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**PHYSICIAN-ASSISTED DEATH
LEGISLATION: ISSUES AND
PRELIMINARY RESPONSES**


by

Russell Korobkin

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Physician-Assisted Death Legislation: Issues and Initial Responses

In two landmark rulings issued in the summer of 1997, the Supreme Court determined that legislators, not courts, should determine whether physician-assisted death should be permitted. Oregon is currently the only state in which physician-assisted death is legal, but at least 10 other states considered (but did not enact) bills in 1997 that would legalize the practice, and many more are certain to revisit the issue in upcoming years in light of the Supreme Court's rulings. This paper examines the key problems that legislation to establish physician-assisted death must confront -- that is, the important implementation issues that are nearly always ignored in the broader debate over the morality and efficacy of physician-assisted death. As a point of reference, the paper reviews, contrasts, and critiques the Oregon assisted suicide law and the 10 proposals recently considered in other states.

PHYSICIAN-ASSISTED DEATH LEGISLATION: ISSUES AND PRELIMINARY RESPONSES

Russell Korobkin *

Introduction

In long-anticipated decisions, the United States Supreme Court concluded its last term by finding Constitutional New York and Washington state laws that criminalize the act of physician-assisted death ("PAD"). 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 PAD, 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 High Court, is a matter for the people and their legislatures, not courts, to debate and resolve.

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This paper was prepared as a companion to the audiotape discussion of physician-assisted suicide released as part of the IGPA "Policy Soundings" series. Comments to the author are invited: Prof. Russell Korobkin, University of Illinois Institute of Government and Public Affairs, 1007 W. Nevada Street, Urbana, IL 61801; internet: korobkin@law.uiuc.edu.

¹ 117 S.Ct. 2293 (1997).

² 117 S.Ct. 2258 (1997).

In November, 1997, the citizens of Oregon responded to the Supreme Court's return of the issue to the states by voting to retain that state's "Death with Dignity Act," an initiative-established PAD law that was narrowly approved by voters in 1994 and tied up in litigation ever since.³ Oregon was in 1994, and is still today, the only state to have legalized PAD. It is a fair prediction, though, that Oregon will not stand alone for long. In the wake of the Supreme Court's recent rulings, legislation seeking to legalize PAD will be proposed and seriously considered during the coming years in virtually every state.

The question of whether or not PAD 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 PAD must confront. The cliché that "the devil is in the details" is true nowhere more than it is in the case of PAD; 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 1997 alone, legislation designed to legalize PAD 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 PAD raises. A review of these bills suggests that there are four critical sets of

³ See, e.g., Judith Graham and Judy Peres, *Assisted-Suicide Door Opens Wide*, CHI. TRIB., Nov. 6, 1997, at sec. 1, 1.

substantive issues⁴ that PAD legislation must confront: (1) what role physicians will play in PAD, (2) which patients will qualify for PAD, (3) which physicians may aid a patient requesting PAD, and (4) what procedures patients and physicians must follow before PAD 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 PAD regime. They should provide guidance for future legislative initiatives, but none should be seen as a perfected model.

Legislative Issues, State Responses

I. Physician Involvement in Death.

The most fundamental issue that “right to die” legislation must confront is whether it will be limited to PAD, 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 PAD is what the plaintiffs in *Glucksberg* and *Quill* sought; the latter is officially condoned (although technically illegal) in the Netherlands.⁵

The arguments for limiting legislation to PAD tend to be pragmatic in nature.⁶ Legalizing voluntary euthanasia (rather than just PAD) would substantially raise the risk

⁴ There are also important *procedural* issues, such as how to monitor and enforce the law’s boundaries, that will not be considered here.

⁵ 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).

⁶ That is, those who oppose active voluntary euthanasia on moral or ethical grounds tend to oppose PAD also and on the same or similar grounds.

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.⁷ The argument for permitting voluntary euthanasia in addition to PAD, in contrast, rests largely on the theoretical principle of horizontal equity--that individuals in "like" circumstances should be treated alike by the law. PAD, 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 PAD 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.⁸

To date, the pragmatic arguments have prevailed over the theoretical. Of the eleven state bills, ten limit the right to die to PAD, and most of these explicitly state that they do not condone or authorize lethal injection, mercy killing, or active euthanasia.⁹ 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.¹⁰ "Aid-in-dying"

⁷ See, e.g., Keown, *supra* note 5 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. LEG. 1, 10 (1996) (arguing that restricting legislation to PAD provides "a stronger assurance of the patient's voluntary resolve to die").

⁸ See Franklin G. Miller, et al., *Regulating Physician-Assisted Death*, 331 N.E.J.M. 119 (1994).

⁹ OR Act § 3.14; 1997 IL H.B. 691 § 5; 1997 HI H.B. 2204 § 17; 1997 ME H.B. 663 § 5-917(A); 1997 MI S.B. 81 § 8(29); 1997 VT H.B. § 2; WA S.B. 5654 § 23. The Maine bill somewhat contradictorily suggests that patient who cannot self-administer medication may elect another person to "assist in the administration of medication." 1997 ME H.B. 663 § 5-917(B).

¹⁰ 1997 NE L.B. 406 § 3(3), 3(11).

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.”¹¹ The overwhelming support among the state bills for the more limited right to PAD 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.¹²

Legislation that distinguishes between assisted suicide and voluntary euthanasia invites a Constitutional challenge on the grounds that it discriminates against patients on the basis of the logically irrelevant difference in their ability to self-administer a lethal dosage of medication, but such a challenge is unlikely to succeed.¹³ When legislation distinguishes between two classes of individuals and neither has been identified as a “suspect class” (i.e. racial minorities), the equal protection clause of the Constitution’s 14th Amendment is satisfied if the distinction merely “bears a rational relation to some legitimate [governmental] end,”¹⁴ traditionally an easy hurdle for legislation to clear. Proponents of legislation limited to assisted suicide can contend that the distinction between PAD and euthanasia serves a state’s interest in protecting vulnerable individuals from an unwanted death, which is more likely to result if euthanasia is permitted than if only assisted suicide is allowed. Such a distinction is almost certain to pass the very minimal “rationality review” that courts are likely to give it.

¹¹ *Id.* § 3(1).

¹² See Rita L. Marker and Wesley J. Smith, *The Art of Verbal Engineering*, 35 DUQUESNE L. REV. 81, 88 (1996).

¹³ But see Jack Schwarz, *Writing the Rules of Death: State Regulation of Physician Assisted Suicide*, 24 J. L. MED. & ETHICS 207, 211 (1996) (suggesting that the “illogic[al]” distinction between assisted suicide and euthanasia is unlikely to survive judicial review).

¹⁴ *Quill*, 117 S.Ct. at 2297 (quoting *Romer v. Evans*, 116 S.Ct. 1620, 1627 (1996)).

II. Qualifying Patients

1. Health Status

In *Glucksberg* and *Quill*, the plaintiffs seeking to overturn the Washington and New York laws prohibiting PAD alleged that they were “terminally ill”; that is, that they were told by their doctors that they had only a short time to live.¹⁵ 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.¹⁶ But there is, of course, nothing inherent in the concept of PAD that requires the practice to be limited to the terminally ill.¹⁷ In theory, PAD could be made available to all individuals who decide they would prefer death to life, it could be circumscribed in some way but offered to a broader class of individuals than the terminally ill, or it could be circumscribed and offered to a class of individuals that excluded the terminally ill.

Model legislation proposed by a group of academicians (the “Harvard Model Law” or “HML”) proposes that PAD be available to patients with either a terminal illness or an “intractable and unbearable illness.”¹⁸ 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.”¹⁹ Notwithstanding the academic support for an expansion of PAD to this broader class of individuals, all eleven state bills explicitly limit the availability of PAD to the terminally ill. Most of these (Oregon, Hawaii, Massachusetts,

¹⁵ *Glucksberg*, 117 S.Ct. at 2261-62; *Quill*, 117 S.Ct. at 2296.

¹⁶ *Glucksberg*, 117 S.Ct. at 2261; *Quill*, 117 S.Ct. at 2296.

¹⁷ See, e.g., Yale Kamisar, *Physician-Assisted Suicide: The Last Bridge to Active Voluntary Euthanasia*, in *EUTHANASIA EXAMINED: ETHICAL, CLINICAL, AND LEGAL PERSPECTIVES* 225, 234 (John Keown, ed. 1995).

¹⁸ Baron, *supra* note 7, (§ 3(a)(2)).

¹⁹ *Id.* at 25 (§ 2(d)).

Maine, Nebraska, Wisconsin) define "terminal illness" as a condition that will lead to death within six months, according to reasonable medical prediction.²⁰ Vermont defines a terminal illness as one that will lead to death within a year;²¹ Washington defines such an illness as one that will lead to death within a "reasonable period of time,"²² and Illinois calls a terminal illness one in which "death is imminent."²³

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.²⁴

2. Age of the Patient.

All eleven state bills further limit the class of citizens eligible for PAD 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.²⁵ Nebraska would

²⁰ OR Act § 1.01(12); 1997 ME H.B. 691 § 5-902(O); 1997 HI H.B. 2204 § 1; 1997 MI S.B. 81 § 30(H); 1997 MA H.B. 1543 § 12DD(I); 1997 WI A.B. 32. §. 156.01(17); 1997 NE L.B. 406 § 3 (11).

²¹ 1997 VT H.B. 109 § 5280(11).

²² 1997 WA S.B. 5654 § 3(8).

²³ 1997 IL H.B. 691 § 10.

²⁴ 1997 MA H.B. 1543 § 12GG(a).

²⁵ 1997 IL H.B. 691 § 10.

require a patient to be 19 years-old or emancipated,²⁶ and Massachusetts would require a patient to have reached the age of 21.²⁷

Importantly, none of the bills specify whether a terminally ill patient who has not reached the age of consent is strictly ineligible for PAD, 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 PAD 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” may request PAD and then that “no person other than the qualified patient may request aid in dying for the qualified patient.”²⁸ Although this language seems to indicate substitutive judgment is prohibited, it could be read to prohibit substitutive judgment only if the patient is mentally competent and has reached the age of majority.

3. Mental Competence.

Even ardent supporters of PAD 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 suggests both its complexity and a need for more attention to be devoted to it in future legislative proposals.

²⁶ 1997 NE L.B. 406 § 3(2).

²⁷ 1997 MA H.B. 1543 § 12EE(b)(1).

²⁸ WA S.B. 5654 § 4(1), (2).

a. 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”²⁹ or “distorts”³⁰ the patient’s judgment.³¹ Unfortunately, none of these attempt 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 PAD, and they presumably would not automatically disqualify patients who suffer some depression as a direct result of their illnesses (a not unusual circumstance³²). 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, for example, 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 PAD legislation. Except in extreme cases, even such professionals have difficulty determining whether the judgment of seriously medically ill patients is impaired.³³ The

²⁹ See, e.g., OR Act § 3.03; 1997 ME H.B. 663 § 5-906.

³⁰ See, e.g. 1997 IL H.B. 691 § 25(2).

³¹ The Washington bill fails to confront the subject of mental competence at all, an obvious shortcoming in that proposal. The Nebraska bill is seems quite confused on the subject generally. It specifies that only a “mentally competent” patient may execute an advance directive governing aid-in-dying, 1997 NE L.B. 406 § 4(1), 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, 1997 NE L.B. 406 § 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 PAD or euthanasia.

³² 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, *Editorial: Competent Care for the Dying Instead of Physician-Assisted Suicide*, 336 N.E.J.M. 54, 56 (1997).

³³ See L. Ganzini, et al., *Attitudes of Oregon Psychiatrists Toward Physician -Assisted Suicide*,

failure of the current crop of bills to seriously address the parameters of mental competence to request PAD is perhaps their most serious shortcoming, and future legislative proposals for PAD should include language that provides a more explicit and useful legal standard for judging mental competence. Current proposals, if enacted, would constitute legislative abdication 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 PAD 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.”³⁴ This provision raises a troubling question skirted by the other PAD bills: may a patient opt for PAD 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 PAD, 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 PAD due to financial difficulties constitutes “distorted” judgment under

153 AM. J. PSYCHIATRY 1469 (1996); *see also* Carl H. Coleman & Alan R. Fleischman, *Guidelines for Physician-Assisted Suicide: Can the Challenge Be Met?*, 24 J. L. MED. & ETHICS 217, 221 (1996) (concluding that “it is doubtful that this line will be drawn consistently from one case to the next”).

³⁴ 1997 MA H.B. 1543 § 12EE(a)(3)(A).

the bill (and therefore disqualifies the individual from PAD), 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 PAD).

b. Procedural Protections.

Following the Harvard Model Law,³⁵ the Illinois, Massachusetts, and Maine bills would require that a patient seeking PAD obtain a consultation with a mental health professional in order to insure that the patient can pass the “impaired judgment” standard.³⁶ Connecticut, Hawaii, Michigan, Oregon, Vermont, and Wisconsin, in contrast, assign to the patient’s treating physician the responsibility of determining whether a mental health consultation is necessary. Most of these bills are drafted to require the physician to obtain a mental health consult if he believes a patient may be suffering from a mental disorder or depression that is impairing her judgment.³⁷ Some of the bills specify that any mental health consult may be with a psychiatrist, clinical psychologist, or social worker,³⁸ while others require such a consult to be with a psychiatrist or psychologist.³⁹ 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 PAD is left to the treating physicians.⁴⁰

³⁵ Baron, et al., *supra* note 7, at 29 (5(b)).

³⁶ 1997 MA H.B. 1543 § 12GG(b); 1997 ME H.B. 663 § 5-906; 1997 IL H.B. 691 § 25(2).

³⁷ OR Act § 3.03; 1997 HI H.B. 2204 § 6.; 1997 MI S.B. 81 § 11; 1997 WI A.B. 32 § 156.11; 1997 VT H.B. 109 § 5284; 1997 CT H.B. 6083 § (4)(2). 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. 1997 ME H.B. 663 § 5-906.

³⁸ 1997 ME H.B. 663 § 5-902(F); 1997 MA H.B. 1543 § 12GG(b); 1997 CT H.B. 6083 § 4(2).

³⁹ OR Act § 1.01(4); 1997 HI H.B. 2204 § 1; 1997 MI S.B. 81 § 11; 1997 WI A.B. 32 § 156.11; 1997 VT H.B. 109 § 1(3). A proposed initiative in Michigan would require the consultation be with a licensed psychiatrist. MI Initiative § 5676(2)(c).

⁴⁰ See WA S.B. § 5(1), (4).

Requiring mental health consultations for all patients requesting PAD would, of course, increase the procedural red-tape that will no doubt accompany PAD. 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 PAD would be granted to incompetent patients.⁴¹

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 PAD) are strictly excluded from receiving PAD, or whether some form of substitutive 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 substitutive judgment.⁴² Future PAD legislation should explicitly address this question. The problem, though, lacks a simple solution. From the perspective of horizontal equity, if PAD 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 PAD 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

⁴¹ Cf. Y. Conwell and E. D. Caine, *Rational Suicide and the Right to Die—Reality and Myth*, 325 N.E.J.M. 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 IN L. & MED. 147 (1992) (same).

⁴² WA S.B. § 4(1),(2).

permitted to make life and death decisions on the patient's behalf. It bears noting, however, that despite the same possible abuses associated with substitutive decision making, surrogates are currently permitted (under certain circumstances) to request the withdrawal of life support systems from incapacitated patients.⁴³

4. Residency Requirements.

When Oregon voters enacted that state's Death With Dignity Act, Oregon became the only state to legalize PAD. It was perhaps not surprising, given this fact, that the Act limited eligibility for the procedure to residents of the state.⁴⁴ 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 PAD 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 residents⁴⁵; the Michigan and Maine bills would require that a patient reside in the state for 6 months prior to being granted PAD,⁴⁶ 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 Law, do not contain a residency requirement.

Although a residency requirement is an issue that should be considered when PAD legislation is drafted, it is not obvious why a state that wishes to provide the option

⁴³ See generally Coleman & Fleischman, *supra* note 33, at 220-21.

⁴⁴ OR Act § 1.01(11).

⁴⁵ 1997 ME H.B. 663 § 5-902(N); 1997 HI H.B. 2204 § 1 (limiting "qualified patients" to residents of the state); 1997 MI S.B. 81 § 8(5)(C); 1997 WI A.B. 32 § 156.03

⁴⁶ 1997 ME H.B. 663 § 5-913.

of PAD to its own citizens would wish to exclude outsiders, other than as a means of reassuring citizens or legislators with strong reservations about PAD legislation that the procedure would not be administered very often. Unlike welfare benefits that are funded by the state treasury, PAD does not threaten to have a major fiscal impact on the state. It is conceivable that states that enact PAD legislation might see an influx 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 PAD.

In addition, residency requirements in this context are Constitutionally suspect. While it is unclear how Constitutional challenges to residency provisions would ultimately be resolved, such provisions are almost certain to be challenged as violating the U.S. Constitution's privileges and immunities clause.⁴⁷

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 substantial interest in treating non-residents differently⁴⁸ – more specifically, whether non-residents are a “peculiar source of the evil at which the statute is aimed.”⁴⁹ In the context of residency requirements for PAD, it is the former inquiry that is likely to present the difficult question (it seems quite unlikely that a state would be able to demonstrate, under the second prong of the test, that non-residents

⁴⁷ 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.”).

⁴⁸ See generally, RONALD D. ROTUNDA & JOHN E. NOWAK, 2 TREATISE ON CONSTITUTIONAL LAW: SUBSTANCE AND PROCEDURE 108 (2d. ed, 1992).

⁴⁹ *Toomer v. Witsell*, 334 U.S. 388, 396 (1948).

requesting PAD might present problems not caused by residents who might request PAD.)

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.”⁵⁰ Although this standard is exacting, it is not so strict as to require non-discrimination only where Constitutionally protected rights are at stake,⁵¹ so the Supreme Court’s rulings in *Glucksberg* and *Quill* that PAD is not guaranteed by the Constitution do not resolve the question of whether non-residents are protected by the privileges and immunities clause from discrimination in PAD legislation. 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,⁵² but they may discriminate against out-of-staters in the granting of licenses for recreational sports, such as hunting and fishing,⁵³ and they may restrict welfare benefits to residents.⁵⁴ While residency requirements in PAD legislation seem to bear an important similarity to resident preferences in private employment legislation, in the sense that employment and death are both central issues in every individual’s life, the High Court has never invoked the privileges and immunities clause to protect non-residents in the context of a law relating to death or to privacy, rather than one related to economic activity or commerce.

⁵⁰ *Corfield v. Coryell*, 6 Fed. Cas. 546, 551 (E.D. Pa. 1823).

⁵¹ ROTUNDA & NOWAK, *supra* note 46, at 109.

⁵² *United Building and Construction Trades Council v. Camden*, 465 U.S. 208 (1981).

⁵³ *Baldwin v. Fish and Game Comm’n of Montana*, 436 U.S. 371 (1978).

⁵⁴ *See* ROTUNDA & NOWAK, *supra* note 46, at 109.

III. Physician Qualifications and Responsibilities

1. The Prescribing Physician

Legislation could reasonably limit the class of physicians permitted to provide PAD. Under one theory, PAD is best provided by a physician with a longstanding professional relationship with the patient, ensuring that the physician knows the “whole” patient, not merely the manifestation of a disease process.⁵⁵ Under a very different theory, PAD is best provided by physicians skilled in pain management. One claim levied by some opponents of PAD is that the practice would be requested only rarely if terminally ill patients received more skillful treatment for pain.⁵⁶ This suggests that such limitations on the provision of PAD could potentially minimize its attractiveness. Even most supporters of PAD believe that attempts at palliative care should be exhausted before assisted suicide is considered.⁵⁷ To date, however, none of the state bills has limited in any meaningful way the class of physicians who may respond to a request for PAD, or even would require a consultation with a palliative care specialist before PAD is provided, as one group of commentators has proposed.⁵⁸ 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.⁵⁹

⁵⁵ See Baron, et al, *supra* note 7, at 17.

⁵⁶ See, e.g., Robert G. Twycross, *Where There is Hope There is Life: A View from the Hospice*, in EUTHANASIA EXAMINED: ETHICAL, CLINICAL, AND LEGAL PERSPECTIVES 141 (John Keown, ed. 1995) (arguing that adequate pain relief is feasible for virtually all cancer patients, and that among such patients virtually all requests for PAD are due to treatable depressive disorders); see also Kamisar, *supra* note 16, at 235-36; American Medical Ass’n Council on Scientific Affairs, *Good Care of the Dying Patient*, 275 J.A.M.A. 474, 475 (1996);.

⁵⁷ See, e.g., Franklin G. Miller, et al., *Can Physician-Assisted Suicide Be Regulated Effectively?*, 24 J. L. MED. & ETHICS 225, 225 (1996).

⁵⁸ *Id.* at 226 (“The most important safeguard is consultation with an independent physician, skilled in palliative care...”); see also Miller, et al., *supra* note 8.

⁵⁹ 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. WA S.B. § 3(2)(a)-(c).

A proposed PAD initiative in Michigan, which supporters are currently attempting to qualify for the state ballot, takes a positive though incomplete step toward ensuring that physicians who participate in PAD 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 PAD must complete 20 hours of continuing medical education “in the 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,⁶⁰ as well as four additional hours of such continuing education at the time of each subsequent license renewal.⁶¹ 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 PAD.

2. 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.”⁶² 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

⁶⁰ MI Initiative § 5687(1)

⁶¹ MI Initiative § 5687(2).

⁶² See Part II(1), *supra*.

capable of making a professional diagnosis, but none of the bills define these terms.⁶³ The proposed Michigan ballot initiative would provide more structure to the requirements of expertise and experience 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.⁶⁴ If the patient suffers from cancer, the initiative would require that the consulting physician be an oncologist.⁶⁵ 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 expertise or experience to serve as a consulting physician -- uncertainty that could make potential consulting physicians nervous about assuming that role and/or attending physicians reluctant to rely on confirming opinions of consulting physicians.

The Maine and Washington bills 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)⁶⁶ 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."⁶⁷

⁶³ OR Act § 1.01(3); 1997 ME H.B. 663 §. 1(D); 1997 HI H.B. 2204 § 1; 1997 MI S.B. 81 § 8(30)(C); 1997 WI A.B. 32 § 156.09.; 1997 VT H.B. 109 § 5280(2); 1997 WA S.B. 5654 § 3(3).

⁶⁴ MI Initiative § 5673(D).

⁶⁵ MI Initiative § 5676(2)(D)

⁶⁶ 1997 WA S.B. 5654 § 3(c)(d).

⁶⁷ 1997 ME H.B. 663 § 1(D).

3. 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.⁶⁸ 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 PAD 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 witnessing a patient's death. Connecticut, Illinois, Massachusetts, Michigan, and Vermont provide that the physician may be present at the time of death.⁶⁹ Following the Harvard Model Law,⁷⁰ Connecticut, 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.⁷¹ The Maine bill would go even further, requiring the responsible physician to be present when the patient self-administers the lethal medication.⁷²

⁶⁸ See Baron, et al., *supra* note 7, 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.").

⁶⁹ 1997 MA H.B. 1543 § 12EE(c) (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]"); 1997 MI S.B. 81 § 8(21) (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 . . .").

⁷⁰ Baron et al., *supra* note 7, at 27 (§ 3(b)).

⁷¹ 1997 IL H.B. 691 § 15(b).

⁷² 1997 ME H.B. 663 § 5-904(K).

4. Physicians Who Wish Not to Participate in PAD.

Consistent with the principle of individual autonomy that underlies the argument in favor of PAD, none of the state bills would require that a physician who receives a request for PAD 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 PAD may not be required to participate or aid in PAD.⁷³

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 PAD 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 PAD 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,⁷⁴ while others affirmatively provide that there is no duty to refer.⁷⁵ The Wisconsin bill takes the contrary position, however, imposing on an attending physician who declines to fulfill a

⁷³ 1997 IL H.B. 691 § 55; *see also* 1997 ME H.B. 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. . .”); 1997 MA H.B. 1543 § MM (a) (“no individual who is opposed to providing a patient with medical means may be required to do so. . .”).

⁷⁴ OR Act § 4.01(4) (providing that if a physician refuses to grant a PAD request and he must transfer “upon request” the patient’s medical records); 1997 ME H.B. 663 § 5-918(D)(providing that if a physician refuses to grant a patient’s request for PAD and *the patient* transfers to the care of another physician, the initial physician must transfer the patient’s medical records); 1997 MI S.B. 81 § 8(24) (same); 1997 VT H.B. 109 § 5293(D) (same).

⁷⁵ 1997 MA H.B. 1543 § MM(c).

request for PAD 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”⁷⁶

The Washington bill appears to impose the same requirement, although its language is somewhat less clear.⁷⁷

Potentially more significant than whether individual physicians may decline to provide PAD is whether hospitals or other health care organizations can prohibit physicians who use their facilities from providing PAD in those facilities. Here, the institution’s claim to the autonomy to decline to participate in PAD can conflict with physician’s claims to the autonomy to provide PAD. This theoretical problem is accentuated by the more practical problem that it would often be more difficult for a patient whose request for PAD 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 PAD, terminally ill patients would have the opportunity to pre-select health care providers based on whether providers will or will not provide PAD. The ability to select an institution that prohibits the practice could provide peace of mind to patients (and their loved ones) who opposed PAD 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 PAD could increase the confidence of patients who strongly favor the practice that, should they ever request PAD, 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,⁷⁸ and in so doing fail to confront the arguments against facility freedom that

⁷⁶ 1997 WI A.B. 32 § 156.07(9)

⁷⁷ 1997 WA S.B. 5654 § 11.

⁷⁸ 1997 MI S.B. 81 § 8(24) and § 8(30)(D) (defining “health care provider”); 1997 HI H.B. 2204 sec. 18(4) and sec. 1 (defining “health care provider”); 1997 ME H.B. 663 § 5-919(D) and § 5-

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 PAD if it gives reasonable notice of the policy to the staff members.⁷⁹ This 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-PAD" 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 PAD, 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 PAD 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 PAD within 48 hours of a patient's request for PAD, and (3) does not attempt to prohibit its staff from providing PAD *outside* the facility.⁸⁰

IV. The Patient's Request for PAD

PAD 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 PAD legislation must ensure that decisions to opt for PAD are informed, thoughtfully considered, and fully voluntary. The irreversible

902(G) (defining "health care provider"); see also WA S.B. 5654 § 14(b) (health care facility may discipline employee who acts contrary to facility's policy).

⁷⁹ 1997 MA H.B. 1543 § MM(b); 1997 IL H.B. 691 § 55(b).

⁸⁰ MI Initiative § 5688(6)(A)-(C).

nature of PAD counsels that legislation, in so doing, should err on the side of excessive caution. Protection of patients *from* PAD can come in three forms: (1) protection from a mistake or administrative error that results in PAD 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 PAD 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.

1. Request Procedures.

Perhaps the most feared types of harm that can result from the legalization of PAD are innocent miscommunications, in which the physician mistakenly believes that the patient has requested PAD, and physicians taking it upon themselves to hasten death when the patient cannot or does not request it. Limiting right-to-die legislation to PAD, 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 PAD and/or the number of requests required, safeguards that can be understood as reducing the potential for fatal error as well as overreaching.

All eleven state bills provide that at least one request for PAD made by a patient to her attending physician must be recorded in some way. Most of the bills (Oregon, Hawaii, Maine, Michigan, Nebraska,⁸¹ Vermont, Wisconsin, Massachusetts) require that

⁸¹ The Nebraska bill requires an advanced directive for voluntary euthanasia, which must be in writing. 1997 NE L.B. 406 § 3(3).

a request be made in writing. This approach provides a safeguard against mistaken administration of PAD, but it does so at the risk of excluding from PAD patients too ill to place their request in writing.⁸² 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.⁸³ The video-tape option, which gives the patient flexibility in how to make her request for PAD 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 PAD by requiring the patient to request PAD on at least two separate occasions,⁸⁴ although all of these permit one of the requests to be oral. It is not clear why, if at least two different requests must 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,⁸⁵ the marginal inconvenience of requiring that request to be in writing or on videotape seems quite small.

⁸² The Washington bill permits a patient to designate a representative to sign the written request if the patient is unable to do so. WA S.B. § 4(4). This procedure eliminates the concern that the incapacitated will not be able to request PAD, but it creates additional concerns as to the voluntariness of requests.

⁸³ 1997 WA S.B. 5654 § 4(5); 1997 CT H.B. 6083 § 2(a)(3)(D). The Illinois bill would permit the actual requests for PAD to be made orally, but would require the physician to document a hold discussion with the patient that covers all the information the patient would need to make an informed choice of PAD and to document that discussion either on videotape or in a writing signed by the patient. 1997 IL H.B. § 20(4).

⁸⁴ The Massachusetts bill requires a request be made on three separate occasions. 1997 MA H.B. 1543 § 12EE(D); Wisconsin and Vermont would require two oral and one written requests. 1997 WI A.B. 32 § 156.13(3); 1997 VT H.B. 109 § 5287.

⁸⁵ The second request requirement can be seen as means to require a waiting period between the time the patient requests PAD and when it is administered (an issue discussed, *infra*), rather than as a safeguard that protects against involuntary PAD. However, waiting periods could be created merely by requiring time to elapse between a single PAD request and the physician's provision of a prescription. There is nothing inherent in the concept of waiting periods that requires multiple requests.

2. Waiting Periods.

Requiring that requests for PAD be made in writing or on video tape reduces the likelihood of administrative error leading to an unwanted administration of PAD, but this safeguard does not protect patients from hastily electing PAD when their preference for death might be transitory rather than stable. The nine bills that require at least two requests for PAD 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,⁸⁶ a seemingly minimal period of enforced reflection, considering the finality of a patient's decision to choose PAD. 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.⁸⁷

3. Informed Consent.

In attempts to insure that patient requests for PAD 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 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.⁸⁸ 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,

⁸⁶ 1997 IL H.B. 691 § 15(a)(3)(D); 1997 MA H.B. 1543 § 12EE(D) (14 days); OR Act § 3.08 (15 days and at least 48 hours after the written request is made); 1997 ME H.B. 663 § 5-909, 5-911 (same); 1997 HI H.B. 2204 § 11 (same); 1997 WI A.B. 32 § 156.07(7)(b) & 156.13(3)(b) (same); 1997 VT H.B. 109 § 5289 (same). The Michigan bill states that the patient shall repeat his request for PAD "within" (rather than "no sooner than") 15 days of the initial request, 1997 MI S.B. 81 § 8(7), but also provides that "at least 15 days shall elapse between the patient's initial oral request and the writing of a prescription...." *Id.* at § 8(15).

⁸⁷ 1997 WA S.B. 5654 § 4(3).

⁸⁸ 1997 WA S.B. 5654 § 5(5).

Vermont, Washington, Wisconsin).⁸⁹ In order to guarantee 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 PAD (or videotaped request, where applicable) include a recitation that the physician has discussed the required issues with them.⁹⁰

While all of the bills require the attending physician to present the patient with certain types of information that might dissuade her from PAD 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. . ."⁹¹ The Illinois bill requires the physician to "offer" the patient the opportunity for this type of consultation,⁹² but its language lacks the implication carried by the Massachusetts bill that the patient must agree to the consultation before the physician may administer PAD.

⁸⁹ OR Act § 3.01(e); 1997 IL H.B. 691 § 20(1); 1997 ME H.B. 663 § 5-904(C)(5); 1997 MI S.B. 81 § 8(9)(B)(V); 1997 HI H.B. 2204 § 4(E); 1997 WI A.B. 32 § 156.07(2)(e); 1997 VT H.B. 109 § 1(6)(E); 1997 VT H.B. 109 § 5282(E); 1997 WA S.B. 5654 § 5(2), (5), (8).

⁹⁰ *See, e.g.*, 1997 ME H.B. 663 § 5-920 (requiring that the request for PAD 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); 1997 HI H.B. 2204 § 21 (substantively identical); 1997 MA 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); 1997 IL H.B. 691 § 20(c) (requiring the physician to document the informed consent discussion with a writing signed by the patient or a videotape of the discussion).

⁹¹ 1997 MA H.B. 1543 § 12FF(b).

⁹² 1997 IL H.B. 691 § 20(2).

4. Witness Requirements.

All eleven bills require that the patient's written or taped request for PAD 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.⁹³ 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.⁹⁴ Nine bills would require that at least one of the witnesses (and in most cases both witnesses) not be related to the patient⁹⁵ (Connecticut and Massachusetts lack this restriction), and a smaller majority of the bills would also disqualify the attending physician as a witness.⁹⁶ 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.⁹⁷ This latter approach would appear to be helpful not only in reducing the risk of patient

⁹³ 1997 WI A.B. § 156.05(1)(c).

⁹⁴ OR Act § 2.02(2)(c); 1997 ME H.B. 663 § 5-903(B)(1); 1997 HI H.B. 2204 § 3(b); 1997 MI S.B. 81 § 8(8); 1997 MA H.B. 1543 § 12FF(d)(1); 1997 IL H.B. 691 § 20(4)(A); 1997 WI A.B. 32 § 156.05(2)(a); 1997 NE L.B. 406 § 4(2); 1997 VT H.B. 109 § 5281(B). The Washington bill specifies that no witness may be the attending physician or "an employee of the attending physician," 1997 WA S.B. 5654 § (4)(5)(d), but employees of hospitals or other health care facilities are not expressly precluded from serving as witnesses.

⁹⁵ OR Act § 2.02(2)(a); 1997 HI H.B. 2204 § 3(b). Under the Maine, Nebraska, Vermont, Washington, and Wisconsin bills, neither witness may be related to the patient. 1997 ME H.B. 691 § 5-903(B)(1)(I); 1997 NE L.B. 406 § 4(2); 1997 WI A.B. 32 § 156.05(2)(1); 1997 VT H.B. 109 § 5281(B); 1997 WA S.B. 5654 § 4(5)(a).

⁹⁶ OR Act § 2.02(3); 1997 ME H.B. 663 § 5-903(B)(2); 1997 HI H.B. 2204 § 3(C); 1997 VT H.B. 109 § 5281(B)(4); 1997 WA S.B. 5654 § (4)(5)(d); 1997 MA 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").

⁹⁷ 1997 MA H.B. 1543 § 12FF(d)(1); 1997 IL H.B. 691 § 20(4)(A), 20(4)(C).

misunderstanding or patient/physician miscommunication, but also in assuring that the patient's choice of PAD 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 made the request for PAD, 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.⁹⁸ While these provisions are laudatory in their effort to protect vulnerable patients from feeling pressured to "choose" PAD, the guidance that they provide to potential witnesses is troublingly vague: none specify what would constitute "coercion," "undue influence," or lack of "voluntariness." If a witness believes that a patient's decision to elect PAD 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 address another complication caused by the witness requirements: there will inevitably be patients who wish to request PAD 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 PAD. 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-

⁹⁸ 1997 ME H.B. 663 § 5-903(b); 1997 HI H.B. 2204 § 3(a); 1997 MI S.B. 81 § 8(8).

employees to serve as witnesses for PAD 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,⁹⁹ 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 other residential-care facilities.¹⁰⁰

Conclusion

As advocates of PAD 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 PAD must be preceeded by the resolution of a series of difficult implementation issues that PAD would create. Recent attempts to legalize PAD by statute, along with the Oregon Death with Dignity Act, can serve as a starting point for these discussions and debates. While the body of proposed legislation on the subject is helpful in identifying what the key implementation issues are, it is often far from successful in resolving those issues at a satisfactory level of specificity. For a PAD regime to succeed in practice, future legislation must surpass the existing proposed legislation in its ability to resolve these difficult implementation issues.

⁹⁹ OR Act § 2.02(4); 1997 ME H.B. 663 § 5-903(B)(3); 1997 HI H.B. 2204 § 21 note.

¹⁰⁰ 1997 WI A.B. 32 § 156.05(2)(b), § 156.19.

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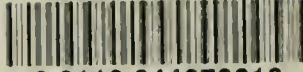
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