legislation intended to authorize euthanasia and/or PAS is similarly titled: Washington's is the "Terminally Ill Patient Act of 1995"; Oregon, Wisconsin, California, New York, Maine, New Hampshire, and Massachusetts have all chosen the title "Death with Dignity"; Colorado's is the "Dignity in Death Act"; Vermont has titled its legislation "An Act Relating to Rights of Terminally Ill Patients"; and, with a commendable display of clarity, Connecticut calls its legislation "An Act Concerning Physician Assisted Suicide."

85. While it is not the purpose of the authors to delve into matters of intent, the use of the same or similar terminology for these two acts (withholding and withdrawing treatment on the one hand, and deliberately putting someone to death on the other) may reasonably raise questions about the motives of the movement behind legalization. It is reasonable to ask why there is such a need to be unclear about the exact purpose of the legislation.

VIII. THE SITUATION IN OREGON

On November 8, 1994, Oregon's "Death with Dignity Act"⁸⁶ was voted into law in that state by a very slight margin.⁸⁷ It was due to go into effect one month later, but on November 23, U.S. District Judge Michael Hogan enjoined it until he could hear arguments regarding its constitutionality.⁸⁸ Subsequently blocked by a temporary restraining order and then a preliminary injunction, it finally culminated in a hearing on April 19, 1995.⁸⁹

Judge Hogan heard arguments from opponents of the statute about the potential for abuse.⁹⁰ The state's attorney general argued, rather chillingly, on behalf of Oregon that the potential for abuse was irrelevant to deciding the constitutionality of the statute.⁹¹ Assistant Attorney General Steve Bushong opined that "[s]ome instances of inappropriate applications are not enough" to invalidate the statute on due process grounds.⁹² Then, Judge Hogan asked the defense attorneys, "[a]t what point do you draw the constitutional line?"⁹³ Could a quadriplegic be eligible for the option of assisted suicide? What about nine-year-old girls who fail a school exam? The line was unclear.⁹⁴ Judge Hogan found the law unconstitutional on August 3, 1995; his decision is on appeal to the Ninth Circuit.

Oregon's "Death With Dignity Act" limits PAS to patients with a life expectancy of six months or less due to a terminal illness.⁹⁵ It requires that the patient wait fifteen days after having made an oral request to his or her physician for a prescription for a lethal amount of medication with which to com-

86. Or. Laws ch. 3 (I.M. 16) (1995).

87. See *supra* note 71.

88. *Judge Hears Suicide Law Arguments*, THE REGISTER-GUARD (Eugene, Oregon), Apr. 19, 1995 at 1A.

89. *Id.*

90. *Id.*

91. *Id.* at 6A.

92. *Id.*

93. *Id.*

94. *Id.*

95. Or. Laws ch. 3 (I.M. 16) § 1.01(12) (1995).

mit suicide.⁹⁶ During the waiting period, the physician must inform the patient of his or her diagnosis and prognosis.⁹⁷ Presumably, this has been done at least once already since a request for PAS is supposed to be invalid if there is a life expectancy of longer than six months. The physician must also inform the patient of alternatives such as hospice care, pain control, and other comfort measures.⁹⁸ A decision to proceed with PAS after receiving this information constitutes an "informed decision."⁹⁹

The physician must also assess the patient's decisionmaking ability and find that the patient is capable of making health care decisions¹⁰⁰ and is "acting voluntarily."¹⁰¹ As a component of this evaluation, the patient is referred to a consulting physician for confirmation of the first physician's diagnosis and prognosis and for confirmation of decisionmaking capacity.¹⁰² If either physician believes that the patient suffers from a psychological or psychiatric condition (not specified) or that the patient's judgment is impaired by depression, the patient must be referred for counseling regarding this impairment.¹⁰³ Depression, by itself, does not invalidate the request for PAS.¹⁰⁴ The patient whose diagnosis and prognosis are confirmed by a consulting physician, and whose judgment is found unimpaired, must then make an additional oral request and also complete a written request.¹⁰⁵ The patient must wait another forty-eight hours and then may be given the prescription.¹⁰⁶

The statute also provides that the patient may change his or her mind and rescind the request, and physicians are permitted to refuse participation.¹⁰⁷ The attending physician must make a note in the patient's record that the above steps have been

96. *Id.* § 3.08.

97. *Id.* § 1.01(7).

98. *Id.*

99. *Id.*

100. *Id.* § 1.01(6) ("capable" is defined as "not incapable").

101. *Id.* § 2.02(1).

102. *Id.* § 3.02.

103. *Id.* § 3.03.

104. *Id.* (specifying that depression must be such that causes "impaired judgment" in order to invalidate a request for PAS).

105. *Id.* § 3.06.

106. *Id.* § 3.06, 3.08.

107. *Id.* § 3.07.

taken, and file in the patient's medical record a report of any counseling and a copy of the patient's written request.¹⁰⁸ A sample of these records will be reviewed each year by the Health Division of Oregon.¹⁰⁹ Also, the public is prohibited from access to any information or records collected about the practice of PAS in Oregon, including compliance or non-compliance with the provisions of the statute.¹¹⁰ Anyone participating in PAS in good faith is immune from civil or criminal liability.¹¹¹ Altering or forging requests or rescissions of requests without the patient's permission are Class A felonies.¹¹² Finally, Oregon's "Death With Dignity Act" stipulates that actions taken pursuant to the statute are not considered suicide or assisted suicide under the law.¹¹³

Six other states have debated virtually identical laws.¹¹⁴ Oregon's model therefore has already been accorded widespread credence and support. A superficial reading of the provisions might suggest to the casual observer that Oregon's is a reasonable approach, with adequate safeguards such as a written request and an evaluation of the competence of the patient. However, the problem is not that there are too few safeguards, or that there should be more, but that they simply will not work.

The difficulty lies not in the procedural steps, but rather in the nature of law, the nature of medicine, the nature of the doctor-patient relationship, and the nature of the act itself. First, legitimizing PAS contemplates a reconstruction of the doctor-patient relationship to allow physicians to help in the taking of life, while at the same time upholding and maintaining the privacy and confidentiality of that relationship. Second, Oregon's procedural safeguards cannot change the fact that there is no legally meaningful self-limiting aspect to the practice of PAS, and consequently, the safeguards are ineffective in

108. *Id.* § 3.09.

109. *Id.* § 3.11.

110. *Id.*

111. *Id.* § 4.01(1).

112. *Id.* § 4.02(1).

113. *Id.* § 3.14.

114. Those states are Colorado, Maine, Massachusetts, Michigan, New Hampshire, and Wisconsin.

limiting the practice of PAS to competent patients or to those who are terminally ill and capable of self-administering lethal medications. Third, Oregon's statute relies, as do the other legislative proposals, on assumptions about the certainty of medical judgment and the determinacy of such terms as "terminal," "competent," "capable" and "voluntary." We will demonstrate the fallacy of such assumptions and, therefore, the danger of regarding these concepts as restrictive limits or safeguards on the practice of PAS or euthanasia. Finally, the remarkable absence in Oregon's law of statutory reporting requirements that would address the need to investigate and stop any unauthorized killing renders the notion of procedural safeguards highly questionable as an antidote to abuse of the practice.

Oregon's approach may well be regarded as the standard for future attempts at legalization. Yet, without any means of evaluating the practice even retrospectively, and no means of public oversight at all, how is the standard to be understood or used for comparison? Oregon proposes to achieve a safe way to limit PAS to those who request it, but this is unachievable and inherently impossible. Examination of the legislation proposed elsewhere will lead to the same conclusion. We now turn to the structure of the statutes, an analysis of the conceptual terrain on which they are built, and to the quicksand in which they are mired.

IX. A TOUR OF THE CONCEPTUAL LANDSCAPE

For decades, proponents of legalized euthanasia and assisted suicide have bolstered their arguments with promises of safeguards, and we will examine the proposed statutes from that perspective. At least four such safeguards are consistently mentioned in the literature: 1) consent; 2) mental competence or capacity; 3) voluntariness; and 4) limited or restricted eligibility.¹¹⁵ We would add that a serious effort to address the potential abuse that even PAS proponents agree is inevitable¹¹⁶

115. Brock, *supra* note 8, at 20; Marcia Angell, *Euthanasia*, 319 NEW ENG. J. MED. 1348 (1988); Miller et al., *supra* note 4, at 120.

116. See Margaret Battin, *Voluntary Euthanasia and the Risks of Abuse: Can We*

would also require, at a minimum, the following: 5) witnesses; 6) a definition of what constitutes abuse; and 7) specific requirements to report, investigate and punish abuse. By using these seven categories, we will examine the provisions of the remaining bills introduced in 1995 in the United States to determine the degree to which these problems are successfully addressed.

A. Consent

Given that some prominent proponents of legalization advance their regulatory framework as "experimental" and also propose research into, among other things, the methods used in PAS,¹¹⁷ while others have characterized the Oregon statute legalizing PAS as "a bold experiment,"¹¹⁸ it seems appropriate to refer briefly to the history and ethics of consent for human experimentation as well as therapeutic medicine. Consent, after all, has been considered the heart of research ethics since the Nuremburg Code was promulgated at the end World War II.¹¹⁹ Valid informed consent is also claimed to be the primary safeguard against abuse of the practice of euthanasia,¹²⁰ and the practice that will allegedly always serve to distinguish "us" from "them" (Nazi practitioners). Given the assumption that the worst abuse would be killing a patient without consent, we will begin our analysis with the concept of consent, to assess wheth-

Learn Anything from the Netherlands?, 20 L. MED. & HEALTH CARE 133 (1992); Brock, *supra* note 8, at 10; Brody, *supra* note 7; Quill et al., *supra* note 8.

117. Miller et al., *supra* note 4, at 122.

118. Ann Alpers & Bernard Lo, *Physician-Assisted Suicide in Oregon: A Bold Experiment*, 274 JAMA 483 (1995).

119. Jay Katz, *The Consent Principle of the Nuremberg Code: Its Significance Then and Now*, in THE NAZI DOCTORS AND THE NUREMBERG CODE 227 (George J. Annas & Michael A. Grodin eds., 1992). While the book concerns the continuing impact of the Nuremberg Code on human experimentation, Jay Katz makes the point that, prior to the nineteenth century, when the curative powers of medicine were quite limited, consent was seldom sought or considered necessary because the physician was presumed to act in the patient's interests for the patient's well being. "However, with the advent of the age of science, a radical break occurred in medical practice: Novel experiment interventions now served not solely—and often not at all—patients' but also future patients' or science's, interests . . . the distinction between patient and research subject became, and ever since has remained, blurred." *Id.* at 229.

120. Brock, *supra* note 8, at 10-11.

er and how the requirement of informed consent may be considered a safeguard against abuse of PAS.

Nearly forty years ago, a leading proponent of euthanasia, Glanville Williams, rested his arguments entirely on the concept of voluntariness or consent.¹²¹ Subsequent literature has maintained that consent to the practice of either assisted suicide or euthanasia is the key to preventing abuse, limiting the practice to those who are awake, alert and want to die,¹²² and assuaging the fears of those who oppose legalization, and/or those who do not wish to be put to death.

A long line of court decisions and modern codes of medical ethics uphold the centrality of consent as the linchpin of patient participation in medical decisionmaking.¹²³ Consent has never been proposed, however, as a means of preventing physician error or physician incompetence, or as a means of evaluating the physician's motives or moral commitments. In theory, the function of consent is to support the patient's right to be free of unwanted touching.¹²⁴ In practice, consent has all too often become a tool of risk management for purposes of creating a liability-proof record of patient care in the event of lawsuits. In practice, the pieces of paper handed to patients for signature prior to treatment, accompanied sometimes by a conversation, focus almost exclusively on the potential risks for which the hospital or other care providers will not be held liable in the event such risks materialize. In practice, why should this process be any different for PAS or euthanasia? Specifically, can any statute ensure a consent process that is better or different than the typical consent process currently experienced by patients throughout the medical system? Whether giving consent

121. GLANVILLE WILLIAMS, *THE SANCTITY OF LIFE AND THE CRIMINAL LAW* (1957).

122. Norman L. Cantor, *A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity Versus the Preservation of Life*, 26 RUTGERS L. REV. 228, 261 (1973) ("So long as careful attention is paid to the capacity of a person to request euthanasia, there is a large gap between voluntary euthanasia and involuntary elimination of social misfits.").

123. *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1962), cert. denied, 409 U.S. 1064 (1972); *Cobbs v. Grant*, 502 P.2d 1 (Cal. 1972); *Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees*, 317 P.2d 170 (Cal. Dist. Ct. App. 1957); *Natanson v. Kline*, 350 P.2d 1093 (1960), clarified in, 354 P.2d 670 (1960); *Schloendorff v. Society of New York Hosp.*, 105 N.E. 92 (N.Y. 1914); *Wilkinson v. Vesey*, 295 A.2d 676 (R.I. 1972).

124. See, e.g., *Schloendorff*, 105 N.E. at 92.

for an X-ray, an arteriogram, or a CT-scan, patients everywhere experience a routinely delivered, often perfunctory, recitation of the pros and cons of recommended treatments. Communication skills vary widely from physician to physician, and listening skills are even more variable and even less likely to be adequate.¹²⁵

An additional factor enters into this process which is disturbingly relevant to the notion of valid consent to euthanasia or PAS—the physician's influence, subtle or overt, on the patient's choice.¹²⁶ An American psychiatrist who has observed and researched the practice of euthanasia in the Netherlands notes that "[d]octors in both the Netherlands and the United States are insufficiently sensitive to the influence a doctor has on a patient's decision in these matters."¹²⁷ As the New York State Task Force points out:

Illness is a quintessential state of vulnerability; it entails a loss of confidence in one's body and one's future. Serious illness also brings with it a loss of physical freedom and the ability to engage in the activities by which we define ourselves. Patients bring this vulnerability to their relationship with physicians. Physicians in turn hold the knowledge and expertise patients may desperately need, adding to the profound dependence that characterizes the doctor-patient relationship.

This dependence is manifested in many aspects of the doctor-patient relationship. Patients turn to their doctors for information about their diagnosis and prognosis, the likely symptoms of illness, and treatment alternatives. *Through their tone, the encouragement they provide or withhold, and*

125. See ERIC J. CASSELL, TALKING WITH PATIENTS 223 (Stanley J. Reiser ed., 1985) (as a meticulous and painstaking personal analysis of the doctor-patient interaction based on theory presented in the first volume, these books are considered classics in their field); see generally COMMUNICATING WITH MEDICAL PATIENTS (Maira Stewart & Debra Roter eds., 1989) (a collection of papers presented at an international symposium of experts in medical communications; most of the papers are reports of original research. Among the most often cited findings is that doctors typically interrupt their patients' communication within 18 seconds).

126. See BERNARD BARBER, INFORMED CONSENT IN MEDICAL THERAPY AND RESEARCH (1980). Barber argues that real consent to treatment is not possible because, in most cases, physicians can influence a patient to agree to whatever the practitioner recommends.

127. Hendin, *supra* note 18, at 131.

*the way they present the information available, physicians can often determine the patient's choice.*¹²⁸

Over the course of some eighty years of Anglo-American jurisprudence and bioethics, medical consent has evolved into informed consent, and in most jurisdictions, a certain amount and kind of information must be imparted to the patient in order for the consent to be valid.¹²⁹ The common law standards of what constitutes adequate information vary from physician-based¹³⁰ to patient-centered¹³¹ and most are somewhere between the two. Ultimately, the quality of the information, the understanding, and the consent are dependent as much on the skills of the physician as on the capabilities of the patient. Decades of court decisions and medical codes of ethics emphasizing the centrality of informed consent have not resulted in any uniform standard for evaluating this concept or interaction in practice. It remains, by definition, a process governed by the individuals involved. At best, the courts have specified the kinds of information that must be included to meet the patient-centered standards¹³² or physician-based standards.¹³³ However, unlike other medical malpractice litigation in which the adequacy of consent may be disputed by the patient or the patient's death itself is considered evidence of negligence, no patient in a situation involving PAS can allege inadequacy of consent, and death is presumed to be the desired outcome. Retrospective evaluation of the adequacy of the information or the patient's understanding of it would be virtually impossible. Not only would the patient be unavailable, but the evidence available for examination would be very limited, consisting primarily of the patient's record which is written by the physician.

128. NEW YORK STATE TASK FORCE, *supra* note 6, at 121-122 (emphasis added). The Task Force was comprised of eight physicians, five ministers or priests, two rabbis, two non-physician bioethicists, a representative of the New York Civil Liberties Union, the state's Commissioner on Quality of Care for the Mentally Disabled, two nurses, including one nurse-attorney, and three other attorneys.

129. *See, e.g.*, *Cobbs v. Grant*, 502 P.2d 1 (Cal. 1972); *Salgo v. Leland Stanford, Jr.*, Univ. Bd. of Trustees, 317 P.2d 170 (Cal. Ct. App. 1957).

130. *Natanson v. Kline*, 350 P.2d 1093, 1106 (Kan. 1960).

131. *Cooper v. Roberts*, 286 A.2d 647, 650 (Pa. 1971).

132. *E.g.*, *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972), *cert. denied*, 409 U.S. 1064 (1972).

133. *E.g.*, *Cobbs*, 502 P.2d at 1.

While the requirement of an informed decision is considered central to the legality of PAS or euthanasia, we do not believe that the legislators have succeeded in crafting bills that overcome the problems we have outlined.

1. Legislative Approaches to Informed Consent for PAS/Euthanasia

Oregon's "Death With Dignity Act" and the six bills modeled on it provide the following definition:

"Informed decision" means a decision, made by a qualified patient, to request and obtain a prescription to end his or her life in a humane and dignified manner, that is based on an appreciation of the relevant facts, and is made after being fully informed by the attending physician of:

- (a) his or her medical diagnosis;
- (b) his or her prognosis;
- (c) the potential risk associated with taking the medication to be prescribed;
- (d) the probable result of taking the medication to be prescribed;
- (e) the feasible alternatives, including, but not limited to, comfort care, hospice care, and pain control.¹³⁴

Several observations can be made. First, this is a passive approach to informed consent because it views the process as involving primarily, if not exclusively, the imparting of information by the physician to the patient. Second, this provision contemplates only providing information about pain medication, hospice care, and other comfort measures, and does not require that any of these alternatives be tried and/or found inadequate. Is the consent valid if it is based only on hearing that some additional relief might be available from analgesics, without ever having tried them? What has happened to the persistent promise of euthanasia advocates that the practice would only be permitted as a last resort, when all other means of relief had been tried and found wanting? What of Howard Brody's insistence that providing the patient with the means to kill himself or herself would only be done in the context of medical failure,

134. Or. Laws ch. 3 (I.M. 16) § 3.01(2) (1995).

when the treatment itself had made death agonizing and horrible?¹³⁵ None of the pending bills examined requires that pain control be attempted, improved, or found inadequate prior to a request for suicide.¹³⁶ Finally, and perhaps most importantly, the definition offered in the Oregon statute is a circular one: an informed decision is a decision made after being given certain information.

The question arises whether these weaknesses could be cured by requiring some evidence of comprehension and appreciation of the gravity of the decision on the part of the patient. Or, more tempting, would it be possible to craft a statute requiring that all other means of pain control and relief of suffering be tried and exhausted? No. That possibility is foreclosed by the assertion of autonomy and self-determination as the basis for the legislation. Having constructed the legal edifice on a foundation of self-determination and autonomy (even assuming that this is appropriate), or on the line of cases supporting the right to privacy or the Fourteenth Amendment as a basis for refusing life-sustaining treatment, there is no basis in law to require a patient to accept pain medication or any other means of alleviating pain or suffering—this would violate the established right to refuse virtually any treatment. By arguing for a vision of unfettered autonomy, proponents of legalization effectively eliminate the possibility of burdening the physician-patient interactions with anything but the most rudimentary procedures.¹³⁷

Michigan's House Bill No. 4134 provides that: "[t]he attending physician and at least one other physician [shall] have counseled the patient regarding the patient's medical diagnosis and prognosis, treatment options, and the nature and risks of the aid-in-dying procedure."¹³⁸ There is no mention here of providing information regarding pain control, comfort care, hospice or other alternatives to death as a relief. More impor-

135. See Brody, *supra* note 7, at 1385.

136. See, e.g., Mich. H.B. 4134, 88th Leg., Reg. Sess. (1995); N.Y. S.B. 1683, 218th Gen. Assembly, 1st Reg. Sess. (1995); Wash. S.B. 5596, 55th Leg., Reg. Sess. (1995).

137. See Robert A. Sedler, *Constitutional Challenges to Bans on "Assisted Suicide": The View from Without and Within*, 21 HASTINGS CONST. L.Q. 777 (1994); Robert A. Sedler, *The Constitution and Hastening Inevitable Death*, 23 HASTINGS CENTER REP., Sept. 1993 at 20; see also Kamisar, *supra* note 71.

138. Mich. H.B. No. 4134, 88th Leg., Reg. Sess., § 4(1)(c)(i) (1995).

tantly, Michigan does not require either terminal illness or suffering as a qualifying pre-condition of either PAS or euthanasia. Interestingly, Michigan provides that the patient must be professionally counseled "regarding both the patient's motivations for requesting aid-in-dying and alternatives to aid-in-dying."¹³⁹ However, under this bill, particular motives or lack thereof cannot be deemed a sufficient reason to preclude the suicide or euthanasia. In Michigan, the absence of any prerequisites for an individual to qualify for medically assisted suicide or physician-administered euthanasia and the lack of any disqualifying motives or conditions makes the goal of such counseling somewhat unclear.

In New York's proposed senate bill, "Death With Dignity," neither informed decision nor consent is mentioned.¹⁴⁰ The process is governed by a written directive, similar to the process involved in a living will. The statute asserts that a "right to choose to eliminate pain and suffering," is "hereby established" and that the right belongs to "mentally competent, terminally ill adults," and the exercise of the right must be "voluntary."¹⁴¹ Oddly, the statute says nothing about informed consent, nor does it specify how or by whom "competency" is to be determined.¹⁴² Instead, it provides that "administration of aid in dying [shall occur] when and only when, a qualified patient determines that the time for physician aid in dying has arrived and has made an enduring request."¹⁴³ "Enduring request," a phrase borrowed from the Netherlands,¹⁴⁴ appears to be a check on both competence and voluntariness. However, it turns out that enduring means simply more than once.¹⁴⁵ Presumably, it is not important how short or how long the interval is between requests, so long as there is more than one request. Thus, the interval might be as short as fifteen minutes, or as long as two months.

139. *Id.* § 4(1)(c)(iii).

140. N.Y. S.B. 1683, 218th Gen. Assembly, 1st Reg. Sess. (1995).

141. *Id.* § 4900.

142. *Id.*

143. *Id.* § 4905 (emphasis added).

144. See *Guidelines for Euthanasia*, *supra* note 36.

145. N.Y. S.B. 1683, 218th Gen. Assembly, 1st Reg. Sess. § 4901(6) (1995).

New York's "Death With Dignity" bill authorizes both assisted suicide and direct administration of a lethal dose of drugs to the patient.¹⁴⁶ Yet, there is no mention of providing information about diagnosis, prognosis, risks, benefits, or alternatives to death as means of relieving pain and suffering. The bill also fails to require that any information at all be imparted to the patient prior to the physician administering aid-in-dying. Indeed, there appears to be no requirement that a physician discuss anything in particular with the patient. However, some personal discussions are contemplated to have taken place in the context of the physician taking reasonable steps to make sure that killing the patient is "in accord with the desires of the patient."¹⁴⁷ Washington's Senate Bill 5596 also makes no mention of an informed decision or consent, although there is "an evaluation of the patient's mental competence."¹⁴⁸

In other words, legislation itself cannot enhance the quality of an informed consent process that depends on the individual skills of the physician, that varies from situation to situation, that involves idiosyncracies of patients, and that takes place in private. Legislation can require that informed consent be an element of the decision, that it be voluntary, and even that some other procedural steps should be required. However, the procedural steps for consent and information sharing specified in PAS legislation do nothing to cure the inherent indeterminacy of capacity and voluntariness.

146. *Id.* § 4901(2). "Aid in dying shall mean a medical procedure which will terminate the life of a qualified patient in a painless, humane and dignified manner whether administered by a physician upon the direction of the patient or provided by a physician to the patient for self administration." *Id.*

147. *Id.* at § 4911. Directive compliance refers to the following:

[p]rior to administering aid in dying to a qualified patient, the attending physician shall take reasonable steps to determine that the directive has been signed and witnessed, and all steps are in accord with the desires of the patient, as expressed in the directive and in their personal discussions. Absent knowledge to the contrary, a physician or other health care provider may presume the directive complies with this article and is valid.

Id.

148. Wash. S.B. 5596, 55th Leg. Sess., Reg. Sess. § 5(4) (1995).

B. *Mental Competence or Decisionmaking Capacity*

Competence is a legal determination, rather than a clinical or medical one.¹⁴⁹ In most states, criteria for adjudicating competence to determine the need for guardianship have been found so lacking in specificity and consistency as to be in violation of due process.¹⁵⁰ Guardianship statutes in many states are under review and a number have been drastically overhauled for, among other reasons, a lack of specificity regarding what is meant by competence. Some experts have identified five different approaches to determine competency to consent to treatment, and these range from the mere indication of a choice to the demonstration of actual understanding.¹⁵¹ Legal definitions of competence and capacity have not significantly improved over the years, and clinical determinations are often informal and based on imprecise and unspecified factors. The literature reflects the view that there is little, if any, agreement in law or in medicine "about how decisional capacity and its absence are recognized and determined, what kinds of decisionmaking skills are necessary for decisional capacity, and what skill levels are sufficient."¹⁵²

In revised guardianship procedures, the recommended approach to determinations of incompetency requires an exhaustive assessment of the individual's functional status.¹⁵³ The assessment includes detailed examinations of the potential ward over the course of several interviews and requests for the per-

149. See *In re Hamlin*, 689 P.2d 1372, 1381 (Wash. 1984) (Rosellini, J., dissenting).

150. See Harriet Haile Shivers, *Guardianship Laws: Reform Efforts in Virginia*, 26 U. RICH. L. REV. 325, 331 (1992) (citing D.W. Page, *Guardians of the Elderly: An Ailing System*, ROANOKE TIMES AND WORLD NEWS, Oct. 6, 1989, at B1, B2.). A 1987 Associated Press report reviewed guardianship law across the country and identified areas in need of reform. The report was compiled by 57 reporters who reviewed 2200 probate court files from every state and identified "an unclear standard for determination of incapacity" as one of five serious shortcomings in the guardianship system. *Id.* The Associated Press report prompted congressional hearings and ultimately guardianship reform efforts in many states.

151. Loren Roth et al., *Tests of Competency to Consent to Treatment*, 134 AM. J. PSYCHIATRY 279 (1977).

152. NANCY M.P. KING, *MAKING SENSE OF ADVANCE DIRECTIVES* 55 (1991).

153. Penelope A. Hommel et al., *Trends in Guardianship Reform: Implications for the Medical and Legal Professions*, 18 LAW, MED. & HEALTH CARE 213, 218 (1990).

formance of a variety of tasks.¹⁵⁴ When feasible, the assessment is conducted in the individual's own environment.¹⁵⁵ This process is vastly more complex and time consuming than the process contemplated for decisions regarding PAS.

No such caution or thoroughness is evident in the process accorded patients who seek the liberty to kill themselves. Michigan, for example, allows a psychologist or psychiatrist to certify the patient's competence without necessarily having seen the patient; no specific personal examination is required.¹⁵⁶ If the attending physician finds that the patient is still competent, of sound mind and conscious three days later, he or she may be euthanized.¹⁵⁷

Neither clinical medicine nor jurisprudence can entirely eliminate the inherent subjectivity of assessing someone to be of sound mind, a phrase which is used interchangeably with capacity in some proposed legislation. Moreover, it is commonly believed that "ordinary 'soundness of mind' is something that everyone is capable of evaluating, and most health professionals are no more nor less expert in ascertaining it than anyone else."¹⁵⁸ Despite an array of tests and clinical instruments for evaluating mental status, the fluidity of the concept itself is its main feature. There is no consensus regarding what is normal capacity in the conditions surrounding health care decisions. Such conditions include significant stress and anxiety, pain, fear, loss of privacy, separation from familiar surroundings and loved ones, medication and sedation, financial worries, and strangers providing often unclear and complicated new information at irregular intervals. Add to these circumstances a terminal illness and a desire to die, and the evaluation of decisional capacity becomes so situational as to be fairly resistant to any statutory regulation or standardization. Clinical determinations of decisionmaking capacity are notoriously result-oriented and subjective. As one writer explained, "a competent patient is one whose treatment decisions are considered valid and to be hon-

154. *Id.* at 218.

155. *Id.*

156. Mich. S.B. No. 4134 § 4(1)(c)(iii),(d)-(e) (1995).

157. *Id.*

158. KING, *supra* note 152, at 81.

ored by caregivers."¹⁵⁹ A refusal of treatment often triggers an evaluation of a patient's mental status, whereas consent to the same treatment would not. If the decision to commit suicide is considered valid as a matter of law, the physician's interpretations of decisionmaking capacity will inevitably be influenced by that shift in the normative perspective; expressions of a wish to die will not raise concerns about a patient's mental status as they once might have.¹⁶⁰

A general rule of thumb which has sometimes been asserted is that the level of capacity required should be related to the gravity of the decision to be made. Because decisional capacity is task specific, the more complex the decision and the more risk involved in potential error, the greater the level of capacity that might be required.¹⁶¹ In other words, consent for an arteriogram or brain surgery should require more alertness and clarity of mind than a decision to take an aspirin. Therefore, it is fair to ask the question: how much is required for a decision to be killed?

It can be argued, however, that many ordinary decisions in life have grave or irreversible consequences and significant risk of one kind or another, and that efforts to prescribe how much ability is needed to make any particular decision would deny some people the possibility of exercising their rights.¹⁶² Moreover, any test of the patient's reasoning process would undoubtedly be considered burdensome and discriminatory, since such tests are not required for decisions to withdraw life-sustaining

159. *Id.* at 55.

160. See Hendin, *supra* note 18, at 123. According to psychiatrist Herbert Hendin, easy accessibility to help with suicide will make suicidal patients more difficult to treat. *Id.* at 164. In addition to the widely reported difficulty that most physicians have in recognizing the symptoms of depression, Hendin warns that the complex interactions between suicidal patients and their treating physicians will become even more complex with the introduction of legalized PAS/euthanasia:

Even patients who desire an early death during a terminal illness are usually suffering from a depression that is treatable; they are likely to be different from those who seek to avoid pain in the last days of terminal illness . . . [t]hose who need to bring suicide and death into the relationship with their physicians and use it coercively may be expressing a more severe depression than their doctors may recognize.

Id. at 164.

161. See KING, *supra* note 152, at 62 n.10.

162. See *id.* at 63 n.10.

treatment. Such tests also risk bias in favor of a decisionmaking process that resembles that of the evaluator.

Thus, the determination of decisionmaking capacity in this context is inevitably a matter of individual case-by-case evaluation that will vary from physician to physician and patient to patient. The only patients who seem to be clearly excluded from most of the pending legislation would be those who are unconscious. Variable capacity, limited capacity, fluctuating capacity, diminished capacity, and even depression and some forms of mental illness are not presently grounds for the automatic invalidation of a patient's consent to or refusal of treatment, but are left to the discretionary judgment of the treating physicians.¹⁶³

A close look at the statutory treatment of decisionmaking capacity illustrates the difficulty of relying on it as a safeguard or a limitation on PAS. Oregon's statute and its progeny in other states define "capable" by first defining "incapable" as "lack[ing] the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the patient's manner of communication if those persons are available. Capable means not incapable."¹⁶⁴

The Oregon model also requires mandatory psychiatric or psychological evaluation only if the treating physician or the consulting physician believes there is reason to question the patient's state of mind.¹⁶⁵ Referral for consultation is not for the purpose of ruling out depression, but only to rule out impaired judgment as a result of depression or some other psychological condition.¹⁶⁶ Again, in the context of official approval for suicidal ideation and a wish to be dead, what constitutes impaired judgment? Implicit is the belief that such ideation and desires for death are sound, rational, and unimpaired. In this context, to speak of impartial or objective evaluation of such states of mind makes no sense; it depends on the consultant's own views of what constitutes impaired judgment. To believe

163. *Rogers v. Okin*, 478 F. Supp 1342 (D. Mass. 1979).

164. Or. Laws ch. 1 (I.M. 16) § 1.01(6) (1995).

165. *Id.* §§ 3.01(4), 3.03.

166. *Id.* § 3.03.

that the continuum along which such determinations are made will not be influenced by legalization seems short-sighted. Is it even possible that legalization can avoid either the subjectivity of individual value judgments or the subtle but pervasive influence of officially changing societal norms? If anything, legalization of previously prohibited behavior for a profession whose ethics and societal trust are founded on that prohibition would seem to enhance both the power of the physician's value judgments and the influence of normative changes regarding the rationality of suicidal ideation in the context of terminal illness.

Michigan's proposed legislation authorizes euthanasia (which it calls aid-in-dying) for patients who are "conscious, of sound mind, and mentally competent to consent to aid-in-dying at the time aid-in-dying is provided."¹⁶⁷ It is the only bill examined which explicitly requires competence at the time the patient is euthanized or drugs are prescribed, as opposed to the time the request is made orally or in writing. According to Michigan's proposal, the requisite level of mental functioning must have been certified by a psychologist or psychiatrist, but there are no limiting criteria, such as terminal illness or suffering or a limited life expectancy, for eligibility.¹⁶⁸ In other words, any competent adult is eligible for euthanasia on request in Michigan.¹⁶⁹ The bill does not specify any criteria or standards for measuring how much competence is enough. Is this more or less competence than one would need to consent to an x-ray?

Moreover, since being suicidal is not grounds to invalidate consent, even a morbidly and treatably depressed patient could be euthanized or assisted in suicide without any attempt to treat the depression, or even diagnose it, even in the absence of any other morbidity, injury, disease, or illness, whether curable or incurable. Merely being tired of living would be enough in Michigan. Presumably, women who experience suicidal ideation in the throes of PMS would also qualify. There is no need for a slippery slope in Michigan; it would appear they have started at the bottom of the hill.

167. Mich. H.B. 4134, 88th Leg., Reg. Sess. § 4(1)(e) (1995).

168. *Id.* § 4(c)(2).

169. *Id.* § 3(1). A patient 18 years of age or older who is of sound mind and mentally competent to consent to aid-in-dying may execute a directive to authorize aid-in-dying. *Id.*

New York's bill refers repeatedly to a "mentally competent adult," but the bill does not define competence or offer any specific process for evaluating it.¹⁷⁰ Since adults are, by law, presumed competent unless formally adjudicated incompetent, this safeguard would appear to leave the door wide open to varying interpretations of a patient's decisionmaking capacity. There is, indeed, no reference to decisionmaking capacity at all. The standard is no standard, as no one is specifically responsible for evaluating or certifying the patient's competence. A written directive may be prepared in advance and witnessed by two strangers who do not attest to the patient's mental status, competence or soundness of mind.¹⁷¹ Psychiatric consultation is discretionary, optional, and subject to the consent of the patient.¹⁷² As a result, the New York approach seems rather loose on the question of the patient's state of mind and decisionmaking capacity both at the time of making the request and at the time PAS or euthanasia is administered. Thus, if the patient is depressed to the point of impaired judgment, however that is determined, he or she could simply refuse a psychiatric consultation and that would be the end of that. Given that one characteristic of depression is a denial of the condition, how effective is an optional referral for a depressed patient?

Washington's bill includes no definition of competence and no reference to decisionmaking capacity at all.¹⁷³ The legislature simply finds that physician aid-in-dying "must be a completely voluntary act" for both the physician and the patient, and that a competent terminally ill adult has the right to make the

170. N.Y. H.B. 6333, 218th Gen. Assembly, 1st Reg. Sess. (1995).

171. *Id.* § 4902. Witnessed directive refers to the following:

a mentally competent adult may at any time voluntarily execute a revocable directive governing the administration of aid in dying. The directive shall be signed by the declarant and witnessed by two adults who at the time of witnessing shall meet the following requirements . . . 1. are not related . . . 2. are not entitled to any portion of the estate . . . 3. have no creditor's claim against the declarant . . . 4. are not the attending physician.

Id.

172. *Id.* § 4910. An attending physician who is requested to provide aid in dying may request a psychiatric or psychological consultation with the consent of the qualified patient, if such physician has any concern about the patient's competence. *Id.*

173. Wash. S.B. 5596, 55th Leg., Reg. Sess. (1995).

request voluntarily.¹⁷⁴ Two physicians are required to evaluate the patient's mental competence,¹⁷⁵ but the criteria for competence are nowhere specified.

Wisconsin's bill defines incapacity as "the inability to receive and evaluate information effectively or to communicate decisions to such an extent that the individual lacks the capacity to manage his or her health care decisions."¹⁷⁶ This definition appears to be workable, until one reads that the only people clearly not considered to be of sound mind are those who are undergoing a formal competency hearing in court for purposes of appointing a guardian.¹⁷⁷ Thus, health care decisional capacity in this context is equated with the broader, and generally lower, standard of legal competence unless adjudicated otherwise by a court of law.

To summarize the difficulties with relying on decisional capacity or competence as a safeguard provided by the process of legalization, we offer an observation by an expert on the issue of competence and decisional capacity in the context of advance directives: "Competence' is a value-laden label that only pretends to scientific objectivity and attempts to deny the reciprocal relationships between patients and physicians, tests and standards, individuals and societies."¹⁷⁸ We would agree. This observation suggests that competence and capacity are ultimately in the eyes of the care provider and are subject to the shifting sands of societal norms and values as much as individual values. At best, these concepts provide a minimal threshold standard, below which the patient's choice would be reasonably denied because the patient is clearly not capable of making the decision. At most, the statutes can only exhort the physician to ascertain some evidence of appreciation of the information provided, the nature of the decision, and the nature of its consequences. In the end, it is a professional judgment call, a professional judgment about a legal criterion which the physician has no particular expertise in ascertaining. To say that this consti-

174. *Id.*

175. *Id.* § 5.

176. Wis. S.B. 90, 92nd Leg. Reg. Sess. § 156.01(7) (1995).

177. *Id.* § 156.03.

178. KING, *supra* note 152, at 60-61.

tutes a safeguard on the practice of PAS would seem to be stretching the point.

Those who work with terminally ill patients and care for them on a day-to-day basis know that such patients are often experiencing extraordinary stress and anxiety which can distort judgment. Whether or not terminally ill patients receive pain medication, which can also distort thinking and judgment, it is a seriously flawed notion that the clarity and soundness of mind of many terminally ill patients are not significantly affected by the illness itself. Moreover, terminal illnesses of their patients may significantly affect the judgment of physicians as well.¹⁷⁹

C. *Voluntariness*

This concept turns out to be even more vacuous and malleable than competence or capacity. Among the bills discussed above, six states provide that at least two witnesses must attest to the fact that the patient is "acting voluntarily" in requesting physician-assisted suicide.¹⁸⁰ California requires the attending physician to attest that the patient is "acting voluntarily,"¹⁸¹ while Michigan requires certification from a psychologist or psychiatrist that the patient is "acting voluntarily."¹⁸² Washington asserts boldly that the legislature "finds" that such an act as PAS "must be a completely voluntary act,"¹⁸³ and New York's drafters simply "find" a right to "voluntarily" execute a written PAS directive.¹⁸⁴ However, not one of the bills examined actually defines the term "voluntary" anywhere. In the context of PAS and euthanasia, involuntary euthanasia generally refers to the practice of euthanizing competent patients against their will or without a request to do so;¹⁸⁵ "nonvolun-

179. Hendin, *supra* note 18, at 164-65.

180. Colo. H.B. 1308, 60th Leg., 1995 Reg. Sess. § 15-18.8-1302(2)(a) (1995); Me. H.P. 552, 117th Leg., 1995 Reg. Sess. § 5-903(b) (1995); Mass. H.B. 3173 179th Leg., 1995 Reg. Sess. § 2(1) (1995); N.H. H.B. 339, 1995 Reg. Sess. § 137-K.4.1. (1995) Death with Dignity Act, ch. 3, 1995 Or. Laws 2.02(1); Vt. H.B. 335, 1995 B. Sess. § 528(b) (1995).

181. Cal. A.B. 1080, 1995-96 Reg. Sess. § 7196.8(c) (1995).

182. Mich. H.B. 4134, 88th Leg., 1995 Reg. Sess. § 4(c)(ii) (1995).

183. Wash. S.B. 5596, 54th Leg., 1995 Reg. Sess. § 2 (1995).

184. N.Y. S.B. 5024, 218th Gen. Assembly, 1st Reg. Sess. § 4902 (1995).

185. P. Singer & M. Siegler, *Euthanasia—A Critique*, 332 N. ENG. J. MED. 1881,

tary" euthanasia is the euthanizing of incompetent patients or those who are unable to express their wishes.¹⁸⁶ Given the evidence discussed earlier that nonvoluntary euthanasia is occurring in the Netherlands with some frequency,¹⁸⁷ the proponents of legalizing PAS and/or euthanasia in the United States presumably hope to allay fears of such occurrences here. The fact that the Dutch guidelines require a voluntary request hardly stops nonvoluntary euthanasia from occurring.¹⁸⁸ We wonder why such requirements would be any more effective in the United States. In particular, in the context of cost containment and the millions of citizens who remain uninsured and underinsured and risk poverty from lengthy or chronic illness, voluntariness is an honorable ideal, although difficult to ensure or guarantee through legislative intent.

The nature of the physician-patient relationship itself militates against voluntariness and may inherently involve undue influence even in the best of circumstances. Ironically, one of the most articulate physician proponents of PAS, Howard Brody, wrote this of the medical environment and the physician's power:

If you would think about it, instead of rejecting authority because it is arrogant and paternalistic, you would see that patients have a need to recognize authority and bow down to it. It is not simply that they trust the person in authority to work miracles for them. It is more basic. To be sick is to feel dependent and childlike, to feel unwhole, broken, defective. To be sick is to be robbed of basic self-esteem, to feel powerless to do what everyone else can do without hesitation or effort. To be sick is to be embarrassed before all onlookers. They say that we doctors reduce our sick patients to dependence and passivity by our arrogance and authoritarianism. But why should we bother when the sickness has already done it for us?¹⁸⁹

1882 (1990).

186. Brock, *supra* note 8, at 10. Brock considers both involuntary and nonvoluntary euthanasia to be "potential unwanted side-effects of permitting voluntary euthanasia." *Id.* at 11.

187. *See supra* part V.

188. *See id.*

189. HOWARD BRODY, *THE HEALER'S POWER* 8 (1992); *see also* NEW YORK STATE TASK FORCE, *supra* note 6, at 121-22.

Autonomy is compromised by the fact of illness, hospitalization, and all the attendant anxiety and stress of the medical environment and medical interventions. In particular, terminal illness would seem to render autonomy and voluntariness more limited in practice than its idealized vision suggests. This does not mean that a practice such as PAS or euthanasia should be nonvoluntary, or that lack of voluntariness is unimportant. On the contrary, it serves to reaffirm our view that legislative assertions that the decision must be voluntary neither guarantee voluntariness nor provide any means to assess it in practice other than by the existence of a recorded request from the patient.

Each of the bills proposed in the United States provides an opportunity to revoke the request, but how this would ensure that the decision was voluntary, rather than ambivalent, is unclear. Despite provisions prohibiting anyone from subjecting the patient to undue influence, most of the legislation does not define this concept. Those statutes that attempt to define undue influence prohibit persuading the patient that he or she is "a financial, emotional or other burden to his or her family, other persons, or the state."¹⁹⁰

The Oregon statute and others modeled on it require a fifteen-day waiting period between the patient's initial oral request and the writing of a lethal prescription, and the statute requires a combination of two oral requests and one written request.¹⁹¹ Presumably this provision is designed to provide a period of time for reflection and perhaps for a change of heart on the part of the patient, but it does not cure the problem of a lack of a definition of, or a standard for evaluating, voluntariness. If the legislation means only that the decision should not be coerced or compelled, this would seem a fairly minimal requirement in a health care setting. Given that coercion is prohibited by all codes of medical ethics and that with the exception of overuse of chemical and physical restraints in some settings, coercion requires a court order unless the cir-

190. See Wash. S.B. 5596, 55th Leg., Reg. Sess. § 161(1) (1995); N.Y. S.B. 1683, 218th Reg. Sess. 1st Sess. § 4915 (1995).

191. Or. Laws ch. 3 (I.M. 16) § 3.06 (1995).

cumstances constitute an emergency, the requirement of voluntariness hardly seems a particular advantage gained by legalization.¹⁹²

D. *Restrictions on Eligibility*

Proponents of PAS and euthanasia have always promised that legislation authorizing the practice would specify narrowly restrictive eligibility criteria as a central safeguard against indiscriminate, involuntary, or widespread use of the authority.¹⁹³ This promise is made in order to lessen the fears of those who raise concerns about the impact of cost containment pressures on large segments of the poor and disadvantaged, the elderly and disabled, and those who are already abandoned by, or under severe economic pressure from, our medical system. As the New York State Task Force on Life and the Law pointed out in its 1994 report on physician assisted suicide and euthanasia:

The risk of harm is greatest for the many individuals in our society whose autonomy and well-being are already compromised by poverty, lack of access to good medical care, advanced age, or membership in a stigmatized social group. The risks of legalizing assisted suicide and euthanasia for these individuals, in a health care system and society that cannot effectively protect against the impact of inadequate resources and ingrained social disadvantages, would be extraordinary.¹⁹⁴

Among the twelve bills we examined, we found that the supposedly limiting criteria turn out to be all but limitless. Particularly troubling is the most common restriction of PAS to those with a life expectancy of six months or less due to terminal illness. There are two components to this criterion: the terminal character of the condition or illness, and the prognosis of six

192. See, e.g., Kamisar, *supra* note 14, at 985-93.

193. Quill et al., *supra* note 8, at 1383. Quill and colleagues promise that the practice will be authorized "only after all other alternatives have been exhausted and failed." *Id.* at 1381; see also, Miller et al., *supra* note 4, at 119 (assuring readers that PAS will be only for those "exceptional" cases where no other measures for relief of suffering exist).

194. NEW YORK STATE TASK FORCE, *supra* note 6, at 120.

months or less remaining of the patient's life. One searches the literature in vain for consistency regarding the meaning of terminal condition or terminal disease. Is terminal illness the same as the length of time spent receiving terminal care? Is one terminal when active or aggressive therapy is no longer considered appropriate? Most of the statutes we examined define terminal as "incurable and irreversible,"¹⁹⁵ and one state defines it as simply "incurable" with death expected within one year.¹⁹⁶ Michigan does not mention terminal illness, or incurable and irreversible disease at all in its bill because it does not restrict PAS to such individuals.¹⁹⁷ At what stage, for example, is cancer incurable? Is it incurable when it recurs after remission? After chemotherapy? Is it incurable if there is only a twenty percent chance of survival after several courses of chemotherapy and radiation, or must there be no chance of survival in order to be incurable? Must the patient have tried chemotherapy prior to being designated incurable? The bills are not clear. Moreover, is there empirical or epidemiological data that suggests physicians are accurately able to predict a life expectancy of six months or one year? Are physicians trained to predict life expectancy?

Surprisingly, despite increased attention in medical literature to the management of terminal illness and tremendous expansion of hospice care in the United States, there is little examination or study of what is meant by terminal illness, or how long this terminal period of care lasts, and what factors are associated with or determine the differences in care and their duration.¹⁹⁸ While there is commonly an association between use of the word terminal and a limited remaining life expectancy, the association is neither precisely measured nor well researched. The few studies that have been done indicate that the designation of six months as a terminal period is entirely arbitrary and that physicians vary drastically in their interpretation of what constitutes this terminal phase of illness.¹⁹⁹

195. Those states are California, Colorado, Maine, Massachusetts, New Hampshire, New York, Oregon, Washington, and Wisconsin.

196. Vt. H.B. 335, 1995 Bi. Sess. 1995 § 5280(11) (1995).

197. Mich. H.B. 4134, 88th Leg., 1995 Reg. Sess. 1995 *passim* (1995).

198. See Jane McCusker, *The Terminal Period of Cancer: Definition and Descriptive Epidemiology*, 37 J. CHRONIC DISEASES 377, 377 (1984).

199. *Id.*

One study suggests that physicians' perceptions of arrival at the terminal phase of illness vary from around eighteen days remaining to around three months.²⁰⁰ Another study found that the average period of time designated as terminal was around ninety-four days or approximately three months.²⁰¹ Moreover, extensive evidence exists that physicians' predictions of expected remaining life are generally inaccurate.²⁰² The flat time-limited frame of reference assigned as an eligibility criterion for these patients ignores the complex and little understood immunological effects of hope, love, support, and other subjective factors on disease progression and, consequently, on life span.²⁰³ It also risks creating a health care environment in which patients are discouraged from harnessing their own resources or seeking needed support from others.

It may not be possible to generalize based on the results of the above studies of terminality beyond the observation that to offer patients the possibility of being helped to die when the disease is expected to produce death within six months involves a far larger population of patients than those customarily considered appropriate for terminal care in many settings. Thus, it would not appear to be as limiting a factor as one might suppose. Would legalization of PAS under such criteria result in a widespread assumption that the final six months of life are to be avoided by the terminally ill, even if most of these patients would not consider suicide in the absence of a permissive (legal) environment for it? What effect will the six-month criterion have on those who might otherwise seek a measure of healing

200. Christopher Evans & Mark McCarthy, *Referral and Survival of Patients Accepted by a Terminal Care Support Team*, 38 J. EPIDEMIOLOGY & COMMUNITY HEALTH 310, 313 (1984). In South Camden, England, 125 cancer patients had been referred to the terminal care support team at widely varying stages in their illness and with widely varying survival times. *Id.* Although precise predictions were not made by the referring physicians, the patients referred by general practitioners had a median survival time of 18 days, compared with 104 days for patients referred by radiologists. *Id.*

201. McCusker, *supra* note 198, at 383.

202. Robert A. Pearlman, *Inaccurate Predictions of Life Expectancy*, 148 ARCHIVES OF INTERNAL MEDICINE 2537 (1988); see also L.H. Heyse-Moore & V.E. Johnson-Bell, *Can Doctors Accurately Predict the Life Expectancies of Patients with Terminal Cancer?* 1 PALLIATIVE MEDICINE 165 (1987).

203. Barrie R. Casileth et al., *Psychosocial Correlates of Survival in Advanced Malignant Disease?*, 312 NEW ENG. J. MED. 1551 (1985).

or peace of mind in the face of incurable illness? Will it not risk leaving such patients with a sense that society as a whole believes there is not much point to the last few months of one's life, indeed that they are not worth living at all?

With regard to the question of physicians' skills at predicting life expectancy, the experience of hospice care providers with prognostication of six months life expectancy is worth noting. Observers of hospice care practices have long known that such certification of six months life expectancy for purposes of obtaining hospice reimbursement under Medicare is done routinely not because it is accurate, but because the law requires it.²⁰⁴ Some physicians have suggested that medical professionals ought to refuse to answer questions about a patient's prognosis on forms aimed at hospice certification because there is "no scientific basis on which to answer this question."²⁰⁵ Is it not reasonable to expect a transfer of this habit of fitting the patient's condition into the bureaucratic or statutory requirements from hospice care to the practice of PAS and euthanasia? We see no particular reason to anticipate that the determination of six months life expectancy will be any more objective or accurate for the practice of finding eligibility for PAS and euthanasia than it has been for hospice eligibility. In any case, no particular data base supports the determination that six months or, as the Vermont legislation suggests, one year, is the appropriate time frame for PAS.²⁰⁶ Again, as does consent and capacity, life expectancy turns on the physician's judgment, not on empirical data.

Nor is there any assurance that the six-month time frame significantly limits the potential universe of patients who may be considered eligible for PAS or euthanasia. Only one state, New Hampshire, restricts eligibility for PAS to those who are experiencing "severe, unrelenting suffering" as well as a "ter-

204. Ronald S. Schonwetter et al., *Estimation of Survival Time in Terminal Cancer Patients: An Impedance to Hospice Admissions?*, 6 HOSPICE J. 65, 67 (1990).

205. Howard Brody & Joanne Lynn, *The Physician's Responsibility Under the New Medicare Reimbursement for Hospice Care* 310 NEW ENG. J. MED. 920 (1984).

206. Vt. H.R. 335, Biennial Sess., § 5280 (11) (1995) (defining terminal condition as "an incurable condition caused by injury or disease which, regardless of the application of lifesaving procedures, would within reasonable medical judgment produce death within one year.").

minal condition," but at the same time, it removes the six-month life expectancy limitation entirely.²⁰⁷

A terminal condition is defined in New Hampshire's bill as "an incurable and irreversible condition, for the end stage of which there is no known treatment which will alter its course to death, and which, in the opinion of the attending physician and consulting physician competent in that disease category, will result in premature death."²⁰⁸ What is meant by premature is anyone's guess. No other time-based criteria are mentioned, although this would neither solve the problem of indeterminacy nor alter the fact that terminal condition has no constitutional meaning.²⁰⁹

Michigan's proposed legislation provides no eligibility restrictions whatsoever other than a minimum age of eighteen years: "A patient 18 years of age or older who is of sound mind and mentally competent to consent to aid-in-dying may execute a directive to authorize aid-in-dying."²¹⁰ Aid-in-dying is defined as: "the provision to another person of a lethal agent with the primary purpose of substantially increasing the probability of the other person's death."²¹¹ In other words, Michigan's bill would authorize physicians to euthanize patients directly provided that the patient is mentally competent and of sound mind at the time—and it does not define either. In Michigan, a patient does not even have to have been under the care of a physician, for "patient" means an individual who executes a directive in accordance with this act."²¹² Thus, there is not even a pretense that the physician should know anything about the

207. N.H. H.R. 339, Reg. Sess., § 137(K)(3) (1995). This bill provides that [a]n adult who is capable and a resident of New Hampshire, or who is a patient regularly treated in a New Hampshire health care facility, and who has been determined by the attending physician and consulting physician to be in a condition of severe, unrelenting suffering from a terminal disease, and who has voluntarily expressed a wish to die, may make a written request for medication for the purpose of ending such person's life in a humane and dignified manner in accordance with this chapter.

Id. The bill was defeated by the N.H. House on January 4, 1996 by 256 to 90.

208. *Id.* § 137(K)(2)(XIII).

209. Thomas J. Marzen, "Out, Out Brief Candle": *Constitutionally Prescribed Suicide for the Terminally Ill*, 21 HASTINGS CONST. L. Q. 799, 814-819 (1994).

210. Mich. H.B. 4134, 88th Leg., Reg. Sess. § 3(1) (1995).

211. *Id.* § 2(9).

212. *Id.* § 2(g).

person's baseline level of functioning, range of moods, values, living situation, or unique ways of communicating. In Michigan, it is sufficient that the individual has executed a directive requesting euthanasia (any reason will do) in order to be considered an eligible patient.²¹³

Oregon, California, Colorado, Maine, Massachusetts, and Wisconsin propose to limit the choice of PAS to those who have a "terminal disease," which is defined as "incurable and irreversible" and expected to cause death "within six months."²¹⁴ Vermont requires a "terminal condition," which is defined as one which is "incurable" and which "regardless of the application of lifesaving procedures" will "produce death within *one year*."²¹⁵

Washington's "Terminally Ill Patient Act of 1995"²¹⁶ is extremely difficult to interpret. If the confusion is not intentional, it is nonetheless difficult to imagine how the provisions could be any more bewildering than they are. Washington considers a terminal condition to be one that will result in death "within a reasonable period of time."²¹⁷ Washington further stipulates that terminal condition really means one in which "life-sustaining treatment serves only to prolong the process of dying."²¹⁸ The parameters for PAS are therefore identical to those for the withdrawal or withholding of life sustaining treatment. The purpose of withholding or withdrawal is to allow a more natural dying process, unimpeded by medical interventions. In the PAS legislation, however, precisely the same conditions are outlined for medical suicide. The language is confusing in the extreme. Yet it looks, at first glance, as if the statute is very

213. Mich. H.B. 4134, 88th Leg., Reg. Sess. § 2(g) (1995).

214. *See generally*, Cal. A.B. § 1310 (1995); Col. H.B. 95-1308 (1995); Me. H.P. 552 (1995); Mass. H.B. 3173; Or. Laws ch. 3 (I.M. 116) (1995); Wis. S.B. 90, 92nd Leg., Reg. Sess. (1995).

215. Vt. H.R. 335, Bi. Sess. § 5280(11) (1995) (emphasis added).

216. Wash. S.B. 5596, 55th Leg. Reg. Sess. (1995).

217. *Id.* § 3(8).

218. *Id.*; *see also* Marzen, *supra* note 209 at 817, stating that:

Apart from the essentially artificial distinction between medical attention and other forms of care necessary to sustain life, it is surely not the case that those who might advocate an exception to the ban on assisted suicide would find acceptable a rule that one must die within a "relatively short time" even with treatment to be eligible for prescribed suicide.

Id.

narrowly drawn and that the safeguard might be truly workable. In fact, this is far from the case.

First, life-sustaining treatment is not defined; it may include virtually any medical or surgical treatment without which the incurable patient would die. Second, the patient must make a request in writing or by a video recording in advance²¹⁹ and send or deliver it to his or her primary care physician, who may be assigned to the patient and thus not acquainted with the patient at all.²²⁰ Third, although the patient's advance request must be witnessed by two adults, the witnesses do not attest to the patient's state of mind, soundness of mind, competence, or decisionmaking capacity at the time the request is written or recorded.²²¹ Although two physicians (the primary care physician and a consulting physician) must personally examine the patient, there is no requirement that these evaluations occur in close proximity to the aid-in-dying.

Finally, in Washington, aid-in-dying turns out to be a "prescription for medication" that will, if self-administered by the patient, "shorten the process of dying."²²² Use of the word "if" creates confusion. Does this mean that the physician and patient may decide that the physician, rather than the patient, should administer the lethal dose directly? The bill, as presently worded, does not appear to preclude this option.

The Washington bill is structured in terms of legislative findings of a constitutionally protected liberty interest. It is propped up by a finding that aid-in-dying must be "completely voluntary."²²³ But careful reading shows that the bill does not necessarily preclude euthanizing incompetent or semi-competent patients who may have been competent at some time, perhaps even at the time of their request (although this does not appear to be verifiable under the provisions of the bill). Even the supposed limitation of "death within a reasonable period of time" is so imprecise as to be virtually useless in guiding behavior.²²⁴

219. Wash. S.B. 5596, 55th Leg. Reg. Sess. § 4(3) (1995).

220. *Id.* § 3(5).

221. *Id.* § 4(4)(a)-(d).

222. *Id.* § 3(1).

223. *Id.* § 2.

224. *Id.* § 3(8).

Thus, the safeguard of limited life expectancy turns out to rest on quicksand. Marzen argues eloquently against the illusion that terminal condition is a basis on which to rest constitutional authority:

[I]ntroduction of a time-based element itself creates new problems. . . . On what basis can one claim the Constitution as authority to make any such distinction? Inherently vague and arbitrary criteria must necessarily be built into any definition of "terminal condition" that employs time-based elements, the fulfillment of which cannot in any case be predicted with any exactitude In sum, the linchpin criterion of an existing "terminal condition" that, it is argued, should warrant constitutionally sanctioned assisted suicide turns out to contain its own "slippery slope," spanning from life itself to a life that no amount of treatment can prolong for even a moment. To select one place or the other as a bright line that renders assisted suicide a crime on one side and a constitutionally protected right on the other would simply be capricious.²²⁵

Improvement in the accuracy of such predictions is considered unlikely. Physicians receive little training in the skill of prognostication, and although their skills might improve from some such training, verifying levels of accuracy through randomized clinical trials is highly problematic.²²⁶ Predicting life expectancy would remain a guessing game.

Moreover, reliance on statutory construction to provide effective safeguards on physician practices, such as imparting and explaining information, assessing and understanding a patient's state of mind, and validating consent, that are already known to be seriously flawed in other areas of medicine is only part of the problem. The perhaps more serious difficulty stems from the unfounded assumption that physicians, as a rule, understand the numerous state and federal laws that already govern the day to day care of their patients. For example, recent studies of the use of advance directives indicate overwhelming evidence that both written directives and verbal instructions by

225. Marzen, *supra* note 209, at 817-18.

226. See Ian R. McWhinney, *Evaluation of a Palliative Care Service: Problems and Pitfalls*, 309 BRIT. MED. J. 1340 (1994); see also Robert E. Enck, *Prognostication of Survival in Hospice Care*, 7 AM. J. OF HOSPICE AND PALLIATIVE CARE 11 (1990).

patients regarding end-of-life treatment preferences are routinely ignored by physicians.²²⁷ Numerous studies have found widespread and significant misunderstandings and misinterpretations among physicians regarding state and federal laws governing the withdrawal of life-sustaining treatment.²²⁸ While medical schools are devoting substantial time to the teaching of medical ethics, far less attention is paid to ongoing legal education. What assurance exists that physicians will be better equipped to interpret and comply with statutory or regulatory guidelines in the practice of PAS or euthanasia?

E. Witnesses

As noted above, one of the arguments proffered by supporters of legalization is the claim that physicians currently practice assisted suicide and euthanasia in secret and therefore the potential for abuse is magnified by the lack of witnesses, records, and monitoring.²²⁹ The claim is that legalization would end this secrecy and provide a means to verify compliance with safeguards and guidelines, thereby reducing the risk of involuntary or nonvoluntary euthanasia or of PAS for persons outside the statutory limits. Interestingly, in a survey of 1355 physicians in the state of Washington, ninety percent identified as the most important safeguard against abuse of PAS or euthana-

227. See Mildred Solomon et al., *Decisions Near the End of Life: Professional Views on Life-Sustaining Treatments*, 83 AM. J. PUB. HEALTH 14, 19 (1993). This study examined the responses to 123-item questionnaires sent to 1,400 doctors and nurses at five major hospitals around the country. The results show that 81% of the respondents admitted that they routinely undertreat pain in terminally ill patients, that they frequently ignore patients' express wishes regarding treatment, and that medical personnel are often unaware of laws and hospital policies regarding the care of patients. See also David Orentlicher, *The Illusion of Patient Choice in End-of-Life Decisions*, 267 JAMA 2101 (1992); SUPPORT Principal Investigators, *A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients: The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT)*, 274 JAMA 1591 (1995); *Dying Well in the Hospital: The Lessons of SUPPORT*, Special Supplement, 25 HASTINGS CENTER REP., Nov. 1995 at S3-S36.

228. E.g., Alan Meisel, *Legal Myths About Terminating Life Support*, 151 ARCHIVES INTERNAL MED. 1497 (1991); Delfi Mondragon, *U.S. Physicians' Perceptions of Malpractice Liability Factors in Aggressive Treatment of Dying Patients*, 6 MED. & L. 441 (1987); Marshall B. Kapp & Bernard Lo, *Legal Perceptions and Medical Decision Making*, 64 MILBANK Q. 163, Supp. 2 (1986).

229. See *supra* part IV.

sia the requirement that the patient's request be witnessed by someone who would not benefit from the patient's death.²³⁰

Yet in the bills examined, witnesses will be present only at the time of writing and/or signing a written directive asking for physician-assisted suicide or euthanasia.²³¹ They will not be present for any conversations between the physician and the patient, during any of the consultations, or during the informed decisionmaking process. In theory, witnesses are meant to provide some sort of oversight about the patient's state of mind and reassurance about the lack of undue influence and other improprieties. Indeed, witnesses appear to be subjected to more stringent qualifications in some of the bills than are patients.²³² One puzzling feature of the Oregon model is that while it requires two individuals to witness the signing of a written request (a pre-printed form for this is conveniently provided), it specifies that one of the witnesses shall not be a relative, a beneficiary of the patient's will, or an employee of the treating health care facility.²³³ Nothing prevents the second witness, however, from being not only a relative but the primary beneficiary of the patient's life insurance.

Although the patient's attending physician cannot be a witness under the Oregon model, it seems that the social worker or psychiatrist could be. The most bizarre and legally suspect witness provision, however, involves a complete lack of choice for those who are residents of long term care facilities. For such patients, one of the witnesses "shall be an individual designated by the facility."²³⁴ From a legal standpoint, this requirement reeks of conflict of interest. How is this provision in any conceivable way consistent with voluntariness and the prohibition of undue influence?

Washington, New York and Maine forbid either of the two required witnesses from being relatives or beneficiaries,²³⁵ and

230. Jonathan S. Cohen et al., *Attitudes Toward Assisted Suicide and Euthanasia Among Physicians in Washington State*. 331 NEW ENG. J. MED. 89, 93 (1994).

231. See, e.g., Wash. S.B. 5596, 55th Leg., Reg. Sess. § 4 (1995).

232. See, e.g., Wis. S.B. 90, 92nd Leg. Sess., Reg. Sess. § 156.05(2)(a)(1)-(4), (1995); Wash. S.B. 5596, 55th Leg. Sess., Reg. Sess. § 4(4)(a)-(d) (1995).

233. Or. Laws ch. 2 (I.M. 16) §§ 2.02(2)(a)-(c), 2.02(3) (1995).

234. *Id.* § 2.02(4).

235. See Wash. S.B. 5596, 55th Leg. Sess., Reg. Sess. (1995); N.Y. S.B. 1683, 218th

Washington generously adds that the witnesses also should not have any creditor's claim against the patient.²³⁶ Wisconsin insists on three witnesses—none of whom are permitted to be related to the patient in any way, entitled to any portion of the patient's estate, directly financially responsible for the patient's health care, or to be a health care provider (other than a chaplain or a social worker).²³⁷ On the other hand, Wisconsin stipulates that "[i]f a requester (a patient requesting PAS) is a patient in a nursing home or community-based residential facility, at least one of the witnesses to the request shall be a patient's advocate" ²³⁸

This raises the same questions we posed earlier with regard to whether palliative care consultants or committees would not inevitably be biased in favor of PAS. Why else would they agree to serve as witnesses? What impact will this have on the role of patient advocates for the elderly or disabled? How will the advocacy role be perceived by those who do not wish suicide and who may actually fear being a victim of non-voluntary or involuntary euthanasia?

Moreover, Wisconsin provides a written form for the "Statement and Signatures of Witnesses" in which the witness asserts: "I know the requester personally or I have received proof of his or her identity and I believe him or her to be of sound mind and at least 18 years of age."²³⁹ This provision does not appear to preclude a complete stranger from attesting to the patient's soundness of mind after being assured of his or her identity by means of a driver's license.

Michigan avoids this problem by not requiring any witnesses at any time. Under Michigan's House Bill 4134, "[a] directive shall be in writing, dated, and executed voluntarily. The directive shall be signed by the patient, or in the patient's presence at his or her direction. The directive may specify conditions under which aid-in-dying will be authorized."²⁴⁰

Gen. Assembly, 1st Reg. Sess. § 4902.1-4902.4 (1995); Me. H.B. 748 (1995).

236. Wash. S.B. 5596, 55th Leg. Sess., Reg. Sess. § 4(U)(C) (1995).

237. Wis. S.B. 90, 92nd Leg. Sess., Reg. Sess. § 156.05(2)(a)(1)-(4) (1995).

238. *Id.* § 156.05(4)(b).

239. *Id.*

240. Mich. H.B. 4134, 88th Leg. Sess., Reg. Sess. § 3(2) (1995). This stipulation is reiterated later in the statute by a provision which states that the statute does not

In other words, the patient decides when and under what circumstances PAS or euthanasia will be appropriate, further expanding the state's already vaporous criteria. The only direct communication from the patient that is required is as follows: "at least fifteen days before aid-in-dying is provided . . . [t]he patient [must have] communicated to the attending physician the patient's request that the aid-in-dying authorized in the directive be carried out."²⁴¹ Such communication, therefore, might actually take place as long as a year before the administration of euthanasia. For example, during an office visit, the patient might deliver his or her directive to the physician with the instruction—"when I am in a bad state such as I've described here, just go ahead and do it." According to the bill, the patient must actually be "conscious, of sound mind, and mentally competent to consent to aid-in-dying at the time the aid-in-dying is provided."²⁴² If the directive is written well in advance, is this not an illustration of exactly the case in which the physician might be sorely tempted to claim that the patient was conscious and alert when, in fact, he or she was not? Who would know?

F. *Definitions of Abuse*

Michigan's proposed statute is wide open in terms of eligibility, and allows euthanasia as well as PAS. The statute, however, does attempt to identify what constitutes abuse: nonvolun-

authorize ending the patient's life other than as provided in the statute. *Id.* § 8.

This act does not authorize a deliberate act or omission to end human life other than aid-in-dying by a physician when voluntarily requested by a conscious patient who is of sound mind and mentally competent to consent to aid-in-dying at the time aid-in-dying is provided in accordance with this act.

Id. This does not, however, preclude subsequent amendments to expand the scope of the act to include unconscious patients, nor does it preclude the subterfuge that occurs in the Netherlands when acts that are outside the scope of the guidelines are not reported or recorded. *Id.*

241. *Id.* § 4(a)(iii) § 10(1)(a),(b),(c),(d). Section 10(2) provides that if the patient dies as a result of coercion or euthanasia without a request, the violation is punishable by life imprisonment. *Id.* at § 10(2). However, section 7(1) provides that anyone who participates in or administers euthanasia or PAS operates with civil and criminal immunity, and also immunity from any administrative sanctions as long as the directive is executed in compliance with the statute. *Id.* § 7(1).

242. *Id.* § 4(e).

tary euthanasia, forging or falsifying a directive, coercion, and concealing or ignoring a revocation of a directive.²⁴³ But since there are no witnesses to the writing and signing of the directive requesting euthanasia, and assisted suicide does not require any witnesses, and since there are no reporting requirements of any kind, where is the oversight or accountability or monitoring of the process? Where, indeed, are the safeguards? The entire interaction may involve only the patient, the attending or treating physician, a psychologist or psychiatrist, and a professional counselor. The entire transaction and the patient's euthanasia or suicide may be accomplished privately within fifteen days after receipt by the attending physician of the unwitnessed directive.²⁴⁴ If relatives hear about it in time, they may challenge the patient's decision in court.²⁴⁵ The directive remains in the patient's record, but there is no report to anyone.

Washington declares it unlawful for anyone to persuade the patient that he or she "is a financial, emotional or other burden to his or her family, other person, or the state."²⁴⁶ The bill prohibits forging or concealing a patient's recorded or written request and/or concealing a revocation.²⁴⁷ As will be discussed, none of these listed abuses must be reported, investigated, or punished.

G. *Reporting Requirements*

Reporting abuse would seem to be an essential step in any meaningful regulation of the practice of PAS or euthanasia. Identification of what constitutes abuse provides no safeguard if no mechanism is in place for reporting it or investigating its occurrence. Astonishingly, neither the Oregon statute nor even one of the other pending bills examined has any provision for reporting suspected abuse, observed abuse, or any kind of abuse of this practice whatsoever.

243. Mich. H.B. 4134, 88th Leg. Reg. Sess. § 10(1)(a)-(d) (1995).

244. *Id.* § 4(1).

245. *Id.* § 6(1).

246. *Id.* § 16(1).

247. *Id.* § 16(3).

For example, in an odd display of priorities, the Washington bill provides for "fair and reasonable" fees for the suicide service,²⁴⁸ and stipulates that "advertising" the service will be regulated by the state,²⁴⁹ but there is no reporting requirement of any kind. Images of Dr. Jack Kevorkian's obituary clinics come disturbingly to mind. Despite all the informing and explaining and reviewing that is supposed to be undertaken by the primary care physician and the consultant, none of the conversations with the patient have to be recorded in the patient's chart. The "completed and witnessed recorded request" must be placed in the patient's permanent medical record, but since no report is required, knowledge of what has transpired is confined to those who participated, all of whom are given a blanket immunity based on their good faith belief that their actions were lawful:

A physician, health care professional, health care facility, employee of a health care facility, or licensed pharmacist, who, acting in good-faith compliance with the requirements of this chapter, participates in, or is present at, aid in dying at the voluntary recorded request of a qualified patient is not subject to civil, criminal, or administrative liability for participating in or being present at the aid in dying. . . .

No physician, or licensed health care professional acting under the direction of a physician, who acts in good-faith compliance with the requirements of this chapter, shall be liable for professional misconduct or disciplinary action solely because of his or her participation in aid in dying.²⁵⁰

If good faith is the standard for immunity from legal liability or professional discipline, would the record-keeping or reporting requirements provide the possibility of evidence to dispute a

248. Wash. S.B. 5596, 55th Leg. Sess. Reg. Sess. § 12 (1995). "Fees—Fees set by physicians or health care facilities for providing aid-in-dying must be fair and reasonable." *Id.*

249. *Id.* § 18(3). Advertising of aid in dying services is subject to regulation by the state of Washington. *Id.* The very fact that they are called services worthy of advertising is peculiar in itself.

250. *Id.* § 14(1)(a),(2).

physician's or other health care professional's own assertions of "good-faith compliance"?

Probably the most stringent reporting provision is New York's:

Hospitals and other health care providers who carry out the directives of qualified patients shall keep a record of the number of such directives executed and report annually to the commissioner the patients' ages, types of illnesses and the dates the directives were carried out. In all cases, the identity of the patients shall not be reported.²⁵¹

While this seems adequate at first glance, closer examination shows that no individual or state agency is identified to review these reports, and oversight of the decisionmaking process is precluded, as elsewhere, by the privacy and confidentiality of the physician-patient relationship. While the bill prohibits "inducement," "tampering," "coercion," and "fraud,"²⁵² there are no means to discover these violations unless they are directly observed and revealed by the observer. No one is required to report such observations to anyone; nor is anyone authorized to investigate any abuse or violations even if they are observed or suspected. Ironically, one provision asserts that "[N]o physician shall be required to take any action contrary to reasonable medical standards in administering aid in dying."²⁵³ Given that these bills, if enacted, will turn centuries of medical ethics upside down, the presumption that euthanasia and PAS fit neatly and comfortably within reasonable medical standards amounts to an extraordinary kind of hubris.

X. HOW ABUSE OF OTHER VULNERABLE POPULATIONS IS HANDLED BY THE LAW

It is instructive to compare the statutes aimed at prevention and control of the abuse of children, spouses, and the elderly with these proposed statutes aimed at legalization of PAS and/or euthanasia on the promise that they will somehow limit

251. N.Y. S.B. 1683, 218th Gen. Assembly, 1st Reg. Sess. § 4818 (1995).

252. *Id.* § 4915.

253. *Id.* § 4912 (discussing medical standards).

the risk of abuse.²⁵⁴ In laws aimed at preventing and/or stopping child abuse, spouse abuse and elder abuse, reporting requirements are clearly spelled out in the body of the statutes, with identification of those professionals required to report, under what circumstances, what kinds of acts, and to which state agency.²⁵⁵ Moreover, state agencies are specifically identified and authorized to investigate suspected abuse, and guidelines are provided for the hiring and training of personnel to accomplish these tasks.²⁵⁶ The assumption is that even though abuse may not always be preventable, it can at least be identified and, with appropriate intervention, the goal should be to see that it stops. In the case of child abuse, certain professionals are subject to mandatory reporting requirements in all fifty states, and there are sanctions for failures to report.²⁵⁷ In some states, a reasonable suspicion of abuse is all that is necessary to trigger the reporting requirement.²⁵⁸ Moreover, immunity from liability (for defamation) is provided for the reporter of the abuse or suspected abuse, not for the accused abuser.²⁵⁹ Mandatory reporting, with civil and criminal penalties for failure to report, exists in most jurisdictions.²⁶⁰

By contrast, the PAS/euthanasia legislation, as currently written, provides no specific requirement for any individual, professional or lay person, to report abuse or suspected abuse of the practice, nor any statutory penalties of any sort. While certain forms of abuse are identified in most of the bills (forging or falsifying directives, coercion and undue influence), no one is obligated to report them, and no one is identified to investigate such practices.

Concern to provide blanket immunity from civil and criminal liability is evident in the proposed legislation. As noted earlier,

254. See Brock, *supra* note 8, at 14; Miller et al., *supra* note 4, at 122.

255. *E.g.*, 210 ILCS 30/1 to 30/6 (West 1995 & Supp. 1995). See, *e.g.*, TEX. FAM. CODE ANN. § 34.01 (Vernon 1982).

256. See, *e.g.*, ARK. STAT. ANN. § 42-808 (1977); MASS. GEN. LAWS ANN. ch. 119, § 51A (West Supp. 1984-85);

257. *Landeros v. Flood*, 551 P.2d 389 (Cal. 1976).

258. S.D. CODIFIED LAWS ANN. § 26-8A-3 (1992); VA. CODE ANN. § 63.1-248.1 (Repl. Vol. 1995).

259. *E.g.*, MASS. ANN. LAWS ch. 119, § 51A (Law Co-op. 1994 & Cum. Supp. 1995).

260. Richard L. Granville, *Immunity*, in LEGAL MEDICINE: LEGAL DYNAMICS OF MEDICAL ENCOUNTERS 110, 110-16 (1983).

Connecticut's very brief bill is aimed exclusively and entirely at this function alone.²⁶¹ Its stated purpose is "to provide an affirmative defense to manslaughter in the second degree for physician assisted suicide."²⁶² Immunity from liability is not only a defense for the defendant against whom a civil or criminal suit has been filed, but it may also prevent discovery of evidence or investigation of facts. Some states already have laws that protect certain hospital and peer review committee records from discovery through immunity provisions.²⁶³ There is no reason to believe that this well-established approach to protecting the health care professional and the medical records from public review and/or investigation would be any different in the case of PAS and euthanasia. If anything, we should expect an intensification of this protectiveness.

The Oregon statute, in fact, illustrates this.²⁶⁴ The relevant provisions, which are replicated verbatim by California,²⁶⁵ Colorado,²⁶⁶ Maine,²⁶⁷ Massachusetts²⁶⁸ and New Hampshire²⁶⁹ require documentation in the patient's medical record of all oral and written requests, all offers to rescind requests, and all determinations of decisionmaking capacity.²⁷⁰ In addition, the statutes require the physician to note in the patient's chart that all appropriate and required steps have been taken pursuant to the statute, and a notation regarding the medication prescribed to the patient.²⁷¹

Oregon then specifies that the Health Department "shall annually review a sample of records maintained pursuant to this Act."²⁷² A sample? How many is a sample? Ten? Three? Fifty? What individual or agency is designated to review this sample? The statute does not say. Nor does it specify any train-

261. See generally *supra* part IV.

262. Conn. S.B. 334, Reg. Sess. (1995).

263. See, e.g., MONT. CODE ANN. § 50-16-205 (1989); OR. REV. STAT. § 41.675(2) (1995); N.Y. EDUC. L. § 6527(3) (McKinney Supp. 1990).

264. See Or. Laws Ch. 3 (I.M. 16) (1995).

265. Cal. A.B. 1080 (1995).

266. Colo. H.B. 1308 (1995).

267. Me. H.P. 552 § 5-912 (1995).

268. Mass. H.B. 3173 § 3(I) (1995).

269. N.H. H.B. 339 Ch. 137-K:10(I-VII) (1995).

270. Or. Laws Ch. 3 (I.M. 16) §§ 3.06, 3.09(1) (1995).

271. *Id.* § 3.09(7).

272. *Id.* § 3.11.

ing or investigative authority for the individual who might review the records. Oregon's "Death with Dignity Act" and the other bills copied from it authorize local health departments to "make rules to facilitate the collection of information," but "the information collected shall not be a public record and may not be made available for inspection by the public."²⁷³ No specific agency, including the health department, is identified or authorized to receive reports of suspected abuse or to investigate them.

In summary, Oregon's statute and all of the other bills appear to provide blanket immunity from civil liability, criminal prosecution, or professional discipline for anyone who in good faith participates in, observes, or carries out the administration or prescription of lethal medication. Coupled with the absence of meaningful reporting requirements and the ongoing protection of privacy and confidentiality, legalization of PAS offers no remedy for secrecy, no safeguard against abuse, and no limitation on the potential universe of eligible patients.

XI. CONCLUSION

Statutes are not written for case-by-case adjudication. They are crafted in broad, general categories designed for a generic situation and cannot, by definition, be designed for each individual circumstance, much less extraordinary circumstances. At best, they outline the boundaries of permissible and prohibited behavior, but they are not capable of capturing the nuances of complex interactions or providing detailed instructions on specific behaviors. Given the documented confusion of terminology and the absence of consistency or consensus from state to state on definitions (of such concepts as terminal, for example, or decisional capacity, or even who should be permitted to avail themselves of medical death), the promise of regulation, standardization, clarity and openness is unfulfilled. In our view, it cannot be fulfilled. Any constitutionally based definitions of these concepts would necessarily preempt conflicting state definitions, but there is no evidence that a basis exists for the

273. *Id.*

Supreme Court to define the terms any more meaningfully.²⁷⁴ Most importantly, in the context of health care, laws are not intended to substitute for the professional judgment of the physician. And it is ultimate reliance on physician judgment and physician disclosure that renders the practice of PAS/euthanasia essentially unregulatable.

Some PAS proponents, notably Quill²⁷⁵ and Brody,²⁷⁶ appear to assume for PAS transactions an idealized picture of the physician-patient relationship as one characterized by relative equality, intimacy, shared power, and open communication. This ideal is rarely realized in practice, as both authors surely know.²⁷⁷ Interestingly, this ideal is in sharp contrast to the physician-patient relationship envisioned by the legislation which, by and large, paints a stark picture of a relationship of strangers, of physicians assigned to patients, and patients who have never before been under the care of the physician designated to help them die. Witnesses can be brought in from the hospital corridors, shown the patient's driver's license and permitted to attest to the patient's soundness of mind. The record is written by the physician who performs the act in private. The public is prohibited access to any records. What is otherwise potentially an experience of overriding intimacy and spirituality becomes rather bureaucratic, mechanistic, and perfunctory.

274. See Marzen, *supra* note 209.

275. See Quill et al., *supra* notes 8, 17, 26, 116; Quill, *supra* note 23 and accompanying text.

276. See BRODY, *supra* note 189; Brody *supra* notes 7, 116, 135; Brody & Lynn, *supra* note 205 and accompanying text.

277. The New York Task Force also warns of the inevitable effects of societal inequality on the practice of PAS and euthanasia:

[I]t must be recognized that assisted suicide and euthanasia will be practiced through the prism of social inequality and prejudice that characterizes the delivery of services in all segments of society, including health care. Those who will be most vulnerable to abuse, error, or indifference are the poor, minorities, and those who are least educated and least empowered. This risk does not reflect a judgment that physicians are more prejudiced or influenced by race and class than the rest of society—only that they are not exempt from the prejudices manifest in other areas of our collective life.

NEW YORK STATE TASK FORCE, *supra* note 6, at 125.

One wonders how a record of the quantity of cases, or an annual reporting of statistical information, will provide any indication of inappropriate or unauthorized euthanasia. The Dutch have acknowledged that one reason the reported incidence of euthanasia is still so low in the Netherlands is that when an incompetent patient is euthanized, it is simply not reported as euthanasia because it was not voluntary.²⁷⁸ How are the bills now pending in the United States going to preclude either physician-patient collusion, or physician-prosecutor collusion not to report PAS?

We maintain that it is not within the capacity of any law to pierce the veil of doctor-patient confidentiality, or to overcome the complex uncertainties of medical decisionmaking, the inherent instability of the concept of terminality, the vagaries of prognosis and mental status, the subtle emotional interactions of the dying and the doctor, or the infinity of human suffering. Would better statutes than those analyzed here correct these deficiencies? We think not. The belief that a better law could enact truly protective guidelines which would enable this practice to live up to the idealized vision of its proponents is to presume vastly more from medicine and law than either is capable of delivering. The legalization of PAS appears to rest, in part, on the unfounded assumption that a statute can enable physicians dispassionately and scrupulously to distinguish the appropriate and voluntary suicide wish from the nonvoluntary and impaired, and that physicians will have no self-interest at stake in hastening the death of patients whom they cannot cure, simply because they cannot cure them.

On another level, the proponents of legalization often claim that statutes will be able to limit the practice to PAS and maintain the prohibition against euthanasia where the state's legislators choose to do so, or that either or both practices can be limited to the conscious and alert patient and will not be administered to the unconscious or the unwilling.²⁷⁹ There is no basis, either in law or in history, for these assumptions. As amply argued elsewhere, there is no basis under constitutional law for limiting the practice to PAS—exactly the same individu-

278. See van der Maas et al., *supra* note 47.

279. See *supra* note 8.

al interests and state interests are at issue, and exactly the same balance would prevail.²⁸⁰ Moreover, the experience of the Netherlands indicates the fallacy of assuming that guidelines, whether laid out in statutes or as a matter of social policy, are effective barriers against unauthorized practices. The entire foundation, structure and edifice rest solely and exclusively on the physician's professional discretion and judgment at all stages of the process.

Apparently cognizant of the fact that restrictions and safeguards will not work, some proponents appear ready to accept this and they argue that the resulting deaths would not be too high a price to pay. Dan Brock, for example, asserts that voluntary active euthanasia may well "slip into nonvoluntary euthanasia,"²⁸¹ but that this would not be too bad because the decisions could be made by surrogates and "would often accurately reflect what the incompetent person would have wanted."²⁸² Thus, the argument seems to be that nonvoluntary euthanasia (the killing of patients who are unable to make an explicit request because incompetent, and who have not made an explicit request for whatever reason) would only have to accord with the patient's wishes often—but not always—to be acceptable.

Is legalization, then, really about regulating PAS and euthanasia at all? Or, on the contrary, is it about de-regulating the physician? As two observers have commented in relation to the Netherlands, the toleration of euthanasia there has resulted not in greater patient autonomy, but in physicians having more power than ever over the life and death of their patients.²⁸³

The fact that the vast majority of physicians are ethical and well-intentioned is beside the point. The adherence to any publicly approved guidelines or safeguards for containing the practice of PAS and euthanasia within certain limits, however flawed such guidelines may be, depends almost exclusively on the good will and professional judgment of the individual physician who acts in private. Thus, it is not the patient's request

280. See Kamisar, *supra* note 71, at 234.

281. Brock, *supra* note 8, at 20.

282. *Id.*

283. Keown, *supra* note 43 at 238-39 (stating opinions of Jos V.M. Welie & Henk A.M.J. ten Have); see also Hendin, *supra* note 18, at 163.

for euthanasia that determines the outcome, but rather the physician's judgment that such a request is appropriate and that the patient is not suffering from impaired thinking in wanting to die. In other words, that the patient's request is warranted because, in the physician's judgment, the patient's life is not worth living. As the New York State Task Force points out:

For all medical treatments, ranging from simple procedures such as blood tests to surgical procedures and treatments such as chemotherapy, physicians also decide which patients are candidates for the treatment. If assisted suicide and euthanasia were accepted as "therapy," physicians would make a medical judgment about which patients are "good" candidates for the practices. Physicians would also do what is routinely called for in good medical practice—they would make a recommendation. Even assuming that all physicians would act in good faith, never attempting to pressure their patients to commit suicide or to accept euthanasia, physicians' recommendations would be a powerful factor in their patients' choices. Indeed, patients generally do what their doctors recommend.²⁸⁴

It has long been noted by physicians and non-physicians alike that there are intense feelings of ambivalence, defensiveness, and even hostility experienced by physicians in the course of caring for terminally ill patients. No physician, however well intentioned or seasoned and experienced, is completely "immune to the fear, anxieties and frustrations engendered by the apparently helpless, hopeless patient."²⁸⁵ More recently, Herbert

284. NEW YORK STATE TASK FORCE, *supra* note 6, at 122.

285. Kamisar, *supra* note 14, at 992. Kamisar quotes at length from numerous medical sources regarding the effects of pain, terminal illness, and analgesics on mental functioning:

Working with a patient suffering from a malignancy causes special problems for the physician. First of all, the patient with a malignancy is most likely to engender anxiety concerning death, even in the doctor. And at the same time, this type of patient constitutes a serious threat or frustration to medical ambition. As a result, a doctor may react more emotionally and less objectively than in any other area of medical practice. . . . His deep concern may make him more pessimistic than is necessary. As a result of the feeling of frustration in his wish to help, the doctor may have moments of annoyance with the patient. He may even feel almost inclined to want to avoid this type of patient.

Hendin had this to say about the attitude of doctors and patients towards terminal illness, "It will not always be possible to know the 'intent of the heart' or to uncover the intense ambivalence that terminal illness and imminent death inflame in both doctors and patients."²⁸⁶

Legalizing PAS/euthanasia means accepting the failure of medicine to confront the reality of death and dying and the powerful emotions it generates within both doctors and patients. Euthanasia provides both an illusion of control for both; it brings death within the diagnostic differential and provides the cure in death itself. Legalizing euthanasia and/or PAS feeds the quick-fix mentality of our society instead of struggling for the difficult and slow process of searching for and perhaps redefining the proper roles and limits of both medicine and law. In the end, medicine cannot save any of us. With its imperfect use of language and its inherently limited reach into the hearts and motives of fallible human beings, law is likewise incapable of being both permissive and respectful of privacy, while also requiring strict accountability and procedural standardization.

The fundamental problem with legalization of PAS and euthanasia lies in the nature of the physician-patient relationship—that it is conducted in private and protected by the ethical and legal requirements of confidentiality. Therefore, it is inherently inconsistent with on-site procedural regulation. There is also the added problem of the relationship of the state or society to the profession. By definition and by social contract, a profession enjoys a position of favor in society that is attributable to several factors. One is the presumption of greater education or training and expertise on the part of the professional. Another is the promise of the profession as a whole to promulgate codes of ethics and to regulate itself according to those codes. Professional autonomy, the most valued characteristic of professional groups, is honored by society and by the state (in its laws) on the basis of the promise of self-regulation.²⁸⁷ Commentators on this issue have pointed out that

Zarling, *Psychological Aspects of Pain in Terminal Malignancies*, in *MANAGEMENT OF PAIN IN CANCER* 213-14 (Schiffman ed. 1956).

286. Hendin, *supra* note 18, at 167 (1994); see also Sherry T. Sutton et al., *Pain Management in the Terminally Ill*, in *HANDBOOK OF CRITICAL CARE PAIN MANAGEMENT* 481, 493 (Robin J. Hamill & John C. Rowlingson eds., 1994).

287. See Criton A. Constantinides, *Professional Ethics Codes in Court: Redefining*

when professional codes (for example, the AMA Code of Ethics or the codes of the various sub-specialties of medicine) recognize an explicit commitment to the public trust, the public willingly accords autonomy to the profession on the promise of self-regulation.²⁸⁸ The courts have judicially recognized the medical profession's codes of ethics as the source of the public's trust in the profession:

[I]t is important to remember that the ethics of the medical profession constitute more than just a set of regulations affecting members of a particular profession; they also grant the public, specifically a patient seeking a physician's help, an affirmative right to rely on his physician to faithfully execute those ethical obligations.²⁸⁹

Legalization of PAS/euthanasia requires a fundamental and drastic realignment of all codes of medical ethics since Hippocrates. At the same time, it requires an adjustment on the part of the public to a new relationship to the medical profession. No longer would the general prohibition against killing or assisting in suicide, and the commitment to healing, be the linchpin of medical integrity. Henceforth, the commitment to healing would be quite unclear.

To regulate PAS, as well as legalize it, would require abandonment of both the privacy of the physician-patient relationship and the confidentiality of medical records and conversations. To regulate the decisionmaking process leading to physician-assisted suicide or euthanasia in a meaningful way, that is to supervise the decisionmaking process for compliance with statutory provisions on a case by case basis, would subject both physicians and patients to what we suspect would be an unacceptable and possibly humiliating intrusion. Declaring PAS or euthanasia a right or a liberty interest of constitutional proportions effectively precludes such an extensive burden on its exercise.

the Social Contract Between the Public and the Professions, 25 GA. L. REV. 1327 (1991).

288. *Id.* at 1351.

289. *Petrillo v. Syntex Laboratories*, 499 N.E.2d 952, 959 (Ill. App. Ct. 1986), *cert. denied*, 483 U.S. 1007 (1987).

We doubt in any event that the medical profession, or the universe of patients who would ultimately seek PAS or euthanasia, would in the long run endorse such a cumbersome and bureaucratic—indeed undignified—passage from life if they fully grasped its implications. The stated goals of those who propose legalization are compassion, dignity, privacy, and relief from suffering. We share their concerns, but we also believe it is impossible to provide this right or liberty interest in the context of a private relationship and at the same time enable its regulation. It is simply not reasonable to grant such awesome power to an already powerful profession, and to maintain its professional autonomy and the public's trust while pretending to regulate and monitor the practice of physician-assisted suicide and euthanasia. Even if one does not share our moral resistance to PAS, the problems of devising effective safeguards against abuse should by themselves be sufficient to cause grave worries and ultimate rejection of PAS.

The presumption that the law can prevent the abuse of authority is unfounded: laws alone cannot prevent abuse of any kind. The function of the law is to identify the range of permitted and prohibited behavior and to punish transgressions. Where the examined bills do address this question directly, as in Washington's "Terminally Ill Patient Act,"²⁹⁰ they nonetheless are crippled in their effect by the nature of the act being proposed and the privacy of the transactions. When one also takes into account the absence of any meaningful reporting requirements or any means of addressing violations of the proposed laws, the assertion that these bills will have any effect on abuse is simply unsubstantiated.

More importantly, the only purpose that will be achieved by these laws is to protect physicians and health care facilities from any liability for their actions in connection with PAS. Whether the legislation is crafted in excruciating detail and attempts to address all possible contingencies and even spells out various acts that are not approved, or whether it is a simple and straightforward offer to protect physicians, the result

290. Wash. S.B. 5596, 55th Leg. Sess., Reg. Sess. § 16(5) (1995) ("Nothing in this chapter may be construed to condone, authorize, or approve the deliberate ending of a life without a qualified patient's documented and witnessed request.").

will be the same. The only purpose that can be served, and the only goal achieved in practice by legislation, will be the deregulation of euthanasia and the de-criminalization and legitimization of PAS—in other words, the protection of the physicians and health care facilities. It will not, and cannot, achieve the goal of protecting patients or of preventing or limiting abuse. If protection of patients and meaningful regulation of PAS/euthanasia is the goal, no legislation can achieve it. If protection of physicians and health care providers who want to perform PAS is the goal, virtually any simple paragraph such as Connecticut's bill²⁹¹ will achieve this purpose.

AFTERWORD

Since the completion of this article in the summer of 1995, significant developments have occurred in the courts in Oregon and, of broader significance, in the Ninth Circuit which includes California, Washington and Oregon. On August 3, 1995, Judge Michael R. Hogan of the United States District Court in Oregon handed down his long awaited opinion on the constitutionality of that state's Death With Dignity Act,²⁹² ruling it unconstitutional on equal protection grounds.²⁹³ Arguing on several levels, Judge Hogan declared, much as we have here, that the safeguards in Oregon's Death with Dignity Act are drastically inadequate to protect vulnerable individuals such as the elderly, the infirm, the disabled, and the mentally unstable from subtle pressures to commit suicide, and that the difficulties inherent in assessing depression, competence, voluntariness, and life expectancy are insurmountable.²⁹⁴ Affirming that all persons are equally entitled to the state's protection against substandard medical care, Judge Hogan rejected the distinction between terminally ill patients who seek suicide and other persons who are suicidal, calling it "illusory."²⁹⁵ Such individuals, he argued, could not be deprived by a majority vote of their

291. *See supra* note 61.

292. *See supra* note 58.

293. *Lee v. Oregon*, 891 F. Supp. 1429 (D. Or. 1995).

294. *Id.*

295. *Id.* at 1433.

right to equal protection of the state's laws aimed at preventing suicide.²⁹⁶

Judge Hogan's decision is on appeal to the United States Court of Appeals for the Ninth Circuit. The Ninth Circuit also agreed to rehear its own prior ruling which found Washington's law prohibiting assisted suicide to be constitutional.²⁹⁷ The two-to-one panel decision was reheard by a court of eleven judges. The rehearing was granted in response to arguments submitted by Washington's chapter of "Compassion in Dying" (the pro-euthanasia society that filed the original lawsuit) that the decision was biased by the Catholic background of one of the judges. That decision, in March 1995, had reversed the ruling by the Chief Judge of the U.S. District Court in Seattle, Barbara Rothstein, that Washington's law against assisting suicide was unconstitutional. Judge Rothstein argued that seeking physician-assisted suicide was not constitutionally distinguishable from exercising the right to forego life sustaining treatment and that, therefore, there is a constitutional right to commit suicide and, by extension, to obtain a physician's help in doing so.²⁹⁸

The Ninth Circuit panel rejected Judge Rothstein's reasoning and maintained the constitutional distinction between committing suicide and refusing life sustaining treatment. This distinction holds, the court stated, because the right to forego life sustaining treatment is based on the line of cases establishing the right to be free of unwanted bodily intrusions and not, as Judge Rothstein had argued, on the line of cases establishing the right to abortion.²⁹⁹

Also during 1995, the Colorado legislature tabled its bill on assisted suicide, although it may still appear on the November 1996 ballot. Washington's version of the bill died in committee as did bills in Maryland, Virginia, and New Mexico³⁰⁰ not ex-

296. *Id.* at 1431.

297. *Compassion in Dying v. Washington*, 49 F.3d 586, *reh'g en banc granted*, 62 F.3d 299 (9th Cir. 1995).

298. *Compassion in Dying v. Washington*, 850 F. Supp. 1454 (W.D. Wash. 1994), *rev'd*, 49 F.3d 586 (9th Cir. 1995).

299. *Compassion in Dying*, 49 F.3d at 590.

300. New Mexico Senate Bill 446 expanded the definition of "terminal illness" to cover painful physical disability and mental illness and would have permitted lethal

amined here. The New Hampshire House Judiciary Committee voted in 1995 to put their bill aside while they study the question of alternatives to assisted suicide, but in 1996 the New Hampshire bill was defeated by a vote of 256 to 90 in the New Hampshire House.³⁰¹ Thus far, Oregon remains the only state to legalize physician-assisted suicide.

Although legalization appears to be moving rather slowly in the state legislatures, the same cannot be said of the courts. A Michigan jury, ignoring the provision of that state's law against assisting suicide, acquitted Dr. Jack Kevorkian of criminal charges for his role in helping two individuals to kill themselves.³⁰²

Even more significantly, on March 6, 1996, the Ninth Circuit Court of Appeals, after re-hearing the case of *Compassion in Dying v. State of Washington*, handed down a ruling which, if upheld, would provide supporters of legalization a strikingly broad and permissive framework within which to pursue their goals.³⁰³ In striking down the Washington law making physician-assisted suicide a felony, the court said that the law violated the Fourteenth Amendment's guarantee of personal liberty.³⁰⁴ The sheer scope of Judge Stephen Reinhardt's decision and reasoning is breathtaking. One wonders why the court believes it is necessary to move with such speed on this issue, particularly in light of evidence that the state's, presumably representing their constituent's views, are not moving forward to legalize or constitutionalize PAS.³⁰⁵ A full discussion of the Ninth Circuit decision is beyond the scope of this article, but we will make several observations which, we believe, support our assertion that legalization represents, at best, a mere facade of regulation by means of unenforceable guidelines and, at worst, an opening to state-sanctioned euthanasia.

injections administered by medical as well as non-medical personnel.

301. Nat Hentoff, *Dr. Kevorkian and Roe v. Wade*, WASH. POST, Mar. 16, 1996, at A17.

302. Jeff Martin et al., *Kevorkian Cleared: Jury Finds Doctor Didn't Break Law in Assisting Two suicides in 1993*, DET. FREE PRESS, Mar. 9, 1996, at A1.

303. *Compassion in Dying v. Washington*, No. 94-35534, 1996 WL 94848 (9th Cir. Mar. 6, 1996).

304. *Id.* at *12.

305. Marc Spindelmann, *Reliance on Public Opinion is Misplaced*, LEGAL TIMES, Mar. 25, 1996, at 23-24.

Meanwhile, a new proposal has emerged from academia which purports to strengthen the procedural aspects of Oregon's statute, correct some of the acknowledged weaknesses in that statute's regulatory features, and provide a "model" for future legislation in this area.³⁰⁶ We will discuss this proposal briefly before addressing the main features of the Ninth Circuit decision.

A. *The Harvard Model*

The authors of *A Model State Act to Authorize and Regulate Physician-Assisted Suicide* argue that the medical and ethical basis for physician-assisted suicide is relief of suffering,³⁰⁷ and that the legal basis is the extension of the right to make decisions on life-sustaining treatment.³⁰⁸ The existence of the latter right, they suggest, means that PAS does not signify a change in medical practice or public policy, but is "a natural and appropriate extension of presently accepted practices."³⁰⁹ For reasons already discussed, we disagree.

It is ironic that the authors of the model statute have chosen to confine their discussion to physician-assisted suicide and simply to ignore the issue of euthanasia. Framing their discussion in this way enables them to avoid noting that the distinction between passive and active euthanasia (removing artificial life support versus injecting lethal medication) is more sustainable than the distinction between physician-assisted suicide and voluntary active euthanasia. We agree with Professor Yale Kamisar's analysis of the implications of erasing the former distinction and the impossibility of maintaining the latter distinction for very long.³¹⁰ To offer a "model" statute that is based on failing to deal with this issue is intellectually strange.

The authors of the Harvard model admit that they choose to avoid addressing the issue of euthanasia out of concern for

306. Charles H. Baron et al., *A Model State Act to Authorize and Regulate Physician-Assisted Suicide*, 33 HARV. J. LEGIS. 1 (1996).

307. *Id.* at 4.

308. *Id.* at 5.

309. *Id.*

310. See Yale Kamisar, *Against Assisted Suicide—Even a Very Limited Form*, 72 U. DET. MERCY L. REV. 735, 749 (1995); Kamisar, *supra* note 71.

public opinion: the public, in their view, would be likely to offer "greater acceptance" of a statute allowing only PAS because of the "perception of voluntariness"³¹¹ and because there exist "strong ethical objections of some physicians and others to euthanasia."³¹² This is hardly a principled reason for avoiding the issue; it seems the triumph of politics over ethics.

The Harvard model neither avoids nor corrects any of the regulatory problems we have pointed out in this article. The inherent impossibility of truly limiting eligibility is acknowledged at the outset. The authors apparently voted on this question and the majority "agreed to allow anyone to be eligible whose illness is incurable and who subjectively feels that the accompanying suffering is worse than death."³¹³ There is, they admit, "no objective standard" for such a condition because it is inherently subjective.³¹⁴ Far from wanting to restrict the practice, the drafters acknowledged that "it was not possible to construct an objective definition that was not overly restrictive as to the patients who would meet it."³¹⁵ Since there is no "cure" for many of the degenerative effects of old age, when is an elderly person "incurable"? The criteria for eligibility remain as indeterminate, subjective, and impossible to limit as ever.

If eligibility is wide open, does the model statute contain viable means of safeguarding the vulnerable elderly or the abandoned cancer patient? The Harvard model contains the minimal requirement that requests for medical means of suicide must be competent, voluntary, informed, and enduring (made at least twice).³¹⁶ We have discussed at length our view that these are unworkable and unenforceable.

What about procedural requirements? The procedures are facilitative, not regulatory. They are intended to ensure that anyone desirous of suicide because of suffering and incurable illness will be able to do so, and that the physician who helps achieve this goal will not be subject to legal sanctions. The

311. *Id.* at 10.

312. *Id.*

313. *Id.* at 11.

314. *Id.*

315. *Id.*

316. *Id.* at 18.

model statute goes so far as to include a provision explicitly extending the blanket of legal immunity to anyone who "assist[s] the responsible physician in providing medical means of suicide to a patient."³¹⁷ What is meant by "assist"? These provisions are clearly not intended to protect patients or restrict the practice. They seem intended to facilitate the practice and protect the providers, apparently acting with or without any supervision by a physician.

Included in the Harvard model is an interesting provision about witnesses: two witnesses must be present for the discussion between the physician and patient regarding the request for medical means of suicide.³¹⁸ The witnesses may also question the patient and/or the physician to ascertain the level of comprehension of the information being provided.³¹⁹ In addition, the physician must document this discussion by written, signed transcript, or by means of audio or video taping. Interestingly, however, of these two witnesses, it is required only that one of them not be involved in the care of the patient and not stand to benefit from the patient's death.³²⁰ Why not preclude both witnesses from belonging to either of these categories? As it stands, it would appear that at least one witness may be either a care provider or stand to profit from the patient's death.³²¹ This provision would hardly seem to qualify as a safeguard.

The model statute would grant wide latitude to state agencies to craft their own rules and regulations for monitoring the suicide process, and to design the form on which physicians would supposedly report their compliance with suicide requests.³²² The model statute contains no provision urging or requiring any individual, professional or lay person, to report suspected violations of the statute. While purporting to offer

317. *Id.* at 30-32.

318. *Id.* at 28-29.

319. *Id.* at 28.

320. *Id.* at 24.

321. *Id.*

322. *Id.* at 22 ("The statute proceeds on the assumption that it is impossible in such a complex field to deal in advance with all possible problems by a legislative act. We believe that a reasonable solution is to enact the legislation and then to provide an administrative body with the power to respond to new patterns of problems through the regulatory rulemaking process.").

“strong safeguards and precise procedural requirements,”³²³ the operating principle of the model statute seems clear from the following:

Section 3(a) [of the model statute] places the responsibility on the responsible physician to ensure that all of its requirements are met. In order to provide the physician with considerable advance assurance that he or she can avoid litigation attempting to second-guess his or her determinations, *the statute makes the physician's standard entirely subjective: the physician need have only an "honest belief" that the elements of section 3(a) have been met in the particular case.*³²⁴

Thus, according to the Harvard proposal, the best that can be offered to reassure the public about adequate safeguards is that, in the event of allegations of malfeasance, the physician can avoid the scrutiny of public accountability through the legal system simply by asserting that it was his or her “honest belief” that the procedures had been appropriately followed.

Another example of the facilitative rather than protective function of the model statute is found in the provisions for consultation during the suicide decisionmaking process. The Harvard model appears to contain some regulatory “teeth” in its requirements for professional consultation prior to PAS. However, as one looks more closely at these provisions, they appear “curiouser and curiouser.” Section 5(a) requires the responsible physician to “secure a written opinion from a consulting physician. . . . that the patient is suffering from a terminal illness or an intractable and unbearable illness.”³²⁵ Section 5(b) requires the physician to “secure a written opinion from a licensed psychiatrist, clinical psychologist, or psychiatric social worker . . . to the effect that the request” for suicide is not the result of distorted judgment or undue influence, and is “reasoned” and “fully informed.”³²⁶ Section 5(c) then requires that the above opinions be placed in the patient’s record.³²⁷

323. *Id.* at 12.

324. *Id.* at 19 (emphasis added).

325. *Id.* at 29.

326. *Id.* at 29.

327. *Id.*

Doesn't this provide a system of checks on the accuracy and appropriateness of the decision? Not at all: the only opinions required to be obtained and placed in the record are opinions corroborating the appropriateness of the suicide. *There is no requirement anywhere that any contradictory opinion, any opinion questioning the appropriateness of the request for suicide, be placed in the record.*

Another interesting departure from the Oregon statute occurs in the provisions regarding reporting of the incidence of PAS. Although the Oregon statute seems drastically deficient in requiring only that the state Health Department annually review "a sample of records maintained pursuant to this statute," the Harvard model requires no annual review of any medical records by anyone. It requires only that participating physicians submit a "report" of the process, the content and form of which is determined by the state health commissioner.³²⁸ The regulatory process is therefore open ended and unspecified and is left to state discretion and, ultimately, the physician's assertion of good faith.³²⁹

What happens in the event of suspected abuse? The Harvard model does not define abuse. The only person reviewing the physician's report is the Commissioner of Public Health or some equivalent state employee. The possibility of the Commissioner obtaining the medical records of a patient in which the decision for PAS seemed questionable appears extremely remote: the Harvard model exempts medical records from public access under the state's public records statute or freedom of information act.³³⁰ Anyone requesting a medical record, therefore, would have to overcome these formidable barriers to access by providing substantial grounds for suspicion of malfeasance. It is difficult to imagine that any participating physician would submit a report containing evidence of unethical or illegal acts.

We are thus offered a model statute in which: (1) the basic criteria of suffering is acknowledged to be subjective and therefore impossible to define or determine by objective standards; (2) the safeguards are carried out by means of an honor system

328. *Id.* at 30.

329. *Id.* at 32.

330. *Id.* at 33.

of physician self-regulation; (3) the only professional consultations required and recorded are those supportive of the request for PAS; (4) the two individuals who witness the suicide discussion may consist of a beneficiary of the patient's will or an exhausted care provider; and (5) any allegation of malfeasance can be defeated by the physician's assertion of good faith.

The fact that the drafters of a model statute choose to sidestep the question of euthanasia entirely speaks volumes: if it were intended that the practice be limited to PAS, then surely the drafters of model legislation would want to demonstrate how that can be achieved in order to reassure the public. Since they fail to demonstrate any such limitations, we conclude that this is not their goal and that the omission serves as implicit acknowledgement of the impossibility of limiting the practice to PAS. We reiterate what so many have pointed out previously—that merely to assert the possibility of limiting this practice either to the terminally ill or only to the final stages of terminal illness,³³¹ or limiting it to physician-assisted suicide only³³²—is simply not good enough. Such assertions remain exactly that: assertions—unproven, unsubstantiated, ungrounded assertions, lacking evidence of workability in the real world of clinical medicine and in present day society. As discussed below, the courts also make these assertions of limitability without attempting in any way to demonstrate their validity.

B. *The Ninth Circuit Decision*

The 1996 Ninth Circuit ruling is an eight-to-three decision affirming the original District Court decision striking down Washington state's law prohibiting assisted suicide³³³ and overturning the 1995 appellate decision by a three-judge panel of the Ninth Circuit which had concluded that there is no due process liberty interest in physician-assisted suicide.³³⁴

331. See Robert A. Sedler, *Are Absolute Bans on Assisted Suicide Constitutional? I Say No*, 72 U. DET. MERCY L. REV. 725 (1995).

332. See Timothy E. Quill et al., *Sounding Board: Care of the Hopelessly Ill—Proposed Clinical Criteria for Physician-Assisted Suicide*, 327 NEW ENG. J. MED. 1380 (1992).

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

334. *Compassion in Dying v. Washington*, 49 F.3d 586 (9th Cir. 1995).

Judge Stephen Reinhardt, writing for the majority, found a constitutional right to physician-assisted suicide for the terminally ill, based on "the compelling similarities between right-to-die cases and abortion cases."³³⁵ Apart from the fact that both decisions involve death, and both decisions are therefore laden with intense moral significance, we believe there is precious little similarity between them. On the contrary, it is the differences which should draw attention. One obvious and relevant distinction, among many, is that abortion has an inherently self-limiting quality: it will never be undergone by anyone outside the universe of pregnant women. The two qualifying attributes of gender and pregnancy are objectively verifiable. Pregnancy is not a matter of opinion or perception, but is a condition subject to an objective test, the results of which can be confirmed by repetition.

By contrast, the characteristics that are alleged to define the parameters of eligibility for PAS have no such objective qualities and are not self-limiting. The problem with concepts like "terminal," "competent" and "voluntary" is not that they cannot be defined, but that the definitions are not *clinically* verifiable with tests or measurements. Although proponents of legalization, including Judge Reinhardt, assure the public repeatedly that the practice can be regulated by means of these established and definable categories of people (terminally ill, competent, suffering, and so on), there is no objective, agreed-on standard in clinical medicine for evaluating these conditions. Since the movement to establish a right to suicide entails establishing a clinical procedure that its proponents promise will be "carefully regulated"³³⁶ and subjected to "rigorous safeguards,"³³⁷ is it too much to expect that some aspect of the clinical evaluation be accessible to objective criteria? Regulation of abortion is, on the basis of clinical criteria, realistic and feasible; the outer limits are knowable and the physical indicia are observable. There are no such qualitative or quantitative limits to the decision for PAS.

335. *Compassion in Dying v. Washington*, No. 94-35534, 1996 WL 94848, at *7 (9th Cir. Mar. 6, 1996).

336. *Id.* at *37.

337. *Id.*

Even if one agrees that permissive attitudes towards abortion may result in more pregnant women choosing that option, the aim of the individual choosing abortion and society's ostensible goals are to protect or enhance the quality of the mother's health or life, either by removing a direct threat to her health or by enabling her to participate more fully in society. There is no comparable rationale for PAS; death does not enhance the well being of the deceased unless non-existence is defined as enhancement.

It is entirely possible that the availability and acceptability of PAS will enhance the lives of care givers, family members, even physicians and nurses, and that it will also enhance the economic well being of hospitals and insurers. The Ninth Circuit seems to acknowledge that patients may well be motivated to seek suicide because they perceive themselves to be a burden, and it suggests that the concern to avoid becoming a financial burden is laudable:

[W]e 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.³³⁸

By acknowledging and apparently approving of the patient's perception of illness as burdensome to others, the way is paved for the medical community and society as a whole to take the same view. Indeed, Judge Reinhardt briefly addresses and then dismisses³³⁹ the concerns that have been raised by a number of commentators, including Yale Kamisar, the New York State Task Force on Life and the Law,³⁴⁰ and John Pickering, Chair of the ABA Commission on Legal Problems of the Elderly,³⁴¹

338. *Id.* at *36.

339. *Id.*

340. See NEW YORK STATE TASK FORCE, *supra* note 6, at 125.

341. See Kamisar, *supra* note 310, at 737-39; see also John H. Pickering, *The Continuing Debate over Active Euthanasia*, BIOETHICS BULLETIN (ABA), Summer 1994, at 1, 2. Mr. Pickering expressed his opposition to a California ballot initiative to legalize physician "aid-in-dying," which included both PAS and active voluntary euthanasia:

[The resolution] calls for "voluntary aid in dying . . . without undue influence or duress. . . ." The lack of access to or the financial burdens of health care hardly permit voluntary choice for many. What may be

regarding the dangers of enacting PAS legislation in a society where gross inequities exist in health care as a result of disparate socio-economic conditions. We share the view that "voluntariness" is an idealized concept which fails to take into account the profound effects of poverty on all aspects of a person's life, health status, access to and quality of health care, as well as manner of death. Rather than seeing these inequities in our society as a compelling reason to maintain the prohibition against PAS and euthanasia, Judge Reinhardt takes the view that the judiciary should "stand aside from that battle." It is odd, indeed, to stand aside from a struggle to provide access to decent health care for everyone in our society, regardless of income or health status, and yet to lead the charge, as it were, toward unlimited access to means of death.

In rendering its opinion, the Ninth Circuit avoids resolving a number of crucial concerns regarding the feasibility of regulation by simply redefining terms and declaring certain previously valued moral distinctions of no importance. First to disappear is the use of the word "terminal" in any consistent manner that enables it to be a useful criterion. The court dismisses this difficulty at the outset with a curious argument. The court points out that, at present, at least forty states have enacted living will statutes that define "terminal illness" in widely varying and inconsistent ways. However, instead of viewing this as evidence of the malleability and permeability of the concept, the court views this definitional smorgasbord as evidence that "terminal" can, indeed, be defined, and so it is simply not a problem.³⁴² As we have pointed out, the issue is not whether the word can be defined, but whether the definition has any basis in clinical reality such that it makes sense to define a class of people in this manner, not only in order to exercise a constitutional right, but also to undergo a medical procedure resulting in death.

voluntary in Beverly Hills is not likely to be voluntary in Watts.

342. *Compassion in Dying*, No. 94-35534, at *32 ("While defining the term 'terminally ill' is not free from difficulty, the experience of the states has proved that the class of the terminally ill is neither indefinable nor undefined. Indeed, all of the persons described in the various statutes would appear to fall within an appropriate definition of the term.").

Even more troubling, however, is the court's attempt to eliminate the terms "suicide" and "euthanasia" from the discussion. In addressing the state's interest in preventing suicide, Judge Reinhardt writes:

We are doubtful that deaths resulting from terminally ill patients taking medication prescribed by their doctors should be classified as "suicide" . . . [because] deaths that result from patients' decisions to terminate life support systems or to refuse life-sustaining food and water, for example, are not.³⁴³

Thus, the court reasons, "we have serious doubt that the state's interest in preventing suicide is even implicated in this case."³⁴⁴ This seems an extraordinary line of reasoning.

Later, in its discussion of the dissent's arguments and concerns about potential abuse, the court tries to dismiss concerns about the inevitable extension of PAS to euthanasia by, again, redefining the terms. Euthanasia, the court insists, is only euthanasia when it is done *involuntarily*.³⁴⁵ The Ninth Circuit cites no reference for this definition: "the act or practice of painlessly putting to death persons suffering from incurable and distressing disease, as an act of mercy, but *not* at the person's request."³⁴⁶ Interestingly, *Black's Law Dictionary* defines euthanasia in exactly the same words, but makes no distinction at all between the involuntariness or voluntariness of the act.³⁴⁷ Most commentators have customarily used the term "non-voluntary euthanasia" when the patient is incompetent, "involuntary euthanasia" when it is done over the patient's protest, and "voluntary euthanasia" when the patient requests it.³⁴⁸ Now the Ninth Circuit declares that because the Washington statute at issue in *Compassion in Dying* is concerned with *requested* death, "the issue of euthanasia is not implicated here."³⁴⁹

343. *Id.* at *26.

344. *Id.*

345. *Id.* at *62 n.120.

346. *Id.* (emphasis in the original).

347. BLACK'S LAW DICTIONARY 497 (5th ed. 1979) ("The act or practice of painlessly putting to death persons suffering from incurable and distressing disease as an act of mercy.")

348. See *supra* notes 185-186.

349. *Compassion in Dying*, No. 94-35534, at *62 n.120.

Finally, the court opens the door to surrogate decisionmaking in this highly complex and complicated arena by focusing all its moral and legal attention on the issue of voluntariness:

[W]e view the critical line in right-to-die cases as the one between the voluntary and involuntary termination of an individual's life. . . . We consider it less important who administers the medication than who determines whether the terminally ill person's life shall end.³⁵⁰

Having effectively eliminated all lines of distinction and demarcation between refusing and removing unwanted medical treatment on the one hand, and providing the means to suicide on the other, the court finds no significant distinction between PAS and euthanasia; what matters is simply that it be "voluntary."³⁵¹ The Ninth Circuit has extraordinary confidence in the feasibility of regulation, the insignificant impact of poverty on health care and medical choices, and the quality of medical decisionmaking by patients and surrogates in this country's hospitals. The question of "voluntariness" is the central issue for the Ninth Circuit, and active euthanasia would be permissible by proxy because "a decision of a duly appointed surrogate decisionmaker is for all legal purposes the decision of the patient himself."³⁵² With all due respect, the decisions of surrogates are usually legally valid only if they accord with the patient's known or ascertainable instructions. A full discussion of this issue is beyond the scope of this article, but raises even more forcefully the importance of addressing the regulatory schemes in light of clinical experience in this area of medical decisionmaking.

The Ninth Circuit decision thus eviscerates the state's interest in preventing suicide or euthanasia by redefining both terms, and by eliminating every line of demarcation heretofore recognized in law and ethics along the continuum from refusing artificial means of life support to injecting a patient with a lethal dose of medicine. The court bypasses all concerns about the difficulty, if not impossibility, of providing clear or enforce-

350. *Id.*

351. *Id.*

352. *Id.*

able limits on the practice by declaring blandly that “while there is always room for error in any human endeavor, we believe that sufficient protections can and will be developed by the various states.”³⁵³ Where? Which state has done so? In its 153-page opinion, not once does the Ninth Circuit attempt to show how this might be accomplished. As we have discussed, we believe that even the Harvard model fails to demonstrate that this can be done.

In conclusion, we reiterate our contention that regulation of the practice of physician-assisted suicide is inherently impossible. We have shown that the intellectual and philosophical arguments of PAS proponents that are based on promises of limiting the practice—both in terms of numbers of eligible patients and in restricting the practice to physicians-assisted suicide—are contradicted by the statutes thus far proposed.

The Ninth Circuit has declared that, in its view, the Fourteenth Amendment’s liberty provisions include a right to assisted suicide. The Supreme Court will soon, no doubt, be faced with whether: (a) to uphold this assertion of a constitutionally protected liberty interest in obtaining medical assistance to hasten one’s death, such that the states may not prohibit PAS, or (b) to reject the view that the Fourteenth Amendment includes such an interest and therefore the states may permit or prohibit selective legalization of PAS as they choose. It remains to be seen whether individual state laws permitting PAS and/or euthanasia will be able to pass constitutional muster even if they result in what appears to us to be very dangerous public policy.

353. *Id.* at *34.

