PHYSICIAN-ASSISTED SUICIDE: DOES "THE END" JUSTIFY THE MEANS?

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I. INTRODUCTION

The nation is currently embroiled in an on-going, often heated and emotional debate over the "right to die."[1] The debate is centered on the rights of competent, terminally-ill patients who seek to die with dignity and with control over the manner and timing of their own deaths. Do these patients have a constitutionally protected right to commit suicide? If so, does that right include the right to the assistance of physicians,[2] and how does the state's right to protect its citizens impact these decisions?

Proponents of the right to physician-assisted suicide link it to the right to refuse life-sustaining medical treatment, which is protected by the Constitution.[3] They claim that the hastening of death of the terminally ill through physician-assisted suicide is no different than the physician's role when life-support treatment is stopped, or when a physician prescribes palliative treatment for patients knowing that the medication required to ease the pain will probably have the effect of

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1. *See, e.g.*, John Leo, *Taking A Right Turn*, U.S. NEWS & WORLD REP., Feb. 23, 1998, at 13; *Maine Lawmakers Reject Bill Allowing Doctor-Assisted Suicides*, N.Y. TIMES, Feb. 12, 1998, at A1; David Van Biema, *Death's Door Left Ajar: The Justices Deny a Sweeping Right to Assisted Suicide But Might Entertain More Modest Claims*, TIME, July 7, 1997, at 30.

2. Physician-assisted suicide

> [o]ccurs when a physician provides a patient with the medical means and/or medical knowledge to commit suicide. For example, the physician could provide sleeping pills and information about the lethal dose, while aware that the patient is contemplating suicide. In physician-assisted suicide, the patient performs the life-ending act, whereas in euthanasia the physician administers the death-causing drug or other agent.

John Glasson, *Report of the Council on Ethical and Judicial Affairs of the American Medical Association: Physician-Assisted Suicide (Resolution 3, A-93)*, 10 ISSUES IN L. & MED. 91, 92 (1994).

3. Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261, 278 (1990) (recognizing that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment).

causing the death of the patient.[4] Additionally, proponents contend that physician-assisted suicide is in fact already occurring in the guise of palliative treatments or undisclosed agreements between physicians and their patients. Therefore, if there is to be a true attempt to control these actions, the practice needs to be legalized, using standard procedures and controls to prevent abuse.[5]

On the other hand, opponents of assisted suicide, who have a significant amount of support from both the legal and medical communities, claim that assisting with suicide is substantially different from the termination of life-sustaining treatment or providing palliative care that results in a foreseeable death.[6] Opponents also point to the slippery slope towards voluntary and involuntary euthanasia that presents itself when assisted suicide is permitted, in even a limited form.[7]

Interwoven within the discussion of the rights of the individual to physician-assisted suicide is the role and the rights of the physician expected to assist in the suicide. The opposing sides in the controversy have widely differing views as to the role of the doctor. Proponents of assisted-suicide assert that the physician is trained and knowledgeable in the art of medicine, an art that includes aiding with a comfortable and dignified death just as much as it does with the rendering of help to the living.[8] Opponents claim that there is no role for a physician in the assistance of committing suicide.[9] The opponents look to the Hippocratic Oath and to the all-consuming duty of a physician to give life, not death.[10] They contend that permitting the physician to assist in suicides will erode both the integrity of the physician and her relationship with her patients.[11]

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4. *See, e.g.*, David Orentlicher, *The Legalization of Physician-Assisted Suicide*, 335 NEW ENG. J. MED. 663, 663 (1996) (arguing that the withdrawal of treatment causes death just as surely as assisted suicide, and that the real issue "is not whether assisted suicide causes death but whether it is a justifiable way to cause death").

5. *See generally* Jonathan R. Rosenn, *The Constitutionality of Statutes Prohibiting and Permitting Physician-Assisted Suicide*, 51 U. MIAMI L. REV. 875, 880–81 (1997) (discussing possible ways to legally treat the issue of assisted suicide).

6. *See infra* notes 133–41 and accompanying text.

7. *See* Washington v. Glucksberg, 117 S. Ct. 2258, 2274 (1997); *id.* at 2291 (Souter, J., concurring).

8. *See, e.g.*, Brief Amici Curiae of the American Medical Student Association and a Coalition of Distinguished Medical Professionals in Support of Respondents in *Vacco v. Quill* and *Washington v. Glucksberg* (No. 96-110) 1996 WL 709332.

9. *See, e.g.*, Brief Amici Curaie of the American Medical Association, the American Nurses Association, and the American Psychiatric Association in Support of Petitioners in *Vacco v. Quill* and *Washington v. Glucksberg* (No. 96-110) 1996 WL 656263.

10. AMERICAN MED. ASS'N, CODE OF MEDICAL ETHICS § 2.211 (1996) ("Physician-assisted suicide is fundamentally incompatible with the physician's role as healer....").

11. *Assisted Suicide in the United States: Hearing Before the Subcomm. on the Constitution of the Comm. on the Judiciary*, 104th Cong., 355–56 (1996) ("The patient's trust in the doctor's whole-hearted devotion to his best interests will be hard to sustain....").

The United States Supreme Court recently considered some of these issues in *Vacco v. Quill*[12] and *Washington v. Glucksberg*.[13] Additionally, the recent enactment of its "Death With Dignity Act" makes Oregon the first state in the nation to allow and establish controls for a physician-assisted suicide.[14]

Part II of this Note examines the narrowness of the decisions in *Vacco* and *Glucksberg* in finding statutes prohibiting physician-assisted suicide constitutional, while refusing to renounce physician-assisted suicide. Part III discusses the avenues for further experimentation by the states that the Court clearly left to be explored and considers the tensions within the legal and medical communities surrounding the rights and needs of the patient, the physician, and the state. Part III also briefly highlights how a few states have responded so far. Part IV concludes that any advantages gained by a loosening of the law and ethical standards relating to physician-assisted suicide are outweighed by the potential for abuse of the system and the diversion of attention and funds from improving treatment of depression in the terminally ill.

II. THE PROHIBITION OF PHYSICIAN-ASSISTED SUICIDE DOES NOT VIOLATE EQUAL PROTECTION OR DUE PROCESS

In 1997, the Supreme Court decided two cases challenging the constitutionality of similar New York and Washington State statutes that make it a crime to assist a person committing or attempting to commit suicide.[15]

A. Vacco v. Quill—*Equal Protection*

In *Vacco v. Quill*, a New York Statute[16] was challenged on grounds that it violated the Equal Protection Clause of the Fourteenth Amendment.[17] The respondents were a group of physicians who asserted that they were deterred from providing medical treatment to "mentally competent, terminally ill patients."[18] The

12. Vacco v. Quill, 117 S. Ct. 2293 (1997).

13. Washington v. Glucksberg, 117 S. Ct. 2258 (1997).

14. OR. REV. STAT. §§ 127.800–897 (1997); *Statelines Oregon: Voters Uphold Physician-Assisted Suicide Law*, APN AM. HEALTH LINE, Nov. 5, 1997 ("Oregon voters Tuesday strongly reaffirmed their support of doctor-assisted suicide on the same day the state attorney general's office said the original law is now in effect."); *Statelines Oregon: Struggles with Assisted-Suicide Implementation*, APN AM. HEALTH LINE, Nov. 7, 1997 ("The Oregon Health Division issued emergency rules Wednesday for implementing the state's Death with Dignity Act.").

15. *Vacco*, 117 S. Ct. 2293; *Glucksberg*, 117 S. Ct. at 2258.

16. N.Y. PENAL LAW § 125.15 (McKinney 1987) provides: "A person is guilty of manslaughter in the second degree when:...(3) He intentionally causes or aids another person to commit suicide. Manslaughter in the second degree is a class C felony." Additionally § 120.30 provides: "A person is guilty of promoting a suicide attempt when he intentionally causes or aids another person to attempt suicide. Promoting a suicide attempt is a class E felony."

17. *Vacco*, 117 S. Ct. at 2296.

18. *Id.* at 2296–97 (citing the declarations of Timothy E. Quill, M.D., Samuel C. Klagsbrun, M.D., and Howard A. Grossman, M.D.). The treatment the physicians sought to

physicians challenged the prohibition against assisted suicide alleging a violation of the Equal Protection Clause of the Fourteenth Amendment because New York allows a competent person to refuse life-sustaining treatment.[19] The physicians asserted that the refusal of life-sustaining medical treatment is essentially the same action as physician-assisted suicide.[20]

The recognition of a distinction between withdrawal of life-support treatment and assisted-suicide is viewed as vitally important and logical by parties opposing assisted-suicides. The distinction, which is recognized by both the medical and legal professions,[21] arises from the basic cause and intent effects of the treatments. When a patient refuses medical treatment and dies, death is caused by the underlying fatal condition;[22] however, when a patient ingests a lethal dose of a drug prescribed by a physician, death is caused by the treatment of the illness.[23] The intent of the physician who stops life-supporting treatment is a compliance with the patients wishes where a foreseeable consequence may be the hastened death of the patient.[24] However, neither the patient nor the physician may have the primary specific intent that the patient die.[25] In direct contrast is the intent of the physician who prescribes a fatal drug medication for the purpose of assisting a patient to commit suicide. Here, the physician's intended purpose is that the patient die.[26] Two acts that have the same result are not viewed the same under the law

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provide included the prescription of a lethal dose of medication for the purpose of assisting the patient to commit suicide. *Id.* at 2296.

19. Quill v. Koppell, 870 F. Supp. 78, 84 (S.D.N.Y. 1994) ("It is established under New York law that a competent person may refuse medical treatment, even if the withdrawal of such treatment will result in death."). *See* N.Y. PUB. HEALTH LAW art. 29-B, §§ 2960–79 (1987) (regulating the right of an adult with capacity to direct issuance of orders not to resuscitate); N.Y. PUB. HEALTH LAW art. 29-B, §§ 2980–94 (1994) (allowing for the appointment of agents to make health care decisions for the principal including decisions to refuse lifesaving treatment).

20. *Vacco*, 117 S. Ct. at 2296.

21. *Id. See also* Glasson, *supra* note 2, at 92 ("Assisted suicide also must be distinguished from withholding or withdrawing life-sustaining treatment, in which the patient's death occurs because the patient or the patient's proxy, in consultation with the treating physician, decides that the disadvantages of treatment outweigh its advantages and therefore treatment is refused.").

22. *See, e.g., In re* Colyer, 660 P.2d 738, 743 (Wash. 1983) ("[D]eath which occurs after the removal of life sustaining systems is from natural causes."); Glasson, *supra* note 2, at 93 ("When a life-sustaining treatment is declined, the patient dies primarily because of an underlying disease.").

23. *See, e.g.*, People v. Kevorkian, 527 N.W.2d 714, 728–29 (Mich. 1994) (discussing the distinction between withdrawal of treatment and deliberately seeking death).

24. *See* Glasson, *supra* note 2, at 92.

25. *Vacco*, 117 S. Ct. at 2299 ("[P]atients who refuse life-sustaining treatment 'may not harbor a specific intent to die' and may instead 'fervently wish to live, but to do so free of unwanted medical technology, surgery, or drugs.'") (citing Matter of Conroy, 486 A.2d 1209, 1224 (N.J. 1985)); Superintendent of Belchertown State School v. Saikewiscz, 370 N.E.2d 417, 426 n.11 (Mass. 1977) ("[I]n refusing treatment the patient may not have the specific intent to die.").

26. *Vacco*, 117 S. Ct. at 2299.

when the intent behind the acts is different.[27] Furthermore, the right to refuse medical treatment is based in the doctrine of informed consent,[28] and finds strong long-standing support in tort law.[29] This right does not extend to a general and abstract right to hasten death.[30] The medical community strongly supports maintaining a bright line between refusal of life-sustaining treatment and assisted-suicide.[31]

The Court found both the ban on assisted suicide and the permitting of patients to refuse medical treatment applied equally to all competent people.[32] In its decision, the Court recognized the state's distinction between the withdrawal of life-support treatment and assistance with a suicide.[33] The Court also determined that this distinction was not arbitrary and that the statutes governing those rights treated everyone equally. Therefore, the laws complied on their faces with, and the prohibition of physician-assisted suicide was not in violation of, the Equal Protection Clause.[34]

B. Washington v. Glucksberg—*Due Process*

In *Glucksberg*, the Court analyzed Washington's prohibition against causing or assisting in a suicide and the Fourteenth Amendment's Due Process Clause.[35] The Washington statute terms assistance in an attempted suicide as a felony.[36] The challenge made against the statute, upheld by the

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27. *Id.*

28. Cruzan v. Director, Missouri Dept. of Health, 497 U.S. 261, 269 (1990).

29. *See, e.g.*, Pratt v. Davis, 79 N.E. 562 (Ill. 1906) (discussing a patient's right to refuse treatment, the court stated: "the free citizen's first and greatest right which underlies all others–the right to the inviolability of his person, in other words, his right to himself...necessarily forbids a physician, however skillful or eminent...to violate without permission the bodily integrity of his patient...."); Schloendorff v. Society of N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914) ("Every human being of adult years and sound mind has a right to determine what shall be done with his own body."). See generally the laws of battery and informed consent, where medical treatment performed without the patient's consent violates principles of individual autonomy and can be treated as battery. W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS §§ 9, 32 (5th ed. 1984).

30. *Vacco*, 117 S. Ct. at 2301.

31. *See* DANIEL CALLAHAN, THE TROUBLED DREAM OF LIFE: IN SEARCH OF A PEACEFUL DEATH 77–78 (1993) ("[T]here must be an underlying fatal pathology if allowing to die is even possible. Killing, by contrast, provides its own fatal pathology. Nothing but the action of the doctor giving the lethal injection is necessary to bring about death.").

32. The Court noted that regardless of any class restrictions, any competent person is permitted to refuse unwanted medical treatment; and that no one is permitted to assist in a suicide. *Vacco*, 117 S. Ct. at 2297–98.

33. *Id.* at 2298.

34. *Id.* at 2296.

35. Washington v. Glucksberg, 117 S. Ct. 2258, 2261 (1997).

36. WASH. REV. CODE § 9A.36.060(1) (1975) states: "A person is guilty of promoting a suicide attempt when he knowingly causes or aids another person to attempt suicide." Additionally, §§ 9A.36.060(2) (1975) and 9A.20.021(1)(c) (1982) provide that promotion of a suicide attempt is a class C felony, punishable by up to five years imprisonment and up to a $10,000 fine. Washington's position on withdrawal of life-

Ninth Circuit,[37] asserted that the Due Process Clause includes a liberty interest that allows control in the time and manner of one's death.[38] Furthermore, the Ninth Circuit court determined that this interest is such that there is a constitutionally protected right to commit suicide and a right to assistance in taking your own life.[39] The Supreme Court, however, determined that the "asserted 'right' to assistance in committing suicide is not a fundamental liberty interest protected by the Due Process Clause."[40]

The Due Process Clause provides heightened protection against government interference with certain "fundamental" rights and liberty interests.[41] The Court conducts a substantive due process analysis whenever it examines the scope of a liberty interest in attempting to determine whether or not an asserted "right" is so fundamental as to be protected by the Due Process Clause.[42] Here, the Court reviewed the long-standing tradition in Anglo-American common-law followed by the states prior to ratification of the Fourteenth Amendment, and which continues today, criminalizing suicide and assisted-suicide.[43] The Court

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support is provided for in its Natural Death Act (1979), which states that the withholding or withdrawal of life-sustaining treatment at a patient's direction "shall not, for any purpose, constitute a suicide...." WASH. REV. CODE § 70.122.070(1) (1979). Section 70.122.051 (1992) provides that a physician who, in accordance with a directive from a patient, withholds or withdraws life-sustaining treatment is immune from civil, criminal, or professional liability.

37. Compassion in Dying v. Washington, 79 F.3d 790 (9th Cir. 1996).

38. *Id.* at 816.

39. *Id.* at 837. The court discussed the balancing of the constitutionally protected interest in controlling the time and manner of death against the state's interests in prohibiting assisted suicide:

> [N]o matter how much weight we could legitimately afford the state's interest in preventing suicide, that weight...is insufficient to outweigh the terminally ill individual's interest in deciding whether to end his agony and suffering by hastening the time of his death with medication prescribed by his physician.... [T]he state has wide power to regulate, but it may not ban the exercise of the liberty interest....

Id.

40. *Glucksberg*, 117 S. Ct. at 2271. *See also* Glasson, *supra* note 2, at 93 (The American Medical Association noted that: "[t]he right of self-determination is a right to accept or refuse offered interventions, but not to decide what should be offered. The right to refuse life-sustaining treatment does not automatically entail a right to insist that others take action to bring on death.").

41. *Glucksberg*, 117 S. Ct. at 2267 (citations omitted).

42. *Id.* at 2267–69. The substantive due process analysis considers the following: (1) is the fundamental liberty interest "so rooted in the traditions and conscience of our people as to be ranked as fundamental" Snyder v. Massachusetts, 291 U.S. 97, 105 (1934), and "implicit in the concept of ordered liberty...[such that] neither liberty nor justice would exist if they [the asserted interests] were sacrificed." Palko v. Connecticut, 302 U.S. 319, 325–26 (1937); and (2) the Court requires a "careful description" of the asserted fundamental right. Reno v. Flores, 507 U.S. 292, 302 (1993).

43. *Glucksberg*, 117 S. Ct. at 2262–67 (noting that for over seven hundred years the common-law has disapproved of both suicide and assisted suicide; that the early American colonies adopted the common-law approach; that by the time of ratification of the

concluded that "[a]ttitudes toward suicide itself have changed since Bracton,[44] but our laws have consistently condemned, and continue to prohibit, assisting suicide."[45] And "[t]he history of the law's treatment of assisted-suicide in this country has been and continues to be one of the rejection of nearly all efforts to permit it.... [T]he asserted 'right' to...committing suicide is not a fundamental liberty interest protected by the Due Process Clause."[46]

The respondents contended that, regardless of history, the Court supports a general tradition of "self-sovereignty," citing the Court's decisions in *Cruzan v. Director, Missouri Dept. Health*, and *Planned Parenthood of Southeastern Pennsylvania v. Casey*.[47] In response, the Court contrasted the lack of historical legal protection afforded assisted suicide against the common-law doctrine of informed consent which provides the basis for protecting the right to refuse medical treatment.[48] Additionally, the Court noted that refusal of unwanted medical treatment and a right to assisted-suicide "are widely and reasonably regarded as quite distinct."[49]

In *Casey*, the Court noted that many of the fundamental rights protected by the Due Process Clause related to "personal decisions...involving the most intimate and personal choices a person may make in a lifetime."[50] The respondents in *Glucksberg* argued that because the decision of how and when to die is a most intimate and personal choice, it is a protected liberty interest. However, the Court limited *Casey*, stating that though many of the liberties protected by the Due Process Clause sound in personal autonomy, *Casey* does not stand for the proposition that all such decisions are protected by the Fourteenth Amendment.[51]

Finally, the Court turned to the Due Process requirement that a state law be rationally related to legitimate government interests. The Court concluded that the state has easily shown sufficient legitimate state interests in prohibiting assisted suicide to satisfy this requirement of Due Process constitutionality[52] and

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Fourteenth Amendment, it was a crime in most states to assist a suicide; that although many states have recently proposed changes to legalize physician-assisted suicide none had yet done so; and that as recently as April of 1997, the Federal Assisted Suicide Funding Restriction Act of 1997 was signed into law, prohibiting the use of federal funds in support of physician-assisted suicide) (citations omitted). Oregon has since enacted changes to legalize physician-assisted suicide, see OR. REV. STAT. §§ 127.800–897 (1997).

44. Henry de Bracton, a legal scholar in the thirteenth century, noted that suicide was a felony. *Glucksberg*, 117 S. Ct. at 2263 (citation omitted).

45. *Id.* at 2267.

46. *Id.* at 2271.

47. *See* Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261 (1990); Planned Parenthood of Southeastern Pa. v. Casey, 505 U.S. 833 (1992).

48. *Glucksberg*, 117 S. Ct. at 2270 (citing *Cruzan*, 497 U.S. at 277–79).

49. *Id.* (citing Vacco v. Quill, 117 S. Ct. 2293, 2298 (1997)).

50. *Casey*, 505 U.S. at 851 (citations omitted).

51. *Glucksberg*, 117 S. Ct. at 2271.

52. *Glucksberg*, 117 S. Ct. at 2272–75. The Court discusses legitimate state interests of (1) an unqualified interest in the preservation of human life, *Cruzan*, 497 U.S. at 282; (2) protection of otherwise vulnerable groups such as the young, old, poor, disabled, depressed and mentally ill; (3) protection of the integrity and ethics of the medical

determined that Washington's prohibition against causing or assisting in a suicide does not violate the Fourteenth Amendment's Due Process Clause.[53]

III. FALLOUT FROM *VACCO* AND *GLUCKSBERG*: THE STATES AS THE LABORATORY FOR EXPERIMENTS IN THE PHYSICIAN-ASSISTED SUICIDE DEBATE

The recent Supreme Court decisions have laid down a foundation for the states to vigorously continue the assisted suicide debate.[54] The Court in *Vacco* recognized the difference between assisted suicide and the protected right of withdrawal of life-sustaining treatment.[55] In *Glucksberg*, the Court held that, at least at this time, the right to assisted suicide is not a "fundamental" right that will derive protection from the Due Process Clause of the Fourteenth Amendment.[56] However, the separate concurring opinions filed in *Glucksberg*, of Justices Souter,[57] O'Connor,[58] Stevens,[59] and Breyer[60] all emphasized the narrowness of the decisions. While protecting states that choose to ban physician-assisted suicides, the Court deliberately refrained from stating that the adoption of a statute permitting assisted suicide would be unconstitutional.

Justice O'Connor concurred in the *Glucksberg* opinion in so far as it states that there is no generalized right to commit suicide.[61] However, she limited the decision, leaving an open door for further debate on physician-assisted suicide.[62] "[R]espondents urge us to address the narrower question whether a mentally competent person who is experiencing great suffering has a constitutionally cognizable interest in controlling the circumstances of his or her

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profession; and (4) protection against the slippery slope effect the state fears will occur once it permits even very limited assisted suicide.

53. *Glucksberg*, 117 S. Ct. at 2261.

54. *Id.* at 2275 ("Throughout the Nation, Americans are engaged in an earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should..."); *Vacco*, 117 S. Ct. at 2302 n.13:

> Justice Stevens [in his concurring opinion]observes that our holding today 'does not foreclose the possibility that some applications of the New York statute may impose an intolerable intrusion on the patient's freedom.' ...This is true, but...a particular plaintiff hoping to show that New York's assisted-suicide ban was unconstitutional...would need to present different and considerably stronger arguments than those advanced by respondents here. (citations omitted).

55. *See supra* notes 16–34 and accompanying text.

56. *See supra* notes 35–46 and accompanying text.

57. *Glucksberg*, 117 S. Ct. at 2275 (Souter, J., concurring).

58. Washington v. Glucksberg, Vacco v. Quill, 117 S. Ct. 2302, 2303 (1997) (O'Connor, J., concurring).

59. *Id.* at 2304 (Stevens, J., concurring).

60. *Id.* at 2310 (Breyer, J., concurring).

61. *Id.* at 2303.

62. *Id.*

imminent death. I see no need to reach that question...."[63] She noted that she expects a state's interest in protecting those who might seek to end their lives under coercion or by mistake can, and will be, balanced against the interests of the terminally ill, mentally competent people that seek to end their suffering.[64] The states will find this balance as they continue to evaluate physician-assisted suicide.[65]

While Justice Stevens also concurred in the opinion, he too left open the door for further debate.[66] He agreed with the Court that the Due Process Clause does not provide a liberty interest of a categorical right to commit suicide that in itself includes a right to assistance in doing so.[67] However, he noted that the constitutionality of the general statutory ban on assisted-suicide does not validate every application of that ban.[68] If a state has authorized the death penalty, it has concluded that the sanctity of human life does not require that it always be preserved;[69] therefore, in those states, it must follow that there are some "situations in which an interest in hastening death is legitimate."[70] This being the case, Stevens went so far as to say that he is "convinced that there are times when [the interest in hastening death] is entitled to constitutional protection." [71]

Justice Souter's concurring opinion in *Glucksberg* emphasized that the constitutionality of Washington's ban on physician assisted suicide is drawn from the legitimacy of the state's interests, rather than a decision that there is no fundamental right to commit suicide.[72] Souter suggested that the respondents'

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63. *Id.*

64. *Id.*

65. *Id.* ("States are presently undertaking extensive and serious evaluation of physician-assisted suicide.... In such circumstances, 'the...challenging task of crafting appropriate procedures for safeguarding...liberty interests is entrusted to the laboratory of the States....'") (citations omitted).

66. *Id.* at 2304 (1997) (Stevens, J., concurring) ("[O]ur holding today is fully consistent with a continuation of the vigorous debate about the 'morality, legality, and practicality of physician-assisted suicide' in a democratic society.") (citations omitted).

67. *Id.* at 2305.

68. *Id.* at 2304. ("Today, the Court decides that Washington's statute prohibiting assisted suicide is not invalid 'on its face,' that is to say, in all cases in which it might be applied. That holding, however, does not foreclose the possibility that some applications of the statute might well be invalid.") (citations omitted).

69. *Id.* Justice Stevens noted that the Supreme Court has "concluded that a State does have the power to place a lesser value on some lives than on others; there is no absolute requirement that a State treat all human life as having an equal right to preservation."

70. *Id.* at 2305.

71. *Id.* Additionally, Justice Stevens, after a discussion of the various legitimate state interests presented by Washington in support of its ban on physician-assisted suicide, concluded that "[a]lthough...these potential harms are sufficient to support the State's general public policy against assisted suicide, they will not always outweigh the individual liberty interest of a particular patient." *Id.* at 2309.

72. Washington v. Glucksberg, 117 S. Ct. 2258, 2290 (1997) (Souter, J., concurring) ("Whether [the individual interest in physician-assisted suicide] might in some circumstances, or at some time, be seen as 'fundamental' to the degree entitled to prevail is

arguments are soundly based.[73] However, he concluded that the states, not the Court, are the appropriate place for experimentation and fact-finding when issues emerge for discussion and that the Court should allow the states to experiment.[74] Furthermore, his concurring opinion in *Vacco* shows he believes that this question has not been resolved.[75]

Following the Justices' clear mandate for further debate, the remainder of this Note discusses critical issues that the states will face as they address physician-assisted suicide and how the states have initially reacted to the Justices' challenge.

A. Physicians Assisting Suicide: Issues Confronting the States, Physicians, and Patients

A majority of the medical profession continues to support a position against physician-assisted suicide which has been an integral part of the medical profession since the ancient Greeks.[76] The question is, how do the states view this position? Do the states have a strong interest in supporting the integrity of the physician and maintaining the current relationship between the doctor-patient? Or is the patient autonomy argument, predominately presented by supporters of physician-assisted suicide, an interest that overwhelms the physicians' interests? Finally, what are the states' interests in the preservation of the lives of their citizens?

The Supreme Court in deciding *Vacco* and *Glucksberg*, clearly has left the debate over physician-assisted suicide open, with the desire that the states will act as "laboratories" to help determine the final outcome of the issue.[77] A critical issue in the states' "experiments" will be their consideration of the need to support the medical profession in its attempts to maintain the integrity of the profession, by continuing to criminalize physician-assisted suicide, against the patient's rights to autonomy. An underlying issue in this decision is whether or not patient autonomy actually includes a right to suicide.[78] Additionally, if indeed patient autonomy

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not...a conclusion that I need draw here, for I am satisfied that the State's interests...are sufficiently serious to defeat the present claim that its law is arbitrary or purposeless.")

73. *Id.*

74. *Id.* at 2293. (Souter notes that the states are quickly going to experiment, and cites the OR. REV. STAT. §§ 127.800–127.897 as an example of such experimentation.).

75. Vacco v. Quill, 117 S. Ct. 2293, 2302 (1997) (Souter, J., concurring) ("Even though I do not conclude that assisted suicide is a fundamental right entitled to recognition at this time....") (emphasis added).

76. *See infra* notes 81–91 and accompanying text.

77. *See supra* notes 55–76 and accompanying text.

78. Philosophers have certainly disagreed on the suicide question. *See, e.g.*, NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT 80–81 (1994) (noting that Kant believed that the taking of one's own life was inconsistent with the notion of autonomy, but that Hume found suicide as an acceptable decision if life was plagued with suffering).

bestows a right to choose suicide, does this include a right to request the help of another in the task?[79]

1. The "Role" of a Physician Is Irreconcilable with Assisted-Suicide

a. The Physicians' Ethical Position and Their Traditional Role

The Hippocratic Oath has for centuries been taken by physicians as they begin their careers in medicine.[80] The Oath requires the physician to refrain from assisting in any manner with a patient's suicide, either actively or by suggestion: "I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect."[81] The Oath prohibits assisting in suicide because the end that medicine ethically serves is the health of the human body and the curing of its illnesses and diseases. To assist in any manner in the death of the patient would go against this most basic of ideals.[82]

Many commentators have argued that the Oath has been severely compromised over the years because the original Oath also contains passages that require a physician to refrain from conducting any kind of surgery and abortions.[83] However, the medical profession in the United States has continued to use modified versions of the Oath and has not wavered in its' absolute repugnance of physician-assisted suicide.[84]

The American Medical Association ("AMA")[85] has defined physician-assisted suicide as occurring when "a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act."[86] In its Code of Medical Ethics, the AMA unequivocally

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79. In judging the right to assisted-suicide, it is important to note the difference between a right to refuse treatment (and thus hasten death) and a right that an affirmative action be taken by a physician.

80. ENCYCLOPEDIA OF BIOETHICS, app. at 2632 (Warren T. Reich ed., rev. ed. 1995).

81. *Id.*

82. Leon R. Kass & Nelson Lund, *Physician-Assisted Suicide, Medical Ethics and the Future of the Medical Profession*, 35 DUQ. L. REV. 395, 402 (1996).

83. ENCYCLOPEDIA OF BIOETHICS, *supra* note 81, at 2632. (The original Oath continues: "I will not give to a woman an abortive remedy,...I will not use the knife,...but will withdraw in favor of such men as are engaged in this work.").

84. The American Medical Association, the American Nurses Association, and the American Psychiatric Association, in their Amicus Brief to the Supreme Court in *Glucksberg* stated: "The power to assist in intentionally taking the life of a patient is antithetical to the central mission of healing that guides both medicine and nursing." Brief Amici Curiae of the American Medical Association, *supra* note 9, at 1.

85. The AMA is a private, voluntary, non-profit organization of physicians. It has approximately 290,000 members who practice medicine in all states and all fields of medical specialization. *Id.* at 1a.

86. CODE OF MEDICAL ETHICS, *supra* note 10, § 2.211. *See, e.g.*, Timothy E. Quill, *Death and Dignity: A Case of Individualized Decision Making*, 324 NEW ENG. J. MED. 691 (1991) (describing a physician's personal account of physician-assisted suicide,

rejects any role of the physician in an assisted-suicide, stating that physician-assisted suicide is "fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks."[87] Unlike the Hippocratic Oath, the Code of Medical Ethics has been reviewed continually by the AMA in recent years and has remained unchanged on this issue.[88]

Clearly, the medical community has maintained a strong position against physician involvement in a patient's suicide. Physicians recognized this at the time of Hippocrates and distinguished even then between allowing a patient to die and actively causing the patient's death.[89] They used the Oath to protect themselves and their patients from their own possible weaknesses. From ancient times to the present, physicians have recognized a need to give their profession a code of ethics.[90] And this code has steadfastly provided that physicians acting with an intent to cause death goes against the most basic of medical ethics.

b. The Doctor-Patient Relationship

Proponents of physician-assisted suicide argue that its prohibition destroys the doctor-patient relationship. They assert that the prohibition conflicts with the medical profession's respect for patient autonomy, forcing doctors to abandon their patients and stopping patients from seeking the doctor's help.[91] The patient, no longer able to rely on the help of the doctor, turns to either attempting suicide without help or seeking the assistance of a lay person. Furthermore, the prohibition creates a lack of openness and causes a chilling effect on the patient's willingness to communicate with his or her doctor.[92] Proponents believe that patients who trust their doctors will not suddenly lose that trust if the doctor supports their decision to die and is willing to actively participate in the death causing act.[93]

Countering these positions, opponents consider the role of the doctor in the doctor-patient relationship as one of counselor and confidant; the doctor's effectiveness in many ways is determined primarily by the amount of trust that the

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including the physician's intentionally providing his patient with the means for suicide, by prescribing barbiturates in an amount certain to cause death).

87. CODE OF MEDICAL ETHICS, *supra* note 10, § 2.211.

88. The AMA has examined and reaffirmed its ethical prohibition on physician-assisted suicide several times in the last twenty years, in 1977, 1988, 1991, 1993, and 1996. AMA Council on Scientific Affairs, *Good Care of the Dying Patient*, 275 JAMA 474, 477 (1996).

89. Kass & Lund, *supra* note 83, at 403.

90. *Id.* The fact that these physicians from long ago recognized an ethical obligation to their profession is easily seen in the oath itself: "[I]n purity and holiness I will guard my life and my art." ENCYCLOPEDIA OF BIOETHICS, *supra* note 81, at 2632.

91. *See, e.g.*, Brief Amici Curiae of The American Medical Students Association, *supra* note 8, at 11–13.

92. *See, e.g., id.* at 16–17.

93. Robert T. Hall, *Final Act: Sorting Out the Ethics of Physician-Assisted Suicide*, 54:6 HUMANIST 10, 14 (Nov./Dec. 1994).

patient has in the doctor. This trust is essential if the patient is to reveal the intensely private physical and mental feelings to the doctor required for the doctor to make an informed decision that will most help the patient.[94] However, if a physician is licensed to take the life of a patient, this trust would be seriously undermined. For example, patients may suddenly be reluctant to speak candidly about the symptoms they are feeling for fear of the discussion of a "voluntary" death.[95] Or, perhaps even more disturbingly, a patient may resist treatment out of fear that the doctor is not thinking of how to heal, but rather how to be cost-effective.[96]

Given the public's current diminishing regard for the health care profession, the major changes that are occurring in fields of managed care and health insurance, and a highly publicized desire by leaders in these fields to cut costs, it is easy to believe that patients will suspect the advice of a doctor prescribing death.[97] Add to this list the pressures on physicians to comply with the current cost-saving push, and the trust between the doctor and the patient looks to be very susceptible to erosion. The doctor-patient relationship will be diminished if doctors are given the power to assist in suicides.

2. Difficulties in Defining Rights and the Slippery Slope to Euthanasia

Opponents of assisted-suicide have questioned the ability to determine who will have the right to a physician's help in dying. Various standards have been offered as the patient population that would be allowed to receive physician-assisted suicide including, "competent and terminally-ill,"[98] "competent terminally-ill in severe pain and suffering,"[99] or "in the final stages

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94. Evidence that this trust has been recognized and supported by society can readily be seen in the privilege granted to the doctor-patient relationship. JOHN W. STRONG ET AL., MCCORMICK ON EVIDENCE, §§ 99, 143 (4th ed. 1992).

95. Kass & Lund, *supra* note 83, at 409; Susan D. Block & J. Andrew Billings, *Patient Request to Hasten Death*, 154 ARCH. INTERN. MED. 2039, 2045 (1994) (proposing that a doctor's refusal to hasten death could harm the doctor-patient relationship as the patient may feel abandoned, rejected or even disgraced for making such a request). *But see* Quill, *supra* note 87 at 694 (arguing that helping a patient commit suicide would not harm the physician-patient relationship).

96. *See generally* Kass & Lund, *supra* note 83, at 406–10 (arguing that the discussion of a physician-assisted suicide option as treatment will severely undermine the trust in the doctor-patient relationship).

97. This is a major concern of the medical profession, as can be discerned from the AMA's arguments to the Supreme Court in *Glucksberg*: "The ban on physician-assisted suicide helps ensure that patients will never lose the trust that must exist for the relationships between health care professionals and patients to flourish." Brief Amici Curiae of the American Medical Association, *supra* note 9, at 30.

98. OR. REV. STAT. § 127.805 (1997) ("An adult who is capable...and has been determined by the attending physician and consulting physician to be suffering from a terminal disease [defined as having less than six months to live]...may make a written request for medication for the purpose of ending his or her life....").

99. Washington v. Glucksberg, Vacco v. Quill, 117 S. Ct. 2302, 2303 (1997) (O'Connor, J. concurring) ("[R]espondents urge us to address the narrower question

of terminal illness."[100] Regardless of which standard a state chooses to use, how will it be defined and implemented? Is less than six months to live an accurate description of terminal? What should be done about chronically ill patients, perhaps suffering from a tremendous amount of pain and suffering, but with years to live? What should be done about terminally ill but incompetent patients? Will the assistance of the physician be limited to providing a means to die, or will the physician actually administer the lethal treatment?

For hospice care, "terminally-ill" is usually defined as having less than six months to live.[101] Yet, one study found that almost 15% of patients in hospice care live longer than 180 days, and more than 8% longer than a year, and this was in a patient population with a median age of over 76.[102] This suggests that in 15% of cases a determination of "terminally-ill" as less than 6 months to live is wrong even in an aging population—so should the definition be a year—which would mean that only 8% would be incorrectly diagnosed? Clearly, there is a significant variation in how long a "terminal" patient will live. When viewed in terms of medicine and admission criteria for hospice care, this variation may not be critical. However, when considered in terms of a standard which will define whether or not a doctor can assist a patient with their suicide, a choice of 6 months seems arbitrary. If the definition is extended, to a year, or 18 months, will a physician have such a broad leeway that there will be virtually no way to find liability against the physician, thus diminishing control of the process?[103]

Additionally, if an element of "pain and suffering" exists in a standard, how will this be determined? Pain is generally considered to be a physical sensation, suffering a psychological state.[104] Both are subjective, highly individualized sensations.[105] Moreover, many terminal illnesses do not have major pain associations, and in more than ninety percent of the cases where pain is

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whether a mentally competent person who is experiencing great suffering has a constitutionally cognizable interest in controlling the circumstances of his or her imminent death.").

100. Richard E. Coleson, *The* Glucksberg *&* Quill *Amicus Curiae Briefs: Verbatim Arguments Opposing Suicide*, 13 ISSUES L. & MED. 3, 50 (1997).

101. Nicholas A. Christakis & Jose J. Escarce, *Survival of Medicare Patients After Enrollment in Hospice Programs*, 335 NEW ENG. J. MED. 172 (1996) (studying survival rates of 6451 Medicare patients enrolled in hospice programs).

102. *Id.* at 172, 174.

103. In the Netherlands, controls on euthanasia requirements are seemingly ignored by physicians in approximately 1000 cases per year, at no cost to the physician. *See* Henk A.M.J. ten Have & Jos V.M. Welie, *Euthanasia in the Netherlands*, 12 CRITICAL CARE CLINICS 97, 101 (1996).

104. CALLAHAN, *supra* note 31, at 95.

105. *See generally* NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, *supra* note 79, at 39 (In treatment of pain, "[t]he appropriate dosage of pain medication can vary tremendously among patients or for the same patient over time.... While half the patients [with advanced cancer] received less than 100 IM morphine equivalent milligrams per day...some patients...required more than nine times that dosage.") (citations omitted).

present, it is controllable.[106] There is no correlation between a given medical condition and the amount of suffering of a given individual.[107] Practically, how will a physician determine if a patient is in sufficient pain and suffering to be covered by any standard?

Furthermore, as difficult as it is to determine the lines between those terminally ill and those in the last stages of terminal illness, what of the chronically ill? The pain and suffering of the chronically ill patient could be equal to the terminal patient's and arguably could be even worse considering that the chronically ill might have a much longer period of pain and suffering to endure.[108] What 'rights' to assisted suicide will we give to such patients?

Oregon is the first state in the nation to pass laws legalizing physician-assisted suicide.[109] The current Oregon statute limits the request for assisted suicides to the provision of a lethal dose of drugs to the mentally competent who have less than six months to live.[110] In setting up the statute, the Oregon legislature has not yet addressed whether the rights of the patient will include the physician doing more than the prescribing of the lethal drug dose.[111] The statute is silent about the rights of the patient who is physically unable to self-administer the drugs and the physician's duty in such cases.[112] The statute is also silent on the chronically ill and/or chronically in pain patients, and has focused solely on the terminally ill.[113] However, the Ninth Circuit, in discussing its decision in *Compassion In Dying*, clearly inferred that it had considered the situations of patients other than the terminally ill.[114]

It is inevitable that challenges to statutes that restrict the right of physician-assisted suicide to only the terminally ill will come from other patient

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106. *See* HARRY VAN BOMMEL, CHOICES: FOR PEOPLE WHO HAVE A TERMINAL ILLNESS, THEIR FAMILIES AND THEIR CAREGIVERS 12 (1986) (discussing pain control and the myths associated with pain medication). *See also* Tony O'Brien, *Symptom Control, in* THE MANAGEMENT OF TERMINAL MALIGNANT DISEASE 34 (Cicely Saunders & Nigel Sykes eds., 3d ed. 1993) (noting that pain occurs in approximately seventy percent of patients with advanced stages of cancer, and that good pain control is possible in approximately ninety-five percent of patients).

107. *See* CALLAHAN, *supra* note 31, at 102 (noting that suffering is highly subjective and variable from one person to another).

108. Yale Kamisar, *Against Assisted Suicide—Even a Very Limited Form*, 72 U. DET. MERCY L. REV. 735, 737–41 (1995).

109. OR. REV. STAT. §§ 127.800–127.897 (1997). *See infra* notes 153–60 and accompanying text.

110. OR. REV. STAT. § 127.805 (1997).

111. OR. REV. STAT. §§ 127.800–127.897 (1997).

112. *Id.*

113. *Id.*

114. Compassion In Dying v. Washington, 79 F.3d 790, 816 (9th Cir. 1996), *rev'd sub nom.* Washington v. Glucksburg, 117 S. Ct. 2258 (1997). In deciding the *Glucksberg* case, the Ninth Circuit stated, "Our conclusion is strongly influenced by, but not limited to, the plight of mentally competent, terminally ill adults. We are influenced as well by the plight of others, such as those whose existence is reduced to a vegetative state or a permanent and irreversible state of unconsciousness."

populations such as the chronically ill. Challenges to definitions of terminally ill and the extent of the physician's role in administering lethal drugs also need to be addressed. If the physician is to be allowed to prescribe a lethal dose of drugs to a patient who can physically self-administer the taking of the drugs, what are the rights of the patient who is viewed as mentally competent but physically unable to administer the lethal dose? Equity would seem to require euthanasia, and suddenly the slippery slope seems very real.

3. Suicide Requests Are not Truly Voluntary

Running throughout the whole debate for and against physician-assisted suicide is the assertion by opponents of suicide, assisted or not, that the real problem is one of lack of good health care treatment for patients who are depressed and/or in pain.[115] The AMA recommendations to medical professionals instead of the acceptance and practice of physician-assisted suicide are that:

• it is critical that the medical profession redouble its efforts to ensure that dying patients are provided optimal treatment for their pain and discomfort;

• health care professional with expertise in the psychiatric aspects of terminal illness should provide evaluation and treatment in order to alleviate the suffering that leads a patient to desire assisted suicide;

• physicians must resist the natural tendency to withdraw physically and emotionally from their patients;

• requests for physician-assisted suicide should be a signal to the physician that the patient's needs are unmet and further evaluation to identify the elements contributing to the patient's suffering is necessary; and

• further efforts to educate physicians about advanced pain management techniques, both at the undergraduate and graduate levels, are necessary to overcome any shortcomings in this area.[116]

Opponents of suicide contend that with good palliative care and treatment for depression very few patients would ever actually voluntarily request death.[117] In

115. *See* Stephanie Graboyes-Russo, *Too Costly to Live: The Moral Hazards of a Decision in* Washington v. Glucksberg *and* Vacco v. Quill, 51 U. MIAMI L. REV. 907, 916–17 (1997); Anthony L. Back et al., *Physician-Assisted Suicide and Euthanasia in Washington State: Patient Requests and Physician Responses*, 275 JAMA 919, 919 (1996).

116. Glasson, *supra* note 2, at 96–97. The AMA also recommended the use of more aggressive comfort care measures to alleviate the physical and emotional suffering that dying patients experience; multidisciplinary intervention, including specialty consultation, pastoral care, family counseling, hospice care, and other modalities, should be sought as clinically indicated. And, when the treatment goals for a patient in the end stages of a terminal illness shift from curative efforts to comfort care, the level of physician involvement in the patient's care should in no way decrease. Additionally, the AMA noted that physicians should recognize that courts and regulatory bodies distinguish between use of narcotic drugs to relieve pain in dying patients and use in other situations.

117. *See* Coleson, *supra* note 101, at 14 ("When patients suffering from terminal illness are given proper palliative and supportive care, the desire for assistance with suicide

fact, there appears to be strong evidence that pain has very little to do with a patient's request for suicide.[118]

Depression is the only consistent factor that has been found to be an indicator of a desire or request for suicide or death.[119] If the amount of pain is actually shown not to affect a patient's decision, where does this leave the standard for those requesting suicide? Certainly, a narrow standard requiring pain such as discussed by Justice O'Connor would seem inappropriate.[120]

Assuming that the current research is correct in naming depression as the determinative factor behind suicide wishes, better treatment of depression is preferable to a legalization of physician-assisted suicide. Additionally, by allowing assisted suicide to become a treatment option, incentives to conduct research in the areas of palliative medicine and depression will be significantly reduced as need for these treatments declines. Furthermore, the incentives to offer these options will change for the patient, doctor, family, hospital, HMO, and insurance company involved.[121]

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generally disappears."). *See generally* Glasson, *supra* note 2, at 95 ("The provision of a humane, low technology environment in which to spend their final days can go far in alleviating patients' fears of an undignified, lonely, technologically dependent death.").

118. Back, *supra* note 116 at 924 (finding in a study of recent requests to physicians in Washington State for assisted-suicide from their patients that "neither severe pain nor dyspnea was a common patient concern, suggesting that intolerable physical symptoms are not the reason most patients request physician-assisted suicide or euthanasia"); Ezekiel J. Emanuel et al., *Euthanasia and Physician-Assisted Suicide: Attitudes and Experiences of Oncology Patients, Oncologists, and the Public*, 347 LANCET 1805, 1809 (1996) ("Patients experiencing pain were not inclined to euthanasia or physician-assisted suicide."); James Henderson Brown et al., *Is it Normal for Terminally Ill Patients to Desire Death?* 143 AM. J. PSYCH. 208, 210 (1986) (reporting that, in a study of forty-four patients in the later stages of cancer, only three had considered suicide, and each of them had a severe clinical depression). *But see* Ezekiel J. Emanuel, *Euthanasia: Historical, Ethical, and Empirical Perspectives*, 154 ARCH. INTERN. MED. 1890, 1897 (1994) (discussing the Remmelink Commission Report, an empirical study commissioned by the Dutch government in 1991, which reported that the most common reason to request euthanasia was a loss of dignity (57%), while pain was the second most common reason (46%)).

119. Emanuel et al., *Euthanasia and Physician-Assisted Suicide*, *supra* note 119, at 1809 ("One of our most striking findings is that patients who had seriously considered and prepared for euthanasia or physician-assisted suicide were significantly more likely to be depressed."); Harvey Max Chochinov et al., *Desire for Death in the Terminally Ill*, 152 AM. J. PSYCH. 1185, 1190 (1995) ("We found that depression, pain, and low family support were significantly intercorrelated with one another,...depression emerged as the only predictor of the desire for death."); James Henderson Brown et al., *supra* note 119, at 210 (1986) (presenting a study of 44 terminally ill patients in which 10 of 11 patients with "clinical depressive illness" expressed some death wish, while none of the 33 not suffering from depression did so).

120. *See supra* note 100.

121. Kass & Lund, *supra* note 83, at 406.

Although the Oregon statute and others proposed all depend upon a voluntary request by a patient,[122] the manner in which a treatment option is presented to a patient will undoubtedly go a long way in determining the actual treatment requested by the patient.[123] It seems reasonable to assume that the "insurance-poor" and other health-care disadvantaged groups such as the elderly, disabled, and minorities will receive unequal guidance about options to physician-assisted suicide.[124] For example, if the Oregon model is followed, then patients on Medicare and Medicaid would be faced with a situation in which a state has legalized physician-assisted suicide and mandatory health care rationing.[125] Coverage for life-sustaining treatment that is not cost-effective could be denied while the cost of a physician-assisted suicide would be covered.[126] In this situation, where do patient autonomy and voluntariness stop and outside interests start?[127] If the choice is between living for as long as possible only if you can afford to, or only at the cost of leaving your family in a financial quagmire on one hand, and a quick, cheap, and "easy" way out on the other, is the suicide still voluntary?

Even patients with health insurance coverage could come under considerable pressure to request suicide if their plan refuses coverage of other options. This possibility is increasingly real—the courts have already set precedents allowing HMOs to deny coverage for treatments thought to be

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122. OR. REV. STAT. §§ 127.800–127.897 (1997).

123. NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, *supra* note 79, at 121–22.

124. Patient populations that are receiving inadequate palliative care and depression treatment are more likely to accept a suicide option. Block & Billings, *supra* note 96, at 2040–41. Health-care facilities with predominately minority patient populations have been found to be three times more likely to have inadequate pain management than non-minority facilities. Charles S. Cleeland et al., *Pain and Its Treatment in Outpatients with Metastatic Cancer*, 330 NEW ENG. J. MED. 592, 595 (1994).

125. Richard M. Doerflinger, *Conclusion: Shaky Foundations and Slippery Slopes*, 35 DUQ. L. REV. 523, 529 (1996).

126. *Id.* Already, Oregon is planning to include coverage for assisted suicide in its state health plan. *All Things Considered* (National Public Radio broadcast, Feb. 27, 1998).

127. *See, e.g.*, Leonard M. Fleck, *Just Caring: Assisted Suicide and Health Care Rationing*, 72 U. DET. MERCY L. REV. 873, 873–74(1995). Professor Fleck argues:

> If voluntary active euthanasia or physician-assisted suicide were socially permitted options,...[vulnerable groups such as the elderly, terminally ill, and disabled] could be subtly cajoled into choosing this type of death. This would result in additional health care savings and provide society with a 'compassionate' response to the otherwise pointless suffering these individuals would endure. But, quite obviously, this is not compassion in any morally defensible sense. Rather, it is a clear compounding of injustices. It is the worst kind of discrimination hypocritically masked as compassion.... A more accurate label for this sort of practice would be nonvoluntary social euthanasia.

Id.

experimental or futile.[128] Furthermore, the health insurance companies appear ready to provide coverage for assisted suicides.[129]

In looking to the Netherlands for guidance on this question,[130] it appears obvious that "voluntariness" is a difficult requirement to effectively evaluate and regulate, even in seemingly extreme circumstances.[131]

4. Palliative Care, Refusal of Treatment, and Physician-Assisted Suicide

Proponents of a right to physician-assisted suicide claim that the role of the physician already includes the administration of death both through palliative care treatments that result in the death of the patient and through the cessation of treatment of a patient.[132] Furthermore, they argue that these "assisted deaths" are

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128. *See, e.g.*, Barnett v. Kaiser Found. Health Plan, 32 F.3d. 413, 417 (9th Cir. 1994) (holding that a managed care plan could refuse to pay for a life-saving liver transplant, rejecting the patient's assertion that the decision was motivated by financial concerns, and holding that a "poor survival rate is an acceptable medical criterion" for determining whether to offer a treatment).

129. Most private insurers have indicated that they will be providing coverage for the prescriptions of lethal dose drugs that the physician prescribes in order to assist a patient with a suicide, potentially adding to the pressures faced by patients and families with minimal health care coverage and the financial burdens of a long illness. *All Things Considered*, *supra* note 127.

130. The Netherlands is one of the few countries that has allowed euthanasia, though still strictly speaking criminal, to be practiced extensively. A physician involved in a euthanasia case must make a report to the authorities; based on the report, the state decides whether to prosecute or not. ten Have & Welie, *supra* note 104, at 98.

131. *See, e.g.*, ten Have & Welie, *supra* note 104, at 100–01 (noting that the 1991 Remmelink Committee's discovery [in an empirical study of euthanasia in Holland commissioned by the Dutch government] of approximately 1000 deaths each year caused or hastened by physicians without the required patient requests has been a non-issue in the Netherlands; this, in a country where euthanasia is practiced about 2300 times a year); Herbert Hendin, *Seduced by Death: Doctors, Patients, and the Dutch Cure*, 10 ISSUES IN L. & MED. 123 (discussing a 1993 case in the Netherlands, in which a Dutch psychiatrist, Dr. Chabot, was acquitted after assisting with the suicide of a physically healthy fifty year old woman, who was obviously suffering from depression after the recent death of her two sons and divorce from her husband. Chabot had determined that the woman's depression was irremediable and had justified her death. The Dutch Court agreed. With this case, the Dutch tolerance for assisted-suicide and euthanasia has now passed beyond the terminally ill, even beyond the chronically ill to the merely severely depressed.).

132. Brief Amici Curiae of The American Medical Students Association, *supra* note 8, at 2–9. (The brief supports the belief that there is no clinical basis for distinguishing between the physician's role in the death of a patient who refuses life-sustaining treatment and a terminally-ill patient who makes a choice to hasten death with the assistance of a physician; and that the difference between a physician's treatment of a patient without the intent to bring death, but with knowledge that death is a foreseeable circumstance of the effort to relieve suffering does not withstand scrutiny.).

currently occurring "underground" in significant numbers and without any regulation or guidelines.[133]

Although the illegality of the practice affects many physicians' decisions when they contemplate a patient's request to die, it is inadequate to say that illegality is the primary reason for the refusal of the majority of such requests. [134] Clearly, the medical community believes in the distinctions it has identified between physician-assisted suicide and both the withdrawal of life-sustaining treatment and death due to the "double effect" occurring when patients die during palliative treatment.

The "double effect" occurs when a terminally ill patient, who will suffer from extreme pain without palliative care in the form of major doses of pain-killing drugs, chooses, in consultation with her physician, to receive treatment that may, as a secondary effect, cause death.[135] Physicians have long maintained that there is a critical distinction, created by the intent of the treatment, between a line of treatment that may have death as a secondary result even when that death is foreseeable and assisted suicide when death is the primary intent.[136] The AMA

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133. *Id.* at 18. ("Both statistical and anecdotal evidence indicate that the practice of physician-assisted suicide, although illegal in virtually all states, is prevalent throughout the United States."). *See also* Back, *supra* note 116, at 919, 922–23 (reporting that, in a study of physicians from Washington state, 1443 doctors were asked whether they had been requested to assist a suicide or perform euthanasia on terminally ill patients in the previous 12 months. Of the 828 doctors that responded, 218 had received such requests and a total of 39 doctors had complied with such requests, three doctors had provided both assisted suicide and euthanasia. Thirty-two doctors had provided a lethal prescription to 38 patients (assisted suicide), and 12 doctors had provided a lethal injection to 14 patients (euthanasia)); David J. Doukas et al., *Attitudes and Behaviors on Physician-Assisted Death: A Study of Michigan Oncclogists*, 13 J. CLINICAL ONCOLOGY 1055, 1058 (1995) (Thirty-eight percent (of 154) of Michigan's practicing oncologists had received requests for suicide assistance, and 18% had complied with those requests; 43% had received requests for euthanasia, and 4% had complied with those requests.).

134. Back, *supra* note 116, at 922 (Only 12% of physician's refused to assist in a patient's suicide because of concerns over the legality of their actions.).

135. Washington v. Glucksberg, Vacco v. Quill, 117 S. Ct. 2302, 2310 (1997) (Stevens, J., concurring).

136. *See, e.g.*, Kass & Lund, *supra* note 83, at 421:

> [I]t is wrong to say that the current use of intravenous morphine in advanced cancer patients already constitutes a practice of medical killing. The physician here intends only the relief of suffering, which presupposes that the patient will continue to live in order to be relieved. Death, should it occur, is unintended and regretted.
>
> ...Such cases [of palliative care with the double effect of death] are distinguished from the morally illicit efforts...that indirectly "relieve suffering" by deliberately providing a lethal dose of the same drug—that is, by eliminating the sufferer. Here we have a deliberate embrace of deadly harm, which is never sanctioned by medical ethics.

See also C. Everett Koop, *The Challenge of Definition*, HASTINGS CTR. REP., Jan.–Feb. 1989, Supp. at 3. In discussing a hypothetical treatment of an old woman with a powerful painkiller, the former Surgeon General stated:

recognizes and supports this distinction in its Code of Medical Ethics. The Code unequivocally promotes the role of the physician in a palliative care situation that may foreseeably hasten death,[137] while denouncing any role in physician-assisted suicide.[138]

Additionally, major improvements in patient care are occurring in the palliative care field.[139] The argument that a patient should be able to request assisted-suicide for relief of pain and suffering is losing ground with every step forward in the field of pain-management care. When combined with the growing evidence that pain is not a significant factor in a patient's request for assisted suicide,[140] it is unlikely that the AMA's position on this issue will change in the foreseeable future.

5. The State Has an Overriding Interest in the Preservation of the Life of Its Citizens

In *Roe v. Wade*, the Supreme Court ruled that a woman has a constitutionally protected liberty interest to autonomy over her body during the first trimester of her pregnancy.[141] The Court also ruled that the state has sufficient legitimate interests in the life of its citizens such that it could regulate treatments that the woman received after the first trimester of the pregnancy.[142] However, once the fetus is viable, the state, in the interests of protecting its citizens, can stop a woman from having an abortion to protect the life of the fetus-citizen.[143] In *Planned Parenthood of Southeastern Pennsylvania v. Casey*, the Court reaffirmed these rights, stating that an abortion was akin to "personal decisions relating to marriage,...child rearing, and education,...[which involve] the most intimate and personal choices a person may make in a lifetime, choices central to personal

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> The intent behind the gradual administration of drugs is to be her ally in her remaining hours or days of her life and to keep her reasonably comfortable as she slips away. The intent behind...the drug overdose [as an assisted suicide] is to get her "out of her misery" –and off our hands– as quickly as possible.

137. CODE OF MED. ETHICS, *supra* note 10, § 2.20 provides that "[p]hysicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This [obligation] includes providing effective palliative treatment even though it may foreseeably hasten death."

138. *See id.*, § 2.211.

139. *See, e.g.*, AMA Council on Scientific Affairs, *supra* note 89, at 475 ("The potential for management of pain has recently improved, both through the development of better techniques and through enhanced care delivery through hospice and palliative care efforts.") However, even though techniques for pain management continue to improve, some experts in the field still report that effective pain management is lacking, due in part to a lack of training of health care professionals in the care of the dying patient. *Id.* at 475, 477.

140. *See supra* note 119 and accompanying text.

141. Roe v. Wade, 410 U.S. 113, 154–55, 163 (1973).

142. *Id.* at 155, 163.

143. *Id.* at 163–64.

dignity and autonomy...."[144] Furthermore, the Court noted that such personal choices are "central to the liberty protected by the Fourteenth Amendment.... [And] [a]t the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life."[145]

These cases would seem to strongly suggest that the right to choose the time and manner of one's own death would be protected as a liberty of choice "central to personal dignity and autonomy."[146] However, in conferring upon the woman a right to choose how to treat her body, the Court simultaneously provided the state with the intrest in the regulation of the treatment that the woman received in order to protect her and/or the fetus' life.[147] Furthermore, the Court has often recognized limits to personal autonomy that can be placed on an individual with a showing by the state of a legitimate state interest.[148] Thus, the question of personal autonomy and a liberty interest in choosing to end one's own life with the aid of another is far from clear.

Regardless of the answer to the personal autonomy/liberty interest question, and given that the decisions in *Vacco* and *Glucksberg* have left enough room for experimentation to suggest that the Court may allow physician-assisted suicides, do the states have a strong enough interest in protecting the lives of their citizens to prohibit assisted suicide? When considered in purely economical terms, it might be argued that if the states can truly restrict the physician-assisted suicides to the terminally ill, a suicide would be a favorable result for the state.[149] However, the difficulty in determining the citizens eligible for assisted-suicide,[150] combined with the potential for abuse of the system resulting in disproportionate suicides among traditionally defenseless groups,[151] suggests that the states need to be very careful indeed in making their decisions.

It is reasonable to believe that the states have a very strong interest in preventing the use of physician-assisted suicide. Certainly, until the medical community can reliably determine who is terminally ill, such that it is ready to recommend protocols that can be accurately implemented thereby helping to minimize abuses, the states have a role to play as prohibitor, rather than as mandator, of physician-assisted suicide.

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144. Planned Parenthood of Southeastern Pa. v. Casey, 505 U.S. 833, 851 (1992).

145. *Id.*

146. *Id.*

147. *Id.* at 860; Roe v. Wade, 410 U.S. at 163–64.

148. *See, e.g.*, Washington v. Harper, 494 U.S. 210, 221 (1990) (holding a state has a legitimate interest in welfare and control of prisoners such that it can administer anti-psychotic medicine to mentally ill patients/prisoners over their objections); Jacobson v. Massachusetts, 197 U.S. 11, 24–30 (1905) (allowing Massachusetts to require the administration of vaccinations and stating that the Fourteenth Amendment does not give an absolute right to be "wholly freed from restraint").

149. If it can be shown that a citizen is about to die, the relatively inexpensive overdose could look as appealing to the state as any other insurance carrier concerned about future health costs.

150. *See supra* notes 99–115 and accompanying text.

151. *See supra* notes 123–28 and accompanying text.

B. Initial Reactions of the "Laboratories"

Oregon, the state at the forefront of this debate, has continued to push for the creation of a right to physician-assisted suicide.[152] In the first few months since the Oregon Death With Dignity Act became effective in late 1997, ten people have requested prescriptions for lethal medications under the state's assisted-suicide law.[153] Eight of the ten took the medication, while two died from their underlying illnesses without taking the lethal prescription.[154] The Oregon statute requires the requesting patient be capable, suffering from a terminal disease, be consulted by two physicians, and make the voluntary request in writing.[155] The patient is not required to undergo counseling before making the decision;[156] nor is the patient required to discuss the decision with any family members.[157] The patient is required to sign a consent form.[158] The Oregon Health Division is currently conducting in-depth interviews of the physicians that assisted with the suicides and will report its findings in early 1999.[159]

However, even in Oregon several questions remain as to the validity of the law, and there is at least one outstanding challenge to the state's law allowing physician-assisted suicide.[160] Other states seem to be refusing to experiment with

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152. *Statelines Oregon: Taxes May Subsidize Assisted Suicide*, APN AM. HEALTH LINE, Feb. 27, 1998. The Oregon Heath Services Commission Chair said in reponse to the commission's support of the proposition that "taxpayers should help pay for the doctor-assisted suicides of terminally ill poor people," that "[p]hysician-assisted suicide has been going on for years. In Oregon we're just bringing it out in the open.").

153. *Oregon: Health Officials Issue First Report on Use of State's Physician-Assisted Suicide Law*, BNA HEALTH CARE DAILY REP., Aug. 20, 1998. [hereinafter *Health Officials Issue First Report*]. Under the law, OR. REV. STAT. §§ 127.800–127.897 (1997), physicians must report any suicides they assist with to the Oregon Health Division. The initial reports show that all ten cases were correctly documented, all ten patients were diagnosed as capable of making the suicide decision, and all ten complied with a fifteen-day waiting period required by the statute between the first and second requests for the lethal prescription. The average time from taking of the drugs to death was forty minutes; the average time from obtaining a prescription for the drugs until death was two days.)

154. *Id.*

155. OR. REV. STAT. § 127.805 (1997).

156. OR. REV. STAT. §§ 127.800–127.897 (1997).

157. *Id.*

158. OR. REV. STAT. § 127.897 (1997).

159. *Health Officials Issue First Report*, *supra* note 154.

160. *Oregon: Federal Judge Postpones Final Decision On Fate Of Controversial Assisted Suicide Law*, BNA DAILY HEALTH CARE REP., Feb. 12, 1998. (A federal court judge has postponed a final decision on the fate of a much litigated challenge to Oregon's assisted suicide law. In 1994, the Judge issued an injunction claiming the law lacked sufficient safeguards to assure the competency of patients choosing physician-assisted suicide. The Ninth Circuit vacated the decision based on a lack of standing. The injunction has been lifted and the law is in effect, but the Judge has refused to dismiss the case. Assisted-suicide opponents are attempting to add a new plaintiff to the case in the hope of continuing their challenge to the law. The Ninth Circuit did not deal with the case on its merits, only stating that the original plaintiffs lacked standing.).

physician-assisted suicide. For example, Virginia[161] and Maine[162] have stiffened their resolve to stop any physician-assisted suicides. Michigan recently passed new laws with potentially high penalties for physicians who assist in a suicide attempt.[163] However, the Michigan legislation may not be effective for very long, as supporters of legalized physician-assisted suicide have placed an initiative supporting their position on the November, 1998 ballot.[164]

No doubt as the debate continues more states will be forced to directly address the issue. Presumably, the Supreme Court itself will have to re-visit the issue as these new laws go into effect and parties from both sides challenge the laws.

IV. CONCLUSION

At the end of all the legal discussions, and no matter their outcome, the final decision after an assisted suicide request will rest with the individual physicians themselves. As already noted, some physicians are assisting with patient suicides regardless of the law.[165] With very little chance of prosecution, even, apparently, in states that outlaw physician-assisted suicide,[166] physicians currently can act as they feel fit in a given situation.

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161. VA. CODE ANN. § 8.01-622.1 (D) (Michie 1998) provides: "[A] licensed health care provider who assists or attempts to assist a suicide shall be considered to have engaged in unprofessional conduct for which his certificate or license to provide health care services in the Commonwealth shall be suspended or revoked by the licensing authority." Additionally, VA. CODE ANN. § 8.01-622.1 (C) (Michie 1998) provides: "[A] spouse, parent, child or sibling of a person who commits or attempts to commit suicide may recover compensatory and exemplary damages in a civil action from any person who provided the physical means for the suicide...."

162. *Statelines Maine: House Rejects Physician-Assisted Suicide Bill*, APN AM. HEALTH LINE, Feb. 13, 1998: "'Members...of the Maine House voted 99–42 Wednesday to reject a bill legalizing physician-assisted death for terminally ill patients.... [The bill] received a 12–1 ought-not-to-pass recommendation last month from the Legislature's Judiciary Committee.' Lawmakers criticized the bill on 'ethical, religious and moral grounds.'" Opponents of the bill hope that its rejection will concentrate attention on the life-affirming alternatives for terminally ill patients and that work to improve Maine's efforts in hospice care and pain management will increase.

163. *Michigan: Engler Signs Bill Banning Assisted Suicide, But Ballot Question May Supercede New Law*, BNA HEALTH CARE DAILY REP., Jul. 30, 1998 [herinafter *Engler Signs Bill*]. Michigan Governor Engler signed new legislation that makes physician-assisted suicide a felony in the state, and carries a penalty of up to five years in prison and/or a $10,000 fine.

164. S.B. 200, 89th Legis. 1st Reg. Sess. (Mich. 1998) (enacted). *See Statelines Michigan: Legalized Assisted-Suicide Could Make Ballot*, APN AM. HEALTH LINE, May 27, 1998 (reporting that supporters collected 379,000 registered voters' signatures to have the legalization of physician-assisted suicide placed on the election ballot, where only 247,000 were needed).

165. *See supra* note 134.

166. *See* NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, *supra* note 79, at 57:

The extreme cases, as represented by many of Dr. Kevorkian's much publicized assisted suicides, suggest that this policy of non-prosecution needs to be revised.[167] Nevertheless, allowing a strong professional ethic with the support of the law to cause a physician significant pause for thought before assisting in a suicide is a good answer to this complex problem. In the majority of cases, the physician and patient can be expected to communicate with each other, and treatment in the best interests of the patient will be administered.

Clearly, a loosening of the laws and ethical standards relating to physician-assisted suicide has the potential for disaster. One only needs to consider any of the evidence coming from the Netherlands to see how quickly a nation and a profession has gone down a slippery slope—a slope that should not even be approached.[168] However, until the medical profession has improved the treatment

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> No person has been convicted in New York State of manslaughter for intentionally aiding or causing a suicide. Nor has anyone been convicted for causing a suicide.... [H]owever, a man was found guilty of reckless manslaughter when he provided a loaded gun to a drunk and despondent individual and actively challenged the individual to commit suicide.
> ... [T]he reluctance of prosecutors to pursue the types of cases that are likely to be most common—assistance provided by physicians or family members to terminally ill or severely ill individuals...no doubt rests in part on the degree of public sympathy they often arouse, and the resulting difficulty of securing an indictment and conviction.

See also 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, 97 (1993) (searching reported decisions but finding no case in which a health care professional had been convicted of "causing, inducing, or assisting in the death of her patient"). *See generally* Larry Tye, *Focus Shifts in Assisted Suicide Debate Beyond Kevorkian, New Thinking on Death*, BOSTON GLOBE, Feb. 9, 1998, at A1 (reporting on a change in momentum in the physician-assisted suicide debate that has occurred in the last decade between Dr. Kevorkian's first publicly assisted-suicide and the more than eighty other suicides he has assisted with since then).

167. *See generally* Zachary R. Dowdy, *Cambridge Man's Death Is Linked to Kevorkian*, BOSTON GLOBE, Feb. 5, 1998, at B3. The article reports a case of assisted-suicide committed by Jack Kevorkian in which a fifty-two year old man with kidney cancer was assisted in his suicide; Kevorkian's attorney told the press that the cancer had spread to the man's spine and that the disease was terminal. However, the medical examiner reported that the cancer was localized, and that the disease may have been cureable with removal of the kidney—a treatment that has a very high success rate. Kevorkian has admitted to attending between eighty to one hundred suicides since 1990.

168. *See supra* note 131 and accompanying text. See also Joseph P. Shapiro, *Euthanasia's Home: What the Dutch Experience Can Teach Americans About Assisted Suicide*, U.S. NEWS & WORLD REP., Jan. 13, 1997, for a report on the experiences of Dutch physicians and the effect legalized euthanasia has had upon their profession. In particular, the physicians consider the conditions that make the practice of euthanasia acceptable in the Netherlands are absent in the United States. "[The conditions] are rooted in culture, politics and the provision of health care." One Dutch physician, who has practiced euthanasia, urges his American counterparts, "For goodness sakes, don't do it. You'll be in trouble." *See also* Washington v. Glucksberg, 117 S. Ct. 2258, 2274 (1997).

of palliative care and depression, it will be very hard to condemn the physician that helps heart-breakingly sick patients, whether those patients are truly terminally ill, or chronically ill and suffering.

As much as the Supreme Court wants to see the states acting as laboratories for this experiment with a clear cut legal determination of whether to allow physician-assisted suicides, the best experiment of all may well be to leave the situation as it now stands; states ban assisted-suicide, but they do not heavily prosecute doctors that may have helped a sick patient with a suicidal wish. However, within the medical community there is still a major concern in these situations relating to the large numbers of depressed patients that are going untreated, or being insufficiently treated, such that the number of requests for assisted-suicide is far greater than it otherwise would be.

Unfortunately, until the treatment of depression is raised to the point that we can be sure every patient contemplating suicide has received appropriate treatment, it will not matter how much we restrict access to assisted-suicide; people will unnecessarily be finding ways to take their own lives.

> The Dutch government's own study revealed that in 1990, there were 2,300 cases of voluntary euthanasia...400 cases of assisted suicide and more than 1,000 cases of euthanasia without an explicit request. In addition to these latter 1,000 cases, the study found an additional 4,941 cases where physicians administered lethal morphine overdoses without the patients' explicit consent.

Id. (citation omitted.).