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CORRALLING KEVORKIAN: REGULATING PHYSICIAN-ASSISTED SUICIDE IN AMERICA

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INTRODUCTION

Despite Dr. Kevorkian's crusade to achieve judicial recognition of the right to die, America's legal and ethical struggle with euthanasia and physician-assisted suicide ("P.A.S.")[1] shows little sign of resolution. In the joint cases of *Washington v. Glucksberg*[2] and *Vacco v. Quill*,[3] the Supreme Court held that New York and Washington statutes banning P.A.S. did not violate the Equal Protection Clause of the Fourteenth Amendment[4]. While there is thus no constitutional right to die or to P.A.S., the Court explicitly left the door open for states to legalize the practice if they felt so disposed.[5]

However, perhaps in keeping within its institutional role apart from the legislature, the Court did not attempt to enter into a serious discussion of the substantive provisions that P.A.S. regulation in America might or should contain. The subject of P.A.S. regulation will almost certainly continue to be a heated issue of legislative and public debate in the coming years, as no personal decision has potentially greater individual and *collective* consequences than

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[1] The definitions of these terms are occasionally in dispute, but I will use "physician-assisted suicide" ("P.A.S.") to encompass the situation where the physician provides the life-ending means to her patient, but where the patient administers those drugs herself. "Euthanasia" also entails the active termination of a person's life, but requires a doctor or other person to administer the life-ending drug to and for the patient, rather than the patient herself. The "right to die" encompasses both of these terms—more than merely a right to refuse treatment, it means the right to the active termination of one's life. This paper will focus primarily on addressing the P.A.S. debate and how we should formulate responsible regulation and legislation to govern its practice in America.

[2] 521 U.S. 702 (1997).

[3] 521 U.S. 793 (1997).

[4] Seven years prior to this decision, in *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261, 278 (1990), the Supreme Court held that there is no constitutional right to die, but rather simply a "liberty interest" in *refusing treatment*. The Court in *Quill* was quite aware that allowing the practice of P.A.S. goes substantially beyond "refusing treatment." 521 U.S. at 796-809.

[5] The majority in *Glucksberg* concluded its opinion by declaring, "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 in a democratic society." 521 U.S. at 735. A few months later, Oregon voters again passed the Oregon Death with Dignity Act, Or. Rev. Stat. §§ 127.800-97 (1998), amended by 1999 Or. Laws Ch. 423, reaffirming their support for an explicitly legalized P.A.S. regime.

the decision to take one's own life. We must keep in mind that the issue does not merely boil down to a patient's autonomy and liberty to end his suffering versus the state's interest in the preservation and sanctity of human life. Numerous other ethical considerations are implicated, including the notion of dignity and control, the distinction between actions and omissions, and whether medical professionals are at society's command or retain their individual values.[6] Moreover, the spectacular rise of managed care introduces a host of additional dilemmas, many of which jump out at any reasonable policy-maker, given the method in which Health Maintenance Organizations ("HMOs") structure financial incentives and control the distribution of information.[7] HMOs know all too well that elderly and terminally ill patients run up huge medical bills in their last months of life[8] (40 percent of Medicare expenditures are made in the last year of life), and it is not unimaginable that P.A.S.—in the absence of regulation—will be introduced as one very haunting method to control these skyrocketing costs.[9]

In light of these serious concerns, we must develop sound guidelines to prepare the health care industry and its patients to function in the presence of a P.A.S. environment that is susceptible to grave abuses if not responsibly legislated and regulated. We need policies in place that limit and control the actions of renegade

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[6] See generally Regulating How We Die: The Ethical, Medical, and Legal Issues Surrounding Physician-Assisted Suicide (Linda L. Emanuel ed., 1998) (presenting a complete discussion of the ethical considerations surrounding P.A.S.).

[7] See John K. Iglehart, The American Health Care System—Managed Care, 327 New Eng. J. Med. 742-47 (1992); National Center for Health Statistics, Health Maintenance Organizations and Enrollment: Selected Years, 1976-97 (visited Oct. 12, 1999) <http://www.cdc.gov/nchswww/fastats/hinsure.htm> [hereinafter NCHS, Health Maintenance Organizations and Enrollment] (noting that HMOs have increased in market share from approximately 4 percent in 1980 to 17.3 percent in 1994).

[8] Lecture given by Mark Zitter at U.C. Berkeley, March 15, 1993. Zitter, President of the Center for Health Outcomes and Information in San Francisco, opined that our nation's health care cost crisis could be solved if we were to offer every American $100,000 today in return for their agreement to die 30 days earlier than they otherwise would (and hence, they would spare society the prohibitive cost of their end-of-life treatment).

[9] Medicare expenditures, 40 percent of which on average come in one's last year of life, continue to grow dramatically with the increasing life expectancies of the elderly. See National Center for Health Care Statistics, Health and Aging Chartbook from Health, United States, 1999 (visited Oct. 14, 1999) <http://www.cdc.gov/nchswww/-products/pubs/pubd/hus/99huschtdes.htm> (noting that enrollment of Medicare patients in managed care plans has increased to 12 percent in 1997).

Kevorkians in order to protect the sanctity of the decision to undertake P.A.S. In judging potential policies, we must focus on whether their guidelines ensure that patients are competent and fully informed, and that their decisions are voluntary and enduring.

Given this backdrop, this paper is broken down into four parts. The first segment tracks the history and development of the right to die in America, beginning with "Do-Not-Resuscitate" orders, extending to the right to refuse medical treatment, and then to the right to refuse even food and water.[10] The legal development to date brings us to a position in America where both a constitutional right to die or to P.A.S. have been explicitly rejected, but one where it is also perfectly possible for states to legislate P.A.S. into existence.

Part II addresses the individual and collective ethical implications surrounding the P.A.S. debate in the United States. Individual considerations in support of allowing the practice include: (1) the notion of mercy, (2) the idea that some killing is justified if it is to relieve unbearable suffering, (3) that dignity lies in control of one's own fate, and (4) that respect for patient autonomy and self-determination should be the highest priority of the medical profession. Militating against these considerations are deontological arguments against the taking of any human life, provocative evidence that calls into question whether true autonomy can ever exist, and the distinction the Supreme Court drew between an act to affirmatively terminate one's life and the decision to simply omit treatment.[11]

Part III considers the additional dangers presented by the rise of the managed care health care environment in which we now live. Managed care organizations have enjoyed a meteoric growth in enrollment in the past decade,[12] and this increase in reach, cou-

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[10] Some of the case law that will be discussed and analyzed on these topics includes: Vacco v. Quill, 521 U.S. 793 (1997); Washington v. Glucksberg, 521 U.S. 702 (1997); Cruzan v. Director, Missouri. Department of Health, 497 U.S. 261, 278 (1990); Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417 (Mass. 1977); In re Conroy, 486 A.2d 1209 (N.J. 1985); In re Quinlan, 355 A.2d 647 (N.J. 1976).

[11] See *Quill*, 521 U.S. at 796-809.

[12] See NCHS, Health Maintenance Organizations and Enrollment, supra note 7 (noting that HMO market share is up from 4 percent in 1980 to 17.3 percent in 1994).

pled with the incentives HMOs implement to control costs and information, represents a serious danger with respect to legalizing P.A.S. in America. The financial inducements these plans offer to limit care and the gag clauses they install to control the flow of information to patients are patently conducive to abuse of P.A.S. Worse, they threaten to irreparably undermine the viability and trusting nature of the traditional doctor-patient relationship. Charles Dougherty warns that patients will reasonably begin to question, "Is my doctor's advice that there is nothing left for me but euthanasia motivated by my best interest or by his, by concern for my suffering or for her delivery network?"[13] That is not the way to run America's healthcare system—confidences will break down and give way to fear and distrust of the medical profession.[14] Responsible policy and legislation must be passed in America in order to install safeguards that minimize the harrowing conflicts that the practice of P.A.S. in the new managed care era presents.

Finally, given the above issues of concern, Part IV explores attempts by states and countries to regulate P.A.S. to ensure that physicians do not irresponsibly engage in the practice. I analyze the instructive guidelines of the Netherlands and the Oregon Death with Dignity Act, the latter being our nation's first and most famous example of P.A.S. legislation. I then consider what I believe to be the most sound policy put forth to date, the Model State Act to Authorize and Regulate Physician-Assisted Suicide.[15] Put together by a team of lawyers, academics, and physicians in Massachusetts, it institutes strict patient and procedural safeguards to help ensure active, informed, voluntary, and competent decision-making by patients. Further, it provides a measure of legal certainty to well-meaning physicians who fear potential liability in the absence of state legislation on the issue. With a few modifications, and ideally uniform implementation, this is the direction I urge that P.A.S. policy takes to minimize the threat of abuse and to secure long-term public confidence and support.

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[13] Charles J. Dougherty, The Common Good, Terminal Illness, and Euthanasia, 9 Issues L. & Med. 151, 164 (1993).

[14] See id. at 164.

[15] See Charles H. Baron et al., A Model State Act to Authorize and Regulate Physician-Assisted Suicide, 33 Harv. J. on Legis. 1 (1996).

I should emphasize here however that the intent of this paper is not to convince or dissuade the reader of the merits of P.A.S. generally.[16] Rather, in light of the reality and potential availability of P.A.S. in the years to come, I urge that we must be exceptionally careful and diligent in creating regulations that maximize the goals that the practice of P.A.S. was intended to achieve, while doing as much as possible to alleviate its morally disturbing potential for abuse. Especially in the relatively new healthcare context of managed care, we must consider how to formulate an organized and disciplined P.A.S. policy in the United States.

I. HISTORY OF THE DEVELOPMENT OF THE RIGHT TO DIE IN AMERICA

Before the ethical and legal implications of P.A.S. can be discussed, we must consider the history of the development of the right to die in America.

A. Resuscitation and DNR Orders

The issue of resuscitation of heart function and accompanying "Do Not Resuscitate" ("DNR") orders are an important part of the debate that arose far before the question of a constitutional right to die was ever contemplated. For hundreds of years, physicians have experimented with resuscitation techniques.[17] One of modern medicine's most dramatic achievements is its ability to rescue people from the brink of death by restoring their heartbeat and breathing. However, along with this accomplishment came the disturbing reality that many patients were being "saved" only to

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[16] Rather, I seek to present the considerations on both sides of the debate in Parts II and III, although on balance I believe that the benefits of a well-formulated P.A.S. policy outweigh the admittedly serious risks.

[17] See President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Deciding to Forego Life-Sustaining Treatment: A Report on the Ethical, Medical, and Legal Issues in Treatment Decisions 232 (1983) [hereinafter President's Commission] (discussing the early history of resuscitation techniques by Vesalius, who first described ventricular fibrillation and its relationship to interrupted breathing, and attempted intubation and artificial respiration with a reed inserted into the trachea. In addition, during the 17th century, William Harvey was credited with the first direct manipulation of a heart (a pigeon's) as a resuscitation technique, and in 18th century Britain, John Hunter was successful in restoring the breathing of a dog by inserting the nozzle of a bellows into its trachea.).

live in permanent vegetative or otherwise seriously disabled states that they would not have voluntarily chosen to endure.

Hospitals and medical associations were at first slow to respond, but more recently a fair number have attempted to establish written standards for DNR (sometimes called "No Code") orders.[18] The 1974 version of the "Standards for Cardiopulmonary Resuscitation (CPR) and Emergency Cardiac Care (ECC)" of the American Heart Association and the National Academy of Sciences declared, "Cardiopulmonary resuscitation is not indicated in certain situations, such as in cases of terminal irreversible illness where death is not unexpected. . . ."[19] Pioneering policies of DNR orders were published by several hospitals in 1976, reflecting professional associations' recognition that non-resuscitation was appropriate when the well-being of a patient would not be served by an attempt to reverse cardiac arrest.

Nevertheless, there remained unresolved issues—still disputed today—of the utmost consequence: Who should have the authority to write the guidelines (doctors, hospitals, or professional associations)? How do they decide when to resuscitate versus when not to? And who should be consulted in the decision (the patient, the patient's family, or no one)? DNR orders began as oral directives promulgated by individual doctors, but it became the general practice for hospitals to create guidelines for their use. However, since hospitals have no licenses to practice medicine, committees composed of doctors became the authors. The further question of how to decide when versus when not to resuscitate pitted the patient's autonomy and self-determination (viewed from a deontological perspective) against her well-being (a paternalistic determination made by the physician) and the utilitarian notion of equity (i.e., what is the best use of limited medical resources?). The courts have found a presumption in favor of resuscitation, which is not surprising given that the effects of its omission are ir-

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[18] See id. at 236 n.23. ("The prevalence of written policies nationwide is not known" and, while the President's Commission found that many hospitals are now drafting these standards, "it is not uncommon, [particularly] for community hospitals, not to have a written policy.").

[19] National Conference on Standards for Cardiopulmonary Resuscitation (CPR) and Emergency Cardiac Care (ECC), 227 JAMA 837, 864 (1974).

reversible.[20] Today, though, a competent patient's preferences for or against resuscitation will be honored over her physician's assessment of the "value" of CPR.[21] At last count, twenty states had statutes of varying complexity that afforded room for a competent patient's consent to DNR (while imposing far greater restrictions on the ability of a surrogate to consent).[22]

B. Right of Incompetent Patients to Refuse Treatment—Quinlan

While competency alleviates many of the difficult decisions implicated in DNR orders, there remains the issue of the incompetent patient whose family or guardian wants to terminate treatment. In 1976, the Supreme Court of New Jersey addressed this question in *In re Quinlan*.[23] Karen Quinlan had ceased breathing for two fifteen minute periods in April of 1975, and was left comatose with decortication in a "chronic persistent vegetative state," requiring a respirator for survival.[24] Her father sought to be appointed guardian in order to authorize the discontinuance of all "extraordinary medical procedures" sustaining her life, since these measures presented no hope for her eventual recovery. In rendering its decision in favor of Quinlan, the court balanced the patient's right to privacy (noting that Karen could, if lucid, refuse the respirator) versus the interests of the state in the preservation and sanctity of human life, and the doctor's right to treat according to her best medical judgment. The *Quinlan* court's balancing test held that both of the state interests diminish and the right of privacy grows as the degree of bodily invasion increases and the patient's prognosis dims.[25] The state had no compelling interest in forcing Karen to vegetate—in effect, life is not sacred *separate*

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[20] See President's Commission, supra note 17, at 239-40.

[21] But cf. In re Dinnerstein, 380 N.E.2d 134, 139 (Mass. App. Ct. 1978) (finding that the decision not to resuscitate an Alzheimer's patient was "peculiarly within the competence of the medical profession"). Note, however, that this represents the early days of jurisprudence on the subject and that patient autonomy has become the trump card today.

[22] New York's DNR statute, N.Y. Pub. Health Law § 2965 (McKinney 1993), for example, allows a proxy to give consent to DNR only if the patient is terminally ill, the patient is terminally unconscious, or CPR would be futile or would place an extraordinary burden on the patient.

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

[24] See id. at 653-55.

[25] See id. at 664.

from the condition in which one is living it. Furthermore, the court ruled that the right of privacy survives incompetency so that it can be exercised by a guardian,[26] and lost in the shuffle was the holding that a doctor's right to treat according to her best medical judgment was now almost totally gone under the weight of patient autonomy. In the court's defense, it should be noted that it felt it was actually *helping* physicians by removing their worries about the legal ramifications that might result from withdrawing treatment. The point of the court was that when it is a hopeless case, doctors should not be locked into traditional "medical ethics" that call for continued futile medical intervention.

C. An Incompetent's Right to Refuse Treatment when There is No Family to Decide—Saikewicz

One year after *Quinlan*, the Supreme Judicial Court of Massachusetts took on the problem that many incompetent elderly patients face, namely, the lack of a family member to guide the end-of-life treatment decision.[27] In *Belchertown State School v. Saikewicz*,[28] a 67 year-old man with the mental age of a two-year-old was diagnosed with leukemia, but was given a 30 to 50 percent chance of remission with aggressive treatment.[29] The court began its discussion by noting that the doctrine of informed consent and the constitutional right to privacy[30] protect the right of a patient to refuse medical treatment in appropriate circumstances; and in the case of an incompetent, the right may be asserted by a guardian.[31] Here, without a family guardian available, the court used a "substituted judgment" standard (i.e., what would Saikewicz want if he could express his wishes?) in holding not to treat him. The court reasoned that he would not understand why he was being subjected to treatment, and that the court's decision would therefore respect his autonomy (i.e., a balancing test where autonomy is the ultimate trump card). The emphasis on "substituted judgment" was

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[26] See id.

[27] See Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417 (Mass. 1977).

[28] 370 N.E.2d 417 (Mass. 1977).

[29] See id.

[30] See Griswold v. Connecticut, 381 U.S. 479, 484 (1965) (holding that the right to privacy is guaranteed by the Constitution).

[31] See *Saikewicz*, 370 N.E.2d at 423-24.

ostensibly intended to get courts out of the business of making value decisions on the worth of one's life. However, Dr. Alan Stone questions whether there was not an implicit quality of life calculus operating under the surface, and worse, the prospect that this decision evidenced discrimination against the mentally retarded.[32] *Saikewicz* has also been criticized for implying that whenever a patient is unconscious or incompetent and we are not sure whether treatment would help, we must look to a court to find out what to do. This would amount to an incredible and impractical intrusion on decision-making in medicine, and the great inconvenience and expense to the patient's family might discourage them from making the right decision in the first place (i.e., to avoid the pain and humiliation of a judicial hearing). In essence, the problem is that conflicts of interest in medical decision-making are quite common; hence, shouldn't they be quite severe before a court *routinely* makes the ultimate decision?[33]

D. Crafting a Right Beyond the Right to Refuse Treatment— Conroy

The case of *In re Conroy*[34] carried far greater consequences than that of *Quinlan,* for it extended the right to refuse treatment to a setting far more prevalent than that of Karen Quinlan's. Claire Conroy was not subject to life in a vegetative coma; rather, she was an 80 year-old woman in a nursing home suffering various ailments in addition to Alzheimer's disease.[35] The issue presented was whether she had a right to withdraw her feeding tube—i.e., was the feeding tube considered a "medical treatment" such that one would have the right to refuse it? Intuitively, rejection of food and water seems qualitatively different than refusal of a respirator or other high-tech means of treatment. Perhaps if a person cannot swallow by herself and she refuses the feeding tube, this act would

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[32] Lecture given by Dr. Stone at Harvard Law School, October 20, 1997.

[33] But cf. In re Spring, 405 N.E.2d 115 (Mass. 1980). The Supreme Judicial Court of Massachusetts ruled that *Saikewicz* was a unique case because he was a ward of the state. See id. at 120. The *Spring* Court said that there is no need to go to court to see if treatment should be given to an incompetent if his family, doctors, and ethics committee are all consulted and agree on the resolution of the issue. See id. at 120-22.

[34] 486 A.2d 1209 (N.J. 1985).

[35] See id. at 1218.

be more akin to refusal of treatment. However, if she can swallow but refuses to do so, this now seems more like suicide, and there is a long tradition of Anglo-American jurisprudence against such a right.[36] Perhaps a better distinction to make would be between extraordinary and ordinary treatment, but the court rejected this notion. So then, one might ask: is suicide something we always want to prevent?[37]

The issue facing the *Conroy* court, though, was not simply what to do when a patient refuses food and water, but whether a feeding tube can be removed once it has been inserted. The court discussed three tests for making the determination.[38] First, when the patient has previously expressed her intent regarding the situation, the individual's subjective choice should be honored.[39] Note, this has nothing to do with the reasonable person; even if the patient's choice is idiosyncratic, the court respects it in the name of autonomy. Evidence of this subjective intent can be found in a living will, advanced directive, durable power of attorney, religious beliefs, or a prior pattern of life conduct.[40] The court will consider the remoteness, consistency, thoughtfulness, and specificity of the prior statement of intent, but also medical evidence, especially pain. On the other hand, if there is not enough evidence to make this substituted judgment, the court invokes the *parens patriae* powers of the state to choose in favor of an incompetent's best interests.[41] In this second scenario, where there is *some* evidence of the patient's wish to refuse treatment, the court engages in a limited objective test, requiring that the burden of continuing treatment clearly outweighs the benefit in order for cessation of treatment to be ordered.[42] However, in the third situation where there is no evidence at all of the patient's intent, the court employs

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[36] See Washington v. Glucksberg, 521 U.S. 702 (1997).

[37] The *Saikewicz* court did in fact make the distinction between rational and irrational suicide. See Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 425-26 & n.11 (Mass. 1977). Justice David Souter's concurrence in *Glucksberg* noted that many states have decriminalized suicide. See *Glucksberg*, 521 U.S. at 773-77 (Souter, J., concurring).

[38] See Conroy, 486 A.2d at 1229-33.

[39] See id. at 1229-31.

[40] See id. at 1229-30.

[41] See id. at 1231.

[42] See id. at 1232.

a purely objective test that yields a strong presumption for preserving life. In order for treatment to be stopped, the burden presented by the treatment must markedly outweigh the benefit, or the treatment must be considered "inhumane."[43]

Conroy is significant in that it explicitly rejected all of the traditional criteria for life and death decision-making, in effect holding that the patient can refuse *any* treatment if her intent is expressed. The court dismissed the medical distinctions of withholding versus withdrawing treatment, actions versus omissions,[44] ordinary versus extraordinary treatment, and medical treatment versus feeding (i.e., receiving food and water). The court then imposed virtually impossible procedures for implementing its decision.[45] It noted the many reasons to be cautious regarding the vulnerable population of nursing home residents, who often have no family, do not know their doctors, and frequently receive poor care from the nursing home because it rarely makes acute care medical decisions.[46] While Claire Conroy herself was held not to meet any of the three tests the court formulated, the case stands as an important step in crafting a right beyond that of simply refusing treatment.

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[43] Id. An "inhumane" treatment is one that causes recurring, unavoidable, and severe pain.

[44] See id. at 1234-36. The *Conroy* court explicitly rejected the distinction between allowing a person to die of a disease by omitting treatment in the first place, versus hastening death by discontinuing treatment. See id. at 1234.

[45] See id. at 1241-42. *Conroy* implemented substantial procedural safeguards for the determination of patient competency and for the ultimate treatment decision. See id. at 1241. The court called for a judicial determination of incompetency by clear and convincing evidence of whether the patient had the ability to understand, evaluate her options, or communicate a decision (there must be no chance of regaining competence). See id. at 1241. If the patient was "unfit to manage her affairs," she received a general guardian. The procedures for the ultimate refusal-of-treatment decision required the guardian, family member, doctor, or nursing home to notify an ombudsman, who investigated the situation. See id. at 1241. Medical evidence is then taken from the nursing home and two other unaffiliated physicians, and the guardian and ombudsman must concur to order the cessation of treatment. See id. at 1242.

[46] See id. at 1240.

E. Is There a Constitutional Right to Die?—Cruzan

The Supreme Court took on the question of "Is there a right to die?" in *Cruzan v. Director, Missouri Department of Health.*[47] Nancy Cruzan was involved in a single car accident, as a result of which she suffered anoxia of the brain and severe brain damage.[48] She fell into a persistent (and then permanent) vegetative state and required a feeding tube to meet her daily essential needs.[49] Her parents requested termination of the stomach tube when doctors concluded there was no chance of Cruzan's return to sapient function, but the hospital would not do so without trial court approval.[50] This permission was granted in light of evidence of a prior conversation Cruzan had with a friend (that she would not want to continue her life unless she could live "halfway normally").[51] The trial court held that there is a fundamental right to end death-prolonging procedures based on the Missouri state and federal Constitutions.[52]

However, on appeal, the Missouri Supreme Court rejected the common law and constitutional rights of privacy that other state courts had upheld, in essence adopting a formulation similar to that in *Saikewicz.*[53] The court held that the state interest in preserving the sanctity of life was great, and that Cruzan's parents did not have the right to decide the question.[54] The court emphasized the state's *parens patriae* duty to its citizens, and the fact that state law determines what power guardians have.[55] Thus, the Missouri Supreme Court required a showing of clear and convincing evidence that Cruzan would have wanted the removal of her feeding tube.[56]

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[47] 497 U.S. 261 (1990).

[48] See id. at 266.

[49] See id.

[50] See id. at 267-68.

[51] See id. at 268.

[52] See Cruzan v. Harmon, 760 S.W.2d 408, 410 (Mo. 1988) (en banc) (outlining the trial court's reasoning of the constitutional right to end death-prolonging treatment).

[53] See id. at 410-20.

[54] See id. at 424-27.

[55] See id.

[56] See id. at 425.

On appeal to the U.S. Supreme Court, Chief Justice William Rehnquist declared that "the question is simply and starkly whether the United States Constitution prohibits Missouri from choosing the rule of decision that it did" (i.e., from implementing procedures that require the family to come to court to present clear and convincing evidence).[57] Once the issue was framed this narrowly, it became far more difficult to argue with the Court's holding. Cruzan would need a fundamental right to privacy that the state could not impinge upon without a compelling interest and narrowly tailored remedy. However, the Supreme Court degraded the right to privacy to a "mere" liberty interest (following the logic of Solicitor General Kenneth Starr in *Bowers v. Hardwick*[58])—i.e., the liberty interest contained in the 14th Amendment was not a general right of privacy.[59] While "liberty" meant at least the freedom from state-imposed physical restraints, it was not an unqualified right and did not automatically extend to an incompetent person. The Rehnquist majority further held that the state's interest in preserving life was great and not diminished by quality of life judgments.[60] Chief Justice Rehnquist declared that Missouri's procedures were rationally designed to serve legitimate state interests, for it is reasonable to place the burden on those who wish to make an irreversible decision.[61] The state was justified in seeking to protect the interest of the individual, as parents do not necessarily know what their adult children would want.[62]

Justice Antonin Scalia concurred in the decision, emphasizing "that the point at which life becomes 'worthless' . . . [is not] set forth in the Constitution nor known to the nine Justices of this Court."[63] Thus, as the Constitution is silent with respect to quality of life considerations, it is not the business of the Court to interfere by making such a determination. Strikingly, Laurence Tribe's 1988 treatise, "Rights of Privacy and Personhood" contains much the same attitude that Justice Scalia expressed, as Tribe contended

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[57] *Cruzan*, 497 U.S. at 277.

[58] 478 U.S. 186, 191-92 (1986).

[59] See *Cruzan*, 497 U.S. at 279, n.7.

[60] See id. at 282.

[61] See id. at 283.

[62] See id. at 286.

[63] Id. at 293 (Scalia, J., concurring).

that courts were using medical criteria and quality of life decisions under the surface to circumscribe the right to self-determination.[64] However, Tribe opined further that a constitutional right to die might be uncontainable and susceptible to grave abuses and thus more troubling to courts than manipulating or extending the right of self-determination.[65]

Justice William Brennan dissented in *Cruzan*, arguing in favor of a fundamental right to privacy over a mere liberty interest.[66] He believed that the state's only interest should be in accuracy, a concept which does not include the state's general interest in life.[67] Furthermore, he raises an interesting philosophic point in that *either* decision (to remove the feeding tube or not) is irrevocable from the patient's perspective—Cruzan will live on "irrevocably" in her permanent vegetative state if it is not withdrawn.[68] While I am not completely convinced of this argument, it is evident that Justice Brennan, more than any of the other Justices, put himself directly into Cruzan's situation, emphasizing that "an ignoble end, steeped in decay, is abhorrent."[69] It is not unlikely that he (and many of us when we think about these life and death issues) was asking, "Is this the way I want to die?"

Nevertheless, the *Cruzan* decision has merit. While the lack of a constitutional right to die may create some situations that seem merciless and require lengthy procedures to be remedied, I would be far more concerned if the Supreme Court haphazardly gave incompetent patients a constitutional right to die without any checks and balances. If that were to have been the Court's holding, I do believe Tribe's admonition about the potential for grave abuses would be quite real indeed.

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[64] See Laurence Tribe, Rights of Privacy and Personhood, American Constitutional Law, 2d ed., 1364-71 (Foundation Press 1988).

[65] See id. at 1370.

[66] See *Cruzan*, 497 U.S. at 304-05 (Brennan, J., dissenting).

[67] See id. at 315-16. Justice Brennan felt that the "clear and convincing evidence" standard served only to load the state's interest unfairly and inaccurately. See id. at 316-21.

[68] See id. at 320.

[69] Id. at 310.

F. *The Last Word to Date on the Constitutionality of the Right to Die—A Look at New York and Washington's Statutes Banning Assisted Suicide*—Quill *and* Glucksberg

The Supreme Court directly examined the issue of P.A.S. in the joint cases of *Vacco v. Quill*[70] and *Washington v. Glucksberg*.[71] In both New York and Washington state, statutes were passed that made it a crime for a physician or other person to assist another person in an attempt to commit suicide.[72] Doctors in both states challenged the law as unconstitutional, alleging it violated the Equal Protection Clause of the 14th Amendment.

Both the Second and Ninth Circuits agreed.[73] The Second Circuit struck down New York's ban on P.A.S., holding it violated Equal Protection to allow those on life-support systems to direct their removal, while "those who are similarly situated, except for the previous attachment of life-sustaining equipment, are not allowed to hasten death by self-administering prescribed drugs."[74] Additionally, the Ninth Circuit held that the patient does have a liberty interest based on the Due Process Clause.[75] The decision then with respect to hastening death comes down to a balancing test between a patient's liberty versus the state's interest in the preservation and sanctity of life, with the outcome shifting in favor of the patient's interest as her quality of life deteriorates. The Ninth Circuit held that this liberty interest was not based only on historical tradition, but also on changing circumstances—with the Supreme Court's decisions regarding abortion in *Roe v. Wade*[76] and *Planned Parenthood v. Casey*,[77] indicating forward-thinking,

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[70] 521 U.S. 793 (1997).

[71] 521 U.S. 702 (1997).

[72] Washington law provides "A person is guilty of promoting a suicide attempt when he knowingly causes or aids another person to attempt suicide." Wash. Rev. Code § 9A.36.060(1) (1994). New York law states "A person is guilty of promoting a suicide attempt when he intentionally . . . aids another person to attempt suicide." N.Y. Penal Law § 120.30 (McKinney, 1993).

[73] See Quill v. Vacco, 80 F.3d 716 (2d Cir. 1996); Compassion in Dying v. Washington, 79 F.3d 790 (9th Cir. 1996).

[74] *Quill*, 80 F.3d at 729.

[75] See *Compassion in Dying*, 79 F.3d at 815-17.

[76] 410 U.S. 113 (1973).

[77] 505 U.S. 833 (1992).

progressive decision-making not bound by past interpretations.[78] The court methodically refuted the state's interests in preserving life and preventing suicide, reasoning (1) that it had passed a law allowing the terminally ill to refuse treatment; and (2) that the state's interest is diminished if the patient cannot be cured.[79] The court went on to address the trauma on the family imposed by watching a loved one deteriorate, and emphasized that voluntariness and procedural safeguards could combat the slippery slope problem.[80]

Nevertheless, the Supreme Court reversed the Circuit Court decisions. In *Glucksberg*, the Court focused on the long tradition of Anglo-American law against suicide, and declared that new substantive rights must be deeply rooted in legal tradition and precisely formulated or they will not be recognized.[81] The Rehnquist majority stated that *Cruzan* was not based on some abstract notion of autonomy, but rather grew out of the common law of battery.[82] On the other hand, P.A.S. was not such a fundamental right. Following *Cruzan*'s logic, the Court concluded that the Washington law against P.A.S. was rationally related to government interests, and that the state has an interest in preventing suicide without regard to quality of life.[83] The state also has a rational interest in maintaining physicians' role as healers, protecting vulnerable people from indifference, prejudice, and psychological and financial pressure to end their lives, and in avoiding the slippery slope towards active euthanasia.[84]

With respect to the Equal Protection issue in *Quill*, the Supreme Court stated that the use of *intent* is firmly rooted in the law as a basis for distinguishing between two acts that have the same result.[85] New York's law makes a rational distinction between the two different groups of patients, those that can refuse unwanted treatment versus those who would need affirmative intervention to

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[78] See *Compassion in Dying*, 79 F.3d at 816, 829.

[79] See id. at 815-16.

[80] See id. at 825-33.

[81] See Washington v. Glucksberg, 521 U.S. 702, 723 (1997).

[82] See id. at 725.

[83] See id. at 728-29.

[84] See id. at 731-33.

[85] See Quill v. Vacco, 521 U.S. 793, 801-03 (1997).

end their life.[86] With respect to withdrawing treatment, the physician purposefully intends only to "respect his patient's wishes and 'to cease doing useless and futile or degrading things to the patient'... [A] doctor who assists a suicide, however, 'must, necessarily and indubitably, intend primarily that the patient be made dead.'"[87] Thus, echoing Yale Kamisar's sentiments,[88] the Court held that the act-omission distinction can be validly used by the state to separate a refusal of treatment (an omission) from that of suicide (which would require an affirmative act).[89] There is no right to hasten death; only a right to refuse an unwanted touching.[90]

Thus, the current state of the law is that there is no constitutional right to die nor to P.A.S. This may be sound in the sense that an unrestricted constitutional right raises the problems of abuse that Professors Tribe and Kamisar focus on. However, the Supreme Court explicitly left open the possibility for states to legalize P.A.S. by statute if they so chose. Already, Oregon voters have given their approval to the Oregon Death with Dignity Act[91] by a 60 to 40 percent margin,[92] and surely many states will respond in various ways to legalize, ban, and otherwise regulate P.A.S. This squares well with Justice Louis Brandeis' desire to see states as the "laboratories of experimentation,"[93] but will inevitably lead to such contradictory results between states that we might ask whether Congressional legislation is desired.[94]

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[86] See id.

[87] Id.

[88] See Yale Kamisar, The Reasons So Many People Support Physician-Assisted Suicide—And Why These Reasons Are Not Convincing, 12 Issues L. & Med. 113, 120-28 (1996).

[89] See *Quill*, 521 U.S. at 807-09.

[90] See id.

[91] Oregon Death with Dignity Act, Or. Rev. Stat. §§ 127.800-97 (1998), amended by 1999 Or. Laws Ch. 423.

[92] See Sam Howe Verhovek, Oregon Resists Federal Action on Assisted Suicides, Milwaukee J. & Sentinel, Nov. 18, 1999, *available in* 1999 WL 21548460.

[93] See New State Ice Co. v. Liebmann, 285 U.S. 262, 310-311 (1932) (Brandeis, J., dissenting) (analogizing states to laboratories in need of the freedom to experiment).

[94] See David Lawder, Assisted Suicide Debate May Rage in States, Reuters, June 27, 1997 (discussing the argument by Susan Wolf, Professor of Law and Medicine at the University of Minnesota, that varying state regulations will certainly force many chronically ill patients to move across state boundaries at the end of life simply to commit suicide). See also infra Part IV, Section E.

II. THE ETHICAL CONSIDERATIONS SURROUNDING PHYSICIAN-ASSISTED SUICIDE

Now that we have examined the legal jurisprudence behind the right to die, we must focus on the ethical arguments for and against P.A.S. before we can address the added dangers managed care poses, and the various attempts by states and countries to legalize and regulate the practice. Somewhat counter-intuitively, utilitarian and deontological arguments are present on *both* sides of the debate, contrary to the stereotype of supporters' utilitarian perspective versus opponents' deontological rights-based approach to the question of assisting in the termination of life. In addition, the practice of P.A.S. in America involves not just the ethical considerations of the individual, but implicates collective concerns as well, both of which must be addressed in our nation's P.A.S. policy.

A. Individual Ethical Considerations with Respect to Physician-Assisted Suicide

1. Mercy/The Patient's Best Interests

In Harvard Medical School's Clinical Lecture Series, Linda Emanuel presents an excellent synopsis of the individual ethical considerations in favor of and opposed to the practice of P.A.S.[95] In support of the practice lies the fundamental principle of mercy—the idea that some killing is justified if it is to relieve the brutal and inhumane suffering that many chronic illnesses cause at the end of life. Coupled with this notion is the fact that many marginally effective treatments aimed at prolonging life fail to serve the patient's best interests because they have little chance of real success and instead only exacerbate patient suffering and quality of life. This view is supported by *New England Journal of Medicine* executive editor Marcia Angell and by Guy Benrubi, the latter of whom emphasizes that it is the advanced technology of the modern medical world that often brings people into a state of prolonged anguish as opposed to allowing quicker, less painful, more

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[95] See Regulating How We Die: The Ethical, Medical, and Legal Issues Surrounding Physician-Assisted Suicide (Linda L. Emanuel ed., 1998).

natural deaths.[96] Given this technological reality—that medical treatments may sometimes be the cause of pain rather than the cure—Benrubi urges that medical professionals are obliged not to abandon their patients by unwaveringly insisting that P.A.S. is impermissible.[97]

Ezekiel Emanuel responds to the above argument by suggesting that pain and suffering is not the main motivation behind P.A.S. decisions.[98] His assertion is bolstered by evidence presented by Professor Robert Burt and Melinda Lee suggesting that the primary reason people request P.A.S. is their fear of being a financial and emotional burden on loved ones, and not out of concern for avoiding pain or furthering their own self-interests.[99]

In addition, critics of the "mercy" notion, such as Nancy Dickey of the American Medical Association ("AMA"), loudly proclaim that killing human life is an intrinsic evil in and of itself that flies in the face of the Hippocratic Oath and traditional medical ethics that require a doctor to "do no harm."[100] With respect to this contention though, Dr. Alan Stone, Professor of Law and Medicine at Harvard, counters that the "do no harm" maxim is nowhere to be found in the Hippocratic Oath, and increasingly students at our nation's top medical schools are swearing to a much less exacting formulation of physicians' ethics formulated by Louis Lasagna.[101] Dr. Angell further refutes the deontological arguments regarding physicians' ethics, proclaiming, "The highest ethical imperative of doctors should be to provide care in whatever

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[96] See Guy Benrubi, Euthanasia—The Need For Procedural Safeguards, 326 New Eng. J. Med. 197, 198 (1992).See also Marcia Angell, The Supreme Court and Physician-Assisted Suicide—The Ultimate Right, 336 New Eng. J. Med 50 (1997).

[97] See Benrubi, supra note 96. See also Angell, supra note 96.

[98] See Ezekiel Emanuel, Empirical Studies on Euthanasia and Assisted Suicide, 6 J. Clin. Ethics 158, 158-60 (1995).

[99] See Robert Burt, Taking Care of Strangers, 1-21, 92-107, 114-21, 124-27, 174-80 (1979); Melinda Lee et al., Legalizing Assisted Suicide—Views of Physicians in Oregon, 334 New Eng. J. Med. 310, 311 (1996). See also discussion infra Part II, Section A(4).

[100] See Nancy W. Dickey, Euthanasia: A Concept Whose Time Has Come?, 8 Issues L. & Med. 521, 523 (1993).

[101] See Alan Stone, A Medical Emergency, Boston Globe, June 27, 1997. Students at UCSF Medical School are now learning and subscribing to Louis Lasagna's "Modern Hippocratic Oath," which abandons the traditional prohibitions against providing "deadly medicine" or abortions to patients. See id.

way best serves patients' interests, in accord with each patient's wishes, [and] not with a theoretical commitment to preserve life no matter what the cost in suffering."[102] She adds, "The greatest harm we [as doctors and society] can do is to consign a desperate patient to unbearable suffering—or force the patient to seek out a stranger like Dr. Kevorkian."[103]

2. Act-Omission Distinction

P.A.S. proponents forcefully claim that decisions to act versus decisions to remain passive are morally indistinguishable. For instance, how can it be ethically sound for a doctor to remove her patient from a respirator based on the conception that this is merely an omission of treatment, while if a stranger came along and removed the plug, it would be a homicide? Furthermore, both the act (of assisting suicide) and the omission (of withdrawing treatment) have the result of hastening death, no matter how much anyone disputes the semantic issue of causation. However, this argument has not carried the day with the U.S. Supreme Court, even if some of the Circuits have been swayed.[104]

Noted ethicists Yale Kamisar and Seth Kreimer have devoted much energy to scholarly pieces emphasizing the distinction between refusal of treatment and P.A.S. In *Against Assisted Suicide—Even a Very Limited Form*, Kamisar opined that there are significant moral and legal distinctions between killing and letting die.[105] Citing to Daniel Callahan, director of the Hastings Center, Kamisar uses language quite similar to that employed later by Chief Justice Rehnquist in *Quill*: "[T]here must be an underlying fatal pathology if allowing to die is even possible. Killing, by contrast, provides its own fatal pathology."[106] Moreover, Kreimer addresses the practical implications of the distinction, arguing that the dangers of allowing P.A.S. are far greater than that of merely permitting cessation of treatment: "[A] right to refuse treatment puts at risk only the lives of those who would die without treat-

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[102] Angell, supra note 96, at 52.

[103] Id.

[104] See supra Part I, Section F.

[105] See Yale Kamisar, Against Assisted Suicide—Even a Very Limited Form, 72 U. Det. Mercy L. Rev. 735, 751 (1995).

[106] Id. at 755.

ment . . . [while] assisted suicide would extend the risk to the entire population."[107] Many further believe that allowing the affirmative action of P.A.S. presents the additional danger of drastically undermining the trust necessary to establish a successful and meaningful doctor-patient relationship.[108]

However, Marcia Angell provocatively counters that the act-omission distinction that opponents of P.A.S. make is "too doctor-centered and not sufficiently patient-centered."[109] She asserts:

> We should ask ourselves not so much whether the doctor's role is passive or active but whether the *patient's* role is passive or active. From that perspective, the three methods of hastening death line up quite differently. When life-sustaining treatment is withdrawn from an incompetent patient at the request of a proxy or when euthanasia is performed, the patient may be utterly passive . . . [and] unaware of the decision. In sharp contrast, assisted suicide, by definition, cannot occur without the patient's knowledge and participation. Therefore, it must be active—that is to say, voluntary.[110]

That element of voluntariness is a critical distinction, because it provides an "inherent safeguard against abuse" of P.A.S. that neither cessation of treatment nor euthanasia offers.[111] Angell concludes then, that contrary to the frequent assertion that permitting the "action" of P.A.S. would lead to distrust of doctors, "distrust would be more likely to arise from uncertainty about whether a doctor will honor a patient's wishes" (i.e., which would result in a regime where P.A.S. was not an option).[112]

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[107] Seth F. Kreimer, Does Pro-Choice Mean Pro-Kevorkian? An Essay on Roe, Casey, and the Right to Die, 44 Am. U. L. Rev. 803, 841 (1995).

[108] See infra Part III, Section D.

[109] Angell, supra note 96, at 51.

[110] Id.

[111] Id.

[112] Id. at 52.

3. Control and Dignity

Thirdly, supporters of P.A.S. assert that dignity lies in control of one's fate and in the avoidance of being a burden upon loved ones. Professor Ronald Dworkin expands upon this concept in *Life's Dominion*,[113] advancing an intellectual argument based on the distinction between critical and experiential interests (one's firmly rooted life goals versus her temporary experiential desires). Dworkin strongly believes we should protect the continuity of one's life plan by allowing the final chapter of death to conform to what one's life subjectively meant to her.[114] If it was important to the individual that her family never see her in a diminished, deteriorated, and undignified state, we should not prevent that desire from eventuating.[115] Only in this manner do we respect the rational self's critical interests over her experiential ones.[116]

4. Autonomy/Self-Determination

Dworkin's arguments are founded upon the final and most crucial ethical consideration that Emanuel presents in favor of P.A.S.—the combined notion of autonomy, self-determination and voluntariness. Dworkin believes that the autonomy, best interests, and sanctity of the person (the three "mortal interests") implore us to honor the individual's choice with respect to end-of-life decisions.[117] Dr. Angell is also a champion of self-determination, as she begins with the generally accepted premise that "one of the most important ethical principles in medicine is respect for each

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[113] Ronald Dworkin, Life's Dominion 179-217 (1993). As an aside, I note that Judge Posner believes it is impossible to make a convincing *moral* argument in either direction regarding end-of-life choices, and thus Dworkin's article and intellectual framework for debate should not merely be summarily dismissed even if one disagrees with his views. See generally Richard Posner, The Problematics of Moral and Legal Theory, 111 Harv. L. Rev. 1637 (1998).

[114] See Dworkin, supra note 113, at 200-13.

[115] See id.

[116] See id.

[117] See id. at 190-96. By "autonomy," Dworkin refers to the ability and independence of the self to govern her own choices. See id. at 190-92. The "best interests" of the patient presents the conflict between a paternalistic assessment of what her best interests are versus a subjective determination. See id. at 192-94. Dworkin would argue that when we allow a patient to commit assisted suicide, we are doing it *for* her, i.e., it is in her best interests. See id. at 216. Finally, with respect to the "sanctity" of the person, this can be viewed as both the intrinsic and the personal value of life. For instance, even if a patient is non-religious, she can believe in the sanctity of life. See id. at 194-96.

patient's autonomy, and that when this principle conflicts with others, it should almost always take precedence."[118] She notes, "this premise has been incorporated into our laws governing medical practice and research, including the requirement of informed consent to any treatment."[119] Finally, she emphasizes, "In medicine, patients exercise their self-determination most dramatically when they ask that life-sustaining treatment be withdrawn" (and implicitly, even more powerfully if they could opt for P.A.S.).[120]

Nevertheless, while autonomy has thus become something of a trump card in the debates of recent years, there is merit to the discussion of whether true and full autonomy really exists. Contrary to Dworkin, Professor Rebecca Dresser believes that most of us do not have the strong sense of critical interests, autonomy, and continuity of the person necessary to adopt Dworkin's thesis.[121] She asserts that Dworkin omits the fact that people make reevaluations all the time. Therefore, Dresser argues for a form of "moral paternalism" whereby we should sometimes disregard the autonomy of person's advanced directive requesting a hastened death.[122] To support this view, she asks: if the continuity of one's life plan is really as crucial as Dworkin and others suggest, then why doesn't everyone make out an advanced directive?[123] She asserts that there is no empirical evidence to support the claim that people want narrative coherence, and that the majority of those who actually make out an advanced directive do so out of a sense of uninformed obligation to their family, not in a quest for self-determination.[124] This

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[118] Angell, supra note 96, at 50.

[119] Id.

[120] Id.

[121] See Rebecca Dresser, Dworkin on Dementia: Elegant Theory, Questionable Policy, 25 Hastings Center Rep. 32, 34-38 (1995).

[122] See id. at 35-38.

[123] See id. at 34.

[124] See id. at 35. To illustrate the lack of self-determination and informed decision-making evident in advanced directives, Dresser cites to a study of dialysis patients who had issued instructions as to treatment in the event of advanced Alzheimer's disease. Upon follow up of the patients who had submitted these advanced directives, "two-thirds of them wanted families and physicians to have some freedom to override the directives." Id. at 35. Furthermore, Dresser notes that a survey of twenty-nine people enrolled in an advance care planning workshop agreed with both of the following inconsistent statements: "I would never want to be on a respirator in an intensive care unit"; and "If a short period of extremely intensive medical care could return me to near-normal condition, I would want it." Id. at 35. See also Lachlan Forrow et al., Advance Directives for

claim is backed up by a survey of Oregon physicians conducted by Melinda Lee, which indicated that the vast majority believed patients might request P.A.S. out of "concern about being a burden to others" (93 percent) or "financial pressure" (83 percent).[125]

Furthermore, Professors Robert Burt and Yale Kamisar more aggressively challenge supporters of the self-determination arguments, openly doubting whether true autonomy is even possible.[126] Kamisar expresses skepticism that the choice to end one's life could ever be sufficiently voluntary, declaring "There is a great deal to be said . . . for Dr. Frohman's pithy comment that the voluntary plan is to be carried out 'only if the victim is both sane and crazed with pain.'"[127] While Kreimer believes (and I agree) that this proclamation goes too far,[128] Burt sides with Kamisar's position, arguing that self-boundaries are decimated by the severe trauma many P.A.S. candidates experience.[129] Thus, rather than focus on the personal choice to die, Burt concentrates on its emotional context. He believes that patients are often temporarily depressed and are expressing the desire to avoid helplessness, dependence, and humiliation rather than the "wish to die."[130] This belief is strengthened by data reviewed by Conwell Yeates and Eric Caine, who found that "90 to 100 percent of the suicide victims die while they have a diagnosable psychological illness," which often is an acute (but treatable) depressive episode that makes the contention of "rational" suicide quite dubious.[131] If one accepts this scenario, then allowing unregulated P.A.S. does not truly respect patient autonomy. While Yeates and Caine's estimates of the incidence of depression and psychological illness may be high due to liberal interpretations of the categories, they

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Medical Care, 325 New Eng. J. Med. 1255 (1991).

[125] See Lee et al., supra note 99, at 311.

[126] See Burt, supra note 99. See also Yale Kamisar, Some Non-Religious Views Against Proposed "Mercy-Killing" Legislation, 42 Minn. L. Rev. 969, 985-93 (1958).

[127] Kamisar, supra note 126, at 985-86.

[128] See Kreimer, supra note 107, at 824.

[129] See Burt, supra note 99, at 10-13.

[130] Id. at 12.

[131] Conwell Yeates & Eric Caine, Rational Suicide and The Right To Die—Reality and Myth, 325 New Eng. J. Med. 1100, 1101 (1991) (citations omitted).;See also Harvey Max Chochinov et al., Desire for Death in the Terminally Ill, 152 Am. J. Psychiatry, 1185 (1995) (finding a correlation between suicidal thoughts and clinical depression among terminally ill patients).

still raise the question of whether it is possible for *self*-determination to exist in all of the contexts in which end-of-life choices are made.

As such, given the limitations on voluntariness, there is much to be said for Dr. Stone's emphatic belief, "Let us not simply genuflect in the direction of total autonomy."[132] The take-home lesson is that responsible P.A.S. policy in America must include strict safeguards to ensure that autonomy of the individual is truly present before allowing the P.A.S. action to be carried out.

B. Collective Ethical Considerations with Respect to Physician-Assisted Suicide

Turning from the individual ethical considerations regarding P.A.S. to the collective ones, Linda Emanuel suggests five additional arguments can be made.[133]

1. Private Versus Public Matters

First, P.A.S. proponents urge that private matters concerning end-of-life determinations should be free of government or other outside interference. I note at the outset that this sounds much like the argument that abortion-rights supporters successfully made in *Roe v. Wade*[134] and in *Planned Parenthood v. Casey*[135] regarding a woman's privacy right over her body.[136] However, as Kamisar believes, the collective implications of P.A.S. are certainly a matter of public concern, and even most supporters of the practice would concede that the state does have a rational interest in the preservation and sanctity of human life.[137] (On the other hand, the *weight* of the state's interests versus the private interest would undoubtedly be in dispute between proponents and foes of P.A.S.[138])

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[132] Lecture given by Dr. Stone at Harvard Law School, November 10, 1997.

[133] See Regulating How We Die: The Ethical, Medical, and Legal Issues Surrounding Physician-Assisted Suicide (Linda L. Emanuel ed., 1998).

[134] 410 U.S. 113 (1973).

[135] 505 U.S. 833 (1992).

[136] See generally *Roe*, 410 U.S. 113; *Casey*, 505 U.S. 833.

[137] See generally Kamisar, supra note 126.

[138] See supra Part I (discussing the legal history and development of the right to die).

2. Role of the Medical Profession

Secondly, supporters and opponents of P.A.S. clash over what I believe to be the most important and difficult collective ethical consideration—whether medical professionals are at society's command, or whether they maintain their individual values. If physicians are at the "command" of their patients and have a duty as medical professionals to serve their patient's interests as the patient sees them, then would a doctor who refuses to offer P.A.S. to her patient be serving her own self-interests and values ahead of her patient's? May a physician who has had a lifelong relationship with her patient abandon him at the end over a disagreement regarding end-of-life decision-making? On the other hand, will the open and legalized practice of P.A.S. undermine the collective trust of the public in the entire medical profession?[139]

On balance, I come down on the physicians' side of this debate—i.e., that their role as professionals in our society should not obligate them to participate in P.A.S. against their will. (However, relieving physicians of a mandatory duty to participate in P.A.S. is not at all inconsistent with legalization and regulation of the practice.) Most commentators, including Dr. Angell, agree that no doctor should be forced to comply with a request for P.A.S. that runs counter to her values. But then, I wonder how this view is consistent with Angell's prior assertion that a doctor's first guiding principle should be respect for each patient's autonomy above all else.[140] Is there a consistent principle at work, or does it come down to the realization that forcing all physicians to provide P.A.S. regardless of their own religious and moral values would be political and professional suicide?[141]

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[139] See infra Part III, Section C (discussing the implications of P.A.S. on the doctor-patient relationship, especially in light of the rise of managed care).

[140] See Angell, supra note 96, at 50.

[141] See Charles H. Baron et al., A Model State Act to Authorize and Regulate Physician-Assisted Suicide, 33 Harv. J. on Legis. 1 (1996). I note that like most commentators, the Model State Act to Authorize and Regulate Physician-Assisted Suicide addresses this concern by similarly relieving physicians of their obligation to participate in P.A.S. against their will. See id. The authors conclude that it is quite possible to legalize, implement, and regulate P.A.S. in the United States while not bestowing any absolute "right" to P.A.S. upon patients. See id. Thus, an individual physician is free to decline to engage in that option without stripping it from all patients or all doctors. See id.

3. Legal Trends Versus the Constitution

Emanuel's third collective consideration in support of P.A.S. focuses on the progression of legal trends over the past two decades that have gravitated towards supporting the expansion of the right to die.[142] While this may be the case, Justice Scalia's concurrence in *Cruzan,* as well as Chief Justice Rehnquist's majority opinion, clearly is based upon the proposition that the U.S. Constitution does not give any indication in support of a *right* to P.A.S.[143] As such, without explicit constitutional backing, the Supreme Court had relatively little trouble in dispatching the question given the extreme heat and passion it engenders.[144] Still, the Court did explicitly allow for the debate to continue in the state legislatures, and we are certain to see more developments on this front in the coming years. It is our obligation then to make sure those developments are sound and responsible ones that respond effectively to the ethical concerns raised by P.A.S.

4. Legal Restraints and Safeguards Versus the Slippery Slope

Proponents of P.A.S. add that societal legalization of the practice would permit effective restraints and safeguards. Perhaps the best anecdotal evidence one can offer in support of this argument is the crusade of Dr. Kevorkian. He had in effect no legal criteria to adhere to as he traveled around in his suicide van (although he proclaimed a set of "personal" guidelines), and stories have emerged that some of his patients were not terminally ill, or felt pressured into the final decision.[145] Furthermore, colleagues of his have gotten into the act, recently assisting in a suicide of a woman whose complaint was, "I am not stressed, oppressed or depressed. I don't have Alzheimer's and am not terminally ill. But I am 82 years old and I want to die."[146] Needless to say, it is frightening to think that on this information alone she would have been an appropriate candidate for P.A.S. Professor Robert Sedler argues that under an explicitly legalized system however, effective controls

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[142] See supra Part I (discussing the legal history and development of the right to die).

[143] See Cruzan v. Director, Missouri. Department of Health, 497 U.S. 261 (1990).

[144] See Vacco v. Quill, 521 U.S. 793, at 809 (1997).

[145] See Kevorkian Associate Said to Assist in Suicide, Reuters, Dec. 4, 1997.

[146] Id. (describing how Dr. Georges Reding, a retired psychologist and friend of Kevorkian's, aided Martha Wichorek in ending her life given the complaints listed above).

could be implemented to ensure that the right to P.A.S. is not abused.[147] I note that this idea is also a fundamental premise behind the Model State Act to Authorize and Regulate Physician-Assisted Suicide, as the authors present numerous patient and procedural safeguards aimed at preserving the benefits of P.A.S. while minimizing its potential for abuse.[148]

However, critics such as Kamisar are adamant that if P.A.S. is legalized, we will be headed on a certain and destructive path towards active euthanasia.[149] This is the classic slippery slope nightmare even supporters of P.A.S. cannot ignore. Linda Ganzini's initial study, *Attitudes of Oregon Psychiatrists Toward Physician-Assisted Suicide*, indicated that 42 percent of those physicians *in favor* of the practice conceded that it might lead to *involuntary* euthanasia either moderately or a great deal (62 percent of opponents of P.A.S. felt this way as well).[150] Additionally, 48 percent of P.A.S. proponents admitted that it may be "misused with disadvantaged persons" either moderately or a great deal, and 74 percent of opponents agreed.[151] Those numbers cannot be summarily dismissed no matter what one's personal view on P.A.S. is, and, therefore, any effort to legalize the practice must devote substantial attention and detail to the prevention of "slippery slope" abuses.[152]

5. Holland's Example—Culture

Nevertheless, as the final collective ethical consideration in support of legalizing P.A.S., proponents assert that Holland's policy has worked out well. Though P.A.S. has not been explicitly legalized by a governmental body, there is a firm understanding between the government and its physicians that the latter can en-

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[147] See Robert A. Sedler, Are Absolute Bans on Assisted Suicide Constitutional? I Say No, 72 U. Det. L. Rev. 725, 726-27 (1995).

[148] See Baron et al., supra note 141.

[149] See Kamisar, supra note 105, at 749-53.

[150] See Linda Ganzini et al., Attitudes of Oregon Psychiatrists Toward Physician-Assisted Suicide, 153 Am. J. Psychiatry, 1469, 1472 (1996).

[151] Id.

[152] I note that a follow-up study conducted by Ganzini found that the slippery slope was not a severe problem in Oregon's experience. P.A.S. cases did not rise sharply between 1998 and 1999 (16 cases versus 27 cases), and more importantly, physicians often attempted to intervene and improve the quality of life for terminally ill patients. See Assisted Suicides Not Rising Sharply in Oregon, Reuters Health, Feb. 23, 2000.

gage in the practice. Supporters of P.A.S. assert that while detractors of Holland's system declared it would be a devastating lesson on the perils of the slipperiest slope in medicine, studies have proven exactly the opposite to be the case. They cite 1990 and 1995 studies of P.A.S. supported by the Royal Dutch Medical Association which concluded that there is no evidence that "physicians in the Netherlands are moving down a slippery slope."[153] In response, critics make the general contention that the culture prevalent in the Netherlands that allows this to be the case is not safely reproducible in America. We have no national health insurance, and more and more, managed care is introducing economic incentives that would send us rapidly skidding down the slippery slope in the U.S.[154]

More decisively, a commentary by Hendin published in the *Journal of the American Medical Association* directly refuted the results offered by the Dutch studies, contending that the Dutch experience has been far from an unqualified success.[155] Hendin offers evidence that the Dutch guidelines have failed to adequately protect patients, citing that 50 percent of physicians reported it would be "appropriate to suggest euthanasia to patients."[156] This raises grave problems with respect to the reality of patient suggestibility, as Kathleen Foley and Richard Coleson have argued that patients do not have much independent autonomy of their own, but rather are easily convinced by their doctors' suggestions.[157] Moreover, Hendin's commentary asserts that death without consent in the Netherlands is not a rarity. In fact, he states that the 1990 study revealed that in 0.8 percent of the deaths (more than 1000 cases) due to P.A.S. in the Netherlands each year, "physicians admitted they actively caused death without explicit con-

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[153] Herbert Hendin et al., Physician Assisted Suicide and Euthanasia in the Netherlands: Lessons From the Dutch, 277 JAMA 1720, 1720 (1997) (quoting P.J. Van der Maas et al., Euthanasia and Other Medical Decisions Concerning the End of Life (1992)).

[154] See infra Part III (discussing Managed Care).

[155] See Hendin et. al., supra note 153, at 1720-22.

[156] Id. at 1721 (citation omitted).

[157] See Richard E. Coleson, The Glucksberg & Quill Amicus Curiae Briefs: Verbatim Arguments Opposing Assisted Suicide, 13 Issues L. & Med. 13 (1997); Kathleen M. Foley, Competent Care for the Dying Instead of Physician Assisted Suicide, 336 New Eng. J. Med. 54, 55 (1997). See also infra Part III, Section D (discussing patient suggestibility).

sent of the patient."[158] Finally, Hendin cites to other studies indicating "voluntariness is compromised, alternatives are not presented, and the criterion of unrelievable suffering is bypassed."[159]

Thus, given the mixed reviews on the Dutch experience and the fundamental differences in the financial structure of American versus Dutch health care, P.A.S. supporters in the United States have good reason to be cautious in implementing our nation's policy.

C. Interim Observations

Whether one comes into the P.A.S. debate as an enthusiastic supporter or rabid opponent, it is clear that compelling individual and collective ethical considerations are present on both sides of the issue. Perhaps this is why Judge Richard Posner has concluded that there is no way to make a convincing moral argument on either side of the debate.[160] My own personal belief is that the ethical arguments detailed in support of allowing the practice are on balance more persuasive with respect to allowing carefully regulated P.A.S., but proving that is not the intention of this paper. Rather, the purpose is to consider all of these arguments, as well as the added dimension of managed care,[161] in formulating sound P.A.S. law and policy in America today.

III. THE IMPACT OF MANAGED CARE ON THE PHYSICIAN-ASSISTED SUICIDE DEBATE

Now that we have a legal and ethical framework in which to ground the debate over P.A.S., we must consider the dramatic impact managed care has had on health care policy and practice in America. The rise of managed care raises a host of serious dilemmas that careful and responsible P.A.S. policy must evaluate and guard against.[162]

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[158] Hendin et al., supra note 153, at 1721.

[159] Id. at 1722 (citations omitted).

[160] See Posner, supra note 113.

[161] See infra Part III (discussing the implications of managed care on P.A.S. policy).

[162] For a more comprehensive discussion of the risks posed by managed care than that which is offered in this paper, see Jefferson Smith, Physician Assisted Suicide, (1998) (unpublished manuscript on file with the Virginia. Journal of Social Policy & the Law).

A. Financial Incentives and United States Health Care Expenditures

The International Anti-Euthanasia Task Force opened its amicus curiae brief to the Supreme Court in *Quill* by proclaiming, "managed care has changed the very basis upon which health care is provided."[163] This was not mere litigation hyperbole. For the better part of this century, health care was provided on a fee-for-service basis marked by large insurance companies (most prominently, Blue Cross/Blue Shield), paying out even larger sums to doctors and hospitals. Under the fee-for-service system, providers were paid for each service they performed, and hence had a financial incentive to exhaust all treatments possible, and even to provide unnecessary care since the more health care that was provided, the greater the provider's income.

Not surprisingly, as the data presented by Joseph Califano and the Health Care Financing Administration attest, U.S. health care expenditures have spiraled nearly out of control to approximately 14 percent of total U.S. Gross National Product today (roughly $1 trillion annually, or 20 percent of America's entire national debt).[164] Katharine Levit's study found that Medicare spending has continued its dramatic growth (on the order of 10 percent per annum), in great part due to our increased lifespan made possible by advances in modern medical technology.[165] Edward Schneider's research further indicates that a good percentage of America's aging population will be afflicted with some form of chronic illness, and that means the need for expensive "medical care in later life [is] likely to increase substantially."[166]

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[163] Brief Amicus Curiae of the International Anti-Euthanasia Task Force in Support of Petitioners, Vacco v. Quill, 521 U.S. 793 (1997) (No. 95-1858), *available in* 1996 WL 656322.

[164] See Joseph A.Califano, Jr., America's Health Care Revolution: Who Lives? Who Dies? Who Pays? 164-66, 173-78 (1986).

[165] See Katharine R. Levit et al., Health Care Spending in 1994: Slowest in Decades, Health Aff. 130, 135 (1996). Levit found that although overall health care expenditures are not growing at nearly the rate they used to, likely due to the new pressures managed care has added on all plans, Medicare spending is continuing to increase rapidly. See id.

[166] Edward L. Schneider & Jacob A. Brody, Aging, Natural Death, and the Compression of Morbidity: Another View, 309 New Eng. J. Med. 854 (1983).

Thus, when one couples America's aging population together with the fact that Medicare enrollment in managed care organizations is rapidly rising,[167] a conflict is brewing that will directly determine the amount of (and whether) care will be given to chronically ill, elderly patients in the future. This problem is particularly acute given that 40 percent of total Medicare expenditures come in the last few months of life,[168] making it a fertile area in which HMOs will try desperately to slash costs, perhaps even encouraging P.A.S. to inappropriate candidates. The managed care industry knows that Maxwell's Paradox is indeed true—the more we spend now on health care, the more we must spend later.[169] Keeping people alive when they are younger means that they will be alive when they are older so that they may die of prohibitively expensive illnesses like cancer instead. Hence, Thurow points out that it is quite evident that the need to control costs is real if America is to avoid bankrupting its health care delivery system.[170] But many wonder if a new regime focusing on controlling costs is compatible with the presence of legalized and unregulated P.A.S.

Nevertheless, riding to the rescue is managed care. Managed care plans have enjoyed a meteoric surge in enrollment in the past ten to fifteen years.[171] HMOs have snuck in without excessive protest because they control costs while often not explicitly changing the benefits that patients are entitled to receive. Instead, they cut costs by controlling the costly treatment decisions that doctors used to make when they were at the center of the health care universe. (For instance, when and how long to hospitalize a patient, what medical procedures to order, when a patient should see a specialist, etc.) In this manner, the plan effectively regulates physicians' standard of care down to the managed care standard.

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[167] See National Center for Health Statistics, Health Maintenance Organizations and Enrollment (visited Oct. 12, 1999) <http://www.cdc.gov/nchswww/fastats/hinsure.htm> [hereinafter NCHS, Health Maintenance Organizations and Enrollment] (HMOs have increased in market share from approximately 4 percent in 1980 to 17.3 percent in 1994).

[168] The dramatically high percentage of Medicare expenditures in the final months of life is a direct result of prohibitively expensive but marginally effective end-of-life care. See generally Schneider & Brody, supra note 166. See also generally John Morrow & Arch B. Edwards, U.S. Health Manpower Policy: Will the Benefits Justify the Costs?, 51 J. Med. Educ. 791, 795 (1976).

[169] See Morrow & Edwards, supra note 168, at 795.

[170] See Lester Thurow, Learning to Say "No", 311 New Eng. J. Med. 1569 (1984).

[171] See NCHS, Health Maintenance Organizations and Enrollment, supra note 167.

The financial incentives for HMOs to act in this way are no mystery. Put simply, managed care organizations have a direct financial incentive to limit care and control costs because every dollar patients pay into the plan that is not spent on care (or on administrative costs) remains in the plan's coffers. This incentive to limit money spent on care is passed on to the plan's physicians in several ways. First, there is the omnipresent threat of termination if a doctor orders more services than her plan deems appropriate.[172] Second, rather than having physicians compensated solely by salary, a significant portion of physician remuneration increasingly comes through "bonuses" paid at year end based on the lack of services ordered (also known as a "withhold").[173] Finally, some managed care plans pass on all of the risk of providing excess care to their doctors by paying them an up front "capitation fee."[174] This entails payment of a flat fee per patient, and in return, the physician is responsible for providing all medical services for each covered patient. Thus, critics, such as the Ad Hoc Committee to Defend Health Care, argue that managed care has caused a shift from doctor as fiduciary to doctor as a steward of resources, conflicted between her obligation to the patient versus her obligation to a community of covered lives.[175]

Even absent any self-interested manipulation by physicians, Seth Kreimer and Daniel Spencer worry that if unregulated P.A.S. is a viable option under managed care, the plans' financial incentives will seriously dampen interest in seeking out state-of-the-art palliative care.[176] This would be particularly troublesome given

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[172] See Julia A. Martin & Lisa K. Bjerknes, The Legal and Ethical Implications of Gag Clauses in Physician Contracts, 22 Am. J. L. & Med. 433, 441-43 (1996).

[173] See John R. Penhallegon, Emerging Physician and Organization Liabilities Under Managed Health Care, 64 Def. Couns. J. 347 (1997).

[174] See id. See also Brief Amicus Curiae of the International Anti-Euthanasia Task Force in Support of Petitioners, Vacco v. Quill, 521 U.S. 793 (1997) (No. 95-1858), *available in* 1996 WL 656322.

[175] See Kathleen Spiessbach, Protest Against Profit-Driven Health Care, Reuters, Dec. 3, 1997. The Ad Hoc Committee To Defend Health Care is a Massachusetts group of doctors and nurses who published a "call to action" letter in The Journal of the American Medical Association, denouncing the "canons of commerce" which threaten to "transform healing from a covenant into a business contract." See id.

[176] See Seth F. Kreimer, Does Pro-Choice Mean Pro-Kevorkian? An Essay on Roe, Casey, and the Right to Die, 44 Am. U. L. Rev. 803, 827 (1995). See also Donald E. Spencer, Practical Implications for Health Care Providers in a Physician-Assisted Suicide Environment, 18 Seattle U. L. Rev. 545, 551 (1995).

pain expert Kathleen Foley's assertion that the availability of adequate control of pain and suffering could eliminate most requests for suicide.[177] In response though, Marcia Angell calls "illogical" the argument that permitting P.A.S. would divert resources from comfort care. She states, "[g]ood comfort care and the availability of physician-assisted suicide are no more mutually exclusive than good cardiologic care and the availability of heart transplantation."[178] While there may be some truth in this proposition, the majority of literature discussing incentives for investing resources in palliative care given the financial conflict of interest comes down on Kreimer's and Spencer's side of the debate.[179]

In the end then, under managed care, the price to be paid for expensive, marginally beneficial treatment to patients at the end of life comes both out of the plan's pockets and those of its physicians as well. In this system, when one factors in the rapidly increasing Medicare enrollment in HMOs, can an elderly, chronically ill patient help but be skeptical of the plan's financial motivation in providing care and potentially suggesting P.A.S.? Kreimer emphasizes the severity of this dilemma, warning that "[p]articularly with the emergence of cost controls and managed care in the United States, the danger of tempting health care providers to persuade chronic patients to minimize costs by ending it all painlessly is no fantasy."[180] As such, any well-formulated P.A.S. policy in America should diligently guard against the possibility that physicians, especially those in HMOs who are keeping a watchful eye on their wallets, might suggest or encourage P.A.S. to vulnerable patients. Absolutely no conscientious human being would opt for a policy where managed care cost controls take precedence over the will and autonomy of an individual who potentially is unable to make strong decisions on her behalf in a time

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[177] See Kathleen M. Foley, The Relationship of Pain and Symptom Management to Patient Requests for Physician-Assisted Suicide, 6 J. Pain & Symptom Mgmt. 289, 290 (1991); but cf. Marcia Angell, The Supreme Court and Physician-Assisted Suicide—The Ultimate Right, 336 New Eng. J. Med. 50, 50 (1997).

[178] Angell, supra note 177, at 51 (1997).

[179] See Assisted Suicides Not Rising Sharply in Oregon, Reuters Health, Feb. 23, 2000 (discussing latest study by Ganzini, et al suggesting that Oregon's legalization of P.A.S. may actually improve palliative care by encouraging physicians to intervene and improve the quality of life for terminally ill patients).

[180] Kreimer, supra note 176, at 841.

conducive to tragic weakness.

B. Managed Care Gag Clauses

Furthermore, less known to the lay public is that managed care gag rules curb what doctors can tell their patients about expensive alternative treatments.[181] Hence, there is a real danger that information and options to patients will be chilled, and P.A.S. will no longer be used solely as a last resort. For instance, a recent notice to doctors working for the Kaiser Permanente HMO in Ohio stated, "Do not discuss proposed treatment with Kaiser Permanente members prior to receiving authorization" from an outside company that "sets guidelines for the treatment of patients."[182] It is not inconceivable under this regime that a managed care physician may be forbidden to tell her patient that there is a slight chance for long term survival if he undergoes radical radiation at prohibitive cost. The case of Ray Mount, a Massachusetts psychologist who formerly contracted with CIGNA, illustrates this point. After being fired within one month of suggesting a patient receive treatment that the plan deemed unnecessary, Mount commented, "you just don't risk making [HMOs] angry."[183] Furthermore, plans such as Aetna protect themselves in this respect by defining "medical necessity" and "covered services" interchangeably, allowing the plan to supersede a physician's judgment regarding the necessity of medical service.[184]

Additionally, even when an elderly depressed patient who is contemplating suicide comes asking for treatment, HMO gag rules may require doctors to prescribe her less expensive and also less effective drug therapies than those that are available elsewhere. For example, a study by Dr. Stephen Bartels found that managed care patients over age 65 were three times more likely than younger patients to be prescribed older antidepressants (such as

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[181] See Martin & Bjerknes, supra note 172, at 441-43.

[182] Robert Pear, Doctors Say HMOs Limit What They Can Tell Patients, N.Y. Times, Dec. 21, 1995 at A1.

[183] Martin & Bjerknes, supra note 172, at 443.

[184] See Sarah A. Klein, Health Plan Has All the Power, Am. Med. News, Dec. 1, 1997 (concluding after an analysis of the terms that Aetna US Healthcare requires of its Florida physicians that there were serious power imbalances between plans and their physicians).

tricyclics) than newer and more efficacious serotonin reuptake inhibitors ("SSRIs").[185] Bartel indicated that this was quite crucial, stating "we know that SSRIs are associated with less side effects among older persons," including mental confusion.[186] When this finding is coupled with the data Ganzini, Yeates, and Chochinov independently present on the strong correlation between depression and patient requests for P.A.S., the effect of managed care gag rules upon what doctors can offer their patients is seriously offensive to our notions of a just social-medical policy.[187] Additionally, a study by Dr. Charles Cleeland found that treatment for pain related to cancer is often not part of the dialogue that takes place between the health care professional and the patient.[188] As such, if patients are going to get treatment for pain, they have to initiate that part of the dialogue.[189] Hence, there is no question that a responsible P.A.S. policy in America must insert safeguards that ensure managed care financial incentives and gag clauses do not limit the patient's options for treatment as described above.

Furthermore, not surprisingly, managed care gag clauses also prohibit physicians from informing patients that doctors who save money by withholding care get financial bonuses.[190] According to Julia Martin and Lisa Bjerknes, plans often "prohibit disclosure of the . . . physician payment and incentive structure, effectively prohibiting discussion of the physician's conflict of interest."[191] When asked what purpose these clauses serve for *patient* interests, Susan M. Pisano, a spokeswoman for Group Health Association of America, claimed that they are a legitimate way to "discourage doctors from disparaging HMOs and encourage them to discuss

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[185] See HMO Care of Older Depressed Lacking, Reuters, Oct. 28, 1997 (discussing the results of Dr. Bartels' study, which was published in 27 Int'l J. Psychiatry Med. 215).

[186] Id.

[187] See Linda Ganzini et al., Attitudes of Oregon Psychiatrists Toward Physician-Assisted Suicide, 153 Am. J. Psychiatry, 1469, 1472 (1996); Conwell Yeates & Eric Caine, Rational Suicide and The Right To Die—Reality and Myth, 325 New Eng. J. Med. 1100, 1101 (1991); Harvey Max Chochinov et al., Desire for Death in the Terminally Ill, 152 Am. J. Psychiatry, 1185 (1995) (finding a correlation between suicidal thoughts and clinical depression among terminally ill patients).

[188] See Charles S. Cleeland et al., Pain and Its Treatment in Outpatients with Metastatic Cancer, 330 New Eng. J. Med. 592, 594-95 (1994).

[189] See id.

[190] See Pear, supra note 182.

[191] Martin & Bjerknes, supra note 172, at 443.

their concerns about payment and treatment policies with doctors and physician managers in the health plan, rather than with patients."[192] David F. Simon, senior vice president of U.S. Healthcare, added that "the purpose was to protect patients, to make sure they were not put in the middle of economic disputes between doctors and the company."[193]

While I cannot be sure of the reader's take on these comments, I do not find them believable or reasonable. The motive behind these gag clauses is so patently economic that it stretches the imagination to ponder how executives of HMOs could say otherwise with a straight face. I find myself in complete agreement with the response of the AMA's ethics authority, the Council on Ethical and Judicial Affairs, which declared recently "that doctors should inform patients of all relevant financial inducements, including incentives to limit care."[194]

Quite disturbingly, we must conclude that both financial and informational limitations imposed by managed care indicate that unregulated P.A.S. has the potential to become a method to control costs rather than a way to respect patients' autonomy to end their lives in a merciful and compassionate manner.

C. Would Managed Care Lead to Competition Between Plans Based on Physician-Assisted Suicide Policy?

Another potential development that would not be implausible in today's managed care environment is that of competition between plans based on their end-of-life policies. For example, Leonard Fleck asks the pointed question: would an individual be able to choose "to join a Medicare HMO that offered substantial supplementary social services to their elderly clients in exchange for their agreeing to give up access to . . . marginally beneficial, expensive, end-of-life care?"[195] The HMOs would argue that this policy simply serves the interests of efficiency and patient autonomy—if someone desires to pay lower plan premiums in return for

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[192] Pear, supra note 182.

[193] Id.

[194] Id.

[195] Leonard M. Fleck, Just Caring: Assisted Suicide and Health Care Rationing, 72 U. Det. Mercy L. Rev. 873, 878 (1995).

foregoing expensive measures late in life, then so be it.

The moral and ethical problems with this kind of competitive system are seriously disturbing. For one, it allows individuals to bargain around the sanctity of human life. Furthermore, as cost pressures mount, the line between what is a marginally beneficial, unworthwhile end-of-life treatment will inevitably creep in a direction adverse to patient interests. And moreover, this kind of price competition over end-of-life decisions will undoubtedly have a disproportionately discriminatory impact on the poor and members of minority groups.[196] For example, Dr. Cleeland's study recently confirmed that Hispanic and African-American cancer patients are less likely than whites to receive adequate treatment for pain,[197] increasing the chance they would find P.A.S. a more palatable outcome.

Thus, serious ethical problems are posed by legalized, unregulated P.A.S. combined with the financial and informational realities of today's managed care environment. When the powerful and positive social values of efficiency and respect for patient autonomy collide without any restraining safeguards, the result is far too likely to be morally pernicious.[198]

D. The Effect of Managed Care and Physician-Assisted Suicide on the Doctor-Patient Relationship

While managed care's financial incentives and gag clauses have an obvious influence on the amount of health care provided, they have only a slightly more subtle deleterious effect on the doctor-patient relationship. Traditionally, there has been a paternalistic ethic in the medical profession—doctors do what is best for their patients given their expertise and duty to serve their patient's interest above all else.[199] The Hippocratic Oath, which en-

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[196] See Charles J. Dougherty, The Common Good, Terminal Illness, and Euthanasia, 9 Issues L. & Med. 151, 164 (1993).

[197] See generally Cleeland et al., supra note 188 (indicating that minority patients receive inferior pain control to that received by white patients, and so are more likely to "voluntarily" opt for P.A.S.).

[198] See Daniel Sulmasy, Managed Care and Managed Death, 155 Archives Internal Med. 133, 136 (1995). See also Fleck, supra note 195, at 886.

[199] See Alan A. Stone, Law's Influence on Medicine and Medical Ethics, 312 New Eng. J. Med. 309, 311 (1985).

joins physicians not to "give a deadly drug to anybody if asked for it, nor make a suggestion to this effect,"[200] is founded upon the conception of a doctor's role as healer who does no harm. Moreover, Kreimer states that "the patient's acquiescence in invasive or dangerous treatment rests in part on the faith that the power the physician exercises is directed [solely] toward the patient's recovery."[201] While strict paternalism has given way to expanded informed consent and patient autonomy in the last two decades,[202] the impact of managed care seriously threatens the trusting relationship between physician and patient.

Even without managed care in the picture, heated debates have raged over the ramifications that the practice of P.A.S. would have on public confidence in the medical profession. In Oregon for example, Ganzini's study indicated that 31 percent of psychiatrists opposed to P.A.S. believed it would result in "a great deal" of distrust of physicians, while only 9 percent of supporters thought that such a threat would materialize.[203] Now, within the growing context of managed care, if P.A.S. became part of a doctor's repertoire of available "treatments," Dougherty proclaims that patients would certainly begin to question, "Is my doctor's advice that there is nothing left for me but euthanasia motivated by my best interest or his, by concern for my suffering, or for her delivery network?"[204] Kreimer adds that the doctor-patient relationship will be further strained in a managed care environment, because personal encounters between physicians and patients are less common and shorter than ever before.[205] Many other medical and legal scholars, including Dougherty and Fleck, have made persuasive cases that the public will lose a great deal of trust in the medical profession "when the role of healer becomes conflated with that of killer."[206]

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[200] Hippocratic Oath, *reprinted in* Thomas A. Mappes & Jane S. Zembaty, Biomedical Ethics 50 (3d ed. 1981).

[201] Kreimer, supra note 176, at 829.

[202] See Stone, supra note 199, at 312.

[203] See Ganzini et al., supra note 187, at 1472.

[204] Dougherty, supra note 196, at 164.

[205] See Kreimer, supra note 176, at 829.

[206] Dougherty, supra note 196, at 164. See also Fleck, supra note 195, at 886-88.

A compelling example of the impact that P.A.S. coupled with managed care would have on the doctor-patient relationship is detailed by Sulmasy and Fleck.[207] Sulmasy paints a picture of Mrs. Jones, an unfortunate woman approaching the final stages of Lou Gehrig's disease. Her HMO physician emphasizes that her plan is committed to respecting all of her rights: both the right to all the care that she finds ameliorates her painful condition, as well as her right to refuse any dehumanizing, death-prolonging interventions she might be offered. The doctor shares his empathy for her tragic situation, affirming he will do everything possible to make her comfortable. However, he points out that palliative care can accomplish only so much, and that there is nothing dignified about incontinence or being placed on a ventilator. In conclusion, he offers that she does have a "right" to a speedier death, and can request aid-in-dying if she feels that would be best to relieve the burden that she and her family will have to endure. This line of persuasion has a decidedly eerie ring to it given Burt and Lee's assertions that most people opt for P.A.S. not out of a quest for self-determination, but rather out of a sense of not wanting to become a financial liability on the shoulders of their family.[208] When one considers Lee's evidence indicating that 93 percent of physicians in Oregon believe that concern about being a burden to others would be a factor in patient's P.A.S. decision,[209] the repercussions of allowing its unregulated practice in a managed care setting conducive to the above coercion are seriously disturbing.

Thus, the patient is left to resolve by herself whether the suggestion of P.A.S. as an option is the sincere and merciful intention of a well-meaning physician, or that of one who might possibly be thinking of his own financial interest passed on by his HMO. Cynical patients who reflected on the managed care system could not help but see the personal rewards for their physicians if they chose to die.[210] In addition to undermining patients' trust in their own doctors, patients may be led to outright hostility, despair, and

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[207] See Sulmasy, supra note 198, at 133-36; Fleck, supra note 195, at 887.

[208] See Robert Burt, Taking Care of Strangers, 1-21, 92-107, 114-21, 124-27, 174-80 (1979); Melinda Lee et al., Legalizing Assisted Suicide—Views of Physicians in Oregon, 334 New Eng. J. Med. 310, 311 (1996).

[209] See Lee et al., supra note 208, at 311.

[210] See Fleck, supra note 195, at 887.

a complete distrust for the entire medical care system. For example, an editorial by Kathleen Foley in *The New England Journal of Medicine* refers to evidence indicating that the legalization of P.A.S. in the Northern Territory of Australia has eroded the Aboriginees' trust in the medical care system.[211] Foley felt that the Australian experience might serve as a useful example for the similarly multicultural United States population. "There is concern that certain patients, particularly members of minority groups that are estranged from the health care system, may be reluctant to receive treatment for their physical or psychological symptoms because of the fear that their physicians will, in fact, hasten death."[212] However not all medical-ethical scholars agree that permitting P.A.S. would lead patients to distrust their physicians.[213] For example, Dr. Angell believes "distrust is more likely to arise from uncertainty about whether a doctor will honor a patient's wishes" to choose P.A.S. in the first place.[214]

Nevertheless, Fleck believes at the very least that physicians of sound moral character would find themselves tormented with self-doubt. While wishing to respect their patients' autonomy with respect to end-of-life choices, they would agonize over whether they had provided their patients with appropriate doses of hope and encouragement, trying not to tip the balance in either direction.[215] When one then factors in the reality of resource limits and cost constraints in managed care, it strains credulity to think that a conscientious physician could go without appropriate regulatory guidance in determining the appropriate amount of care and treatment to pursue.[216]

Finally with respect to the doctor-patient relationship is the issue of respect for patient autonomy versus the reality of patient suggestibility. There is abundant empirical evidence indicating that physicians exert a great deal of control over the "independent" choices of their patients merely by presenting them with informa-

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[211] See Kathleen M. Foley, Competent Care for the Dying Instead of Physician Assisted Suicide, 336 New Eng. J. Med. 54, 57 (1997).

[212] Id.

[213] See supra Part II, Section A(2).

[214] Angell, supra note 177, at 52.

[215] See Fleck, supra note 195, at 887.

[216] See id.

tion and suggestions. Not surprisingly, "studies of patients' preferences for care at the end of life demonstrate that physicians' preferences strongly influence those of their patients."[217] Thus, Richard Coleson argues that "the public is suffering from a false illusion that legalizing assisted suicide and euthanasia will give them greater autonomy."[218] To the contrary, he cites the Dutch experience with P.A.S. for the proposition that legalizing the practice actually increases the power and control of doctors who suggest or encourage it, for they often fail to propose obvious alternatives and ignore patients' ambivalence about suicide.[219] Hence, besides critics who directly question the integrity of managed care physicians given the financial conflicts they face, there is the additional and highly significant factor of unconscious or conscious steering of patient choices by their physicians. Thus, if we are to allow P.A.S. as an option in our society, especially as an option under managed care, we must account for this potential danger in order to ensure the voluntary and autonomous nature of the patient's decision. For instance, the threat of patient suggestibility and the further deterioration of the doctor-patient relationship might justify a severe limitation or outright ban on the ability of physicians to initiate the P.A.S. discussion.[220]

Hence, in the absence of strict legal safeguards protecting against potential abuses of P.A.S. in managed care, the combination of perverse financial incentives to limit care, gag clauses to control the flow of information, and competition to cut costs may have serious morally pernicious results.[221] Moreover, without careful regulation of P.A.S., the doctor-patient relationship will be at best severely threatened, and at worst, reduced to a state of such distrust that it loses its fiduciary and beneficial character altogether.

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[217] Foley, supra note 211, at 55.

[218] Richard E. Coleson, The Glucksberg & Quill Amicus Curiae Briefs: Verbatim Arguments Opposing Assisted Suicide, 13 Issues L. & Med. at 87 (1997).

[219] See id.

[220] See infra Part IV, Section D(5) (discussing suggestions for P.A.S. regulation).

[221] See Fleck, supra note 195, at 886.

IV. EFFORTS TO LEGALIZE AND REGULATE PHYSICIAN-ASSISTED SUICIDE

A. General Considerations in Formulating Physician-Assisted Suicide Policy

Given the spectacular rise in managed care and the legal developments of the past few decades (and especially the *Quill* decision), the reality in America is that we must prepare the public and medical profession to act responsibly in a potentially legalized P.A.S. environment.[222] Regardless of one's moral-ethical stance on the subject, we must address the crucial considerations in formulating sound P.A.S. policy, for every state is now in a position to make the practice available if they so choose. We should strive to achieve regulations that protect patients and minimize the potential abuses of P.A.S., while still preserving it as an option for autonomous adults. Fundamentally, P.A.S. regulation should ensure that patients are competent and fully informed as to alternatives, and that their decision is voluntary and enduring.

Barry Furrow and Donald Spencer independently lay down basic introductory criteria that serve as a foundation for "setting limits in the dying zone."[223] Furrow emphasizes that the dialogue over end-of-life decisions must be "out in the open" to help ensure that vulnerable groups are not exploited. He urges first that limits on access to treatment be applied fairly across the population, so that "the poor, the passive, and the uninformed" are not limited in their treatment options.[224] I do not believe anyone would question the horrific tragedy of legalized P.A.S. if we found that its implementation vastly and disproportionately cast its net over impoverished, elderly minorities in the inner city. Spencer supports this fundamental proposition, arguing for specific safeguards to ensure that the uninformed public knows all reasonable alternatives available.[225] Quite logically, Furrow also states that "treatment deci-

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[222] See Donald E. Spencer, Practical Implications for Health Care Providers in a Physician-Assisted Suicide Environment, 18 Seattle U. L. Rev. 545, 545-47 (1995).

[223] Barry Furrow, Setting Limits in the Dying Zone: Assisted Suicide, Scarce Resources, and Hard Cases, 72 U. Det. Mercy L. Rev. 901, 924-26 (1995). See Spencer, supra note 222, at 553-56.

[224] Furrow, supra note 223, at 924.

[225] See Spencer, supra note 222, at 546-50.

sions or denials should be transparent to all concerned," reflecting a recognition that managed care organizations often disguise lack of coverage.[226] "Whatever the decision," Furrow proclaims, "we are entitled to as much information as possible about its bases, and to an opportunity to respond to the justifications for limit setting."[227]

Spencer further believes that the problem in generating P.A.S. policy and legislation is not that reasonable professionals disagree over whether it should be regulated. Rather, physicians on both sides of the debate agree that we must create patient safeguards, but the question posed is: how extensive should that regulation be (keeping in mind it has a cost in terms of patient privacy and physicians' ability to practice)?[228] "Certain safeguards are nearly universally agreed upon," including that "the person choosing a physician-assisted suicide must. be terminally ill, uncoerced, and competent to make the decision."[229] However, there is disagreement about how far such public policy safeguards should go in order to ensure appropriate protection to patients at a time when they are vulnerable to coercion and abuse as well as suffering.

Below, I will consider and evaluate specific efforts to ensure that a patient's decision to opt for P.A.S. is voluntary, informed by all reasonable alternatives, competent, and free from depression and coercion. The most popular examples known to the public are those of the Netherlands and Oregon, both of which serve as useful foundations. However, I believe the best of the models put forth to date is the Model State Act to Authorize and Regulate Physician-Assisted Suicide ("Model Act"), and as such, I focus the greatest attention on its provisions.[230] Drafted by a team of lawyers, physicians, and academics in Massachusetts, the Model Act takes great strides to curb the potential dilemmas detailed throughout this paper while still making P.A.S. available to the segment of the population that can benefit from it. I feel that with a few modifications and borrowings from other regulatory exam-

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[226] Furrow, supra note 223, at 924-25.

[227] Id.

[228] See Spencer, supra note 222, at 548.

[229] Id.

[230] See Charles H. Baron et al., A Model State Act to Authorize and Regulate Physician-Assisted Suicide, 33 Harv. J. on Legis. 1 (1996).

ples, the Model Act is the direction in which legislatures should head when formulating P.A.S. policy.

B. Physician-Assisted Suicide Criteria in the Netherlands

As a backdrop, American legislators would be served well to look to the procedural requirements imposed in the Netherlands. Although P.A.S. has not been statutorily legalized, there is a firm understanding between the government and Dutch physicians that allows and attempts to regulate the practice.

Aida Koury describes how the Netherlands safeguards the public with five stringent criteria.[231] First, the patient must be experiencing "lasting and unbearable physical and mental suffering."[232] I immediately note that defining such a criterion is a tremendously difficult and subjective task, something the authors of the Model Act wrestled with as well.[233] Secondly, the patient must have a clear understanding of the available alternatives. This is a substantially different requirement than merely presenting the patient with her options, and one that would do well to be added to American P.A.S. policy. Third, the decision must be voluntary, a troublesome but essential requirement the Model Act attempts to ensure. Next, there must be no other reasonable alternative for the patient to pursue. I believe this condition to be a bit strong and potentially problematic with respect to *who* should be the party interpreting what is a "reasonable alternative." For example, the decision to opt for P.A.S. in the first place is certainly not one which all reasonable people are likely to agree with. Finally, the Dutch system requires that "the manner of death must not cause unavoidable misery to others."[234] This sounds completely sensible at first blush, but I wonder if it is ever possible that death by P.A.S. might not cause misery to some.

Hence, while I believe all of the factors governing the practice of P.A.S. in the Netherlands are worthy of consideration in America, I worry that some, especially the reasonableness and manner

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[231] See Aida A. Koury, Physician-Assisted Suicide for the Terminally Ill: The Ultimate Cure?, 33 Ariz. L. Rev. 677, 697 (1991).

[232] Id.

[233] See infra Part IV, Section D.

[234] Koury, supra note 231, at 697.

of death requirements, may not be practical (or even good) to implement in the United States. The Dutch policy does provide measures to ensure that the patient's choice is informed, but it needs greater safeguards to guarantee that the patient is competent, and that her decision is enduring and truly voluntary. Methods to accomplish these latter criteria are discussed in conjunction with the Model State Act to Authorize and Regulate P.A.S.[235]

C. Oregon's Measure 16—The Death with Dignity Act

Oregon's Death with Dignity Act is the most famous of American experiments with legalizing and regulating P.A.S.[236] Passed originally in November of 1994 when voters narrowly approved a ballot initiative, it was quickly barred by an injunction and underwent three years of legal wrangling. Opponents were initially victorious in persuading United States District Court Judge Michael Hogan to rule the measure unconstitutional on equal protection grounds, because it failed to offer terminally ill persons the same protections against suicide afforded to the majority.[237] However, the Ninth Circuit overturned the decision in *Lee v. Oregon*,[238] holding that the plaintiffs lacked standing since there was no clear risk of injury.[239] The plaintiffs then unsuccessfully petitioned the Supreme Court, with lead attorney James Bopp arguing that the Ninth Circuit had taken "the untenable position that persons must be in the throes of suicidal depression and seeking assistance in killing themselves before bringing suit."[240] Before the Act could take effect though, opponents were able to obtain yet another vote on the matter. Bringing a close to the suspense, Oregon citizens supported the measure again, this time by a decisive 60 to 40 percent margin.[241] In 1998, the first year for

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[235] See infra Part IV, Section D.

[236] Or. Rev. Stat. § 127 (1998), amended by 1999 Or. Laws Ch. 423. It was not the first such experiment however, as states such as California, Washington, Iowa, Maine, Michigan, and New Hampshire have all addressed the topic of euthanasia or P.A.S. in some manner.

[237] See Lee v. Oregon, 107 F.3d 1382, 1283 (9th Cir. 1997).

[238] 107 F.3d 1382 (9th Cir. 1997).

[239] See id.

[240] Ashbel S. Green, Ruling Won't Mean Suicides Soon, The Oregonian, Oct. 15, 1997.

[241] See Sam Howe Verhovek, Oregon Resists Federal Action on Assisted Suicides,

which statistics are available, 16 patients used the measure to end their lives.[242]

Under the Oregon law, an attending physician may prescribe a lethal dose of medication to a terminally ill patient for self-administration.[243] To be eligible, the patient must be a competent adult resident of Oregon who is expected to live less than six months.[244] She must make one written and two oral requests for P.A.S. during a fifteen day period.[245] To help protect against coercion of vulnerable patients by their physicians (which is especially crucial in today's era of managed care), a second doctor must confirm the diagnosis, the patient's decision-making capacity, and the voluntary nature of the request.[246] In addition, if the patient's decision seems to be impaired by depression or other psychiatric disorders, referral to a mental health professional is mandatory.[247] The Oregon Act also requires its physicians to ask the patient to disclose their decision to family members, but the patient is not forced to do so.[248] Finally, doctors must report their participation in P.A.S. to the state health division, but are protected from professional censure and legal liability for their actions.[249]

Critics have challenged the adequacy of the Oregon safeguards however. Melinda Lee's study of Oregon physicians revealed that half of those surveyed felt that they could not be certain they could predict whether a patient would die within six months.[250] While this is not something to disregard, this problem is not very likely to cause great potential for abuse. More seriously, Ganzini's first study of P.A.S. in Oregon reported that psychiatrists believed the fifteen day waiting period between the first request for P.A.S. and its administration was not sufficient to protect against a patient's

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Milwaukee J. & Sentinel, Nov. 18, 1999, *available in* 1999 WL 21548460.

[242] See Assisted Suicides Not Rising Sharply in Oregon, Reuters Health, Feb. 23, 2000 [hereinafter Assisted Suicides Not Rising].

[243] See Or. Rev. Stat. § 127.885 (1998), amended by 1999 Or. Laws Ch. 423.

[244] See Or. Rev. Stat. § 127.805 (1998), amended by 1999 Or. Laws Ch. 423.

[245] See Or. Rev. Stat. § 127.897 (1998), amended by 1999 Or. Laws Ch. 423.

[246] See Or. Rev. Stat. § 127.815 (1998), amended by 1999 Or. Laws Ch. 423.

[247] See Or. Rev. Stat. § 127.825 (1998), amended by 1999 Or. Laws Ch. 423.

[248] See Or. Rev. Stat. § 127.835 (1998), amended by 1999 Or. Laws Ch. 423.

[249] See Or. Rev. Stat. § 127.865 (1998), amended by 1999 Or. Laws Ch. 423.

[250] See Melinda Lee et al., Legalizing Assisted Suicide—Views of Physicians in Oregon, 334 New Eng. J. Med. 310, 312 (1996).

transitory desire to die.[251] If this is accurate, sound P.A.S. policy should consider extending the time required, as well as more stringently assessing the patient's state of mind. Perhaps a mandatory referral to a mental health professional would be in order even in cases where the treating physician does not suspect the patient is depressed. However, Ganzini asserted that the requirement of referral to a psychiatrist in the case of a depressed patient would not be very effective. In support of this proposition, she presented survey data of Oregon psychiatrists which indicated that 51 percent were not confident that they could adequately assess from a single evaluation whether a mental disorder such as depression was influencing a patient's decision.[252] Ganzini noted that psychiatrist's confidence was significantly increased if they had a longer relationship with the patient.[253] We must also keep in mind the possibility that selection bias may have occurred with respect to those psychiatrists who returned surveys. One might reasonably expect that physicians who felt strong moral or religious convictions against P.A.S. would be more likely to make their voices heard than those who supported or were merely not opposed to the practice.

Indeed, a follow-up study conducted by Ganzini in 1999 found that many of the physicians' concerns were not realized.[254] Data showed that the number of assisted suicides did not rise sharply between 1998 and 1999 (16 cases versus 27 cases), quelling fears that legalization would result in a rapid escalation of deaths.[255] More importantly, the study suggested that physicians often attempted to intervene and improve the quality of life for terminally ill patients. Thus, the mere availability of P.A.S. may be responsible for improved palliative care which deters suicides in the first place.

Overall, I believe the Oregon Death with Dignity Act takes several sound precautions to ensure patient autonomy, competence, and diagnosis, but perhaps could be bolstered somewhat to

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[251] See Linda Ganzini et al., Attitudes of Oregon Psychiatrists Toward Physician-Assisted Suicide, 153 Am. J. Psychiatry, 1469, 1471-72 (1996).

[252] See id. at 1473.

[253] See id.

[254] See Assisted Suicides Not Rising, supra note 242.

[255] See id.

achieve greater protection of vulnerable patients. Measures should be included to inform patients of all of their alternatives, especially the availability of palliative care. Patients must understand their options if autonomy and self-determination are to mean anything. Despite this shortcoming, the Oregon law does add a good measure of certainty to liability-wary physicians who might not have participated in P.A.S. previously, a factor which the public debate on the subject frequently neglects. The Model Act takes the framework laid down by Oregon and creates a detailed structure in which P.A.S. may be more safely practiced in America.

D. The Model State Act to Authorize and Regulate Physician-Assisted Suicide

Given the above regulatory examples, and considering all of the moral, ethical, and legal dilemmas P.A.S. presents (especially those caused by the added dimension of managed care), a team of lawyers, physicians, and academics in Massachusetts recently developed "A Model State Act to Authorize and Regulate Physician-Assisted Suicide."[256] The Model Act takes its foundation from the regulatory models described above, but has expanded coverage and procedural safeguards designed to minimize the potential for abuse while preserving P.A.S. as a legal option for the segment of the population which stands to benefit from it. Its authors submitted a persuasive article in the *Harvard Journal on Legislation* in conjunction with the Model Act that aids in illuminating its purposes and features.

1. The Need for the Model Act

The authors emphasize three critical reasons for the need for an explicit statutory authorization of P.A.S.[257] First, they argue that even if laws restricting P.A.S. in some states are struck down or state legislatures fail to speak on the subject, explicit regulation is still necessary to provide thorough oversight and protection against abuse of the practice.[258] Second, a statute "more clearly requires and establishes the public support" necessary for such a

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[256] See generally Baron et al., supra note 230.

[257] See id. at 7-9.

[258] See id. at 9.

controversial practice.[259] Third, it provides a measure of legal certainty to well-meaning physicians who wish to serve their patient's best interests but fear liability due to the current absence of legislative action in most states.[260] While Dr. Kevorkian's crusade enjoyed unprecedented success in bringing the practice of P.A.S. to the media forefront, the unregulated individual actions taken by him and doctors similarly situated provide for none of the purposes that the Model Act and other analogous legislation accomplishes.[261]

Relying upon the newfound certainty fostered by the Model Act, the authors argue that physicians will be able to consult openly with and seek advice from colleagues and other professionals, presumably enhancing the quality of their decision-making.[262] In comparison, as Troyen Brennan notes, physicians have access to a wide variety of professional consultations, frequently including review by ethics committees, in conjunction with other profoundly serious ethical issues.[263] Additionally, a regulated system such as the Model Act's, which requires monitoring and enforcement by the State Department of Health, will ensure accountability on the part of physicians and eliminate renegade "Kevorkians." Moreover, in line with concerns expressed by Dr. Angell, explicit legislation that preserves the option of P.A.S. for patients will prevent numerous premature suicides that occur

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[259] Id. at 7.

[260] See id. at 8-9. With respect to physicians' fears of liability, I note that Lee's survey of Oregon physicians indicated that 53 percent worried that the patient's family would sue in the absence of statutorily protected P.A.S., and approximately 25 percent were concerned that writing a prescription for a lethal dose of medication might violate federal laws, jeopardize their license to practice in another state, or lead to sanctions by hospitals. See Lee et. al., supra note 250, at 311-12.

[261] It is impossible to estimate the number of physicians who currently participate surreptitiously in P.A.S., but there are anecdotal accounts virtually every week of other doctors engaging in P.A.S. with virtually no legal safeguards in place. See, for example, Kevorkian Associate Said to Assist in Suicide, Reuters, Dec. 4, 1997, which describes a suicide attended by Georges Reding in which his patient, Martha Wichorek, was not terminally ill. She wrote in a letter, "I don't have Alzheimer's and am not terminally ill. But I am 82 years old and I want to die." Id. I shudder to think of the vast potential for abuses in cases such as hers if P.A.S. occurs in the absence of government legislated safeguards.

[262] See Baron et al., supra note 230, at 8-9.

[263] See id. (citing Troyen A. Brennan, Ethics Committees and Decisions to Limit Care: The Experience at the Massachusetts General Hospital, 260 JAMA 803 (1988)).

today by terminally ill patients who fear the opportunity to end their lives may not arise later should their suffering become too severe to endure.[264] This belief is endorsed by Derek Humphrey and Kevorkian attorney Geoffrey Fieger, the latter of whom proclaimed at a lecture given at Harvard, "assisted suicide often gives people the strength to go on *living*, knowing it is there if things go wrong down the line."[265]

2. Requirements for Patient Eligibility

Turning to the specifics of the Model Act, the authors first propose that active euthanasia be proscribed, and only voluntary P.A.S. be permitted.[266] This threshold for eligibility is hardly surprising given prior regulatory efforts, and is an essential first step for assuring the voluntary nature of the patient's act. Sadly though, in the name of curbing possible abuses of active euthanasia on vulnerable patients, the Model Act (as well as all of the regulatory efforts previously discussed) will inevitably haunt some persons who, due to the fate of their injury or illness, are either incompetent, paralyzed, or otherwise unable to administer the lethal treatment themselves. However, this is a price responsible P.A.S. policy must pay.

Next comes the Model Act's first main departure from Oregon's measure. In defining the individuals eligible for P.A.S., the authors focused on those who are "terminally ill" (utilizing the same criteria as Oregon), but also included those who are suffering from "unrelievable and unbearable distress due to bodily illness, that is so great that they prefer death."[267] The inclusion of this latter category of "unbearable suffering" is sure to arouse significant criticism and controversy over the slippery slope problem. However, on balance I believe it is a courageous stand to bring in those individuals who are truly sound cases for P.A.S., and one made possible and sensible given the strict procedural safeguards the

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[264] See id. See also Marcia Angell, The Supreme Court and Physician-Assisted Suicide—The Ultimate Right, 336 New Eng. J. Med. 50, 53 (1997); Derek Humphrey, Final Exit: The Practicalities of Self-Deliverance and Assisted Suicide for the Dying 103-05 (1991).

[265] Dr. Kevorkian's Attorney Defends Right to Die, Harv. L. Rec., Oct. 10, 1997.

[266] See Baron et al., supra note 230, at 9-10.

[267] Id.

Act employs.[268] The Model Act prevents easy manipulation of the "unbearable suffering" category by limiting it to those "whose illness is *incurable* and who subjectively feel that the accompanying suffering is worse than death."[269] The rationale behind this is that it is not possible to construct a more objective definition that would not be overly restrictive, and that the desire to end life is an inherently subjective determination on which rational, autonomous people differ. Furthermore, in addition to the safeguards detailed below to protect patients from the slippery slope, it is also essential to recognize that the Model Act does not bestow a "right" to P.A.S. on any patient. Rather, the physician retains the ability to decide whether the individual case warrants such relief.[270]

3. Four Basic Criteria Designed to Safeguard Patients and Physicians

To protect patients and physicians, the crux of the Model Act goes beyond Oregon's and the Netherlands' basic procedures, requiring that four detailed conditions be met before one can receive P.A.S. The patient must be (1) competent; and (2) fully informed; her choice must be (3) voluntary; and (4) enduring.[271]

A "competent" request under § 3(a)(3)(A) is "a reasoned request for physician-assisted suicide from a patient, based on the patient's ability to *understand* his or her condition and prognosis, the benefits and burdens of available alternative treatments, and the consequences of suicide."[272] A request distorted by clinical depression or mental illness would be disallowed, but depression would not prevent competency if the patient's judgment is not distorted—i.e., if the patient can make a reasoned decision consistent with her long-term values.[273] While Ganzini and Chochinov emphasize that a substantial portion of terminally ill patients are clinically depressed,[274] I find crucial the distinction that the Model

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[268] See infra Part IV, Sections D(3) and D(4).

[269] Baron et al., supra note 230, at 11 (emphasis added).

[270] See id.

[271] See id. at 17-18.

[272] Id. at 18 (emphasis added).

[273] See id.

[274] See generally Ganzini et al., supra note 251. See also Harvey Max Chochinov et al., Desire for Death in the Terminally Ill, 152 Am. J. Psychiatry, 1185, 1187 (1995) (finding a correlation between suicidal thoughts and clinical depression among termi-

Act makes. It takes a strong position by allowing for the fact that a terminal illness is inherently depressing, and to deny a competent and reasonable patient P.A.S. based on their sadness or depression would be improper and contrary to physicians' imperative to best serve their patients' interests.[275]

The second of the four prongs, that the patient be "fully informed" (§ 3(a)(3)(B) and § 4), relates to the competency requirement in that it calls for the patient to *understand* the medical options available and their *consequences*. This is similar to the Netherlands' provision, and it goes a good deal beyond merely "presenting the patient with all reasonable alternatives," as some authors have suggested with the best of intentions.[276] Thus, physicians must discuss all medical treatments that might improve the patient's condition or prognosis, including palliative care, and their benefits and burdens (§ 4(a)). Furthermore, borrowing from Dr. Quill's article in *The New England Journal of Medicine*, *Care for the Hopelessly Ill*, I believe the Model Act should extend this provision to place an affirmative duty on physicians to ensure that the patient's decision to opt for P.A.S. does not arise out of inadequate provision of comfort care.[277] In addition, the Model Act requires that physicians must inform their patients of the opportunity to consult with a social worker (§ 4(b)) as well as the patient's family (§ 4(c)). In the end then, for a request to be "fully informed," the patient must understand all of these alternatives and "make a reasoned decision to seek suicide."[278]

Third, § 3(a)(3)(C) requires a "voluntary" request by the patient—one that is made independently, free from coercion or undue influence. The authors cite to the definition of undue influence in the Second Restatement of Contracts, and add that "[t]he patient may consider the suggestions and recommendations of others, in-

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nally ill patients).

[275] See Baron et al., supra note 230, at 18. See also Angell, supra note 264, at 52.

[276] See Spencer, supra note 222, at 549 (urging that all reasonable alternatives be presented, in order to rightly seek out justice for members of vulnerable groups. However, the Model Act believes that we must go further than mere suggestions of options in order to ensure the protection of patients.).

[277] See Timothy E. Quill et al., Care of the Hopelessly Ill: Proposed Clinical Criteria For Physician-Assisted Suicide, 327 New Eng. J. Med. 1380 (1992).

[278] Baron et al., supra note 230, at 19.

cluding the responsible physician, but the patient's choice must be his or her own decision."[279] While the authors warn that passive acquiescence in the recommendations of others would not qualify, here lies one area in which I would propose a significant strengthening of the Model Act. Given the evidence on patient suggestibility presented by Foley and Coleson,[280] and the dangers of managed care financial incentives, I believe sound P.A.S. policy can only help ensure the voluntary nature of the decision by insisting that the patient initiate the first discussion of the subject. Physicians should be flatly prohibited from initially suggesting or recommending P.A.S. if we hope to curb the insidious effect of managed care and the erosion of medical ethics.

Lastly, § 3(a)(3)(D) requires that the patient's desire for P.A.S. be "enduring." Going marginally beyond Oregon's procedures, the Model Act demands that at a minimum, the request "must be stated to the responsible physician on at least two occasions that are at least two weeks apart, *without self-contradiction* during that interval."[281] This makes good common sense, because any evidence of a wavering mind is enough to warrant the disallowance of P.A.S. It is worthwhile to note that Dr. Kevorkian as well states that he would immediately cease to aid a patient who changes her mind, and never return, out of extreme caution for an indecisive mind.[282] In response to Ganzini's evidence that many Oregon physicians believe a two week waiting period would be inadequate to prevent suicides arising from a transitory desire for death,[283] I again suggest that policy-makers consider increasing the duration of the period slightly.

4. Procedural Safeguards

In addition to the four basic requirements detailed above, further procedural safeguards are imposed to ensure fulfillment of the Model Act's purposes of preventing abuses of P.A.S. Section 3(a)

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[279] Id.

[280] See Richard E. Coleson, The Glucksberg & Quill Amicus Curiae Briefs: Verbatim Arguments Opposing Assisted Suicide, 13 Issues L. & Med. 13 (1997); Kathleen M. Foley, Competent Care for the Dying Instead of Physician Assisted Suicide, 336 New Eng. J. Med. 54 (1997).

[281] Baron et al., supra note 230, at 19 (emphasis added).

[282] See Dr. Kevorkian's Attorney Defends Right to Die, supra note 265.

[283] See Ganzini et al., supra note 251, at 1471-72.

places the responsibility on the treating physician to ensure that all of the Act's requirements are met. To achieve immunity from litigation over a patient's suicide, the doctor must not only have an "honest belief" that the four elements of § 3 are met, but he must also satisfy the procedural requirements of §§ 4, 5, and 6 discussed below.[284] These sections are aimed at producing independent corroboration that the physician's belief is not merely honest or reasonable, but accurate. Section 4(d) enforces the competency and informational requirements by calling for two uninterested adults to witness, *and question as they see fit*, the discussion of diagnosis, prognosis, and medical treatment options with the patient.[285] The responsible physician must also tape or summarize this conversation in writing, and have the patient and witnesses sign and attest to its accuracy.[286] As mentioned above, § 4(b) also puts the onus on physicians to make a social worker available "to discuss non-medical options that might change the patient's decision to seek suicide."[287] Section 4(c) further requires that the doctor must suggest to the patient that she consult with family members regarding her decision, but out of respect for her autonomy, the patient need not do so.[288]

Section 5 contains additional corroboration requirements. Section 5(a) obliges the doctor to obtain from a second physician corroboration in writing of the patients diagnosis and prognosis. Section 5(b) serves as a final patient safeguard, demanding a written medical-factual opinion that the patient's decision is competent, fully informed as to alternatives, and voluntary. With respect to administrative and bureaucratic measures, § 6 of the Model Act requires physician documentation of the provision of medical means of suicide, and § 8(a) and § 9(d) authorize the state Department of Public Health to collect data and report on the effectiveness of legalized, regulated P.A.S. (which ideally allows for modifying improvements in future years).

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[284] Baron et al., supra note 230, at 17-21. One should note though that no physician is "relieved of any liability that they may otherwise incur as a result of any malpractice that they commit in the process of assisting in a suicide." Id. at 20.

[285] See id. at 28.

[286] See id. at 28-29.

[287] Id. at 20.

[288] See id. at 21.

5. Assessment of the Model Act and Summary of Suggestions for Modifications

The Model Act is by its own admission not a utopian solution, and acknowledges that its safeguards "come at a significant cost to the patient and to the physician-patient relationship."[289] To ensure that the patient's decision meets the Model Act's stringent requirements necessarily entails a severe intrusion into the patient's right to privacy, as physicians ascertain and confirm her competent, informed, understanding, and voluntary choice. Additionally, there are some inevitable line-drawing decisions that impose costs despite the necessary safety they afford. For instance, while considerations of potential abuses require allowing only voluntary P.A.S. (versus active euthanasia), I am troubled by the terminally ill, competent patient who has lost the strength (or is paralyzed) to administer life-ending drugs herself. If she is competent and fully informed under the Model Act, why shouldn't she be able to voluntarily instruct that the life-ending treatment be administered to her? Finally, the Model Act is likely to be the target of criticism for expanding its coverage beyond the terminally ill to those who are experiencing "unbearable suffering," but I feel it takes affirmative precautions to prevent this enlargement of scope from becoming its downfall.

With respect to improvements upon the Model Act, as discussed above, I believe that sound P.A.S. policy should do more to combat the problem of patient suggestibility (by preventing doctors from making the initial suggestion of P.A.S.). P.A.S. regulation would also do well to take up Dr. Quill on his recommendation that physicians have a duty to make certain that the patient's decision to opt for death does not arise from inadequate palliative care. Additionally, policy-makers should consider extending the two-week waiting period by another seven days to counter the problem of transitory desires for suicide presented by Ganzini.

Furthermore, similar to Oregon's initiative, the Model Act does not require a doctor to be present when the fatal dose is taken by the patient. In contrast, physicians in the Netherlands and Australia's Northern Territory are expected to be present at the time

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[289] Id. at 13.

the patient ingests the lethal medication, and are permitted to administer a lethal injection if the oral dose does not result in death.[290] Without deciding whether the second half of this foreign provision is warranted in the United States, at the very least a physician's presence should be mandatory to ensure that the medication is taken properly and that it is not given to someone else.[291] The proposition that the patient should not be left alone to commit suicide is also endorsed by Dr. Quill. He further sensibly emphasizes the need for a meaningful doctor-patient relationship, without which medication to assist in a suicide should not be prescribed.[292]

E. Would Federal Legislation Be Best?

Still, these quarrels with the Model Act are relatively small compared to the enormous social good it offers. Sensible P.A.S. regulation makes possible the relief of unbearable and demeaning suffering, while mitigating the potential for abuse by renegade Kevorkians by imposing rigid safeguards. The larger concern then, looking forward to the Model Act's implementation in the real world, is that the authors do not propose a complete solution. They, along with the vast majority of medical and ethical scholars, fail to address the issue of what will happen now that the P.A.S. debate is left for states to resolve individually. This problem is essential to confront, as it is the precise situation America faces after the Supreme Court's decision in *Quill*. Time will surely show that massively contradictory results from state to state will be the outcome.[293] While there is something to be said for Justice Brandeis' desire to see states as the laboratories of experimentation,[294] Susan Wolf, Professor of Law and Medicine at the University of Minnesota, warns that many elderly and terminally ill will be forced to move to another part of the country—and likely away from what-

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[290] See Lee et al., supra note 250, at 313.

[291] Lee's study of Oregon physicians indicated that 51 percent were concerned about the possible harm if an attempt failed, and 33 percent worried that someone other than the patient might use the lethal prescription. Id.

[292] See Washington v. Glucksberg, 521 U.S. 702, 748 (1997) (Stevens, J., concurring).

[293] See David Lawder, Assisted Suicide Debate May Rage in States, Reuters, June 27, 1997.

[294] See New State Ice Co. v. Liebmann, 285 U.S. 262, 310-11 (1932) (Brandeis, J., dissenting) (analogizing states to laboratories in need of the freedom to experiment).

ever family support network they have—simply to end their life in they manner they choose.[295]

Uniform federal regulation of P.A.S., especially in the managed care context, should thus be our ultimate goal in enabling society's values, preferences, and fears to be balanced and resolved in the most sensible and just manner possible. While Congress is currently considering legislation that would prohibit appropriating federal funds for P.A.S. and which would revoke the license of physicians who prescribe the necessary drugs,[296] I believe this approach is too extreme. Crafting a uniform federal policy regulating P.A.S. will undoubtedly prove to be a political minefield, but it is the most responsible and viable option in addressing and resolving the P.A.S. debate. I believe the Model Act, along with the minor improvements that I and others have suggested, would serve Congress quite well as a guiding tool to face the nation's P.A.S. policy goals.

CONCLUSION

I have struggled internally with the P.A.S. debate for many years. In the interest of objectivity, I should disclose that I have witnessed the long and painful decline and deaths of three of my very close relatives. The insufferable agony and daily trauma of such an experience is enough to convince most anyone of the merciful role of P.A.S., and I was once an outspoken supporter of an absolute, unqualified "right to death." Now, however, with the rise of managed care, and given the questions as to the existence of true patient autonomy, I am far more wary of an unequivocal embrace of P.A.S. As Jefferson Smith has opined, our nation is now "forced to decide which risk is worse—state action coercing someone to live who should not live, or subtle action coercing someone to die who should not die."[297] With this in mind, I certainly do not urge that all constitutional questions surrounding P.A.S. be resolved forever in its favor. Still though, while the deci-

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[295] See Lawder, supra note 293.

[296] See Pain Relief Promotion Act of 1999, HR 2260 (1999). The Act does not explicitly repeal state P.A.S. laws, but the ban on prescribing the medications needed to effectuate P.A.S. would serve to effectively criminalize the practice.

[297] See Jefferson Smith, Physician Assisted Suicide, at 18 (1998) (unpublished manuscript on file with the Virginia Journal of Social Policy & the Law).

sion to terminate life is perhaps the most difficult one any human being could face, I remain convinced that on balance P.A.S. has a place in a merciful and compassionate society. The crucial point to take away from the valuable anti-P.A.S. research is not that the practice should banned outright, but that it must be carefully scrutinized and regulated if its beneficial purpose is to be realized.

No personal decision has greater consequences than the one to take one's own life, and thus the common-sense goal of America's P.A.S. policy must be to ensure active, informed, voluntary, and competent decision-making by the patient. The moral ramifications of P.A.S. in any setting disturb many Americans, but the added financial incentive dimension of managed care delivery systems would make the idea and practice of unregulated P.A.S. unconscionable. I believe that only with tight controls and uniform governmental oversight can the practice survive the legal and ethical assaults it inevitably faces in the years to come. The temptation for abuse is simply unacceptable in America's current scattered state of healthcare regulation, and the pressure for cost-containment is only growing worse. It thus behooves our society to listen closely to the warnings of opponents of P.A.S. regardless of any individual's political, religious, or moral views on the subject. Only by a reasoned, systematic analysis of the benefits and pitfalls, such as that given by the team of physicians and academics who formulated the Model Act, can the potential abuses of legalized P.A.S. be curbed. With some minor modifications of the Model Act, I urge that uniform federal implementation and regulation play an essential part in securing long-term public support for P.A.S. Our policy must maximize the goals the practice was intended to achieve while doing as much as possible to alleviate its morally disturbing potential for abuse.

The key then is not unattainable perfection, but rather workable regulation and realism, allowing thousands of suffering human beings the opportunity to choose if and when to terminate their lives. This monumental decision, inevitably in time of deep personal crisis, should not be forced upon or encouraged of anyone, nor should it be stripped from the realm of autonomous, competent, fully-informed adults. Only with serious legislation and regulation of P.A.S. in America can we achieve this most worthwhile balance.