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PHYSICIAN-ASSISTED SUICIDE LEGISLATION: ISSUES AND PRELIMINARY RESPONSES

RUSSELL KOROBKIN*

INTRODUCTION

In long-anticipated decisions, the United States Supreme Court concluded its 1996-97 Term by finding constitutional New York and Washington state laws that criminalize the act of physician-assisted suicide ("PAS"). The Court's unanimous rulings in *Vacco v. Quill*[1] and *Washington v. Glucksberg*[2] do not pass judgment on the ethics or desirability of PAS, but merely express a consensus among a jurisprudentially conservative set of Justices that the United States Constitution has nothing to say about the issue one way or another. The right to die, so says the Court, is a matter for the people and their legislatures, not courts, to debate and resolve. "Throughout the Nation, Americans are engaged in an earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide,"[3] observed Chief Justice William Rehnquist writing for the Court. "Our holding permits this debate to continue, as it should in a democratic society."[4]

In November, 1997, in the wake of the Supreme Court's decisions, citizens of Oregon voted to retain that state's "Death with Dignity Act," an initiative-established PAS law that was narrowly approved by voters in 1994 and tied up in litigation ever since.[5] Oregon was in 1994, and is still today, the only state to have legalized PAS. It is a fair prediction, though, that Oregon will not stand alone for long. In the wake of the Supreme

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1. 117 S. Ct. 2293 (1997).
2. 117 S. Ct. 2258 (1997).
3. *Id.* at 2275.
4. *Id.; see also id.* at 2303 (O'Connor, J., concurring) ("States are presently undertaking extensive and serious evaluation of physician-assisted suicide . . . . the challenging task of crafting appropriate procedures for safeguarding . . . liberty interests is entrusted to the 'laboratory' of the States . . . .").
5. *See, e.g.*, Judith Graham & Judy Peres, *Assisted-Suicide Door Opens Wide*, CHI. TRIB., Nov. 6, 1997, at 1.

Court's recent rulings in *Glucksberg* and *Quill*, and its decision not to review a lower court's decision upholding the Constitutionality of the Oregon Act,[6] legislation seeking to legalize PAS will be proposed and seriously considered during the coming years in virtually every state.

The question of whether or not PAS is sound policy has been considered elsewhere in detail and will not be repeated here. Instead, this article examines the issues that legislation proposing to legalize PAS must confront. The cliché that "the devil is in the details" is true nowhere more than it is in the case of PAS; even if supported in theory by legislative majorities, "right to die" legislation must resolve a series of complex definitional and implementation issues.

In grappling with these issues, policy makers need not etch on a clean slate. Oregon's Death with Dignity Act can serve as a departure for debate, of course, but a surprising number of other proposals have been put forward as well. During the course of calendar-year 1997 alone, legislation designed to legalize PAS was introduced in ten other states. Although none of these bills were voted out of committee, the ten, along with the Oregon Act (collectively the "state bills"), provide context in which to explore the legislative issues that PAS raises.[7] A review of these bills suggests that there are four critical sets of primary issues[8] that PAS legislation must confront: (1) what role physicians will play in PAS, (2) which patients will qualify for PAS, (3) which physicians may aid a patient requesting PAS, and (4) what procedures patients and physicians must follow before PAS can be granted. All of the bills confront these issues to some degree, but none adequately resolve all of the difficult implementation issues. The state bills, then, should serve simultaneously as examples of *how to* and *how not to* establish a PAS regime. They should provide guidance for future legislative initiatives, but none should be seen as a perfected model.

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6. *See* Lee v. Harcleroad, 118 S. Ct. 328 (1997), *denying cert. to* Lee v. Oregon, 107 F. 3d 1382 (9th Cir. 1997) (upholding the constitutionality of the Oregon Death With Dignity Act).

7. In 1998, prior to this article going to press, bills that would legalize physician-assisted suicide were introduced in at least two additional states. *See* H.B. 1433, 155th Leg., Reg. Sess. (N.H. 1998); S.B. 2869, 1997-98 Leg. Sess. (R.I. 1998). These bills do not differ significantly from the bills introduced in 10 states in 1997 that are analyzed in detail in this article.

8. There are also a number of important secondary issues, such as how to monitor and enforce the law's boundaries, but these will not be considered in this article.

I. PHYSICIAN INVOLVEMENT IN DEATH

The most fundamental issue that "right to die" legislation must confront is whether it will be limited to PAS, in which the physician prescribes a lethal dose of medication but the patient must self-administer the dose, or extend to active voluntary euthanasia, in which the physician may administer the lethal dose to the patient who requests death, most likely in the form of a lethal injection. The more limited right to PAS is what the plaintiffs in *Glucksberg* and *Quill* sought; the latter is officially condoned (although technically illegal) in the Netherlands.[9]

The arguments for limiting legislation to PAS tend to be pragmatic in nature.[10] Legalizing voluntary euthanasia (rather than just PAS) would substantially raise the risk that individuals who do not want to die (or, at least, do not express a preference for dying) would be put to death by mistake. Legalizing voluntary euthanasia would also increase the risk of coercion or outright murder of the ill and/or the elderly by rendering it difficult to distinguish involuntary deaths from those that were truly voluntary.[11] The argument for permitting voluntary euthanasia in addition to PAS, in contrast, rests largely on the theoretical principle of horizontal equity—that individuals in "like" circumstances should be treated alike by the law. PAS, by its nature, is restricted to those who are not so ill or incapacitated that they are unable to self-administer the lethal medication. Legalizing PAS but not voluntary euthanasia could be viewed as discriminating against incapacitated individuals, even though they have a moral claim to the right to end their lives that is equally strong (or perhaps even stronger, due to their incapacity) as that of individuals who are not incapacitated.

To date, the pragmatic arguments have prevailed over the theoretical. Of the eleven state bills, ten limit the right to die to PAS, and most of these explicitly state that they do not condone or authorize lethal injection, mercy killing, or active euthana-

9. *See generally* John Keown, *Euthanasia in the Netherlands: Sliding Down the Slippery Slope?*, *in* EUTHANASIA EXAMINED: ETHICAL, CLINICAL AND LEGAL PERSPECTIVES 261 (John Keown ed., 1995) [hereinafter EUTHANASIA EXAMINED].

10. That is, those who oppose active voluntary euthanasia on moral or ethical grounds tend to opposed PAS also and on the same or similar grounds.

11. *See, e.g.*, Keown, *supra* note 9, at 262 (describing the argument that a line between voluntary and involuntary euthanasia would be difficult to maintain in practice); Charles H. Baron et al., *A Model State Act to Authorize and Regulate Physician-Assisted Suicide*, 33 HARV. J. ON LEGIS. 1, 10 (1996) (arguing that restricting legislation to PAS provides "a stronger assurance of the patient's voluntary resolve to die").

sia.[12] The Nebraska bill stands out as distinctly different from the other ten by explicitly permitting voluntary euthanasia. It provides that an individual may provide an "advanced directive" that requests aid-in-dying if he or she becomes terminally ill.[13] "Aid-in-dying" is in turn defined as "the administration by a physician of a lethal injection or a lethal dose of medication that . . . will terminate the life of the declarant in a painless, humane, and dignified manner."[14] The overwhelming support among the state bills for the more limited right to PAS likely reflects a political calculation that the more limited right would generate greater public support. Oregon's Death with Dignity Act as originally drafted would have permitted active voluntary euthanasia, but this provision was dropped by supporters of the initiative, apparently out of fear that it would jeopardize the initiative's chance of passage.[15]

II. QUALIFYING PATIENTS

A. *Health Status*

In *Glucksberg* and *Quill*, the plaintiffs seeking to overturn the Washington and New York laws prohibiting PAS alleged that they were "terminally ill;" that is, that they were told by their doctors that they had only a short time to live.[16] In fact, none of the patients who were plaintiffs when either case was filed survived to hear the Supreme Court render its decisions in those cases.[17] But there is, of course, nothing inherent in the concept of PAS that requires the practice be limited to the terminally ill.[18] In theory, PAS could be made available to all individuals who decide they would prefer death to life, or it could be circumscribed in some way but offered to a broader class of individuals than the

12. *See* OR. REV. STAT. § 127.880 (1995); H.B. 2204, 19th Leg., Reg. Sess. § 17 (Haw. 1997); H.B. 691, 90th Gen. Assembly, 1997-98 Reg. Sess. § 5 (Ill. 1997); H.P. 663, 118th Leg., 2d Reg. Sess. § 5-917(a) (Me. 1997); S.B. 81, 89th Leg., 1997 Reg. Sess. § 8(29) (Mich. 1997); H.B. 109, 64th Biennial Sess. § 2 (Vt. 1997); S.B. 5654, 55th Leg., 1st Reg. Sess. § 23 (Wash. 1997). The Maine bill somewhat contradictorily suggests that a patient who cannot self-administer medication may elect another person to "assist in the administration of medication." Me. H.P. 663 § 5-917(b).

13. *See* L.B. 406, 95th Leg., 1st Reg. Sess. §§ 3(3), 3(11) (Neb. 1997).

14. *Id.* § 3(1).

15. *See* Rita L. Marker & Wesley J. Smith, *The Art of Verbal Engineering*, 35 DUQ. L. REV. 81, 88 (1996).

16. *See* Washington v. Glucksberg, 117 S. Ct. 2258, 2261 n.4 (1997); Quill v. Vacco, 117 S. Ct. 2293, 2296 n.4 (1997).

17. *See Glucksberg*, 117 S. Ct. at 2261; *Quill*, 117 S. Ct. at 2296.

18. *See, e.g.*, Yale Kamisar, *Physician-Assisted Suicide: The Last Bridge to Active Voluntary Euthanasia*, *in* EUTHANASIA EXAMINED, *supra* note 9, at 225, 234.

terminally ill. Limiting a right to PAS to terminally ill patients, at a minimum, raises questions of fairness for chronically – but not terminally—ill patients, especially those experiencing a good deal of suffering as a result of their illnesses.

Model legislation proposed by a group of academicians (the "Harvard Model Law" or "HML") proposes that PAS be available to patients with either a terminal illness or an "intractable and unbearable illness."[19] It defines the latter as a "bodily disorder (1) that cannot be cured or successfully palliated, and (2) that causes such severe suffering that a patient prefers death."[20] While this approach makes an effort to address the equitable claims of the chronically ill to the same treatment as the terminally ill, it does so at the cost of creating a more vague standard for determining which patients are eligible for PAS.

Notwithstanding the academic support for an expansion of PAS to this broader class of individuals, all eleven state bills explicitly limit the availability of PAS to the terminally ill. Most of these (Oregon, Hawaii, Massachusetts, Maine, Nebraska, Wisconsin) define "terminal illness" as a condition that will lead to death within six months, according to reasonable medical prediction.[21] Vermont defines a terminal illness as one that will lead to death within a year;[22] Washington defines such an illness as one that will lead to death within a "reasonable period of time;"[23] and Illinois calls a terminal illness one in which "death is imminent."[24]

As a precaution designed to avoid errant medical determinations that a patient's illness is terminal when in fact there is hope for recovery, all except the Nebraska bill require that, in addition to the patient's treating physician diagnosing the patient's illness as "terminal" under the statute, the treating physician refer the patient to a second "consulting" physician to confirm the terminal nature of the diagnosis. The Massachusetts bill, perhaps in a fit of excessive caution, requires a third confirming opinion as to the terminal nature of the patient's illness.[25]

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19. Baron et al., *supra* note 11, at 26.

20. *Id.* at 25.

21. *See* OR. REV. STAT. § 127.800 (1995); H.B. 2204, 19th Leg., Reg. Sess. § 1 (Haw. 1997); H.P. 663, 118th Leg., 2d Reg. Sess. § 5-902(o) (Me. 1997); H.B. 1543, 181st Gen. Court, 1997 Reg. Sess. § 12DD(i) (Mass. 1997); S.B. 81, 89th Leg., 1997 Reg. Sess. § 8(30)(H) (Mich. 1997); L.B. 406, 95th Leg., 1st Reg. Sess. § 3(11) (Neb. 1997); A.B. 32, 93rd Reg. Sess. § 156.01(17) (Wis. 1997).

22. *See* H.B. 109, 64th Biennial Sess. § 5280(11) (Vt. 1997).

23. S.B. 5654, 55th Leg., 1st Reg. Sess. § 3(8) (Wash. 1997).

24. H.B. 691, 90th Gen. Assembly, 1997-98 Reg. Sess. § 10 (Ill. 1997).

25. *See* Mass. H.B. 1543 § 12GG(a).

B. *Age of the Patient*

All eleven state bills further limit the class of citizens eligible for PAS by specifying that the terminally ill must reach a certain age before qualifying for the procedure. Nine of the bills place the age of consent at 18 (Connecticut, Hawaii, Illinois, Maine, Michigan, Oregon, Vermont, Washington, and Wisconsin), although Illinois would permit an exception for a minor who is legally emancipated.[26] Nebraska would require a patient to be 19 years-old or emancipated,[27] and Massachusetts would require a patient to have reached the age of 21.[28]

Importantly, none of the bills specifies whether a terminally ill patient who has not reached the age of consent is strictly ineligible for PAS, or whether a legal guardian can provide legally valid consent. The failure of the legislation to specify any method by which a minor could become eligible for PAS suggests a legislative intent to exclude all minors. In at least the Illinois and Nebraska bills, however, the exceptions to the age of consent for emancipated minors could be read to imply that parental consent is possible for those who have not reached the appropriate age, because emancipation laws generally permit a minor to exercise rights that otherwise may be exercised by her legal guardian. The Washington bill suggests a contrary position, providing that a "mentally competent adult eighteen years of age or older"[29] may request PAS and then that "no person other than the qualified patient may request aid in dying for the qualified patient."[30] Although this language seems to indicate substituted judgment is prohibited in all cases, it could be read to prohibit substituted judgment only if the patient is mentally competent and has reached the age of majority.

C. *Mental Competence*

Even ardent supporters of PAS agree that the option should not be available to people who are not mentally competent to choose it. But how should the law, substantively and procedurally, attempt to guarantee competence? The inability of the current bills to resolve this issue suggest both its complexity and a need for more attention to be devoted to it in future legislative proposals.

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26. *See* Ill. H.B. 691 § 10.
27. *See* L.B. 406, 95th Leg., 1st Reg. Sess. § 3(2) (Neb. 1997).
28. *See* Mass. H.B. 1543 § 12EE(b)(1).
29. S.B. 5654, 55th Leg., 1st Reg. Sess. § 4(1) (Wash. 1997).
30. *Id.* § 4(2).

1. Substantive Standards

Nine of the state bills create a substantive standard that the patient should not be suffering from a mental disorder or depression that "impairs"[31] or "distorts"[32] the patient's judgment.[33] Unfortunately, none of these attempts to delineate the circumstances under which a patient's judgment would be so impaired or distorted. These "impaired judgment" standards presumably would disqualify delusional patients with no grasp on reality from opting for PAS, and they presumably would not disqualify patients who merely suffer some depression as a direct result of their illnesses (a not unusual circumstance).[34] But the bills offer little if any legal guidance as to how medical personnel should judge circumstances that fall between these polar extremes. What if the patient who, due to an illness-created depression, appears to systematically underweight the positive potential of life but has a general understanding of the pros and cons of continuing to live?

Leaving determinations of whether a patient suffers from impaired judgment to mental health professionals is unlikely to result in a coherent or consistent application of PAS legislation. Except in extreme cases, even such professionals have difficulty determining whether the judgment of seriously medically ill patients is impaired.[35] The failure of the current crop of bills to seriously address the parameters of mental competence to request PAS is perhaps their most serious shortcoming, and future legislative proposals for PAS should include language that provides a more explicit and useful legal standard for judging

31. *See, e.g.*, OR. REV. STAT. § 127.825 (1995); H.P. 663, 118th Leg., 2d Reg. Sess. § 5-906 (Me. 1997).

32. *See, e.g.*, H.B. 691, 90th Gen. Assembly, 1997-98 Reg. Sess. § 25(2) (Ill. 1997).

33. The Washington bill fails to confront the subject of mental competence at all, an obvious shortcoming in that proposal. The Nebraska bill seems quite confused on the subject generally. It specifies that only a "mentally competent" patient may execute an advance directive governing aid-in-dying, *see* L.B. 406, 95th Leg., 1st Reg. Sess. § 4(1) (Neb. 1997), but does not define "mentally competent." Further, it permits an attending physician who receives an aid-in-dying request to request a psychiatric evaluation to determine the patient's mental competence, *see id.* § 13, but "mental competence" appears only to be a requirement at the time the patient issues the advanced directive, not at the time the physician is asked to provide PAS or euthanasia.

34. A majority of patients suffering from advanced forms of cancer have been reported to suffer from psychiatric disorders of some kind. *See* Kathleen M. Foley, *Competent Care for the Dying Instead of Physician-Assisted Suicide*, 336 NEW ENG. J. MED. 54, 56 (1997).

35. *See generally* Linda Ganzini et al., *Attitudes of Oregon Psychiatrists Toward Physician-Assisted Suicide*, 153 AM. J. PSYCHIATRY 1469 (1996).

mental competence. Current proposals, if enacted, would constitute legislative abdication to the medical community of what is – at least in many cases – an ethical determination about what reasons for dying society should validate rather than a medical judgment.

The Massachusetts bill goes one step beyond the others, providing that distorted judgment that would prevent a patient from opting for PAS can be caused not only by mental illness or depression (or by alcohol or substance abuse), but also by "homelessness, financial difficulties, or the absence of health care insurance adequate to defray the cost of continuing health care."[36] This provision raises a troubling question skirted by the other PAS bills: may a patient opt for PAS in part because he fears that continuing to live will create a financial burden for his loved-ones after he dies? It is troubling to think that individuals will be driven by economic concerns to choose PAS, rather than concerns with the quality of life and/or of death; on the other hand, the financial burden that intensive medical care can impose on those who lack either health insurance or substantial personal resources is often quite real, and it would be hard to say that patients who take this into account are behaving irrationally. Although the Massachusetts bill implicates this issue, a textual ambiguity leaves uncertain whether the bill resolves it. The bill's language leaves unclear whether a decision to select PAS due to financial difficulties constitutes "distorted" judgment under the bill (and therefore disqualifies the individual from PAS), or whether financial difficulties are merely a factor that can, in some circumstances, lead to the "distortion" of the patient's judgment (such that he would be disqualified from receiving PAS).

2. Procedural Protections

Following the Harvard Model Law,[37] a minority of PAS proposals (Illinois, Massachusetts, and Maine) would require that a patient seeking PAS obtain a consultation with a mental health professional in order to insure that the patient can pass the "impaired judgment" standard.[38] A majority of existing proposals (Connecticut, Hawaii, Michigan, Oregon, Vermont, and Wisconsin), in contrast, assign to the patient's treating physician the responsibility of determining whether a mental health consulta-

36. H.B. 1543, 181st Gen. Court, 1997 Reg. Sess. § 12EE(b)(3)(A) (Mass. 1997).

37. *See* Baron et al., *supra* note 11, at 29.

38. *See* H.B. 691, 90th Gen. Assembly, 1997-98 Reg. Sess. § 25(2) (Ill. 1997); H.P. 663, 118th Leg., 2d Reg. Sess. § 5-906 (Me. 1997); Mass. H.B. 1543 § 12GG(b).

tion is necessary. Most of these bills are drafted to require the physician to obtain a mental health consultation if he believes a patient may be suffering from a mental disorder or depression that is impairing her judgment.[39] Some of the bills specify that any mental health consult may be with a psychiatrist, clinical psychologist, or social worker,[40] while others require such a consultation to be with a psychiatrist or psychologist.[41] The outlier on this issue is the Washington bill, which fails to provide explicitly for a consultation with a mental health professional under any circumstances – the determination of whether the patient is mentally competent to request PAS is left to the treating physicians.[42]

Requiring mental health consultations for all patients requesting PAS would, of course, increase the procedural red-tape that will no doubt accompany PAS. The cautionary argument for mandatory mental health consultations, however, seems compelling: a patient's treating physician will often have little or no training or experience dealing with clinical depression or other mental health problems, and relying on the judgment of such physicians concerning whether a mental competence evaluation by a trained professional is necessary would probably substantially increase the risk that PAS would be granted to incompetent patients.[43] The case for mandatory mental health consultations is even stronger where proposed legislation formulates a vague substantive standard like "impaired" or "distorted" judgment that would require medical personnel to exercise a

39. *See* OR. REV. STAT. § 127.825 (1995); H.B. 6083, 1997 Reg. Sess. § 4(2) (Conn. 1997); H.B. 2204, 19th Leg., Reg. Sess. § 6 (Haw. 1997); S.B. 81, 89th Leg., 1997 Reg. Sess. § 8(11) (Mich. 1997); H.B. 109, 64th Biennial Sess. § 5284 (Vt. 1997); A.B. 32, 93rd Reg. Sess. § 156.11 (Wis. 1997). The Maine bill merely *permits* (but does not require) the treating physician to refer the patient to a mental health professional in order to insure that the "impaired judgment" test is met. *See* Me. H.P. 663 § 5-906.

40. *See* Conn. H.B. 6083 § 4(2); Me. H.P. 663 § 5-902(f); Mass. H.B. 1543 § 12GG(b).

41. *See* OR. REV. STAT. § 127.800(4); Haw. H.B. 2204 § 1; Mich. S.B. 81 § 8(11); Vt. H.B. 109 § 5280(3); Wis. A.B. 32 § 156.11. A proposed initiative in Michigan would require the consultation be with a licensed psychiatrist. *See* Mich. Initiative § 5676(2)(c).

42. *See* S.B. 5654, 55th Leg., 1st Reg. Sess. §§ 5(1), 5(4) (Wash. 1997).

43. *Cf.* Y. Conwell & E.D. Caine, *Rational Suicide and the Right to Die–Reality and Myth*, 325 NEW ENG. J. MED. 1100 (1991) (reporting that primary care physicians underdiagnose depression in elderly patients); David Clark, *Rational Suicide and People with Terminal Conditions or Disabilities*, 8 ISSUES L. & MED. 147 (1992) (same).

large amount of discretion in making the required competence determinations.[44]

As is the case with the young, none of the eleven state bills explicitly consider whether patients suffering from impaired judgment (and are thus ineligible to opt for PAS) are strictly excluded from receiving PAS, or whether some form of substituted judgment (provided by a guardian preselected by the patient or appointed after the patient becomes incompetent) is possible, although the Washington bill strongly suggests there can be no substituted judgment.[45] Future PAS legislation should explicitly address this question. The problem, though, lacks a simple solution. From perspective of horizontal equity, if PAS is generally available, it would seem unfair to deny some individuals the right solely because they suffer a mental impairment. On the other hand, prudence dictates that legislatures exercise extreme caution when permitting a legal representative of an impaired patient to request PAS on behalf of the patient. The prospect of substituted judgment is especially troubling because most representatives selected by the patient or appointed by a court likely would be relatives with a financial interest in the patient's estate, and therefore have a potential conflict of interest if permitted to make life and death decisions on the patient's behalf.

D. *Residency Requirements*

When Oregon voters enacted that state's Death With Dignity Act, Oregon became the only state to legalize PAS. It was perhaps not surprising, given this fact, that the Act limited eligibility for the procedure to residents of the state.[46] Presumably, the residency provision was added to the initiative to assuage fears that Oregon would be flooded with terminally ill patients from other states who wanted to take advantage of PAS but could not do so at home. The state bills introduced since the enactment of the Oregon initiative have split evenly on the question of whether residency should be required for program eligibility. The Hawaii, Michigan, Vermont, Wisconsin and Maine bills follow Oregon's lead in restricting eligibility to residents[47]; the

44. *Cf.* Donald H.J. Hermann, *The Question Remains: Are There Terminally Ill Patients Who Have a Constitutional Right to Physician Assistance in Hastening the Dying Process*, 1 DEPAUL J. HEATH CARE L. 445, 490 (1997) (recommending that PAS legislation require a determination of mental competence by *two* mental health specialists).

45. *See* Wash. S.B. 5654 §§ 4(1), 4(2).

46. *See* OR. REV. STAT. § 127.800(11).

47. *See* H.B. 2204, 19th Leg., Reg. Sess. § 1 (Haw. 1997) (limiting "qualified patients" to residents of the state); H.P. 663, 118th Leg., 2d Reg. Sess.

Maine bill would require that a patient reside in the state for six months prior to being granted PAS,[48] while the other bills (along with the Oregon Act) do not themselves specify the requirements for residency under the law. The Connecticut, Illinois, Massachusetts, Nebraska and Washington bills, following the lead of the Harvard Model Act, do not contain a residency requirement.

Although a residency requirement is an issue that should be considered when PAS legislation is drafted, it is not obvious why a state that wishes to provide the option of PAS to its own citizens would wish to exclude outsiders, other than as a means of reassuring citizens or legislators with strong reservations about PAS legislation that the procedure would not be administered very often. Unlike welfare benefits that are funded by the state treasury, PAS does not threaten to have a major fiscal impact on the state, unless the state decides independently of its decision to legalize PAS that it will also pay to provide the procedure to some or all of its citizens.[49] It is conceivable that states that enact PAS legislation might see in influx in the number of terminally ill patients who would qualify for Medicaid, and thus an impact on state finances is possible. This potential problem, however, would seem better addressed through limitations on eligibility for Medicaid than through limitations on eligibility for PAS.

In addition, residency requirements in this context are constitutionally suspect. Such provisions are almost certain to be challenged as violating the U.S. Constitution's Privileges and Immunities Clause,[50] and will likely be struck down.

The Supreme Court has established a two-part test for determining whether a state law that discriminates against non-residents of the state violates the Privileges and Immunities Clause. First, courts will consider whether the opportunity denied to non-residents is one that falls within the scope of the clause. If the answer is yes, courts will then ask whether the state has a

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§ 5-902(n) (Me. 1997); S.B. 81, 89th Leg., 1997 Reg. Sess. § 8(5)(C) (Mich. 1997); A.B. 32, 93rd Reg. Sess. § 156.03 (Wis. 1997).

48. *See* Me. H.P. 663 § 5-913.

49. The Oregon Health Services Commission recently decided to fund PAS for its Medicaid clients by categorizing the procedure as covered "comfort care" treatment for terminal illnesses. *See* Steve Woodward, *Oregon Will Cover Assisted Suicide,* PORTLAND OREGONIAN, Feb. 27, 1998, at A1, *available in* 1998 WL 4186822. Under a federal law enacted last year, no federal funds may be used to provide PAS to Medicaid patients. *See* 42 U.S.C. § 14402 (1994 & Supp. IV 1998).

50. *See* U.S. CONST. art. IV., § 2, cl. 1 ("The Citizens of each State shall be entitled to all Privileges and Immunities of Citizens in the several States.").

substantial interest in treating non-residents differently[51] – more specifically, whether non-residents are a "peculiar source of the evil at which the statute is aimed."[52] It seems quite unlikely that a state would be able to demonstrate, under the second prong of the test, that non-residents requesting PAS might present problems not caused by residents who might request PAS.

States more plausibly could argue, under the first-prong of the test, that assisted suicide is not covered by the clause at all. The Privileges and Immunities Clause does not protect non-residents from all forms of discrimination—only discrimination in contexts that are "in their nature, fundamental."[53] In attempting to draw the line between what is sufficiently fundamental for Privileges and Immunities Clause protection and what is not, the Supreme Court has held that states cannot require private employers (even those working under a government contract) to give hiring preference to residents without running afoul of the clause,[54] but they may discriminate against out-of-staters in the granting of licenses for recreational sports, such as hunting and fishing,[55] and they may restrict welfare benefits to residents.[56]

An abortion decision is the precedent closest to being on point. In *Doe v. Bolton*,[57] the U.S. Supreme Court invalidated as a violation of the Privileges and Immunities Clause a Georgia requirement that abortions could be performed only if the woman seeking the procedure was a resident of the state.[58] Importantly, the Court did not defend its decision in *Bolton* on the unique importance of abortion rights. Rather, it held that the Privileges and Immunities Clause must "protect persons who enter Georgia seeking the *medical services* that are available there. . . . A contrary holding would mean that a State could limit to its own residents the general medical care available within its borders. This we could not approve."[59] PAS, where legal, would seem to be a "medical service" that, under *Bolton*, cannot be restricted to state residents. Since Supreme Court jurisprudence has clearly established that the Privileges and Immunities Clause is not so narrow as to require non-discrimination only where con-

51. *See generally* RONALD D. ROTUNDA & JOHN E. NOWAK, 2 TREATISE ON CONSTITUTIONAL LAW: SUBSTANCE AND PROCEDURE 108 (2d. ed. 1992).

52. Toomer v. Witsell, 334 U.S. 385, 398 (1948).

53. Corfield v. Coryell, 6 F. Cas. 546, 551 (C.C.E.D. Pa. 1823).

54. *See* United Bldg. & Constr. Trades Council v. Mayor of Camden, 465 U.S. 208 (1981).

55. *See* Baldwin v. Fish & Game Comm'n, 436 U.S. 371 (1978).

56. *See* ROTUNDA & NOWAK, *supra* note 51, at 109.

57. 410 U.S. 179 (1973).

58. *See id.* at 183-84.

59. *Id.* at 200 (emphasis added).

stitutionally protected rights are at stake,[60] the fact that *Bolton* dealt with the constitutionally-protected right to abortion whereas *Glucksberg* and *Quill* established that PAS is not constitutionally guaranteed is unlikely to save the legality of PAS residency requirements.

III. PHYSICIAN QUALIFICATIONS AND RESPONSIBILITIES

A. *The Prescribing Physician*

Legislation could reasonably limit the class of physicians permitted to provide PAS. Under one theory, PAS is best provided by a physician with a long-standing professional relationship with the patient, ensuring that the physician knows the "whole" patient, not merely the manifestation of a disease process.[61] Under a very different theory, PAS is best provided by physicians skilled in pain management. One claim levied by some opponents of PAS is that the practice would be requested only rarely if terminally ill patients received more skillful treatment for pain.[62] This suggests that such limitations on the provision of PAS could potentially minimize its attractiveness. To date, however, none of the state bills have limited in any meaningful way the class of physicians who may respond to a request for PAS. All of the bills require only that a participating physician be licensed to practice medicine in the state and have some responsibility for the treatment of the terminally ill patient.[63]

A proposed PAS initiative in Michigan, which will be voted on in that state's November 1998 election, takes a positive though incomplete step toward ensuring that physicians who participate in PAS have at least minimal knowledge of modern advances in palliative care. The draft initiative provides that two years after it takes effect physicians that participate in PAS must complete twenty hours of continuing medical education "in the

60. *See* ROTUNDA & NOWAK, *supra* note 51, at 109.

61. *See* Baron et al., *supra* note 10, at 17.

62. *See, e.g.*, Robert G. Twycross, *Where There is Hope There is Life: A View from the Hospice, in* EUTHANASIA EXAMINED, *supra* note 9, at 141 (arguing that adequate pain relief is feasible for virtually all cancer patients, and that among such patients virtually all requests for PAS are due to treatable depressive disorders); *see also* Kamisar, *supra* note 18, at 235-36; American Medical Ass'n Council on Scientific Affairs, *Good Care of the Dying Patient*, 275 JAMA 474, 475 (1996).

63. The Washington bill provides some limitations unrelated to this specific problem, requiring the "attending physician" to not be related to the patient, not be entitled to any portion of the patient's estate, and not have any creditor's claims against the patient. *See* S.B. 5654, 55th Leg., 1st Reg. Sess. §§ 3(2)(a)-(c) (Wash. 1997).

theory and practice of comfort care, hospice care, pain control, sedation coma, removal of nutrition and hydration, psychiatric counseling, and the prescription to medications authorized by this part" in order to renew their licenses,[64] as well as four additional hours of such continuing education at the time of each subsequent license renewal.[65] It is questionable whether these education requirements are sufficiently stringent, but at the very least the initiative's requirements should serve as a starting point for discussion about what specialized training and expertise is appropriate to require of physicians who participate in PAS.

B. *The Qualifications of the Consulting Physician*

As discussed above, ten of the state proposals require at least one "second opinion" to confirm that the patient's condition satisfies the statutory definition of "terminal."[66] The majority of bills provide no firm restrictions on the qualifications of consulting physicians other than that they (like the treating physicians) be licensed to practice medicine in the state. Consistent with the obvious purpose of requiring a second opinion, the Oregon, Connecticut, Hawaii, Maine, Michigan, Vermont, Washington, and Wisconsin bills would require that the consulting physician possess "expertise" or experience in treating the disease that has caused the patient to become terminal and be capable of making a professional diagnosis, but none of the bills define these terms.[67]

The proposed Michigan ballot initiative would provide more structure to the requirements of expertise and experiences by requiring that the consulting opinion be provided by a physician certified as a specialist in the patient's disease by the relevant specialty board, as well as being currently active in that specialty area.[68] If the patient suffers from cancer, the initiative would require that the consulting physician be an oncologist.[69] This more specific definition of expertise is desirable because it removes the uncertainty that would otherwise often surround the question of whether a given physician had the appropriate exper-

64. Mich. Initiative § 5687(1)
65. *See id.* § 5687(2).
66. *See supra* Part II.A.
67. *See* OR. REV. STAT. § 127.800(3) (1995); H.B. 2204, 19th Leg., Reg. Sess. § 1 (Haw. 1997); H.P. 663, 118th Leg., 2d Reg. Sess. § 5-902(d) (Me. 1997); S.B. 81, 89th Leg., 1997 Reg. Sess. § 8(30)(C) (Mich. 1997); H.B. 109, 64th Biennial Sess. § 5280(2) (Vt. 1997); Wash. S.B. 5654 § 3(3); A.B. 32, 93rd Reg. Sess. § 156.09 (Wis. 1997).
68. *See* Mich. Initiative § 5673(D).
69. *See id.* § 5676(2)(D)

tise or experience to serve as a consulting physician—uncertainty that could make potential consulting physicians nervous about assuming that role and/or attending physicians nervous about relying on confirming opinions of consulting physicians.

The Maine and Washington legislative proposals provide an interesting gloss on the role of the consulting physician, perhaps anticipating that these physicians can provide a check on an attending physician's potential conflicts of interest in addition to providing a confirming diagnosis. The Washington bill prohibits practice partners of the attending physician from serving as a consulting physician (although the two physicians may be members of the same health maintenance organization)[70] while the Maine bill provides that the consulting physician "may not be a partner or similar business associate of the attending physician" or even "have an office in the same building as the attending physician."[71]

C. *Physician Presence at the Time of Death*

Dedication to the value of patient care and comfort suggests that the physician who prescribes the lethal dose of medication be permitted to be present when the patient takes her own life.[72] On the other hand, permitting physicians to be present at the time of death risks subtle (and perhaps not so subtle) coercion of patients who have an eleventh-hour inclination to reconsider hastening their deaths. Furthermore, physician attendance at the patient's bedside at the time the patient's life is taken could easily blur the line between PAS and voluntary euthanasia. Despite the firm desire of most of the state bills to prohibit voluntary euthanasia, none of the bills that explicitly address this issue have opted to preclude the attending physician from witnesses a patient's death. Connecticut, Illinois, Massachusetts, Michigan, and Vermont provide that the physician may be present at the time of death.[73] Following the Harvard Model Law,[74] Connecti-

70. *See* Wash. S.B. 5654 § 3(3)(d).

71. Me. H.P. 663 § 5-902(d).

72. *See* Baron et al., *supra* note 10, at 21 ("We hope that the responsible physician will be present at the patient's death in order to reassure the patient and to make certain that the process is carried out effectively.").

73. *See* H.B. 1543, 181st Gen. Court, 1997 Reg. Sess. § 12EE(c) (Mass. 1997) (providing that the responsible physician "may, if the patient so requests, be present at the time that the patient makes use of the means [of death]"); S.B. 81, 89th Leg., 1997 Reg. Sess. § 8(21) (Mich. 1997) (providing that "a person" shall not be subject to liability for "being present when an individual takes medication prescribed to end his or her life . . .").

74. *See* Baron et al., *supra* note 10, at 27.

cut, Illinois and Massachusetts go so far as to state that the physician may "assist" the patient in making use of the means to hasten death, so long as the "actual use" is a "voluntary physical act" of the patient.[75] The Maine bill would go even further, *requiring* the responsible physician to be present when the patient self-administers the lethal medication.[76]

D. *Physicians Who Wish Not to Participate in PAS*

Consistent with the principle of individual autonomy that underlies the argument in favor of PAS, none of the state bills would require that a physician who receives a request for PAS provide the patient with the means of death. The Illinois bill, for example, includes a "Provider's Freedom of Conscience" clause, which explicitly provides that physicians who object to PAS may not be required to participate or aid in PAS.[77]

Freedom of conscience for physicians seems clearly a proper principle for legislation that is ultimately grounded in respect for individual autonomy. But a more difficult question is whether a physician who receives a request for PAS and declines to fulfill the request should have an affirmative duty to refer to the patient to a physician who is willing. To resolve this issue, legislatures must trade-off requiring a doctor who is morally opposed to PAS to assume some complicity in the matter (even if she is absolved from having to write the prescription herself) against the possibility that a terminally ill requesting patient may not have the wherewithal to locate on his own a willing physician.

The majority of bills have not imposed on conscientious objectors an affirmative duty to refer a requesting patient; some are silent on the question,[78] while others affirmatively provide that there is no duty to refer.[79] The Wisconsin bill takes the con-

75. *See* H.B. 691, 90th Gen. Assembly, 1997-98 Reg. Sess. § 15(b) (Ill. 1997).

76. *See* Me. H.P. 663 § 5-904(k).

77. *See* Ill. H.B. 691 § 55; *see also* Me. H.P. 663 § 5-918(d) ("A health care provider is not under a duty, whether by contract, by law or by any other legal requirement, to provide medication to end the patient's life. . ."); Mass. H.B. 1543 § 12MM(a) ("no individual who is opposed to providing a patient with medical means may be required to do so. . .").

78. *See* OR. REV. STAT. § 127.885(4) (1995) (providing that if a physician refuses to grant a PAS request he must transfer "upon request" the patient's medical records); Me. H.P. 663 § 5-918(d) (providing that if a physician refuses to grant a patient's request for PAS and *the patient* transfers to the care of another physician, the initial physician must transfer the patient's medical records); 1997 Mich. S.B. 81 § 8(24) (same); H.B. 109, 64th Biennial Sess. § 5293(d) (Vt. 1997) (same).

79. *See* Mass. H.B. 1543 § 12MM(c).

trary position, however, imposing on an attending physician who declines to fulfill a request for PAS a duty "make a good-faith attempt to transfer the requester's care and treatment to another physician . . . who will comply with the requester's request . . . ."[80] The Washington bill appears to impose the same requirement, although its language is somewhat less clear.[81]

Potentially more significant than whether individual physicians may decline to provide PAS is whether hospitals or other health care organizations can prohibit physicians who use their facilities from providing PAS in those facilities. Here, the institution's claim to the autonomy to decline to participate in PAS can conflict with physician's claims to the autonomy to provide PAS. This theoretical problem is accentuated by the more practical problem that it would often be more difficult for a patient whose request for PAS is denied by an institution to change institutions than it would be for a patient whose request is denied by a physician to switch physicians. On the other hand, however, if institutions are permitted to opt out of PAS, terminally ill patients would have the opportunity to pre-select health care providers based on whether providers will or will not provide PAS.[82] The ability to select an institution that prohibits the practice could provide peace of mind to patients (and their loved ones) who opposed PAS but fear being subjected to an early death because of a mistake, coercion, or loss of mental competence; the ability to select a provider that supports PAS could increase the confidence of patients who strongly favor the practice that, should they ever request PAS, their request would be honored.

Most of the legislative proposals to date grant without comment or explanation the same freedom of conscience to health care facilities as they grant to individual providers,[83] and in so doing fail to confront the arguments against facility freedom that are not applicable to provider freedom. The Illinois and Massachusetts bills tangentially touch on this problem by providing that a health care facility may prohibit its staff members from providing PAS if it gives reasonable notice of the policy to the

80. A.B. 32, 93rd Reg. Sess. § 156.07(9) (Wis. 1997).

81. *See* S.B. 5654, 55th Leg., 1st Reg. Sess. § 11 (Wash. 1997).

82. In the Netherlands, health care facilities may opt-out of practicing voluntary euthanasia, and it is not uncommon for hospitals or nursing care facilities to advertise whether they will or will not provide this service. *See* RICHARD A. EPSTEIN, MORTAL PERIL: OUR INALIENABLE RIGHT TO HEALTH CARE? 324-25 (1997).

83. *See* H.B. 2204, 19th Leg., Reg. Sess. §§ 1, 18(4) (Haw. 1997); H.P. 663, 118th Leg., 2d Reg. Sess. §§ 5-902(g), 5-919(d) (Me. 1997); Mich. S.B. 81 §§ 8(24), 8(30)(D); *see also* Wash. S.B. 5654 § 14(1)(b) (health care facility may discipline employee who acts contrary to facility's policy).

staff members.[84] The notice requirement is useful, but the bills are still deficient on this issue because they do not require that notice of a facility's "no-PAS" policy be given to patients. They are further deficient because their text leaves unclear whether a physician with staff privileges constitutes a "staff member" under the statutes and can thus be prohibited by a facility from providing PAS, or whether such a physician, as an independent contractor, would be unaffected by the provision.

The Michigan ballot initiative best addresses these problems and strikes a balance between the needs of health care facilities and patients by permitting facilities to prohibit PAS but only if it (1) provides notice of its policy to the public as well as its staff, (2) transfers patients to facilities that do permit PAS within 48 hours of a patient's request for PAS, and (3) does not attempt to prohibit its staff from providing PAS *outside* the facility.[85]

IV. THE PATIENT'S REQUEST FOR PAS

PAS legislation offers individuals the choice of ending their lives in certain situations, thus promoting individual autonomy; its greatest challenge is protecting the autonomy of those who do not wish to take advantage of this option. There is nearly universal agreement that responsible PAS legislation must ensure that decisions to opt for PAS are informed, thoughtfully considered, and fully voluntary. The irreversible nature of PAS counsels that legislation, in so doing, should err on the side of excessive caution. Protection of patients *from* PAS can come in three forms: (1) protection from a mistake or administrative error that results in PAS being administered by accident; (2) protection from the coercive or undue influence of third parties who have their own interests rather than the patients interests at heart; and (3) protection from the patient herself, who might opt for PAS out of a lack of information or to satisfy a fleeting desire even when doing so comes at the expense of a contrary, more stable preference for continued life. Request procedures, waiting periods, informed consent provisions, and witness requirements each can offer one or more of these types of protections.

A. *Request Procedures*

Perhaps the most feared types of harm that can result from the legalization of PAS are innocent miscommunications, in which the physician mistakenly believes that the patient has

84. *See* H.B. 691, 90th Gen. Assembly, 1997-98 Reg. Sess. § 55(b) (Ill. 1997); Mass. H.B. 1543 § 12MM(b).

85. *See* Mich. Initiative §§ 5688(6)(A)-(C).

requested PAS, and physicians taking it upon themselves to hasten death when the patient cannot or does not request it. Limiting right-to-die legislation to PAS, in which the patient must self-administer the lethal dosage of medication, rather than permitting active voluntary euthanasia, reduces the likelihood that either type of harm will result in a fatality, but this precaution is not foolproof: an elderly or ill patient is likely to take the medication that his doctor prescribes without questioning the prescription. All of the state bills place requirements on the method of requesting PAS and/or the number of requests required, safeguards which can be understood as reducing the potential for fatal error or overreaching.

All eleven state bills provide that at least one request for PAS made by a patient to her attending physician must be recorded in some way. Most of the bills (Oregon, Hawaii, Maine, Michigan, Nebraska,[86] Vermont, Wisconsin, Massachusetts) require that a request be made in writing. This approach provides a safeguard against mistaken administration of PAS, but it does so at the risk of excluding from PAS patients too ill to place their request in writing.[87] The Connecticut, Illinois, and Washington bills avoid this problem by providing the patient with the option of recording her request on video tape instead of placing it in writing.[88] The video-tape option, which gives the patient flexibility in how to make her request for PAS without reducing the protection against error or overreaching, seems quite appropriate. Nine of the bills (all except Connecticut and Nebraska) provide an additional safeguard against mistaken administration of PAS by requiring the patient to request PAS on at least two separate occasions,[89] although all of these permit one of the requests to be oral. It is not clear why, if at least two different requests must

86. The Nebraska bill requires an advanced directive for voluntary euthanasia, which must be in writing. *See* L.B. 406, 95th Leg., 1st Reg. Sess. § 3(3) (Neb. 1997).

87. The Washington bill permits a patient to designate a representative to sign the written request if the patient is unable to do so. *See* Wash. S.B. 5654 § 4(4). This procedure eliminates the concern that the incapacitated will not be able to request PAS, but it creates additional concerns as to the voluntariness of requests.

88. *See* H.B. 6083, 1997 Reg. Sess. § 2(a)(3)(D) (Conn. 1997); Wash. S.B. 5654 § 4(5). The Illinois bill would permit the actual requests for PAS to be made orally, but would require the physician to document and hold discussion with the patient that covers all the information the patient would need to make an informed choice of PAS and to document that discussion either on videotape or in a writing signed by the patient. *See* Ill. H.B. 691 § 20(4)(C)(1).

89. The Massachusetts bill requires a request be made on three separate occasions. See Mass. H.B. 1543 § 12EE(b)(3)(D). Wisconsin and Vermont would require two oral requests and one written request. *See* H.B. 109, 64th

be made, the bills do not require them both to be in the same medium. If a second request is in fact an important safeguard,[90] the marginal inconvenience of requiring that request to be in writing or on videotape seems quite small.

B. *Waiting Periods*

Requiring that requests for PAS be made in writing or on video tape reduces the likelihood of administrative error leading to an unwanted administration of PAS, but this safeguard does not protect patients from hastily electing PAS when their preference for death might be transitory rather than stable. The nine bills that require at least two requests for PAS attempt to mitigate this risk by mandating a minimum waiting period between the time that the requests are made. All but one bill require a waiting period of 14 or 15 days,[91] a seemingly minimal period of enforced reflection, considering the finality of a patient's decision to choose PAS. The Washington bill is an outlier on this issue, require a waiting period of only 72 hours between the two patient requests that are required before a physician can prescribe a lethal dose of medication.[92]

C. *Informed Consent*

In attempts to insure that patient requests for PAS are not only stable but also well-informed, all of the bills except for Nebraska's specify certain information that must be communicated by the attending physician to the patient before the patient's request may be honored. All ten of these require that

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Biennial Sess. § 5287 (Vt. 1997); A.B. 32, 93rd Reg. Sess. § 156.13(3) (Wis. 1997).

90. The second request requirement can be seen as means to require a waiting period between the time the patient requests PAS and when it is administered, an issue discussed below, rather than as a safeguard that protects against involuntary PAS. However, waiting periods could be created merely by requiring time to elapse between a single PAS request and the physician's provision of a prescription. There is nothing inherent in the concept of waiting periods that requires multiple requests.

91. *See* Ill. H.B. 691 § 15(a)(3)(D) (14 days); Mass. H.B. 1543 § 12EE(d) (same); OR. REV. STAT. § 127.850 (1995) (15 days and at least 48 hours after the written request is made); H.B. 2204, 19th Leg., Reg. Sess. § 11 (Haw. 1997); H.P. 663, 118th Leg., 2d Reg. Sess. §§ 5-909, 5-911 (Me. 1997) (same); Vt. H.B. 109 § 5289 (same); Wis. A.B. 32 §§ 156.07(7)(b), 156.13(3)(b) (same). The Michigan bill states that the patient shall repeat his request for PAS "within" (rather than "no sooner than") 15 days of the initial request, *see* S.B. 81, 89th Leg., 1997 Reg. Sess. § 8(7) (Mich. 1997), but also provides that "at least 15 days shall elapse between the patient's initial oral request and the writing of a prescription . . . ." *Id.* § 8(15).

92. *See* Wash. S.B. 5654 § 4(3).

the physician review with the patient her diagnosis, prognosis, and other available medical options—the Washington bill requires that the consulting physician do so as well.[93] The majority of bills also explicitly require the attending physician to review with the patient options for palliative care including hospice and/or pain control possibilities (Oregon, Illinois, Hawaii, Maine, Michigan, Vermont, Washington, Wisconsin).[94] In an apparent attempt to ensure that this information is not only communicated by the physician but also understood by the patient, many of the bills require that the patient's written request for PAS (or videotaped request, where applicable) include a recitation that the physician has discussed the required issues with him.[95]

While all of the bills require the attending physician to present the patient with certain types of information that might dissuade her from PAS prior to granting her request, the Massachusetts legislation is unique in requiring the attending physician to refer the patient elsewhere for such information. That legislation would require the physician to refer a requesting patient to a social worker (or equivalent) "to determine whether services are available to the patient that could improve the patient's circumstances sufficiently to cause the patient to reconsider his or her request. . ."[96] The Illinois bill requires the physician to "offer" the patient the opportunity for this type of consultation,[97] but its language lacks the implication carried by the Massachusetts bill that the patient must agree to the consultation before the physician may administer PAS.

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93. *See id.* § 5(5).

94. *See* OR. REV. STAT. § 127.815(e) (1995); Ill. H.B. 691 § 20(1); Haw. H.B. 2204 § 4(2)(E); Me. H.P. 663 § 5-904(c)(5); Mich. S.B. 81 § 8(9)(B)(v); Vt. H.B. 109 § 5280(6)(E); Wash. S.B. 5654 §§ 5(2), 5(5), 5(8); Wis. A.B. 32 § 156.07(2)(e).

95. *See, e.g.*, Me. H.P. 663 § 5-920 (requiring that the request for PAS must include statements that the physician has explained to the patient her diagnosis, prognosis, alternative treatments (including hospice and comfort care), and that the patient makes the request voluntarily and with the understanding that she may revoke the request at any time); Haw. H.B. 2204 § 21 (substantively identical); Mass. H.B. 1543 § 12FF(d)(3) (requiring the responsible physician to document in writing (signed by the patient and witnesses) or by audio or video tape (during which both the patient and the witnesses are present) the content of his discussion with the patient of the patient's prognosis and treatment options); Ill. H.B. 691 § 20(4)(C) (requiring the physician to document the informed consent discussion with a writing signed by the patient or a videotape of the discussion).

96. Mass. H.B. 1543 § 12FF(b).

97. *See* Ill. H.B. 691 § 20(2).

D. *Witness Requirements*

All eleven bills require that the patient's written or taped request for PAS be witnessed. Most agree that a minimum of two witnesses must observe this request, although the Wisconsin bill would require three and the Connecticut bill only one.[98] All of the bills specify that at least one witness (and in most cases both witnesses) may not be entitled to "any portion" of the patient's estate either by will or by operation of law, and all but the Washington bill specify that at least one (and in most cases both) may not be employed by the hospital or other organization providing care or residence to the patient.[99] Nine bills would require that at least one of the witnesses (and in most cases both witnesses) may not be related to the patient[100] (Connecticut and Massachusetts lack this restriction), and a smaller majority of the bills would also disqualify the attending physician as a witness.[101] While the majority of bills require witnesses to observe the patient's request, the Massachusetts and Illinois bills go further by requiring the witnesses to observe the physician's informed consent discussion with the patient.[102] This latter approach would appear to be helpful not only in reducing the risk of patient misunderstanding or patient/physician miscommunication, but also in assuring that the patient's choice of PAS is an informed and considered one.

The bills diverge in their specification of what precisely the witness must attest to, and thus, implicitly, what harms the witness requirement is intended to protect against. All of the bills presume that the witnesses will attest that the patient actually

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98. *See* Wis. A.B. 32 § 156.05(1)(c).

99. *See* OR. REV. STAT. § 127.810(2)(c); Haw. H.B. 2204 § 3(b); Ill. H.B. 691 § 20(4)(A); Me. H.P. 663 § 5-903(b)(1); Mass. H.B. 1543 § 12FF(d)(1); Mich. S.B. 81 § 8(8); L.B. 406, 95th Leg., 1st Reg. Sess. § 4(2) (Neb. 1997); Vt. H.B. 109 § 5281(b); Wis. A.B. 32 § 156.05(2)(a). The Washington bill specifies that no witness may be the attending physician or "an employee of the attending physician," Wash. S.B. 5654 § (4)(5)(d), but employees of hospitals or other health care facilities are not expressly precluded from serving as witnesses.

100. *See* OR. REV. STAT. § 127.810(2)(a); Haw. H.B. 2204 § 3(b). Under the Maine, Nebraska, Vermont, Washington, and Wisconsin bills, neither witness may be related to the patient. *See* Me. H.P. 663 § 5-903(b)(1)(i); Neb. L.B. 406 § 4(1)(a); Vt. H.B. 109 § 5281(b)(1); Wash. S.B. 5654 § 4(5)(a); Wis. A.B. 32 § 156.05(2)(a)(1).

101. *See* OR. REV. STAT. § 127.810(3); Haw. H.B. 2204 § 3(c); Me. H.P. 663 § 5-903(b)(2); Vt. H.B. 109 § 5281(b)(4); Wash. S.B. 5654 § (4)(5)(d); Mass. H.B. 1543 § 12FF(d)(1) (requiring that at least one of two witnesses not be "affiliated with any person that is involved in the care of the patient").

102. *See* Ill. H.B. 691 §§ 20(4)(A), 20(4)(C); Mass. H.B. 1543 § 12FF(d)(1).

made the request for PAS, but a minority also include provisions requiring witnesses to certify that the patient's election was voluntary and did not result from coercion or undue influence.[103] While these provisions are laudatory in their effort to protect vulnerable patients from feeling pressured to "choose" PAS, the guidance that they provide to potential witnesses is troublingly vague: none specifies what would constitute "coercion," "undue influence," or lack of "voluntariness." If a witness believes that a patient's decision to elect PAS was influenced by the request of emotionally or financially exhausted family members, for example, could the witness appropriately certify that the patient was not the subject of undue influence or coercion? The lack of clarity on this point is a major weakness in all of the bills proposed to date.

None of the proposed bills adequately addresses another complication caused by the witness requirements: there will inevitably be patients who wish to request PAS who have no disinterested friends to serve as witnesses. The restrictions on witness service of relatives, individuals with a financial interest in the patient's estate, employees of the health care organization caring for the patient, and the attending physician, would severely restrict many patients' likely witness pools. This could, perhaps, render a lack of available, qualified witnesses a fairly common stumbling block to the administration of PAS. Restrictions that prevent representatives of the health care organization providing care from serving as witnesses are particularly troublesome in this regard, as they make uncertain whether a health care provider may even recruit disinterested non-employees to serve as witnesses for PAS requests. Terminally ill patients who are bedridden and do not have family or friends to call on might have few other options for locating individuals to witness their requests.

The Oregon, Hawaii, and Maine bills partially address this problem by providing that if the patient is a resident of long-term care facility, the facility may designate (with some restrictions) one of the necessary witnesses,[104] but this provision, of course, only helps certain patients, and at best only solves "half" the problem of locating two witnesses. The Wisconsin bill would establish a class of persons called "patient's advocates" who may potentially constitute all of a patient's witnesses, but this provision, too, would only apply to residents of nursing homes or

103. *See* Haw. H.B. 2204 § 3(a); Me. H.P. 663 § 5-903(b); Mich. S.B. 81 § 8(8).

104. *See* OR. REV. STAT. § 127.810(4); Haw. H.B. 2204 § 21; Me. H.P. 663 § 5-903(b)(3).

other residential-care facilities.[105] Although the motivations for strict limitations on who may serve as witnesses of PAS requests are understandable, there is no evidence that the costs associated with such limitations have been considered in the process of drafting existing PAS proposals. Future proposals should consciously seek to balance the protection *from* PAS that witness limitations provide against risk that preventing conflicts of interests on the part of witnesses can also effectively deprive some patients with strong moral claims to PAS of the procedure.

CONCLUSION

As advocates of PAS take their battle to state legislatures in the wake of the Supreme Court's determination that the issue should be resolved in the political rather than the legal arena, they will have to move beyond high-level arguments for autonomy in life and dignity in death. Legislative recognition of PAS must be proceeded by the resolution of a series of difficult implementation issues that PAS would create. Recent attempts to legalize PAS by statute, along with the Oregon Death with Dignity Act, can serve as a starting point for these discussions and debates. The body of proposed legislation on the subject is helpful in identifying the key implementation issues; it is often far from successful in resolving those issues at a satisfactory level of specificity. For a PAS regime to succeed in practice, future legislation must surpass the existing proposed legislation in its ability to resolve these difficult implementation issues.

105. *See* Wis. A.B. 32 §§ 156.05(2)(b), 156.19.