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## Release from Terminal Suffering? The Impact of AIDS on Medically Assisted Suicide Legislation

Jody B. Gabel

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**RELEASE FROM TERMINAL SUFFERING?: THE IMPACT  
OF AIDS ON MEDICALLY ASSISTED SUICIDE  
LEGISLATION**

JODY B. GABEL\*

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## I. INTRODUCTION

Many courts have recognized the right to die, either by removal or refusal of life-sustaining procedures, as an inherent right under the constitutional right to privacy, or as part of the liberty interest component of the Fourteenth Amendment.<sup>1</sup> Court decisions have upheld this right for both competent and incompetent patients by honoring an individual's interest in maintaining control over medical decisions that affect his or her life.<sup>2</sup> To protect individual autonomy, most states have enacted living will or right-to-die legislation as a process to prospectively reject life-sustaining measures in the event of a terminal medical condition.<sup>3</sup> In 1984, the Netherlands expanded the right to die by legalizing active voluntary euthanasia, or medically assisted suicide, under specific guidelines for terminally ill patients.<sup>4</sup> Ten years later in November 1994, the citizens of Oregon enacted the "Oregon Death With Dignity Act," resulting in the unprecedented legalization of medically or physician assisted suicide in the United States.<sup>5</sup> If the unique Oregon statute survives legal challenge,<sup>6</sup> the right to die in this

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1. See, e.g., *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 278 (1990) (majority finding a "constitutionally protected liberty interest in refusing unwanted medical treatment"); *Bouvia v. Superior Court*, 225 Cal. Rptr. 297 (Cal. App. 2d 1986) (holding that a patient has an unqualified right to refuse life-sustaining treatment); *In re Quinlan*, 355 A.2d 647, 663 (N.J. 1976) (holding that the right to privacy is "broad enough to encompass a patient's decision to decline medical treatment"), cert. denied, 429 U.S. 922 (1976).

2. *Bouvia*, 225 Cal. Rptr. at 301-02; *Quinlan*, 355 A.2d at 664.

3. For a complete analysis and listing of all right-to-die legislation throughout the United States, see Juliana Reno, Comment, *A Little Help From My Friends: The Legal Status of Assisted Suicide*, 25 CREIGHTON L. REV. 1151, 1175-83 (1992) (Appendix).

4. Helga Kuhse, Ph.D., *The Case for Active Voluntary Euthanasia*, 14 LAW, MED. & HEALTH CARE 145, 146 (1989) (describing Holland's highest court's decision in November 1984 providing that a doctor may practice "active voluntary euthanasia" in situations where a competent, terminally ill patient persistently requests assistance in dying).

5. *Ballot Measures At a Glance*, OREGONIAN, Nov. 9, 1994, at B5 (showing 201,238 votes or 51% in favor and 194,665 votes or 49% opposed to the Oregon Death With Dignity Act, Ballot Measure 16, with 306 out of 2,300 precincts reporting). The early election returns for the Oregon Death With Dignity Act, Ballot Measure 16, did not account for more than 265,000 absentee ballots or one-fifth of the vote, which were still being counted on Nov. 9, 1994. Carol J. Castaneda, *Oregon Awaiting Death-With Decision*, USA TODAY, Nov. 10, 1994, at 5A. On Nov. 15, 1994, the ballot returns showed the Act approved by a margin of 32,000 votes with only 10,000 votes uncounted. Telephone Interview with Debbie Hembree, Clerk, Elections Division, State of Oregon, Office of the Secretary of State (Nov. 15, 1994). The intended effective date for the Act was December 8, 1994.

6. The possibility of a legal challenge to the Act was anticipated immediately after the announcement of the election results. See, e.g., Cynthia Hubert, *New Assisted Suicide Law Splits Oregon*, SACRAMENTO BEE, Nov. 20, 1994, at A1 (reporting that "[o]pponents of Measure 16 are considering legal and legislative challenges to measure 16, but acknowledge that it will be a tough fight"); Q&A: *Doctor Assisted Suicide*, OREGONIAN, Nov. 10, 1994, at A1 (referring to comment by Robert J. Castagna, General Counsel and Executive Director of the Oregon Catho-

country may evolve to include legal recognition of a right to medically assisted suicide in situations where a competent person, suffering from a terminal condition, seeks to retain control over a prolonged dying process and select the time of his or her death.<sup>7</sup>

Since 1990, at least seven states have attempted to legalize medically assisted suicide for terminally ill patients, through what is generally referred to as death with dignity legislation.<sup>8</sup> With the exception of the Oregon enactment, voters have rejected the legalization of medically assisted suicide because of fears that assistance in death will establish the predicate for coercion, abuse and possibly involuntary extermination of people based on a diagnosis of terminal illness.<sup>9</sup> Yet anecdotal

lic conference that, "while no decision has been made, opponents will use the 30-day window allowed by law to examine legal barriers"); and Debra J. Saunders, *Sharpened Pencils Ready to Reduce High Cost of Dying*, OREGONIAN, Nov. 17, 1994, at D13 (reporting speculation by "suicide guru" Derek Humphry that "he anticipates a rapid challenge to the initiative by a patient who is not physically capable of taking lethal pills" and the subsequent expansion of the new law to allow lethal injections). On December 1, 1994, opponents of physician assisted suicide filed suit in the United States District Court in Eugene, Oregon, challenging the constitutionality of the Death With Dignity Act. Dee Lane & Spencer Heinz, *Opponents of Suicide Tab OHSU*, OREGONIAN, Dec. 2, 1994, at B1. On December 7, 1994, the federal judge granted a motion for a temporary restraining order, postponing the effective date of the enacted statute until at least December 19, 1994. Spencer Heinz, *Assisted Suicide: Advocates Weigh In*, OREGONIAN, Dec. 9, 1994, at A1. The federal judge granted a preliminary injunction on December 27, 1994, which prohibits the application of the Death With Dignity Act until the constitutionality of the statute is determined. Dee Lane, *Suicide: Status Quo Likely, Law or Not*, OREGONIAN, Dec. 29, 1994, at A1.

7. See, e.g., Kuhse, *supra* note 4, at 148 (concluding that an "autonomous person may well decide to request to die so as to avoid unnecessary suffering when terminally ill, or to avoid the indignity of a dehumanized existence"); Timothy E. Quill, M.D. et al., *Care of the Hopelessly Ill: Proposed Clinical Criteria for Physician-Assisted Suicide*, 327 NEW ENG. J. MED. 1380 (1992) (arguing that "it is not idiosyncratic, selfish, or indicative of a psychiatric disorder for people with an incurable illness to want some control over how they die"); Julia Pugliese, Note, *Don't Ask—Don't Tell: The Secret Practice of Physician-Assisted Suicide*, 44 HASTINGS L.J. 1291, 1329 (1993) (stating that "assisted suicide is the next logical step in granting patients the right of self-determination"); Dick Lehr, *Physicians Face Wrenching Choices, Requests for Help in Dying Produce a Professional Crisis*, BOSTON GLOBE, Apr. 27, 1993, at 1 [hereinafter Lehr, *Wrenching Choices*] (reporting that Charles H. Baron, law professor at Boston College, is working with others to draft a model bill allowing physician-assisted suicide "in the hopes that this will make relief from suffering more readily available and in a less discriminatory fashion and with greater patient autonomy").

8. The states were California, Iowa, Maine, New Hampshire, Oregon, and Washington. Lehr, *Wrenching Choices*, *supra* note 7, at 1 (also reporting that the legislatures in Connecticut and Wisconsin were drafting similar proposals but none had been introduced as of Apr. 27, 1993). The seventh state to attempt legislation was Michigan, in 1991. For a detailed analysis of the Michigan bills, see Frank C. Zischerk, Jr., Comment, *Michigan's Proposed Assisted Suicide Legislation: Strong Public Policy or Legislative Rhetoric?*, 69 U. DET. MERCY L. REV. 33 (1991).

9. B.D. Colen, *Campaign 92 Initiatives: California Is Voting on the Right to Die Act, Would Legalize Some Forms of Mercy Killing*, NEWSDAY, Oct. 29, 1992, at 23 (reporting on voter opposition to physician assisted suicide in California); see *infra* notes 188-222 and accompanying text (discussing arguments in opposition to medically assisted suicide in relation to

reports in newspapers throughout the United States indicate that more often than one realizes, a person suffering from a terminal illness chooses to end a prolonged decline into death and seeks assistance in executing such a decision.<sup>10</sup> Many of the accounts of assisted suicide involve people suffering from acquired immune deficiency syndrome or AIDS.<sup>11</sup> The chronic debilitation, extensive suffering and fatality of AIDS places persons with this disease in the forefront of the debate regarding assisted death. The *Boston Globe* published the comment of a person diagnosed with AIDS who considered physician assisted suicide as an option to "avoid declining into 'an emaciated lump in a wheelchair, babbling and drooling and wetting my pants.'"<sup>12</sup>

While personal comments and accounts provide impassioned support for the legalization of assisted suicide, opponents' concerns are intensified in the context of persons with AIDS. The cost of health care, the social attitude toward HIV infection and AIDS, and the pre-

AIDS patients); see also *Donaldson v. Van de Kamp*, 4 Cal. Rptr. 2d 59, 63-64 (Cal. App. 2d 1992) (providing general discussion of state's legitimate interests in protecting society against abuses inherent in assisted suicide situations); Willard Gaylin, M.D. et al., 'Doctors Must Not Kill,' 259 JAMA 2139, 2140 (1988) (postulating that physician assisted suicide could occur with "dispensable" patients who never request such an option).

10. In 1993 the *Boston Globe* published three articles in a series detailing the actions of several physicians who assisted patients in suicide and individuals who sought the help of friends when physicians were unwilling to provide such assistance. Lehr, *Wrenching Choices*, *supra* note 7, at 1; Dick Lehr, *Death & the Doctor's Hand, Increasingly, Secretly, Physicians Are Helping the Incurably Ill to Die*, BOSTON GLOBE, Apr. 25, 1993, at 1 [hereinafter Lehr, *Physicians Are Helping*]; and Dick Lehr, *More Learn of a Practice Long Hidden*, BOSTON GLOBE, Apr. 26, 1993, at 1 [hereinafter Lehr, *Long Hidden Practice*]. The *San Francisco Chronicle* reported the assisted suicide of Steven Shiflett who was dying of AIDS. Lori Olszewski, *One Man's Choice: Assisted Suicide Didn't Turn Out as AIDS Patient Planned*, S.F. CHRON., Oct. 19, 1992, at A1. Also, the participation of Dr. Jack Kevorkian in 21 suicides provides additional anecdotes of assisted suicides in this country. Carol J. Castaneda, *Kevorkian Attends 20th Suicide, Opponents Stress 'Other Answers'*, USA TODAY, Nov. 23, 1993, at 3A. *Kevorkian Helps Another Suicide As Ban Expires, Woman in 'Unending Pain' Is 21st He Has Assisted*, ARIZONA REPUBLIC, Nov. 27, 1994, at A3 [hereinafter *Kevorkian Helps*]. These are only a few examples of the reported incidents of assisted suicide in the United States.

11. See, e.g., Stephen Braun, *Deliver Them From AIDS*, L.A. TIMES, Aug. 28, 1988, at 1 (describing the participation of Marty James, a gay-rights activist, in the assisted suicides of several men with AIDS); Daniel Golden, *A Time to Die, Increasingly, the Terminally Ill Are Turning to Suicide Out of Horror at the Expensive, Intrusive, Lonely, Prolonged Nightmare that So-Called Natural Death Has Become*, BOSTON GLOBE, Oct. 7, 1990, at 16 (reporting on the assisted suicide of "Dean," a man dying of AIDS); Olszewski, *supra* note 10, at A1 (reporting the assisted suicide of Steven Shiflett who was dying of AIDS); Tim Rutten, *Who Will Have the Last Word on Death with Dignity?*, L.A. TIMES, Oct. 15, 1992, at 1 (describing the suicide of Ian, terminally ill with AIDS, who was assisted by two friends). Please note that this Article uses the full description "person or persons with AIDS" rather than the acronym "PWA" because such abbreviations dehumanize the suffering and impugn the dignity of people who live with this disease.

12. Lehr, *Wrenching Choices*, *supra* note 7, at 1 (reporting the comment of Keri Duran, gay activist).

liminary stage of medical research in this area create a heightened possibility for persons with AIDS to contemplate suicide regardless of the stage of their disease progression.<sup>13</sup> The legalization of physician assistance in such decisions may make suicide an expectation for persons with AIDS rather than a legal and voluntary option. Thus, AIDS fuels valid fears on both sides of the debate regarding medically assisted suicide and also provides a context for assessing the merit of legalizing such an option.

This Article proposes that AIDS is both a compelling impetus for medical assistance in death and a mandate for safeguards to protect against the potential for coercion and abuse associated with medically assisted suicide legislation. Part II of this Article presents a general discussion of medically assisted suicide and the degree of public support for such an option. Part III concentrates on the relationship between AIDS and medically assisted suicide through a brief overview of the progression of AIDS and the related treatments; statistical evidence of a correlation between persons with AIDS and assisted suicide; and accounts of persons with AIDS who ended their lives with the assistance of others. Part IV discusses the constitutional basis for a right to assisted death and concludes that courts should uphold a statute providing such a right,<sup>14</sup> under precedent recognizing the right to refuse or remove life-sustaining measures. Part V presents arguments in opposition to medically assisted death and formulates a paradigm of concerns related to persons with AIDS which must be addressed in any legislative proposal. Part VI evaluates attempted legislation in Washington, California and Maine, followed by an assessment of the enacted Oregon statute and the application of these proposals to persons with AIDS. Finally, Section VII presents a model death with dignity statute which provides specific protections for persons with AIDS.

## II. MEDICALLY ASSISTED SUICIDE

The concept of legalizing medically assisted suicide runs counter to the basic ideal of modern health care, which operates to extend life as

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13. See *infra* notes 188-222 and accompanying text (presenting arguments in opposition to medical assistance in death).

14. Throughout this Article, the "right" to assisted suicide means the ability to legally seek and receive assistance in hastening one's death. The "right" is based upon a person's subjective decision to end his or her life with the assistance of a willing physician, just as the person in a "right-to-die" situation makes a decision to remove or refuse life-sustaining treatment.

long as possible. Nevertheless, some people afflicted with protracted, irreversible and terminal illnesses seek assistance through medication in order to die peacefully and without pain when they can no longer endure the suffering associated with the natural course of dying.<sup>15</sup> Medically assisted suicide entails the assistance by a physician, through either prescribing or administering an overdose of sedative medication, when a person decides to terminate his or her life.<sup>16</sup> Increased individual exposure to the "lingering death of a loved one" as a consequence of life-sustaining treatment has fostered public support for medically assisted death.<sup>17</sup> Many people seek an earlier alternative to refusing life-prolonging measures in a hospital setting.

A 1986 survey of 1,998 Americans revealed that 62% of men and 63% of women "agreed that doctors should 'end the patient's life if there is no hope of recovery and the patient requests it.'"<sup>18</sup> Also, court decisions and right-to-die legislation in many states have forever altered the relationship between physician and patient.<sup>19</sup> No longer is the physician the sole arbiter in deciding the correct treatment for an individual patient.<sup>20</sup> The patient now has equal authority with the phy-

15. David Orentlicher, M.D., J.D., Ethics & Health Policy Counsel, *Physician Participation in Assisted Suicide*, 262 JAMA 1844 (1989) (describing that many patients request physician assistance in executing an earlier death due to "intolerable suffering with no prospect of improvement").

16. This Article focuses on medically assisted suicide which involves physician participation by either administering a lethal dose of pain medication, such as morphine or other barbiturates, or prescribing a lethal dose for the patient's own administration. Many terms have been used to describe this type of suicide which may appear in sources used in this Article. For example, the term active euthanasia often is used to describe physician-administered overdoses of medication at the patient's request. See George D. Lundberg, M.D., 'It's Over, Debbie' and the Euthanasia Debate, 259 JAMA 2142, 2143 (1988) (defining the different types of euthanasia including passive, semipassive, semiactive, accidental, suicidal, and active). Rational suicide describes a request from a competent patient to end a terminal illness that results in a prolonged and protracted death. For an explanation of rational suicide, see the decision in *Michigan v. Kevorkian*, 62 U.S.L.W. 2411, 2412 (Mich. Cir. Ct. Dec. 13, 1993) (defining rational suicide as a decision by a competent person to end his or her life in a reasonable response to a condition that is causing the quality of life to be significantly impaired). These are but a few examples of the terms used to describe assisted suicide by a competent person who is suffering from a terminal illness or condition.

17. Diane M. Giannelli, *A Right to Die: Debate Intensifies Over Euthanasia and the Doctor's Role*, AM. MED. NEWS, Jan. 7, 1991, at 9; see also Greg Gajus, Editorial, 'He Died Peacefully, Held By His Friends,' MIAMI HERALD, June 13, 1992, at 23A (describing his friend's physical decline following AIDS diagnosis, which included blisters in his mouth, emaciation to 75 pounds, continuous pain and emotional despair).

18. Marilyn Lewis & Chris Christoff, *AIDS Fuels Euthanasia Debate, Terminally Ill Press Demand for Legal Right to Die*, DET. FREE PRESS, Nov. 22, 1987, at 17A (describing a poll conducted by Roper Organization, Inc. for the Hemlock Society).

19. See *supra* notes 1-3 and accompanying text (describing the evolution of patient autonomy in medical decisions).

20. Ronnie Scheier, *Who Lives? Who Dies? Who Decides?*, AM. MED. NEWS, Jan. 7, 1991, at 3.



sician in treatment selection and rejection, if the patient so chooses.<sup>21</sup>

The publicized participation of Michigan physician, Dr. Jack Kevorkian in twenty-one suicides<sup>22</sup> is a blatant example of recurrent physician assistance in suicide, and also a basis for heightened concerns regarding the secret implementation of such requests.<sup>23</sup> Other physicians comprehend the agony associated with a prolonged death from a terminal disease and assist their terminally ill patients in committing suicide through medication overdoses.<sup>24</sup> A 1988 University of Colorado poll of approximately 2,000 physicians revealed that more than half "said euthanasia would have been justified for some of their patients" and a third "said they had actually given pain medication they knew would hasten a patient's death."<sup>25</sup> People suffering from cancer, and more recently AIDS, constitute the majority of patients who consult their physicians about the possibility of assisted suicide.<sup>26</sup>

### III. THE RELATIONSHIP BETWEEN AIDS AND ASSISTED SUICIDE

The mortality rate for persons with AIDS in the United States at the end of 1991 was 64.8%, which equaled 133,554 deaths from the disease, out of 206,171 Americans with reported AIDS diagnoses.<sup>27</sup> The three-year mortality rate from the time of confirmed diagnosis approaches 90%.<sup>28</sup> The association between AIDS and assisted suicide

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21. See *Thor v. Superior Court*, 855 P.2d 375, 382 (Cal. 1993) (explaining that in treatment decisions "effectuating the patient's freedom of choice remains the ultimate arbiter").

22. *Kevorkian Helps*, *supra* note 10, at A3 (reporting that Kevorkian assisted in a twenty-first suicide on November 26, 1994, involving a 72-year-old woman inflicted with severe rheumatoid arthritis, advanced osteoporosis and other disorders).

23. Jennifer A. Zima, *Assisted Suicide: Society's Response to a Plea for Relief or A Simple Solution to the Cries of the Needy?*, 23 RUTGERS L. REV. 387 (1992) (describing Dr. Kevorkian's assistance in the death of Janet Adkins through the use of his "suicide machine," which intravenously infused a mixture of saline solution, pain killer and potassium chloride, in the back of a Volkswagen bus parked in a public campground).

24. Lehr, *Wrenching Choices*, *supra* note 7, at 1 (reporting examples of anonymous physician-assisted suicide in the Boston area); see also Richard Knox, *1 in 5 Doctors Say They Assisted a Patient's Death, Survey Finds*, BOSTON GLOBE, Feb. 28, 1992, at 5 (reporting the results of several surveys of physicians in the United States who deliberately assisted in the death of their patients).

25. Patrick Cooke, *The Gentle Death*, 3 HIPPOCRATES 50 (1989).

26. Lehr, *Physicians Are Helping*, *supra* note 10, at 1 (reporting that cancer and AIDS provide the most common context for assisted death requests).

27. CDC, *HIV/AIDS Surveillance* 1, 13 (Feb. 1992) (referring to Table 8, AIDS cases, case-fatality rates and deaths in the United States through Jan. 1992); see also SURGEON GENERAL'S REPORT TO THE AMERICAN PUBLIC ON HIV INFECTION AND AIDS, 1, 24 (1993) [hereinafter 1993 SURGEON GENERAL'S REPORT] (reporting that by the end of 1992 more than 170,000 Americans had died as a result of AIDS, and the total number of AIDS cases rose to 253,448).

28. Paul A. Volberding, M.D. et al., *Zidovudine in Asymptomatic Human Immunodeficiency Virus Infection*, 322 NEW ENG. J. MED. 941, 948 n.6, 949 n.7 (1990) (referring to a study conducted in New York, in 1987, of the clinical progression of 5833 AIDS cases, and a 1988 study, in San Francisco, of the survival patterns of the first 500 patients with AIDS).

goes beyond these dismal statistics. Because AIDS encompasses a group of diseases and conditions resulting from severe immunosuppression, infected patients experience the ravages of many debilitating illnesses and a recurrent cycle of infirmity and intermittent recovery.<sup>29</sup> A basic overview of the most common afflictions of AIDS patients provides insight into the choice of assisted suicide by many people suffering from the disease.

#### A. *The Manifestation of HIV and AIDS: Diseases and Treatment*

Upon initial infection with the human immunodeficiency virus (HIV),<sup>30</sup> an individual usually experiences a flu-like illness with fever, chills, and general malaise.<sup>31</sup> Although no external symptoms may occur, HIV invades a specific type of T-cells, CD4+ T-lymphocytes, which normally activate the immune system to ward off invading infections.<sup>32</sup> Although a person may remain HIV-positive for seven to ten years before exhibiting symptoms associated with HIV infection or an AIDS diagnosis,<sup>33</sup> infection with HIV is incurable and eventually fatal. The objective of medical treatment for HIV infection is to forestall the decline in health associated with T-cell destruction by the virus and a subsequent AIDS diagnosis.<sup>34</sup> Early treatment with

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29. Gina Kolata, *How AIDS Smolders: Immune System Studies Follow the Tracks of H.I.V.*, N.Y. TIMES, Mar. 17, 1992, at C1; see also Abe M. Macher, *HIV Disease/AIDS: Medical Background*, in AIDS AND THE LAW 1 (Wiley Law Publications Editorial Staff eds., 2d ed. 1992) (defining AIDS and referencing the initial reports of unusual opportunistic infections observed in homosexuals in 1981). The Federal Center for Disease Control and Prevention uses the following criteria for assessing HIV infection in persons 13 years or older:

- a) repeatedly reactive screening tests for HIV antibody (e.g., enzyme immunoassay) with specific antibody identified by the use of supplemental tests (e.g., Western blot, immunofluorescence assay);
- b) direct identification of virus in host tissues by virus isolation;
- c) HIV antigen detection; or
- d) a positive result on any other highly specific licensed test for HIV.

CENTERS FOR DISEASE CONTROL, *1993 Revised Classification System for HIV Infection and Expanded Case Definition for AIDS Among Adolescents and Adults*, 41 MORBIDITY & MORTALITY WEEKLY REP. No. RR-17 1, 2 (Dec. 18, 1992) [hereinafter CDC, *1993 Revised Classification*].

30. 1993 SURGEON GENERAL'S REPORT, *supra* note 27, at 6 (explaining that HIV is transmitted through exposure to blood, semen, and perinatally from mother to fetus).

31. Kolata, *supra* note 29, at C1.

32. Macher, *supra* note 29, at 4.

33. *Update: Acquired Immunodeficiency Syndrome—United States*, 35 MORBIDITY & MORTALITY WEEKLY REP. No. 35, 17, 29 (Jan. 17, 1986) (reporting that the time from HIV exposure to the diagnosis of AIDS may extend as long as seven years); see also Kolata, *supra* note 29, at C1 (reporting that the span between HIV infection and AIDS diagnosis ranges from two to ten years).

34. Volberding, *supra* note 28, at 942; see also Macher, *supra* note 29, at 16 (stating that "treatment with AZT may increase a patient's survival time by delaying further deterioration of the immune system"). For a definition and description of AIDS diagnoses, see *infra* notes 38-40 and accompanying text.

zidovudine (AZT) reduces the progression from HIV infection to AIDS diagnosis by directly inhibiting the replication or manufacture of HIV in the immune system.<sup>35</sup> Zidovudine treatment must be closely monitored to avoid adverse effects such as anemia, blood disorders, and liver dysfunction.<sup>36</sup> Even though the interval between HIV infection and clinical diagnosis increases with zidovudine treatment, the overall survival rate of eighteen months from the time of AIDS diagnosis is unaltered. Additionally, many AIDS patients may experience serious adverse reactions to the drug.<sup>37</sup>

Clinical diagnosis of AIDS is based upon the presence of specific opportunistic infections which generally occur as a result of severe immunosuppression.<sup>38</sup> For example, Kaposi's sarcoma, a skin cancer creating purple lesions on the skin, and pneumocystis carinii pneumonia are indicators of the decline in the immune system function and heightened susceptibility to infections that are otherwise uncommon in the general population.<sup>39</sup> The Center for Disease Control and Prevention (CDC) also classifies AIDS cases in part according to a T-cell count below 200 cells per microliter of blood.<sup>40</sup> Physicians and HIV-positive individuals monitor the T-cell count to assess the degree of immunosuppression and associated vulnerability to opportunistic infections. The most common opportunistic infection afflicting HIV-positive individuals is pneumocystis carinii pneumonia (PCP), "occurring at some point in at least 85 percent of patients."<sup>41</sup> Physicians

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35. John D. Hamilton et al., *A Controlled Trial of Early Versus Late Treatment with Zidovudine in Symptomatic Human Immunodeficiency Virus Infection*, 326 NEW ENG. J. MED. 437, 442 (1990). Zidovudine was formerly referred to as antiretroviral zidovudine or AZT. Macher, *supra* note 29, at 16. Zidovudine treatment is recommended for both asymptomatic and early HIV infection when the T-cell count is less than 500 cells per microliter of blood. Volberding, *supra* note 28, at 947.

36. Volberding, *supra* note 28, at 946 (demonstrating significant decreases in the rate of AIDS diagnosis in HIV-infected patients who receive both low doses of zidovudine—500 milligrams per day—and high-doses of 1500 milligrams per day).

37. Hamilton, *supra* note 35, at 442.

38. 1993 SURGEON GENERAL'S REPORT, *supra* note 27, at 5.

39. *Id.*

40. CDC, *1993 Revised Classification*, *supra* note 29, at 2 (chart showing that the revised classification now requires reporting for any individual with a CD4+ T-cell count of less than 200 cells per microliter of blood, even if the underlying HIV infection is asymptomatic, effective Jan. 1, 1993). The T-cell count in a healthy person is typically in the range of 1000 cells per microliter of blood. David W. Webber, *1994 Cumulative Supplement*, in *AIDS AND THE LAW* 1, 10 (Wiley Law Publications Editorial Staff eds., 2d ed. 1994).

41. Margaret M.E. Schneider, M.D. et al., *A Controlled Trial of Aerosolized Pentamidine or Trimethoprim-Sulfamethoxazole as Primary Prophylaxis Against Pneumocystis Carinii Pneumonia in Patients with Human Immunodeficiency Virus Infection*, 327 NEW ENG. J. MED. 1836 (1992) (study comparing results of pentamidine and co-trimoxazole treatment with PCP infections). For a definition of PCP infections, see Macher, *supra* note 29, at 15.

treat PCP infections with antibiotics to minimize the onset of respiratory difficulties, but the treatment itself may result in low-grade fever, nausea and vomiting.<sup>42</sup>

An HIV-positive individual typically suffers not only from the progressive complications of HIV infection, but also from the many adverse reactions associated with the treatment of secondary infections. Beyond the recurrence of opportunistic infections that may be minimized by treatment, HIV-positive individuals are also susceptible to AIDS related mental illnesses, categorized under the general term AIDS dementia complex.<sup>43</sup> Perhaps the most feared complication of HIV infection, AIDS dementia may occur before physical symptoms warrant an actual AIDS diagnosis.<sup>44</sup> Clinical studies suggest that 50% to 70% of HIV-positive and AIDS patients will develop an organic mental disorder during the course of their illness.<sup>45</sup> Patients with AIDS dementia complex experience abnormalities in their memory capability, motor skills, and behavior patterns.<sup>46</sup> As a result of these impairments, a person may be unable to continue in his or her employment, and may experience a growing apathy toward social and recreational activities.<sup>47</sup> The likelihood of impairment or incompetency in the course of HIV infection instills in many AIDS patients a fear of losing control of their affairs, and raises serious concerns about the requisites for medically assisted suicide legislation.<sup>48</sup>

Following symptoms of HIV infection or confirmation through testing, an HIV-positive individual engages in a constant vigil, monitoring such indicators as the T-cell level, weight loss, any changes in memory or motor abilities, and the advent of associated opportunistic infections.<sup>49</sup> This constant, personal health assessment must also in-

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42. Schneider, *supra* note 41, at 1840 (referring to Table 3 entitled "Adverse Reactions Requiring Discontinuation of the Study Drug" including pentamidine and co-trimoxazole). Research indicates that co-trimoxazole can forestall PCP infection and possibly other types of opportunistic infections which target the respiratory systems of HIV-infected individuals. *Id.* at 1839-40.

43. John Parry, *Life Services Planning for Persons With AIDS-Related Mental Illnesses*, 13 MENTAL & PHYSICAL DISABILITY L. REP. 82 (Mar.-Apr. 1989).

44. Richard W. Price et al., *The Brain in AIDS: Central Nervous System HIV-1 Infection and AIDS Dementia Complex*, 239 Sci. 586 (1988). This medical study indicates that HIV infection of the central nervous system "is relatively common and may even be the rule" in the early, asymptomatic stage of HIV infection. *Id.* at 588.

45. Parry, *supra* note 43, at 82.

46. Price, *supra* note 44, at 586.

47. *Id.* at 587.

48. See Parry, *supra* note 43, at 82 (explaining that "[m]ost, if not all, of the results of decisions made by persons with AIDS dementia complex will be affected by their legal competence to make decisions").

49. Beyond the cellular infection of CD4+ T-cells, HIV often targets macrophages or

clude close monitoring for any adverse effects caused by AIDS-related medication. This description is only a general characterization of the hardships associated with HIV-infection, but nevertheless provides insight into the attitudes and frustrations of many people infected with HIV, who are both knowledgeable of the progression of the disease, and aware of the clinical episodes that indicate an irreversible decline into full-blown AIDS.

*B. Incidence of Suicide Among Persons with AIDS: Statistical Evidence*

National statistics show that the incidence of suicide for persons with AIDS is remarkably high in comparison to the suicide rate for the general population.<sup>50</sup> Several clinical studies indicate that persons with AIDS may have a heightened tendency to contemplate either individual or assisted suicide. In 1985, a Cornell University Medical College study demonstrated that the likelihood of suicide in men with AIDS was sixty six times greater than that of the general population.<sup>51</sup> The study warned health care professionals to assess patients diagnosed with AIDS, significantly affecting men at that time, for signs of suicidal inclinations, and to recommend counseling to prevent future attempts.<sup>52</sup> Although the Cornell University study was the first documented assessment of suicide in persons with AIDS, the results sug-

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clean-up cells that move throughout the body, thereby infiltrating different organ systems. Marsha F. Goldsmith, *Physicians at AMA Amsterdam News Seminar Offer Panoramic View of Their Varied Roles in Pandemic*, 268 JAMA 1237 (1992). For example, HIV-infected macrophages may move to the kidney, causing renal insufficiency, or to the bone marrow, resulting in blood disorders and anemia. *Id.* at 1239. When HIV targets intestinal cells, these cells become hypersecretory causing "clean diarrhea" for which no bacterial or viral cause can be identified. *Id.* Other complications, such as persistent oral thrush, recurrent herpes zoster, and pelvic inflammatory disease, are also associated with HIV infection. CDC, *1993 Revised Classification*, *supra* note 29, at 3-4.

50. Golden, *supra* note 11, at 16 (providing general information regarding CDC statistics on national suicide and occurrence in AIDS patients). For a general assessment of the occurrence of all forms of euthanasia from 1980 until 1991, see Stacy L. Mojica & Dan S. Murrell, *The Right to Choose—When Should Death Be in the Individual's Hands?*, 12 WHITTIER L. REV. 471, 485-87 (1991) (explaining that "[n]inety-seven percent of all murder/suicides, almost 90% of double suicides, 71% of assisted suicides and 72% of all mercy killings have occurred since 1980") (footnotes omitted).

51. Peter M. Marzuk et al., *Increased Risk of Suicide in Persons With AIDS*, 259 JAMA 1333 (1988) (reporting a study involving 3828 reported AIDS cases in New York City during 1985 out of which 12 suicides in men between the ages of 20 to 59 occurred).

52. *Id.* at 1337 (recognizing that the number of actual suicides by persons with AIDS was low, but also suggesting that because of the high rate of under-diagnosis of the disease at the time of this study, additional suicides could possibly be related to AIDS).

gest that AIDS is a significant risk factor for suicide.<sup>53</sup> A 1989 report of civilian applicants for military service also noted a higher occurrence of suicide in HIV-positive individuals.<sup>54</sup>

Research in the Netherlands provides additional information regarding the incidence of assisted suicide among AIDS patients. Active voluntary euthanasia, or medically assisted suicide, has occurred in the Netherlands under specific guidelines since at least 1984.<sup>55</sup> To be eligible for medically assisted suicide, a patient must make an enduring uncoerced request for a lethal overdose of pain medication, and must suffer from severe physical or mental pain without hope of relief.<sup>56</sup> In 1990, the Rummelink Commission conducted the most definitive study of the prevalence of assisted suicide among persons with AIDS in the Netherlands.<sup>57</sup> The Commission interviewed 405 physicians and reviewed the circumstances of 7,000 deaths to produce reliable estimates of the incidence of euthanasia and other end-of-life decisions in that country.<sup>58</sup> The study revealed that "between 10 and 20 percent of all deaths among terminal AIDS patients involve euthanasia or assisted suicide."<sup>59</sup>

In 1991, a smaller study conducted by the Netherlands Institute of Mental Health reported a similar incidence of assisted suicide in AIDS

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53. Richard M. Glass, M.D., *AIDS and Suicide*, 259 JAMA 1369 (1988) (recognizing that this study is the first epidemiologic documentation of the relationship between AIDS and suicide).

54. Andrew L. Dannenberg, M.D., et al. *Mortality Among 1862 HIV-Antibody-Positive Civilian Applicants for Military Service: Preliminary Results*, 321 NEW ENG. J. MED. 1267 (1989) (reporting that preliminary data on military applicants from October 1986 through December 1987 were insufficient to calculate death rates from specific causes, but showing that 3 out of 1862 HIV-positive applicants committed suicide as compared to 2 out of 5583 HIV-negative applicants).

55. Kuhse, *supra* note 4, at 146 (describing Holland's highest court's decision in November 1984 that a doctor may practice "active voluntary euthanasia" in situations where a competent, terminally ill patient persistently requests assistance in dying).

56. Cooke, *supra* note 25, at 5.

57. Paul J. van der Maas et al., *Euthanasia and Other Medical Decisions Concerning the End of Life*, 338 LANCET 669 (1991) (presenting the first results of the Dutch nationwide study on euthanasia and other end-of-life decisions established by Prof. J. Rummelink, attorney general of the Dutch high court in 1990).

58. *Id.*

59. Maurice de Wachter, A.M., HASTINGS CENTER REP. Nov.-Dec. 1991, at 2 (describing the more detailed aspects of the study regarding four special categories of patients and end-of-life decisions, including severely defective newborns, children with fatal diseases, psychiatric patients, and patients with AIDS). A 1992 report at the Eighth International Conference on AIDS in Amsterdam indicated that 2200 persons have been diagnosed with AIDS in the Netherlands. Goldsmith, *supra* note 49, at 1244 (including a comment by Pieter L. Meenhorst, M.D., Ph.D., head of the AIDS unit in the Slotervaart Medical Center in Amsterdam, that "the Dutch commission estimates that as many as 20% of all AIDS patients die as a result of euthanasia").

patients.<sup>60</sup> This study involved "in-depth structured interviews [of] 59 relatives of deceased AIDS patients," to assess the occurrence of euthanasia for these patients under the Dutch system. Although the study did not indicate the actual number of AIDS patients involved, it did provide informative data regarding the frequency of euthanasia requests and related deaths. The study revealed that "euthanasia was discussed by 60 percent of all patients, mainly because of their fear of dementia and physical deterioration."<sup>61</sup> AIDS patients died from selected euthanasia in 23% of the cases investigated.<sup>62</sup> From these findings, the authors concluded that "[e]uthanasia is a major theme for people with AIDS."<sup>63</sup> These clinical studies show that both suicide and assistance in suicide are significant considerations for persons with AIDS. Beyond clinical studies and general statistics, the accounts of several individuals with AIDS who either contemplated or actually died as a result of assisted suicide evidence not only the occurrence of such acts, but also autobiographical details of the circumstances leading to these difficult decisions.

### C. *Personal Accounts of Assisted Suicide by Persons with AIDS*

The story of Dr. Stephen Yarnell, a psychiatrist diagnosed with AIDS, illustrates the plans of many people affected with this disease.<sup>64</sup>

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60. C. Mead et al., *AIDS, Euthanasia and Grief*, AIDS WEEKLY, July, 22, 1991, at 16 (article presented at the Seventh International Conference on AIDS in Florence, Italy, June 16-21, 1991). A newspaper report in 1987 included a comment by a Dr. Sven Danner, head of the AIDS unit at Amsterdam's Academic Medical Center, who "estimated this week that at least 12 of his hospital's 97 AIDS patients who have died were killed by lethal injections administered by physicians." Doug Cosper, *In Netherlands, Some AIDS Patients Choosing Euthanasia, Doctors Say*, PHILA. INQUIRER, Apr. 2, 1987, at A3.

61. Mead, *supra* note 60, at 16. For a general overview of the physical manifestations of HIV infection and AIDS, see Macher, *supra* note 29, at 5-15. In 1987, a group of 19 British doctors supported voluntary euthanasia for well-informed AIDS patients who seek to "end their lives rather than face mental and physical deterioration in the final stages of the disease." *AIDS Euthanasia Option Advocated*, PHILA. INQUIRER, Nov. 14, 1987, at C8. The doctors stated that the AIDS epidemic increased the need for euthanasia because "more people now survive to suffer the sort of physical and psychological distress which cannot be adequately relieved even by the best medical and hospice care." *Id.*

62. Mead, *supra* note 60, at 16.

63. *Id.* In June 1993, Derek Humphry, founder of the Hemlock Society, held a seminar in San Francisco providing information to more than 150 people on the "drugs to use for suicide, how to avoid a botched attempt and whether to involve their loved ones and doctors." *Hemlock Society Holds Seminar for Those Diagnosed with AIDS*, STAR TRIB. (San Francisco), June 21, 1993, at 7A. Most of the 150 people who attended were gay men with AIDS. Humphry commented: "If people are revolted by what I'm saying and doing, then we must change the law." *Id.* Humphry included a "demonstration of how to use a plastic bag and a rubber band for self-asphyxiation." *Id.*

64. Lewis & Christoff, *supra* note 18, at 17A (stating that interest in changing the law against assisted suicide in California is growing as "AIDS condemns outspoken people like Yarnell, 44, to the prospect of grim, wasting deaths").

In 1987, Yarnell refused to explain the actual mechanics of his planned death, but indicated that he had a "cache of barbiturates" in sufficient quantity to kill himself.<sup>65</sup> He was already monitoring the damage done to his brain by AIDS through periodic psychological testing. Yarnell viewed the option of assisted suicide as "no more than a chance to die with dignity."<sup>66</sup>

In 1990, a similar article in the *Boston Globe* chronicled the suicide of a man dying from AIDS, named "Dean."<sup>67</sup> Dean tested positive for HIV in 1984 and expected to die shortly thereafter. Contrary to his fears, Dean showed no ill effects until 1989, when he experienced a six-month episode of diarrhea, an indication that severe immunosuppression had commenced.<sup>68</sup> Although he started to contemplate suicide at this time, Dean pursued experimental treatments and gained renewed hope of tolerating the secondary diseases associated with AIDS. But in 1990, Dean was hospitalized for pneumonia and toxoplasmosis.<sup>69</sup> The medications he took "sapped his energy and made him so nauseated that he had to reduce the dosages."<sup>70</sup> He wrote a living will prospectively refusing artificial life support, gave a friend power of attorney to ensure that his wishes would be followed, and arranged his own memorial service.<sup>71</sup> With the final details in place, Dean started researching suicide as a "practical option."<sup>72</sup> He contacted a physician who was also a personal friend and obtained a "prescription for a fatal dose of medication."<sup>73</sup> Many months later, Dean's condition continued to deteriorate: "[h]e has continued to lose weight, his right side is partially paralyzed, and the slightest movement or speech is difficult for him."<sup>74</sup> The reporter concluded the article with a quote by Dean and a reference to his final act of suicide: "'I take the pills, then I'll sleep.' That night, he did."<sup>75</sup>

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65. *Id.* (Dr. Yarnell also evidenced concern about the involvement of other people in his planned suicide because the "law says it's a felony punishable by five years in prison for a person to aid or abet a suicide").

66. *Id.*

67. Golden, *supra* note 11, at 16 (also reporting that several terminally ill people followed similar planning patterns for their own suicides).

68. *Id.* (also reporting that as Dean waited for the illness to begin, he watched many of his friends succumb to AIDS and stated: "I'd pose in front of the mirror and say to myself, 'You look great, but you're rotting inside'").

69. *Id.*

70. *Id.*

71. *Id.*

72. *Id.*

73. *Id.*

74. *Id.* (describing how Dean discussed his intended suicide with his parents, who indicated their resignation to respect his wishes and their desire not to be involved with his decision).

75. *Id.*



In 1992, The *San Francisco Chronicle* reported the final hours of Steven Shiflett as he executed the plan for his assisted suicide.<sup>76</sup> Steven was dying of AIDS: he could only make out blurred images when he looked at people with his "disease-ridden" eyes; he had to wear diapers because constant diarrhea made him so weak that he could not physically travel to the bathroom; and eventually he was reduced to swallowing a teaspoon of olive oil periodically for nutrition because his body no longer absorbed nutrients from his intravenous fluids.<sup>77</sup> Realizing the protracted aspect of his death from AIDS, Steven set the date for his suicide.<sup>78</sup> In a brown bag labeled "euthanasia kit," Steven had assembled several vials of medication and a plastic garbage bag to put over his head if he underestimated the dosage of the drugs required to end his life.<sup>79</sup> Steven wanted to be asleep when the fatal drugs were injected, and asked a friend, who was HIV-positive, to administer the lethal dose.<sup>80</sup>

On the chosen night, Steven held a living wake to celebrate his death with close friends. After saying good-bye, Steven retired to his bedroom and consumed a large number of sleeping pills and morphine to induce sleep.<sup>81</sup> The carefully crafted plan went awry because Steven's diseased digestive system was incapable of absorbing the oral medication, thus precluding his ability to fall asleep. To further complicate the situation, Steven's "assistant" was startled by an unannounced visitor in the bedroom and abandoned Steven after injecting only a portion of the lethal dosage.<sup>82</sup> The friends remaining in the apartment made a panicked call to Steven's physician for advice on how to proceed. Confronted with an extremely difficult situation, the doctor chose to assist. The article described his troubled recollections:

Steven had been very clear with me about what he wanted . . . so I told them how to finish what had been started. It crossed the line for

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76. Olszewski, *supra* note 10, at A1 (reporting that the article was the beginning of a two-part series on the euthanasia movement in the United States, including the account of Steven Shiflett's assisted suicide and a discussion of Proposition 161, which would legalize "physician aid in dying").

77. *Id.*

78. *Id.* (recounting Shiflett's impression of his existence one week before he died: "I drip and I shit. That is my life now").

79. *Id.*

80. *Id.*

81. *Id.*

82. *Id.* (explaining that this situation is commonly called a "botched" attempt at assisted suicide).

me; I was involved way more than I wanted to be. It should have remained just between Steve and me. When I hung up the phone, I thought "Oh my God, I just helped kill somebody." But Steven was going to be dead in a week or two. Steven was looking to shorten his death, not to shorten his life.<sup>83</sup>

One of Steven's friends administered the remainder of the lethal medication and shortly thereafter, Steven died.<sup>84</sup> His cause of death was listed in the city record as AIDS and related infections.<sup>85</sup>

Finally, in 1993 the *Boston Globe* published the account of a Boston physician who assisted the suicide of a man with AIDS.<sup>86</sup> A forty-seven year-old man contacted the physician, fictitiously referred to in the article as Dr. Green, to obtain a lethal prescription of pills. Initially resistant to the idea of assisted suicide, Dr. Green consulted a psychiatrist who determined that the man "was not depressed, but steady and rational."<sup>87</sup> Dr. Green learned that the patient had lived with AIDS for five years and had become so weak that he could no longer get out of the house. The patient was not in intractable pain or near death at this time, but he did suffer from fatigue, loss of appetite, and infections.<sup>88</sup> The man explained that his interest in suicide arose out of a need to control his life when its quality was diminishing so rapidly.<sup>89</sup> After the man suffered a period of confusion and paranoia one evening, Dr. Green decided to prescribe a month's supply of barbiturates and a potent pain narcotic.<sup>90</sup> A few days later, the man swallowed all of the medication and, surrounded by his friends, died peacefully while Dr. Green waited patiently in another part of the house.<sup>91</sup>

These are a only a few examples of the personal accounts of assisted suicide by people with AIDS that have been published in newspapers.

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83. *Id.*

84. *Id.*

85. *Id.*

86. Lehr, *Physicians Are Helping*, *supra* note 10, at 1 (also reporting on other physicians who assisted in the suicides of terminally ill patients).

87. *Id.*

88. *Id.*

89. *Id.*

90. *Id.*

91. *Id.* Not all accounts of assisted suicide occur by ingestion or injection of lethal doses of pain medication. In January 1990, hospital officials at Cedars-Sinai Medical Center in Los Angeles reported a murder-suicide involving an AIDS patient and his male companion. Kenneth J. Garcia & Victor F. Zonana, *AIDS-Suicide Link Worries Health Professionals*, L.A. TIMES, Jan. 6, 1990, at 1. Steven Charles Jenkins was dying of AIDS in the hospital. His companion entered the hospital room and shot Jenkins "through the head before turning the gun on himself." *Id.* Hospital officials believed that the tragedy involved a secret suicide pact. *Id.*

The accounts describe the decisions of four men to control the time of death rather than wait to naturally succumb to AIDS. Every example includes some form of assistance by a physician, either by unknowingly prescribing pain medication which the patient accumulated for a future suicide, or actively participating in the circumstances of the patient's death. Advocates of medically assisted suicide cite accounts such as these as support for the legalization of assistance in death. Theoretically, the "botched" suicide attempt in the Steven Shiflett story would not have occurred if his physician could have been legally present to administer the lethal dosage.<sup>92</sup>

Although personal accounts provide compelling support for the legalization of assisted suicide, many states prohibit aiding and abetting suicide through either specific statutory provisions,<sup>93</sup> or prosecution under murder or attempted murder charges.<sup>94</sup> Advocates of legalized assisted suicide must overcome the criminal law history in many states by establishing that the right to assisted suicide is not only supported by the public, but also constitutionally valid. The most advantageous method for altering the current law is to demonstrate a protected constitutional right to medical assistance in death, or alternatively, that the enactment of a statute establishing a right to assisted suicide will be upheld as constitutional.

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92. For example, Dr. John P. Geyman, a physician-plaintiff in *Compassion in Dying v. Washington*, 850 F. Supp. 1454 (W.D. Wash. 1994), described the importance of physician assistance: "Terminally ill persons who seek to hasten death by consuming drugs need medical counseling, . . . . Knowing what drug, in what amount, will hasten death for a particular patient, in light of the patient's medical condition and medication regimen, is a complex medical task." *Id.* at 1457 (citing the Declaration of John P. Geyman, M.D., pp. 3-5). Dr. Geyman explained that patient efforts to hasten death through a drug overdose "are often unsuccessful" and "[v]ery often, patients who survive a failed suicide attempt find themselves in worse shape than before the attempt." *Id.* See also *Hemlock Society Holds Seminar for Those Diagnosed with AIDS*, STAR TRIB. (San Francisco), June 21, 1993, at 7A (reporting on a seminar held by Derek Humphry that provided information on how to avoid a "botched" suicide attempt in the absence of physician assistance).

93. Pugliese, *supra* note 7, at 1295 n.20 (listing all of the states with laws prohibiting assisted suicide), see also Reno, *supra* note 3, at 1176-83 (1992) (appendix providing the text of each state law prohibiting assisted suicide).

94. See, e.g., *People v. Cleaves*, 280 Cal. Rptr. 146 (Cal. Ct. App. 1991) (upholding conviction of second degree murder for defendant who assisted AIDS sufferer in strangulation suicide); *Gentry v. State*, 625 N.E.2d 1268 (Ind. Ct. App. 1993) (affirming defendant's murder conviction for suffocating his mother while she was affected by a drug overdose in an attempted suicide); *State v. Sage*, 510 N.E.2d 343 (Ohio 1987) (affirming aggravated murder conviction for assisting in the suicide of a friend). But see *In re Joseph G.*, 667 P.2d 1176 (Cal. 1983) (finding that minor, who entered a genuine suicide pact, but survived, was guilty only of aiding and abetting suicide, not murder). For a general discussion of the different state criminal provisions regarding assistance in suicide through either aiding and abetting or murder charges, see John H. Derrick, J.D., Annotation, *Criminal Liability for Death of Another as Result of Accused's Attempt to Kill Self or Assist Another's Suicide*, 40 A.L.R.4th 702 (1985); and Catherine D. Shaffer, *Criminal Liability for Assisting Suicide*, 86 COLUM. L. REV. 348 (1986).

#### IV. THE CONSTITUTIONAL BASIS FOR A RIGHT TO ASSISTED SUICIDE

Advocates of assisted suicide claim that court decisions recognizing the right to refuse and remove life-sustaining treatment also establish the basis for the right to medically assisted suicide. The following analysis of several court decisions provides a constitutional rationale for the right to assisted suicide,<sup>95</sup> even though the courts have cautiously and explicitly excluded assisted suicide from the scope of their decisions. This assessment begins with *In re Quinlan*,<sup>96</sup> the landmark case that recognized the right to refuse medical treatment, followed by *Cruzan v. Director, Missouri Department of Health*,<sup>97</sup> the first assessment by the United States Supreme Court of the issue of the "right to die." The recent decision in *Compassion In Dying v. Washington*<sup>98</sup> explicitly held that the constitutional basis for a "right to die" also encompasses a protected liberty interest in the decision to seek assistance in suicide. Thereafter, the extent to which other state courts have extended the right to refuse life-sustaining care will be discussed in order to evaluate the constitutional basis for a statutory right to assisted suicide.

##### A. *In re Quinlan and Cruzan: The Foundation of Patient Autonomy*

In the 1976 case, *In re Quinlan*,<sup>99</sup> the New Jersey Supreme Court held that a life-support system could be removed from a comatose patient who, based on a consensus of medical opinions, had no reasonable possibility of recovery from a persistent vegetative state.<sup>100</sup> The *Quinlan* decision initiated public acceptance of a person's deci-

95. An extensive analysis of the constitutional basis for the right to assisted suicide is beyond the scope of this Article. For a detailed discussion of this topic, see James Bopp, Jr., J.D., *Is Assisted Suicide Constitutionally Protected?*, 3 ISSUES IN L. & MED. 113 (1987). James Bopp, Jr., is the attorney leading the challenge against the Oregon Death With Dignity Act on the grounds that the Act violates the constitutional right to freedom of religion and due process. Dee Lane, *Attorney Is Veteran of Right-To-Die Cases*, OREGONIAN, Dec. 11, 1994, at A12.

96. 355 A.2d 647 (N.J.), cert. denied, 429 U.S. 922 (1976). Chief Justice Rehnquist recognized *In re Quinlan* as the "seminal decision" on the issue of the "right-to-refuse-treatment" in *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 270 (1990).

97. 497 U.S. 261 (1990) (Chief Justice Rehnquist stating for the Court that this "is the first case in which we have been squarely presented with the issue whether the United States Constitution grants what is in common parlance referred to as a 'right to die'").

98. 850 F. Supp. 1454 (W.D. Wash. 1994). This decision is currently on appeal by the state to the Court of Appeals for the Ninth Circuit in San Francisco. Muriel Dobbin, *Courts, Voters Asked to Wrestle with Assisted Suicide Questions*, SACRAMENTO BEE, Aug. 28, 1994, at A14.

99. 355 A.2d 647 (N.J. 1976) (providing that the decision to discontinue the life-support system would be made by the attending physicians and Karen's father, followed by a consultation with the hospital "Ethics Committee" or similar body of the hospital in which Karen was then hospitalized).

100. *Id.* at 671-72. The testimony of several medical experts "characterized Karen as being in

sion to reject life-sustaining treatment, and thus, a right-to-die under certain circumstances.<sup>101</sup> The court weighed an individual's constitutional right to privacy against the merit of the state's interest in preserving human life and protecting the integrity of the medical profession.<sup>102</sup> Under this balancing test, the state's interest "weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims."<sup>103</sup> The court concluded that termination of life support under these circumstances would constitute neither homicide nor "aiding suicide" because the subsequent death would occur from "existing natural causes."<sup>104</sup> Under the facts presented, the court held that an incompetent patient's right to privacy could be asserted by her family on her behalf, due to her debilitated condition.<sup>105</sup>

In comparison, the United States Supreme Court decision in *Cruzan v. Director, Missouri Department of Health*<sup>106</sup> recognized the right to refuse hydration and nutrition for a comatose patient under the liberty component of the Fourteenth Amendment.<sup>107</sup> While acknowledging that "a competent person has a constitutionally protected liberty

a 'chronic persistent vegetative state'" as a result of a respiratory arrest and associated anoxia. *Id.* at 653-55. Karen Ann Quinlan's father petitioned the court for appointment as her guardian with the express power to discontinue all extraordinary life-support measures. *Id.* at 651.

101. *Physician Assisted Suicide and the Right to Die with Assistance*, 105 HARV. L. REV. 2021, 2022 (1992).

102. *Quinlan*, 355 A.2d at 663-64. This conclusion was based on the implicit guarantee of the right to privacy as established in several United States Supreme Court decisions. *Id.* at 663 (citing *Eisenstadt v. Baird*, 405 U.S. 438 (1972), *Stanley v. Georgia*, 394 U.S. 557 (1969), and *Griswold v. Connecticut*, 381 U.S. 479, 484 (1965)). The court explained that presumably this "right is broad enough to encompass a patient's decision to decline medical treatment under certain circumstances." *Id.* (citing *Roe v. Wade*, 410 U.S. 113, 153 (1973)).

103. *Id.* at 664; accord *Guardianship of Doe*, 583 N.E.2d 1263 (Mass.), cert. denied 112 S.Ct. 1512 (1992) (recognizing the right of a guardian to refuse hydration and nutrition for an incompetent patient on the basis of the patient's fundamental right to bodily integrity).

104. *Quinlan*, 355 A.2d at 670 n.9. The court recognized that the termination of treatment would "accelerate Karen's death." *Id.* at 669. In the assessment of the County Prosecutor and Attorney General's argument that criminal liability would result, the court explained:

[T]he exercise of a constitutional right such as we have here found is protected from criminal prosecution. The constitutional protection extends to third parties whose action is necessary to effectuate the exercise of that right where the individuals themselves would not be subject to prosecution or the third parties are charged as accessories to an act which could not be a crime. And, under the circumstances of this case, these same principles would apply to and negate a valid prosecution for attempted suicide, were there still such a crime in this State.

*Id.* at 670 (citations omitted). The court also concluded that a proposed and independent offense of aiding suicide "would not be incriminatory in circumstances similar to those presented in this case." *Id.* at 670 n.9.

105. *Id.* at 664.

106. 497 U.S. 261 (1990).

107. *Id.* at 277. The Fourteenth Amendment provides that no State shall "deprive any person of life, liberty, or property, without due process of law." U.S. CONST. amend. XIV, § 1.

interest in refusing unwanted medical treatment,"<sup>108</sup> the Court cautioned that this right may be governed by procedural safeguards "where a guardian seeks to discontinue nutrition and hydration" of a person in a permanent vegetative state.<sup>109</sup> The Court explained that a situation in which a "surrogate" must make a choice between life and death justifies a heightened evidentiary burden to demonstrate the incompetent person's wishes.<sup>110</sup> The Court emphasized the state's interest in preserving life and requiring a clear intent to discontinue such treatment by noting that "the majority of States in this country have laws imposing criminal penalties on one who assists another to commit suicide."<sup>111</sup>

*Quinlan* and *Cruzan* recognize the right of both competent and incompetent persons to refuse or request the removal of life-sustaining medical treatment. Many advocates of assisted suicide argue that the Supreme Court's recognition of the constitutional right to refuse food and water under certain circumstances must similarly include the right to assisted suicide.<sup>112</sup> But *Quinlan* and *Cruzan* also contain qualifying comments that position assisted suicide beyond the scope of the constitutional right to die.<sup>113</sup>

Both decisions emphasize a distinction between assisted suicide and the right to remove or refuse medical treatment by referring to the history of state prohibitions against aiding and abetting suicide. Be-

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108. 497 U.S. at 278-79.

109. *Id.* at 284 (referring to the Missouri Supreme Court's application of a clear and convincing evidence standard for discontinuation of such treatment for an incompetent patient). Nancy Beth Cruzan suffered severe injuries as a result of an automobile accident and thereafter existed in a persistent vegetative state. *Id.* at 266. The court defined "persistent vegetative state" as "a condition in which a person exhibits motor reflexes but evinces no indications of significant cognitive function." *Id.* Her parents obtained an order from the state trial court authorizing the termination of artificial hydration and nutrition after it became apparent that her condition was irreversible. *Id.* at 267-68. The trial court found both a state and federal constitutional right to refuse or direct the removal of "death prolonging procedures." *Id.* at 268. However, the Missouri Supreme Court reversed due to the lack of clear and convincing evidence of Nancy's intent to refuse treatment under these circumstances. *Id.* at 268-69. The United States Supreme Court affirmed the Missouri Supreme Court's decision. *Id.* at 270-78.

110. *Id.* at 280.

111. *Id.* (explaining that "[w]e do not think a State is required to remain neutral in the face of an informed and voluntary decision by a physically able adult to starve to death").

112. See, e.g., Pugliese, *supra* note 7, at 1311 (asserting that assisted suicide "is the next logical step in granting patients the right of self-determination"); Lehr, *Wrenching Choices*, *supra* note 7, at 1 (reporting Lawrence O. Gostin, Executive Director of the American Society of Law and Ethics, favors legislation intended to legalize physician assisted suicide); and Sidney H. Wanzer et al., *The Physician's Responsibility Toward Hopelessly Ill Patients*, 320 NEW ENG. J. MED. 844, 848 (1989) (commenting that "it is not immoral for a physician to assist in the rational suicide of a terminally ill person").

113. See *Cruzan*, 497 U.S. at 280 & n.8 (emphasizing the illegality of assisted suicide in the "majority of States"); *Quinlan*, 355 A.2d at 670 n.9 (distinguishing "aiding suicide" from the discontinuation of life-support measures).

cause state prohibitions against assisted suicide existed at the time of these decisions, both courts had to explain why a person who actually removed life-support, thus hastening the death of another person, would not be subject to criminal liability under the current state law.<sup>114</sup> The *Quinlan* court recognized the right to remove unwanted medical treatment as an aspect of the constitutional right to privacy.<sup>115</sup> Participation in the removal of invasive, but life-sustaining treatment constituted merely an exercise of the patient's right to be free from unwanted personal intrusion rather than illegal assistance in suicide. In *Cruzan*, the Court harmonized the constitutional "right-to-die" with current state law by focusing on the patient's liberty interest, the freedom to make a personal decision to remove medical treatment.<sup>116</sup> If the decision itself is protected by the Constitution, then the assistance of another person in actually executing the decision to remove life-sustaining treatment cannot be penalized as aiding and abetting suicide under the state law. Therefore, the decisions in *Quinlan* and *Cruzan* do not stand for the proposition that assisted suicide is repugnant or offensive to the rights expressly provided or judicially construed under the United States Constitution. The decisions merely exempt the right to discontinue or refuse life-sustaining treatment from the province of existing state prohibitions against aiding and abetting suicide and negate any inference that such actions would incur criminal liability under State law.

Although the cases distinguish the right to remove life-sustaining treatment from assistance in death, they do not expressly rule out the feasibility of such a right. The decision to terminate or refuse life-sustaining treatment is a constitutionally protected liberty interest which may prevail under certain circumstances when balanced against the state's interest in preserving life. Obviously, the state's interest in preserving life is paramount in the context of assistance in suicide.<sup>117</sup> But a strong argument can be made that a person's constitutional liberty interest is broad enough to encompass a competent and voluntary decision to request an expedited death rather than suffer through the indignity and pain of a protracted natural death from an irreversible and terminal illness.<sup>118</sup>

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114. See *Cruzan*, 497 U.S. at 280 & n.8 (referring only to state laws against assistance in suicide); *Quinlan*, 355 A.2d at 670 n.9 (commenting only on illegality under state penal code).

115. *Quinlan*, 355 A.2d at 669-70.

116. *Cruzan*, 497 U.S. at 279-80.

117. The asserted state interests include protection and preservation of life and protecting the integrity and responsibility of the medical profession. *Quinlan*, 355 A.2d at 663.

118. See *Compassion In Dying v. Washington*, 850 F. Supp. 1454 (W.D Wash. 1994) (recognizing a constitutionally protected right to commit suicide under both the liberty interest compo-

### B. Express Recognition of a Constitutional Right to Assisted Suicide

In *Compassion in Dying v. Washington*,<sup>119</sup> the Federal District Court for the Western District of Washington invalidated a state statute<sup>120</sup> prohibiting all forms of assisted suicide as both an infringement of the liberty interest component and a violation of the Equal Protection Clause under the Fourteenth Amendment.<sup>121</sup> In challenging the statute, the plaintiffs asserted that mentally competent, terminally ill adults have a "constitutionally protected right to be free from undue governmental intrusion on their decision to hasten death and avoid prolonged suffering."<sup>122</sup>

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ment of the Fourteenth Amendment to the Constitution); *Michigan v. Kevorkian*, 62 U.S.L.W. 2411 (Mich. Cir. Ct. Dec. 13, 1993) (lower court decision recognizing a constitutionally protected right to commit suicide), *rev'd in part, aff'd in part sub nom. Hobbins v. Attorney General*, 518 N.W.2d 487 (Mich. Ct. App. 1994) (reversing lower court's recognition of a constitutional right to commit suicide while upholding invalidation of statute).

119. 850 F. Supp. 1454 (W.D. Wash. 1994). This opinion is on appeal by the state to the Ninth Circuit Court of Appeals in San Francisco. Dobbin, *supra* note 98, at A14. On December 7, 1994, a three-judge panel of the United States Circuit Court of Appeals for the Ninth Circuit initiated a review of the lower court's decision. Patrick O'Neill, *Federal Judge Blocks Suicide Law*, OREGONIAN, December 8, 1994, at A1.

120. The Washington statute banned "aiding or causing the suicide of another: A person is guilty of promoting a suicide attempt when he knowingly causes or aids another person to attempt suicide." *Id.* at 1458-59 (citing RCW 9A.36.060(1)). The court noted that "[p]romoting a suicide attempt is a class C felony punishable by imprisonment for a maximum of five years and a fine of up to ten thousand dollars." *Id.* at 1459 (citing RCW 9A.36.060(2) and 9A.20.020(1)(c)).

121. *Id.* at 1467.

122. *Id.* at 1459. The plaintiffs in the case consisted of "a coalition of three terminally ill patients, five physicians who treat terminally ill patients, and Compassion in Dying, an organization which provides support, counseling and assistance to mentally competent terminally ill adults considering suicide." *Id.* at 1456. Due to the numerous plaintiffs in this case, the text will discuss the patient-plaintiffs' constitutional claims. A brief description here of each plaintiff's situation is pertinent to the discussion of assisted suicide and provides insight into the context of the constitutional challenge in this case.

One of the three patient-plaintiffs was Jane Roe, a 69-year-old retired pediatrician and cancer patient. *Id.* She was in the terminal phase of her illness, bedridden since June 1993, and experienced constant pain that was not fully alleviated by available medication. *Id.* The court noted that she "is mentally competent and wishes to hasten her death by taking prescribed drugs with the help of plaintiff Compassion in Dying." *Id.*

Another patient, John Doe, was a 44-year-old artist dying of AIDS. "Since his diagnosis in 1991, he has experienced two bouts of pneumonia, chronic, severe skin and sinus infections, grand mal seizures and extreme fatigue. He has already lost 70% of his vision to cytomegalovirus retinitis, a degenerative disease which will result in blindness." *Id.* John Doe was the primary caregiver for his long-term companion who died of AIDS in June of 1991. The court also noted that he is "mentally competent, understands there is no cure for AIDS, and wants his physician to prescribe drugs which he can use to hasten his death." *Id.* at 1456-57.

The third patient was James Poe, a 69-year-old retired sales representative who suffered from emphysema. *Id.* at 1457. He was connected to oxygen at all times, took morphine regularly to quell the panic associated with his constant sensation of suffocation, and also suffered from heart failure, resulting in severe leg pain and circulation problems. The court noted that Mr. Poe



The court assessed the Supreme Court decisions regarding abortion rights<sup>123</sup> and the right to die<sup>124</sup> in concluding that a competent, terminally ill adult has a constitutionally guaranteed right under the Fourteenth Amendment to physician-assisted suicide.<sup>125</sup> As with individual decisions regarding abortion and refusal or removal of unwanted medical treatment, the decision of a terminally ill person to end his or her life constitutes one of the most "intimate and personal choices a

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was "mentally competent and wishes to commit suicide by taking physician-prescribed drugs." *Id.*

The physician-plaintiffs included Dr. Harold Glucksberg, assistant professor of medicine at the University of Washington School of Medicine, who also practiced in the treatment of cancer. *Id.* Dr. Glucksberg stated in his declaration that the "cancer patient is fully aware of his or her present suffering and anticipates certain future suffering." *Id.* He described the end stages of cancer as a deterioration of the patient's mental and physical functions and a state of excruciating, unrelenting pain. Dr. Glucksberg stated that "some patients do not want to end their days either racked with pain or in a drug-induced stupor." *Id.*

Dr. John P. Geyman, former professor and chair of the Department of Family Medicine from 1976 through 1990 at the University of Washington School of Medicine, was in private family practice at the initiation of the case. *Id.* Dr. Geyman stated in his declaration that a "subset of dying patients desire to shorten their dying process and thereby avoid a lingering death and associated pain, suffering and loss of dignity." *Id.*

The other physicians were Dr. Thomas A. Preston, chief of cardiology at Pacific Medical Center in Seattle, Dr. Abigail Halperin, family medicine practitioner who occasionally treats terminally ill patients with cancer or AIDS, and Dr. Peter Shalit, general internal medicine practitioner who treats a substantial number of patients with HIV infection and AIDS. *Id.* at 1458.

The final plaintiff was an organization called Compassion in Dying, "a Washington non-profit organization" which provided assistance in death through the use of prescription medications pursuant to a detailed written protocol and strict eligibility requirements for the individuals to whom it provides services. *Id.*

123. 850 F. Supp. 1454, 1459 (W.D. Wash. 1994). The court reviewed the analysis in *Planned Parenthood v. Casey*, 112 S. Ct. 2791 (1992), and found that the "suffering of a terminally ill person cannot be deemed any less intimate or personal, or any less deserving of protection from unwarranted governmental intrusion, than that of a pregnant woman." *Id.* If the government cannot resolve the philosophical question of abortion "in such a definitive way that a woman lacks all choice in the matter," then the same liberty concerns must apply to the "profound spiritual and moral questions" surrounding the decision of a mentally competent, terminally ill individual's decision to end his or her life. 850 F. Supp. at 1459.

124. *Id.* The court assessed Chief Justice Rehnquist's decision for the Court in *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261 (1990), which recognized that a competent person has a protected liberty in refusing unwanted and life-sustaining treatment. The court then phrased the issue as whether there is "a difference for the purposes of finding a Fourteenth Amendment liberty interest between the refusal of unwanted treatment which will result in death and committing physician-assisted suicide in the final stage of life." 850 F. Supp. at 1459.

125. It is important to note the context of the patient-plaintiffs' claims. All of the patients were associated with either the organization, Compassion in Dying, or a physician who was willing to aid such individuals in an end-of-life decision. *Id.* at 1456-58. The Washington statute under challenge would prosecute participating physicians for aiding a terminally ill and competent adult patient in a request for assistance in death. *Id.* at 1458-59. Therefore, the decision of the District Court encompasses only situations where a competent, terminally ill adult makes the decision to hasten inevitable death with the participation of a willing and supportive physician. The decision could not be construed to force an unwilling physician to assist such a patient in assisted suicide.

person may make in a lifetime."<sup>126</sup> The liberty interest component of the Fourteenth Amendment encompasses the right to make intensely private decisions about matters which are "essential to personal autonomy and basic human dignity."<sup>127</sup> The court reasoned that there "is no more profoundly personal decision, nor one which is closer to the heart of personal liberty, than the choice which a terminally ill person makes to end his or her suffering and hasten an inevitable death."<sup>128</sup> In this context, no constitutional distinction can be drawn "between refusing life-sustaining medical treatment, and physician-assisted suicide by an uncoerced, mentally competent, terminally ill adult."<sup>129</sup>

Upon finding a constitutionally protected liberty interest in the decision to request physician-assisted suicide, the court weighed the State's interest in maintaining a total prohibition on all assisted suicides against the interests of terminally ill, mentally competent, adult patients.<sup>130</sup> In evaluating the State's interest in "detering suicide by young people and others with a significant natural life span ahead of them," the court noted that the plaintiffs are people suffering through the final stages of a terminal disease which places them beyond the scope of the State's legitimate interest.<sup>131</sup> "As to them, preventing suicide simply means prolonging a dying person's suffering, an aim in which the State can have no interest."<sup>132</sup> The court surmised that the State legislature could devise regulations to specifically limit the scope of permissible physician-assisted suicide to mentally competent, termi-

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126. *Id.* at 1459-61 (analyzing the Supreme Court decisions and reasoning in *Casey* and *Cruzan*).

127. *Id.* at 1461.

128. *Id.*

129. *Id.*

130. The court provided an extensive discussion of the appropriate standard of review in a constitutional challenge to a state statute. The defendants asserted that a facial challenge to the validity of the Washington statute required the plaintiffs to demonstrate that the statute was invalid under any and all circumstances to succeed in their claim. *Id.* at 1462 (referring to the decision in *United States v. Salerno*, 481 U.S. 739 (1987)). The court, however, followed the standard set forth in *Casey* which required the plaintiffs to show that the statute constituted an "undue burden" on the exercise of their constitutionally protected right to physician-assisted suicide. *Id.* at 1462-63 (noting that *Casey* involved the liberty interest in being free from unwarranted governmental intrusion into fundamental and personal matters as those involved in this case).

It is pertinent to note that the Court of Appeals for the Ninth Circuit has several alternative bases for reversing the District Court's decision. First, the Circuit Court could find that the liberty component of the Fourteenth Amendment does not encompass a right to physician-assisted suicide. Alternatively, the Circuit Court could recognize such a right, but find that the District Court failed to apply the correct standard of review for a facial constitutional challenge. Finally, the Circuit Court could find that neither the liberty component nor the Equal Protection Clause of the Fourteenth Amendment are violated by the Washington statutory prohibition on all types of assisted suicide.

131. *Id.* at 1464.

132. *Id.*

nally ill, adult patients, while maintaining the legitimate State interest in preventing suicide.<sup>133</sup>

While regarding the State's interest in protecting people from committing suicide due to undue influence or duress as a legitimate concern, the court reasoned that terminally ill people who make informed and voluntary decisions to commit physician-assisted suicide "by definition fall outside the realm of the State's concern."<sup>134</sup> Beyond this conclusion, the court emphasized that Washington State law permits a competent individual to refuse or request the discontinuation of life-sustaining treatment and recognizes the exercise of such decisions on behalf of an incompetent patient by a legally authorized representative.<sup>135</sup> The risk of abuse or undue influence is equally significant in cases where patients request the removal life-sustaining treatment, and is even more daunting in situations where a surrogate exercises this type of decision for an incompetent patient.<sup>136</sup> The court concluded that through the total ban on assisted suicide, the challenged statute placed an undue burden on a mentally competent, terminally ill adult's constitutional right to seek physician assisted suicide.<sup>137</sup>

Finally, the court assessed the claim that the statute unconstitutionally distinguished between two similarly situated groups of mentally competent, terminally ill adults in violation of the Equal Protection Clause of the Fourteenth Amendment.<sup>138</sup> The plaintiffs asserted that current state law permitted terminally ill persons sustained on life-support equipment or artificial nutrition and hydration to legally request the assistance of a physician in terminating this type of treatment and thereby hasten death.<sup>139</sup> Whereas the law denied patients who suffer from terminal illnesses, but do not require the application of life-sustaining treatment, the option of hastening death with medical assistance.<sup>140</sup> The defendants maintained that the state's interest in

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133. 850 F. Supp. at 1465. The court referred to the State's interest in prohibiting any type of assisted suicide as a reaction to the "slippery slope" problem. *Id.* at 1464. In essence, the State perceives any exception to a total ban as a threat of gradual acceptance of suicide and the ultimate increase in suicides by individuals who are temporarily afflicted or distraught rather than limiting the option to competent and terminally ill adults. *Id.* at 1464. For further discussion of the arguments against physician-assisted suicide, see notes 188-222 and accompanying text.

134. *Id.* at 1465.

135. *Id.* (referring to Washington's Natural Death Act, Washington Supreme Court decisions, and the acceptance of a durable power of attorney for health care).

136. *Id.*

137. *Id.*

138. *Id.* The Equal Protection Clause of the Fourteenth Amendment provides that no State shall "deprive any person of life, liberty, or property, without due process of law; nor deny any person within its jurisdiction the equal protection of the laws." U.S. CONST. amend. XIV, § 1.

139. *Compassion in Dying*, 850 F. Supp. 1454, 1466 (W.D. Wash. 1994).

140. *Id.*

preventing suicide is only implicated in the context of physician-assisted suicide because death resulting from the removal of life-sustaining treatment is natural and thereby unassisted.<sup>141</sup>

The court concluded that the two groups of competent terminally ill patients were similarly situated, thus requiring the State to demonstrate a compelling interest to justify the disparate treatment of the two groups under Washington law.<sup>142</sup> The court failed to recognize the distinction between "natural" and "artificial" death as a justification because both types of "patients may be terminally ill, suffering pain and loss of dignity and subjected to more extended dying process without some medical intervention, be it removal of life support systems or the prescription of medication to be self-administered."<sup>143</sup> In addition to infringing upon the liberty interests of the patient-plaintiffs, the court held that the Washington statute violated the equal protection guarantee of the Fourteenth Amendment by burdening the fundamental rights of one group in comparison to the rights of a similarly situated group.<sup>144</sup>

Although the *Compassion In Dying* decision has been appealed, the district court's reasoning provides a basis for recognizing that a personal decision to seek assistance in death falls within the province of the liberty interest component of the Fourteenth Amendment. By focusing on the nature of the decisions afforded protection under the Constitution, the district court could not find a distinction between the decision of a competent, terminally ill adult to request the removal of life-sustaining treatment or to seek the assistance of a willing physician to end a protracted death. Both decisions involve a personal choice to end a prolonged decline into death. To be executed, both decisions require the voluntary assistance of a health care professional.

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141. *Id.*

142. *Id.* at 1467.

143. *Id.*

144. *Id.* In *Cruzan*, Chief Justice Rehnquist briefly addressed the petitioner's claim that the state violated the equal protection guarantee under the Fourteenth Amendment by treating incompetent patients differently from competent patients in assessing decisions to discontinue life-sustaining treatment. In a footnote, Justice Rehnquist provided:

The differences between the choice made by a competent person to refuse medical treatment, and the choice made for an incompetent person by someone else to refuse medical treatment, are so obviously different that the State is warranted in establishing rigorous procedures for the latter class of cases which do not apply to the former class.

497 U.S. 261, 287 n.12 (1990). In *Compassion in Dying*, the justification for the class distinction is less obvious than in *Cruzan*. However, the Court of Appeals for the Ninth Circuit may find a distinction between the two groups that is sufficient to reverse the District Court's recognition of an equal protection violation.

Distinctions may be drawn between the natural occurrence of death following the removal of life-sustaining treatment and the artificially induced demise of a patient resulting from physician assisted suicide, however the precipitating factor in both scenarios is the patient's personal decision that existence in the end stages of a terminal illness can no longer be endured. The reasoning in *Compassion in Dying* and *Cruzan* establish a predicate for recognizing that the focus should be on the mentally competent, terminally ill adult's right to make decisions regarding his or her existence in comparison to the magnitude of the state's interest in preserving the specific life in question.

### C. *Implicit Recognition of a Right to Assisted Suicide*

Although *Compassion In Dying* is the only decision explicitly recognizing a constitutionally protected right to assisted suicide, other state courts have adopted a "quality of life" rationale which implicitly encompasses the right to assistance in a controlled death. In *Bouvia v. Superior Court*,<sup>145</sup> a California appellate court extended the constitutional right to refuse medical treatment to competent patients who are not terminally ill, but existing in a life devoid of quality—and possibly meaning.<sup>146</sup> The court granted the request of a competent woman, suffering from severe cerebral palsy and quadriplegia, to remove the nasogastric tube through which she received nutrition.<sup>147</sup> Although Elizabeth Bouvia was not terminally ill, the court explained that the additional number of years Bouvia could live under her current medical treatment must be balanced against the quality of that extended existence.<sup>148</sup> Bouvia remained mentally alert and intelligent.<sup>149</sup> Nevertheless, her illness reduced her physical existence to chronic pain, total immobility, and absolute reliance on the physical acts of others.<sup>150</sup>

The court recognized that competent as well as incompetent patients may exercise the constitutional right to refuse medical treatment,<sup>151</sup> reasoning that "there is no practical or logical reason to limit the exer-

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145. 225 Cal. Rptr. 297 (Cal. Ct. App. 1986).

146. *Id.* at 304. Because *Bouvia* was decided before the 1990 Supreme Court decision in *Cruzan*, the *Bouvia* court based its analysis on Supreme Court precedent regarding the right to privacy under the United States Constitution and the treatment of this issue by courts in several states.

147. *Id.* at 307.

148. *Id.* at 304.

149. *Id.* at 304-05.

150. *Id.* at 300. The California appellate court also noted that Ms. Bouvia had expressed the desire to die on several occasions and once attempted to starve herself to death. *Id.*

151. *Id.* at 301 (explaining that the obvious corollary to informed consent is a competent adult patient's right to refuse medical treatment).

cise of this right to 'terminal' patients."<sup>152</sup> In upholding Bouvia's right to refuse continued tube feedings, the court concluded that the state interest in preserving life could not possibly justify inflicting "such an ordeal upon anyone" against their will.<sup>153</sup> Therefore, it was "immaterial that the removal of the nasogastric tube [would] hasten or cause Bouvia's eventual death."<sup>154</sup>

The language and reasoning used by the *Bouvia* court establishes the basis for extending the constitutional right to die to patients who seek assistance in executing a decision to die. Yet the court distinguished Bouvia's decision to possibly "accept an earlier death" rather than rely on tube feedings from the act of suicide, because her situation did not involve "real parties aiding and abetting" this decision.<sup>155</sup> This is a perfunctory distinction at best because it implies that the removal of hydration and nutrition does not implement a physically incompetent person's decision to die from starvation.<sup>156</sup> As in *Quinlan* and *Cruzan*, the true distinction lies in the state prohibition against assistance in suicide rather than the means by which death occurs.<sup>157</sup> The *Bouvia* court postulated that "a desire to terminate one's life is probably the ultimate exercise of one's right to privacy."<sup>158</sup> If an individual's right of privacy encompasses a decision to commit suicide, then the right should also include a complementary decision to seek assistance in suicide under certain circumstances.

Other judicial decisions recognize that at some point the quality of a competent adult patient's life is so diminished that the individual

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152. *Id.* at 302 (rejecting the assertion that the right to refuse medical treatment is available only for terminally ill patients); see also Anne Reigle Crosswaite, Comment, "Do Not Resuscitate Order" Allowed for an Infant with AIDS: In the Interest of C.A., 26 J. OF HEALTH & HOSP. L. 11 (1993) (discussing an Illinois appellate court decision upholding the prospective authority of a guardian of an infant with AIDS to consent to a "do not resuscitate order" even though the infant was not comatose or in a persistent vegetative state).

153. 225 Cal. Rptr. 297, 305 (Cal. Ct. App. 1986).

154. *Id.* (noting that the goal of removing the nasogastric tube was "not to hasten death, though its earlier arrival may be an expected and understood likelihood").

155. *Id.* at 306 (explaining that Bouvia's motives behind the request for withdrawal of the tube feedings are irrelevant).

156. The quality of life for Steverr Shiflett, discussed in the preceding section, bears a striking resemblance to the quality of life Elizabeth Bouvia experienced. Olszewski, *supra* note 10, at A1. Shiflett was essentially blind, forced to wear diapers due to his inability to walk to the bathroom, unable to eat, and reduced to swallowing spoonfuls of olive oil for sustenance. *Id.* The only distinction from the facts in *Bouvia* is that Shiflett was not sustained on life-support equipment while he suffered from AIDS. Rather than starve to death, Shiflett elected to die from an overdose of medication while he slept. *Id.*

157. *Bouvia*, 225 Cal. Rptr. at 306 (assuring that no "criminal or civil liability attaches to honoring a competent, informed patient's refusal of medical service" in the context of a state statute prohibiting aid in suicide).

158. *Id.*

right to privacy or liberty interest in refusing or removing life-sustaining treatment must prevail over the state's interest in preserving life. In *McKay v. Bergstedt*,<sup>159</sup> the Supreme Court of Nevada held that competent adult patients who have either a terminal illness or a limited life expectancy may exercise their right to refuse or remove medical treatment without any consideration of the state's interest upon satisfaction of specific procedural requirements.<sup>160</sup> Although the petitioner died prior to the decision, in order "to provide guidance to others who may find themselves in similar predicaments,"<sup>161</sup> the court assessed the merit of a quadriplegic's request seeking the removal of respiratory support and administration of sedation to lessen any pain encountered during his demise.<sup>162</sup> The court found that the petitioner was entitled to the relief sought because his "liberty interest in controlling the extent to which medical measures were used to continue to sustain his life and forestall his death outweighed the State's interest in preserving his life."<sup>163</sup>

The court distinguished the removal of artificial life support from the choice to commit suicide, reasoning that the former results in death from natural causes whereas the latter is achieved through "some deadly means either self-inflicted or through the agency of another."<sup>164</sup> However, the court explained that the person's motives for seeking removal of life-support are relevant in the balancing of the individual's liberty interest in self-determination against the state's in-

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159. 801 P.2d 617, 620 (Nev. 1990). The court addressed the merit of granting a quadriplegic's request to be removed from a breathing apparatus and to receive sedation to lessen the pain he encountered during his demise. *Id.*

160. *Id.* at 630. The court required written certification by two non-attending physicians that the patient was competent, suffering from a terminal condition, and free of coercion or pressure in making his or her decision before the removal or rejection of life-sustaining treatment. *Id.* However, the court required that the right of non-terminal patients to refuse or discontinue such treatment be weighed against the state's interests in a court proceeding. *Id.* The court established this procedure in the absence of controlling legislation in the State of Nevada regarding the right to die. *Id.* at 629. The procedure outlined in the court's opinion is paralleled in the attempted legislation in several states for legalized assisted suicide. See *infra* notes 225-278 and accompanying text.

161. *Bergstedt*, 801 P.2d at 629. For a detailed analysis of the ramifications of the *Bergstedt* decision, see M. Lisa Wilson-Clayton & Mark A. Clayton, *Two Steps Forward, One Step Back: McKay v. Bergstedt*, 12 WHITTIER L. REV. 439 (1991).

162. *Bergstedt*, 801 P.2d at 620.

163. *Id.* at 625.

164. *Id.* at 627; accord *Thor v. Superior Court* 855 P.2d 375, 385 n.13 (Cal. 1993) (recognizing the distinction between removal or rejection of medical intervention and the deliberate act of suicide, with citations to several state courts espousing the same view); *Donaldson v. Van de Kamp*, 4 Cal. Rptr. 2d 59, 63 (Cal. Ct. App. 1992) (rejecting the request by petitioner to have another person provide a lethal injection to hasten his death in preparation for cryogenic suspension, on the basis that the right to refuse or remove life-support does not include the right to consent to murder or assistance in suicide).

terests in preserving life and preventing suicide.<sup>165</sup> The patient's motives can be judged by factors such as "severity of physical condition, diagnosis, prognosis, and quality of life."<sup>166</sup> Therefore, a competent, terminally ill patient has the right to elect discontinuation of medical treatment rather than living in a condition of hopelessness, total dependence, and a complete lack of dignity.<sup>167</sup>

The *Bergstedt* court attempted to distinguish suicide from the choice to discontinue medical treatment which ultimately results in the death of the patient. Yet the factors assessed by the court apply to assisted suicide as well, the central issue being the value of the person's existence, based upon his or her own judgment regarding the quality of life, in relation to the state's interest in preserving that person's life with medical treatment. The right to die is based upon the patient's subjective assessment of his or her existence in conjunction with a terminal medical diagnosis. To deny that a person has a right to seek assistance in ending the same type of dismal existence in the absence of medical intervention frustrates the principles of self-determination and individual autonomy.<sup>168</sup>

#### D. *Recognizing the Constitutionality of a Statutory Right to Assisted Suicide*

At a minimum, a state could constitutionally recognize a person's right to control his or her existence through the enactment of a statutory right to assisted death. Upon satisfaction of specific statutory requisites such as confirmation of a terminal medical diagnosis, incessant suffering, limited life expectancy, and the lack of any mental

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165. *Bergstedt*, 801 P.2d at 627.

166. *Id.*

167. *Id.*

168. The personal account of Joseph Leone illustrates this premise. Leone, dying of AIDS, made this statement to a *Boston Globe* reporter: "I have the utmost respect for life. Don't get me wrong. . . . But when you can't have quality of life, that's when you have to start looking and start drawing the line." Dick Lehr, *Man With AIDS, 38, Exerts His Will and Dies*, *BOSTON GLOBE*, May 12, 1993, at 30. Plagued by numerous illnesses and fighting the end stages of AIDS, Leone searched for a physician who would agree to "secretly assist him if he chose to commit suicide." *Id.* Leone never asked his personal physician because he did not want to implicate his friend and physician in a crime. However, Leone was able to exercise his constitutional right to die while on respiratory support following an emergency hospitalization. *Id.* Leone regained consciousness and after his initial outrage at being on a ventilator, requested that the tubes and respiratory support be removed. Thirty minutes later, Leone died. *Id.* The distinction in this scenario is that Leone could only control his death legally by virtue of his need for life-sustaining equipment. It seems illogical, but in the absence of a respiratory arrest, Leone would have had no right to assistance in exercising a decision about ending his protracted battle with AIDS, regardless of the diminished quality and associated suffering he would have endured as he waited for a "natural" death.



disorder or depression, the choice of assistance in death under controlled circumstances should be recognized in order to avoid a quality of death that mirrors the diminished quality of life forming the basis for such a decision. The decision in *Donaldson v. Van de Kamp*<sup>169</sup> supports the validity of a statutory right to assistance in death. While refusing to recognize a constitutional right to "state-assisted death," the court in *Donaldson* noted that the provision of such an option was within the prerogative of the state legislature.<sup>170</sup>

Donaldson petitioned the court for an injunction protecting a friend from criminal prosecution for ending Donaldson's life through pre-mortem cryogenic suspension or a lethal injection immediately preceding such a procedure.<sup>171</sup> The court recognized that Donaldson could take his own life "as the exercise of a fundamental right," but refused to extend the right to provide immunity to third persons who provide assistance in such a decision.<sup>172</sup> The court reasoned that the state's interest in maintaining social order through enforcement of the criminal laws and protecting "the lives of those who wish to live no matter what their circumstances" outweighed Donaldson's interest in ending his life through the assistance of a third party in violation of the state's penal laws.<sup>173</sup> While sympathetic to the medical situation and the plaintiff's special needs, the court explained that "it is conceivable to devise a judicial procedure to supervise Donaldson's assisted death," but the overriding state interests in such a situation compel a legislative response rather than a judicial solution.<sup>174</sup>

The criminalization of assistance in suicide operates as a safeguard against the exertion of emotional distress, family pressure, or blatant

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169. 4 Cal. Rptr. 2d 59, 63 (Cal. Ct. App. 1992).

170. *Id.* at 64. Under *Donaldson*, an individual does not have a constitutional right to assisted suicide in the form of actual assistance or the advice and support of a third person. This ruling directly conflicts with the holding in *Compassion in Dying v. Washington*, 850 F. Supp. 1454 (W.D. Wash. 1994), which recognized the right to physician-assisted suicide for mentally competent, terminally ill adult patients; see also Margaret B. Reynolds, Esq., *Patient's Constitutional Rights Do Not Include the Right to an Assisted Suicide for Cryogenic Suspension*, HEALTHCARE L. NEWSL., Aug. 1992, at 6 (analyzing the ramifications of the *Donaldson* decision).

171. *Donaldson*, 4 Cal. Rptr. 2d at 61. Donaldson was suffering from a malignant brain tumor which would ultimately induce a persistent vegetative state and death. *Id.* at 60-61. Donaldson wanted to end his life through cryogenic suspension in hope of subsequent reanimation following the development of a curative treatment for his malignant condition. *Id.* at 61. The freezing process would result in "irreversible cessation of circulatory and respiratory function and irreversible cessation of all brain function." *Id.* Alternatively, Donaldson would end his life by a lethal dose of medication, for which he sought the assistance of a friend to minimize the time between his death and the commencement of the cryogenic suspension of his body. *Id.*

172. *Id.* at 63.

173. *Id.*

174. *Id.* at 64.

coercion in an individual's decision to end his or her own life.<sup>175</sup> If a state were to enact a statute legalizing assisted suicide with precautions equivalent to the policies inherent in the existing criminal laws, the statute should be deemed constitutional based upon the reasoning in all of the aforementioned cases.

The decision in *Hobbins v. Attorney General*,<sup>176</sup> further supports the premise that a state could constitutionally enact a statutory right to assisted suicide. In *Hobbins*, the Michigan appellate court declared as unconstitutional a state statute creating a commission on death and dying and a "new crime of 'criminal assistance to suicide,'" because the law violated a single subject requirement under the Michigan Constitution.<sup>178</sup> Due to anticipation of supreme court review, the court addressed the plaintiffs' additional challenge that the criminalization of assisted suicide infringed upon the exercise of a constitutional right protected by the Due Process Clause of the Fourteenth Amendment.<sup>179</sup>

As in *Compassion In Dying*, the court reviewed United States Supreme Court decisions to determine whether constitutional protection could encompass a right to assisted suicide.<sup>180</sup> Because a right to assisted suicide is not explicitly found in the text of the Constitution, the court noted that such a right must fall within the category of fundamental liberties that are either "implicit in the concept of ordered liberty" or "deeply rooted in the Nation's history and tradition."<sup>181</sup> The court concluded that the right to commit assisted suicide is not a

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175. *Id.* at 63 (explaining that the prohibition against assistance in suicide is based upon the state interest in protecting "the lives of those who wish to live no matter what their circumstances").

176. 518 N.W.2d 487 (Mich. Ct. App. 1994). This case was a consolidation of several appeals: *Hobbins v. Attorney General*, 61 U.S.L.W. 2764 (Mich. Cir. Ct. 1993) (declaring the Michigan statute which criminalized assisted suicide unconstitutional as a violation of the single subject requirement), and *People v. Kevorkian*, 62 U.S.L.W. 2411 (Mich. Cir. Ct. 1993) (recognizing a constitutionally protected right to commit "rational" suicide).

177. *Hobbins*, 518 N.W.2d at 490. Section one of the Michigan act provided: "The legislature finds that the voluntary self-termination of human life, with or without assistance, raises serious ethical and public health questions in the state. To study this problem and to develop recommendations for legislation, the Michigan commission on death and dying is created." *Id.* at 490 (referring to MICH. COMP. LAWS § 752.1021 .28.547(121)) (1993)). Section seven of the act created the new crime of "criminal assistance to suicide," which established a felony for either providing the physical means or participating in a physical act which results in another person's attempt or commission of suicide. *Id.* (citing to MICH. COMP. LAWS § 752.1027(1)(a), (b) (1993)). The court held that the Michigan statute "has two distinct objects that, although encompassing the same 'subject,' are not germane to each other, are directed toward different purposes and, when grouped together in one act, offend the constitutional one-object provision." *Id.* at 4910.

178. *Id.* at 492 (referring to Article IV, Section 24 of the Michigan Constitution of 1963).

179. *Id.*

180. *Id.* at 492-94.

181. *Id.* at 492 (citing *Bowers v. Hardwick*, 478 U.S. 186, 191-92 (1986)).

fundamental liberty because neither justice nor liberty would be offended as a result of "this Court's decision not to accord it constitutional status."<sup>182</sup> The fact that states have traditionally penalized the acts of suicide and assisted suicide negates any implication that a right to these actions "is rooted at all in our nation's history."<sup>183</sup>

As a final basis for rejecting a constitutional rationale for a right to assisted suicide, the court asserted that judicial restraint is warranted in the creation of new constitutional rights and emphasized this contention through the comments of Justice Byron White:

'Realizing that the present construction of the Due Process Clause represents a major judicial gloss on its terms, as well as on the anticipation of the Framers, . . . the Court should be extremely reluctant to breathe still further substantive content into the Due Process Clause so as to strike down legislation adopted by a State or city to promote its welfare.'<sup>184</sup>

Based upon this reasoning, the court declined to find a constitutional right to commit suicide or assisted suicide.<sup>185</sup>

The Michigan appellate court's decision, in particular the quote from Justice White, underscores the distinction between the role of the judiciary in construing the Constitution and the role of an individual state in legislating for the welfare of its citizens. The traditional history of state prohibition against suicide and later, assisted suicide evinces the conviction of the state's citizens that such acts should be illegal. In the event that the consensus of public opinion evolves to accept assisted suicide under limited circumstances, it would be within the prerogative of the state legislature, either through a legislative enactment or the passage of an initiative measure, to legalize assistance in death for terminally ill, mentally competent adults who voluntarily seek such aid from a willing physician.<sup>186</sup>

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182. 518 N.W.2d at 493.

183. *Id.*

184. *Id.* at 494 (citing *Moore v. East Cleveland Ohio*, 431 U.S. 494, 544 (1977) (White, J., dissenting)).

185. *Id.* at 493. For additional debate on the issue of whether the decision of a terminally ill, competent adult falls within the protection of the Due Process Clause of the Fourteenth Amendment, see the dissenting opinion of Judge Donald E. Shelton in *Hobbins*. *Id.* at 494-99 (stating that "the court does not believe that a distinction can be drawn between refusing life-sustaining treatment and physician-assisted suicide by an uncoerced, mentally competent, terminally ill adult").

186. See *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 292-300 (1990) (Scalia, J., concurring) (asserting that the citizens of a state rather than the federal courts should decide, through their elective representatives what course the law should take in right-to-die issues); *Compassion In Dying v. Washington*, 850 F. Supp. 1454, 1465-66 (W.D. Wash. 1994) (providing "[t]he court has no doubt that the legislature can devise regulations which will define the appropriate boundaries of physician-assisted suicide for terminally ill individuals").

If there is no express or implicit right to assisted suicide under the Constitution, then there is conversely no direct constitutional prohibition against a state enacting a statutory right to such an option if it comports with the requisite safeguards and precautions in the precedent "right-to-die" decisions. For example, a statute that requires clear and convincing evidence of a competent adult patient's intent to voluntarily seek medically assisted suicide should meet the standard established in *Cruzan* for the discontinuation of life-sustaining treatment for incompetent patients. Moreover, a statute with procedural safeguards such as medical confirmation of a patient's terminal diagnosis, limited prognosis and mental competency can ensure the legalization of assisted suicide for only competent terminally ill adults who make an informed election for assistance in death. Therefore, the state's interests in preserving life and preventing suicide may be altered to allow medically assisted death as an adjunct to the right to die.<sup>187</sup>

#### V. OPPOSITION TO MEDICALLY ASSISTED SUICIDE: SPECIFIC CONCERNS FOR PERSONS WITH AIDS

Although the enactment of a statute creating a right to assisted suicide should be deemed constitutional, the actual passage of such an initiative requires a favorable consensus of the voting public. For each positive aspect illustrated in personal accounts of assisted suicide, such as respect for personal autonomy and deliverance from suffering, there is an opposite concern of equal magnitude. Although the option of medically assisted suicide garnered voter approval in Oregon, it is prudent to discuss the common arguments raised in opposition to assisted suicide in order to establish a paradigm of essential safeguards for legalizing medically assisted suicide in relation to persons with AIDS.

##### A. *General Concerns Regarding AIDS and Assisted Suicide*

Opponents of assisted suicide view the participation of a compassionate physician in a patient's suicide as an affirmation that a person

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187. Because the outcome of the legal challenge to the Oregon Act is pending, this section of the Article assesses the constitutionality of an enacted statutory right to medically assisted suicide, such as the Oregon Death With Dignity Act. Because legal challenges have not been initiated regarding the Oregon statute to date, this Article provides an argument for upholding such a statute without direct references to the Oregon Act. See Lane & Heinz, *supra* note 6, at B1 (reporting that a constitutional challenge to the Act was filed on December 1, 1994 in the United States District Court in Eugene, Oregon); Lane, *supra* note 6, at A1 (reporting that the federal judge granted a preliminary injunction on December 27, 1994, prohibiting the application of the Death With Dignity Act until the constitutionality of the statute is determined); and Saunders, *supra* note 6, at D13 (reporting speculation of a challenge to expand the new law to allow lethal injections by "a patient who is not physically capable of taking lethal pills").

with a terminal illness or AIDS does not possess a quality of life sufficient to justify continued existence in our society.<sup>188</sup> Opponents argue that "[h]uman life has value, even in suffering."<sup>189</sup> It is the suffering which should be alleviated through the provision of emotional, medical and financial assistance for patients with terminal illnesses rather than promoting the availability of assistance in suicide.<sup>190</sup>

The difficulty with assisted suicide decisions based upon quality-of-life assessments lies in defining the quantum of decline in "quality" necessary to justify such an alternative. In many proposals, eligibility requirements for medically assisted suicide include a terminal diagnosis and the likelihood of death within six months. "But prognoses for survival are never that accurate; about 10 percent of patients admitted to hospices to die end up being discharged home because of either remission or inappropriate diagnosis."<sup>191</sup> HIV infections and AIDS give rise to even greater uncertainty. For example, should assisted suicide be an option upon receipt of an HIV-positive test result, or when the first sign of severe immunosuppression occurs, or only after an AIDS diagnosis?<sup>192</sup>

Because HIV ultimately leads to AIDS, the HIV infection alone could arguably constitute eligibility for medical assistance in suicide. Yet research indicates that a person may remain HIV-positive for several years before exhibiting symptoms of the infection or receiving an AIDS diagnosis.<sup>193</sup> Receipt of an HIV-positive test result does not signal an automatic decline in the quality of one's life, nor establish a compelling basis for assistance in suicide. The diverse progression of HIV infection precludes a definitive prognosis for most persons with

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188. Lehr, *Physicians Are Helping*, *supra* note 10, at 1 (reporting the comment of Arthur Dyck, an ethics professor at Harvard Divinity School, regarding assisted suicide under any circumstances: "The message is that life isn't worth it, and that life for people in similar conditions isn't worth living.").

189. Rita Raysa, *Voice of the People—'This is Murder,'* CHI. TRIB., June 23, 1990, at 9 (publishing a letter of a citizen opposed to assisted suicide legislation).

190. J. Gay-Williams, *The Wrongfulness of Euthanasia*, in EUTHANASIA 97, 101-02 (Robert M. Baird & Stuart E. Rosenbaum eds., 1989) (stating "we have a clear duty to comfort those in need and to ease their suffering when we can").

191. D. Alan Shewmon, *Active Voluntary Euthanasia: A Needless Pandora's Box*, in EUTHANASIA 129, 130 (Robert M. Baird & Stuart E. Rosenbaum eds., 1989).

192. 'Dr. Death' is No Angel of Mercy, NEWSDAY (New York), Nov. 29, 1992, at 33 (editorial warning that there "might be a doctor for whom a positive HIV test might be enough, in and of itself, to suggest assisted suicide").

193. *Update: Acquired Immunodeficiency Syndrome—United States*, 35 MORBIDITY & MORTALITY WEEKLY REP. No. 35, 17, 29 (Jan. 17, 1986) (reporting that the time from HIV exposure to AIDS diagnosis may last as long as seven years); see also Kolata, *supra* note 29, at C1 (reporting that the span between HIV infection and AIDS diagnosis ranges from two to ten years).

AIDS.<sup>194</sup> Although vulnerability to opportunistic infections results in recurrent illnesses and possible hospitalizations, patients in this stage of HIV infection cannot generally be categorized by a medical prognosis of imminent death.<sup>195</sup>

Moreover, a person with a T-cell count of less than 200 cells per microliter of blood currently falls within the category of reportable AIDS cases under CDC guidelines, even in the absence of clinical symptoms associated with the disease.<sup>196</sup> In essence, an individual can be HIV-positive and asymptomatic, but fall within the classification of an AIDS diagnosis solely on the basis of a diminished T-cell count.<sup>197</sup> If a statute recognized an AIDS diagnosis as the basis for eligibility for medically assisted suicide, a person who is merely HIV-positive could qualify for such an option without any physical illness or change in his or her quality of life. Therefore, the eligibility requirement of any proposal legalizing assisted suicide must minimize the potential for including individuals on the basis of a medical diagnosis who are neither terminal nor suffering from any physical debilitation.

### 1. *Fear of Intentional or Inadvertent Coercion*

Even if medically assisted suicide was limited only to people in the final stage of AIDS, opponents argue that this creates a status quo expectation for people with the disease.<sup>198</sup> The accounts of "Dean," Steven Shiflett, and the patient assisted by Dr. Green<sup>199</sup> would become

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194. Although medical studies indicate that the average survival rate following an AIDS diagnosis is 18 months, prophylactic therapies such as zidovudine and antibiotic treatments may forestall the advent of such a diagnosis, and increase the period of resistance to opportunistic infections and debilitation. Hamilton, *supra* note 35, at 442.

195. For example, pneumocystis carinii pneumonia (PCP), a common opportunistic infection, occurs at some point in at least 85% of HIV-positive individuals. Schneider, *supra* note 41, at 1836. Yet prophylactic treatments with pentamidine and co-trimoxazole reduce the incidence of PCP infections as well as other opportunistic infections. *Id.* at 1839-40 (reporting that co-trimoxazole is effective against hemophilus influenza, streptococcus pneumonia and toxoplasmosis). Secondary illnesses associated with severe immunosuppression are treatable and therefore, should not be considered sole operative events for the election of medically assisted suicide.

196. CDC, *1993 Revised Classification*, *supra* note 29, at 2 (referring to Table 1, depicting expanded AIDS surveillance case definition based upon T-cell suppression and AIDS-indicator conditions); see also Webber, *supra* note 40, at 10 (explaining that the T-cell count of a healthy person is in the range of 1000 cells per microliter of blood).

197. CDC, *1993 Revised Classification*, *supra* note 29, at 2 (referring to "Clinical category A, Asymptomatic, acute (primary) HIV" in Table 1).

198. Rutten, *supra* note 11, at 1. The article reported the comments of Bob, a gay man who assisted his lover in suicide, and vacillates on the issue of legalizing this practice: "I think of Ian and all the other people I know with AIDS. If euthanasia is the norm, why not put them all out of their misery? After all, they're all going to die anyway." *Id.*

199. See also *supra* notes 64-98 and accompanying text (describing the personal accounts of AIDS patients who planned or committed assisted suicide).

the norm because the availability of assisted suicide could result in a feeling of obligation for people with AIDS or terminal illnesses to "choose death to spare their families the emotional and financial burden of their care."<sup>200</sup> Subtle coercion based upon expectations or financial concerns is difficult to prevent or detect even if the physician has knowledge of the patient's intimate relationships and family situation.<sup>201</sup>

Opponents also fear that physicians will routinely discuss this practice with their patients, as in the example of Dr. Ben Aidant, who has offered the option of assisted suicide to his cancer patients for two decades.<sup>202</sup> The mere sympathetic discussion of assisted suicide between physician and patient may convey the impression that assisted suicide is not only an option, but also a desirable alternative in the physician's opinion.<sup>203</sup> By this reasoning, the opportunities for coercion, whether overt or implied, are too pervasive to consider legalizing such an option.

Additionally, the personal accounts of Dr. Yarnell, "Dean," Steven Shiflett, and Dr. Green's patient<sup>204</sup> suggest that these men had access to reasonable health care, evinced by the references to medication and treating physicians. In contrast, more than thirty-one million Americans lack health insurance.<sup>205</sup> Many individuals cannot afford even minimal health care.<sup>206</sup> These deficiencies in basic medical access only serve to heighten the likelihood of desperation and suicidal thoughts

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200. Orentlicher, *supra* note 15, at 1845; see also William Reichel & Arthur J. Dyck, *Euthanasia: A Contemporary Moral Quandary*, LANCET, Dec. 2, 1989, at 1321, 1322 (postulating "[i]f euthanasia were legalized [sic], individuals themselves might believe that society does not want them to live").

201. Nancy W. Dickey, M.D., *Euthanasia: A Concept Whose Time Has Come?*, 8 ISSUES IN L. & MED. 521, 528 (1993) (describing the possibility of subtle coercion for patients to choose euthanasia to sustain the current financial security of the family); see also Eugenie Anne Gifford, *Artes Moriendi: Active Euthanasia and the Art of Dying*, 40 UCLA L. REV. 1545, 1562-63 (1993) (explaining that patients "may feel that they are undue burdens on their families and so should remove themselves").

202. Lehr, *Physicians Are Helping*, *supra* note 10, at 1 (reporting that the doctor, referred to as Ben Aidant, "has assembled a team, enlisting nurses who share his perspective to perform the actual killing of a patient with whom he has a death pact").

203. Orentlicher, *supra* note 15, at 1845 (asserting that "the hopelessly ill patient will not feel entirely free to resist a suggestion from the physician that suicide would be appropriate, particularly since it comes from the person whose medical judgment the patient relies on").

204. See *supra* notes 64-98 and accompanying text (referencing the involvement of physicians and availability of health care in these personal accounts of assisted suicide).

205. Scheier, *supra* note 20, at 3; see also Mary Margaret Penrose, *Assisted Suicide: A Tough Pill to Swallow*, 20 PEPP. L. REV. 689, 715-16 (also arguing that the financial pressures arising out of the unavailability of medical insurance for many people in this country makes decisions regarding assisted suicide suspect).

206. Scheier, *supra* note 20, at 3.

for an uninsured person diagnosed with AIDS.<sup>207</sup> Opponents of assisted suicide contend that until adequate health care is available for all Americans, the prospect of medically assisted suicide is not only improper, but also a discriminatory inducement for individuals to seek assistance in death because of financial inability to obtain treatment for a terminal, or perhaps merely debilitating illness.<sup>208</sup>

## 2. *Fear of Eugenics or Involuntary Selection*

Opponents fear that a statutory right to choose assisted suicide may lead to a program of controlled selection for involuntary euthanasia reminiscent of the Nazi era.<sup>209</sup> Inherent in any legislation allowing medically assisted suicide is the power to dictate who will live and who will die as a result of a physician's diagnosis. Before the Holocaust, German physicians selected mentally and physically incompetent patients for euthanasia based on an assessment that their lives were "devoid of value" and their institutional care was a drain on the national economy.<sup>210</sup> A valueless existence coupled with the exorbitant treatment costs for AIDS patients provides a foundation for the same type of political class distinctions which fostered a national policy of involuntary euthanasia and eugenics in Nazi Germany.<sup>211</sup> Opponents argue that minorities or low-income patients with diseases such as AIDS may be disproportionately counseled by physicians and families to opt

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207. Kay Longcope, *AIDS-Related Suicide Up: Sometimes Victims, and Those Who Love Them Only Wish to End the Pain*, BOSTON GLOBE, Mar. 17, 1990, at 25 (interviewing Larry Kessler, member of the Massachusetts AIDS Action Committee, who explained that suicides tend to increase as services decline and the "numbers climb as more of the sick try to access a limited system").

208. Penrose, *supra* note 205, at 715; James Podgers, *Matters of Life and Death: Debate Grows Over Euthanasia*, 78 A.B.A. J. 60, 62 (May 1992) (reporting the comment of John Pickering, chair of the ABA Commission on Legal Problems of the Elderly: "We must recognize that as long as there is no universal health insurance, families and health care institutions can exert a subtle pressure on patients to terminate their lives because of the costs involved in life-sustaining treatment").

209. Geraldine Baum, *Bishops Battle Euthanasia*, NEWSDAY (New York), Nov. 2, 1987, at 4; see also Reichel & Dyck, *supra* note 200, at 1322 (comparing legalization of assisted suicide with foundation for euthanasia movement in Germany before the Holocaust); Penrose, *supra* note 205, at 703-04 (discussing the analogy between the Nazi program and the current American proposals for assisted suicide).

210. Reichel & Dyck, *supra* note 200, at 1322; see also Penrose, *supra* note 205, at 703-04 (describing the Nazi goal of "freeing national resources otherwise squandered on the mental and physical dependents of the State").

211. Paul K. Longmore, Ph.D., *Elizabeth Bouvia, Assisted Suicide and Social Prejudice*, 3 ISSUES IN L. & MED. 141, 145-46 (1987); see also Reichel & Dyck, *supra* note 200, at 1322 (asserting that what "begins for the patient's own wishes, may later be endorsed for economic reasons" in relation to cost-containment and autonomy for AIDS patients in assisted suicide decisions).



for medically assisted suicide as an alternative to receiving expensive health care.<sup>212</sup> Finally, some opponents fear that the publicized suffering of people like Steven Shiflett and "Dean" may provide an emotional platform for passing assisted suicide legislation, and establish a precedent for categorizing elderly, mentally impaired, or disabled individuals as involuntary candidates for this practice.<sup>213</sup>

### 3. Physicians Should Treat, Not Kill

Opponents of medically assisted suicide regard physician participation as an abhorrent abuse of the Hippocratic oath, which provides: "I will neither give deadly drug to anybody if asked for it, nor will I make suggestion to this effect."<sup>214</sup> A physician's duty is to preserve life, not to actively assist in a patient's death.<sup>215</sup> To allow otherwise would turn a relationship of trust and respect between physician and patient into one of suspicion and fear if the patient is diagnosed with AIDS or another terminal illness.<sup>216</sup> Additionally, physicians may be-

212. Lehr, *Long Hidden Practice*, *supra* note 10, at 1 (reporting the comment by Dr. Nicholas Parkhurst Caballeira, director of the Boston-based Latino Health Institute, to the effect that medically assisted suicide could easily result in racist decisions due to heightened counseling for minorities to consider such an option).

213. See, e.g., Lynn D. Wardle, J.D., *Sanctioned Assisted Suicide: "Separate But Equal" Treatment for "New Illegitimates,"* 3 *ISSUES IN L. & MED.* 245, 251-55 (1987) (asserting that seven distinct groups of people "would be the victims of an open discrimination in the name of mercy" if assisted suicide becomes a legal option); Pugliese, *supra* note 7, at 1313-14 (explaining that opponents of "physician-assisted suicide fear that if legislation is passed, it will not be limited to the sympathetic cases of the terminally ill, but will also be used to encourage the elderly or disabled to choose death rather than become a burden"); Lewis & Christoff, *supra* note 18, at 17A (reporting the comment of Alexander Capron, the Topping Professor of Law, Medicine and Public Policy at the University of Southern California Law Center, and a renowned medical ethicist, to the effect that legalizing assisted suicide "could culminate in the killing of frail, old or disabled people who don't consent").

214. Gifford, *supra* note 201, at 1554 (1993) (citing LUDWIG EDELSTEIN, *The Hippocratic Oath: Text, Translation and Interpretation*, in *ANCIENT MED.* 6 (1967)); see also Gaylin, *supra* note 9, at 2139 (stating that "[w]estern medicine has regarded the killing of patients, even on request, as a profound violation of the deepest meaning of the medical vocation").

215. See Shewmon, *supra* note 191, at 137 (arguing that advocates of medically assisted suicide seek to use physicians to provide an air of respectability and credibility to a cause which will result in irreparable harm to society by transforming the "image of [a] physician from healer to killer"). The religious aversion to assistance in death and the philosophical arguments are beyond the scope of this Article. For a detailed analysis of the religious and ethical arguments against medically assisted suicide, see *TO DIE OR NOT TO DIE?: CROSS DISCIPLINARY, CULTURAL AND LEGAL PERSPECTIVES ON THE RIGHT TO CHOOSE DEATH* (Arthur S. Berger & Joyce Berger eds., 1990); and George P. Smith, II, *All's Well That Ends Well: Toward a Policy of Assisted Rational Suicide or Merely Enlightened Self-Determination?*, 22 *U.C. DAVIS L. REV.* 275 (1989).

216. *Assisted Suicide Faces Fight in N.H.: Living-Will Backers Say Bill Goes Too Far*, *BOSTON GLOBE*, Nov. 10, 1991, at 47 (reporting the comment of Warren Emley, physician and president of the New Hampshire Medical Society, "[i]t really makes the doctor the executioner, and no doctor can truly predict when a patient is going to die"); see also Gaylin, *supra* note 9, at

come professional executioners like Dr. Kevorkian, the Michigan physician who has assisted in the suicides of twenty-one people whom he did not know prior to the fatal events.<sup>217</sup> Rather than assisting a patient's death, physicians should view suicidal impulses as an indication for either psychiatric treatment or improved management of the pain and suffering associated with diseases such as AIDS.<sup>218</sup>

Opponents attribute most suicidal intentions to clinical depression or AIDS dementia<sup>219</sup> which require immediate assessment and treatment, rather than affirmation through physician acquiescence in suicide plans.<sup>220</sup> The need for psychological counseling and support is crucial for persons with AIDS given the "social stigma attached to AIDS and the specter of an inexorable illness that, before it kills, can cause pain, disfigurement, dementia, blindness and emaciation."<sup>221</sup> The heightened possibility of an AIDS patient requesting assistance in death due to a temporary period of depression or AIDS dementia should compel physicians to recommend counseling and psychological

2140 (arguing that "if physicians become killers or are even merely licensed to kill, the profession—and, therewith, each physician—will never again be worthy of trust and respect as healer and comforter and protector of life in all its frailty"); Podgers, *supra* note 208, at 62 (reporting the comment of James Bopp, a lawyer active in the right-to-life movement, on the issue of physicians directly assisting in a patient's death: "This would destroy the special role of the physician. . . . If a physician's role is to take your life [as well as preserve it], that injects a lot of ambiguity into the relationship").

217. Penrose, *supra* note 205, at 716-17; see also Zima, *supra* note 23, at 401 (stating that one of Dr. Kevorkian's patients, Janet Adkins, answered an advertisement Kevorkian placed in a magazine to find a volunteer to test his suicide machine); 'Dr. Death' Is No Angel of Mercy, *NEWSDAY* (New York), Nov. 29, 1992, at 33 (arguing that medically assisted suicide "would give the imprimatur of societal approval not only to the kind and sensitive physician, but to those who are unscrupulous and may have twisted motives as well"); and Kevorkian Helps, *supra* note 10, at A3 (reporting that Kevorkian assisted in a twenty-first suicide on November 26, 1994).

218. Dickey, *supra* note 201, at 525; Glass, *supra* note 53, at 1370 (advocating that physicians should consider suicide in "AIDS patients as in others, as an untoward illness outcome to be diagnosed, treated, and prevented"); Longcope, *supra* note 207, at 25 (interviewing Robin Miller of the Boston Visiting Nurse Association's AIDS program, who "deals daily with AIDS patients, for whom, throughout the disease, 'the thought of killing themselves comes up off and on'").

219. Parry, *supra* note 43, at 82 (stating that "50 to 70 percent [of persons with AIDS] will develop an organic mental disorder sometime during the course of their illness," all of which are included in the term AIDS dementia complex).

220. See Glass, *supra* note 53, at 1370 (advocating the importance of "social support systems" and vigorous treatment for psychiatric complications from AIDS, particularly "depression, delirium or dementia"); Podgers, *supra* note 208, at 62 (quoting a 1991 report on "Decisions Near the End of Life" by the AMA's Council on Judicial Affairs, which provided: "There is evidence to suggest that most requests for euthanasia or assisted suicide would be eliminated if patients were guaranteed that their pain and suffering will be eased and their dignity and self-sufficiency promoted"); Zima, *supra* note 23, at 403 (proposing that "[t]reating the underlying pain, depression, or delirium may eliminate the patient's wish to die").

221. Garcia & Zonana, *supra* note 91, at B1 (reporting on several counseling programs available to AIDS patients in the Los Angeles area and the high incidence of suicides in this group).

assessment rather than validate suicidal inclinations. Opponents essentially argue that a "rational patient simply does not and cannot choose euthanasia."<sup>222</sup>

*B. A Paradigm for Medically Assisted Suicide: Protection for Persons with AIDS*

From this brief discussion of the most common arguments against medically assisted suicide, three dominant areas of concern emerge: 1) eligibility; 2) physician involvement; and 3) potential for coercion, involuntary euthanasia, and incompetency of the requesting person due to mental disorders or depression. In order to legalize medically assisted suicide through either a legislative enactment or an initiative measure, a proposal must satisfactorily address each of these areas of concern for the public. Initially, a proposal must establish stringent prerequisites that limit the option of medically assisted suicide to only those individuals who suffer from a protracted and terminal condition.<sup>223</sup> Eligibility is particularly important in the context of AIDS because of the versatility of HIV infection and the broad scope for AIDS classification under current CDC guidelines.

The degree of physician involvement encompasses both the preliminary medical diagnostic procedure and the type of participation provided under such a statute. Recognizing that the argument against physicians killing patients is formidable, a proposal must at a minimum provide a detailed process for an "informed consent" type of discourse between the physician and the requesting patient, and a reporting requirement for all assisted deaths.<sup>224</sup> A proposal must also establish methods for disqualification on the basis of coercion, psychological impairment, or depression to limit medical assistance in death to competent patients who voluntarily seek this option. Finally, a proposal should specifically define the extent of direct physician participation in the patient's death.

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222. Smith, *supra* note 215, at 337 (1989) (emphasis added); see also Kuhse, *supra* note 4, at 147 (presenting the argument that a patient "cannot rationally and autonomously choose euthanasia").

223. Quill, *supra* note 7, at 1381 (advocating that a patient requesting physician-assisted suicide "must have a condition that is incurable and associated with severe, unrelenting suffering").

224. Cooke, *supra* note 25, at 50 (reporting that criteria in the Netherlands for active voluntary euthanasia includes examination of all other options prior to the implementation of this option); Quill, *supra* note 7, at 1381 (explaining that the "patient must understand the condition, prognosis, and the types of comfort care available as alternatives").

## VI. ATTEMPTS TO LEGISLATE A RIGHT TO ASSISTED SUICIDE

Using the summarized paradigm of concerns as a standard, this section will analyze the recent proposals presented in Washington, California and Maine in chronological order, to assess the improvements in later proposals based upon the previous experiences in other states. With safeguards closely paralleling the court requirements in "right-to-die" cases, these proposals failed to be enacted for differing reasons. Thereafter, this section evaluates the successful enactment of the "Oregon Death With Dignity Act" and the reasons for voter approval in comparison to the previous proposals in other states. A survey of the provisions common to both the Oregon Act and the unsuccessful proposals, and a discussion of their inherent deficiencies, provides a foundation for the drafting of a model act for medically assisted suicide with an emphasis on additional protections specific to persons with AIDS.

### A. 1991: Washington's "Death With Dignity Act"

The Washington Initiative Measure 119, the "Death With Dignity Act," entitled mentally competent adults to "aid-in-dying" if they had a certified terminal or irreversible condition and executed a voluntary written directive requesting such aid.<sup>225</sup> The Act limited eligibility to conscious, competent, adult patients with a "terminal condition," defined as an incurable or irreversible condition that would result in death within six months.<sup>226</sup> Two physicians, the patient's primary or attending physician and an additional physician, had to certify in writing that the patient had a terminal condition.<sup>227</sup> Physicians would personally provide aid in dying to competent qualified adults "in a dignified, painless and humane manner" upon the voluntary request of the patient through a written directive.<sup>228</sup> A patient in a terminal condition could execute at any time, a directive requesting aid in dying. The Act provided a sample directive form which required attesta-

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225. Proposed amendment to WASH. REV. CODE §§ 70.122.010-900 (1991), reprinted in OFFICE OF THE SECRETARY OF STATE OF WASHINGTON, VOTERS PAMPHLET, *Initiative Measure 119* 27 (1991) (referring to section 1). For ease of reference, the provisions of *Initiative Measure 119* will be cited to both the amended portions of the Washington statute and the corresponding page in the WASHINGTON VOTER'S PAMPHLET.

226. Proposed amendment to WASH. REV. CODE § 70:122.020(7) (1991); WASH. VOTER'S PAMPHLET, at 27-28.

227. Proposed amendment to WASH. REV. CODE § 70.122.020(6)(7) (1991); WASH. VOTER'S PAMPHLET, at 27-28.

228. Proposed amendment to WASH. REV. CODE § 70.122.020(9) (1991); WASH. VOTER'S PAMPHLET, at 28.

tion by two disinterested witnesses that they believed the declarer "to be of sound mind."<sup>229</sup>

The Act contained several precautions, including the right to revoke a directive at any time without regard to the patient's "mental state or competency" through physical, written or verbal actions.<sup>230</sup> Also, prior to the provision of aid in dying, the attending physician had to "make a reasonable effort" to determine that the directive met the procedural requirements of the Act, and if the patient was mentally competent, that the directive was executed in accord with the current desires of the requesting patient.<sup>231</sup> Participation in assisted suicide by a physician or health facility was completely voluntary, but the Act required a refusing party to make a good faith effort to transfer a qualified patient to an accommodating physician or facility.<sup>232</sup> Death resulting from the provision of aid in dying would not constitute suicide nor any criminal act.<sup>233</sup> The Act also imposed a penalty for the alteration or concealment of another person's directive.<sup>234</sup>

On November 5, 1991, the people of Washington rejected Initiative 119 with 54% of the votes in opposition and, remarkably, 46% in favor, constituting a difference of less than 100,000 votes.<sup>235</sup> Commentators pointed to the lack of adequate safeguards as the primary reason for public rejection of the initiative.<sup>236</sup> Although requiring the written certification of two physicians that the patient's condition was terminal, the Act lacked a provision for psychiatric evaluation prior to the execution of a directive,<sup>237</sup> thus entitling persons with AIDS to

229. Proposed amendment to WASH. REV. CODE § 70.122.030(1) (1991); WASH. VOTER'S PAMPHLET, at 28.

230. *Id.*

231. Proposed amendment to WASH. REV. CODE § 70.122.060(1) (1991); WASH. VOTER'S PAMPHLET, at 29.

232. Proposed amendment to WASH. REV. CODE § 70.122.060(2) (1991); WASH. VOTER'S PAMPHLET, at 29.

233. Proposed amendment to WASH. REV. CODE § 70.122.070 (1991); WASH. VOTER'S PAMPHLET, at 29. Physicians and health care facilities would be immune from any liability for aid in dying if the requirements of the Act were followed in good faith. Proposed amendment to WASH. REV. CODE § 70.122.050 (1991); WASH. VOTER'S PAMPHLET, at 29. The Act also provided that no "policy of life insurance shall be legally impaired or invalidated in any manner" by the provision of aid in dying to an insured patient. Proposed amendment to WASH. REV. CODE § 70.122.070(2) (1991); WASH. VOTER'S PAMPHLET, at 29.

234. Proposed amendment to WASH. REV. CODE § 70.122.090 (1991); WASH. VOTER'S PAMPHLET, at 29-30.

235. Janny Scott, *Suicide Aid Focus Turns to California*, L.A. TIMES, Nov. 7, 1991, at A3.

236. Penrose, *supra* note 205, at 710 (explaining that Derek Humphry, President and Founder of the Hemlock Society, considered the lack of sufficient protections against abuse as the basis for the public's rejection of the initiative).

237. WASH. VOTER'S PAMPHLET, at 13 (explaining in *Statement against Initiative Measure 119* that the Act has "No safeguards for depressed persons who in a moment of despair ask for a lethal injection. . . . No safeguards to stop someone from ending their life only because they have no money for health care").

qualify upon physician certification for aid in dying without any precautionary evaluation for AIDS dementia or depression. The Act provided the right to assistance in death, but failed to clearly define the procedure for implementing aid in dying and the actual participation by the attending physician.<sup>238</sup> In summary, the language of the Act was too vague and poorly drafted to provide sufficient protection against the potential for abuse in medically assisted suicide.<sup>239</sup> However, Initiative 119 quantified the level of public support for assistance in dying and also provided the impetus for similar legislation in California shortly thereafter.

### B. 1992: California's "Death With Dignity Act"

Ironically, on November 5, 1992, the voters in California rejected the "Death With Dignity Act"<sup>240</sup> with 54% of the votes in opposition and 46% in favor, the same margin which defeated the Washington Initiative.<sup>241</sup> Using the same definitions as in the Washington proposal, Proposition 161 granted mentally competent adults with a certified terminal condition the right to voluntary "aid-in-dying" upon execution of a written directive.<sup>242</sup> Two physicians were required to certify that the requesting patient had a terminal condition.<sup>243</sup> A directive could be revoked at any time.<sup>244</sup>

Although similar to the Washington proposal, the California Act specifically defined the degree of physician participation and provided

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238. *Id.* (claiming that "I-119 protects the doctor who takes your life, but has no safeguards for you").

239. *Wash. Voters Reject Proposal to Legalize Euthanasia*, PHILADELPHIA INQUIRER, Nov. 7, 1991, at A21 (reporting on the comments of ethicists around the country which criticized the measure as "poorly written" and lacking adequate safeguards). Another reason for the failure of Initiative 119 was the provision for the active participation by physicians in a patient's death: "a patient's right to die doesn't give physicians a right to kill." Giannelli, *supra* note 17, at 9 (quoting former California Med. Ass'n President Laurens P. White, M.D.).

240. Proposed CAL. CIV. CODE §§ 2525-2525.24 (1992), reprinted in OFFICE OF SECRETARY OF STATE, CALIFORNIA BALLOT PAMPHLET, *Proposition 161* 68 (1992). For ease of reference, the provisions of *Proposition 161* will be cited to both the proposed portions of the California statute and the corresponding page in the CALIFORNIA VOTER'S PAMPHLET.

241. Steven Green, *Right-To-Die Proposition Is Defeated*, SACRAMENTO BEE, Nov. 4, 1992, at A5.

242. Proposed CAL. CIV. CODE § 2525.2(h) (1992); CAL. BALLOT PAMPHLET, at 68.

243. Proposed CAL. CIV. CODE § 2525.2(j) (1992); CAL. BALLOT PAMPHLET, at 68. "Terminal condition" was defined as an "incurable or irreversible condition which will, in the opinion of two certifying physicians exercising reasonable medical judgment, result in death within six months or less." *Id.*

244. Proposed CAL. CIV. CODE § 2525.5 (1992); CAL. BALLOT PAMPHLET, at 68. The Act required that a directive requesting aid in dying be witnessed by two disinterested parties and executed by a mentally competent adult. Proposed CAL. CIV. CODE § 2525.3 (1992); CAL. BALLOT PAMPHLET, at 68.

additional safeguards. Aid in dying would occur by the physician either administering a medical procedure at the patient's direction, or providing the means for such a procedure to the patient for self-administration.<sup>245</sup> This provision would provide assistance in death to patients unable to digest oral medications through the option of physician administration.<sup>246</sup> An attending physician could execute a valid directive only at the patient's determination that the time for physician aid in dying had arrived, and following at least two previous requests for such assistance.<sup>247</sup> Attending physicians could request a psychiatric or psychological consultation if any concern arose regarding the competency of the patient, but only with the patient's consent.<sup>248</sup>

Additionally, the Act deemed a directive inoperative if the "declarant" was a patient in a skilled, intermediate or community care facility at the time of execution, unless witnessed by a Patient Advocate or special Ombudsmen on aging.<sup>249</sup> This provision required special assurance that patients receiving custodial care made such a decision willingly and voluntarily. Finally, the California Act had a record-keeping requirement and mandated annual reporting to the State Department of Health Services, of the requesting patients' age, type of illness, and date the directive was executed.<sup>250</sup>

As with Washington Initiative 119, critics of the California Act contended that it lacked sufficient safeguards to protect against abuses. For example, critics argued that the term "attending physicians" was too broad because it could authorize all physicians, regardless of their specialty or expertise, to assist a patient in dying.<sup>251</sup> They also pointed

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245. Proposed CAL. CIV. CODE § 2525.2(k) (1992); CAL. BALLOT PAMPHLET, at 68.

246. See, e.g., *supra* notes 76-85 and accompanying text (describing the "botched" suicide attempt of Steven Shiflett due in part to his weakened digestive system).

247. Proposed CAL. CIV. CODE §§ 2525.7, 2525.2(i)(1992); CAL. BALLOT PAMPHLET, at 68. Under the Act, execution of a directive required an "enduring request" by the patient for physician aid in dying rather than a single request at the time the directive was executed. *Id.*

248. Proposed CAL. CIV. CODE § 2525.13 (1992); CAL. BALLOT PAMPHLET, at 69.

249. Proposed CAL. CIV. CODE § 2525.4 (1992); CAL. BALLOT PAMPHLET, at 68. Private hospitals and health care professionals would be under no compulsion to administer aid in dying. Proposed CAL. CIV. CODE § 2525.8 (1992); CAL. BALLOT PAMPHLET, at 68-69.

250. Proposed CAL. CIV. CODE § 2525.21 (1992); CAL. BALLOT PAMPHLET, at 69. The Act provided for the continuance and payment of life insurance after the execution of a directive, and penalized coercion, pressure, or fraudulent inducement of another to create a directive as a misdemeanor, and if death resulted, as a felony. Proposed CAL. CIV. CODE §§ 2525.17-2525.18 (1992); CAL. BALLOT PAMPHLET, at 69.

251. Colen, *supra* note 9, at 23 (reporting the comment of Dr. Gale Katterhagen, a Southern California cancer specialist, who stated "the way the law is written an osteopathic allergist could set up a death mill out here. I've got nothing against osteopathic allergists, as long as they practice allergy"); see also CAL. BALLOT PAMPHLET, at 35 (claiming in *Argument Against Proposition 161* that "Proposition 161 does not require that either the 'attending physician' or the second opinion be made by a specialist capable of making a terminal diagnosis").

out that the Act failed to require patient name reporting in the annual records for deaths from aid in dying. Critics perceived this lack of patient identification as an avenue for potential abuse because of the absence of a direct review procedure in the reporting system.<sup>252</sup> Although Proposition 161 provided for psychiatric and psychological consultations, the patient seeking the execution of a directive had the right to refuse such an evaluation even if clinically indicated.<sup>253</sup> This amounted to a critical deficiency in qualifying the competency of requesting patients with AIDS. Even though California Proposition 161 evidenced an improved attempt in drafting assisted suicide legislation, the failure to provide sufficient safeguards again outweighed the impetus for legalizing assistance in dying.

### C. 1993: Maine's "Act Concerning the Terminally Ill"

In May of 1993, Senator Pamela Cahill introduced "An Act Concerning the Terminally Ill" providing competent adults, suffering from a terminal condition, the right to obtain medical assistance in death.<sup>254</sup> A review of the Act demonstrates that Senator Cahill heeded the criticisms raised in opposition to the Washington and California proposals through several improvements in the procedures and safeguards for medically assisted suicide. Nevertheless, the Act was rejected by the Maine Senate Judiciary Committee on January 24, 1994 and defeated shortly thereafter in the Maine House of Representa-

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252. Diane M. Giannelli, *California Initiative Would Legalize Doctor-Assisted Euthanasia*, AM. MED. NEWS, Nov. 2, 1992, at 1. Opponents also criticized the lack of any requirement to notify the family of a person who requests to end his or her life. CAL. BALLOT PAMPHLET, at 35 (*Argument Against Proposition 161*).

253. Paul Jacobs, *Proposition 161: Outcome of Death Measure May Rest on 11th Hour Ads*, L.A. TIMES, Oct. 28, 1992, at 3. Opponents also criticized the lack of a waiting period before the execution of a directive and the failure to identify the means by which aid in dying would occur. *Id.*

254. Legislative Document 1420, 116th Leg., 1st Sess. (Me. 1993) (presented as S.P. 453 by Senator Cahill, Sagadahoc) (to be codified throughout ME. REV. STAT. ANN. tit. 18-A, § 5-701-5-715 (West 1993)). Citations to the Maine Act will reference both the sections to be amended and the corresponding page of Legislative Document 1420. This was the second bill offered by Senator Cahill on the issue of medically assisted death. A similar proposal was introduced in January 1992 which was subsequently defeated in the Maine Senate Judiciary Committee on March 2, 1992. 1991 ME S.P. 885 (SN) (*available in WESTLAW, Bills-Old Library, State Net Summary*). The 1992 Act allowed "a person diagnosed with a terminal condition that is likely to lead to death and whose condition has been certified by 2 consulting physicians to request a medically assisted death" under the Maine Living Will Statute. *Id.* After the failure of the 1992 proposal, Senator Cahill attempted to redraft the bill to provide additional safeguards raised during the consideration of Senate Paper 885. However, the new proposal was similarly defeated in the Maine legislature. Telephone Interview with Susan Pinette, Clerk, Maine Senate Judiciary Committee (Mar. 23, 1994). 1991 ME S.P. 885 (SN) (*available in WESTLAW, Bills-Old Library, State Net Summary*).



tives, even though it contained strict and specific criteria for allowing assistance in death.<sup>255</sup>

As in the proposals already discussed, the Act recognized eligibility for medically assisted suicide where a declaration was executed by a competent adult, in the presence of two disinterested witnesses, and then presented to the declarant's attending physician.<sup>256</sup> However, the Act contained several distinctions in the evaluation process that merit discussion. First, the Act expressly required the attending physician to assess both the patient's competency to request medically assisted death and the existence of a terminal condition.<sup>257</sup> Two consulting

255. Telephone Interview with Susan Pinette, Clerk, Maine Senate Judiciary Committee (Mar. 23, 1994). Testimony presented before the Maine Senate Judiciary Committee included strident arguments in opposition to the proposal and riveting personal accounts raised in favor of the Act. For example, Paul Christian, Program Director for the Office of Social Justice & Peace for Catholic Charities, asserted that the bill was "bad medicine . . . bad morality . . . bad economics . . . [and] bad public policy." Paul Christian, Testimony Against L.D. 1420, presented before the Maine Senate Judiciary Committee (Jan. 11, 1994) (copy of letter on file with author and available in Office of the Maine Senate Judiciary Committee). Christine Gianopoulos, Director of the Bureau of Elder and Adult Services, questioned "if a referendum on this subject will result in undue attention to an issue which is not at this time a public policy priority, given all the other pressing problem [sic] facing the State." Christine Gianopoulos, Testimony presented before the Maine Senate Judiciary Committee (Jan. 11, 1994) (copy of letter on file with author and available in Office of the Maine Senate Judiciary Committee).

Testifying in favor of the Act, Louise Hansen described her first reaction upon hearing that she had terminal cancer and only a few months to live:

"I was first and foremost *determined* to locate an exit pill. I knew there would be no one to help me if I were to spiral down into the clutches of a long and protracted painful death process. I wanted to avoid the humility, the expense, and the total loss of any control over stopping such an unnecessary horror."

Louise Hansen, Testimony before the Maine Senate Judiciary Committee (Jan. 11, 1994) (copy of letter on file with author and available in the Office of the Maine Senate Judiciary Committee). Finally, Diane Grover described her father's slow and painful death: "My father opted to suffer because he didn't know if his insurance company would pay his beneficiary should he decide to take his life, and he was very concerned that my mother should be cared for the rest of her life which his insurance would guarantee." Darlene Grover, Testimony before the Maine Senate Judiciary Committee (Jan. 11, 1994) (copy of letter on file with author and available in the Office of the Maine Senate Judiciary Committee).

256. Proposed amendment to ME. REV. STAT. ANN. tit. 18-A, § 5-702-A (a) (West 1993); L.D. 1420, at 1.

257. Proposed amendment to ME. REV. STAT. ANN. tit. 18-A, § 5-715 (West 1993); L.D. 1420, at 5. "Terminal condition" was defined as "an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of the attending physician, result in death within a relatively short time." ME. REV. STAT. ANN. tit. 18-A, § 5-701 (b)(9) (West 1989). The existing Uniform Rights Of The Terminally Ill Act employed the term "terminal condition" rather than "terminal illness" for specific reasons:

Terminal illness, as generally understood, is both broader and narrower than terminal condition. Terminal illness connotes a disease process that will lead to death; "terminal condition" is not limited to disease. Terminal illness also connotes an inevitable process leading to death, but does not contain limitations as to the time period prior

physicians had to corroborate both the patient's competency and terminal condition.<sup>258</sup> Medically assisted death would only occur upon a unanimous diagnosis by all three physicians.<sup>259</sup> Perhaps this heightened eligibility requirement countered the fear of coercion or involuntary selection for assistance in death. Most notably, the Act contained a provision allowing the attending physician, consulting physicians or a "health care facility," which included a "hospital, nursing home, home health agency, or hospice," to assist in a patient's death upon compliance with the certification process.<sup>260</sup> This would allow a terminally ill person to die at home in a familiar setting rather than at a health care facility.

Although the review process was clearly and succinctly explained in comparison to the Washington and California proposals, the Act contained several critical deficiencies. The Act vaguely defined medically assisted death as a "medical service that will end the life of a patient."<sup>261</sup> This definition did not address the means by which such an option would occur. Moreover, the Act ambiguously described physician participation as "assistance" to ensure that the "individual's death is dignified, painless and humane."<sup>262</sup> The Act did not include a provision for psychological or psychiatric evaluation, nor a reporting requirement for physicians and health care facilities that carried out patient declarations. As in the Washington and California proposals, the Act used the general term "attending physician," suggesting that

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to death, or potential for nonreversibility, as does "terminal condition."

ME. REV. STAT. ANN. tit. 18-A, § 5-701 Historical Notes (West Supp. 1993). The use of "relatively short time" was employed to "avoid both the unduly constricting meaning of 'imminent' and the artificiality of another alternative—fixed time periods, such as six months, one year, or the like." *Id.*

258. Proposed amendment to ME. REV. STAT. ANN. tit. 18-A, § 5-715 (West 1993); L.D. 1420, at 5.

259. *Id.* Washington Proposition 119 required two certifying physicians for a valid directive, one of whom would be the attending physician. Proposed amendment to WASH. REV. CODE § 70.122.020(6) (1991); WASH. VOTER'S PAMPHLET, at 27. California Proposition 161 used the same language by requiring certification by only "two physicians" that the person is afflicted with a terminal illness. Proposed CAL. CIV. CODE § 2525.1(h) (1992); CAL. BALLOT PAMPHLET, at 68.

260. Proposed amendment to ME. REV. STAT. ANN. tit. 18-A, § 5-701 (2-A) (West 1993); L.D. 1420, at 1.

261. Proposed amendment to ME. REV. STAT. ANN. tit. 18-A, § 5-701 (b)(4-A) (West 1993); L.D. 1420, at 1.

262. Proposed amendment to ME. REV. STAT. ANN. tit. 18-A, § 5-715 (West 1993); L.D. 1420, at 6. Many physicians in the State of Maine opposed medically assisted death because "killing as a medical option in the care of cancer patients" is totally incompatible with the role of physicians. Letter from Ronald J. Carroll, M.D. et al., to the Chairperson of the Judiciary Committee, Maine State Legislature (Jan. 10, 1993) (copy on file with author and available in the Maine Senate Judiciary Committee). The vague definition of physician "assistance" and the lack of any reporting requirement in the Act added to the general apprehension about physicians killing their patients.

any physician would be qualified to provide medical assistance in death, regardless of his or her practice or level of expertise. While the Act defined a stringent and distinct qualification procedure, the actual process for providing assistance in dying was exceptionally unclear.

*D. 1994: Enactment of Oregon's "Death With Dignity Act"*

In an unprecedented election outcome on November 8, 1994, the citizens of Oregon voted in favor of the "Oregon Death With Dignity Act,"<sup>263</sup> legalizing physician assisted suicide under limited circumstances.<sup>264</sup> As in the previous proposals, a capable adult patient, suffering from a confirmed terminal disease is eligible to execute a written request for medication to end "his or her life in a humane and dignified manner."<sup>265</sup> As in the California proposal, an individual specifically qualified by the State Department of Human Resources must witness a request executed in a long term care facility.<sup>266</sup> Under the Act, only Oregon residents may qualify for medically assisted death.<sup>267</sup>

In contrast to the proposals in other states, the Oregon Act extensively delineates physician participation and the process for patient qualification. Upon receipt of a valid request, the attending physician

263. The Oregon Death With Dignity Act, Ballot Measure 16, was passed by a majority of the voters and was scheduled to take effect on December 8, 1994 upon certification of the election results by the Oregon Secretary of State. Telephone Interview with Debbie Hembree, Clerk, Elections Division, State of Oregon, Office of the Secretary of State (Nov. 15, 1994). However, a federal judge granted a temporary restraining order on December 7, 1994, in a suit challenging the constitutionality of the Act. Heinz, *supra* note 6, at A1. Thereafter, the federal judge issued a preliminary injunction on December 27, 1994, which postpones the effective date pending the final determination of the constitutionality of the Act. Lane, *supra* note 6, at A1. For ease of reference, this Article refers to the provisions of the proposed Oregon Death With Dignity Act as printed in the Oregon initiative measure. THE OREGON DEATH WITH DIGNITY ACT, *Initiative Measure* (Dec. 14, 1993) [hereinafter OREGON PROPOSED ACT] (filed with the Secretary of State by Peter Goodwin, Barbara Coombs, and Elven O. Sinnard for the 1994 general election).

264. The Act required exemption for participating physicians from state prosecution for aiding a suicide. This was the basis for a challenge of the Oregon initiative in *Kane v. Attorney General*, 871 P.2d 993 (Or. 1994). The petitioners challenged the initiative summary because it failed to alert voters of a major change in the criminal law of Oregon. *Id.* at 998. The proposed initiative "would exempt physicians who comply with the provisions of the proposed measure from prosecution" under statutes prohibiting aiding a suicide—"a privilege not enjoyed by other Oregonians." *Id.* Therefore, the Oregon Supreme Court required an alteration in the ballot summary explaining the exemption from criminal liability for participating physicians. *Id.* at 998-99.

265. OREGON PROPOSED ACT, *supra* note 263 at § 2.01. Under the initiative, "terminal disease" means "an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six (6) months." *Id.* at § 1.01(12). A valid request for medication must be written and witnessed by two people, one of whom must be a disinterested party. *Id.* at §§ 2.02(1), 2.02(2).

266. *Id.* at § 2.02(4); cf. Proposed CAL. CIV. CODE § 2525.4 (1992); CAL. BALLOT PAMPHLET, at 68 (providing a heightened attestation requirement to ensure a voluntary and uncoerced request by a patient in a long-term care facility).

267. OREGON PROPOSED ACT, *supra* note 263, at § 3.10.

has the duty to determine that the person is capable,<sup>268</sup> making a voluntary request, and suffering from a terminal disease.<sup>269</sup> Additionally, the attending physician must inform the patient of his or her medical diagnosis and prognosis, the risks associated with the prescribed medication, and the feasible alternatives, such as comfort care, hospice care and pain control.<sup>270</sup> The Oregon Act requires confirmation of the patient's competency and medical diagnosis by only one consulting physician, a lower confirmation standard than the Maine proposal.<sup>271</sup> However, the Act requires mandatory counseling if either physician believes that the patient is suffering from a condition which may impair his or her judgment.<sup>272</sup> The Act limits physician involvement to prescribing medication for self-administration by the patient, through an explicit prohibition against death by lethal injection or active euthanasia.<sup>273</sup> Finally, the attending physician must ask the patient to notify next of kin of the request for medication, but failure to notify cannot result in a denial of the request.<sup>274</sup>

The requirements for counseling and informed consent are only two of the fourteen safeguards included in the Oregon Act to ensure a voluntary and informed request for medication to end one's life.<sup>275</sup> The Act requires an enduring request by the qualified patient, and imposes a waiting period followed by a mandatory inquiry by the attending physician to ensure that the patient understands the right to rescind the request prior to receiving the prescription.<sup>276</sup> These precautions also serve to protect persons with terminal illnesses, through unequivocal verification that their decisions to seek medical assistance in dying are both voluntary and informed. The Act requires documentation in the patient's medical record of all duties performed by the attend-

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268. The Act defines "capable" as possessing "the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the patients manner of communicating if those persons are available." *Id.* § 3.01(1).

269. *Id.* § 3.01(1).

270. *Id.* § 3.01(2).

271. *Id.* § 3.01(1); *cf.* Proposed amendment to ME. REV. STAT. ANN. tit. 18-A, § 5-715 (1993); L.D. 1420, at 5 (requiring unanimous certification by the attending physician and two consulting physicians that the patient meets the eligibility criteria).

272. Oregon Proposed Act, *supra* note 263, § 3.03 (providing that either physician "shall" refer the patient to counseling if a mental disorder or depression is suspected).

273. *Id.* § 3.14 (also providing that actions "taken in accordance with this Act shall not, for any purpose constitute suicide, assisted suicide, mercy killing or homicide, under the law").

274. *Id.* § 3.01(5).

275. *Id.* §§ 3.01-3.14 (including provisions for attending physician responsibilities, consulting physician confirmation, counseling, informed decision, family notification, enduring request, right to rescind, imposed waiting period, documentation and reporting, residency, and construction of the Act in relation to other state statutes).

276. *Id.* § 3.06.

ing physician,<sup>277</sup> and requires the State Health Division to collect information and conduct record reviews.<sup>278</sup>

The most striking differences in the Oregon Act are the residency requirement and the extensive precautionary aspects of the process for requesting assistance in dying. For many voters requirements such as family notification, a waiting period, reporting requirements, and review by the State Health Division constituted sufficient precautionary measures to outweigh the common fear of abuse in favor of patient autonomy.<sup>279</sup> In general, the Act appealed to voters "who believe it is a patient's prerogative to determine medical destiny, including death."<sup>280</sup> Under the Oregon Act, the responsibility for assisted suicide primarily lies with the patient: initiating a request for qualification, obtaining the prescribed medication, and completing the final act by ingesting the medication.<sup>281</sup> Moreover, many voters viewed the prohibition against lethal injections and active euthanasia as a means to ensure that "suicide is the will of the patient" while limiting physician participation to the single act of writing a prescription.<sup>282</sup> Therefore, the Act empowers a terminally ill patient to execute his or her decision to commit suicide, rather than making the physician an immediate participant.<sup>283</sup>

The passage of the Oregon Act has also invoked strident criticisms. Opponents assert that any form of physician participation in a patient's suicide is fundamentally inappropriate, regardless of the cir-

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277. *Id.* § 3.09.

278. *Id.* § 3.11. The Oregon State Health Division convened to establish "emergency rules to fulfill its record-gathering obligations under the law" prior to the intended effective date. *Where Does Measure 16 Stand Today?*, OREGONIAN, Dec. 4, 1994, at A32.

279. See, e.g., Jann Mitchell, *Two Men Facing Death Offer Opposing Views of Measure 16*, OREGONIAN, Nov. 13, 1994, at A16 (reporting the comment of Stacy R. Scott, diagnosed with AIDS and lymphoma, that "he doesn't understand people's concern; the measure has so many safeguards against impetuosity"); David Brown, *Medical Community Still Divided on Oregon's Assisted Suicide Act*, WASH. POST, Nov. 13, 1994, at A20 (interviewing Dr. Peter Goodwin, head of the Oregon Right to Die Committee, who called the law "'very tightly drafted and very specific,' and added that 'nobody is going to dare to act in a cavalier, arrogant or negligent way'"); and Susan W. Tolle, M.D., *Measure 16: A Wake-Up Call to Medicine*, OREGONIAN, Nov. 13, 1994, at C1 (stating that "Measure 16 is about a patient's desire for more control").

280. Mark O'Keefe et al., *Oregon Agonizes on Moral Issues*, OREGONIAN, Nov. 9, 1994, at B5.

281. Hubert, *supra* note 6, at A1. The article also reported that Dr. Leigh Dolin, President of the Oregon Medical Association, made a pact with one of his terminally ill patients, William E. Richards, "that if Richards was near death and did not want to go on, he would prescribe the necessary medications to end his patient's life." *Id.* Dr. Dolin stated that his "feeling is that the patient should be the boss in these very personal decisions." *Id.*

282. *Oregon's Experiment*, SACRAMENTO BEE, Nov. 15, 1994, at B6.

283. *Debate Didn't Die with Passage of Oregon's Assisted Suicide Law*, SACRAMENTO BEE, Nov. 14, 1994, at A8 (reporting the comment of Peter Goodwin, a Portland Oregon medical physician, that "it is the patient who is empowered by this initiative and not the physician").

cumstances.<sup>284</sup> Although the Act requires psychiatric evaluation if mental impairment is suspected, opponents maintain that suicide requests may represent a "desperate plea for help by a distraught patient in physical or emotional pain."<sup>285</sup> Critics stress that contemporary medical care should focus on alleviating pain and addressing the fears associated with dying, rather than providing assistance in death.<sup>286</sup>

More specifically, the operation and application of the Oregon Act in the context of persons with AIDS may present serious problems. For example, patients who are either too weak or physically unable to digest oral medications will be excluded from medically assisted death under the Oregon proposal. As in the previous proposals, the patient's terminal disease or illness is diagnosed and confirmed by physicians who are not required to have special training in the field related to the patient's underlying condition. Because AIDS is an immunosuppressive disease, subject to secondary illnesses with differing degrees of fatality, a legislative proposal for medically assisted suicide must be broad enough to extend this option to people who are in the end stages of the disease, but carefully crafted to avoid the mere diagnosis of AIDS from qualifying as an operative illness under the act. The following section will set forth improvements in the qualification process and the procedure for providing medical assistance in death to ensure the highest degree of protection for persons with AIDS who seek medically assisted suicide.

#### VII. A PROPOSAL FOR MEDICALLY ASSISTED SUICIDE LEGISLATION IN THE CONTEXT OF AIDS: A MODEL DEATH WITH DIGNITY ACT

Using the heightened safeguards of the Oregon Act as a guide, this Article presents a model proposal for a statutory right to medically assisted suicide, applicable to terminally ill AIDS patients. Because of

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284. Brown, *supra* note 279, at A20 (reporting the comment of Thomas Reardon, an Oregon physician, that "[p]hysicians should not be involved in the active demise of a patient"). Opponents also criticize the neutral stance taken by the Oregon Medical Association during the election campaign. Mark O'Keefe, *Suicide Vote Fits Oregon's Maverick Character*, SAN JOSE MERCURY NEWS, Nov. 12, 1994, at 1A (publishing the comment of Robert Castagna, head of public-policy for Oregon's Roman Catholic Church, regarding the refusal of the Oregon Medical Association to take a stand on the issue: "What other profession would not stand up for its own ethics?"). One opponent, a pharmacy student, noted that the only novel aspect of the Oregon Act in comparison to other state proposals "is that it shunts the responsibility of dispensing lethal medications from the physician to the pharmacist." Michelle Frame Corvallis, *Doctors Pass Buck to Pharmacists*, OREGONIAN, Nov. 18, 1994, at D12.

285. Don Colburn, *Assisted Suicide Bill Passes, Oregon Law Puts State at Center of Ethical Debate*, WASH. POST, Nov. 15, 1994, at Z9.

286. *Id.*

public apprehension and current criminal penalties for aiding and abetting suicide in many states, the model proposal is entitled the "Model Death With Dignity Act," and uses the term "medically assisted death" rather than medically assisted suicide. An enacting clause or declaration of purpose is crucial for public comprehension of the Model Act's purpose and the reasons for suggesting this type of legislation. Therefore, the Model Act's principle stated purpose is the recognition of self-determination and autonomy in medical treatment decisions, including assistance upon request for a dignified and humane death. The previously summarized paradigm of concerns influenced the sections in the Model Act, which include: 1) eligibility requirements; 2) process for medically assisted death, including an explicit description of physician responsibilities; 3) procedural safeguards; and 4) immunities and liabilities under the Act. The Model Act is presented in its entirety in the attached appendix<sup>287</sup> and is hereafter discussed in a section-by-section analysis, focusing on the most pertinent provisions and specific additions for persons with AIDS.

#### A. Eligibility: Qualified Patient Status

Under section one of the Model Act, a competent adult suffering from a confirmed terminal condition has a right to medically assisted death upon the execution of a valid directive.<sup>288</sup> The Model Act's eligibility requirements vary from the previous state proposals in several respects. The Model Act defines "terminal condition" as an incurable and irreversible condition which will result in death within a relatively short time, based upon a consensus of medical opinions. To allow flexibility in the medical assessment of the patient's condition, and to avoid an artificial time period for qualification, the Model Act uses the phrase "relatively short time" rather than establishing a fixed time period. Physicians may hesitate to make predictions about life expectancy based upon a fixed standard, or may use the fixed period as a default prognosis. The "relatively short time" standard respects considerations such as the strength of the diagnosis, the type of the disorder

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287. The Model Act introduced in this Article is intended as only an illustrative academic presentation of the possible provisions for a comprehensive act relating to medically assisted death and the concerns specific for persons with AIDS. Provisions from the proposals in Washington, California, Maine and Oregon were included verbatim in different sections and will be referenced if specifically discussed in the text. Finally, the format of "The Oregon Death With Dignity Act" was used for clarity and ease of discussion. For the full text of the Model Act, see Appendix, *infra*.

288. The sample Directive in the Model Act was based upon the Oregon directive as provided in *Kane v. Attorney General*, 871 P.2d 993, 1005-06 (Or. 1994) and added to "The Oregon Death With Dignity Act" as Section 6, Form of the Request.

der, and the reasonable judgment of physicians in making such medical determinations.<sup>289</sup>

Also, one must question the ability of physicians to render a medical opinion regarding the time at which an AIDS patient has only six months to live. AIDS may clinically result in several crisis events whereby a patient suffers an opportunistic infection or severe illness, but ultimately recovers to merely an immunosuppressed status. The recurrent cycle of devastating illness and subsequent recovery increases the potential for an alarmist or premature diagnosis of imminent death.<sup>290</sup> In addition to vulnerability to a pessimistic medical prognosis, an AIDS patient may also suffer from an irreversible opportunistic infection which some physicians may exclude from the category of terminal condition, based upon inexperience or outdated medical information.<sup>291</sup> Because of the complexity of AIDS and the heightened possibility of inaccurate diagnoses, the Model Act requires confirmation of the patient's "terminal condition" and prognosis by two consulting physicians, one of whom must be a specialist in the field pertaining to the terminal disease. Thus, the Model Act requires heightened confirmation of the patient's diagnosis and prognosis rather than adhering to a fixed time period for life expectancy.

For example, the Model Act would require an infectious disease specialist or similar specialist, and one other consulting physician, to confirm the prognosis and terminal condition of an AIDS patient. Although this requirement will result in additional expense, the versatile nature of AIDS and the differing fatalities of secondary diseases warrant a medical opinion based upon expertise in HIV infection and AIDS. Confirmation by a specialist that the patient's condition will result in death in a relatively short time should be based upon clinical experience and management of patients suffering from the same type of illness. A person with a depressed T-cell count may fall within the CDC classification for a reportable AIDS case, while suffering none

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289. See ME. REV. STAT. ANN. tit. 18-A, § 5-701 Historical Notes (West Supp. 1993) (using a "relatively short time" standard in the Uniform Rights Of The Terminally Ill Act because the "circumstances and inevitable variations in disorder and diagnosis make unrealistic a fixed time period").

290. See *supra* notes 30-49 and accompanying text (describing the clinical manifestations of HIV infection and AIDS).

291. See Macher, *supra* note 29, at 5-15 (listing the secondary diseases associated with AIDS); Goldsmith, *supra* note 49, at 1237 (describing the process of HIV infection and the various clinical manifestations associated with AIDS). Spencer Heinz, *End Game*, OREGONIAN, Dec. 5, 1994, at A1 (reporting the comment of Ann G. Jackson, Executive Director of the Oregon Hospice Association, that "many doctors wait too long to make the six-month diagnosis that opened the option of hospice care").



of the symptoms of HIV infection or AIDS.<sup>292</sup> The Model Act ensures that such a patient would not qualify for medically assisted death merely on the basis of an AIDS diagnosis. Each state should determine the qualifications necessary for a physician to fall within the category of "specialist" for the purposes of the Act.

The qualification process imposes several duties upon the attending physician who is responsible for the primary treatment and care of the requesting patient. In addition to making the initial determination regarding the patient's eligibility, the attending physician must also verify that the patient is competent, and is making a voluntary request for medically assisted death. The issue of competency is critical for AIDS patients because of the increased occurrence of AIDS dementia and the possibility of depression.<sup>293</sup> Section 3.03 of the Model Act mandates psychiatric or psychological counseling and evaluation if the attending or consulting physicians suspect a mental disorder which may impair the patient's judgment. Section 2.04 of the Model Act requires the attending physician to inform the patient of his or her medical diagnosis, prognosis, and the feasible alternatives to medically assisted death, including such options as comfort care, hospice care and pain control.<sup>294</sup> As in the Maine proposal, assistance in death shall be provided only if the physicians unanimously agree, within reasonable medical judgment that the patient is competent, making a voluntary request, and has a terminal condition which will result in death in a relatively short time.<sup>295</sup>

Upon medical qualification, the attending physician must also ask the patient to notify his or her family of the request for medically assisted death. As in the Oregon Act, this requirement is permissive, and refusal or failure to notify family members does not provide a basis for denying the implementation of a valid directive.<sup>296</sup> Fear of family disapproval or coercion to rescind a medical assistance directive may compel a person with AIDS or a terminal illness to reject

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292. See *supra* notes 29-32, 39-40 and accompanying text (describing the 1993 CDC Classification for AIDS cases including T-cell counts of less than 200 cells per microliter of blood).

293. See *supra* notes 43-48 and accompanying text (describing the incidence of AIDS dementia for HIV-positive individuals).

294. This requirement is based upon the provision in the Oregon proposal for "Attending Physician Responsibilities." See THE OREGON DEATH WITH DIGNITY ACT, *Initiative Measure* § 3.01(2) (Dec. 14, 1993).

295. See Proposed amendment to ME. REV. STAT. ANN. tit. 18-A, § 5-715 (West 1993); L.D. 1420, 116th Leg., 1st Sess. (Me. 1993) (requiring medical confirmation by attending physician and two consulting physicians of patient's eligibility for medically assisted death).

296. See THE OREGON DEATH WITH DIGNITY ACT, *Initiative Measure* § 3.05 (Dec. 14, 1993) (mandating a physician request for patient to notify next of kin, but allowing the patient right to refuse such notification).

family notification. The patient's right to refuse family notification may be very important in the context of AIDS patients. For homosexual persons with AIDS, fears of family intrusion and exclusion of a partner at the time of medically assisted death may provide a plausible basis for rejecting such a suggestion.<sup>297</sup> A person has the right not only to elect medical assistance under the Model Act, but also to control who will be notified of the execution of such an option. The permissive notification of family members is a crucial protection of the patient's autonomy and right to privacy under the Model Act.

### *B. Implementation of Medically Assisted Death: Physician Involvement*

The Model act provides for the implementation of medically assisted death through voluntary physician participation and involvement. In an effort to curtail public apprehension regarding physicians as sanctioned killers for the state, section 2.03 of the Model Act provides that no attending physician shall be under any duty to participate in a qualified patient's request for medically assisted death. The Act requires a physician who, at any time, is unable or unwilling to participate in a qualified patient's request to inform the patient of his or her reluctance to participate in the execution of a directive. Pursuant to the patient's request, the attending physician must refer the patient and related medical records to a new attending physician. Unlike the previously discussed proposals, the Model Act provides a specific section for patient referral in the event an attending physician refuses to participate in a patient's request for medically assisted death.<sup>298</sup>

Upon qualification for medically assisted death, section 2.05 of the Model Act imposes a waiting period of a least seven days between the date of the patient's qualification and the execution of a medical assistance directive. This allows time for the qualified patient to reflect on the feasible alternatives, the option for family notification, and the possibility that the request may be premature. After the waiting pe-

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297. Miriam Horn, *Grief Re-examined*, U.S. NEWS & WORLD REP., June 14, 1993, at 81, 82 (explaining that gay lovers "may be locked out of memorials, denied access to shared belongings, or remains" by their partner's families).

298. The legalization of medically assisted death would occur under the Model Act through either a statutory enactment or initiative measure. A scenario where no physicians would be willing to participate in a patient's request for medically assisted death is not likely to occur. Moreover, the surveys mentioned in this Article regarding physician reaction to assistance in death evidence a positive inclination under certain circumstances. For example, the Oregon Medical Association "refused to take a position on the state-assisted suicide initiative," measure 16 on the November 1994 ballot. Dobbin, *supra* note 98, at A14. This decision by the Oregon Medical Association conflicts with the position of the American Medical Association, "which

riod, the qualified patient decides when and where assistance in death will occur.

Under the Model Act, the patient has the right to die with medical assistance at home or in a clinical setting. The Model Act recognizes that "death with dignity" must include a provision which allows terminal patients to choose to die in familiar surroundings. The personal accounts of "Dean," Steven Shiflett and Dr. Green's patient illustrate the importance that these men placed on being at home, surrounded by friends and family, in their final moments.<sup>299</sup> It makes little sense to provide the right to medically assisted death, yet mandate that the location for such assistance must be in the clinical setting of a hospital. The patient's right to seek medically assisted death must also include the right to decide where such assistance will occur.

Prior to the delivery of medical assistance in death, the attending physician must verify that the qualified patient is making an informed request, and provide an opportunity for the patient to revoke the request prior to the actual execution of the directive. Unlike most of the state proposals, the Model Act provides medically assisted death through a prescription for oral or intravenous medication, depending upon the physical condition of the patient.<sup>300</sup> Although the prospect of a physician administering a lethal dose of medication invokes an image of a medical killer sanctioned by the state, assistance in death must include physician administration in order to extend this option to some persons with AIDS. Many patients suffering from AIDS or other terminal illnesses experience a collapse of the digestive system which necessitates an option for intravenous administration.<sup>301</sup> There-

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remains opposed to such proposals." *Id.* The fact that the Oregon Medical Association elected not to oppose the initiative measure for medically assisted death evidences some degree of physician support for this option. See *Assisted Suicide Medicine Will Change Stance*, SEATTLE TIMES, May 20, 1994, at B7 (editorial by William O. Robertson, M.D., stating that the decision of the Oregon Medical Association signifies a change in attitude toward assisting terminal patients in hastening their deaths). Following the November election, the Oregon Medical Association's End of Life Task Force began assessing "what guidance to give its members in complying with the new law," indicating anticipated physician support and participation in patients requests for assistance in death. *Where Does Measure 16 Stand Today?*, OREGONIAN, Dec. 4, 1994, at A32.

299. See *supra* notes 64-91 and accompanying text (providing the personal accounts of "Dean," Steven Shiflett, and Dr. Green's patient).

300. See Howard Brody, M.D., Ph.D., *Assisted Death—A Compassionate Response to a Medical Failure*, 327 NEW ENG. J. MED. 1384, 1386 (1992) (describing defensibility of medically assisted death through patient and physician administration depending upon the condition of the patient).

301. See *supra* notes 81-85 and accompanying text (describing the "botched" suicide attempt of Steven Shiflett due in part to his weakened digestive system). Dr. Pelter Admiraal, experienced in euthanasia in the Netherlands, explained the problem with limiting assistance in death to only oral medications: "We estimated 20 to 30 percent [of the patients] in the Netherlands

fore, section 2.05 of the Model Act provides a hierarchy of physician involvement which increases as the patient's physical condition deteriorates.

Following a patient's decision that the time for medically assisted death has arrived, the attending physician must assess the patient's physical ability to effectively digest oral medications. If the patient is able to digest oral medication, the physician shall prescribe oral medication for self-administration by the patient. If the patient is physically unable to digest oral medication, then the attending physician must prescribe intravenous medication as the means for medically assisted death. The physician shall assist the patient in administering the intravenous medication if the patient is mentally and physically able to participate in the administration. This alternative envisions the delivery of an intravenous medication mixture over a short period of time under the patient's control, rather than one instantaneous lethal injection. In this manner, the patient will succumb after sufficient infusion of the sedative mixture and thus remove the physician from the immediacy of a lethal injection. Finally, if the patient lacks the physical and mental ability to participate, the physician shall control the infusion rate of the medication until death occurs.

The continuum of physician involvement is based upon the patient's ability to control all aspects of his or her death. When physically and mentally capable, the patient controls the actual administration of the prescribed medication and thus, the actual time of death.<sup>302</sup> The alternative for physician administration may invoke a critical reaction, but the inclusion of such an option is crucial for persons with AIDS and other terminal illnesses. The option of intravenous administration recognizes the right of all terminal patients to receive medical assistance in death, even those who cannot digest oral medication. If a statute provided for medical assistance in death through no other means than oral medication, it might subtly coerce patients to opt for medically assisted death prematurely, because of fear of disqualification at a later time when oral medication could be ineffective. The concept of death with dignity must include individuals who seek assistance in

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cannot swallow, or they vomit it up. . . . Well, what do you do then? We know that in the Netherlands we can use an injection. Of course, you can't do that in Oregon." Mark O'Keefe & Patrick O'Neill, *Dutch Researcher Warns Of Lingering Deaths*, OREGONIAN, Dec. 4, 1994, at A1.

302. See Cospers, *supra* note 60, at A3 (reporting the comment of euthanasia advocate Jeanne Tromp Meesters that AIDS patients requesting assistance in death "are young people, and they take their lives in their own hands . . . . They know what is ahead of them, that there is no hope").

death, but choose to live with the dying process beyond their ability to ingest oral medication. A statutory right must focus on the patient's wishes rather than the physician's degree of participation.

### C. Safeguards and Precautions

The Model Act includes additional safeguards in an effort to address the paradigm of concerns regarding medically assisted death. Section 3.08 of the Model Act requires the attending physician to document each phase of the qualification process in the patient's medical record. Also, the state must establish an annual record review process and a confidential reporting procedure, which must include the name of a patient who dies as a result of medical assistance, the assisting physician or health care provider, the terminal illness, and the date, time and place of death. These requirements provide the basis for statistical analysis of the utilization of medically assisted death, the precipitating illnesses, and a tracking mechanism for possible abuses in the process. Reporting and review requirements would operate as an adjunct to the eligibility requirements, minimizing the potential for coercion and abuse in the implementation of medically assisted death for persons with AIDS and other terminal illnesses.

As in the Oregon Act and the California proposal, section 2.02(4) of the Model Act provides that a patient in a long term care facility seeking to execute a "medical assistance directive" shall have as one witness, an individual with qualifications specified by the appropriate state agency overseeing nursing homes and extended care facilities.<sup>303</sup> This provision ensures that patients with AIDS or other terminal illnesses are not coerced by family pressure or health care costs to seek medically assisted death. The high costs associated with extended care may subtly coerce an AIDS patient to opt for assistance in death in order to preserve the financial security of his or her family.<sup>304</sup> The inevitable fatality of AIDS and the high costs of custodial care increase the likelihood that these patients may be disproportionately

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303. Cf. Proposed CAL. CIV. CODE § 2525.4 (1992), reprinted in OFFICE OF SECRETARY OF STATE, CALIFORNIA BALLOT PAMPHLET, *Proposition 161* 68 (1992) (requiring special witness approved by the Department of Aging for directive executed in a skilled nursing facility); and THE OREGON DEATH WITH DIGNITY ACT, *Initiative Measure* § 2.02 (4) (Dec. 14, 1993) (providing exact language used in the Model Act).

304. See Reichel & Dyck, *supra* note 200, at 1322 (postulating that patients may perceive their protracted illness as "causing a financial and emotional hardship on the loved ones" which would end with the selection of assistance in death); see also Gifford, *supra* note 201, at 1562-63 (describing that the coercion for terminally ill patients may be subtle and unspoken, but hinted at by families as an alternative).

counseled about the availability of assistance in death.<sup>305</sup> Heightened safeguards are necessary for such patients to ensure that requests for assistance in death are not based upon subtle coercion, financial concerns, or insinuations that their incapacitation warrants such an election.

Additionally, section 4 of the Model Act provides that any person or physician who coerces or exerts undue influence on a patient to execute a medical assistance directive shall be guilty of a class A felony or equivalent crime in the enacting state. The same penalty results for destroying or concealing a revocation of a request for medically assisted death. A physician who qualifies a patient in the absence of a terminal condition or upon clinical indication of a psychiatric or psychological disorder shall be subject to licensure revocation and prosecution for a class A felony. These provisions serve to deter the possibility of involuntary selection of persons with AIDS or other terminal illnesses, and ensure compliance with the qualification process for all requesting patients.

Under section 3.01 of the Model Act, the requesting patient must also be a resident of the state in order to qualify for medically assisted death.<sup>306</sup> Upon the passage of the "Death With Dignity Act," the enacting state may attract an influx of terminally ill patients who cannot legally receive assistance in death in their state of residency.<sup>307</sup> The actual demand for such an option cannot be adequately estimated on a national level, but medical studies indicate that obtaining assistance in death is an increasing concern for persons with AIDS and other terminal illnesses.<sup>308</sup> This limitation would operate as protection for the state by minimizing the potential for over-utilization of the state's

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305. Gaylin, *supra* note 9, at 2140 (arguing that the "[h]igh costs of care for the old and incurable already tempt some physicians to regard as 'dispensable' some patients who never express the wish to die"); see also "Dr. Death" Is No Angel of Mercy, *NEWSDAY* (New York), Nov. 29, 1992, at 33 (arguing that "there's always a possibility that the patient, however inadvertently, will get the idea that AIDS has such a high cost for the individual, the family and society as a whole that suicide is the better alternative").

306. Based upon § 3.10 of the Oregon proposal. THE OREGON DEATH WITH DIGNITY ACT, *Initiative Measure* § 3.10 (Dec. 14, 1993). Because a residency requirement for a statute permitting medical assistance in death has not been challenged in any state thus far, the constitutionality of a resident requirement in this situation is unknown. Therefore, the Model Act includes a severability clause in section 5 which provides that an invalidated provision shall not affect any remaining sections of the Act which can be given full effect in the absence of the invalid provision.

307. See Michael Betzold, *State Regulation Could Ensure Dignified End for Those in Pain*, *DET. FREE PRESS*, Sept. 20, 1992, at 1F (providing a parody of Michigan in the year 1997 following the enactment of assisted suicide and postulating an influx of 2000 non-residents annually to a state purporting to be "[a] great place to live, a peaceful place to die").

308. See *supra* notes 15-26, 50-98 and accompanying text (explaining that public support for medically assisted suicide is increasing, especially among persons with AIDS).

health care services immediately following the enactment of such a right.

Moreover, the requirements for reporting and annual review of medically assisted deaths are critical protections against the potential for abuses in the process. A rapid influx of non-resident patients may impede the initial monitoring and evaluation procedure adopted by the state and consequently decrease the effectiveness of such precautions. The Model Act seeks to provide a right to medically assisted death with heightened protections against the potential for coercion, involuntary selection, and clandestine assistance in death as seen in the practices of Dr. Jack Kevorkian. Therefore, the state's interest in maintaining responsible administration and effective record review should outweigh the interest of non-residents who may have a compelling medical basis for seeking medically assisted death.<sup>309</sup>

As in the California and Oregon proposals, section 3.10 of the Model Act ensures that the execution of a medical assistance directive shall have no effect upon the validity of a qualified patient's health, life or accident insurance policy.<sup>310</sup> Section 4 provides that actions taken in accordance with the Model Act shall not constitute suicide, assisted suicide, mercy killing, or homicide under current laws. Physicians and health care providers shall not be subject to civil or criminal liability or professional disciplinary action for participating in good faith compliance with the provisions of the Model Act. Recognizing the possibility of moral and ethical opposition to assisting a patient's death, physicians and health care providers have no duty to provide assistance, but must transfer or refer a requesting patient to an accommodating physician or facility. Through these safeguards, the Model Act attempts to minimize the possibility of discrimination and abuse for persons with AIDS or any other terminal illness who qualify for medical assistance in death.

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309. The traditional state interests, including preservation of human life, preventing suicide, protecting innocent third parties, and maintaining the ethical integrity of the medical profession should outweigh the interest of nonresidents in seeking medically assisted suicide in the event of a constitutional challenge. See *Donaldson v. Van de Kamp*, 4 Cal. Rptr. 2d 59, 62 (Cal. Ct. App. 1992).

310. See Proposed CAL. CIV. CODE § 2525.17 (1992), reprinted in OFFICE OF SECRETARY OF STATE, CALIFORNIA BALLOT PAMPHLET, *Proposition 161* 68, 69 (1992) (providing similar restrictions on the issuance and premiums for insurance in relation to the administration of aid in dying); THE OREGON DEATH WITH DIGNITY ACT, *Initiative Measure* § 3.13 (Dec. 14, 1993) (providing substantially the same language as the Model Act regarding insurance restrictions). Because such an insurance restriction in a statute permitting medical assistance in death has not been challenged in any state thus far, the constitutionality of such a restriction on the insurance industry is unknown. Therefore, the Model Act includes a severability clause in section 5 which provides that an invalidated provision shall not affect any remaining sections of the act which can be given full effect in the absence of the invalid provision.

## VIII. CONCLUSION

This Article presents the Model Act as an invitation to consider the ramifications of legalized medical assistance in death for persons with AIDS. The suffering of terminally ill AIDS patients gives rise to some of the most compassionate and compelling arguments in support of medically assisted suicide. The personal accounts presented in this Article demonstrate the severe and debilitating effects of AIDS, and the rational prospect of deciding to shorten one's death under excruciating and protracted circumstances. Such accounts support the premise that the right to die must include an option for death with dignity in the absence of life-sustaining treatment if self-determination and autonomy are to have practical meaning and effect. Yet legislative proposals must be carefully drafted to ensure that societal pressure is not exerted upon people suffering from terminal illnesses to opt for medically assisted suicide based merely upon their medical diagnosis or financial situation, rather than their personal choice.

Persons with AIDS may be particularly vulnerable to duress, coercion, or subtle societal pressure to opt for medically assisted death due to the extremely high costs of treating AIDS, the stigma associated with HIV infection and AIDS, and the inevitable fatality from the disease. Moreover, the likelihood of developing some form of AIDS dementia complex makes persons with this disease even more susceptible to subtle pressure regarding the election of medically assisted death. Stringent qualification requirements, thorough competency assessments, and precise implementation procedures are necessary to protect all terminally ill persons, especially those suffering from AIDS.

Although a strong argument exists that the constitutional rationale in the "right-to-die" cases should also encompass decisions to end one's life, the judiciary cannot effectively ensure the safe and responsible implementation of medically assisted death on a case-by-case basis. The paradigm of concerns summarized in this Article warrant the provision of medical assistance in death through a statutory enactment to ensure, at a minimum, consistency in application and appropriate review. The Model Act addresses the primary factors that mandate consideration in any legislative proposal intended to legalize medical assistance in death.

The process in the Model Act for obtaining medical assistance in death is cautious, comprehensive and expensive. A major deficiency of this proposal is its hidden requirement for qualification: substantial amounts of money. Under the Model Act, only patients with sufficient finances could afford the fees of a consulting physician, a specialist's consultation, and the possibility of psychiatric evaluation or



psychological counseling. However, a statute legalizing assistance in death must include requirements to ensure proper diagnosis and evaluation of AIDS patients. The consequence of limiting the option of medical assistance in death to financially secure terminally ill patients appears too discriminatory to comport with the notion of individual autonomy and self-determination. But this is the reality of attempting legislation in this area.

Although the legal sufficiency of the procedures, safeguards and application of the Oregon Death With Dignity Act is undetermined at the present time, the passage of the Act evidences increasing public support for medically assisted death or suicide under specific circumstances. Nevertheless, because of the potential for abuses in a process designed to hasten death, the prospect of legalizing such an option induces hesitation. The analysis of the right-to-die cases indicates that a state should be able to enact a statute establishing the right to medically assisted death that would withstand a constitutional challenge. However, to enact a statutory right to medical assistance in death, the voting public must conclude that such a change in public policy is both warranted and correct. Thus, to ensure the integrity of such a process, a legislative proposal or ballot initiative must provide extremely heightened, and thereby expensive, protections against abuse and discrimination. When a legislative proposal incorporates the ideal combination of stringent eligibility requirements, optimal safeguards, and responsible enforcement, the right to medically assisted suicide may become a legal option for persons with AIDS and other terminal illnesses who competently and voluntarily seek release from terminal suffering.

APPENDIX  
MODEL DEATH WITH DIGNITY ACT  
PROVIDING MEDICALLY ASSISTED DEATH

**SECTION 1: GENERAL PROVISIONS**

The following words and phrases, when used in this Act, shall have the following meaning:

- (1) "Attending physician" means the physician who has primary responsibility for the treatment and care of the patient.
- (2) "Consulting physician" means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis of the patient's condition.
- (3) "Counseling" means a consultation between a state licensed psychiatrist or psychologist and a patient for the purpose of determining whether the patient is suffering from a psychiatric or psychological disorder or depression causing impaired judgment.
- (4) "Declarant" means a person who executes a directive in accordance with this Act.
- (5) "Directive" means a written document voluntarily executed by the declarant in accordance with the requirements of Section 2 of this Act.
- (6) "Health care facility" means a hospital, nursing home, home health agency, or hospice.
- (7) "Health care provider" means a person licensed, certified, or otherwise authorized or permitted by the law of this State to administer health care in the ordinary course of business or practice of a profession, and includes a health care facility.
- (8) "Informed decision" means a decision by a qualified patient, to request and obtain medication to end his or her life in a humane and dignified manner, that is based on an appreciation of the relevant facts and being fully informed by the attending physician of:
  - (a) his or her medical diagnosis;
  - (b) his or her prognosis;
  - (c) the feasible alternatives, including, but not limited to, comfort care, hospice care, and pain control.
- (9) "Medically assisted death" means a prescription for oral or intravenous medication that will end the life of a patient and has been requested, authorized, prescribed, and administered in accordance with the provisions of this Act.
- (10) "Medically confirmed" means the medical opinion of the attending physician has been confirmed by two consulting physicians, one of whom is a specialist in the area relating to the terminal condition of the patient, who have examined the patient and the patient's relevant medical records.

(11) "Qualified patient" means a mentally competent person at least 18 years of age who meets the following requirements:

- (a) is a resident of this state;
- (b) has voluntarily executed a written Directive as defined in this section;
- (c) has a terminal condition as verified by the attending physician and two consulting physicians in writing; and,

(d) has expressed an informed request for medical assistance to end his or her life in a humane and dignified manner in accordance with the provisions of this Act.

(12) "Terminal condition" means an incurable and irreversible condition, that has been medically confirmed and will, in the written opinions of the attending physician and consulting physicians, result in death within a relatively short time.

## SECTION 2: DIRECTIVE AND PROCESS FOR MEDICALLY ASSISTED DEATH

### SECTION 2.01 ELIGIBILITY FOR MEDICALLY ASSISTED DEATH DIRECTIVE

An adult who is competent, is a resident of this state, and has been determined by the attending physician and two consulting physicians to be suffering from a terminal condition, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner in accordance with this Act.

### SECTION 2.02 WRITTEN DIRECTIVE REQUIREMENTS

(1) A valid request for medication under this Act shall be signed and dated by the patient and witnessed by two individuals who, in the presence of the patient, attest that to the best of their knowledge and belief the patient is capable, acting voluntarily, and is not being coerced to the sign the request. The Directive must be made on the following form:

#### *DIRECTIVE FOR MEDICALLY ASSISTED DEATH*

I, \_\_\_\_\_, am an adult of sound mind. I am suffering from \_\_\_\_\_, which in the opinion of my attending physician, is a terminal condition. Terminal condition means a condition that is incurable and irreversible and that, in the opinion of my attending physician, is likely to result in death in a relatively short time. I understand that my physician will not be able

to assist me unless my terminal condition is confirmed by two consulting physicians, one of whom must be a specialist in the field of my terminal condition. I have been fully informed of my diagnosis, prognosis, the nature of the medication to be prescribed or administered and the potential risks, the expected result, and the feasible alternatives, including comfort care, hospice care and pain control. In order that I may die in a dignified, painless and humane manner, I have voluntarily elected to obtain medically assisted death. INITIAL ONE SELECTION: \_\_\_\_ I have informed my family of my decision. \_\_\_\_ I have decided not to inform my family of my decision. \_\_\_\_ I have no family to inform of my decision. I understand that a waiting period of seven (7) days must occur after my verbal request for the execution of this directive in order to ensure that my decision is final. I understand that I have the right to revoke this directive at any time and that if I revoke this directive, I will have to make a new directive if I again choose medically assisted death. I understand the full import of this request and I expect to die when I take or receive the medication prescribed. I make this request voluntarily and without reservation.

Signed this \_\_\_\_\_ day of \_\_\_\_\_.

Signature: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

#### *DECLARATION OF WITNESSES*

We declare that the person signing this request: (a) Has provided proof of identity; (b) Appears to be of sound mind; (c) Signed this request voluntarily and in our presence; (d) Is not a patient for whom either of us is attending physician.

Witness 1: \_\_\_\_\_ Date: \_\_\_\_\_

Witness 2: \_\_\_\_\_ Date: \_\_\_\_\_

- (2) One of the witnesses shall be a person who is not:
- (a) A relative of the patient by blood, marriage, or adoption;
  - (b) A person who at the time the request is signed would be entitled to any portion of the estate of the qualified patient upon death under any will or by operation of law; or
  - (c) An owner, operator or employee of a health care facility where the qualified patient is receiving medical treatment or is a resident.
- (3) The patient's attending physician at the time the request is signed shall not be a witness.

(4) If the patient is a patient in a long term care facility at the time the written request is made, one of the witnesses shall be an individual designated by the facility and having qualifications specified by the state department responsible for supervision of such facilities.

#### SECTION 2.03 VOLUNTARY PARTICIPATION OF ATTENDING PHYSICIAN

(1) No attending physician shall be under any duty to participate in a qualified patient's request for medically assisted death, as provided in Section 4 of this Act.

(2) If, at any time, an attending physician is unable or unwilling to carry out a qualified patient's request under this Act, the attending physician shall:

(a) Immediately inform the patient that the attending physician is unable or unwilling to carry out the patient's request under this Act;

(b) Refer the patient, upon request, to a new attending physician;

(c) Transfer, upon request, a copy of the patient's medical records to the new attending physician.

#### SECTION 2.04 ATTENDING PHYSICIAN PRELIMINARY RESPONSIBILITIES

The attending physician shall:

(1) Make the initial determination of whether the patient has a terminal condition, is competent, had has made the request voluntarily.

(2) Inform the patient of:

(a) his or her medical diagnosis;

(b) his or her prognosis;

(c) the feasible alternatives, including, but not limited to, comfort care, hospice care, and pain control.

(3) Refer the patient to two consulting physicians, one of whom must be a specialist in the field relating to the patient's terminal condition, for:

(a) medical confirmation of the patient's medical diagnosis and prognosis through a physical examination of the patient and a review of the patient's medical record; and

(b) a determination that the patient is competent and acting voluntarily.

(4) Refer the patient for counseling if, in the opinion of the attending physician or consulting physicians, the patient appears to be suffering from a psychiatric or psychological disorder, or depression causing impaired judgment. Medication to end a patient's life in a humane and dignified manner shall not be prescribed until the person performing the counseling determines that the patient is not suffering from a

psychiatric or psychological disorder, or depression causing impaired judgment.

(5) Request that the patient notify next of kin.

(6) Inform the patient that he or she has the right to revoke the written Directive at any time, and in any manner.

(7) Fulfill the medical record documentation requirements of Section 3.08.

#### **SECTION 2.05 ATTENDING PHYSICIAN RESPONSIBILITIES FOR EXECUTION OF DIRECTIVE**

(1) Following receipt of written medical confirmation of the declarant's terminal condition, competence, and voluntary request for medically assisted death by two consulting physicians, the attending physician shall:

(a) make the Directive and written medical confirmation a part of the patient's medical record; and

(b) inform the patient of the medical confirmation and compliance of the Directive with the requirements of this Act.

(2) The qualified patient shall make the determination that the time for medically assisted death has arrived and shall communicate this decision to the attending physician following the medical and psychiatric or psychological confirmation if applicable.

(a) No less than seven (7) days shall elapse between the medical confirmation of the patient's eligibility and the execution of a valid Directive for medically assisted death;

(b) After the seven day period, a qualified patient may request medically assisted death and the attending physician shall execute the Directive subject to the provisions in Section 2.03.

(c) The patient shall select the place in which medically assisted death will occur which may include, but is not limited to, a private residence or health care facility.

(d) The attending physician shall verify that the qualified patient is making an informed decision and shall provide an opportunity for the qualified patient to revoke the request for medically assisted death prior to actual execution of the Directive.

(3) The attending physician shall determine if the patient is physically able to ingest prescribed oral medication as the means for medically assisted death and the following process for administration shall be followed based on the outcome of the attending physician's assessment at the time the qualified patient has completed all of the requirements of this Act and determined the time for actual execution of the Directive:

(a) If the attending physician determines that the qualified patient is able to digest oral medications, then medical assistance in death shall be provided by a prescription for oral medication and shall be administered by the patient;

(b) If the attending physician determines that the qualified patient is mentally alert but unable to digest oral medication, then medical assistance in death shall be provided through intravenous medication. The physician or health care provider shall assist the patient in the administration of the prescribed medication;

(c) If the attending physician determines that the qualified patient is physically or mentally unable to administer the intravenous medication, then the physician or health care provider shall perform the administration of the medication to provide medically assisted death.

(4) The attending physician shall complete the death certificate of a qualified patient by listing medically assisted death and the underlying terminal condition as the cause of death.

### SECTION 3: SAFEGUARDS

#### SECTION 3.01 RESIDENCY REQUIREMENT

Only requests by residents of this state shall be granted.

#### SECTION 3.02 CONSULTING PHYSICIAN CONFIRMATION

Before a patient is qualified under this Act, two consulting physicians shall examine the patient, one of whom shall be a specialist in the field relating to the patient's terminal condition. Both consulting physicians shall confirm, in writing, the attending physician's diagnosis that the patient is suffering from a terminal condition, and verify that the patient is competent, is acting voluntarily and has made an informed decision.

#### SECTION 3.03 COUNSELING REFERRAL

If in the opinion of the attending physician or either of the consulting physicians, the patient may be suffering from a psychiatric or psychological disorder, or depression causing impaired judgment, any physician shall refer the patient for counseling. Medication to end a patient's life in a humane and dignified manner shall not be prescribed until the person performing the counseling determines that the patient is not suffering from a psychiatric or psychological disorder, or depression causing impaired judgment.

**SECTION 3.04 INFORMED DECISION**

No person shall receive a prescription for medication to end his or her life in a humane and dignified manner unless he or she has made an informed decision as defined in Section 1 (8). Immediately prior to providing a prescription for medication under this Act, the attending physician shall verify that the patient is making an informed decision.

**SECTION 3.05 FAMILY NOTIFICATION**

The attending physician shall ask the qualified patient to notify next of kin of his or her request for medication pursuant to this Act. A qualified patient who declines or is unable to notify next of kin shall not have his or her request denied for that reason.

**SECTION 3.06 WAITING PERIOD**

No less than seven (7) days shall elapse between the medical confirmation of the patient's eligibility for medically assisted death and the execution of a Directive under this Act. The qualified patient shall notify the physician that he or she has decided that the time for medically assisted death has arrived and indicate the location where medical assistance shall occur.

**SECTION 3.07 RIGHT TO REVOKE REQUEST**

A qualified patient may revoke his or her request at any time and in any manner without regard to his or her mental state. No prescription for medication under this Act may be written without the attending physician offering the qualified patient a right to revoke the request. If the qualified patient does revoke the request, the attending physician shall be responsible for immediately removing the written directive and medical confirmation from the patient's chart. The patient shall be required to comply with the entire process in order to become eligible for medically assisted death following a revocation of a prior written Directive.

**SECTION 3.08 MEDICAL RECORD DOCUMENTATION REQUIREMENTS**

The following shall be documented in the patient's medical record:

- (1) A written Directive for medically assisted death signed by the patient and two attesting witnesses;



- (2) The attending physician's written diagnosis, prognosis and verification that the patient is competent, acting voluntarily and has made an informed decision;
- (3) The consulting physicians' written medical confirmation of the patient's diagnosis, prognosis and verification that the patient is competent, acting voluntarily and has made an informed decision;
- (4) A report of the outcome and determinations made during counseling, if performed;
- (5) The attending physician's offer to the patient to revoke his or her request prior to the actual execution of the Directive; and
- (6) A notation by the attending physician indicating that all requirements under this Act have been met and indicating the means selected for medically assisted death based upon the patient's physical and mental condition on the date of execution of the Directive.

#### SECTION 3.09 REPORTING REQUIREMENTS

- (1) The state health department or designated state agency shall annually review a sample of records pursuant to this Act.
- (2) The state health department or designated state agency shall make rules to facilitate the collection of information regarding compliance with this Act and ensure the confidentiality of such information, including, but not limited to, the name of the requesting patient, the assisting physician or health care provider, the terminal condition, and the date, time and place of death. The information collected shall not be a public record and shall not be available for inspection by the public.
- (3) The state health department or designated state agency shall generate and make available to the public an annual statistical report of the information collected under this Act.

#### SECTION 3.10 INSURANCE OR ANNUITY POLICIES

The sale, procurement, or issuance of any life, health, or accident insurance or annuity policy or the rate charged for any policy shall not be conditioned upon or affected by the making or revoking of a request, by a qualified patient, for medication to end his or her life in a humane and dignified manner. Neither shall a qualified patient's act of ingesting or receiving intravenous medication to end his or her life in a humane and dignified manner have an effect upon a health, life or accident insurance or annuity policy.

## SECTION 4: IMMUNITIES AND LIABILITIES

### SECTION 4.01 IMMUNITIES

Except as provided under Section 4.02:

(1) No person shall be subject to civil or criminal liability or professional disciplinary action for participating in good faith compliance with this Act. This includes being present when a qualified patient takes prescribed medication or administering the prescribed medication to the qualified patient to end his or her life in a humane and dignified manner.

(2) No health care provider shall be under any duty to participate in the provision to a qualified patient of medication to end his or her life in a humane and dignified manner. If a health care provider is unable or unwilling to carry out a patient's request under this Act, and the patient transfers his or her care to a new health care provider, the prior health care provider shall transfer, upon request, a copy of the patient's medical records to the new health care provider.

### SECTION 4.02 LIABILITIES

(1) A person who, without authorization of the patient, willfully alters or forges a Directive for medication or conceals or destroys a revocation of a Directive with intent or effect of causing a patient's death shall be guilty of a Class A felony.

(2) A person who coerces or exerts undue influence on a patient to complete a Directive for ending the patient's life, or to destroy a revocation of such a request, shall be guilty of a Class A felony.

(3) A physician who coerces or exerts undue influence on a patient or conspires to validate a Directive either (a) in the absence of a valid terminal condition or (b) upon clinical indication of a psychiatric or psychological disorder in the patient shall be subject to licensure revocation in this state and shall be guilty of a Class A felony.

## SECTION 5: SEVERABILITY

Any section of this Act being held invalid as to any person or circumstance shall not affect the application of any other section of this Act which can be given full effect without the invalid section or application.

