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COMMENTS

PHYSICIAN-ASSISTED SUICIDE: IS IT TIME?

I. INTRODUCTION

From birth, our mortality is a harsh fact of life that we all face. “Mortality” is defined as “the state or condition of being subject to death.”¹ In other words, once born, we are all destined to die. Despite this inevitability, most individuals are uncomfortable with the idea of death and the finality of its occurrence. Facing one’s own mortality is not an easy task for the vast majority of the human population.

Coming to terms with one’s own mortality and impending death is made even more difficult when death is contemplated in conjunction with a terminal illness that is nothing more than a constant and excruciating source of pain for the patient. Such patients are not content to wait and let natural death claim their lives. To these individuals, advances in medical science and technology, which have enabled the medical profession to prolong the lives of terminally ill patients beyond what was possible before, represent progress that merely aggravates their suffering and pain.

Progress in medical science directed towards decreasing pain and prolonging life has, to be sure, blurred the line between life and death. To the terminally ill facing constant pain, this progress merely represents the means to prolong their suffering. Justifiably, these individuals who are suffering unbearable pain demand a hastening of their death so that they may be relieved of pain and an existence that offers nothing more than palliative care that is certain to fail at some point in the treatment.

Consequently, terminally ill patients request their physician’s assistance in hastening their death and putting an end to their pain and suffering. This would require the physician to engage in physician-assisted suicide, a practice that has been ethically and legally sanctioned nationwide for years. While many courts have recognized a patient’s right to die by refusal or withdrawal of life-support mechanisms,² physician-assisted suicide is still criminally sanctioned in all the states of this country, except Oregon.³ On

1. WEBSTER’S NEW COLLEGIATE DICTIONARY 773 (9th ed. 1991) (entries under “mortality” and “mortal”).

2. See, e.g., *Cruzan v. Director, Missouri Dep’t of Health*, 497 U.S. 261, 278 (1990); *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127 (Cal. Ct. App. 1986); *In re Quinlan*, 355 A.2d 647, 663 (N.J. 1976).

3. See *International Anti-Euthanasia Task Force, Special Report: Oregon’s Death Wish*:

November 4, 1997, the people of Oregon voted in favor of legalizing physician-assisted suicide for terminally ill patients.⁴ Since 1990, several other states have attempted to legalize physician-assisted suicide for terminally ill patients, but voters in these states have rejected such proposed legislation.⁵

This comment will analyze approved legislation as well as a proposition being formulated to legalize physician-assisted suicide in the United States. In particular, the analysis will focus on the safeguards incorporated in the legislation, and the proposal against the abuse of this practice that has been observed in the Netherlands. Part II of this comment discuss physician-assisted suicide and the moral, ethical, and medical considerations associated with this practice. Part III will deal with physician-assisted suicide in the Netherlands. Part IV will describe the current state of U.S. law regarding physician-assisted suicide. Part V will analyze Oregon's "Death With Dignity Act" and the safeguards it incorporates to combat abuse, while part VI will deal with California's attempt to legalize physician-assisted suicide. Finally, part VII will provide a conclusion to this comment.

II. PHYSICIAN-ASSISTED SUICIDE

Physician-assisted suicide refers to a physician's involvement in providing a painless, rapid, and humane death to a patient in intractable pain who wishes to die, but is unable to do so unassisted.⁶ According to the American Medical Association, physician-assisted suicide occurs when a physician facilitates the death of a patient by providing the necessary means to enable the patient to end his or her life.⁷ In other words, the doctor gives the patient a death-producing means with which the patient brings about his or her own death.

It has been said that physician-assisted suicide is incompatible with the role of a physician as a healer.⁸ Implied by this is the notion that a physician's duty is to provide treatment, not cause death, even upon the patient's request.⁹ In fact, it has been argued that requests for physician-assisted sui-

The Vote and the Aftermath (visited Apr. 13, 1999) <<http://www.iaetf.org>>.

4. See Ellen Goodman, *Oregon's Parachute for the Terminally Ill*, INDIANAPOLIS STAR, Nov. 10, 1997, at A09; Patrick O'Neill, *Oregon Medical Association Will Follow Suicide Provisions*, PORTLAND OREGONIAN, Nov. 10, 1997, at A01; Patrick O'Neill & Steve Woodward, *Assisted Suicide Turns From Theory to Details*, PORTLAND OREGONIAN, Nov. 9, 1997, at A01; Ellen Goodman, *Nation Turns to Oregon*, PORTLAND OREGONIAN, Nov. 8, 1997, at D06.

5. See Dick Lehr, *Physicians Face Wrenching Choices, Requests For Help in Dying Produce a Professional Crisis*, BOSTON GLOBE, Apr. 27, 1993, at 1.

6. See Leslie L. Mangini, *To Help or Not to Help: Assisted Suicide and its Moral, Ethical, and Legal Ramifications*, 18 SETON HALL LEGIS. J. 728, 731 (1994).

7. *Id.* at 745 (citing *Council Report: Decisions Near the End of Life*, 267 JAMA 2229 (1992)).

8. Leon Kass, *Neither For Love Nor For Money: Why Doctors Must Not Kill*, 94 PUB. INTEREST 25, 30 (1989).

9. See Council on Ethical and Judicial Affairs, American Medical Association, *Physi-*

cide are to be regarded as cries for help.¹⁰ However, while the physical pain patients feel can be alleviated, this is not true for all physical pain. There comes a point in the treatment when the patient is beyond responding to palliative pain medication, and must endure pain and suffering until death.

It has been stated that physicians are providers of comfort just as much as they are healers of illness.¹¹ In the event of a conflict between these two roles, it is unclear why the physician's role as a provider of comfort is treated as subordinate to his role as a healer.¹² If a physician's fundamental role is to relieve disease and discomfort, and included within this role is promotion of health, then physician-assisted suicide may be regarded as not only compatible with the physician's role, but in fact incumbent on the physician.¹³ While it has been reported that physician-assisted suicide would threaten the doctor-patient relationship,¹⁴ what breeds mistrust between patients and physicians is not that physicians will prescribe lethal agents, but that they will not do so in the face of patients' intolerable suffering.¹⁵

As expressed by its representative, the American Medical Association (AMA) is vehemently opposed to physician-assisted suicide, and considers it to irreversibly exclude other medical, psychological, and social avenues available to the ill patient.¹⁶ The AMA argues that physician-assisted suicide is simply an intentional taking of the patient's life, even if it is with the patient's consent, and that such an act is not considered to be within the realm of medical practice.¹⁷

Further, the government opposes physician-assisted suicide. During a Presidential campaign in Detroit, in 1992, President Clinton expressed his opposition to physician-assisted suicide.¹⁸ He also stated that he would veto any bill attempting to legalize that practice in this country.¹⁹

Opponents of physician-assisted suicide provide several reasons for

Physician-Assisted Suicide, 10 ISSUES L. & MED. 91, 93 (1994).

10. See Mangini, *supra* note 6, at 750 (citing Harry R. Moody, *In My Opinion*, AARP BULL., Sept. 1993, at 22).

11. See David Orentlicher, *The Legalization of Physician-Assisted Suicide: A Very Modest Revolution*, 38 B.C. L. REV. 443, 452 (1997) (citing Ezekiel J. Emanuel, *Euthanasia: Historical, Ethical, and Empiric Perspectives*, 154 ARCHIVE INTERNAL MED. 1890, 1893 (1994)).

12. See *id.*

13. See *id.*

14. See Mangini, *supra* note 6, at 750 (citing Dr. John King, Address at the American Medical Ass'n National Meeting (1991)).

15. See *id.* at 751-52.

16. See Samuel F. Hunter, *Active Euthanasia Violates Fundamental Principles*, 262 JAMA 3074 (1989).

17. See Note, *Physician-Assisted Suicide and the Right to Die With Assistance*, 105 HARV. L. REV. 2021, 2021 n.4 (citing COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS OF THE AMER. MED. ASS'N REPORTS § 12, at 2 (1989)).

18. See Mangini, *supra* note 6, at 755 (citing NATIONAL CONFERENCE OF CATHOLIC BISHOPS/SECRETARIAT FOR PRO-LIFE ACTIVITIES, A CHRONICLE OF EUTHANASIA: TRENDS IN AMERICA, LIFE AT RISK 1 (1992)).

19. *Id.*

their opposition to this practice. First, this practice would destroy the doctor-patient relationship; the patient cannot be sure of the doctor's role as a healer because he would also be authorized to kill.²⁰ Next, opponents fear that this practice will increase the number of misdiagnosed cases, leading to involuntary deaths of patients.²¹ Further, physician-assisted suicide would lead to a decreased incentive to research and develop new methods of providing palliative care and life-sustaining treatment.²² Finally, public policy argues against this practice which, if legitimized, would lead to a degradation of societal values.²³

Although there is significant opposition to the physician-assisted suicide movement in this country, many doctors and members of the public appear to support this practice.²⁴ The people of Oregon have voted to legalize physician-assisted suicide in Oregon with the passage of the "Death With Dignity Act."²⁵ Commentators and scholars have opined that physician-assisted suicide of terminally ill patients, which allows them to die with dignity, does not constitute a violation of society's moralistic values.²⁶

Physician-assisted suicide is also supported by the Hemlock Society, whose founder and former Executive Director, Dr. Derek Humphrey, is a staunch advocate of this practice for several social, professional, and medical reasons.²⁷ However, he acknowledges that a physician should assist only in the death of a terminally ill patient who requests assistance.²⁸

Proponents of physician-assisted suicide favor the practice for several reasons. They demand legalization of this practice so that a terminally ill patient may have total control over his or her quality of life.²⁹ This would allow a dying patient to exercise his or her personal liberty, free of any restraint, in requesting assistance in dying.³⁰ Further, a dying patient's choice to request

20. See BARRY R. FURROW ET AL., *HEALTH LAW* §17-69, at 423-24 (1995); Mark E. Chopko & Michael F. Moses, *Assisted Suicide: Still a Wonderful Life?*, 70 NOTRE DAME L. REV. 519, 527 (1995).

21. See FURROW ET AL., *supra* note 20, §17-69, at 423-24.

22. See *id.*

23. See Alison C. Hall, *To Die With Dignity: Comparing Physician Assisted Suicide In the United States, Japan and the Netherlands*, 74 WASH. U. L.Q. 803, 809 (1996) (citing Chopko & Moses, *supra* note 20, at 527).

24. See generally Ronald Kotulak, *Murder Charge Dismissed Against Suicide Doctor*, CHI. TRIB., Dec. 14, 1990, at C1.

25. 13 OR. REV. STAT. § 2.01 (1998).

26. See Note, *supra* note 17, at 2021 n.4 (citing Sidney H. Wanzer, *The Physician's Responsibility Toward Hopelessly Ill Patients: A Second Look*, 320 NEW ENG. J. MED. 844, 848 (1989)); Timothy E. Quill, *Death and Dignity—A Case of Individualized Decision Making*, 324 NEW ENG. J. MED. 691 (1991).

27. See Mangini, *supra* note 6, at 752-53.

28. See *id.*

29. See Hall, *supra* note 23, at 810 (citing John W. Dalbey Donahue, *Physician-Assisted Suicide: A "Right" Reserved Only For the Competent?*, 19 VT. L. REV. 795 (1995)).

30. See *id.*

assistance affects only that patient, and harms no one else.³¹ Finally, it has been argued that a patient's right to self-determination outweighs all other interests.³² It is more humane to relieve patients of suffering and allow them to end their life, particularly when current medical practice supports the patient's right to refuse or withhold treatment or other life-sustaining techniques.³³

Physician-assisted suicide is a topic of national debate, and is charged with emotion. An individual's right to privacy and self-determination has been established by the Supreme Court of the United States, in *Griswold v. Connecticut*³⁴ and *Roe v. Wade*.³⁵ When applied to the issue of physician-assisted suicide, however, these constitutionally guaranteed rights directly conflict with a state's compelling interest in preserving human life, which in turn conflicts with an individual's compelling interest in maintaining dignity, even in death. This conflict has, therefore, created a national controversy which promises to be ensconced in American society for years to come. That being true, the American legal system now faces a time of evaluation and, perhaps, change.

III. PHYSICIAN-ASSISTED SUICIDE IN THE NETHERLANDS

Right-to-die advocates often rely on the practice in the Netherlands as a model for the way in which physician-assisted suicide may be practiced in this country for the benefit of competent, but terminally ill, patients wishing to end their pain and suffering. While physician-assisted suicide has not been legalized under the Dutch penal code and is illegal in the Netherlands, it has been openly practiced there since 1973.³⁶ This practice remains a crime, albeit one that is free from sanctions if performed in accordance with guidelines established by the Dutch courts in 1981.³⁷ Since then, physician-assisted suicide has been practiced according to these guidelines, as interpreted by the Dutch courts and the Royal Dutch Medical Association.

In order to avoid prosecution for physician-assisted suicide, the physician must adhere to the following guidelines designed to protect the interests of the patient: (1) the patient must be experiencing unbearable pain that cannot otherwise be relieved by medical intervention; (2) the patient must be conscious; (3) the patient must make an informed, voluntary, express death

31. *See id.*

32. *See Hall, supra note 23, at 807 n. 24.*

33. *See id.*

34. 381 U.S. 479 (1965).

35. 410 U.S. 113 (1973).

36. *See FURROW ET AL., supra note 20, § 17-70, at 425.*

37. *See International Anti-Euthanasia Task Force, Euthanasia in the Netherlands* (visited Apr. 13, 1999) <<http://www.iaetf.org>> (citing CARLOS GOMEZ, REGULATING DEATH: EUTHANASIA AND THE CASE OF THE NETHERLANDS 32 (1991)) [hereinafter *Euthanasia in the Netherlands*].

request; (4) the patient must be given alternatives to death and time to consider these alternatives; (5) there must be no other reasonable solutions to the patient's problem; (6) the patient's death must not inflict unnecessary suffering on others; (7) more than one person must be involved in the decision, so that the attending physician must consult with another independent physician; (8) only a physician may assist in the patient's death; (9) great care must be taken in making the decision; and (10) the attending physician must report the facts of the patient's case to the coroner.³⁸

While the Royal Dutch Medical Association intended for physicians to assist in the death of only terminally ill patients in unbearable physical pain, these guidelines now also encompass those patients enduring psychological pain. In 1993, a Dutch court acquitted Dr. Chabot, a psychiatrist, who assisted in the suicide of his patient.³⁹ This patient was a fifty year old woman in good physical health, but plagued with feelings of depression over her divorce and the deaths of her two sons.⁴⁰ Dr. Chabot, after consulting with seven other experts, decided to help her end her life by supplying her with a combination of a narcotic, a muscle relaxant, and a sedative hypnotic.⁴¹

The court concluded that the patient's life was unbearable and hopeless, and that even with lengthy treatment, her recovery would have been limited.⁴² The court found Dr. Chabot's indictment to be correct, but declared his actions to be justifiable and necessary in order to put the welfare of his patient above the law.⁴³ Thus, the availability of physician-assisted suicide has not only been provided to patients suffering from intractable physical pain, but has also been extended to patients experiencing psychological pain.

While the guidelines associated with physician-assisted suicide in the Netherlands were intended to protect the patient from making coerced or involuntary requests for death, several scholars and experts suggest that this practice has not been effectively regulated by the guidelines, and that the safeguards have failed to protect patients.⁴⁴ Despite the long-term practice of physician-assisted suicide in the Netherlands, no studies had been conducted to determine the actual nature of the practice. However, in 1990, a Dutch government commission, headed by Dr. Jan Remmelink, undertook a na-

38. See *id.* (citing CARLOS GOMEZ, REGULATING DEATH: EUTHANASIA AND THE CASE OF THE NETHERLANDS 39 (1991)). See also Ezekiel Emanuel, *Whose Right To Die*, THE ATLANTIC MONTHLY, Mar. 1997, at 73.

39. See Herbert Hendin, *Seduced By Death: Doctors, Patients and the Dutch Cure*, 10 ISSUES L. & MED. 123 (1994).

40. See Gene Kaufmann, *State v. Chabot: A Euthanasia Case From the Netherlands*, 20 OHIO N.U. L. REV. 815, 816 (1994).

41. See *id.* at 817.

42. See *id.* at 818.

43. See Hendin, *supra* note 39, at 139.

44. See *id.* See generally Herbert Hendin, *The Slippery Slope: The Dutch Example*, 35 DUQ. L. REV. 427 (1996); *Euthanasia in the Netherlands*, *supra* note 37; John Keown, *Euthanasia in the Netherlands: Sliding Down the Slippery Slope?*, 9 NOTRE DAME J.L. ETHICS & PUB. POL'Y 407 (1995).

tionwide survey to investigate the Dutch euthanasia practice, including the practice of physician-assisted suicide.⁴⁵ The results of this official government study, released in 1991, are commonly referred to as the Rummelink Report.⁴⁶

The Rummelink Report revealed that 25,306 cases of euthanasia occur annually in the Netherlands.⁴⁷ This number accounts for 19.4% of the 130,000 annual deaths in the Netherlands.⁴⁸ While a majority of the euthanasia cases involved situations where life-prolonging treatment was withdrawn or withheld, these 25,306 cases included 2,300 cases of active voluntary euthanasia where each patient's death occurred as a result of the physician administering a lethal means to the patient upon the patient's request.⁴⁹ Also included are 400 cases of physician-assisted suicide in which each patient's death occurred as a result of the physician providing the patient with a lethal means upon the patient's request,⁵⁰ and about 1,000 cases of involuntary euthanasia in which the patients' lives were terminated by their physicians without the patients' knowledge or consent.⁵¹ Of those patients who underwent involuntary euthanasia, 14% were fully competent, 11% were partially competent, and 8% were demented elderly individuals.⁵² Further, of these approximately 1,000 cases of involuntary euthanasia, 72% of the patients had never expressed a desire to terminate their lives,⁵³ and, in 8% of the cases physicians performed involuntary euthanasia despite the existence of other treatment alternatives.⁵⁴

The Rummelink Report also indicated that approximately 22,500 patients died from morphine overdoses.⁵⁵ Of these patients, 8,100 (36% of the cases) were administered morphine, not for palliative purposes, but with the intent to terminate life.⁵⁶ While these figures document the prevalence of euthanasia in the Dutch society, the Rummelink Report does not include cases of euthanasia performed on newborn infants with disabilities, children with life-threatening conditions, psychiatric patients, or patients with AIDS.⁵⁷

Other important findings of the study indicate that about 6,700 requests

45. See, e.g., Paul J. van der Maas et al., *Euthanasia and Other Medical Decisions Concerning the End of Life*, 338 LANCET 996, 672 (1991).

46. See Richard Fenigsen, *The Report of the Dutch Governmental Committee on Euthanasia*, 7 ISSUES L. & MED. 339 (1991) (citations omitted).

47. See *id.*

48. See *id.*

49. See *id.*

50. See *id.*

51. See *id.*

52. See *id.*

53. See *Euthanasia in the Netherlands*, *supra* note 37.

54. See Fenigsen, *supra* note 46, at 343.

55. See *id.*

56. See *id.*

57. See *id.*

for euthanasia are rejected by physicians, which suggests that such requests are not readily granted, but are given serious consideration by the physicians.⁵⁸ The problems associated with physician-assisted suicide thus became apparent with the release of the Rummelink Report. While this report is a critical reservoir of information concerning the practice of assisted death in the Netherlands, it is the data on involuntary euthanasia that raise concern and tend to advocate against legal approval of assisted death in the United States.

The Rummelink Report was updated in 1996.⁵⁹ According to this update, 0.4% of the 9700 assisted suicide requests are acceded to.⁶⁰ Also, 53% of physicians in the Netherlands had participated in physician-assisted suicide in the past, while only 29% of them had assisted within the prior two years.⁶¹ While the 1996 update demonstrated only a minimal increase in the number of assisted death requests, it has been suggested that the problems identified by the Rummelink Report have not been eliminated.⁶²

The 1996 update still showed that there was no decrease in the number of involuntary euthanasia cases, and that involuntary euthanasia was still performed on incompetent patients who could not have expressly and voluntarily requested assistance in dying.⁶³ Another disturbing observation was that in 59% of the assisted death cases physicians did not adhere to the established guidelines.⁶⁴ Next, the update also acknowledged that the practice was being performed on an estimated 10 to 15% of newborns with fatal or severely disabling defects.⁶⁵ Finally, while assisted suicide is available to those in excruciating physical pain, it is also available to those patients who are enduring psychological pain.⁶⁶

Although the practice of physician-assisted suicide is accepted in the Netherlands, there is some concern regarding the factors that motivate a patient to request assistance in dying. Contrary to common perception, pain is not the major motivating factor. Instead, depression, general psychological distress, perceived loss of dignity, feelings of being a burden, and the fear of losing independence appear to be the leading factors.⁶⁷ Another matter of concern is whether the physician has exhausted all other means of palliative respite before acceding to the patient's request for assistance in dying. All these issues are of significant importance when determining the propriety of accepting the practice of physician-assisted suicide as an alternative avail-

58. *See id.*

59. *See Emanuel, supra note 38, at 76.*

60. *See id.*

61. *See id.*

62. *See id. at 77.*

63. *See id.*

64. *See id.*

65. *See id.*

66. *See id. at 78.*

67. *See id. at 75.*

able to patients in the course of their medical care. Attempts to legalize this practice should ensure that these issues are never in conflict with the patients' best interests.

While the Dutch courts and Royal Medical Association have established guidelines for the protection of patients, it appears from the Rammelink Report, and its 1996 update, that the practice of physician-assisted suicide is still fraught with problems. There appears to be wide-spread violation of the safeguards, and a consequent abuse of the practice. To some opponents of physician-assisted suicide, this may suggest that legalization of this practice would be detrimental to society. The resultant problems that have surfaced from the long-term practice of physician-assisted suicide in the Netherlands may provide citizens and lawmakers in the United States an opportunity to preempt those problems and, instead, adopt the successes associated with the Dutch practice.

IV. PHYSICIAN-ASSISTED SUICIDE: CURRENT CASE LAW IN THE UNITED STATES

Physician-assisted suicide is illegal in every state in the United States except Oregon. In June 1997, the United States Supreme Court, in a unanimous decision, held that an asserted right to assistance in committing suicide is not a fundamental liberty interest protected by the due process clause of the United States Constitution.⁶⁸ The Court found the State of Washington's ban on assisted suicide to be rationally related to legitimate government interests.⁶⁹

In *Washington v. Glucksberg*, three terminally ill patients, four physicians, and a nonprofit organization brought action against the State of Washington claiming that a Washington statute banning assisted suicide violated the Due Process clause of the Fourteenth Amendment to the United States Constitution.⁷⁰ The Court held that the ban did not violate the Due Process Clause.⁷¹ The Court stated that assisted suicide bans in this country are long-standing expressions of the states' commitment to the protection and preservation of human life, and that they are consistent and enduring themes of the philosophical, legal, and cultural heritage of this country.⁷² The Court also recognized the refusal of medical treatment as being distinct from the decision to commit suicide with the assistance of another.⁷³

In this case, the Court found that Washington's ban on assisted suicide was rationally related to several legitimate government interests. Included among them is Washington's unqualified interest in the preservation of hu-

68. See *Washington v. Glucksberg*, 521 U.S. 702, 117 S.Ct. 2258 (1997).

69. See *id.* at 2271.

70. See *id.* at 2258.

71. See *id.* at 2261.

72. See *id.* at 2263.

73. See *id.* at 2270.

man life.⁷⁴ The State also has an interest in protecting the integrity and ethics of the medical profession. The Court recognized that physician-assisted suicide could blur the line between healing and harming, and consequently undermine the trust that is essential to the doctor-patient relationship.⁷⁵ Further, “the State has a [strong] interest in protecting vulnerable groups—including the poor, the elderly, and disabled persons—from abuse, neglect, and mistakes.”⁷⁶ According to the Court, these individuals are at the greatest risk of harm as their “autonomy and well-being are already compromised by poverty, lack of access to good medical care, advanced age, or by virtue of being a member of a stigmatized group.”⁷⁷ Finally, the State may have a justifiable fear that legalizing physician-assisted suicide may lead to involuntary euthanasia.⁷⁸ According to the Court, this may be a legitimate concern based upon observations of the practice of euthanasia in the Netherlands. The Court commented that despite the existence of various reporting procedures, abuses continue, with the vulnerable being affected the most.⁷⁹ The Court thus concludes that what is touted as a limited right to assisted suicide may in effect provide a broader than anticipated license to assist in suicide, which would be difficult to police and control.⁸⁰

While it may seem to appear that this Supreme Court ruling has settled the issue of physician-assisted suicide, quite the contrary is true. In fact, the Court decision encourages continued debate about the morality, legality, and practicality of legalizing physician-assisted suicide in the United States.⁸¹ While the Court does not recognize a categorical constitutional right to assisted suicide, Justice Stevens’ concurring opinion states in certain situations, hastening death is a legitimate interest entitled to constitutional protection.⁸² Further, Justice Stevens states that the Court’s holding does not foreclose the possibility that a future plaintiff seeking assistance in dying may prevail in a more particularized challenge of a state’s ban on assisted suicide.⁸³

In a companion case, the United States Supreme Court analyzed equal protection arguments as related to physician-assisted suicide.⁸⁴ In *Vacco v. Quill*, three physicians and three patients brought action against New York

74. See *id.* at 2272 (citing *Cruzan v. Director, Missouri Dep’t of Health*, 497 U.S. 261, 282 (1990)).

75. See *id.* at 2273 (citing *Assisted Suicide in the United States, Hearing before the Subcomm. on the Constitution of the House Comm. on the Judiciary*, 104th Cong., 2d Sess., 355-56 (1996)) (testimony of Dr. Leon R. Kass) [hereinafter *Kass Testimony*].

76. *Id.*

77. *Id.*

78. See *id.* at 2274.

79. See *id.*

80. See *id.*

81. See *id.* at 2275.

82. See *id.* at 2302-05 (Stevens, J., concurring).

83. See *id.* at 2309.

84. See *Vacco v. Quill*, 521 U.S. 793, 117 S. Ct. 2293 (1997).

State's Attorney General, challenging the constitutionality of New York statutes making it a crime to aid a person in committing suicide.⁸⁵ The challenge was based on the claim that New York's ban on assisted suicide violated the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution.⁸⁶ The Court held that New York's prohibition on assisted suicide did not violate the Equal Protection Clause.⁸⁷

The physician respondents claimed that because New York permits a competent patient to refuse life sustaining treatment, the banning of assisted suicide violated the Equal Protection Clause as refusal of medical treatment and assisted suicide were "essentially the same thing."⁸⁸ The Court, however, recognized a distinction between physician-assisted suicide and refusal of unwanted medical treatment, based upon legal traditions and endorsement by the medical profession.⁸⁹ The Court found this "distinction comports with fundamental legal principles of causation and intent."⁹⁰

In focusing on the causation issue, the Court reasoned that "when a patient refuse[d] life-sustaining treatment, [the patient's death results] from an underlying fatal disease or pathology."⁹¹ In a physician-assisted suicide situation, however, the patient ingests a lethal medication which is the cause of the patient's death.⁹² Thus, the causation issue serves to distinguish between refusal of medical treatment and physician-assisted suicide.

The Court also analyzed the issue of intent. The Court stated that "a physician who withdraws, or honors a patient's refusal to begin, life-sustaining treatment . . . intend[s] only to respect the patient's wishes."⁹³ The Court also found the same to be true when a physician administered "aggressive palliative care . . . [which may have] hasten[ed] the patient's death, [because] the physician's purpose and intent [were] only to ease the patient's pain," not to cause death.⁹⁴ According to the Court, physician-assisted suicide, however, "must, necessarily and indubitably, intend primarily that the patient be made dead."⁹⁵ Thus, the intent issue also provides a distinction between refusal of unwanted medical treatment and physician-assisted suicide.

Recognizing a distinction between a patient's right to refuse unwanted medical treatment and the practice of physician-assisted suicide, the Court found no violation of the equal protection clause because New York was en-

85. *See id.*

86. *See id.* at 2295.

87. *See id.* at 2296.

88. *Id.*

89. *See id.* at 2298.

90. *Id.*

91. *Id.*

92. *See id.*

93. *Id.*

94. *Id.* at 2298-99.

95. *Id.* at 2299 (citing *Kass Testimony*, *supra* note 75, at 367).

titled to treat unlike cases differently.⁹⁶ The Court stated that “the Constitution does not require things which are different in fact or opinion to be treated in law as though they were the same.”⁹⁷

Current case law demonstrates adherence to an almost universal tradition which rejects an asserted right to physician-assisted suicide. Further, the Supreme Court’s decision in *Glucksberg* has clearly taken into consideration the possible abuses of this practice, if legalized, even when extensively regulated. While the Supreme Court has not completely foreclosed the possibility of legalization of physician-assisted suicide, it has left that decision to the individual states to legislate and regulate. Therefore, while there is no constitutional right to physician-assisted suicide, it is entirely within each state’s domain to legalize and regulate the practice of physician-assisted suicide within that state. It is clearly within the power of the voters in any state to legalize physician-assisted suicide, and has been so demonstrated by voters in Oregon.

V. OREGON’S “DEATH WITH DIGNITY ACT”

In 1994, Oregon voters approved a physician-assisted suicide law, known as Measure 16 or “Death With Dignity Act.”⁹⁸ This law, which allowed terminally ill patients to end their lives by requesting a physician’s prescription for lethal medication, however, was barred from taking effect because of a constitutional challenge.⁹⁹ Passage of Oregon’s “Death With Dignity Act” (Oregon Act) in November 1997, for the second time, which permitting physician-assisted suicide, has now placed Oregon at the forefront of a national debate regarding this practice.¹⁰⁰

The Oregon Act allows a capable terminally ill adult patient who is a resident of Oregon to initiate a request for lethal medication.¹⁰¹ Specifically, the patient who is determined by the attending physician and the consulting physician to be terminally ill may voluntarily express his or her wish to die by making an oral request, followed by a written request, for lethal medication.¹⁰² Unlike the Dutch practice, assistance in dying will be afforded only to patients suffering from a terminal illness. Patients in psychological pain are not included under the Oregon Act. The Oregon Act also requires that the

96. *See id.* at 2297 (citing *Plyler v. Doe*, 457 U.S. 202, 216 (1982)).

97. *Id.* (quoting *Tigner v. Texas*, 310 U.S. 141, 147 (1940)).

98. 13 OR. REV. ST. § 2.01 (1998).

99. *See Lee v. State of Oregon*, 891 F.Supp. 1421 (D. Or. 1995).

100. *See See International Anti-Euthanasia Task Force, Special Report: Oregon’s Death Wish: The Vote and the Aftermath* (visited Apr. 13, 1999) <<http://www.iaetf.org>>; Goodman, *supra* note 4; *see also Oregon Residents Back Suicide Law*, L.A. DAILY NEWS, Nov. 5, 1997, at N10; Kim Murphy, *Voters in Oregon Soundly Endorse Assisted Suicide*, L.A. TIMES, Nov. 5, 1997, at A1; Brad Cain, *Oregon Suicide Issues Remain, But Lawyers Debate Whether Path is Clear*, THE FRESNO BEE, Nov. 6, 1997, at A6.

101. 13 OR. REV. STAT. § 2.01 (1998).

102. *See id.*

patient's decision be an informed decision.¹⁰³ The written request must be signed and dated by the patient, and witnessed by at least two individuals.¹⁰⁴ Strict requirements and exclusions apply to the choice of witnesses. If the requirements of Section 2.01 of the "Death With Dignity Act" are met, the patient may be prescribed a lethal dose of medication to enable the patient to end his or her life.

According to the Oregon Act, an "adult" is an individual who is at least eighteen years of age, and "capable" is defined as being able to make and communicate health care decisions to health care providers.¹⁰⁵ The "attending physician" is the doctor with primary responsibility for the care and treatment of the patient, while the "consulting physician" is the doctor qualified by specialty or experience to render a professional diagnosis and prognosis about the patient's condition.¹⁰⁶ Further, a "terminal" disease is one that is incurable and irreversible, and that has been medically confirmed to produce the patient's death within six months.¹⁰⁷ An "informed decision" is defined as one made when the patient appreciates the relevant facts after being fully informed by the attending physician of the patient's medical diagnosis and prognosis, as well as the potential risks associated with, and the probable result of, taking the prescribed medication.¹⁰⁸

In order to protect the interests of patients and health care providers, the Oregon Act incorporates a number of safeguards to prevent involuntary suicide requests. First, the attending physician is charged with the duty to fully inform the patient regarding the diagnosis and prognosis, potential risks and probable result of the prescribed medication, and feasible alternatives.¹⁰⁹ This ensures that the patient is being given the relevant information with which to make a reasoned and informed decision. It gives the patient an opportunity to assess his or her pending decision in view of the choices available.

Next, the attending physician is also required to refer the patient to a consulting physician before prescribing lethal medication.¹¹⁰ This clearly prevents one physician from making a unilateral decision regarding prescribing lethal medication. Further, this safeguard provides for an additional evaluation of the patient and his or her decision to end life. The prevalence of involuntary euthanasia, as seen in the Netherlands, would thus be avoided.

Also, the attending and consulting physicians are required to refer the patient to a counselor if either of them is of the opinion that the patient may be suffering from a psychiatric or psychological disorder.¹¹¹ While this pro-

103. *See id.*

104. *See id.*

105. *See id.* § 1.01.

106. *Id.*

107. *Id.*

108. *Id.*

109. *See id.* § 3.01.

110. *See id.* § 3.02.

111. *See id.* § 3.03.

cedure is in the patient's best interest, it appears to be an inadequate safeguard because attending and consulting physicians are not trained to recognize and treat patients with psychiatric or psychological disorders. Further, according to the Rummelink Report, the motivating reasons for many patients who requested assistance in dying were depression and psychological distress.¹¹² Based on this information, it is even more critical that the attending and consulting physicians be required to refer the patient to a psychiatrist or psychologist for further evaluation.

The flaw in this safeguard is that referring the patient to a counselor first requires the attending or consulting physician to identify a psychiatric disorder, which the physician may not be competent to do. Prescribing lethal medication to a patient who has arrived at his or her decision while in a state of psychological distress does not serve the patient's interests. In such an instance, a request for lethal medication is made by an "incapable" patient, and prescribing lethal medication to such a patient would be a violation of the Oregon Act. To prevent the possibility of such a violation, consultation with a psychiatrist should have been included as a mandatory requirement.

Another safeguard is the requirement that the patient make both an oral and a witnessed written request for lethal medication.¹¹³ This procedural requirement forces the patient to evaluate his or her condition and impresses upon the patient the significance of his or her request. This safeguard also provides the health care provider with a record of the patient's wishes to justify prescribing lethal medication.

The patient must also be given the opportunity to rescind his or her request at any time.¹¹⁴ In fact, the attending physician is prohibited from prescribing a lethal dose of medication without offering the patient an opportunity to rescind the prescription request.¹¹⁵ This requirement helps ensure that the patient's request is a voluntary one by allowing the patient an additional opportunity to evaluate the decision and change it if he or she so desires. This clearly protects the best interests of the patient by encouraging the patient to evaluate and reevaluate his or her decision, and also provides the prescribing physician with an unambiguous indication of the voluntary nature of the patient's decision. Additionally, with the satisfaction of knowing that there exists a way out, the patient may even decide to postpone decision-making until later. The right to rescind, as afforded by the Oregon Act, takes this aspect into consideration to better protect the patient.

The Oregon Act also imposes extensive documentation and reporting requirements on patients' medical records.¹¹⁶ This helps ensure that health care providers comply with the Oregon Act, and also facilitates monitoring of physicians' compliance by state health agencies. This, in turn, protects the

112. See Fenigsen, *supra* note 46, at 339.

113. OR. REV. STAT. § 3.06 (1998).

114. See *id.* § 3.07.

115. See *id.*

116. See *id.* §§ 3.09, 3.11.

patients' interests.

While these numerous safeguards are designed to serve the patients' interests and protect against the abuses that have been uncovered in the Netherlands, there still appear to be some flaws that may not necessarily serve the goal of the Oregon Act, which is to provide a dying patient with the right to request lethal medication to end his or her life in a humane and dignified manner. While the Oregon Act is applicable to all residents of Oregon, the requirements of residency in Oregon are not stated. This allows physicians to make determinations of residency, which could allow every citizen in this country to seek relief under this Act regardless of resident status in Oregon. In effect, Oregon would become a haven for terminally ill patients in other states who wish to end their lives, but cannot legally obtain lethal medication in their state.

Next, the Oregon Act allows a physician to prescribe only lethal medication to be taken by the patient without assistance from any third parties.¹¹⁷ This requirement clearly prohibits lethal injection, mercy killing, or active euthanasia.¹¹⁸ While the Oregon Act does not expressly state so, the limitation imposed by this safeguard indicates that the patient may be given only oral medication that he or she can self-administer. That being the case, it is of immense concern that oral medication may not necessarily end the patient's life. In fact, it has been reported that with lethal oral medication, death may take hours, or may not occur at all.¹¹⁹ Patients being administered narcotic pain killers, such as opiates, develop tolerance to the drugs.¹²⁰ Doses of medication given to such patients, therefore, must be determined by experimentation, which would only prolong the patients' suffering. A lethal injection, however, would rapidly achieve blood levels of the medication sufficient to meet the patient's desired end. In such a situation, if the patient is to benefit from the right provided by the Oregon Act in choosing a humane and dignified way to die, lethal injection should be allowed so that the patient does not linger on against his or her wishes.

Also, oral medication may be difficult or impossible for many terminally ill patients to keep down due to nausea and other effects of their diseased states. In such circumstances, lethal injection may be the only alternative for these patients to exercise their rights under the Oregon Act. The Oregon Act, however, does not permit administration of lethal injection, thereby blocking out a segment of the terminally ill population who wishes to end its pain and suffering but cannot because oral lethal medication would

117. See *id.* § 3.14.

118. See *id.*

119. See *International Anti-Euthanasia Task Force, Special Report, Oregon Takes a Closer Look At Assisted Suicide* (visited Apr. 13, 1999) <<http://www.iaetf.org>> (citing B. Coombs Lee et al., *Physician Assisted Suicide*, in 2 OREGON HEALTH L. MANUAL 8-12 (1997)).

120. See D. R. Jasinski, *Tolerance and Dependence to Opiates*, 41 ACTA ANAESTHESIOL. SCAND. 184 (1997).

be almost futile.

Finally, while the Oregon Act provides a terminally ill and capable adult patient the right to request lethal medication, the Oregon Act does not require health care providers to comply with the patient's request. In fact, the Oregon Act clearly states that no health care provider is under any duty to participate in the provision of medication to a patient who desires to end his or her life.¹²¹ Instead, the health care provider who is unable or unwilling to carry out the patient's request is required to transfer the patient and his records to a new health care provider.¹²² This requirement creates a situation where the patient may wish to obtain lethal medication, but will find the right afforded by the Oregon Act to be hollow. The patient will not be able to obtain the requested prescription without delay. This delay, which would be created by his or her transfer to another health care provider, only means that the patient will linger on for some more time and will continue to endure pain. Besides the delay involved with the transfer, the new health care provider may wish to evaluate the patient again because the Oregon Act does not mandate that the new health care provider simply accept the previous physician's evaluation and prescribe the requested medication.

Oregon's "Death With Dignity Act" provides several safeguards against abuse so that the patients' interests are protected. While these procedural requirements will help ensure that the abuses observed in the Dutch system do not pervade the practice of physician-assisted suicide in Oregon, in practice, the various flaws of this legislation may interfere with the patients' right to a humane and dignified end. As the Oregon Act has taken effect in Oregon, it will function as an experiment of physician-assisted suicide practice in the United States. While this legislation will no doubt serve the interests of a majority of qualifying terminally ill patients, legislative modification of this law seems to be inevitable.

VI. ATTEMPTS TO LEGALIZE PHYSICIAN-ASSISTED SUICIDE IN CALIFORNIA

Besides legislatures that have attempted to legalize physician-assisted suicide, public interest groups have advocated to legalize the practice in the United States. In 1988, the Hemlock Society attempted to place an initiative on the California ballot, but was unsuccessful in procuring sufficient support for the initiative.¹²³ Subsequently, in 1992, California's "Death With Dignity Act" was placed on the ballot as Proposition 161.¹²⁴ Although Proposition 161 was popularly supported prior to the vote, it failed to pass. It has been suggested that moral uncertainty and the fear of inadequate safeguards con-

121. See OR. REV. STAT. § 4.01 (1997).

122. See *id.*

123. See Antonios P. Tsarouhas, *The Case Against Legal Assisted Suicide*, 20 OHIO N.U. L. REV. 793, 797 (1993).

124. See *id.*

tributed to the defeat of Proposition 161.¹²⁵

The purpose of California's "Death With Dignity Act" (California Act) was to provide mentally competent terminally ill adults the legal right to voluntarily request and receive a physician's assistance in dying.¹²⁶ The California Act gives a terminally ill patient the freedom of self-determination and the right to choose to eliminate pain and suffering.¹²⁷ Accordingly, a mentally competent terminally ill adult patient could execute a directive governing the administration of aid-in-dying.¹²⁸ This directive had to be in writing, signed by the patient, and witnessed by two adults.¹²⁹ Strict witness requirements were included to protect the patient's interests. Although the California Act imposed certain basic requirements, it was flawed by the lack of procedural requirements designed to protect the patient's interests. Thus, the absence of safeguards left room for abuse.

Unlike the Oregon Act, the California Act did not mandate that the patient's decision be an informed decision. In fact, the text of the California Act was silent regarding the physician's responsibility to explain to the patient the medical diagnosis, prognosis, probable result of lethal medication, and other available alternatives.¹³⁰ According to the California Act, the terminally ill patient had to be competent.¹³¹ This would imply that the patient make an informed decision. Without providing the patient all the relevant information, however, it is impossible to ensure that the decision is an informed one.

Next, the decision to render aid in dying was that of a single physician. The California Act did not require the attending physician to refer the patient to a consulting physician.¹³² This allowed the attending physician to make a unilateral decision. Instead, involving another physician in the consultation would allow for a more confident evaluation of the patient's competence and the voluntary nature of his or her request to end life.

Like the Oregon Act, the California Act did not require that the patient be referred to a psychiatrist or psychologist for evaluation prior to complying with the patient's request. Instead, the attending physician could refer the patient for a psychiatric consultation if the physician had any concerns regarding the patient's competence. Thus, the initial determination of a patient's competence would be made by the attending physician who, in all probability, would have had no training in psychiatry and would, therefore, not be the ideal evaluator of the patient's competence. As observed in the

125. See Eugenie A. Gifford, *Artes Moriendi: Active Euthanasia and the Art of Dying*, 40 UCLA L. REV. 1545, 1547 (1993).

126. See Tsarouhas, *supra* note 123, at 797.

127. See *id.*

128. See *id.*

129. See *id.*

130. See *id.*

131. See *id.*

132. See *id.*

Netherlands, if the patient's request for assistance in dying was rooted in depression or psychological despondency, the patient would be allowed to receive assistance in dying even when he or she was mentally incapable of making such a decision. Such a patient would have had no protection under the California Act. Clearly, this was a serious flaw in the California Act.

Further, like the Oregon Act, the California Act disapproved of mercy killing.¹³³ This provision implied that only those lethal methods could be provided that the patient could self-administer. Thus only a lethal dose of oral medication, which the patient could administer without a physician's assistance, could be prescribed according to the California Act. Oral medication, however, would not assist those patients who were battling serious bouts of nausea due to their illnesses. Also, if the oral medication did not lead to the patient's death, the patient's suffering would continue because administering a lethal injection would violate the California Act. While this may not be regarded as a flaw, it is certainly a shortcoming of a legislation that purported to provide a terminally ill patient the right to choose when to end suffering and pain.

Finally, the California Act allowed any health care provider to refuse to comply with a patient's request for assistance in dying if the provider was religiously, morally, or ethically opposed to participating in such a practice.¹³⁴ In such a situation, the health care provider would be required to transfer the patient to another health care professional. Once again, while this is not necessarily a flaw that raises concerns of possible abuse, it creates the possibility that patients may not be able to exercise their right to choose when to end the suffering brought on by a terminal illness. The delay that would be caused by transfer arrangements would only prolong the patient's suffering.

The California Act did not appeal to the voters, probably because of the various flaws that could be anticipated to surface. While a voluntary and repeated request by the patient was required before the physician could prescribe lethal medication,¹³⁵ the various shortcomings of the California Act would have undoubtedly undermined the ability of patients to request assistance in dying.

Subsequently, in 1996, a team of Hemlock Society members, physicians, lawyers, and academicians drafted the Model State Act to Authorize and Regulate Physician-Assisted Suicide.¹³⁶ The principal purpose of this Act was to enable a terminally ill individual to request and receive assistance from a physician in obtaining the medical means to end his or her life.¹³⁷ Legislators were invited to use this Model Act when formulating the provi-

133. *See id.*

134. *See id.*

135. *See id.*

136. *A Model State Act to Authorize and Regulate Physician-Assisted Suicide* (visited Mar. 21, 1996) <<http://www.finalexit.org>>.

137. *See id.* § 1.

sions of proposed physician-assisted suicide laws.¹³⁸

The Model State Act (Model Act) includes improved provisions compared to the Oregon Act and the California Act. Included are safeguards to protect against involuntary euthanasia, as observed in the Dutch practice, as well as provisions ensuring that the requesting patient's right to request assistance in dying is honored. Like the Oregon Act and the California Act, the Model Act offers physician-assisted suicide only to terminally ill competent adult patients.¹³⁹ It also requires the responsible or attending physician to secure a written opinion from a consulting physician who has evaluated the patient requesting assistance in dying.¹⁴⁰ Further, the health care provider is not required to administer the medical means of suicide to the patient if the provider is conscientiously opposed to such a practice.¹⁴¹

Unlike the Oregon Act and the California Act, however, the Model Act would require the attending physician to also secure a written opinion from a licensed psychiatrist, clinical psychologist, or psychiatric social worker who is qualified to make assessments of the patient's mental state and who has evaluated the patient.¹⁴² This provision is designed to safeguard the patient's interests and ensure that the patient is competent to make a request for a lethal medical means. Thus, a patient who requests assistance in dying while under the influence of depression or psychological distress may be appropriately counseled. This safeguard provides a means to combat the abuse as evidenced in the Dutch practice wherein mentally depressed patients were euthanized because of the lack of psychiatric evaluation by trained psychiatrists.

Further, the Model Act would authorize a physician to provide a qualifying terminally ill patient with a medical means of suicide.¹⁴³ "Medical means of suicide" is defined as medical substances or devices supplied to the patient for the purpose of enabling the patient to end his or her life.¹⁴⁴ The Model Act would also allow the physician to be present and assist the patient at the time the patient makes use of such medical means.¹⁴⁵ These provisions overcome the flaws inherent in the Oregon Act and the California Act. If oral medication proves to be ineffective in carrying out the patient's request, the physician would be authorized to administer to the patient any other medical means, including lethal injection, thus preventing continued suffering of the patient.

Another attempt to legalize physician-assisted suicide in California was made in 1997, with the Proposed Model California Act of 1997 (Proposed

138. *See id.*

139. *See id.* § 3(a).

140. *See id.* § 5(a).

141. *See id.* § 11.

142. *See id.* § 5(b).

143. *See id.*

144. *Id.* § 2(d).

145. *See id.* § 3(b).

California Act).¹⁴⁶ The Proposed California Act maintains provisions common to the Oregon Act and the California Act, but also incorporates some of the provisions of the Model Act. The Proposed California Act requires a second medical opinion, recognizes the dying patient's absolute right to revoke consent to receiving assistance in dying, requires reporting of the assisted death to the State Director of Health Services, and allows health care providers to refuse to assist the patient in dying if they are opposed to such a practice.¹⁴⁷

While the Proposed California Act does not require referral of the patient to a mental health professional, as does the Model Act, it recommends such an evaluation.¹⁴⁸ This would help ensure the mental competency of the patient so that it is certain that a competent patient's request is being complied with. In this manner, three opportunities for evaluation of the patient are afforded to health care providers to ensure that the patient's decision is voluntary, informed, and competent. Because the Proposed California Act does not mandate psychiatric evaluation, there is room for mistake, particularly when the attending and consulting physicians are not competent to make determinations of patients' mental conditions.

The Proposed California Act, like the Model Act, would permit administration of lethal drugs or devices to bring about the patient's death.¹⁴⁹ It states that if the chosen means do not produce death in four hours, other means would be allowed.¹⁵⁰ This provision indicates that if oral lethal medication was futile in achieving the patient's request for death, lethal injection could be administered by the physician. The Proposed California Act, therefore, would permit a physician to administer the lethal means to the patient. Thus, the patient's right to request an end to his or her pain and suffering would not be merely a hollow right.

While the enhanced provisions of the Proposed California Act will guard against some of the abuses prevalent in the Dutch practice, such as involuntary euthanasia, the Proposed California Act is not guaranteed to ensure that the patient's decision is made while he or she is competent. To ensure a competent decision, consultation by a psychiatric professional must be made mandatory, as in the Model Act. Amendment of this provision, to include mandatory evaluation by a psychiatrist or clinical psychologist, would probably make the Proposed California Act more acceptable to voters.

VII. CONCLUSION

Immense pain and suffering, and loss of dignity stemming from the patient's lack of bodily control and autonomy associated with a terminal ill-

146. See Tsarouhas, *supra* note 123, at 799.

147. See *id.*

148. See *id.*

149. See *id.*

150. See *id.*

ness, supports compelling arguments in favor of legalization of physician-assisted suicide. While it is necessary that a patient be given the right to determine when to end pain and suffering, it is also necessary that any legislation legalizing physician-assisted suicide be designed to protect the patient's best interests, and guard against abuse of the practice whereby patients' lives are, in effect, involuntarily terminated. Designing laws in the United States that take into consideration the pitfalls of the Dutch practice will help ensure that only competent and voluntary requests for assistance in dying are complied with. The Oregon Act, Proposed California Act, and Model Act strive to achieve this end by the inclusion of several desirable safeguards. While it may seem almost certain that these acts will need to be amended so as to better serve patients' interests while still guarding against abuses, these acts represent significant strides in favor of establishing a patient's right to autonomy and choice in determining end of life issues.

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