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A Model State Act to Authorize and Regulate Physician-Assisted Suicide

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STATUTE

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Despite laws in many states prohibiting assisted suicide, an unknown but significant number of people each year commit suicide with the aid of a physician. In recent years, the phenomenon of physician-assisted suicide has attracted greater attention as physicians have openly risked prosecution to shed light on the subject, advocates have raised a series of legal challenges to laws banning assisted suicide, and a federal judge has struck down the nation's first statute allowing physicians to assist patients in suicide.

In this Article, nine authors from the fields of law, medicine, philosophy, and economics propose a comprehensive statute to permit and regulate physician-assisted suicide for patients suffering from terminal illnesses or unbearable pain. The proposed statute provides a specific series of procedural requirements designed to prevent mistaken decisions and affords limited legal protection to physicians who follow its requirements.

In recent years, the prerogatives of competent patients to make end-of-life medical treatment decisions have been clarified, afforded legal protection, and increasingly accepted in medical practice.[1] These prerogatives include the right of competent patients to hasten the moment of their death by refusing treatment that would otherwise prolong their suffering.[2] Under legal regimes that afford terminal patients this prerogative, physicians and other health care practitioners must comply with the decisions of such patients to withhold or withdraw medical treatment and may do so without fear of legal liability.[3] As rights to forgo life-sustaining treatment have become established at law, many people have come to believe that a patient's control over his or her dying should be extended to permit active means to hasten death when there is no life-sustaining treatment to forgo.[4]

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[1] *See* COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, AMERICAN MEDICAL ASS'N, CODE OF MEDICAL ETHICS: CURRENT OPINIONS WITH ANNOTATIONS § 2.20 (1994) [hereinafter CODE OF MEDICAL ETHICS] (recognizing that patient preferences with regard to life-prolonging treatment should prevail). *See generally* THE HASTINGS CENTER, GUIDELINES ON THE TERMINATION OF LIFE-SUSTAINING TREATMENT AND CARE OF THE DYING (1987); PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT (1983); ROBERT F. WEIR, ABATING TREATMENT WITH CRITICALLY ILL PATIENTS (1989); George J. Annas & Leonard H. Glantz, *The Right of Elderly Patients to Refuse Life-Sustaining Treatment*, 64 MILBANK Q. supp. no. 2, at 95 (1986); Sidney H. Wanzer et al., *The Physician's Responsibility Toward Hopelessly Ill Patients*, 310 NEW ENG. J. MED. 955 (1984).

[2] *See* UNIF. RIGHTS OF THE TERMINALLY ILL ACT § 2 (1989) (enacted in seven states and Virgin Islands, previous version enacted in six states); *id.* introductory comment, 9B U.L.A. supp. 135 (1995) (citing similar laws in 31 states and District of Columbia); Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261, 269–79 (1990) (suggesting the existence of a liberty interest in refusing such treatment and reviewing state and federal cases).

[3] *See* UNIF. RIGHTS OF THE TERMINALLY ILL ACT §§ 3, 9 (1989).

[4] *See, e.g.*, JAMES RACHELS, THE END OF LIFE: EUTHANASIA AND MORALITY (1986); HUMPHREY TAYLOR, DOCTOR-ASSISTED SUICIDE: SUPPORT FOR DR. KEVORKIAN REMAINS STRONG AND 2-TO-1 MAJORITY APPROVES OREGON-STYLE ASSISTED SUICIDE BILL (The Harris Poll No. 9, 1995); Marcia Angell, *Euthanasia*, 319 NEW ENG. J. MED.

The issue remains a source of ethical, religious, and legal controversy. Anecdotal reports and occasional confidential surveys of physicians reveal that some physicians occasionally assist patients with suicide,[5] but data on the frequency with which physician-assisted suicide occurs are not reliable.[6] Moreover, threats of criminal charges and civil litigation make even the most empathetic physicians wary of complying with a patient's request for such assistance in the absence of clear-cut legal guidance and protection.[7]

Sharing the belief that physician-assisted suicide should be an option available to competent patients, we met together over a two-year period to draft a model statute to authorize physician-assisted suicide. Several of us were panel members at a symposium sponsored by the Massachusetts Bar Association in 1992 that focused on the state of the law in the Commonwealth concerning assistance in dying.[8] With the addition of several others, we authors now include three attorneys who represent patients, hospitals, and physicians; two law professors with interests in medical and constitutional law; a professor of philosophy who specializes in bioethics; a patient advocate and public policy economist; and two physicians with experience in academic medicine and community practice.

1348 (1988); Dan W. Brock, *Voluntary Active Euthanasia*, HASTINGS CENTER REP., Mar.-Apr. 1992, at 10 [hereinafter Brock, *Voluntary Active Euthanasia*]; Howard Brody, *Assisted Death—A Compassionate Response to a Medical Failure*, 327 NEW ENG. J. MED. 1384 (1992); Christine K. Cassel & Diane E. Meier, *Morals and Moralism in the Debate over Euthanasia and Assisted Suicide*, 323 NEW ENG. J. MED. 750 (1990); Note, *Physician-Assisted Suicide and the Right to Die with Assistance*, 105 HARV. L. REV. 2021 (1992); Richard A. Knox, *Poll: Americans Favor Mercy Killing*, BOSTON GLOBE, Nov. 3, 1991, at 1.

[5] *See, e.g.*, Robyn S. Shapiro et al., *Willingness to Perform Euthanasia: A Survey of Physician Attitudes*, 154 ARCHIVES INTERNAL MED. 575, 581 (1993) (revealing that 2.2% of physicians surveyed had performed euthanasia); Timothy E. Quill, *Death and Dignity: A Case of Individualized Decision Making*, 324 NEW ENG. J. MED. 691 (1991) (firsthand account by physician of assisted suicide); Dick Lehr, *Death & the Doctor's Hand: Increasingly, Secretly, Doctors Are Helping the Incurably Ill to Die*, BOSTON SUNDAY GLOBE, Apr. 25, 1993, at 1 (profiling two doctors who have assisted patients in suicide); New Hampshire Medical Society, End-of-Life Issues: Survey Results (Sept. 17, 1994) (press release, on file with the *Harvard Journal on Legislation*) (reporting that 4.4% of physicians responding had prescribed a lethal dose of medication for a terminally ill patient and that 1.9% had administered a lethal dose to such a patient).

[6] *See* Shapiro et al., *supra* note 5, at 576 (noting 33% response rate); New Hampshire Medical Society, *supra* note 5, at 2 (noting 44% response rate).

[7] *See infra* part I.B.

[8] For further information on the symposium, see Massachusetts Bar Ass'n, Assisted Suicide & the Right to Die: A Massachusetts Perspective (Nov. 1992) (symposium materials, on file with the *Harvard Journal on Legislation*).

Part I of this Article explains the relationship of physician-assisted suicide to the current law and to current thinking in medicine and philosophy. Part II explores the difficult choices that we made in determining what form of physician-assisted suicide should be available, who should be able to receive assistance, and how simultaneously to protect privacy and prevent abuse. Part III examines the constitutionality of our model statute. Finally, Part IV presents a detailed overview of the provisions of our statute.

I. THE MEDICAL, ETHICAL, AND LEGAL CONTEXT OF PHYSICIAN-ASSISTED SUICIDE

The statute that we propose is designed to provide the option of physician-assisted suicide to competent patients who either have a terminal illness or are suffering from unrelievable and unbearable distress, due to bodily illness, that is so great that they prefer death.[9] The statute can be fully understood only in light of current medical, ethical, and legal constraints on physician-assisted suicide.

A. *The Medical and Moral Basis for Physician-Assisted Suicide*

We believe that it is reasonable to provide relief from suffering for patients who are dying or whose suffering is so severe that it is beyond their capacity to bear. Some opponents of physician-assisted suicide see such a step as a radical moral departure from present medical practice,[10] but we believe it is consistent with the fundamental values underlying the legal and ethical requirements of respect for the right of competent patients to give or withhold their consent to any treatment, including life-sustaining treatment.[11] The most basic values that support and guide all

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[9] *See infra* A Model State Act to Authorize and Regulate Physician-Assisted Suicide § 1 [hereinafter Model Act].

[10] *See, e.g.*, Willard Gaylin et al., *Doctors Must Not Kill*, 259 JAMA 2139 (1988) (opposing assisted suicide as inconsistent with medical principles); Leon R. Kass, *Neither for Love nor Money: Why Doctors Must Not Kill*, PUB. INTEREST, Winter 1989, at 25 (opposing assisted suicide as, *inter alia*, unprofessional, harmful to doctor-patient relationship, and a violation of Hippocratic Oath).

[11] *See* Cobbs v. Grant, 502 P.2d 1, 9 (Cal. 1972); Harnish v. Children's Hosp. Medical Ctr., 439 N.E.2d 240, 242 (Mass. 1982); UNIF. RIGHTS OF THE TERMINALLY ILL ACT

health care decision making, including decisions about life-sustaining treatment, are the same values that provide the fundamental basis for physician-assisted suicide: promoting patients' well-being and respecting their self-determination or autonomy.[12]

The legal right to decide about life-sustaining treatment has given most patients appropriate control over their own dying, and we believe strongly that this control, along with proper supportive care, meticulous attention to details, and truly adequate pain relief measures, will meet the needs of the great majority of dying patients and usually obviate the occasion for the patient to consider the possibility of hastening death.[13] However, for some patients who are undergoing severe suffering and confronting an unbearable or meaningless existence, either no life-sustaining treatment is available to be forgone or forgoing such treatment will result in a prolonged, unbearable, and inhumane dying process. Even when optimal care has been given, intolerable distress may remain in these patients, such that they may conclude rationally that hastening death is the only appropriate goal.[14] For these patients, more active means of hastening death are necessary, supported by the very same values that promote patients' well-being and respect their self-determination.

Viewed in this way, making physician-assisted suicide available to patients who choose it is not a radical departure in medical practice or public policy, but a natural and appropriate extension of presently accepted practices. Physicians are uniquely able to provide this necessary assistance with a combination of expert knowledge, compassionate concern for the patient, pro-

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§ 2 (1989); DAN W. BROCK, *Death and Dying, in* LIFE AND DEATH: PHILOSOPHICAL ESSAYS IN BIOMEDICAL ETHICS 144, 148–53 (1993).

[12] *See generally* PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, MAKING HEALTH CARE DECISIONS (1982).

[13] *But see* Marcia Angell, *The Quality of Mercy*, 306 NEW ENG. J. MED. 98 (1982) (calling for renewed attention to the problem of inadequate pain relief); Charles S. Cleeland et al., *Pain and Its Treatment in Outpatients with Metastatic Cancer*, 330 NEW ENG. J. MED. 592 (1994) (noting that many cancer patients receive inadequate pain treatment); Marilee M. Donovan et al., *Incidence and Characteristics of Pain in a Sample of Medical-Surgical Inpatients*, 30 PAIN 69 (1987) (recognizing that treatment of pain remains a significant problem); Robert D. Truog et al., *Barbiturates in the Care of the Terminally Ill*, 327 NEW ENG. J. MED. 1678 (1992) (noting tension between easing pain and hastening death).

[14] *See* TIMOTHY E. QUILL, DEATH AND DIGNITY: MAKING CHOICES AND TAKING CHARGE 104–13 (1993); Sidney H. Wanzer et al., *The Physician's Responsibility Toward Hopelessly Ill Patients: A Second Look*, 320 NEW ENG. J. MED. 844, 847–48 (1989).

fessional responsibility to the patient and to society, and the ability to determine and prescribe the medication that the patient will usually require to achieve a humane and certain death.[15] They should be able lawfully to provide the assistance necessary to achieve that goal. Our model statute would allow such assistance, while at the same time attempting to provide adequate protection against possible abuses.

B. *Current Legal Obstacles to Physician-Assisted Suicide*

In a jurisdiction without a statute authorizing physician-assisted suicide, a physician who provided means of suicide to a patient could be convicted of manslaughter[16] or a specific crime of aiding or assisting a suicide or an attempted suicide.[17] Under certain circumstances, such a physician could be convicted of murder, but in many states, a murder conviction requires active participation in the death rather than merely supplying the means of death.[18] Nevertheless, even the possibility of murder charges is likely to have a deterrent effect on a physician who would otherwise consider assisting a patient to commit suicide. Indeed, even in a jurisdiction where assisted suicide is not prohibited by statute, a physician who assisted in a patient's suicide could be convicted of a common-law felony.[19]

Among the civil threats to physicians undertaking assisted suicide are liability for wrongful death[20] and medical malpractice.[21] A physician might also face professional sanctions, either

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[15] *See* Ann Alpers & Bernard Lo, *Physician-Assisted Suicide in Oregon: A Bold Experiment*, 274 JAMA 483 (1995) (suggesting a number of issues to be considered by physicians in light of legalization of physician-assisted suicide).

[16] *See, e.g.*, N.Y. PENAL LAW § 125.15(3) (McKinney 1987).

[17] *See, e.g.*, MODEL PENAL CODE § 210.5(2) (1962); N.Y. PENAL LAW § 120.30 (McKinney 1987).

[18] *See, e.g.*, People v. Cleaves, 280 Cal. Rptr. 146, 151 (Cal. Ct. App. 1991); People v. Kevorkian, 527 N.W.2d 714, 738–39 (Mich. 1994), *cert. denied*, 115 S. Ct. 1795 (1995); State v. Sexson, 869 P.2d 301, 304 (N.M. Ct. App. 1994).

[19] *See, e.g.*, *Kevorkian*, 527 N.W.2d at 739.

[20] *See, e.g.*, MASS. GEN. L. ch. 229, § 2 (1994); 42 PA. CONS. STAT. ANN. § 8301(a) (Supp. 1995).

[21] A physician can be found liable for malpractice when a patient commits suicide against the wishes of the physician. *See, e.g.*, Peoples Bank of Bloomington v. Damera, 581 N.E.2d 426, 429 (Ill. App. Ct. 1991); Stepakoff v. Kantar, 473 N.E.2d 1131, 1135 (Mass. 1985); Champagne v. United States, 513 N.W.2d 75, 76–77 (N.D. 1994). By the same reasoning, a physician who actually *expected* a patient to commit suicide could be found liable.

as a result of specific ethical prohibitions on assisted suicide[22] or because of the philosophical or political opposition of the reviewing disciplinary board. Finally, a physician who assisted in a suicide could lose staff privileges at a hospital that objected to the practice.

The net result of these obstacles to physician-assisted suicide is to deter physicians from considering the practice, even if they might otherwise have no objection to it.[23] As we explain in the next section, we believe that a statute is needed to enable physicians to assist patients in suicide in appropriate circumstances.

C. *The Need for a Specific Statute*

Laws that deprive persons of access to physician-assisted suicide have been challenged recently on constitutional grounds in federal and state courts in several jurisdictions.[24] We feel that a preferable way to establish a right to physician-assisted suicide is to make this option available to persons through explicit statutory authorization. Even if laws restricting assisted suicide are struck down, laws or regulations will be necessary to provide oversight and protection against abuse.[25] Our statutory approach permits the careful development of procedures necessary to limit abuse. A statute also more clearly requires and establishes the public support that should exist for the practice before it is made legally available.

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[22] *See* CODE OF MEDICAL ETHICS, *supra* note 1, § 2.211 ("Physician assisted suicide is fundamentally incompatible with the physician's role as healer . . . ."). The Hippocratic Oath also prohibits direct assistance in death. *See* TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 226–27 (4th ed. 1994).

[23] *See* Shapiro et al., *supra* note 5, at 581 (noting that although 35.2% of physicians responding had been asked to perform euthanasia and 27.8% would be willing to perform euthanasia if it were legal, only 2.2% had actually performed it).

[24] *See* Compassion in Dying v. Washington, 49 F.3d 586 (9th Cir.), *reh'g en banc granted*, 62 F.3d 299 (9th Cir. 1995); Quill v. Koppell, 870 F. Supp. 78 (S.D.N.Y. 1994); People v. Kevorkian, 527 N.W.2d 714 (Mich. 1994), *cert. denied*, 115 S. Ct. 1795 (1995). *See generally* Yale Kamisar, *Are Laws Against Assisted Suicide Constitutional?*, HASTINGS CENTER REP., May-June 1993, at 32 (arguing against a right to assisted suicide).

[25] *See* Guy I. Benrubi, *Euthanasia—The Need for Procedural Safeguards*, 326 NEW ENG. J. MED. 197 (1992); Franklin G. Miller et al., *Regulating Physician-Assisted Death*, 331 NEW ENG. J. MED. 119 (1994); Timothy E. Quill et al., *Care of the Hopelessly Ill: Proposed Clinical Criteria for Physician-Assisted Suicide*, 327 NEW ENG. J. MED. 1380 (1992).

Commentators have argued that there is no need for legislation in states where assisted suicide is not specifically outlawed by statute, because physicians in those states may legally provide patients with means of suicide or, in any event, need not fear prosecution for doing so.[26] Others have maintained that to legalize physician-assisted suicide would make suicide "too easy," opening the option to patients whose conditions do not warrant such an extreme measure and risking that it would be urged on patients who do not want it.[27] Some contend that legislation would impose onerous regulations on the conduct of a procedure that already takes place when, in the judgment of the physician, the situation warrants it.[28]

On the contrary, for the following reasons, we believe that society and the medical profession would be better served by a statute that expressly permits physician-assisted suicide under certain well-defined circumstances, rather than by no law at all:

First, in states that do not explicitly prohibit any form of assisted suicide, the law's silence leaves physicians in serious doubt concerning the legality of providing means of suicide to a patient,[29] while in states that do outlaw assisted suicide, physicians must risk prosecution for a felony in order to assist in a patient's suicide.[30] As a result, patients who seek means of dying are often denied assistance,[31] and success in finding a physician who will help may be a result of luck more than of need.

Second, physicians who now provide assistance in suicide may be compelled by fear of prosecution to do so in secret,[32] without the opportunity to discuss the case fully and freely with colleagues or other professionals. In contrast, physicians have ac-

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[26] *See, e.g.*, Leonard H. Glantz, *Withholding and Withdrawing Treatment: The Role of the Criminal Law*, 15 LAW, MED. & HEALTH CARE 231, 232 (1987–1988) ("No physician has ever been successfully prosecuted for an act of either omission or commission that led to the death of a seriously ill patient."). As noted above, however, the lack of a statute prohibiting physician-assisted suicide does not preclude prosecution. *See supra* note 19 and accompanying text.

[27] *See, e.g.*, George J. Annas, *Death by Prescription—The Oregon Initiative*, 331 NEW ENG. J. MED. 1240, 1243 (1994) (noting risks to poor, elderly, and minorities); J. David Velleman, *Against the Right to Die*, 17 J. MED. & PHIL. 665, 675 (1992) (recognizing danger of coercion).

[28] *See, e.g.*, Annas, *supra* note 27, at 1242–43.

[29] *See supra* note 19 and accompanying text.

[30] *See supra* text accompanying notes 16–18.

[31] *See* DEREK HUMPHRY, LET ME DIE BEFORE I WAKE 7–11, 34–44 (5th ed. 1987) [hereinafter HUMPHRY, LET ME DIE] (relating stories of two patients whose physicians refused to aid them in suicide); Shapiro et al., *supra* note 5, at 581.

[32] *But see* Timothy E. Quill, *Death and Dignity: A Case of Individualized Decision Making*, 324 NEW ENG. J. MED. 691 (1991).

cess to a variety of professional consultations, often including review by ethics committees or consultants, in connection with other profoundly serious medical-ethical decisions.[33]

Third, physicians who now provide assistance in suicide do so without any form of accountability, procedures, requirements, or guidelines to assure that the patient's request for assistance is competent, fully informed, voluntary, and enduring and that the diagnosis and treatment options have been confirmed and fully explained to the patient.

Fourth, in the absence of assistance from a physician, many terminally ill patients now attempt to end their lives on their own, often in ignorance of and without access to the best means of doing so.[34]

Fifth, some terminally ill patients prematurely elect to end their lives by forgoing treatment because they fear that the opportunity to end their lives will not arise later should their suffering become unendurable.[35]

Finally, with or without assistance from a physician, many patients who end their lives may feel obliged to do so in solitude, without the professional advice of a physician or the presence and comfort of loved ones.

II. THREE FUNDAMENTAL ISSUES

A. *Active Euthanasia Versus Physician-Assisted Suicide*

Our proposed statute would legalize physician-assisted suicide under certain conditions, but it does not address voluntary active euthanasia. By "physician-assisted suicide," we mean providing

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[33] *See* Troyen A. Brennan, *Ethics Committees and Decisions to Limit Care: The Experience at the Massachusetts General Hospital*, 260 JAMA 803 (1988); John LaPuma et al., *An Ethics Consultation Service in a Teaching Hospital: Utilization and Evaluation*, 260 JAMA 808 (1988). *See generally* INSTITUTIONAL ETHICS COMMITTEES AND HEALTH CARE DECISION MAKING (Ronald E. Cranford & A. Edward Doudera eds., 1984).

[34] *See, e.g.*, GEORGE H. COLT, THE ENIGMA OF SUICIDE 373 (1991) (reporting several disastrous suicide attempts); HUMPHRY, LET ME DIE, *supra* note 31, at 45–55 (relating story of a bungled suicide attempt); Jody B. Gabel, *Release from Terminal Suffering?: The Impact of AIDS on Medically Assisted Suicide Legislation*, 22 FLA. ST. U. L. REV. 369, 384–95 (1994) (discussing a nearly botched suicide).

[35] *See* DEREK HUMPHRY, FINAL EXIT: THE PRACTICALITIES OF SELF-DELIVERANCE AND ASSISTED SUICIDE FOR THE DYING 103–05 (1991); Stephen A. Newman, *Euthanasia: Orchestrating "The Last Syllable of . . . Time"*, 53 U. PITT. L. REV. 153, 183 (1991).

the patient with the means, such as a drug that can be lethal in certain doses, to end his or her own life. Voluntary active euthanasia, in contrast, requires the active participation of the physician in performing the action, such as administering a lethal injection, that ends the patient's life. Members of the public and the medical community disagree, and we disagree among ourselves, as to whether there is an important difference between the two concepts.[36]

We have chosen to allow only physician-assisted suicide for two main reasons. First, we consider the voluntariness of the patient's act to be critical. Restricting the statute to physician-assisted suicide provides in many cases a stronger assurance of the patient's voluntary resolve to die and of the central role of patient responsibility for the act. Second, we believe that there would be greater acceptance of the model statute by the public, legislators, and physicians if it were limited to physician-assisted suicide, partly because of the public perception of voluntariness and partly because of the strong ethical objections of some physicians and others to euthanasia.[37]

B. *Which Patients Should be Eligible for Physician-Assisted Suicide?*

We agreed from the outset that to be eligible for physician-assisted suicide, the patient must be an adult, aged eighteen years or older.[38] We also agreed that anyone who is terminally ill, that is, likely to die from an illness within six months, should qualify without having to demonstrate that his or her suffering is unbearable.[39] We continued to debate until the very end of our

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[36] *Compare, e.g.*, Diane E. Meier, *Physician-Assisted Dying: Theory and Reality*, 3 J. CLINICAL ETHICS 35, 35 (1992) (significant difference between the two) *with, e.g.*, Brody, *supra* note 4, at 1386 (a psychological, but not an ethical, difference) *and* Brock, *Voluntary Active Euthanasia, supra* note 4, at 10 (no significant difference).

[37] *See supra* note 10 and accompanying text.

[38] *See* Model Act § 3(a)(1).

[39] *See id.* § 2(*i*). Patients with terminal illnesses have generally been seen as the least controversial candidates for the recognition of a right to die. Early decisions in this field began by recognizing the right of such patients to refuse life-prolonging treatment. *See, e.g.*, Superintendent of Belchertown State School v. Saikewicz, 370 N.E.2d 417 (Mass. 1977). Likewise, early living-will legislation offered the right to refuse life-prolonging treatment only to those with terminal illnesses. *See, e.g.*, California Natural Death Act, sec. 1, § 7187(e)–(f), 1976 Cal. Stat. 6478, 6479 (repealed 1991). The fact that terminal patients will die soon, with or without treatment, may be seen as reducing the strength of any countervailing state interest in preventing such patients from deciding to shorten their lives further and as reducing the cost of any errors that may

deliberations as to how far, if at all, to broaden this eligibility beyond the six-month limit. Our major concern was whether and how to extend the option to patients who are not likely to die from their illnesses within six months but have bodily disorders that cause intractable and unbearable suffering, such as AIDS, advanced emphysema, some forms of cancer, amyotrophic lateral sclerosis, multiple sclerosis, and many other debilitating conditions.

With respect to this issue, we faced the difficulty of defining unbearable suffering in a sufficiently objective fashion that physician-assisted suicide would not be available to everyone who had some form of physical or psychological suffering and merely requested it. In the end, a bare majority of us agreed to allow anyone to be eligible whose illness is incurable and who subjectively feels that the accompanying suffering is worse than death.[40] We rejected a more objective definition of the patient's suffering for two principal reasons. First, we found that it was not possible to construct an objective definition that was not overly restrictive as to the patients who would meet it. Second, and more important, we realized that whether one's suffering is sufficiently unbearable to make death preferable to continued life is an inherently subjective determination on which people differ, and for which no objective standard should be imposed on everyone. Because the statute does not endow the patient with a right to physician-assisted suicide, however, the physician still retains the ability to decide whether the case warrants providing such relief. In addition, because the statute requires competency,[41] the subjective preference for death of a clinically depressed or mentally ill patient would be insufficient to qualify that patient for assisted suicide.

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be made in the process of the decision to refuse treatment. The physical and psychological pain suffered by a terminally ill patient also suggests that his or her desire to hasten death may be reasonable. Finally, the restriction of the right to the terminally ill establishes a boundary that helps to address slippery-slope concerns. *See infra* text accompanying note 42.

[40] *See* Model Act § 2(d).

[41] *See id.* § 3(a)(3)(A).

C. *Protecting Patients and Physicians Versus Maintaining Privacy*

Procedural safeguards that adequately protect both patients and physicians unavoidably conflict with the privacy of patients and families and the privacy of the physician-patient relationship. To maximize privacy, we considered proposing a statute that would simply state in very general terms that physician-assisted suicide was legal under certain stated factual circumstances but would not prescribe procedural requirements. Under this abbreviated approach, an assisted-suicide statute might comprise only a few simple provisions to the effect that a physician would not be guilty of unlawfully assisting a patient to commit suicide, provided that: (1) the physician's assistance were limited to making available a substance used by the patient to end the patient's life; (2) the patient had an illness that was either terminal or caused the patient intractable and unbearable suffering; (3) the patient had made a decision to hasten death because of the illness; and (4) the patient's decision was fully informed as to relevant medical facts and was not the result of a mental illness or undue influence from other persons. We concluded that such an abbreviated approach would not adequately protect patients or physicians.

The procedures, conditions, and documentation requirements built into the model statute are designed to ensure that physician-assisted suicide is restricted to patients who are truly terminally ill or suffering from intractable and unbearable illnesses, and whose requests are demonstrably competent, fully informed, voluntary, and enduring. To govern the practice in accordance with these principles, it is necessary that the statute contain strong safeguards and precise procedural requirements. Such detailed requirements will counter a common objection to making physician-assisted suicide legally permissible: the so-called "slippery slope" argument.[42] While it is not possible to guarantee that abuse and unjustified extension of the practice cannot or will not take place, we believe strong and effective safeguards, together with a clear understanding of the rationale for the practice and

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[42] *See, e.g.*, Daniel Callahan, *When Self-Determination Runs Amok*, HASTINGS CENTER REP., Mar.-Apr. 1992, at 52, 54; Gaylin et al., *supra* note 10, at 2139–40; Peter A. Singer & Mark Siegler, *Euthanasia—A Critique*, 322 NEW ENG. J. MED. 1881, 1883 (1990). *See generally* Wibren van der Burg, *The Slippery Slope Argument*, 102 ETHICS 42 (1991) (outlining various forms of the argument).

the limits to which it applies, can reasonably meet concerns about a slippery slope.[43]

From the physician's perspective, an abbreviated approach such as that described above would preserve the physician's autonomy, would avoid imposing burdensome regulations on the physician, and would not intrude into the physician-patient relationship. It would not, however, adequately protect physicians and could make them unwilling to provide assistance in suicide even in appropriate situations. Because the conditions under which physicians could legally assist patients in suicide would be stated so generally, physicians would not know in advance whether a particular case fit those conditions and what actions they should take to obviate any significant risk of criminal charges. Even if a physician acted on a good-faith belief that the statutory conditions were met, he or she might be vulnerable to legal charges later. This possibility would almost certainly leave many physicians, who might have no principled objection to physician-assisted suicide, reluctant to provide it to any of their patients who might request it.[44]

Thus, not only for the protection of patients, but also for the protection of physicians, we chose to outline specific requirements that, when followed, offer the physician legal protection. Moreover, we concluded that extensive safeguards would both protect the integrity of the medical profession and help ensure that public trust in that integrity remains warranted.[45] If the public is to ask the medical profession to participate in physician-assisted suicide, then strong safeguards are a reasonable cost for the public and patients to bear.

It would be a mistake, however, to think that procedural safeguards do not come at a significant cost to the patient and to the physician-patient relationship. At what will typically be an emotionally difficult time for the patient and family, unfamiliar third-party consultants, evaluators, and witnesses must intrude into the physician-patient relationship. Patients and their families will often quite reasonably view the procedures as a profound inva-

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[43] *Cf.* Margaret Battin, *Voluntary Euthanasia and the Risks of Abuse: Can We Learn Anything from the Netherlands?*, 20 LAW, MED. & HEALTH CARE 134 (1992) (advocating voluntary euthanasia if accompanied by strong procedural safeguards).

[44] In this respect, a general statute would be little better than no statute at all. *See supra* note 23 and accompanying text.

[45] *See* Gaylin et al., *supra* note 10, at 2139–40; David Orenthlicher, *Physician Participation in Assisted Suicide*, 262 JAMA 1844 (1989).

sion of their privacy at a point when time is short and privacy is especially important. We feel, nevertheless, that such procedures are necessary in order to ensure that in less-than-ideal relationships and conditions, misuse or abuse of the practice of physician-assisted suicide does not occur.

The detailed procedures also provide an openness to the practice of physician-assisted suicide that can give society greater assurance that the practice is operating as intended, and can provide feedback to government and professional bodies about needed refinements and revisions in the practice over time. In our final formulation of the statute, we therefore leaned in the direction of more extensive and comprehensive safeguards, acknowledging the costs to some patients and physicians.

III. CONSTITUTIONALITY OF THE MODEL ACT: *LEE V. OREGON*

In November 1994, Oregon voters enacted by initiative the nation's first statute explicitly permitting and regulating physician-assisted suicide.[46] The Oregon Act, which is similar in a number of respects to our proposed statute,[47] was promptly challenged in federal court on grounds that it violated the Fourteenth Amendment to the United States Constitution. On August 3, 1995, in *Lee v. Oregon*,[48] District Judge Michael R. Hogan declared the statute unconstitutional under the Equal Protection Clause of the Fourteenth Amendment.[49] The case is now on appeal to the United States Court of Appeals for the Ninth Circuit.[50]

We believe that the *Lee* case was wrongly decided and that our proposed statute will withstand appropriate constitutional scrutiny.

In 1990, the Supreme Court of the United States rendered its only decision to date on the subject of the right to die. In *Cruzan v. Director, Missouri Department of Health*,[51] the Court held that, where an incompetent patient is involved, a state may constitutionally require "clear and convincing" proof that the patient

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[46] Oregon Death With Dignity Act, 1995 Or. Laws ch. 3 [hereinafter Oregon Act].

[47] In the interest of disclosure, we feel that we should mention that one of us played a minor role as an adviser to the drafters of the Oregon Act.

[48] 891 F. Supp. 1429 (D. Or. 1995).

[49] *Id.* at 1439.

[50] Lee v. Harcleroad, *appeal docketed*, No. 95-35804 (9th Cir. Aug. 11, 1995).

[51] 497 U.S. 261 (1990).

would want life-prolonging treatment withdrawn.[52] In passing, the Court recognized a patient's "constitutionally protected liberty interest" in refusing unwanted medical treatment.[53] Four Justices believed this liberty interest to be so strong in the context of a patient in a persistent vegetative state that they would have held the Missouri law restricting it unconstitutional under the Due Process Clause of the Fourteenth Amendment.[54] The other Justices, with the exception of Justice Scalia, also recognized such a constitutionally based right.[55] But they recognized as well a strong interest of the state in protecting the autonomy of an incompetent patient,[56] and they held that a state could constitutionally advance its interests, if it chose to do so, by requiring clear and convincing evidence of the patient's wishes.[57]

Judge Hogan's opinion in *Lee* turned *Cruzan* on its head. Whereas *Cruzan* dealt with state legislation that restricted a patient's right to be free from unwanted treatment, *Lee* dealt with state legislation advancing that right. Whereas *Cruzan* protected the right of the legislature to regulate the details of practice in this developing area, even though the regulation impinged upon a protected liberty interest, *Lee* struck down a popularly mandated measure that advanced that liberty interest.

The fault in the Oregon Act, from Judge Hogan's point of view, was that it did not advance patients' liberty interests as rationally as it might. In particular, the *Lee* court was concerned that (1) the Oregon Act permits "physicians who may not be psychiatrists, psychologists, or counselors to make an evaluation whether a condition is causing [the patient to exercise] impaired judgment";[58] (2) "[t]here is no requirement that the [patient] consult a certified social worker or other specialist to explore social services which might assist the person to live in greater comfort";[59] and (3) these and other failures in protection of the rights of patients apply only to the "terminally ill."[60] The court's sug-

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[52] *Id.* at 280.
[53] *Id.* at 278.
[54] *See id.* at 316 (Brennan, J., dissenting, joined by Marshall and Blackmun, JJ.); *id.* at 350–51 (Stevens, J., dissenting).
[55] *See id.* at 278–79 (Rehnquist, C.J., for the Court); *id.* at 287 (O'Connor, J., concurring). *But see id.* at 299–300 (Scalia, J., concurring) (arguing that case does not implicate Constitution).
[56] *Id.* at 281–82.
[57] *Id.* at 284–85.
[58] *Lee*, 891 F. Supp. at 1435.
[59] *Id.*
[60] *Id.* at 1437.

gestion was that somehow the Oregon Act discriminated against the terminally ill as a class in violation of the Equal Protection Clause. Yet in the case of the Oregon Act and other legislation classifying patients on the basis of terminal illness, it is those persons who fear that they will one day find themselves among the terminally ill who are urging the enactment of such legislation to protect themselves from a lingering, undignified death. Clearly invidious motives are not at work when such statutes use terminal illness as a basis for classification.

Because the Oregon Act does not impinge upon a fundamental right and does not establish a classification on a basis that raises suspicions of invidious discrimination, the court was required to review the measure under the most lenient of constitutional standards.[61] It could find the Oregon Act unconstitutional only if one could conceive of no rational basis upon which the state could have used the means employed to advance a legitimate state interest.[62] In fact, Judge Hogan appears to have applied his own version of rational review and struck down the Oregon Act because it was not as rational as he thought it should have been. This sort of constitutional review is reminiscent of the discredited doctrine of *Lochner v. New York*.[63] A proper application of the rational-basis test would find both the Oregon Act and the statute that we propose here to be constitutional under the Fourteenth Amendment.

While we believe *Lee* will be reversed by the Ninth Circuit, we should note that our proposed statute addresses several of what Judge Hogan perceived to be the shortcomings of the Oregon Act. Our statute provides for a review of the patient's competency by a licensed psychiatrist, clinical psychologist, or psychiatric social worker;[64] allows patients the opportunity to consult with a social worker about alternatives to suicide;[65] and refuses to relieve physicians from liability for such actions as a negligent diagnosis.[66]

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[61] *See* Schweiker v. Wilson, 450 U.S. 221, 230 (1981).
[62] *See id.*; FCC v. Beach Communications, Inc., 113 S. Ct. 2096, 2101 (1993).
[63] 198 U.S. 45 (1905).
[64] *See* Model Act § 5(b).
[65] *See id.* § 4(b).
[66] *See id.* § 13(c).

IV. Overview of the Model Act

A. *Who May Provide Physician-Assisted Suicide?*

The model statute allows a "responsible physician" to practice physician-assisted suicide and places a series of responsibilities on that physician.[67] The first question that we faced was who should be allowed to assume that role. Ideally, the physician who assists in a patient's suicide will be the one who has managed the patient's illness and who has a close professional relationship with the patient. However, the statute recognizes that because ethical constraints may prevent some physicians from assisting in suicide, a patient may need to have another physician provide him or her with the means of suicide. Section 2(h)[68] therefore allows any physician who has assumed full or partial responsibility for a patient's care to assume the role of responsible physician, even though he or she is not the patient's primary physician.

B. *Other Definitions*

Section 2(e) defines "medical means of suicide" as a medical substance or device prescribed for or supplied to a patient by the responsible physician. The use of the term "medical" requires that the means of suicide be otherwise consistent with sound medical practice; thus, providing a patient with an unapproved drug or a firearm (to take an extreme example) would not be permissible.

The definitions of "intractable and unbearable illness" and "terminal illness" are discussed above.[69] The remaining definitions in section 2 are self-explanatory.

C. *Conditions to be Met Before a Patient Receives Assistance in Suicide*

A fundamental goal of the statute is to protect patients from coercion or premature judgment. Section 3(a)(3) thus requires

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[67] *See id.* § 3(a).

[68] All further references in the text of this Article to "section" are references to sections of the Model Act unless otherwise specified.

[69] *See supra* part II.B.

that four basic conditions be met before a physician may grant a patient's request for assisted suicide: the request must be competent, fully informed, voluntary, and enduring. The first three requirements are similar to those required for informed consent to ordinary medical treatment,[70] and the fourth is designed to ensure the consistent resolve of the patient. However, because of the seriousness and finality of the patient's decision, the requirements of the statute exceed those of consent to ordinary treatment.[71]

A competent request within the meaning of section 3(a)(3)(A) is a reasoned request for physician-assisted suicide from a patient, based on the patient's ability to understand his or her condition and prognosis, the benefits and burdens of available alternative treatments, and the consequences of suicide. A request distorted by clinical depression or other mental illness or impairment is not competent. However, the statute does not prohibit physician-assisted suicide for a patient suffering from clinical depression if the patient's judgment is not distorted—in other words, if the patient can make a reasoned decision consistent with his or her long-term values. A terminal illness is inherently depressing, and denying a patient assistance in suicide only because he or she feels sad or depressed would not be proper.[72] Nevertheless, the statute mandates that a professional mental health care provider evaluate the patient to determine that his or her decision is fully informed, free of undue influence, and not distorted by depression or any other form of mental illness.[73]

A fully informed request within the meaning of section 3(a)(3)(B) means that the patient understands the medical options available and their consequences. Section 4 requires the physician to dis-

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[70] *See* Canterbury v. Spence, 464 F.2d 772, 782–89 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); Cobbs v. Grant, 502 P.2d 1, 10–11 (Cal. 1972); Harnish v. Children's Hosp. Medical Ctr., 439 N.E.2d 240, 243–44 (Mass. 1982).

[71] Informed consent to ordinary treatment does not generally require consultations with respect to diagnosis or competency, witnessing of the informed-consent discussion, or documentation with the specificity required by our statute. *Compare* cases cited *supra* note 70 *with* Model Act §§ 4(d), 5.

[72] *See* Linda Ganzini et al., *The Effect of Depression Treatment on Elderly Patients' Preferences for Life-Sustaining Medical Therapy*, 151 AM. J. PSYCHIATRY 1631 (1994) (noting that in study of mild to moderate depression, remission of depression did not alter patients' desire for life-sustaining therapy); Melinda A. Lee, *Depression and Refusal of Life Support in Older People: An Ethical Dilemma*, 38 J. AM. GERIATRICS SOC'Y 710, 712 (1990) ("[W]hen suffering is unlikely to abate, a decision [by a depressed patient] that death is preferable to life may not necessarily be unreasonable.").

[73] *See* Model Act § 5(b).

cuss all medical treatments that might improve the patient's condition or prognosis that are practicably available, including treatment for pain, and their benefits and burdens; to offer the patient the opportunity to consult with social workers about social services that may improve his or her condition; and to advise the patient of the options for ending his or her life and their benefits and burdens. For a request to be fully informed, the patient must understand all of this information and make a reasoned decision to seek suicide. Section 3(a)(3)(B) is intended to ensure active decisionmaking by the patient; passive acquiescence in the recommendations of others would not constitute a fully informed and reasoned decision.

Section 3(a)(3)(C) requires that the patient's request be voluntary, meaning that it is made independently, free from coercion or undue influence. The patient may consider the suggestions and recommendations of others, including the responsible physician, but the patient's choice must be his or her own decision.[74]

Finally, section 3(a)(3)(D) requires that the patient's request be enduring. Ideally, the patient will have discussed physician-assisted suicide with a number of individuals on multiple occasions. At a minimum, however, the request must be stated to the responsible physician on at least two occasions that are at least two weeks apart, without self-contradiction during that interval. The two-week period is an attempt to balance the prevention of hasty decisionmaking against the prolonging of unbearable suffering.

Section 3(a) places the responsibility on the responsible physician to ensure that all of its requirements are met. In order to provide the physician with considerable advance assurance that he or she can avoid litigation attempting to second-guess his or her determinations,[75] the statute makes the physician's standard entirely subjective: the physician need have only an "honest belief" that the elements of section 3(a) have been met in the particular case. However, to compensate for the lack of any

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[74] *Cf.* RESTATEMENT (SECOND) OF CONTRACTS § 177(1) (1981) ("Undue influence is unfair persuasion of a party who is under the domination of the person exercising the persuasion or who by virtue of the relation between them is justified in assuming that that person will not act in a manner inconsistent with his welfare."); Maurath v. Sickles, 586 S.W.2d 723, 730 (Mo. Ct. App. 1979) (holding that undue influence in probate context is influence that destroys the free choice of the person making the will).

[75] *See supra* text accompanying note 44.

requirement of reasonableness, the responsible physician enjoys the protection conferred by the statute only if he or she also satisfies the procedural requirements of sections 4, 5, and 6,[76] which are designed to produce and preserve independent corroboration that the physician's belief is not merely honest or reasonable, but accurate. If the responsible physician materially complies with these requirements[77] and there is no proof that he or she lacked the requisite honest belief, he or she is protected from liability for assisting in a suicide.[78] As discussed below,[79] however, the responsible physician and other participants are not relieved of any liability that they may otherwise incur as a result of any malpractice that they commit in the process of assisting in a suicide.

D. *Procedures to be Followed Before and After a Patient Receives Assistance in Suicide*

Section 4 outlines the information that the responsible physician must present to the patient in order to ensure that the patient's decision is fully informed and reasoned. Section 4(a) requires the responsible physician to offer the patient any medical care that may cure or palliate the illness or relieve its symptoms. Hospice care must be offered if available, but treatments that are inconsistent with accepted medical practice or impracticable need not be.[80] Section 4(b) requires the responsible physician to make a social worker available to the patient to discuss non-medical options that might change the patient's decision to seek suicide.

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[76] *See* Model Act § 3(a).

[77] *Cf.* 2 E. ALLAN FARNSWORTH, FARNSWORTH ON CONTRACTS § 8.16 (1990) (discussing material breach and substantial performance in contract law).

[78] *See* Model Act §§ 3(a), 13(a)–(b).

[79] *See infra* part IV.H.

[80] Sometimes treatments or other services will be impracticable because the patient lacks the resources or health insurance necessary to pay for them. Such a situation presents health care providers and patients with a painful ethical dilemma. On the one hand, it seems plainly wrong for a patient to be forced to consider suicide because of a lack of ability to obtain treatments or services that might mitigate his or her condition or circumstances. On the other hand, if there is no way to right this wrong in a particular situation, it seems doubly wrong to deny the patient the medical means of suicide that he or she has requested. We believe that if society fails to meet its moral obligation to provide appropriate health care and other services to all its citizens, it cannot justifiably deny individuals relief from conditions that they find all the more unbearable because of society's moral failure.

The responsible physician must suggest to the patient under section 4(c) that he or she consult family members about the decision to request assistance in suicide, but the patient need not do so. Although mandatory family notification has been upheld against constitutional challenges in similarly sensitive situations,[81] we believe that competent, adult patients should not be required to notify family members of their intended suicide against their will. The items required to be discussed by section 4(d) have been mentioned previously,[82] but that section also requires a recorded or documented account of the discussion with two witnesses who are entitled to question the responsible physician and the patient.

Section 5 contains the corroboration requirements. Section 5(a) requires a second medical opinion as to the patient's diagnosis and prognosis, while section 5(b) requires a combination medical-factual opinion as to the patient's qualifications for physician-assisted suicide under section 3(a)(3). Broadly worded, unsupported opinions should be insufficient to enable the responsible physician to proceed; instead, each opinion should evidence a thorough investigation and demonstrate that the patient meets the statutory standards. An opinion that conflicts with the responsible physician's opinion should prevent the responsible physician from proceeding with an assisted suicide, at least until circumstances change substantially and a consultant then agrees with the responsible physician's opinion.

Finally, section 6 requires the responsible physician to document promptly the provision of medical means of suicide to a patient, both in the patient's records and with the state's regulatory authority.

E. *Presence at the Patient's Death*

Ending one's life in solitude can be a lonely and frightening undertaking, fraught with uncertainty, ambivalence, and opportunities for failure. 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. Section 3(b) allows, but does not require, the physician to be

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[81] *Cf.* Planned Parenthood of Southeastern Pa. v. Casey, 112 S. Ct. 2791, 2832 (1992) (upholding requirement of parental notification before minor obtains abortion).

[82] *See supra* part IV.C.

present if the patient so desires, and section 7(a) also allows the presence of any other persons selected by the patient. Each section requires only that the final physical act of administering the means of suicide be the knowing, intentional, and voluntary act of the patient.

F. *Monitoring and Enforcement*

The submission of reports by responsible physicians allows the state Department of Public Health (or a similar regulatory agency) to collect the data (specified in section 8(a)) necessary to improve the statute's operation and to make the annual public report of its effectiveness required by section 9(d). For purposes of tracking the operation of the statute, it would be desirable to determine how often and under what circumstances medical means of suicide were actually used by patients to end their lives. However, because the responsible physician need not be present at the patient's death, and because the physician who signs the death certificate may not be the same physician who provided the deceased with the means of suicide, there appears to be no way of accurately determining the extent to which medical means of suicide are actually used.

A physician's report must not include the patient's name for reasons of privacy, but section 8(b) requires a coded link between the report and the patient's name, which may be used if legal or ethical questions should arise after the patient's death.

Section 9 requires the agency to monitor and enforce the requirements of the statute and grants the agency rulemaking authority. The statute proceeds on the assumption that it is impossible in such a complex field to deal in advance with all possible problems by a legislative act. We believe that a reasonable solution is to enact the legislation and then to provide an administrative body with the power to respond to new patterns of problems through the regulatory rulemaking process.

G. *Confidentiality, Conscientious Objection, and Discrimination*

To protect the privacy and confidentiality of everyone involved in a particular physician-assisted suicide, section 10(a) declares that any information about a patient must be kept confidential.

Section 10(b) further specifies that a responsible physician's report on file with the regulatory agency is also confidential and is not subject to the customary state statutes regarding public records.

Section 11 protects the decisions of physicians, hospital employees, and hospitals themselves to refuse to participate in physician-assisted suicide on grounds of conscience. A hospital or other institution may forbid physician-assisted suicide on its premises or within its jurisdiction if the institution notifies its staff in advance of the policy.

Finally, section 12 protects patients from discrimination by physicians, institutions, and insurers. No health care provider or insurer is permitted to require any patient to request physician-assisted suicide as a condition of eligibility for services, benefits, or insurance. At the same time, section 12 protects patients from discrimination (including the voiding of life insurance policies) because they have chosen to pursue assisted suicide. Unless physicians, institutions, and insurers opt out for reasons of conscience under section 11, they must honor patients' choices to seek or avoid assistance in suicide.

H. *Liability and Sanctions*

Section 13 protects those who participate in physician-assisted suicide from the types of liabilities identified in Part I.B. of this Article. The protection of section 13(a), however, is limited to the mere fact that a person has participated in an assisted suicide; he or she may not be convicted of homicide, for example, solely on the basis that he or she provided deadly drugs to a patient who committed suicide. On the other hand, section 13(c) notes that the statute does not limit the civil or criminal liability of any person for intentional or negligent actions merely because those actions were part of a physician-assisted suicide. Thus if a responsible physician or consulting physician commits malpractice by erroneously diagnosing a patient's condition, he or she is liable for the damages caused by that malpractice. The responsible physician is not, however, stripped of protection against liability for assisting in a suicide per se unless he or she has failed to meet the requirements of one or more sections of the statute.[83]

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[83] *See* Model Act § 13(a).

Section 14 declares that a willful violation of a provision of section 3, 4, 5, 6, or 7 is a crime (the precise grade of the crime is left to the individual state). Whether an action results in the death of a patient or not is immaterial. Of course, a violation of one of these provisions may also render a person liable under another provision of law; for example, a responsible physician who does not comply in all material respects with sections 4, 5, and 6 does not enjoy the protection from liability for assisting in a suicide that section 13 otherwise affords. In appropriate cases, section 14 provides a prosecutor with a method for enforcing the statute that falls short of a prosecution for homicide or assisting in a suicide.

As for other wrongful acts, such as coercing a person to request or use medical means of suicide, section 13(c) leaves the definition of offenses and the imposition of sanctions to existing law.

V. Conclusion

Physician-assisted suicide has become a subject of increasingly widespread and intense public and professional debate. A growing array of efforts is also underway to make physician-assisted suicide available under the law. As noted in Part III, Oregon recently adopted legislation to allow physician-assisted suicide. Constitutional challenges to laws prohibiting assisted suicide in Washington, Michigan, and New York have recently wound their way through the courts.[84] Legislation to permit physician-assisted suicide has been introduced recently in a number of state legislatures.[85] As these efforts approach fruition, it becomes increasingly important that debates about physician-assisted suicide address concrete issues of morality and policy design. Supporters of physician-assisted suicide have a special responsibility to propose specific, detailed proposals for a well-regulated and suitably circumscribed practice. We intend the statute presented below to help meet that responsibility.

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[84] *See supra* note 24.

[85] *See, e.g.*, Cal. A.B. 1080, 1995-96 Reg. Sess.; Colo. H.B. 1308, 60th Gen. Ass., 1st Reg. Sess. (1995); Mass. H.B. 3173, 179th Gen. Ct., 1st Ann. Sess. (1995); N.H. H.B. 339, 1995 Reg. Sess.; N.Y. S.B. 1683, 218th Gen. Ass., 1st Reg. Sess. (1995); Wis. A.B. 174, 92d Leg. Sess., 1995-96 Reg. Sess.

A MODEL STATE ACT TO AUTHORIZE AND REGULATE PHYSICIAN-ASSISTED SUICIDE

SECTION 1. STATEMENT OF PURPOSE

The principal purpose of this Act is to enable an individual who requests it to receive assistance from a physician in obtaining the medical means for that individual to end his or her life when he or she suffers from a terminal illness or from a bodily illness that is intractable and unbearable. Its further purposes are (a) to ensure that the request for such assistance is complied with only when it is fully informed, reasoned, free of undue influence from any person, and not the result of a distortion of judgment due to clinical depression or any other mental illness, and (b) to establish mechanisms for continuing oversight and regulation of the process for providing such assistance. The provisions of this Act should be liberally construed to further these purposes.

SECTION 2. DEFINITIONS

As used in this Act,

(a) "Commissioner" means the Commissioner of the Department.

(b) "Department" means the Department of Public Health [or similar state agency].

(c) "Health care facility" means a hospital, hospice, nursing home, long-term residential care facility, or other institution providing medical services and licensed or operated in accordance with the law of this state or the United States.

(d) "Intractable and unbearable illness" means a bodily disorder (1) that cannot be cured or successfully palliated, and (2) that causes such severe suffering that a patient prefers death.

(e) "Medical means of suicide" means medical substances or devices that the responsible physician prescribes for or

supplies to a patient for the purpose of enabling the patient to end his or her own life. "Providing medical means of suicide" includes providing a prescription therefor.

(f) "Patient's medical record" means (1) in the case of a patient who is in a health care facility, the record of the patient's medical care that such facility is required by law or professional standards to compile and maintain, and (2) in the case of a patient who is not in such a facility, the record of the patient's medical care that the responsible physician is required by law or professional standards to compile and maintain.

(g) "Person" includes any individual, corporation, professional corporation, partnership, unincorporated association, government, government agency, or any other legal or commercial entity.

(h) "Responsible physician" means the physician, licensed to practice medicine in this state, who (1) has full or partial responsibility for treatment of a patient who is terminally ill or intractably and unbearably ill, and (2) takes responsibility for providing medical means of suicide to the patient.

(*i*) "Terminal illness" means a bodily disorder that is likely to cause a patient's death within six months.

SECTION 3. AUTHORIZATION TO PROVIDE ASSISTANCE

(a) It is lawful for a responsible physician who complies in all material respects with Sections 4, 5, and 6 of this Act to provide a patient with medical means of suicide, provided that the responsible physician acts on the basis of an honest belief that

(1) the patient is eighteen years of age or older;

(2) the patient has a terminal illness or an intractable and unbearable illness; and

(3) the patient has made a request of the responsible physician to provide medical means of suicide, which request

(A) is not the result of a distortion of the patient's judgment due to clinical depression or any other mental illness;

(B) represents the patient's reasoned choice based on an understanding of the information that the responsible physician has provided to the patient pursuant to Section 4(d) of this Act concerning the patient's medical condition and medical options;

(C) has been made free of undue influence by any person; and

(D) has been repeated without self-contradiction by the patient on two separate occasions at least fourteen days apart, the last of which is no more than seventy-two hours before the responsible physician provides the patient with the medical means of suicide.

(b) A responsible physician who has provided a patient with medical means of suicide in accordance with the provisions of this Act may, if the patient so requests, be present and assist the patient at the time that the patient makes use of such means, provided that the actual use of such means is the knowing, intentional, and voluntary physical act of the patient.

SECTION 4. DISCUSSION WITH PATIENT AND DOCUMENTATION

Before providing medical means of suicide to a patient pursuant to Section 3 of this Act, the responsible physician shall

(a) offer to the patient all medical care, including hospice care if available, that is consistent with accepted clinical practice and that can practicably be made available to the patient for the purpose of curing or palliating the patient's illness

or alleviating symptoms, including pain and other discomfort;

(b) offer the patient the opportunity to consult with a social worker or other individual trained and experienced in providing social services 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 for medical means of suicide;

(c) counsel the patient to inform the patient's family of the request if the patient has not already done so and the responsible physician believes that doing so would be in the patient's interest; and

(d) supply to and discuss with the patient all available medical information that is necessary to provide the basis for a reasoned decision concerning a request for medical means of suicide, including all such information regarding the patient's diagnosis and prognosis, the medical treatment options and the medical means of suicide that can be made available to the patient, and their benefits and burdens, all in accordance with the following procedures:

> **(1) at least two adult individuals must witness the discussion required by this paragraph (d), at least one of whom (A) is not affiliated with any person that is involved in the care of the patient, and (B) does not stand to benefit personally in any way from the patient's death;**
>
> **(2) the responsible physician shall inform each witness that he or she may question the responsible physician and the patient to ascertain that the patient has, in fact, heard and understood all of the material information discussed pursuant to this paragraph (d); and**
>
> **(3) the responsible physician shall document the discussion with the patient held pursuant to this paragraph (d), using one of the following methods:**

(A) an audio tape or a video tape of the discussion, during which the witnesses acknowledge their presence; or

(B) a written summary of the discussion that the patient reads and signs and that the witnesses attest in writing to be accurate.

The documentation required by this subparagraph (3) must be included and retained with the patient's medical record, and access to and disclosure of such records and copies of them are governed by the provisions of Section 10 of this Act.

SECTION 5. PROFESSIONAL CONSULTATION AND DOCUMENTATION

Before providing medical means of suicide to a patient pursuant to Section 3 of this Act, the responsible physician shall

(a) secure a written opinion from a consulting physician who has examined the patient and is qualified to make such an assessment that the patient is suffering from a terminal illness or an intractable and unbearable illness;

(b) secure a written opinion from a licensed psychiatrist, clinical psychologist, or psychiatric social worker who has examined the patient and is qualified to make such an assessment that the patient has requested medical means of suicide and that the patient's request meets the criteria set forth in Sections 3(a)(3)(A), 3(a)(3)(B), and 3(a)(3)(C) of this Act to the effect that the request is not the result of a distortion of the patient's judgment due to clinical depression or any other mental illness, is reasoned, is fully informed, and is free of undue influence by any person; and

(c) place the written opinions described in paragraphs (a) and (b) of this section in the patient's medical record.

SECTION 6. RECORDING AND REPORTING BY THE RESPONSIBLE PHYSICIAN

Promptly after providing medical means of suicide to a patient, the responsible physician shall (a) record the provision of such means in the patient's medical record, (b) submit a report to the Commissioner on such form as the Commissioner may require pursuant to Section 8(a) of this Act, and (c) place a copy of such report in the patient's medical record.

SECTION 7. ACTIONS BY PERSONS OTHER THAN THE RESPONSIBLE PHYSICIAN

(a) An individual who acts on the basis of an honest belief that the requirements of this Act have been or are being met may, if the patient so requests, be present and assist at the time that the patient makes use of medical means of suicide, provided that the actual use of such means is the knowing, intentional, and voluntary physical act of the patient.

(b) A licensed pharmacist, acting in accordance with the laws and regulations of this state and the United States that govern the dispensing of prescription drugs and devices and controlled substances, may dispense medical means of suicide to a person who the pharmacist reasonably believes presents a valid prescription for such means.

(c) An individual who acts on the basis of an honest belief that the requirements of this Act have been or are being met may counsel or assist the responsible physician in providing medical means of suicide to a patient.

SECTION 8. RECORD KEEPING BY THE DEPARTMENT

(a) The Commissioner shall by regulation specify a form of report to be submitted by physicians pursuant to Section 6(b) of this Act in order to provide the Department with such data regarding the provision of medical means of suicide as the Commissioner determines to be necessary or appropriate to enable effective oversight and regulation of the operation

of this Act. Such report shall include, at a minimum, the following information:

(1) the patient's diagnosis, prognosis, and the alternative medical treatments, consistent with accepted clinical practice, that the responsible physician advised the patient were practicably available;

(2) the date on which and the name of the health care facility or other place where the responsible physician complied with the patient's request for medical means of suicide, the medical means of suicide that were prescribed or otherwise provided, and the method of recording the discussion required by Section 4(d) of this Act;

(3) the patient's vital statistics, including county of residence, age, sex, race, and marital status;

(4) the type of medical insurance and name of insurer of the patient, if any;

(5) the names of the responsible physician, the medical and mental health consultants who delivered opinions pursuant to Section 5 of this Act, and the witnesses required by Section 4(d) of this Act; and

(6) the location of the patient's medical record.

(b) The Commissioner shall require that the report described in paragraph (a) of this section not include the name of the patient but shall provide by regulation for an anonymous coding or reference system that enables the Commissioner or the responsible physician to associate such report with the patient's medical record.

SECTION 9. ENFORCEMENT AND REPORTING BY THE DEPARTMENT

(a) The Commissioner shall enforce the provisions of this Act and shall report to the Attorney General and the appro-

priate board of registration [or similar state agency] any violation of its provisions.

(b) The Commissioner shall promulgate such rules and regulations as the Commissioner determines to be necessary or appropriate to implement and achieve the purposes of this Act and shall, at least ninety days prior to adopting any rule or regulation affecting the conduct of a physician acting under the provisions of this Act, submit such proposed rule or regulation to the Board of Registration in Medicine [or similar state agency] for such Board's review and advice.

(c) The Board of Registration in Medicine [or similar state agency] may promulgate no rule or regulation inconsistent with the provisions of this Act or with the rules and regulations of the Department promulgated under it and shall, at least ninety days prior to adopting any rule or regulation affecting the conduct of a physician acting under the provisions of this Act, submit such proposed rule or regulation to the Commissioner for the Commissioner's review and advice.

(d) The Commissioner shall report to the Legislature annually concerning the operation of this Act and the achievement of its stated purposes. The report of the Commissioner shall be made available to the public upon its submission to the Legislature. In order to facilitate such annual reporting, the Commissioner may collect and review such information as the Commissioner determines to be helpful to the Department, the Board of Registration in Medicine [or similar state agency], or the Legislature and may by regulation require the submission of such information to the Department.

SECTION 10. CONFIDENTIALITY OF RECORDS AND REPORTS

(a) The information that a person acting under this Act obtains from or about a patient is confidential and may not be disclosed to any other person without the patient's consent or the consent of a person with lawful authority to act on the patient's behalf, except as this Act or any other provision of law may otherwise require.

(b) The report that a responsible physician files with the Department pursuant to Section 6(b) of this Act is confidential, is not a public record, and is not subject to the provisions of [the state public records statute or freedom of information act].

SECTION 11. PROVIDER'S FREEDOM OF CONSCIENCE

(a) No individual who is conscientiously opposed to providing a patient with medical means of suicide may be required to do so or to assist a responsible physician in doing so.

(b) A health care facility that has adopted a policy opposed to providing patients with medical means of suicide and has given reasonable notice of such policy to its staff members may prohibit such staff members from providing such means to a patient who is within its facilities or under its care.

SECTION 12. PATIENT'S FREEDOM FROM DISCRIMINATION

(a) No physician, health care facility, health care service plan, provider of health or disability insurance, self-insured employee health care benefit plan, or hospital service plan may require any individual to request medical means of suicide as a condition of eligibility for service, benefits, or insurance. No such physician or entity may refuse to provide medical services or medical benefits to an individual because such individual has requested medical means of suicide, except as Section 11 of this Act permits.

(b) A patient's use of medical means of suicide to end such patient's life in compliance with the applicable provisions of this Act shall not be considered suicide for the purpose of voiding a policy of insurance on the life of such patient.

SECTION 13. LIABILITY

(a) No person who has acted in compliance with the applicable provisions of this Act in providing medical means of

suicide to an individual shall be subject to civil or criminal liability therefor.

(b) No individual who has acted in compliance with the applicable provisions of this Act in providing medical means of suicide to a patient shall be subject therefor to professional sanction, loss of employment, or loss of privileges, provided that such action does not violate a policy of a health care facility that complies with Section 11(b) of this Act.

(c) Except as provided in paragraphs (a) and (b) of this section, this Act does not limit the civil, criminal, or disciplinary liability of any person for intentional or negligent misconduct.

SECTION 14. CRIMINAL PENALTIES

In addition to any other civil, criminal, or disciplinary liability that he or she may otherwise incur thereby, an individual who willfully violates Section 3, 4, 5, 6, or 7 of this Act is guilty of a [specify grade of offense].