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# Comment

## An Illinois Physician-Assisted Suicide Act: A Merciful End to a Terminally Ill Criminal Tradition

### I. INTRODUCTION

In October of 1996, Nancy DeSoto left her home in Bourbonnais, Illinois, and traveled to suburban Detroit to see Dr. Jack Kevorkian.<sup>1</sup> There, in a strange hotel room, Dr. Kevorkian gave Nancy a breathing mask connected to a metal canister and showed her how to turn on the gas.<sup>2</sup> A victim of Lou Gehrig's disease, Nancy ended her life through the narcosis of carbon monoxide poisoning.<sup>3</sup> The local prosecutor filed no charges, although her death was officially ruled a homicide.<sup>4</sup>

Despite it being a criminal offense in nearly every American jurisdiction,<sup>5</sup> including Illinois,<sup>6</sup> doctors and the friends and family of ill patients continue to engage in "assisted suicide," largely unbothered

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1. David Lawder, *Kevorkian Brings 43rd Assisted Death to Hospital*, REUTERS, Oct. 17, 1996, available in LEXIS, News Library, Curnws File. Dr. Kevorkian is a well known advocate of physician-assisted suicide. *Id.* In addition to Nancy DeSoto, Dr. Kevorkian is reported to have provided the means for at least 42 others to end their lives. *Id.* Dr. Kevorkian is credited with putting the issue on the national agenda, beginning with his first reported assistance in 1990. Melinda Beck et. al., *The Doctor's Suicide Van*, NEWSWEEK, June 18, 1990, at 46.

2. See Lawder, *supra* note 1.

3. *Kevorkian Aids in Woman's Suicide*, L.A. TIMES, Oct. 18, 1996, at A15. Dr. Kevorkian sometimes provides those wishing to die with a device consisting of a breathing mask, connected to a bottle of carbon monoxide. Don Colburn, *Debate on Assisted Suicide Gains Steam*, WASH. POST, May 10, 1994, at Z8. The user commits suicide by turning a switch that allows the gas to flow into the mask, where the patient inhales it. *Id.* The effect is that the person first becomes unconscious, then dies of insufficient oxygen. Ian Harvey, *Right to Die Activist Speaks From the Grave*, TORONTO SUN (Final Edition), May 9, 1996, at 7. It is a physically painless experience. Catherine Gibbs, *Debate Over Kindest Death for Animals*, SACRAMENTO BEE, May 5, 1996 at B1, available in LEXIS, News Library, Curnws File.

4. *Kevorkian Aids in Woman's Suicide*, *supra* note 3, at A15.

5. See *infra* notes 34-35 and accompanying text.

6. See 720 ILL. COMP. STAT. ANN. 5/12-31 (West 1993 & Supp. 1996) (criminalizing the inducement to commit suicide, and making it a Class 2 felony). See also *infra* note 72 (providing relevant text of statute).

by legal sanctions.<sup>7</sup> The result is an unsatisfactory nether land where the practice is neither legal and regulated, nor effectively illegal.<sup>8</sup>

This Comment begins by examining the history of physician-assisted suicide as a crime.<sup>9</sup> Next, it explores the relationship between dying and the law, including the doctrine of informed consent,<sup>10</sup> and the principle of "double effect."<sup>11</sup> This Comment then examines constitutional foundations of the right to die,<sup>12</sup> and the law of physician-assisted suicide in Illinois.<sup>13</sup> Discussing the present legal status of physician-assisted suicide, this Comment reviews the contemporary crime of assisting a suicide,<sup>14</sup> and the role of double effect.<sup>15</sup> This Comment next examines legislative efforts to legalize physician-assisted suicide, and analyzes the provisions<sup>16</sup> and outcomes of modern legislative efforts.<sup>17</sup> A discussion<sup>18</sup> and analysis<sup>19</sup> of the constitutional implications of physician-assisted suicide laws follows. This Comment then analyzes the crime of assisting a suicide<sup>20</sup> and its relation to double effect.<sup>21</sup> Next, various approaches to statutory legalization of physician-assisted suicide are examined.<sup>22</sup> To end the uncertainty and to protect the rights of the terminally ill, this Comment proposes that the Illinois General Assembly adopt a law<sup>23</sup> authorizing physician-assisted suicide.

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7. Prosecutions for assisting a suicide are rare and convictions even more scarce. No physician has been successfully prosecuted for assisting a patient in committing suicide. See *infra* note 83 and accompanying text.

8. See Julia Pugliese, *Don't Ask—Don't Tell: The Secret Practice of Physician-Assisted Suicide*, 44 HASTINGS L.J. 1291, 1293 (1993).

9. See *infra* Part II.A.

10. See *infra* Part II.B.

11. See *infra* Part II.C. In the context of physician-assisted suicide, the "double effect" refers to the practice of giving a terminally ill patient a lethal dose of pain killers, knowing it will kill him, but with the sole intention to relieve pain.

12. See *infra* Part II.D.

13. See *infra* Part II.E.

14. See *infra* Part III.A.

15. See *infra* Part III.A.3.

16. See *infra* Part III.B.1.

17. See *infra* Part III.B.2.

18. See *infra* Part III.C.

19. See *infra* Part IV.A.

20. See *infra* Part IV.B.

21. See *infra* Part IV.C.

22. See *infra* Part IV.D.

23. See *infra* Part V and Appendix A.

## II. BACKGROUND

### A. Traditional Criminal Treatment of Physician-assisted Suicide

In medieval England, committing suicide was considered a criminal act.<sup>24</sup> This policy endured and was maintained by the American colonies, and later by some states within the United States.<sup>25</sup> At common law, one who assisted in a suicide was also guilty of a crime—accessory to suicide.<sup>26</sup> Usually, such persons were charged either with murder or manslaughter.<sup>27</sup> As long as suicide itself remained a punishable offense, it was not necessary to establish an independent crime of assisting a suicide.<sup>28</sup>

A difficulty arose when the states universally de-criminalized suicide.<sup>29</sup> This mass elimination did not reflect a new societal

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24. WAYNE R. LAFAVE & AUSTIN W. SCOTT, JR., *SUBSTANTIVE CRIMINAL LAW* § 7.8 (2d ed. 1986). Laws against suicide have their origin in Judeo-Christian values, particularly the principle of the sanctity of life. See Richard Doerflinger, *Assisted Suicide: Pro-Choice or Anti-Life?*, in *MORAL ISSUES AND CHRISTIAN RESPONSE* 363 (Paul Jersild & Dale Johnson eds. 1993). This ethic includes the idea that any life is better than no life at all. JERRY B. WILSON, *DEATH BY DECISION, THE MEDICAL, MORAL AND LEGAL DILEMMAS OF EUTHANASIA* 23 (1975) [hereinafter *DEATH BY DECISION*]. In feudal times, the personal possessions of one who committed suicide went to his lord. LAFAVE & SCOTT, *supra* § 7.8. Suicide was eventually classified as a felony as a means of enriching the crown, since personal possessions of a felon would escheat to the state. *Id.* (citing Hales v. Petit, 1 Polwd. 253, 75 Eng. Rep. 387 (C.B. 1565)). For a detailed history of suicide and assisted suicide as a crime, see Maria T. Celocruz, *Aid-in Dying: Should We Decriminalize Physician-Assisted Suicide and Physician-Committed Euthanasia?*, 18 *AM. J. L. & MED.* 369, 373-77 (1992).

25. *Compassion in Dying v. State of Washington*, 79 F.3d 790, 809, n.39 (9th Cir.), *cert. granted*, 117 S. Ct. 37 (1996).

26. ROLLIN M. PERKINS, *CRIMINAL LAW* 585 (1957). Generally, such persons were charged as principals in the second degree. See *Commonwealth v. Hicks*, 82 S.W. 265 (Ky. 1904) (noting that one who provides another with the means to commit suicide is a principal in the second degree even though he does not actually perform the action which causes death). See also *McMahan v. State*, 53 So. 89 (Ala. 1910) (holding that even though the distinction between first and second degree no longer exists, one who assists another in a suicide is a principal to the suicide).

27. See, e.g., *Hicks*, 82 S.W. at 266 (stating that knowingly providing a person with morphine for the purpose of assisting that person's suicide is murder); *State v. Ludwig*, 70 Mo. 412 (1879) (a person assisting another in the commission of self-murder was guilty of first-degree manslaughter), *overruled in part on other grounds by State v. Fitzgerald*, 32 S.W. 1113 (Mo. 1895).

28. Cf. PERKINS, *supra* note 26, at 586. See also, e.g., *Sanders v. State*, 112 S.W. 68 (Tex. Crim. App. 1908) (holding that although directly administering poison to a willing recipient would indeed be considered murder, supplying a person with poison used to commit suicide was not criminal as long as suicide itself was not a crime), *overruled on other grounds by Aven v. State*, 277 S.W. 1080 (Tex. Crim. App. 1925).

29. See LAFAVE & SCOTT, *supra* note 24, § 7.8, at 649.

acceptance of suicide; rather, it was done for practical reasons.<sup>30</sup> An effective suicide was an unpunishable crime.<sup>31</sup> Failed attempts were deemed to be the acts of depressed or mentally ill persons, who were in greater need of psychological attention than criminal punishment.<sup>32</sup> However, because suicide was still considered an evil to be discouraged, many states enacted assisted suicide laws to continue to punish accessories.<sup>33</sup> Criminal codes of at least thirty-four jurisdictions classified assisting a suicide either as manslaughter, or as an independent crime.<sup>34</sup> Even in states which have not enacted a specific law to punish assisted suicide, the act could still be punished as a common law subdivision of murder.<sup>35</sup> In the history of such laws, no explicit exceptions were made for physicians who knowingly helped suffering patients die.<sup>36</sup> The role of physicians and medicine, however, greatly impacted the assisted suicide issue.<sup>37</sup>

### B. *The Role of Informed Consent*

Traditionally, medicine has been viewed as a paternalistic profession, where the educated doctor knew best and made most, if not all, of the decisions related to patient treatment and care.<sup>38</sup> In 1914, a phrase in the *Schloendorff v. Society of New York Hospital*<sup>39</sup> case dramatically altered the doctor-patient relationship.<sup>40</sup> Writing for

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30. *See id.*

31. *See* Richard S. Myers, *An Analysis of the Constitutionality of Laws Banning Assisted Suicide From the Perspective of Catholic Moral Teaching*, 72 U. DET. MERCY L. REV. 771, 775 (1995) (analyzing the constitutionality of laws banning assisted suicide from the perspective of traditional Catholic teaching).

32. *Id.*

33. *See* LAFAVE & SCOTT, *supra* note 24, § 7.8(c), at 651-52.

34. Jeremy A. Sitcoff, Note, *Death With Dignity: AIDS and a Call for Legislation Securing the Right to Assisted Suicide*, 29 J. MARSHALL L. REV. 677, 693 nn.113-15. (1996) (identifying thirty-four states that have statutory bans, nine that have a common law prohibition, and only one state, Ohio, that does not punish those who assist in suicide). The Illinois law is Inducement to Commit Suicide, Act 720 ILL. COMP. STAT. 5/12-31. *See* LAFAVE & SCOTT, *supra* note 24, § 7.8(c), at 651-52.

35. *See* LAFAVE & SCOTT, *supra* note 24, § 7.8(c), at 651-52; *see, e.g.*, *People v. Roberts* 178 N.W. 690 (Mich. 1920), *overruled in part by People v. Kevorkian*, 527 N.W.2d 714 (Mich. 1994).

36. *See, e.g.*, *People v. Kevorkian*, 517 N.W.2d 293, 297 (Mich. Ct. App.) (holding that the common law ban on assisted suicide still exists and applies to physicians), *vacated and remanded*, 527 N.W.2d 714 (Mich. 1994).

37. *See infra* Part II.B.

38. *Informed Consent, Parental Permission, and Assent on Pediatric Practice*, 95 PEDIATRICS 314, (Feb. 1995) [hereinafter *Informed Consent, Parental Permission*].

39. 105 N.E. 92 (N.Y. 1914), *overruled on other grounds by Bing v. Thunig*, 143 N.E.2d 3 (N.Y. 1957).

40. *See* W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 32, at

the New York Court of Appeals, Justice Cardozo stated: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body."<sup>41</sup> The decision did not concern a physician who acted without consent, rather one who acted in contradiction to his patient's explicit wishes.<sup>42</sup> However, the decision came to represent that all patients had the right to determine how they will be medically treated.<sup>43</sup> This principle of self-determination included the patients' right to make informed decisions about their own health care and established two duties for doctors.<sup>44</sup> The first duty requires doctors to give patients sufficient information to allow them to make informed, rational health care decisions.<sup>45</sup> The second duty requires doctors to abide by a patient's wishes.<sup>46</sup>

*Schloendorff* represented more than just a redefinition of the physician's role, it was the basis of a dramatic shift of power from the doctor to the patient.<sup>47</sup> Informed consent puts patients in charge of their medical decisions and shifts the physician's role from paternalistic decision maker to facilitator of the patient's will.<sup>48</sup>

### C. *The Double Effect*

Reflecting the belief among doctors that occasionally the obligation to alleviate suffering should outweigh a mechanical extension of life, physicians engage in the "double effect."<sup>49</sup> The term double effect comes from the philosophical principle that an act having two effects, one good and one bad, is justified when the good outweighs the bad and the actor's intention is to do good.<sup>50</sup> In the context of physician-assisted suicide, the double effect describes the practice of knowingly prescribing a lethal dose of pain killers, if the patient is dying and if the

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190 (5th ed. 1984) [hereinafter PROSSER & KEETON].

41. *Schloendorff*, 105 N.E. at 93.

42. *Id.* at 93.

43. RUTH FADEN ET AL., A HISTORY AND THEORY OF INFORMED CONSENT 123 (1986) (noting that while the *Schloendorff* decision did not require a doctor to inform his patient, it is nevertheless widely cited as the foundation of a patient's right to self-determination)

44. *Id.* at 125. See PROSSER & KEETON, *supra* note 40, at §§ 18, 32.

45. See FADEN, *supra* note 43, at 123.

46. *Id.*

47. See *Informed Consent, Parental Permission*, *supra* note 38, at 315.

48. See PROSSER & KEETON, *supra* note 40, at 191.

49. See Anthony Fisher, *Did God Kill Jesus? The Limits to the Duty of Care*, in THEOLOGICAL ASPECTS OF EUTHANASIA 323-24 (John Keown ed., 1995)

50. *Id.* This principal has its origin in Catholic doctrine, which places primary importance on the actor's subjective intention to do good. *Id.*

primary purpose in administering the drugs is to alleviate pain.<sup>51</sup> Usually, though not always, doctors prescribe such medication with the knowledge and consent of their patient.<sup>52</sup> In any event, the physician plays an active role, professionally assessing the patient's prognosis and pain level to determine medical options.<sup>53</sup>

*D. Dying and the Law: The Constitutional Right  
To Refuse Medical Treatment*

Nancy Cruzan was a high school student who lost control of her car in early 1983.<sup>54</sup> As a result of the accident, Nancy suffered tremendous injuries that rendered her unconscious but still able to breathe.<sup>55</sup> At the hospital, Nancy remained in a "persistent vegetative state," and was kept alive by means of a feeding tube.<sup>56</sup> When it became apparent that Nancy had virtually no chance of recovering her mental capabilities, Nancy's parents asked that her feeding tubes be removed.<sup>57</sup> The hospital staff refused.<sup>58</sup>

Nancy's parents sued, and the case went to the Supreme Court. In *Cruzan v. Missouri Department of Health*,<sup>59</sup> the United States Supreme Court ruled that the hospital was not required to allow Nancy to die absent clear evidence that death was her intent.<sup>60</sup> The *Cruzan* Court recognized that the question of intent essentially belonged to the state.<sup>61</sup> The Court also recognized that Missouri had a legitimate interest in ensuring that Nancy did not intend to exist in a persistent vegetative state, attached to machines.<sup>62</sup> Although the Court did not allow Nancy's parents to terminate her life support, it did generally

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51. *Id.*

52. Thomas A. Preston, *Physician Involvement in Life-Ending Practices* 18 PUGET SOUND L. REV. 531, 539 (1995) (noting that obtaining consent to a double effect procedure is complicated by the necessity of performing the act with no intention to cause death).

53. See Dieter Giesen, *A Comparative Legal Perspective*, in THEOLOGICAL ASPECTS OF EUTHANASIA 205 (John Keown ed., 1995).

54. See *Cruzan v. Missouri Dep't of Health*, 497 U.S. 261, 265 (1990).

55. *Id.*

56. *Id.*

57. *Id.*

58. *Id.*

59. 497 U.S. 261 (1990).

60. *Id.* at 286; see also *id.* at 292 (Scalia, J., concurring).

61. *Id.* at 292 (Scalia, J., concurring).

62. *Id.* at 283.

acknowledge a person's right to refuse treatment.<sup>63</sup> The Court based this right on a constitutionally protected liberty interest.<sup>64</sup>

In a subsequent state court hearing, Nancy's co-workers told a judge that Nancy said she would not want to live like a vegetable on a machine.<sup>65</sup> This testimony established the requisite "clear intent," and a Missouri judge allowed her feeding tube to be removed.<sup>66</sup> Nancy died in 1990, shortly after the release of the *Cruzan* decision.<sup>67</sup>

The *Cruzan* decision sparked a flurry of state regulations permitting the withdrawal or refusal of medical treatment.<sup>68</sup> It also helped fuel debate over the scope of a person's right to die and the conditions under which a person should be permitted to end her life.<sup>69</sup> Legal scholars argued that *Cruzan* raised a question that the decision failed to answer directly: does the right to die include physician-assisted suicide?<sup>70</sup>

### E. The Illinois Perspective

By the turn of the century, Illinois officially recognized assisting or promoting a suicide as a common law subdivision of murder.<sup>71</sup> In

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63. *Id.* at 278.

64. *Id.* at 278-79. However the Court also held that this interest must be balanced against competing state interests. *Id.* at 279. It is a legitimate state interest to prevent the erroneous disconnection of life support. *Id.* at 283. Accordingly, the Court held that Missouri could require clear evidence of Nancy's intent to die. *Id.* at 284.

65. *Nancy Cruzan Dies, But the Issue Lives On*, CHI. TRIB., Dec. 27, 1990, at § 1.

66. *Id.*

67. See Robert Stienbrook, *Comatose Woman Dies after Artificial Feedings are Halted*, L.A. TIMES, Dec. 17, 1990, at A3.

68. See Rita W. Morales, *The Twilight Zone of Nancy Beth Cruzan: A Case Study of Nancy Beth Cruzan v. Director, Missouri Department of Health*, 34 How. L.J. 201, 223.

69. See Scott Charton, *Court Stops Father from Transferring Ill Daughter*, COMMERCIAL APPEAL, Dec. 31, 1990, at A2.

70. See John A. Robertson, *Cruzan and the Constitutional Status of Nontreatment Decisions for Incompetent Patients*, 25 GA. L. REV. 1139, 1172 (1991).

71. See *Burnett v. People*, 68 N.E. 505 (Ill. 1903). The defendant, a married man, was having an affair with a married woman. *Id.* at 506-07. The woman became despondent over the prospect of moving back to Tennessee with her husband. *Id.* at 506-07. The defendant provided the woman with morphine, which she used to kill herself. *Id.* at 507. The court stated:

Though the [defendant] may have known that the deceased intended to kill herself, and may have even assented to it . . . unless the evidence shows beyond a reasonable doubt that he did or said something which aided, encouraged, or induced the deceased to kill herself, he cannot be held guilty of the charge of murder.

*Id.* at 511. The defendant's conviction was reversed on a failure of the lower court to instruct the jury to consider evidence of the defendant's amicable relationship with the deceased woman. *Id.* at 511-12.



1990, the Illinois General Assembly made inducing suicide a crime.<sup>72</sup> In response to physicians who were openly helping patients die, the statute was amended to include assisting a suicide.<sup>73</sup>

As in the rest of the United States, physician-assisted suicide is not an unusual practice in Illinois.<sup>74</sup> Yet, no person has ever been charged under the inducement to commit suicide statute.<sup>75</sup> In fact, no person has ever endured criminal consequences for assisting a suicide in Illinois.<sup>76</sup> A rare prosecution for assisting a suicide ended under unusual circumstances in a finding of not guilty.<sup>77</sup>

In that case, Anna Werner, a Chicago resident, suffered from rheumatoid arthritis.<sup>78</sup> When the pain inflicted by her disease became

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72. 720 ILL. COMP. STAT. ANN. 5/12-31 (West 1993 & Supp. 1996). The statute reads:

(a) A person commits the offense of inducement to commit suicide when he or she does either of the following:

(1) Coerces another to commit suicide and the other person commits or attempts to commit suicide as a direct result of the coercion, and he or she exercises substantial control over the other person through

(i) control of the other person's physical location or circumstances;

(ii) use of psychological pressure; or

(iii) use of actual or ostensible religious, political, social, philosophical or other principles.

(2) With knowledge that another person intends to commit or attempt to commit suicide, intentionally

(i) offers and provides the physical means by which another person commits or attempts to commit suicide, or

(ii) participates in a physical act by which another person commits or attempts to commit suicide.

For the purposes of this Section, "attempts to commit suicide" means any act done with the intent to commit suicide and which constitutes a substantial step toward commission of suicide.

*Id.*

73. *Id.*

74. See Siegfried M. Pueschel, M.D., *Ethical Considerations in the Life of a Child with Down Syndrome*, 5 ISSUES IN LAW & MED. 87, 91 (1989) (stating that in 1961, a survey of 250 Chicago physicians revealed that 61% admitted knowing of, or participating in, instances of euthanasia). See *infra* Part III.A.1 for a general discussion of the prevalence of physician-assisted suicide among doctors.

75. 720 ILL. COMP. STAT. ANN. 5/12-31 (West 1993 & Supp. 1996). See also Tim Landis, *Test of State's Assisted-Suicide Law Looms*, STATE JOURNAL-REGISTER, Mar. 18, 1996, at 1. A man who handed a loaded gun to his depressed girlfriend saying "here, do it" might be the first person charged. *Id.* To date no charges have been filed.

76. See *supra* note 71 for a brief discussion of a conviction that was reversed.

77. See Glanville Williams, *Euthanasia and Abortion*, 38 U. COLO. L. REV. 178, 184-87 & n.15 (1966) (quoting a portion of the trial transcript of *People v. Werner* in the Criminal Court of Cook County, Illinois, Justice A. L. Marovitz presiding, 1958). This case involved a husband (rather than a physician) assisting in a suicide of his wife. *Id.*

78. *Id.* at 185 n.15 (noting that the disease incapacitated the victim).

unbearable, Mrs. Werner begged to be relieved of her misery, a request that Mrs. Werner's husband, Otto, honored.<sup>79</sup> Never denying what he did, Otto pleaded guilty to manslaughter.<sup>80</sup> After hearing about the sixty-nine year old man's loyalty and affection for his wife, the trial judge allowed him to withdraw his guilty plea.<sup>81</sup> Before acquitting Mr. Werner, the trial judge stated that "if . . . testimony was [sic] brought out of his devotion and care to his wife in her incurable illness and of her constant pain and suffering, the jury would not be inclined to return a verdict of guilty."<sup>82</sup>

### III. DISCUSSION

#### A. *The Modern Crime of Physician-Assisted Suicide*

##### 1. The Prevalence of Physician-Assisted Suicide

Although assisting a suicide has always been a crime in the United States, no American doctor has ever been convicted of providing a patient with the means to end his or her own life.<sup>83</sup> While a lack of

79. *Id.*

80. *Id.* at 184 n.15.

81. *Id.* at 185-86 n.15. In order to determine whether probation might be an appropriate sentence, Justice Marovitz heard testimony about the Werners' relationship from their children, their physician and their pastor. *Id.*

82. *Id.* at 186 n.15. Justice Marovitz further stated:

Mr. Werner, this is a time in one's life where good reputation and decency over a span of years pay off. I can't find it in my heart to find you guilty. I am going to permit you to go home with your daughter and live out the rest of your life in as much peace as you can find it in your heart to have.

*Id.*

83. See H. Tristram Engelhardt, Jr. & Michele Malloy, *Suicide and Assisting Suicide: A Critique of Legal Sanctions*, 36 Sw. L.J. 1003, 1029 (1982) (noting that as of 1982, "[n]o published American opinions . . . reported convictions of physicians for . . . assisting suicide"); see also Celacruz, *supra* note 24, at 383 (stating that "[j]uries seem unwilling to convict doctors of assisted suicide . . . even when other citizens are held criminally responsible for such conduct"). A search of the LEXIS mega library and mega file consisting of: (DOCTOR OR PHYSICIAN OR (MEDIC! W/2 PRACTITION! OR(HEALTH W/2 PROVID!)) W/3 (CONVICT! OR GUILT! OR RESPONSIBL! OR CHARGE! OR LIABL!) W/3 ((AID.! OR ABET! OR PROMOT! OR ASSIST! OR SOLICIT! PROCUR!) W/3 (SUICIDE OR DIE OR DEATH OR DYING)) returned only one case. That decision, *People v. Kevorkian*, 527 N.W.2d 714 (Mich. 1994), stated that Michigan's statute criminalizing assisted suicide was validly enacted under both the Michigan and the United States Constitutions. *Id.* at 444-45. On remand, Kevorkian was acquitted of all charges. *Michigan Senate Moves to Ban Assisted Suicides*, WASH. POST, Dec. 8, 1994, at A2. Another commentator notes that prior to Kevorkian's activities, only nine American doctors were ever charged. Michael J. Roth, *A Failed Statute, Geoffrey Feiger, and the Phrenetic Physician: Physician-Assisted Suicide in Michigan and a Patient-Oriented Alternative*, 28 VAL. U. L. REV. 1415, 1415 (1994). Similar searches of LEXIS

guilty verdicts does not mean that these physicians' actions comply with the law,<sup>84</sup> a significant number of doctors use their positions to provide means for their patients to commit suicide.<sup>85</sup> In one study, seven percent of respondents acknowledged that they had written prescriptions for lethal dosages for at least one patient.<sup>86</sup> Considering there are over 650,000 doctors licensed to practice in the United States, this amounts to a substantial number of incidents of physician-assisted suicide.<sup>87</sup> Additionally, an unknown number of doctors who engage in physician-assisted suicide do so more than once during their careers.<sup>88</sup>

Part of the difficulty in determining the prevalence of physician-assisted suicide is that most of the time the practice occurs in secret.<sup>89</sup> Still, not all physicians assist under cover; some make it a public affair.<sup>90</sup> In 1991, New York physician Dr. Timothy Quill published an article in the *New England Journal of Medicine* describing his

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news databases revealed no convictions.

84. See Pugliese, *supra* note 8, at 1305-06.

85. See *id.* (noting that many physicians assist suicides without receiving Kevorkian's notoriety). See also Anthony L. Back et al., *Physician-Assisted Suicide and Euthanasia in Washington State: Patient Requests and Physician Responses*, 275 *JAMA* 919, 919-20, 922 (1996) (reporting that 26% of polled physicians had received a request for physician-assisted suicide and that these physicians wrote lethal prescriptions for 24% of all requesting patients); Paul Jacobs, *Quietly, Doctors Already Help Terminal Patients Die*, *L.A. TIMES*, Sept. 29, 1992, at A1 (noting that many doctors assist in suicide but fear the legal consequences); Andrew H. Malcolm, *Giving Death a Hand: Rending Issue*, *N.Y. TIMES*, June 9, 1990, at A6 (describing the increasing trend of quiet physician-assisted suicide).

86. Melinda A. Lee et al., *Legalizing Assisted Suicide—Views of Physicians in Oregon*, 334 *N. ENG. J. MED.* 310, 313 (1996). Most surveys on the subject reporting much higher figures are unreliable in part because the overly-broad way in which the question is presented fails to confine the results to physician-assisted suicide. See generally Ezekiel J. Emanuel et al., *Euthanasia and Physician-Assisted Suicide: Attitudes and Experiences of Oncology Patients, Oncologists, and the Public*, 347 *THE LANCET* 1805 (June 29, 1996) (posing a broad survey question seeking circumstance information as well as physician-assisted suicide statistics). Still, those higher figures may include deaths resulting from the double effect. See *supra* Part II.C.

87. See BUREAU OF THE CENSUS, U.S. DEP'T OF COMMERCE, *STATISTICAL ABSTRACT OF THE UNITED STATES 1995*, at 121 (115th ed. 1995). The data also shows that the number of physicians in the United States has increased with every Census, and has doubled between 1970 and 1993. *Id.*

88. See, e.g., Dick Lehr, *Increasingly, Secretly, Physicians are Helping the Incurably Ill to Die*, *BOSTON GLOBE*, April 25, 1993 (City Edition), § Metro/Region, at 1 (profiling a doctor who has assisted over 20 patients in suicide); see also Jacobs, *supra* note 85, at A1 (describing a physician who has participated in physician-assisted suicide twice).

89. Pugliese, *supra* note 8, at 1306.

90. Timothy E Quill, *Death And Dignity—A Case of Individualized Decision Making*, 324 *N. ENG. J. MED.* 691 (1991).

experience in prescribing a lethal dose of pain killers to a terminally ill patient.<sup>91</sup> Not only did Dr. Quill “confess” to committing a crime, he did it in one of the most widely read and well respected medical journals in the world.<sup>92</sup> Dr. Quill intended to stir discussion, but the resulting noise was too much for the state of New York to ignore.<sup>93</sup> Despite plain evidence that Quill violated both the manslaughter<sup>94</sup> and promotion of attempted suicide statutes,<sup>95</sup> a grand jury refused to indict.<sup>96</sup> In a disciplinary hearing before the New York Board for Professional Medical Conduct, members said that, while they could not condone physician-assisted suicide, Quill’s actions were “legal and ethically appropriate.”<sup>97</sup>

## 2. The Role of the American Medical Association & the Hippocratic Oath

The American Medical Association (“AMA”) is officially opposed to physician-assisted suicide.<sup>98</sup> The AMA views such acts as antithetical to a doctor’s fundamental role as a healer and guardian of life.<sup>99</sup> Many individual doctors agree.<sup>100</sup> Even the Hippocratic Oath seems to be explicitly opposed to physician-assisted suicide. It states:

91. *Id.* at 691-94 (describing “Diane,” her horrible illness, her strength, and her difficult decision to elect physician-assisted suicide).

92. *Id.*

93. TIMOTHY E. QUILL, M.D., *DEATH AND DIGNITY* 21 (1993). “My intention . . . was to challenge the medical profession to take a more personal, in-depth look at end-of-life suffering.” *Id.* at 20. Dr. Quill adds: “After the article was published, I received an unwanted education as to how our legal system both works and doesn’t work. . . . I underestimated the extent to which the general public and the legal system would become interested and involved.” *Id.* at 21.

94. *See* N.Y. PENAL LAW § 125.15 (McKinney 1987) (providing in pertinent part: “A person is guilty of manslaughter in the second degree when [h]e intentionally causes or aids another person to commit suicide”).

95. *Id.* § 120.30 (making it a felony to “intentionally cause[or aid] another person to attempt suicide”).

96. *See generally* *Doctor Who Aided Suicide Cleared of Misconduct*, L.A. TIMES (Bulldog Edition), Aug. 18, 1991, at A32 (noting that the state health board cleared Quill).

97. *Id.* (commenting that the board cleared Quill because Quill could not know what the patient would do with the barbituates he prescribed for her).

98. *See* Janet Firshein, *US Medics Oppose Physician-Assisted Suicide*, 348 LANCET 1439, 1439 (November 23, 1996). Despite recent efforts at changing the policy, the AMA affirmed this position after only ten minutes of debate. *A.M.A. Keeps Its Policy Against Aiding Suicide*, N.Y. TIMES, June 26, 1996 (Late Edition), at C9.

99. Jeremy Manier, *AMA Affirms Opposition to Assisted Suicide*, CHI. TRIB., June 26, 1996, at N6 (stating that the AMA overwhelmingly upheld its opposition to physician-assisted suicide).

100. *Id.*

“I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect.”<sup>101</sup>

However, another overarching theme of the oath is the prevention of suffering.<sup>102</sup> Many doctors believe that there are circumstances where this principle overrides a compulsion to extend life.<sup>103</sup> In fact, recent polling data suggests that a majority of Michigan doctors favor legalizing physician-assisted suicide.<sup>104</sup> Physicians holding this belief are influenced in part by their experiences with individual patients.<sup>105</sup> Many have been directly requested to assist a patient in suicide.<sup>106</sup> Often, when faced with what they considered to be “the right circumstances,” they helped a patient to die.<sup>107</sup> Still, doctors are concerned with the legal repercussions of their actions and most feel that some form of regulation is needed.<sup>108</sup>

Ironically, such willingness on the part of doctors to engage in illegal activity has its roots in a rule of law.<sup>109</sup> The doctrine of informed consent changed the way physicians practiced medicine.<sup>110</sup> Under the paternalistic approach, doctors were less likely to assist a

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101. GEORGE M. BURNELL, M.D., *FINAL CHOICES: TO LIVE OR TO DIE IN AN AGE OF MEDICAL TECHNOLOGY* 344 (1993) (quoting L. Edelstien, *The Hippocratic Oath: Text, Translation and Interpretation*, in *ANCIENT MEDICINE* 3-63 (O. Temkin & C. Lillian Temkin eds., 1967)).

102. See Cheryl K. Smith, *What about Legalized Assisted Suicide?*, 8 *ISSUES IN LAW MED.* 503, 512 (1993) (noting that the Hippocratic oath, and medicine in general, direct physicians to eliminate suffering). See also QUILL, *supra* note 93, at 43 (same).

103. See Roth, *supra* note 83, at 1418-19 (medical community recognizes the dilemma physicians face).

104. Jerald G. Bachman et al., *Attitudes of Michigan Physicians and the Public Toward Legalizing Physician Assisted Suicide and Voluntary Euthanasia*, 334 *NEW ENG. J. MED.* 303, 303 (1996) (finding that “most Michigan physicians prefer either the legalization of physician-assisted suicide or no law at all; fewer than one fifth prefer a complete ban on the practice”).

105. See Lehr, *supra* note 88, at § Metro/Region, at 1.

106. See Back et al., *supra* note 85, at 920.

107. *Id.* at 922. “Physicians provided a prescription to 24% (38 of 156) of the patients who requested physician-assisted suicide, and appeared to consider physical symptoms and expected survival in these decisions.” *Id.*

108. See Bachman et al., *supra* note 104, at 303. “When the physicians were given a wider range of choices, 40 percent preferred legalization, 37 percent preferred ‘no law’ (i.e., no government regulation), 17 percent favored prohibition, and 5 percent were uncertain.” *Id.*

109. Note, *Physician-Assisted Suicide and The Right to Die with Assistance*, 105 *HARV. L. REV.* 2021, 2025 (1995). But see Willard C. Shih, *Assisted Suicide, The Due Process Clause and “Fidelity in Translation,”* 63 *FORDHAM L. REV.* 1245, 1258 (1995) (arguing that there is no logical connection).

110. See BURNELL, *supra* note 101, at 153-54 (arguing that doctors expect patients to take a more active role in decision-making).

patient in suicide,<sup>111</sup> primarily because doctors were unwilling to make a decision of such gravity for another.<sup>112</sup> Also, under the paternalistic approach, doctors were less respectful of a patient's opinion about the best medical course.<sup>113</sup> Over time, the informed consent doctrine helped to change the attitude of doctors toward physician-assisted suicide.

### 3. The Double Effect and the Present Law of Physician-Assisted Suicide

As a practice, the double effect enjoys broad-based approval from religious groups, physicians, and euthanasia advocates.<sup>114</sup> Many commentators also maintain that the practice is generally legal.<sup>115</sup> In

111. Cf. WILSON, *supra* note 24, at 98-99 (illustrating the doctor's dilemma, and noting that public expectations and the professional oath require the doctor to keep his patient alive).

112. Cf. *id.*

113. Cf. BURNELL, *supra* note 101, at 153-54.

114. The origin of Catholic acceptance comes from the writings of Pope Pius XII. He stated:

If, between the [relief of pain through medication] and the shortening of life, there exists no direct causal link, imposed either by the intention of the interested parties or the [circumstances] (*as would be the case if the suppression of the pain could be obtained only by the shortening of life*) and if, on the contrary, the administration of the [medication] produces two distinct effects, one the relief of pain and the other the shortening of life, then the action is lawful; however it must be determined whether there is a reasonable proportion between these two effects and whether the advantages of the one effect compensate for the disadvantages of the other. It is also important to ask . . . whether the present state of science does not make it possible for the same result to be obtained by other means. Finally, in the use of the [medication,] one should not go beyond the limits which are actually necessary.

4 THE POPE SPEAKS 48 (1957) (emphasis added).

A commentator writes: "[a] class of actions can be designated 'double effect euthanasia.' Theologically and morally it is acceptable for a patient to choose palliative treatments that may result in death and for a physician to administer potentially lethal analgesia in the relief of pain." Kenneth L. Vaux, *The Theological Ethics of Euthanasia*, in MORAL ISSUES AND CHRISTIAN RESPONSES 360 (Paul T. Jerslid & Dale A. Johnson eds., 5th ed. 1993). "The administration of a drug necessary to ease the pain and suffering of a patient who is terminally ill and suffering . . . may be appropriate . . . even though the effect of the drug may be to shorten life." *Decisions Near the End of Life*, 267 JAMA 2229 (1992) (quoting a conclusion of the AMA Council on Ethical & Judicial Affairs). Dr. Timothy Quill writes that "[a]ccepting the double effect in the care of the terminally ill has humanized and substantially improved the quality of life before death for many patients." See QUILL, *supra* note 93, at 78.

115. See, e.g., Yale Kamisar, *Physician-Assisted Suicide: the Last Bridge to Active Voluntary Euthanasia*, in EUTHANASIA EXAMINED: ETHICAL, CLINICAL AND LEGAL PERSPECTIVES 240 (John Keown ed., 1995) (remarking without citation that "[t]he law contains a number of exceptions . . . [and] recognizes the principal of the 'double effect'

fact, there is no evidence to suggest that the double effect acts as a common law exception to the crime of assisting a suicide.<sup>116</sup> It is widely acknowledged, however, that the double effect is a more or less routine procedure.<sup>117</sup>

### *B. Regulating Physician-Assisted Suicide Through Legislation*

Although only one piece of legislation authorizing physician-assisted suicide has ever been enacted in the United States, bills have been proposed to legislatures in several states.<sup>118</sup> Statutes and proposed legislation that permit physician-assisted suicide do so by conferring criminal immunity on the assisting physician.<sup>119</sup> However, these laws differ in two ways: (1) how they accomplish the result of allowing physician-assisted suicide; and (2) the limitations and duties imposed on the various actors.<sup>120</sup>

#### 1. Design and Structure: Varying Means to the Same End

All modern physician-assisted suicide legislation share common objectives. These objectives include defining the participants, i.e. who is permitted to assist and who is permitted to die, preserving the legal status of those involved,<sup>121</sup> and safeguarding the process. Guiding these objectives are two essential purposes of physician-assisted suicide laws: the availability of a safe, dignified, and effective means to end otherwise untreatable suffering, and protection of a patient's

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. . . . It does so by exempting 'prescribing, dispensing or administering' medication or treatment designed 'to relieve pain or discomfort and not to cause death, even if the medication or procedure may hasten or increase the risk of death'").

116. See *infra* text accompanying notes 370-75 for an analysis of the common law treatment of the double effect.

117. Ben A. Rich, *Postmodern Medicine: Deconstructing the Hippocratic Oath*, 65 U. COLO. L. REV. 77, 89 (1993) (noting that the patient's death results from an acceptable action).

118. See Oregon Death with Dignity Act, OR. REV. STAT. § 127.810 -.897 (1995) [hereinafter ODWDA]. This statute faces constitutional challenges that question the validity of physician-assisted suicide laws generally. See *infra* Part III.B.2 for a discussion of the Oregon law and its constitutionality. For an example of a proposed physician-assisted suicide law, see S. 334, Gen. Assembly, Jan. Sess. (Conn. 1995).

119. For the purposes of this Comment, "laws" include proposed laws. Most physician-assisted suicide laws also extend civil immunity to participants. See, e.g., H.R. 109, 69th Biennial Sess. § 5293(A) (Vt. 1997).

120. See *infra* Part III.B.1.

121. Aside from granting civil and criminal immunity from liability, physician-assisted suicide laws seek to eliminate any legal complications for patients or their families. See, e.g., H.R. 1023, 1996 Leg. Sess., Reg. Sess. (Mass. 1996) (citing such a goal in the statement of purpose). Pay-outs from insurance, the construction of wills and the dispositions of estates remain unchanged by participation in legalized physician-assisted suicide. *Id.*

basic right of self-determination.<sup>122</sup> To accomplish these goals, each physician-assisted suicide law also shares common requirements.<sup>123</sup> Still, physician-assisted suicide laws are not identical: various means are used to achieve the same basic goals. Generally, the differences are procedural, but some differences are attributable to nuances among definitions.

#### a. The Requesting Patient

One area where requirements can vary greatly is the qualifications placed on participants, especially the requesting patient. For example, although all proposed physician-assisted suicide legislation requires a requesting patient to be diagnosed as "terminal," definitions of this term differ.<sup>124</sup> Most legislation attaches a time limitation to the impending death. Of these, nearly all define terminal to mean that the patient has less than six months to live.<sup>125</sup> A fraction do not consider a patient's life expectancy in the definition.<sup>126</sup> Another variation

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122. *See, e.g., id.* (stating that the purpose of the act is "to end one's life in a humane and dignified manner"). *See also* H.R. 339, Reg. Sess. (N.H. 1995) (stating that "persons have a right, founded in the autonomy of the person, to control the decisions relating to the rendering of their own medical care" and permitting physician-assisted suicide for "a patient in a condition of 'severe, unrelenting suffering'"). *See also* Annette E. Clark, *Autonomy and Death*, 71 TUL. L. REV. 45, 104 (1996); *see also supra* notes 39-48 (discussing Justice Cardozo's opinion in *Schloendorff*).

123. *See, e.g., S. 334*, Jan. Sess. (Conn. 1995) (capsulizing these requirements into a simple defense to manslaughter). The proposed law provided that:

the general statutes be amended to provide an affirmative defense to manslaughter in the second degree for physician-assisted suicide if:

the physician is licensed in this state,

the victim made a written request to the physician for the medication which was self-administered,

the victim was eighteen years of age or older and able to understand the nature and consequences of such medication and

the victim was deemed to be in terminal condition.

*Id.*

124. A medical dictionary defines a terminal illness as "an illness that because of its nature can be expected to cause the patient to die. Usually a chronic disease for which there is no known cure." *TABER'S CYCLOPEDIA MEDICAL DICTIONARY* 1708 (Clayton L. Thomas, M.D., M.P.H. ed., 15th ed. 1985). All physician-assisted suicide laws agree that at a minimum, terminal means that the condition causing the suffering will eventually result in the patient's death.

125. *See, e.g., H.R. 5015*, 88th Leg., Reg. Sess. § 1(n) (Mich. 1995). *But see, H.R. 109*, 64th Biennial Sess. (Vt. 1997) (defining "terminal" to mean a condition that is likely to produce death within one year).

126. *See Terminally Ill Patient Act of 1995*, S. 5596, 454th Leg., Reg. Sess. § 3.8 (Wash. 1995) (requiring only that death will result within a "reasonable period of time, in accordance with accepted medical standards").



involves the cause of a patient's impending death.<sup>127</sup> Some restrict the cause to mean a disease.<sup>128</sup> Others use broader terms such as "condition"<sup>129</sup> or "bodily disorder."<sup>130</sup> Following the traditional medical meaning, most laws also require that a terminal illness be incurable and irreversible.<sup>131</sup>

The biggest disparities in qualifying a patient are found in the area of competency.<sup>132</sup> Competency, as it relates to physician-assisted suicide, can be divided into several aspects. These include adulthood, the ability to understand and articulate medical decisions, and freedom from depression or some other mental disorder.<sup>133</sup> Restricting a request for physician-assisted suicide to competent patients reflects a long standing legal tenet that only persons who are able to comprehend the consequences of a decision should be allowed to make it.<sup>134</sup> Interestingly, while all physician-assisted suicide laws require that the requesting patient be an adult, not all require that the patients be able to understand what they request.<sup>135</sup> However, many laws do state that a requesting patient must have "the ability to make and communicate health care decisions."<sup>136</sup> Leaving no room for doubt, one law

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127. See *infra* notes 128-31 and accompanying text for various definitions of impending death.

128. See, e.g., Colorado Dignity in Death Act, H.R. 1185, 60th Gen. Assembly., 2d Reg. Sess. (Colo. 1996) (defining terminal disease as an incurable and irreversible disease).

129. See, e.g., S. 1007, 42d Leg., 2d Reg. Sess. (Ariz. 1996) (defining terminal condition as a condition from an accident or disease that will cause death within 6 months).

130. See, e.g., S. 2985, 1996 Leg., Jan. Sess. (R.I. 1996) (defining terminal illness as a bodily disorder that is likely to cause death within 6 months).

131. See, e.g., H.R. 5015, 88th Leg., Reg. Sess. (Mich. 1995). *But see* S. 2985, Jan. Sess. (R.I. 1996) (defining terminal illness as "a bodily disorder that is likely to cause a patient's death within six months" and permitting physician-assisted suicide for any person diagnosed as having either a "terminal illness or from a bodily illness that is intractable and unbearable"). See *supra* note 124 for the traditional medical meaning of terminal illness.

132. See *infra* notes 133-48 and accompanying text for a discussion of the competing definitions.

133. See H.R. 474, 1996 Leg. Sess. (Md. 1996). The law permits a "qualified patient" to request physician-assisted suicide and defines qualified as having "a mentally competent adult patient." *Id.* at § 5.701(J) The law forbids the writing of a lethal prescription to any patient whose request for physician-assisted suicide was motivated by depression. *Id.* at § 5.705(B)(4).

134. Cf. 17 AM. JUR. 2D *Contracts* § 23 (1995) (stating that "[t]he parties must be capable of intelligent assent in order to make a valid contract. Where there is no capacity to understand or agree, there can be no contract.>").

135. See, e.g., S. 1007, 42d Leg., 2d Reg. Sess. § 36-3101(8) (Ariz. 1996) (requiring that a patient be "competent" without defining what that means.)

136. Colorado Dignity in Death Act, H.R. 1185, 60th Gen. Assembly, 2d Reg. Sess.

provides that “[i]ncapable means [that a patient is] unable to understand and appreciate the nature and consequences of health care decisions, including the administration of aid-in-dying, or unable to communicate in any manner whatsoever an informed health care decision.”<sup>137</sup>

A competent patient must also have rational motivations.<sup>138</sup> Accordingly, many laws require the assisting physician to refer a patient to a licensed counselor or psychiatrist if he suspects that patient may be suffering from depression or some other psychological disorder.<sup>139</sup> If the counselor confirms these suspicions, the physician is prohibited from assisting the patient.<sup>140</sup> Other laws are more thorough, requiring psychological evaluations as a matter of course.<sup>141</sup> However, not all physician-assisted suicide laws automatically reject a patient who is suffering from depression or mental impairment.<sup>142</sup> Some do so only when the request is motivated by the psychological disorder, or when the disorder makes a requesting patient unable to understand his diagnosis or request.<sup>143</sup>

In order to ensure competency through procedural safeguards, physician-assisted suicide laws often regulate the timing of events. The most common of such regulations is a mandatory waiting period.<sup>144</sup> Generally, statutes prescribe a minimum amount of time a patient must wait between his first and second requests.<sup>145</sup> Waiting

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(Colo. 1996).

137. Physician Aid-In-Dying Act, L.N. 1259, 94th Leg., 2d Sess. (Neb. 1995). This law authorizes “voluntary active euthanasia,” *not* physician-assisted suicide. Voluntary active euthanasia (“VAE”) is defined as “the deliberate administration of life-shortening substances with the intention to cause death in order to end pain and suffering.” See Giesen, *supra* note 53, at 202. Active euthanasia is distinguished from assisted-suicide in two ways. *Id.* at 206. First, a person assisting in a suicide does not perform the immediate act which causes death. *Id.* Second, a person engaging in active euthanasia may not be doing so according to the wishes of the patient. *Id.*

138. See S. 2985, 1996 Leg., Jan. Sess. § 23-4.12-1 (R.I. 1996) (stating that a purpose of the act is “to ensure that the request for . . . assistance is complied with only when it is . . . reasoned”).

139. See, e.g., S. 1007, 42d Leg., 2d Reg. Sess. § 36-3105(A) (Ariz. 1996).

140. *Id.* § 36-3105(B).

141. See S. 2985, 1996 Leg., Jan. Sess. § 23-4.12-5 (R.I. 1996).

142. See H.R. 474, 1995 Leg. Sess. § 5.705(B)(4) (Md. 1996) (forbidding the writing of a lethal prescription to any patient whose request for physician-assisted suicide was motivated by depression).

143. *Id.* (The bill states, “the . . . physician shall . . . determine that . . . the patient’s request . . . was not a *result of* clinical depression”) (emphasis added).

144. See, e.g., Colorado Dignity in Death Act, H.R. 1185, 60th Gen. Assy., 2d Reg. Sess. § 15-18.8-111 (Colo. 1996).

145. See, e.g., *id.*

periods are almost exclusively set at fourteen or fifteen days.<sup>146</sup> Many laws also limit the maximum amount of time elapsing between a patient's second request and the writing of a prescription.<sup>147</sup> No physician-assisted suicide law is silent on the issue of timing.<sup>148</sup>

#### b. The Assisting Physician

In contrast to the many restrictions imposed on the requesting patient, proposed and existing physician-assisted suicide legislation places few qualifications on the physician.<sup>149</sup> Most rely solely on state licensing bodies, and ensure only a minimum medical training.<sup>150</sup> Others require the physician to be a specialist in the care of the dying.<sup>151</sup> Many laws require a special relationship between the assisting physician and the requesting patient.<sup>152</sup> Usually this means that the physician must have "primary responsibility for the care of the patient and the treatment of the patient's terminal disease."<sup>153</sup>

Physician-assisted suicide laws are concerned not only with the free choice of patients, but also with the free choice of physicians.<sup>154</sup> Present in every physician-assisted suicide statute is a section that specifically allows physicians and health care facilities to refrain from assisting patients if they choose.<sup>155</sup> However, this can be a qualified immunity. Washington State, in its proposed law, requires an

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146. See, e.g., *id.* (specifying a fifteen day waiting period). But see Terminally Ill Patient Act of 1995, S. 5596, 54th Leg., Reg. Sess. (Wash. 1995) (specifying no waiting period).

147. See, e.g., OR. REV. STAT. § 127.850 (Supp. 1996) (specifying no longer than 48 hours).

148. See, e.g., Terminally Ill Patient Act of 1995, S. 5596, 54th Leg., Reg. Sess. (Wash. 1995).

149. See *infra* notes 150-53 and accompanying text.

150. See, e.g., Death with Dignity Act H. 663, 118th Leg., 1st Reg. Sess. § 5-902(M) (Me. 1987).

151. See, e.g., Terminally Ill Patient Act of 1995, S. 5596, 54th Leg., Reg. Sess. § 3.5 (Wash. 1995) (defining the assisting physician as one "who treats dying patients in the ordinary course of practice and is selected by, or assigned to, the qualified patient with primary responsibility for the treatment and care of the qualified patient").

152. See, e.g., H.R. 5015, 88th Leg., Reg. Sess. § 1(b) (Mich. 1995).

153. *Id.* See also Charles H. Baron et al., *A Model State Act to Authorize and Regulate Physician-Assisted Suicide*, 33 HARV. J. ON LEGIS. 1 (1996) (requiring full or partial responsibility).

154. See *infra* text accompanying notes 155-57.

155. See, e.g., S. 2985, 1996 Leg., Jan. Sess. § 23-4.12-11(a) (R.I. 1996). On the provider's freedom of conscience, the bill provides in pertinent part:

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.

*Id.*

objecting physician to refer a patient to another doctor.<sup>156</sup> Similarly, hospitals and other health care providers are free to make rules prohibiting physician-assisted suicide within their facilities, but cannot otherwise restrict the actions of their doctors or their patients.<sup>157</sup>

### c. Procedural Safeguards

Proposed and existing physician-assisted suicide legislation employs a variety of procedural safeguards.<sup>158</sup> These regulations involve the making and revocation of a valid request and the disclosures required of physicians.<sup>159</sup> Some of the most extensive regulation of procedure is found in the rules governing a patient's request.<sup>160</sup> Nearly all laws require that a person wishing to die make one written, witnessed request.<sup>161</sup> Only one proposed law requires neither a valid request nor disclosure.<sup>162</sup> In some cases, the definition of "written" is expanded to include video taping.<sup>163</sup> Many laws also require two oral requests.<sup>164</sup> The first accompanies the initial written request and the second comes immediately before a physician provides the means to commit suicide.<sup>165</sup> Additionally, a patient may not be

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156. Terminally Ill Patient Act of 1995, S. 5596, 54th Leg., Reg. Sess. § 5.3 (Wash. 1995).

157. See, e.g., S. 2985, 1996 Leg., Jan. Sess. § 23-4.12-11(b) (R.I. 1996). On the provider's freedom of conscience, the Rhode Island Bill continues:

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.

*Id.*

158. Gloria J. Banks, *Legal & Ethical Safeguards: Protection of Society's Most Vulnerable Participants in a Commercialized Organ Transplantation System*, 21 AM. J. L. & MED. 45, 98 (1995).

159. Thomas S. Ulen, *The Law and Economics of the Elderly*, 4 ELDER L.J. 99, 118 (1996) (reviewing RICHARD A. POSNER, *AGING AND OLD AGE* 243 (1995)).

160. See Baron et al., *supra* note 153, at 17-20 (discussing the regulation of a patient's request under the heading "Conditions to be Met Before a Patient Receives Assistance in Suicide").

161. See, e.g., Colorado Dignity in Death Act, H.R. 1185, 60th Gen. Assembly, 2d Reg. Sess. § 15-18.8-109 (Colo. 1996).

162. See, e.g., S. 2985, 1996 Leg., Jan. Sess. (R.I. 1996). This proposal nevertheless employs the most extensive requirements for documenting a physician's disclosures and diagnosis. *Id.* § 23-4.12-8. It also calls for an administrative board to review all cases and to promulgate rules as needed. *Id.* § 23-4.12-9.

163. See, e.g., Terminally Ill Patient Act of 1995, S. 5596, 54th Leg., Reg. Sess. § 4.3 (Wash. 1995) (allowing video requests).

164. See, e.g., Colorado Dignity in Death Act, H.R. 1185, 60th Gen. Assembly, 2d Reg. Sess. § 15-18.8-109 (Colo. 1996).

165. See, e.g., *id.*

permitted to show any doubts concerning his decision.<sup>166</sup> In some cases, expressing an “inconsistent intent” between the first and second requests nullifies both.<sup>167</sup> A patient can always revoke his request for assistance to suicide.<sup>168</sup> Still, physician-assisted suicide laws vary greatly in their treatment of revocation.<sup>169</sup> The strictest of laws on this point provide for a sort of constructive revocation if a patient conveys any contrary intentions between his first and second requests.<sup>170</sup> An equally conclusive, though more nebulous approach, allows a patient to rescind his request “at any time and in any manner” by which he or she is able to communicate an intent to do so.<sup>171</sup> Other laws use more precise directions, requiring that the patient make his intentions clear.<sup>172</sup> In such cases, rescission may occur by destroying the written request or executing a new, written revocation.<sup>173</sup> Most laws also permit verbal revocation; however, it must be communicated to the physician who then confirms the revocation with the requesting patient.<sup>174</sup>

In the area of informed consent, there is more uniformity.<sup>175</sup> All physician-assisted suicide laws require that a patient be advised of his terminal diagnosis and prognosis.<sup>176</sup> Many also require a physician to discuss all the potential dangers associated with using the requested lethal substance.<sup>177</sup> Physicians must inform their patient that if used

166. *See, e.g.*, S. 2985, 1996 Leg., Jan. Sess. § 23-4.12-3(a)(3)(D) (R.I. 1996) (requiring a request to be “repeated without self-contradiction by the patient on two separate occasions at least fourteen days apart); *see also* Death with Dignity Act, H. 4134, 88th Leg., Reg. Sess. § 5 (Mich. 1995) (allowing a patient to revoke a request “in any manner by which he or she is able to communicate an intent to do so”) (emphasis added).

167. *See* S. 2985, 1996 Leg., Jan. Sess. § 23-4.12-3(a)(3)(D) (R.I. 1996).

168. *See, e.g.*, S. 5024, 218th Assembly, 1st Reg. Sess. § 4910 (N.Y. 1995).

169. *See infra* text accompanying notes 170-74.

170. *See, e.g.*, S. 2985, 1996 Leg., Jan. Sess. § 23-4.12-3(a)(3)(D) (R.I. 1996).

171. *See* S. 1007, 42d Leg., 2d Reg. Sess. § 36-3103(A)(6) (Ariz. 1996). This law is based on a model law allowing a patient to make an advance directive authorizing Voluntary Active Euthanasia, but has been modified here to allow physician-assisted suicide. *See* Death with Dignity Act, H.R. 4134, 88th Leg., Reg. Sess. § 5 (Mich. 1995) for an example of this format authorizing VAE only. VAE involves the direct administration of a lethal substance by one person into another who requested it. *See* DEREK HUMPHRY, *LAWFUL EXIT 12* (1993); BURNELL, *supra* note 101, at 248.

172. *See, e.g.*, Terminally Ill Patient Act of 1995, S. 5596, 54th Leg., Reg. Sess. § 8.1 (Wash. 1995).

173. *See, e.g., id.* § 8.1(a)-(b).

174. *See, e.g., id.* § 8.1(c). The communication need not be direct, thus the need for confirmation. *Id.*

175. *See infra* text accompanying notes 176-84.

176. *See, e.g.*, S. 2985, 1996 Leg., Jan. Sess. § 23-4.12-4(d) (R.I. 1996).

177. *See, e.g.*, S. 1007, 42d Leg., 2d Reg. Sess. § 36-3103(A)(2)(C) (Ariz. 1996).

properly, the substance they prescribe will result in that patient's death.<sup>178</sup>

Disclosures are not merely required, but they must also be documented.<sup>179</sup> Generally, assisting doctors will simply sign an affidavit acknowledging that they fully informed their patient.<sup>180</sup> A similar acknowledgment is often made by the patient.<sup>181</sup> One law in particular puts an extraordinary emphasis on documenting informed consent.<sup>182</sup> Specifically, under the Rhode Island proposal, physicians must record their disclosure on audio or video tape, or document it in a written record signed by the patient.<sup>183</sup> In addition, a witness must observe the exchange.<sup>184</sup>

As an additional precaution against duress and undue influence, proposed physician-assisted suicide statutes frequently include provisions that remove all questionable incentives from participants.<sup>185</sup> The most common of these requires persons carrying out duties under such a law to have no financial relationship to the requesting patient.<sup>186</sup> An exception is allowed for ordinary or reasonable fees.<sup>187</sup> Certain physician-assisted suicide statutes also forbid the existence of a financial relationship between any of the physicians or counselors.<sup>188</sup> Most physician-assisted suicide laws also exclude family members from participating as either physicians or counselors.<sup>189</sup> Additionally, for those requiring a witnessed request, one of the two witnesses must be unrelated to the requesting patient.<sup>190</sup> A few laws have no such safeguards.<sup>191</sup>

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178. See, e.g., *id.* § 36-3103(A)(2)(D).

179. See, e.g., H.R. 5015, 88th Leg., Reg. Sess. § 12 (Mich. 1995).

180. See, e.g., *id.* § 6.

181. See, e.g., *id.* § 4.

182. See S. 2985, 1996 Leg., Jan. Sess. § 23-4.12-4 (R.I. 1996).

183. See, e.g., *id.* § 23-4.12-4(d)(3)(A).

184. *Id.*

185. See e.g., S. 2985, 1996 Leg., Jan. Sess. § 23-4.12-4(d)(1) (R.I. 1996) (prohibiting certain financial relationships); S. 5024, 218th Assembly, 1st Reg. Sess. § 4903(1)(B) (N.Y. 1995) (same); H.R. 339, Reg. Sess. § 137-K:4(III) (N.H. 1995) (prohibiting participation of family members in certain roles). See also *infra* notes 196-203 and accompanying text (discussing legislatively prescribed immunity and liability as safeguards that act by defining civil and criminal culpability).

186. See, e.g., S. 5024, 218th Assembly, 1st Reg. Sess. § 4903(1)(B) (N.Y. 1995).

187. See, e.g., Terminally Ill Patient Act of 1995, S. 5596, 54th Leg., Reg. Sess. § 12 (Wash. 1995).

188. See, e.g., *id.* § 23-4.12-4(d)(1).

189. See, e.g., H.R. 339, Reg. Sess. § 137-K:4(III) (N.H. 1995).

190. See, e.g., *id.* § 137-K:4(II)(a).

191. See, e.g., Colorado Dignity in Death Act, H.R. 1185, 60th Gen. Assembly, 2d Reg. Sess. § 15-18.8-103(2)(B)(I) (Colo. 1996).

Although their substantive role is limited, family members are not excluded altogether from the process.<sup>192</sup> A family member, for example, is not prohibited from acting as a second witness to a request.<sup>193</sup> Additionally, the support and participation of family in the decision-making process is a concern of many physician-assisted suicide laws.<sup>194</sup> However, while all laws authorizing physician-assisted suicide require a physician to *ask* patients to notify family members of their decision, family notification itself is not necessary.<sup>195</sup>

#### d. Immunity and Liability

Another kind of safeguard focuses on defining the boundaries of liability for acting outside the terms of a given law. These boundaries establish the limits of civil or criminal culpability.<sup>196</sup> For the purposes of civil immunity, all statutes allowing physician-assisted suicide prescribe a standard of care by which a physician or counselor must act.<sup>197</sup> Many such laws apply a subjective test, relying on the actor's own judgment to gauge liability.<sup>198</sup> Less commonly, physician-assisted suicide laws require a physician or counselor to meet the objective standards of their professions.<sup>199</sup>

Although proposed and existing legislation authorizing physician-assisted suicide operate as exceptions to the criminal law, most also contain their own criminal provisions for non-compliance.<sup>200</sup> Mostly, these focus on fraudulent breaches of procedure, but sometimes include special penalties for non-physicians who assist in suicide.<sup>201</sup>

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192. *See, e.g.*, H.R. 339, Reg. Sess. § 137-K:5(V) (N.H. 1995) (mandating that one of the duties of the attending physician is to notify "next of kin"); *see also id.* § 137-K:4 (requiring the patient request to be witnessed by at least 2 witnesses, only one of whom *must* be a non-family relation—hence, leaving room for family participation).

193. *See e.g.* H.R. 339, Reg. Sess. § 137-K:4 (N.H. 1995).

194. *See e.g., id.* § 137-K:5(V) (physician must request that patient notify next of kin); *see also* H.R. 663, 118th Leg., 1st Reg. Sess. § 5-904(F) (Me. 1996) (same).

195. *See supra* note 194.

196. *See* Baron et al., *supra* note 153, at 23.

197. *See, e.g.*, H.R. 5015, 88th Leg., Reg. Sess. § 18(a) (Mich. 1995).

198. *See* Or. Rev. Stat § 127.885 (1993 & Supp. 1996) (providing "no person shall be subject to civil or criminal liability or professional disciplinary action for participating in good faith compliance with [this law]"); *see also* S. 2985, 1996 Leg., Jan. Sess. § 23-4.12-3 (R.I. 1996) (permitting physicians to assist, when they have an "honest belief" that the terms of the law are being complied with).

199. *See, e.g.*, Terminally Ill Patient Act of 1995, S. 5596, 54th Leg., Reg. Sess. § 8.1 (Wash. 1995).

200. *See e.g.*, H.R. 5015, 88th Leg., Reg. Sess. § 19 (Mich. 1995) (making inducement of suicide without patient request a felony).

201. *See e.g.*, H.R. 1023, Reg. Sess. § 19(1) (Miss. 1996) (setting a maximum term of thirty years in prison for forging a request for medication); *see also* Terminally Ill

Many laws make it a crime to exert duress or undue influence on a person to encourage them to request assistance to suicide.<sup>202</sup> Others simply make reference to that jurisdiction's existing criminal ban on assisting a suicide, as a catch all for those who don't comply.<sup>203</sup>

## 2. Enacting Physician-Assisted Suicide Legislation: An End to the Means

Legislative efforts to make assisting suicide legal in the United States date back to the turn of the century.<sup>204</sup> These early efforts permitted anyone to assist.<sup>205</sup> Beginning around 1990, the willingness of a few doctors to openly assist patients in dying brought national attention to the issue.<sup>206</sup> Since then a number of states have considered the issue, adding a requirement that a doctor do the assisting.<sup>207</sup> Most often, these laws were proposed to legislatures, where they met with decisive defeat.<sup>208</sup> More recently, proponents have put the issue directly to the voters, by placing physician-assisted suicide laws onto state referenda.<sup>209</sup> These efforts produced extremely close contests.<sup>210</sup> Still, referenda proved no more successful than putting the issue to the legislators until the Oregon Death With Dignity Act ("ODWDA").<sup>211</sup>

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Patient Act of 1995, S. 5596, 54th Leg., Reg. Sess. § 24 (Wash. 1995) (amending its law against promoting a suicide attempt to exclude physicians who comply with the terms of the proposed physician-assisted suicide law).

202. See e.g., H.R. 1023, Reg. Sess. § 19(2) (Miss. 1996).

203. See e.g., S. 1007, 42d Leg., 2d Reg. Sess. § 36-3117(D) (Ariz. 1996) (specifying no penalties for non-physicians who assist others in suicide, but providing that "[t]he penalties in this article do not preclude criminal penalties applicable under any other law for conduct that is inconsistent with this article").

204. DEREK HUMPHRY & ANN WICKETT, *THE RIGHT TO DIE* 12 (1986). The first such law was proposed to the Ohio legislature, where it was defeated by a vote of seventy-eight to twenty-two. *Id.*

205. *Id.*

206. See *supra* notes 91-97 and accompanying text for an example of one such physician, Dr. Timothy Quill.

207. See, e.g., S. 1007, 42d Leg., 2d Reg. Sess. § 36-3103(A) (Ariz. 1996) (defining mandatory duties of an attending physician, hence mandating the assistance of a physician).

208. See Shih, *supra* note 109, at 1280.

209. Linda Greenhouse, *High Court Hears Two Cases Involving Assisted Suicide*, N.Y. TIMES, Jan. 9, 1997, (Late ed.) at A5. See also Kathy T. Graham, *Last Rights: Oregon's New Death With Dignity Act*, 31 WILLAMETTE L. REV. 601, 601 n.5 (1995). Proposition 161 in California proposed an amendment to the California Penal Code, Section 401 (1992). Initiative 119 in Washington proposed an amendment to Wash. Rev. Code, Sections 701.122.10-.900. *Id.* at n.6.

210. See Greenhouse, *supra* note 209, at A5.

211. ODWDA, *supra* note 118, § 127.810-.897.



ODWDA was passed in 1995, attracting just fifty-one percent of the popular Oregon vote.<sup>212</sup> The law made it legal for physicians to prescribe a lethal substance to a terminally ill patient at the patient's request.<sup>213</sup> However, before anyone died under the protection of the act, a group of terminally ill persons challenged the law's constitutionality in *Lee v. Oregon*.<sup>214</sup> That group argued in *Lee* that the Oregon law violated First Amendment freedoms of association and exercise of religion, as well as Fourteenth Amendment guarantees of due process and equal protection.<sup>215</sup> Ruling on a motion for summary judgment, the district court in Oregon held that ODWDA violated the Equal Protection Clause of the United States Constitution and permanently enjoined the state from enforcing it.<sup>216</sup>

In *Lee*, the district court limited its analysis to a "mere rationality" review.<sup>217</sup> Such an examination is the most lenient of equal protection

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212. *U.S. Judge Keeps Oregon's New Suicide Law in Limbo*, L.A. TIMES, Dec. 28, 1994, at 5.

213. ODWDA, *supra* note 118, §§ 127.800-.897.

214. *See Lee v. Oregon*, 891 F. Supp. 1429, 1431 (D. Or. 1995), *vacated and remanded*, 107 F.3d 1382 (9th Cir.), *amended by* No. 95-35804, 1997 U.S. App. LEXIS 5429 (9th Cir. March 21, 1997) (previous opinion amended to include the text of the ODWDA as an appendix).

215. *Id.* at 1431. In addition to their constitutional challenges, the *Lee* plaintiffs alleged violations of the Americans with Disabilities Act, 42 U.S.C. §§ 12101-12213, and further attacked the ODWDA as being "void for vagueness." *Id.* at 1431, 37. Due to the district court's determination of the case on equal protection grounds, the statutory claims were left undecided. *Id.* at 1431. *See also infra* note 247 (discussing how the Ninth Circuit treated the plaintiffs' statutory claims on appeal).

216. *Id.* (holding the ODWDA unconstitutional and permanently enjoining the Oregon district attorney from recognizing the constitutionality of the ODWDA and from recognizing it as an exception to Oregon's criminal law).

217. *Id.* at 1431 n.2 (stating that review was so limited because plaintiffs did not argue for application of a heightened or strict scrutiny standard).

When legislation affects certain groups it is analyzed under one of two more stringent levels of review, "heightened" or "strict" scrutiny. For example, legislation that is alleged to treat people differently on the basis of sex is analyzed under a "heightened" scrutiny. *United States v. Virginia*, 116 S. Ct 2264, 2275 (1996). The "heightened" scrutiny standard is applied to groups that are sometimes termed "quasi-suspect." *City of Cleburne v. Cleburne Living Ctr., Inc.*, 473 U.S. 432, 442 (1985). Legislation that is alleged to treat people differently on the basis of race is generally analyzed under "strict" scrutiny because such a classification is said to be "suspect." *Massachusetts Bd. of Retirement v. Murgia*, 427 U.S. 307, 312-14 (1976) (recognizing that this is the law, while distinguishing the facts of the case).

The *Lee* court's application of the mere rationality test is appropriate because the Supreme Court has held that persons with reduced mental capacity, the group the *Lee* decision claims is denied equal protection, are not considered a "suspect" or "quasi-suspect" class. *City of Cleburne*, 473 U.S. at 442 (holding that the mentally retarded are not a quasi-suspect class). Accordingly, legislation affecting such a group is not afforded "heightened" or "strict" scrutiny. *Id.*

standards, in which legislation is presumed valid if it is rationally related to a legitimate state interest.<sup>218</sup> This is especially true of social legislation.<sup>219</sup> Nevertheless, the court held that the means employed by the ODWDA were not rationally related to the goal of permitting assisted suicide.<sup>220</sup>

Broadly, the court reasoned that the relationship<sup>221</sup> was irrational because the Oregon law failed to adequately protect all of its citizens, particularly the incompetent.<sup>222</sup> In essence, the court argued that the procedures employed by ODWDA were insufficient.<sup>223</sup> To illustrate this point, the court cited a number of examples in which other Oregon laws impose more substantial procedures in dealing with incompetent persons.<sup>224</sup>

In its opening, the court discussed *Cruzan*, the Supreme Court decision affirming a patient's right to die by refusing medical treatment.<sup>225</sup> The court remarked that, while *Cruzan* recognized an incompetent person's right to allow "substituted judgment" by third parties on his behalf, the Oregon law does not.<sup>226</sup> Under such a "safeguard," third parties may act "as proxies to implement what a patient would choose under particular circumstances."<sup>227</sup>

As an example of an even more extensive system of protections the law provides to incompetent persons, the court cited Oregon's laws relating to commitment procedures.<sup>228</sup> The court noted that under these laws, a physician may initiate commitment proceedings for

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218. *City of Cleburne*, 473 U.S. at 440.

219. *Lee*, 891 F. Supp. at 1431 n.2.

220. *Id.* at 1437 (stating that "[t]he state interest and the disparate treatment are not rationally related and [the ODWDA] therefore, violates the Constitution of the United States").

221. The relationship in question being that between the methods established by the ODWDA and the state's purpose in permitting assisted suicide.

222. *See Lee*, 891 F. Supp. at 1437 (maintaining that the ODWDA "provides a means to commit suicide to a severely over-inclusive class who may be competent, incompetent, unduly influenced or abused by others").

223. *Id.* at 1434.

224. *Id.* at 1434-35.

225. *Id.* at 1434. *See supra* Part II.D for a discussion of the *Cruzan* decision.

226. *See Lee*, 891 F. Supp. at 1434.

227. *Id.* (citing *Cruzan v. Missouri Dep't of Health*, 497 U.S. 261, 279-80 (1990)). The *Lee* court relied on *Cruzan* for the proposition that "a capable adult may designate in writing a competent adult to serve as attorney-in-fact for health care and to direct withdrawal of life support." *Id.* Such a designation is made in advance as a part of a "living will" and requires the maker to become incompetent before judgment can be substituted. *See Louise Harmon, Falling Off the Vine: Legal Fictions and the Doctrine of Substituted Judgment*, 100 YALE L.J. 1, 45 (1990).

228. *Lee*, 891 F. Supp. at 1434-35.

persons he suspects might be “dangerous to themselves” because of a “mental disorder.”<sup>229</sup> A physician may hold such a person for up to five days, in anticipation of a judicially supervised examination and commitment hearing.<sup>230</sup> The court pointed out that “none of these safeguards applied to [ODWDA].”<sup>231</sup> The court further explained that not all physicians are trained to evaluate a person’s competence.<sup>232</sup> Not only might a doctor fail to recognize a condition such as depression, he might unwittingly encourage a compulsion to suicide.<sup>233</sup> The danger is especially great, the court stated, because depressed persons are unusually malleable and a physician, not recognizing the condition, might reinforce feelings of unworthiness by suggesting physician-assisted suicide.<sup>234</sup> Another weakness of the Oregon law, the court revealed, is found in the law’s definition of “terminal.”<sup>235</sup> The court intimated that the six month restriction presents no meaningful boundaries, legal or otherwise.<sup>236</sup>

The court also criticized the Oregon law for failing to require that a requesting patient consult with a social worker to determine whether services exist that might alleviate discomfort.<sup>237</sup> This responsibility, the court noted disapprovingly, rests solely with the assisting physician.<sup>238</sup>

Another, deeper flaw revealed by the court was the physician’s standard of care defined by ODWDA. In all other circumstances, Oregon requires that physicians “use that degree of care, skill and diligence which is used by ordinarily careful physicians . . . in similar circumstances. . . .”<sup>239</sup> The court, however, observed that under the ODWDA, a subjective, “good faith” standard applies.<sup>240</sup> In one of

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229. *Id.* at 1434 (citing OR. REV. STAT. §§ 426.005(1)(d)(A), 426.070 (1993 & Supp. 1996)).

230. *Id.* at 1434-35 (citing OR. REV. STAT. §§ 426.231, 426.070, 426.110, 426.120 (1993 & Supp. 1996)).

231. *Id.* at 1435. The court added that “there is no independent oversight for the decision and implementation of an assisted suicide request by medical professionals, i.e., review by a probate court, as there is with civil commitment.” *Id.* at 1436.

232. *Id.* at 1435.

233. *Id.*

234. *Id.*

235. *Id.* Section 127.800 of the ODWDA defines “terminal disease [as] an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six (6) months.” ODWDA, *supra* note 118, § 127.800.

236. *See Lee*, 891 F. Supp at 1432-33 n.3.

237. *Id.* at 1435.

238. *Id.*

239. *Id.* at 1436 (quoting OR. REV. STAT. 677.095 (1993 & Supp. 1996)).

240. *Id.*

only two applications of the mere rationality test, the court concluded that this defect annulled any rational relation between the Oregon law and its goal.<sup>241</sup>

In the other application of the mere rationality test, the court commented that “[t]here is no set of facts under which it would be rational to conclude that a state may sanction providing people the means to commit suicide without consideration of their circumstances at the time of the suicide.”<sup>242</sup> The court rested this conclusion on the fact that there is no confirmation of a patient’s competence at the critical moment when he decides to end his life.<sup>243</sup> The court concluded that the relationship between the Oregon law’s classification and the goal of permitting physician-assisted suicide “is too attenuated without some protection at the time of taking the fatal drug dosage.”<sup>244</sup>

Without deciding whether the ODWDA violates the Equal Protection Clause of the United States Constitution,<sup>245</sup> the Ninth Circuit Court of Appeals reversed the district court in *Lee*.<sup>246</sup> The unanimous court held that none of the plaintiffs had standing<sup>247</sup> to challenge the ODWDA, and that certain claims were not sufficiently ripe.<sup>248</sup> The Ninth Circuit vacated the district court decision, and instructed that court to dismiss the case.<sup>249</sup>

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241. *Id.* at 1437. Specifically, the court concluded “that there is no set of facts under which it would be rational for terminally ill persons under [ODWDA] to receive a standard of care from their physicians under which it did not matter whether they acted with objective reasonableness, according to professional standards.” *Id.*

242. *Id.*

243. *Id.*

244. *Id.*

245. Nor did the court decide whether any other substantive claims raised by the *Lee* plaintiffs were violated. *See supra* note 227 and accompanying text.

246. *Lee v. Oregon*, No. 95-35804, 1997 U.S. App. LEXIS 5429, at \*24 (9th Cir. March 21, 1997).

247. The Ninth Circuit in *Lee* ruled that none of the plaintiffs could allege an “injury in fact” sufficient to sustain either the equal protection or American with Disabilities Act claims. *Id.* at \*18. This deficiency also precluded the plaintiffs from succeeding on claims under the Rehabilitation Act, 29 U.S.C. §§ 791-794 (1973), and the Religious Freedom & Restoration Act (“RFRA”), 42 U.S.C. §§ 2000bb to 2000bb-4 (1993). *Id.* at \*18, \*22, \*24. Furthermore, the court ruled that the plaintiff-physicians could not bring an action on behalf of their patients that the patients had no standing to bring themselves. *Id.* at \*17. Nor did the plaintiff-physicians have standing to assert a claim under the First Amendment or RFRA. *Id.* at \*22, \*24.

248. The First Amendment and RFRA claims by plaintiff-physicians, suggesting that the ODWDA would require them to participate in activities that conflict with their religious beliefs, were rejected on ripeness grounds. *Id.* at \*23. The court noted that the plaintiff-physicians did not identify a “hardship that would befall them if their claims were not considered at this time.” *Id.*

249. *Id.* at \*24. The Ninth Circuit held that the plaintiffs’ claims suffered from “both standing and ripeness defects.” *Id.* at \*23. The court concluded that federal courts,

### C. Authorizing Physician-Assisted Suicide Through the Courts

#### 1. The United States—A Constitutional Right to Physician-Assisted Suicide

If a terminally ill person has a right to die by refusing “extraordinary medical treatment,” does that right comprehend physician-assisted suicide? In 1995, a group of physicians and terminally ill patients challenged Washington State’s criminal ban<sup>250</sup> on assisting a suicide.<sup>251</sup> The physicians properly had standing in the case because they wished to assist patients in suicide but felt endangered by the Washington statute.<sup>252</sup> The district court ruled that the criminal statute violated the privacy and equal protection provisions of the Fourteenth Amendment to the United States Constitution.<sup>253</sup> This decision was reversed on appeal to the Ninth Circuit Court of Appeals.<sup>254</sup> However, in *Compassion in Dying v. Washington*, an en banc rehearing of the case, the Ninth Circuit reversed its prior decision, holding that the Fourteenth Amendment included a right to die.<sup>255</sup>

Shortly after the *Compassion in Dying* decision, the Second Circuit Court of Appeals announced its decision on an identical issue.<sup>256</sup> In *Quill v. Vacco*, the court held that the New York criminal ban on assisted suicide was unconstitutional as applied on equal protection grounds.<sup>257</sup> The court reasoned that since a patient had a right to refuse life support and other extraordinary means, it was unlawful to deny other terminally ill patients assistance in ending their lives.<sup>258</sup>

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therefore, do not have Article III jurisdiction over the claims. *Id.* at \*24.

250. See WASH. REV. CODE § 9A.36.060 (1995).

251. See *Compassion in Dying v. Washington*, 850 F. Supp. 1454 (W.D. Wash. 1994) (statute criminalizing assisted suicide violates Equal Protection Clause), *rev'd*, 49 F.3d 586 (9th Cir. 1995) (statute does not deprive anyone of constitutionally protected liberty interest), *rehearing en banc*, 79 F.3d 790 (9th Cir.) (statute violates equal protection), *cert. granted* by *Washington v. Glucksberg*, 117 S. Ct. 37 (1996). See also *U.S. Judge Keeps Oregon’s New Suicide Law in Limbo*, *supra* note 212, at A5.

252. See *Compassion in Dying*, 79 F.3d at 795-96 (rehearing en banc affirming the district court’s ruling on standing).

253. See *Compassion in Dying*, 850 F. Supp. at 1467.

254. *Compassion in Dying*, 49 F.3d at 588.

255. *Compassion in Dying*, 79 F.3d at 793 (concluding “that there is a constitutionally-protected liberty interest in determining the time and manner of one’s own death”).

256. See *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996), *cert. granted* by *Washington v. Glucksberg* 117 S. Ct. 36 (1996). “Quill” is Dr. Timothy Quill. See *supra* notes 91-97 and accompanying text for a discussion of Dr. Quill.

257. *Quill*, 80 F.3d at 727.

258. *Id.* at 729.

However, the court specifically rejected the existence of a Fourteenth Amendment right to assisted suicide.<sup>259</sup>

As the case law suggests, there is little consensus about the constitutionality of physician-assisted suicide.<sup>260</sup> However, there is an end in sight to some of the confusion. The Supreme Court has agreed to jointly review *Compassion in Dying* and *Quill v. Vacco*.<sup>261</sup> This decision promises to resolve whether a constitutional right to physician-assisted suicide exists.<sup>262</sup> However, this decision will leave unanswered the question of whether laws such as the Oregon Death With Dignity Act are constitutional.<sup>263</sup>

## 2. International Case Law

In the Netherlands, physician-assisted suicide has enjoyed a kind of quasi-legal status for a number of years.<sup>264</sup> Although the Dutch penal code prohibits euthanasia, a judicially-created exception exists for physician-assisted suicide arising under a defense of necessity.<sup>265</sup> This exception was established in the *Schoonheim* decision, a criminal proceeding against a doctor who helped a patient end her life.<sup>266</sup> In response to a patient's request, Dr. Schoonheim injected her with a lethal combination of drugs.<sup>267</sup> At trial, Dr. Schoonheim pleaded a defense of necessity, claiming he had conflicting legal obligations.<sup>268</sup>

In finding the defendant doctor not guilty, the Dutch Supreme Court explained that the doctor's duty is not limited to following the criminal code; according to the court, the doctor is also legally constrained to

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259. *Id.* at 724-25.

260. *Lee, Compassion in Dying*, and *Quill* all contradict each other to some degree. Unfortunately, *Cruzan v. Missouri Dep't of Health* does not clearly dispose of the issue.

261. *See* *Washington v. Glucksberg*, 117 S. Ct. 37 (1996) (granting certiorari).

262. *See* *Greenhouse*, *supra* note 209, at A1.

263. Simply because there is no constitutional right to engage in physician-assisted suicide does not mean that the right cannot be created by statute. Even traditionally criminal behavior may be permitted, though there is no "Fourteenth Amendment substantive due process" right to engage in such. In *Bowers v. Hardwick*, 478 U.S. 186, 195 (1986), for example, the Court ruled that there is no substantive due process right to engage in sodomy. *Id.* Nevertheless, the practice is permitted in over one half of all states. *See* Janet E. Halley, *Reasoning about Sodomy: Act and Identity in and after Bowers v. Hardwick*, 79 VA. L. REV. 1721, 1732 (1993).

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

265. *Id.*

266. *See* BURNELL, *supra* note 101, at 264-65.

267. *Id.*

268. For a discussion of the *Schoonheim* case, see Julia Belian, Comment, *Deference to Doctors in Dutch Euthanasia Law*, 10 EMORY INT'L L. REV. 255, 267-70 (1996).

act within the current standards of medical ethics.<sup>269</sup> Current medical ethical standards, the court added, included consideration of a patient's interest in ending his life under certain circumstances.<sup>270</sup> Thus, the doctor indeed faced conflicting legal responsibilities, and could not acknowledge one without violating the other.<sup>271</sup> The Dutch Supreme Court reasoned that these conflicting interests must be balanced against each other and remanded the case to the trial court with instructions to do so.<sup>272</sup> Deciding that Dr. Schoonheim had indeed acted within current medical ethical guidelines, the trial court acquitted him.<sup>273</sup>

The effect of the *Schoonheim* decision was to give doctors the power to decide if and when a patient could legally be put to death.<sup>274</sup> More importantly, it allowed doctors to actively administer lethal doses of medicine.<sup>275</sup> While most Dutch patients choose death under the protection of the necessity exception to the law criminalizing euthanasia, it has been estimated that at least 0.8% of all Dutch citizens die from "euthanasias" performed on them without their explicit request.<sup>276</sup> One publicized example involved the "euthanizing" of an infant with spina bifida and hydrocephalus.<sup>277</sup> Nevertheless, authorities in the Netherlands continue to express satisfaction with their system, stating that "the medical actions and decision process concerning the end of life are of high quality."<sup>278</sup>

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269. See BURNELL, *supra* note 101, at 264.

270. *Id.*

271. *Id.*

272. *Id.*

273. *Id.*

274. See *Euthanasia in the Netherlands*, *supra* note 264, at 282.

275. *Id.* at 264.

276. *Id.* at 269 (citing results of the Van der Maas Survey, undertaken by the Reemelink Commission in 1990 and published in Dutch in 1991). These acts were admittedly intended to hasten the death of the patient. *Id.* In addition, approximately 17% (22,500/130,000) of Dutch euthanasias were performed by giving suffering patients an overdose of pain killers, the identical actions taken by doctors who practice the double effect in the United States. *Id.* Of these, 12% (14,625/130,000) were performed with the intention only to alleviate pain, the theoretical definition of the double effect in the United States. *Id.* Another 5% (6,750/130,000) were performed only partly with the intent to kill, and an additional 2% (1,350/130,000) were done explicitly so that the patient would die. *Id.*

277. See *World News Briefing*, ROCKY MOUNTAIN NEWS, July 19, 1994, at 19A.

278. See *Euthanasia in the Netherlands*, *supra* note 264, at 282 (citation omitted).

## IV. ANALYSIS

A. *The Constitutionality of Physician-Assisted Suicide*

*Lee v. Oregon* is the first step toward what will undoubtedly be a long path of litigation over the constitutionality of laws authorizing physician-assisted suicide.<sup>279</sup> Although it is a trial level decision, the district court in *Lee* raises a legitimate question about whether a law authorizing physician-assisted suicide can withstand constitutional scrutiny.<sup>280</sup> At present, that question must remain unanswered since the Ninth Circuit ruled that the federal courts lack jurisdiction to resolve the *Lee* dispute.<sup>281</sup> However, in a different decision, the Ninth Circuit Court of Appeals recently stated (en banc) that “[t]he [*Lee v. Oregon*] reasoning conflicts squarely with the reasoning of this opinion and with the legal conclusions we have reached.”<sup>282</sup> A Supreme Court determination of this conflict is expected to be issued in the summer of 1997.<sup>283</sup>

It is uncertain whether the controversy in *Lee v. Oregon* will ultimately reach the Supreme Court. However, if a future reviewing court supports the district court’s application of mere rationality and its conclusion in *Lee* that the Oregon statute violated the Fourteenth Amendment, then this would clearly represent a new understanding of the mere rationality test.<sup>284</sup> Only a few statutes have ever failed this

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279. See, e.g., *Lee v. Oregon*, 891 F. Supp. 1429 (Or. 1995), *vacated and remanded*, 107 F.3d 1382 (9th Cir.), *amended by* No. 95-35804, 1997 U.S. App. LEXIS 5429 (9th Cir. March 21, 1997).

280. See James Bopp, Jr. & Richard E. Coleson, *The Constitutional Case Against Permitting Physician-Assisted Suicide for Competent Adults with “Terminal Conditions,”* 11 ISSUES IN L. & MED. 239 (1995). See also Stephen K. Bushong & Thomas A. Balmer, *Breathing Life into the Right to Die: Oregon’s Death with Dignity Act*, 11 ISSUES IN L. & MED. 269 (1995) (for an in-depth review of the constitutionality of the ODWDA).

281. See *Lee v. Oregon*, No. 95-35804, 1997 U.S. App. LEXIS 5429, at \*24 (9th Cir. March 21, 1997) (holding that “federal courts do not have Article III jurisdiction over Plaintiff’s claims. . . . Accordingly we vacate . . . and remand with instructions to dismiss . . . for lack of jurisdiction”). See also *supra* text accompanying notes 245-49 (discussing the Ninth Circuit decision to vacate).

282. *Compassion in Dying v. Washington*, 79 F.3d 790, 837-38 (9th Cir. 1996), *cert. granted*, *Washington v. Glucksberg*, 117 S. Ct. 37 (1996).

283. See Joan Beck, *Wrestling with Physician-Assisted Suicide*, CHI. TRIB., Jan. 9, 1997, at N25. See also *Washington v. Glucksberg*, 117 S. Ct. 37 (1996) (granting certiorari).

284. See generally *Lee v. Oregon*, 891 F. Supp. 1429 (D. Or. 1995) (applying the mere rationality standard to Oregon’s statute criminalizing assisted suicide, and nevertheless finding that the statute violates the Fourteenth Amendment), *vacated and remanded*, 107 F.3d 1382 (9th Cir.), *amended by* No. 95-35804, 1997 U.S. App. LEXIS 5429 (9th Cir. March 21, 1997). See *supra* notes 217-24 and accompanying text.



standard of review.<sup>285</sup> This broadly deferential standard is meant to create a solid presumption that a law will withstand constitutional challenge.<sup>286</sup> Indeed, it is likely (assuming that the jurisdictional questions in *Lee* did not require a reversal) that the Ninth Circuit would still have vacated the district court's finding that the statute contravened the Fourteenth Amendment, since the district court misapplied the mere rationality test.<sup>287</sup> The district court directly applied the mere rationality standard in two instances in *Lee*,<sup>288</sup> erring in both applications.

The district court's first direct application of the test involved analysis of the subjective "good faith" standard employed by the Oregon law.<sup>289</sup> Failing to provide a requesting patient with a safeguard available to him during all other dealings with his physician is a mistake.<sup>290</sup> However, although the court made an excellent point regarding the inexplicable use of this standard,<sup>291</sup> it is not a constitutional error.<sup>292</sup> By definition, *most* physicians conduct themselves according to the ordinary, reasonable standards of their profession.<sup>293</sup> Every circumstance in which a doctor legally assists a competent patient in suicide, while meeting the reasonable standards of his profession, is a set of facts under which it would be rational to do so.<sup>294</sup> This is true regardless of whether he is so required by statute.

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285. See D. Don Welch, *Legitimate Government Purposes and State Enforcement of Morality*, 1993 U. ILL. L. REV. 67, 73 n.29 (1993).

286. *Id.*

287. See Baron et al., *supra* note 153, at 16.

288. See *Lee*, 891 F. Supp. at 1432-37.

289. *Lee*, 891 F. Supp. at 1436-37.

290. *Id.* at 1437.

291. See *id.*

292. See Bushong & Balmer, *supra* note 280, at 277-78. See also Baron et al., *supra* note 153, at 14, 19-20 (concluding that the district court in *Lee* incorrectly found the ODWDA unconstitutional and advocating a subjective standard for physicians who participate in physician-assisted suicide).

293. RESTATEMENT (SECOND) OF TORTS § 299A (1997). "[O]ne who undertakes to render services in the practice of a profession or trade is required to exercise the skill and knowledge normally possessed by members of that profession or trade in good standing in similar communities." *Id.*

294. *But see Lee*, 891 F. Supp. at 1437 (stating that "[t]he state interest and the disparate treatment [between competent and incompetent patients] are not rationally related"). In other words, because the ODWDA fails to protect incompetent persons in all circumstances, it cannot rationally support the state goal of allowing competent persons to choose physician-assisted suicide. *Id.* (stating "[the ODWDA] provides a means to commit suicide to a severely over-inclusive class who may be competent, incompetent, [or] unduly influenced"). However, the law requires that there be no set of circumstances under which the relationship would be rational. *Id.* Thus, to support this conclusion, the court must decide that no rational (competent) person would choose

The mere rationality test does not render a law unconstitutional on the mere possibility that something will go wrong.<sup>295</sup> On the contrary, a law must be upheld if there is a set of facts under which it would be rational to do so.<sup>296</sup>

In its second application of the mere rationality test, the district court in *Lee* discussed how there is no assurance that the requesting patient is competent at the time he uses his fatal prescription.<sup>297</sup> As the court suggested, it could be months before the prescription is used.<sup>298</sup> Of course, this presents the danger that once he receives his prescription, a requesting patient may become incompetent or suffer duress. Indeed, the *Lee* court identified a hypothetical circumstance under which the law would fail to prevent an incompetent person from using a lethal prescription.<sup>299</sup> This argument fails, however, since the court misapplied the mere rationality test.<sup>300</sup> The rule is not that a classification must be upheld *unless* there is any conceivable set of facts that could provide *no* rational basis for the classification.<sup>301</sup> The test is “*if* there is *any* reasonably conceivable state of facts that could provide a rational basis for the classification,” the law must be upheld.<sup>302</sup> In fact, an instance where a patient would become incompetent before using his prescription surely would be the exception to the rule.<sup>303</sup> A more likely set of facts provides a rational basis for classification. For example, a patient is screened for competency when he receives a prescription.<sup>304</sup> Some patients will use their prescriptions within one week, most without succumbing to incompetence.<sup>305</sup> Interestingly, in a survey of physicians illegally

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physician-assisted suicide. In so doing, one judge must decide that 618,751 Oregon voters made an irrational, and therefore unconstitutional, decision. *See Lee*, 1997 U.S. App. LEXIS 5429, at \*2.

295. *See Lee*, 891 F. Supp at 1432 (stating “[a] classification must be upheld against an equal protection challenge if there is any reasonably conceivable state of facts that could provide a rational basis for the classification” (quoting *FCC v. Beach Communications*, 113 S. Ct 2096, 2100 (1993))).

296. *Id.*

297. *Id.* at 1437.

298. *Id.*

299. *Id.* (hypothesizing that a patient might become incompetent within hours, days, weeks or months of obtaining his prescription).

300. *See supra* text accompanying notes 295-96.

301. *Cf. Lee*, 891 F. Supp. at 1437.

302. *Id.* at 1432 (quoting *FCC v. Beach Communications*, 113 S. Ct. 2096, 2100 (1993) (emphasis added)).

303. *See supra* notes 290-98 and accompanying text.

304. *See ODWDA, supra* note 118, § 127.830 (requiring a physician to confirm that a patient is making an informed request before writing the prescription).

305. *See Back et al., supra* note 85, at 922. One author, discussing competence in

providing physician-assisted suicide, thirty-nine percent of patients prescribed a lethal substance did not use it.<sup>306</sup> Knowing that physician-assisted suicide was illegal, these patients put themselves and their doctors at risk in order to obtain the prescription, only to refrain from using it to end their lives.<sup>307</sup> The peace that many were searching for was the freedom from fear of an indeterminate but excruciating death, and the opportunity to control the end of their lives.<sup>308</sup> An arbitrary time limit could compel some to use the lethal prescription when they might not otherwise do so.

The remainder of the court's criticisms of the ODWDA are not part of its holding.<sup>309</sup> Nevertheless, the court raises some interesting points.<sup>310</sup> Beginning its analysis of the ODWDA, the court refers to substituted judgment.<sup>311</sup> Substituted judgment is used when the patient is already determined to be incompetent.<sup>312</sup> For instance, in *Cruzan*, it was used to allow a family member of an unconscious patient to "substitute [the family member's] judgment" for that of the patient, allowing the life support to be removed.<sup>313</sup> The analogy is inappropriate to this context, however, because it would allow third parties to substitute their judgment for that of the incompetent patient, giving that third party the power to determine whether the incompetent patient should end his life through suicide. This is a calamity the act specifically seeks to avoid.<sup>314</sup> If, however, the court intends to allow substituted judgment in the context of physician-assisted suicide, then

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terms of making a living will, writes "[t]he law presumes an individual is competent unless legally determined otherwise." Lester J. Perling, Comment, *Health Care Advance Directives: Implications for Florida Mental Health Patients*, 48 U. MIAMI L. REV. 193, 195 n.13 (1993). Speaking abstractly about legal competency, Mr. Perling posits that it may make no difference that a person becomes incompetent after making a decision to undergo a particular medical treatment. *Id.* See also Bernard M. Dickens, *Legal Aspects of the Dementias*, 349 THE LANCET 948, 948 (1997) (noting that "[w]hen patients are found to have become mentally disordered, their former wishes cannot simply be ignored or discounted").

306. See Back et al., *supra* note 85, at 922.

307. See Back et al., *supra* note 85, at 922 (noting that the patients did not use the prescription).

308. See QUILL, *supra* note 93, at 13, 104-05.

309. See generally *Lee v. Oregon*, 891 F. Supp. 1429, 1438 (D. Or. 1995), *vacated and remanded*, 107 F.3d 1382 (9th Cir.), *amended by* No. 95-35804, 1997 U.S. App. LEXIS 5429 (9th Cir. March 21, 1997).

310. See generally *id.*

311. *Id.* at 1434.

312. See Harmon, *supra* note 227, at 53 n.238.

313. See *Cruzan v. Missouri Dep't of Health*, 497 U.S. 261, 284 (1990).

314. See ODWDA, *supra* note 118, § 127.825.

the argument fails because the analogy is irrelevant. An incompetent person is not permitted to end his life under the act.<sup>315</sup>

The court correctly criticizes the Oregon act for not requiring a counseling referral to rule out depression as the cause of a patient's request.<sup>316</sup> Many physicians may not be trained to adequately identify such a situation.<sup>317</sup> It is interesting, however, that the court also cites section 426.231 of the Oregon Revised Statutes as an example of a safeguard not available under the ODWDA.<sup>318</sup> This section authorizes a physician to begin commitment proceedings for any person whom the physician suspects may be suffering from a mental defect.<sup>319</sup> In the physician-assisted suicide context, however, a physician who suspects the same of a requesting patient is obliged not to assist him in ending his life.<sup>320</sup> Thus, there is no need for the extensive hearings and procedures the cited laws entail, unless a person must affirmatively prove competency before he is permitted to request assistance in suicide.<sup>321</sup> Requiring such procedures would only be reasonable if it is assumed that all persons who request physician-assisted suicide are dangerous to themselves because of a mental defect.<sup>322</sup> Judge Hogan intimates as much in a footnote.<sup>323</sup> Such an argument might state good policy against physician-assisted suicide laws in general, but it is irrelevant to an equal protection argument.<sup>324</sup>

Additionally, the court forcefully argued that physicians may not be adequately versed in the area of comfort care.<sup>325</sup> However, following

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315. *Id.*

316. *See Lee*, 891 F. Supp. at 1435 (the court noted that failure of the ODWDA to mandate second opinions results in a failure to assure that patients are "qualified" under the act). *See also* Yeates Conwell & Eric D. Caine, *Rational Suicide and the Right to Die—Reality and Myth*, 325 N. ENG. J. MED. 1100, 1101-02 (1991) (noting that "primary care physicians often fail to recognize treatable depression"). *Cf* Baron et al., *supra* note 153, at 29 (requiring referral to a licensed psychiatrist, clinical psychologist, or psychiatric social worker).

317. *See Lee*, 891 F. Supp. at 1435 (noting the difficulty, even for experts, to determine depression). *See also* Conwell & Caine, *supra* note 316.

318. *See Lee*, 891 F. Supp. at 1434-35. *See also* OR. REV. STAT. § 426.231 (West 1996).

319. *Id.*

320. *See* ODWDA, *supra* note 118, at § 127.825.

321. *See* OR. REV. STAT. § 426.231.

322. *See Lee*, 891 F. Supp. at 1434 n.6 (stating that "[i]t is . . . 'rational' to conclude that a person could never receive a benefit from self-destruction").

323. *See id.*

324. *See* Baron et al., *supra* note 153, at 16 (noting that "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").

325. *See Lee*, 891 F. Supp. at 1435; *see* QUILL, *supra* note 93, at 102.

the court's suggestion of requiring mandatory consultation with a social worker would add needless red tape.<sup>326</sup> A better approach would be to require that one of the physicians be a specialist in comfort care, hospice care or the care of the dying.<sup>327</sup>

*B. Prohibitions of Physician-Assisted Suicide:  
When is a Crime not a Crime?*

Undoubtedly, the lack of criminal consequences for doctors who participate in physician-assisted suicide is due in part to the fact that it is done in secrecy.<sup>328</sup> Doctors have plenty of incentives to keep such procedures hidden<sup>329</sup> and have little difficulty in doing so.<sup>330</sup> It is not unusual to treat patients using large quantities of potentially lethal medication.<sup>331</sup> When the medication is given to allow a person to end his own life, the physician need only record the patient's cause of death as the terminal disease and the case is closed.<sup>332</sup> Many such cases could be discovered with a minimum amount of investigation.<sup>333</sup> However, this does not occur because there is little public will to investigate and prosecute such offenses.<sup>334</sup> In essence, the practice enjoys tacit legal approval, as long as physicians keep it quiet.<sup>335</sup>

326. See QUILL, *supra* note 93, at 102.

327. See *id.*

328. See Pugliese, *supra* note 8, at 1306; see also Malcolm, *supra* note 85, at A6.

329. Doctors face the possibility of criminal sanctions and of losing their license. See QUILL, *supra* note 93, at 22. Doctors also worry for the families of the patient. *Id.* at 20. Families, for example, face potential criminal charges, an unwanted autopsy, potential insurance, pension and probate difficulties, and other unwanted scrutiny at an already difficult time. See *id.* at 22, 174. See also Stephen P. Croley & Jon D. Hanson, *The Non-Pecuniary Costs of Accidents: Pain-And-Suffering Damages in Tort Law*, 108 HARV. L. REV. 1785, 1872 (1995) (noting that "most insurance policies exclude coverage for death by suicide within the first one or two years of the commencement of coverage").

330. See Lehr, *supra* note 88, at 1.

331. *Id.*

332. *Id.*

333. *Id.* The profiled doctor explained:

I mean, if you were the feds and wanted to look at my morphine prescriptions—that's all FDA-recorded—and you wanted to correlate that with obituaries, and you found out that. . . . I wrote six prescriptions for escalating morphine concentrations and . . . this woman died, you could call me up and say, "Well, what's going on here?"

*Id.*

334. See Pugliese, *supra* note 8, at 1297-99.

335. *Id.*

But even celebrated cases go unpunished.<sup>336</sup> In Michigan, Dr. Kevorkian has been prosecuted five times.<sup>337</sup> Yet, in spite of admitting to assisting his patients in suicide, he has not been convicted.<sup>338</sup> Similarly, while the public in New York apparently supports maintaining its criminal prohibition on assisted suicide, it ignores irrefutable evidence of the crime, refusing to indict Dr. Quill.<sup>339</sup> State licensing authorities treated Dr. Quill's case in a schizophrenic manner, verbally denouncing his actions while refusing to take official action.<sup>340</sup> After deciding not to sanction Dr. Quill, the licensing board stated that "[u]ltimately, these are decisions left to the patients."<sup>341</sup> The potential loss to Dr. Quill was great—he faced the prospect of losing his license<sup>342</sup> and spending fifteen years in prison.<sup>343</sup> Such dire consequences imply a heinous crime. Yet despite freely acknowledging his actions, Dr. Quill received no punishment.<sup>344</sup>

It is a strange dichotomy that criminalizing physician-assisted suicide enjoys strong enough support that new prohibitions continue to be enacted,<sup>345</sup> yet, repeatedly and predictably, prosecutors are unable, or unwilling, to convict.<sup>346</sup> The AMA takes only ten minutes to reject a proposal to embrace physician-assisted suicide, yet a majority of doctors would allow the practice.<sup>347</sup> It is easy to oppose physician-

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336. See *supra* text accompanying notes 89-97 (discussing the case involving Dr. Timothy Quill).

337. *A Prosecutor Drops Kevorkian Charges*, N.Y. TIMES, Jan. 12, 1997, at A20.

338. *Id.* The prosecutor noted that trying Kevorkian would be "an exercise in futility." *Id.*

339. See *Doctor Who Aided Suicide Cleared of Misconduct*, *supra* note 96, at A32.

340. *Id.*

341. *Id.*

342. See Greg Livadas & Mitch McKenney, *No Charges Will be Filed Against Doctor in Suicide*, GANNETT NEWS SERV., July 26, 1991, available in LEXIS, News library, Curnws file.

343. See *Doctor Who Aided Suicide Cleared of Misconduct*, *supra* note 96, at A32.

344. In a sense Dr. Quill could dispute this and he would be correct. See B.D. Colen, *It Wasn't a Crime: No charges for M.D. Who Aided Dying Patient's Suicide*, NEWSDAY, July 27, 1991, at 5. The processes Dr. Quill endured in defending himself against both actions were physically, emotionally, and financially draining. *Id.* This author believes it is appropriate to question the wisdom and fairness of subjecting physicians to such procedural punishment when the systems involved refuse to officially punish.

345. A law criminalizing assisting a suicide was enacted in Rhode Island in 1996. R.I. GEN. LAWS § 11-6-1 (1996).

346. See Pugliese, *supra* note 8, at 1297-98.

347. See A.M.A. *Keeps Its Policy Against Aiding Suicide*, *supra* note 98, at C9. See also Bachman et al., *supra* note 104, at 303 (finding that 56% of physicians favored legalizing physician-assisted suicide over an explicit ban, and that given more choices, 40% favored legalization, while 37% favored no law on the subject, while only 17% favored prohibition).

assisted suicide in a general way.<sup>348</sup> When organized in groups and confronted with the subject in the abstract, people tend to think it is a bad idea.<sup>349</sup> However, when confronted with individual stories about real people, opinions shift toward allowing the practice.<sup>350</sup> When asked whether physician-assisted suicide should be made legal, the legislature in New York said no.<sup>351</sup> However, when asked if Dr. Quill should be indicted, the people of New York said no.<sup>352</sup>

### C. *Prohibitions of Physician-Assisted Suicide and the Double Effect*

The philosophy of the double effect does not lend itself well to wholesale application in the criminal law.<sup>353</sup> The criminal law favors punishing for intent over punishing for effect.<sup>354</sup> This is because the traditional elements of a criminal offense are a guilty act (*actus reus*) and a guilty mind (*mens rea*).<sup>355</sup> Behavior that includes both but lacks the expected result is still criminal, usually criminal attempt of the expected result.<sup>356</sup>

Despite its name, the double effect focuses primarily on intent.<sup>357</sup> According to the philosophy, one is only responsible for the results that he intends, and not those he merely foresees.<sup>358</sup> However, there is an important difference between intent in the criminal law and intent in the double effect: measurability.<sup>359</sup> In criminal law, a person who

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348. See, e.g., *supra* text accompanying notes 98-101 (discussing the Hippocratic oath and the AMA's stated opposition to physician-assisted suicide).

349. See Bachman et al., *supra* note 104, at 303.

350. See Pugliese, *supra* note 8, at 1292-98.

351. See John Machacek, *Justices Appear Wary of Granting Right to Physician-Assisted Suicide*, GANNETT NEWS SERV., Jan. 8, 1997, available in LEXIS, News library, Curnws file.

352. See *Doctor Who Aided Suicide Cleared of Misconduct*, *supra* note 96, at A32.

353. See generally *supra* text accompanying notes 49-53 and 114-17 (discussing double effect).

354. At common law all crimes required some kind of "fault" or intent to bring about the prohibited result. See LAFAVE & SCOTT, *supra* note 24, § 3.8, at 242.

355. See Rebecca Frank Dallet, Note, *Foucha v. Louisiana: The Danger of Commitment Based on Dangerousness*, 44 CASE W. RES. L. REV. 157 (1993).

356. See LAFAVE & SCOTT, *supra* note 24, § 6.2, at 495. For example, if John aims a gun at another with the intent to kill him, pulls the trigger but misses, he is guilty of the crime of attempted murder in Illinois. 720 ILL. COMP. STAT. ANN. 5/8-4 (West 1993 & Supp. 1996).

357. See generally John Finnis, *A Philosophical Case Against Euthanasia*, in EUTHANASIA EXAMINED: ETHICAL, CLINICAL AND LEGAL PERSPECTIVES 25-30 (John Keown ed., 1995).

358. *Id.*

359. See *infra* notes 362-66 (noting the difficulty in determining subjective intent (the standard for the double effect), compared to objective intent (the standard for

commits a proscribed act and who is proven to have had the intent to do so will be found guilty.<sup>360</sup> This is a strong disincentive to be honest or forthcoming about one's intent. In addition, the constitutional right against self-incrimination protects those who commit crimes from having to reveal their true intentions.<sup>361</sup> To account for this, the law allows a fact finder to determine criminal intent through an objective look at the circumstances.<sup>362</sup> To illustrate, if John tells a person to "say your prayers," and then throws a bottle at him, a fact finder may decide that John attempted murder.<sup>363</sup> John is not automatically exonerated by claiming that his true intent was for the person to pray.<sup>364</sup> On the other hand, the double effect focuses on a person's actual, subjective intent.<sup>365</sup> At trial, if John claimed that subjectively, he only wanted the other to pray, he would still go to jail—even though under the double effect he is innocent.<sup>366</sup>

In Illinois, John has another problem. A person is guilty of murder when he performs an act and knows that the act creates a strong probability that another will die.<sup>367</sup> Imagine John as a doctor, caring for a terminally ill patient. If John gives that patient a lethal dose of morphine, knowing it will kill him, but wishing only to eliminate his

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criminal law), which may be proven by circumstantial evidence).

360. See LAFAVE & SCOTT, *supra* note 24, § 3.4, at 212.

361. See U.S. CONST. amend. V.

362. See *People v. Koshiol*, 262 N.E.2d 446, 449 (Ill. 1970) (holding that "intent is a state of mind, and, if not admitted, [it] can be shown by surrounding circumstances"), *overruled on other grounds by* *People v. Nunn*, 304 N.E.2d 81 (Ill. 1973) (defendant's Fourth Amendment right against unreasonable search and seizure violated when police conducted warrantless search).

363. See *People v. Tye*, 565 N.E.2d 931, 938 (Ill. 1990) (the fact finder need not ignore circumstantial evidence of severe child beating in deciding that the defendant had the requisite mental state for murder, even though the defendant stated he intended only to discipline his child).

364. *Id.*

365. See Finnis, *supra* note 357, at 27.

366. *Id.* Finnis argues that while a person who "choos[es] to kill someone with drugs (administered over . . . three days in order not to arouse suspicion) in order to relieve them of their pain and suffering" is guilty of murder, he is not legally responsible for murder (because of the double effect) if he "chooses to relieve someone of their pain by giving drugs . . . foreseeing that the drugs in that dosage will cause death in . . . three days." *Id.* The law suggests a less expansive view of the double effect, permitting a fact finder to equate such knowledge with criminal intent. See HUMPHREY & WICKETT, *supra* note 204, at 17-18 (reporting a manslaughter conviction for a man who "chloroformed" his son in order to "end my boy's misery").

367. See 720 ILL. COMP. STAT. ANN. Ch. 5/9-1 (West 1993 & Supp. 1996).



patient's pain, John is still guilty of murder.<sup>368</sup> He is guilty in spite of his intention to do good.<sup>369</sup>

As a common law defense, the double effect does not absolve a person of criminal liability.<sup>370</sup> This is true in spite of a person's subjective intent to do good.<sup>371</sup> Still, the philosophy of the double effect enjoys some support in the law.<sup>372</sup> Discussing whether a surprise price increase constituted bad faith during a contract negotiation, Judge Posner writes that:

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368. See *People v. Cardona*, 634 N.E.2d 720, 723 (Ill. 1994) (distinguishing between the mental state necessary to sustain a murder conviction, including intentionally causing death, and performing acts that create a strong probability of death).

369. See *People ex rel Hegeman v. Corrigan* 87 N.E. 792, 796 (N.Y. 1909). The court in *Hegeman* stated:

[I]t is the knowledge or belief of the actor at the time that stamps identically the same intent as either criminal or innocent, for the intent to take life, unless under circumstances that the law regards as sufficient to justify the taking, is the criminal intent and the only criminal intent that can exist in case of murder (excepting where the killing is done in the commission of an independent felony). So, ordinarily, a criminal intent is an intent to do knowingly and willfully that which is condemned as wrong by the law and common morality of the country, and if such an intent exists, it is neither justification nor excuse that the actor intended by its commission to accomplish some ultimate good.

*Id.* (quoting 1 BISHOP'S CRIM. LAW § 341 ).

370. Cf. *Chase v. United States*, 468 F.2d 141, 148 n. 21 (7th Cir. 1972). In a criminal prosecution for conspiracy, a defendant claimed the double effect as an insanity defense. *Id.* The defendant stated:

I think the principle of double effect comes in there because it was not my intent to destroy draft records as such, to conspire to destroy draft records and so forth. . . . My intent, and I think I'm using that in a technical sense, was to influence change in this country and in American foreign policy. So that there was a double effect, obviously.

*Id.* Justice Stevens, writing for the majority, rejected the defendant's arguments. *Id.* at 149.

371. See *People v. Gindorf*, 512 N.E.2d 770, 778 (Ill. App. Ct. 1987). The Court in *Gindorf* stated:

Defendant . . . contends the trial court erred when it found her guilty of murder and not voluntary manslaughter where it was established by all the expert testimony that she believed that it was necessary to kill her children, albeit an unreasonable belief, to avoid the greater injury to the children of forcing them to continue living, after defendant's suicide, their lives doomed to be spent in misery and suffering. She argues that she believed her conduct was justified by reason of necessity, an affirmative defense. . . . Defendant cites no authority that the defense of necessity would justify the taking of another's life under these facts. To so hold here would sanction conduct which amounts to "mercy killing," a proposition which finds no support in Illinois law.

*Id.* at 778-79.

372. See *infra* notes 373-76.

[the defendant] would not be acting in bad faith to demand that amount from [the plaintiff] even if it knew that [the plaintiff] would not go so high. [The defendant] would be acting in bad faith only if its purpose in charging more than [the plaintiff] would pay was to induce [the plaintiff] to back out of the deal.<sup>373</sup>

According to Judge Posner, liability depended not on the foreseen result, but rather on the purpose of the behavior.<sup>374</sup> Such reasoning applies to the principle of the double effect.<sup>375</sup> Also, in a case before the Kentucky Supreme Court upholding a patient's right to refuse medical treatment, a dissenting justice stated that "[c]ertainly there is room for consideration of the principle of double effect. Philosophically, you may foresee the result but not intend it."<sup>376</sup>

The writing of a potentially lethal prescription for the sole purpose of alleviating pain is legal only where explicitly authorized.<sup>377</sup> Like other exceptions to the criminal law, legislative action is strongly favored over judge-made law.<sup>378</sup> In fact, in some jurisdictions, the double effect is codified as a statutory exception to the crime of physician-assisted suicide.<sup>379</sup>

373. *Venture Assocs. Co. v. Zenith Data Sys. Corp.*, No. 95-3574 1996 U.S. App. LEXIS 24653, \*14-15 (7th Cir. 1996) (Judge Posner noted that "the analogy to . . . the Catholic doctrine of double effect [sic], should be apparent").

374. *See supra* text accompanying notes 365-66.

375. *See supra* note 50 and accompanying text (defining the double effect).

376. *DeGrella v. Elston*, 858 S.W.2d 698, 715 (Ky. 1993) (Wintersheimer, J., dissenting).

377. *Cf. United States v. Moore*, 423 U.S. 122 (1975) (holding that a physician may dispense controlled substances only in accordance with established legal guidelines). *But see* *Compassion in Dying v. Washington*, 79 F.3d 790, 828 n.102 (9th Cir.) (en banc) (stating that "the administration of dual effect medication, with informed consent, does not constitute a criminal act"), *cert. granted* *Washington v. Glucksberg*, 117 S. Ct. 37 (1996).

378. *See People v. Woodard*, No. 80374, 1997 Ill. LEXIS 20, \*10 (Ill. Feb. 20, 1997) (stating that "where an enactment is clear and unambiguous, the court is not free to depart from the plain language and meaning of the statute by reading into it exceptions, limitations, or conditions that the legislature did not express"). The defense of necessity, for example, is a narrowly defined application of the principle that some crimes are excusable if the results are not intended and the actions are necessary to promote a greater good. *See* 720 ILL. COMP. STAT. ANN. Ch. 5/7-13 (West 1993 & Supp. 1996). Section 5/7-13 provides:

Conduct which would otherwise be an offense is justifiable by reason of necessity if the accused was without blame in occasioning or developing the situation and reasonably believed such conduct was necessary to avoid a public or private injury greater than the injury which might reasonably result from his own conduct.

*Id.*

379. *See, e.g.,* IND. CODE ANN. § 35-42-1 to 2.5(a)(1) (West 1996) (exempting from

However, allowing a simple criminal exception for the double effect essentially legalizes physician-assisted suicide.<sup>380</sup> This is because there is no way to observe the theoretical distinction.<sup>381</sup> Legally, there is no difference between giving a person a lethal dose of medication to alleviate his pain, which will most likely kill him, and giving a person a lethal dose of medication to alleviate his pain *because* it will kill him.<sup>382</sup> This does not mean that there is no ethical distinction between the two, only that the law cannot see the distinction because the law cannot see into a person's heart.<sup>383</sup>

The greatest flaw with the double effect is that it actually includes a broader range of behavior than physician-assisted suicide.<sup>384</sup> A physician engaging in physician-assisted suicide does so at the request of the patient, while a physician engaging in the double effect may act according to his own conscience.<sup>385</sup> The principle of the double effect accounts only for the intention of the actor, and not for the wishes of the patient.<sup>386</sup> In fact, assuming that the actor intends a worthy enough good, it is justifiable to act in opposition to the wishes of another.<sup>387</sup>

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the crime of assisting suicide “[any] licensed health care provider who administers . . . medications or procedures to relieve a person’s pain or discomfort, even if the medicine or procedure may hasten . . . death, unless such medications or procedures are intended to cause death”).

380. See *supra* text accompanying notes 376-78.

381. Criminal law punishes a person when a judge or jury finds that the person intended to do harm. See generally LAFAYE & SCOTT, *supra* note 24, at § 3.5(f), at 316-18. Judges and juries cannot read a defendant's thoughts, and so must make an objective determination about what the defendant intended. *Id.* The double effect, on the other hand, absolves a defendant if he truly intended to do good—something only he knows. Therefore, for legal purposes, where a difference exists between a person's objective (observed) intent and his subjective (true) intent, that difference is inconsequential—his observed intent prevails. Cf. 2 CLIFFORD S. FISHMAN, JONES ON EVIDENCE § 13:1, at 468-69 (7th ed. 1992) (noting in a discussion about proving intent through circumstantial evidence that “direct evidence . . . may be unavailable, inadmissible, unpersuasive, or untrue”).

382. See *Compassion in Dying*, 79 F.3d. at 824 (stating “we see little, if any, difference for constitutional or ethical purposes between providing medication with a double effect and providing medication with a single effect, as long as one of the known effects in each case is to hasten the end of the patient's life”).

383. For an in depth discussion of intent and its role in this distinction, see Finnis, *supra* note 357, at 25-30.

384. See *infra* notes 385-87 and accompanying text.

385. Justification of a double effect action depends on the actor's intent to do good. See *supra* text accompanying note 50 for a definition of the double effect. In the context of physician-assisted suicide, an intent to do good essentially means an intent to alleviate pain. See *supra* text accompanying note 51.

386. See *supra* Part II.C (on the double effect).

387. See Finnis, *supra* note 357, at 30. Mr. Finnis states that merely knowing that there will be a negative result, or “harm to the basic human good,” does not make one's actions unreasonable. *Id.*

However, as long as a patient is conscious and rational, the established doctrine of informed consent prohibits any such action.<sup>388</sup>

#### D. *The Varied Approaches of Physician-Assisted Suicide Regulations*

At the root of all laws permitting physician-assisted suicide are common, basic principles.<sup>389</sup> Individual versions also have their own particular objectives.<sup>390</sup> The various ways in which physician-assisted suicide laws are written reveal both the emphases that individual laws put on the common goals as well as any additional agenda.<sup>391</sup> Certain drafting styles also create unintended, and at times unwanted, results.

##### 1. Restrictions on the Requesting Patient

One area where even minor variations in form signify fundamental differences in philosophy involves defining the participants.<sup>392</sup> This is

388. *Schloendorff v. Society of New York Hospital*, 105 N.E. 92 (1914), *overruled on other grounds*, *Bing v. Thunig*, 143 N.E.2d 3 (1957). Some argue the opposite, raising points reminiscent of a paternalistic past:

To be autonomous means to be . . . self-determining in the conduct of one's life. But what exercises of this capacity are genuinely valuable and, as such, to be respected?

. . . .  
 . . . [T]he notion of 'best interests' as applied to the care of patients has an objective interpretation within the moral framework. . . . What *medically* serves a patient's best interests is what secures either a patient's restoration to health or some approximation to health, or if the patient is dying, effectively controls distressing symptoms.

Luke Gormally, *Walton, Davies, Boyd and the Legalization of Euthanasia*, in *EUTHANASIA EXAMINED* 113, 118-19 (John Keown ed., 1995).

389. See *supra* text accompanying notes 124-30 (noting that all legislation permitting physician-assisted suicide requires that the requesting patient be "terminal").

390. Compare *Death with Dignity Act*, H.R. 663, 118th Leg., 1st Reg. Sess. (Me. 1997) (requiring a physician to be present when the patient uses the fatal prescription), with *Colorado Dignity in Death Act*, H.R. 1185, 60th Gen. Assembly, 2d Reg. Sess. (Colo. 1996) (not requiring, but allowing a physician or another person to be present when the patient uses the fatal prescription).

391. Some physician-assisted suicide laws place greater emphasis on a patient's pain as a requirement to request assistance. Compare H.R. 109, 64th Biennial Sess. (Vt. 1997) (requiring a requesting patient to suffer from a "terminal illness"), with H.R. 474, 1995 Leg. Sess. (Md. 1996) (requiring a requesting patient to suffer from a "painful fatal condition"). Some physician-assisted suicide laws place a greater emphasis on physician immunity than others. Compare S. 2985, 1996 Leg., Jan. Sess. (R.I. 1996) (applying a subjective standard for physician liability), with *Terminally Ill Patient Act of 1995*, S. 5596, 54th Leg., Reg. Sess. (Wash. 1995) (determining physician liability under an objective standard).

392. Compare *Death With Dignity Act*, H.R. 663, 118th Leg., 1st Leg. Sess. (Me. 1997) (restricting the relationship between the assisting and consulting physician by forbidding them from having offices in the same building), with *Mississippi Death with Dignity Act*, H.R. 1023, Reg. Sess. (Miss. 1996) (placing no restriction on the

expressed most vividly in the different qualifications physician-assisted suicide laws place on requesting patients.<sup>393</sup> Perhaps the most important and widely varied of all qualifications is the definition of the "terminal" requirement.<sup>394</sup>

Although it is questionable whether such a requirement has a strong basis in medical practice, nearly all physician-assisted suicide laws impose a prognosis of death within six months.<sup>395</sup> The origin for this requirement may lie in Medicare guidelines which limit hospice reimbursements to situations where a physician can certify a six month prognosis.<sup>396</sup> The distinction is legal, not medical, and it results in one significant effect.<sup>397</sup> It provides a bright line in defending against the slippery slope arguments that plague efforts to legalize physician-assisted suicide.<sup>398</sup> A required, quantified life expectancy provides a simple definition for excluding persons, and so clearly and effectively limits the application of a physician-assisted suicide law.<sup>399</sup> Unfortunately, such an arbitrary limitation does not differentiate among requesting patients in a meaningful way.<sup>400</sup> In fact, such a definition ignores the basic principle that physician-assisted suicide should be made available to alleviate suffering.<sup>401</sup> A person with brain

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relationship between the assisting and consulting physician).

393. Compare H.R. 109, 64th Biennial Sess. (Vt. 1997) (requiring a requesting patient to suffer from a "terminal illness"), with H.R. 474, 1995 Leg. Sess. (Md. 1996) (requiring a requesting patient to suffer from a "painful fatal condition").

394. See *supra* notes 124-26 (although the definition of terminal varies by jurisdiction, in all jurisdictions with such laws, the definition at a minimum means that the condition causing the suffering will eventually result in the patient's death).

395. See A.B. 32, 93rd Sess. (Wis. 1997) (providing that the terminal disease will cause death within six months). But see H.B. 109, 64th Biennial Sess. (Vt. 1997) (defining terminal as likely to produce death within one year). For a medical definition of terminal see TABER'S CYCLOPEDIA MEDICAL DICTIONARY, *supra* note 124.

396. See 42 U.S.C. § 1395x(dd)(3)(A) (1994) (providing that "[a]n individual is considered to be 'terminally ill' if the individual has a medical prognosis that the individual's life expectancy is 6 months or less"); 42 C.F.R. §§ 418.20-22 (1996) (providing that "to be eligible to elect hospice care under Medicare, an individual must be . . . [c]ertified as being terminally ill in accordance with § 418.22," which provides that "the certification must specify that the individual's prognosis is for a life expectancy of 6 months or less").

397. Brian C. Goebel, Note, *Who Decides if There is "Triumph in the Ultimate Agony?" Constitutional Theory and the Emerging Right to Die with Dignity*, 37 WM. & MARY L. REV. 827, 894 (1996).

398. See Baron et al., *supra* note 153, at 10-11.

399. *Id.*

400. Excerpts from the Supreme Court Decision on *Physician-Assisted Suicide* [Washington v. Glucksburg], WASH. POST, Jan. 9, 1997, at A16. "[W]hy is it limited to those on the threshold of death? I mean suppose . . . the doctor says you're going to be in terrible pain for ten years. . . . Why shouldn't I have the right to suicide?" *Id.*

401. See *supra* text accompanying note 122 (noting the twin goals of physician-

cancer who has two months to live may feel fine, while an AIDS patient who has more than a year remaining might suffer excruciating pain.<sup>402</sup> To insist on a requirement so disconnected from any essential goal of physician-assisted suicide laws does nothing to flatten slippery slope claims, and may actually support them.<sup>403</sup> Such an unprincipled qualification supports the conclusion that any limitation is illusory.<sup>404</sup>

While defining a terminal condition<sup>405</sup> as one that will eventually result in death presents no serious diagnosis problems, the same is not necessarily true for defining “unbearable physical suffering.”<sup>406</sup> Nevertheless, this is not an insurmountable problem.<sup>407</sup> It is true that the determination that a patient is feeling unbearable pain or suffering begins with the patient’s own subjective determination.<sup>408</sup> However, physicians are specifically trained to interpret a patient’s own subjective determination about pain and suffering.<sup>409</sup> In addition, “pain management” is fast becoming an important and accepted new area of practice that includes its own specialists and treatment centers.<sup>410</sup>

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assisted suicide laws: (1) providing an effective means to end untreatable suffering; and (2) protecting the patient’s right of self-determination). *But see* Kamisar, *supra* note 115, at 235 (arguing that basing a right to physician-assisted suicide on intractable suffering is no less arbitrary than basing it on “terminal illness” and is further complicated by the extreme difficulty, if not impossibility, of objective measurement).

402. *Good Care of the Dying Patient*, 275 JAMA 474, 475 (1996) (report of the American Medical Association’s Council on Scientific Affairs).

403. A physician-assisted suicide law having such a qualification might be the basis for an equal protection argument that physician-assisted suicide should be made available to everyone.

404. *See* Goebel, *supra* note 397, at 893-95 (arguing that an arbitrary six month limitation renders physician-assisted suicide laws unconstitutional); *see infra* Appendix A, § 7.3.

405. *See infra* Appendix A § (2)(a).

406. *See infra* Appendix A § (2)(b). *See also* Kamisar, *supra* note 115, at 235-36 (arguing that not all pain is truly unbearable, that pain is under-treated, that pain and suffering are too subjective to be defined and determined, that psychological and physical pain are indistinguishable, and that, ultimately, one is limited to the patient’s own determinations of the terms).

407. *See infra* text accompanying notes 409-10.

408. *See Finding the Right Cure for Chronic Pain*, 14 BUSINESS & HEALTH 17, 19 (1996) (noting that “the highly subjective nature of pain creates a diagnostic challenge for physicians”).

409. *See* Sridhar V. Vasudevan & Timothy N. Lynch, *Pain Centers—Organization and Outcome; Rehabilitation Medicine; Adding Life to Years*, 154 THE WESTERN J. MED. 532, 532 (1991).

410. *See generally*, Shannon Brownlie, et al., *The Quality of Mercy Effective Pain Treatments Already Exist. Why aren’t doctors using them?*, U.S. NEWS & WORLD REP., Mar. 17, 1997, at 54 (offering that with effective pain management physician-assisted suicide is probably unnecessary).

One potential pitfall in the definition of terminal is the label "terminal illness" itself.<sup>411</sup> It is possible to argue that an illness only includes disease or infections.<sup>412</sup> However, not all terminal conditions are the result of such limited causes.<sup>413</sup> Defining terminal to include a condition or bodily disorder clarifies that the cause of a person's terminal status is irrelevant.<sup>414</sup>

Competency is arguably the most important limitation placed on requesting patients.<sup>415</sup> The first, admittedly arbitrary hurdle, adulthood, is a common restriction in the law.<sup>416</sup> Some have suggested that if physician-assisted suicide is allowed for anyone, it should be allowed for all.<sup>417</sup> However, it is widely recognized that children need special protection from the law.<sup>418</sup> Simply excluding them from coverage under physician-assisted suicide laws is an appropriate and efficient means to afford them that protection.<sup>419</sup>

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411. See, e.g., *Katskee v. Blue Cross / Blue Shield of Nebraska*, 515 N.W.2d 645, 651 (Neb. 1994) (arguing whether the plaintiff's breast-ovarian carcinoma syndrome was an 'illness' for purposes of insurance coverage, or, as the defendant-insurer proffered, merely a predisposition to an illness since the plaintiff did not actually have cancer).

412. *Id.* at 649-51.

413. For example, Nancy Cruzan's condition was the result of a car accident. *Cruzan v. Missouri Dep't of Health*, 497 U.S. 261, 265 (1990).

414. See, e.g., H.R. 109, 64th Biennial Sess. § 5280(11) (Vt. 1997) (defining "terminal condition" as "an incurable condition caused by injury or disease").

415. See generally *Lee v. Oregon*, 891 F. Supp. 1429 (D. Or. 1995), *vacated and remanded*, 107 F.3d 1382 (9th Cir.), *amended by* No. 95-35804, 1997 U.S. App. LEXIS 5429 (9th Cir. March 21, 1997). See also *supra* text accompanying notes 132-47 (discussing competency).

416. See *Bellotti v. Baird*, 443 U.S. 622, 643 n.23 (1979). "[T]he fact that a minor may be very much an adult in some respects does not mean that his or her need and opportunity for growth under parental guidance and discipline have ended." *Id.*

417. See, e.g., *Lee*, 891 F. Supp. at 1433. "While the practical effect of a state law may be to create some inequality between particular classes of persons . . . it cannot create an illusory classification where the reasons for the law apply equally to all members of the public." *Id.*

418. See Marvin R. Ventrell, *Rights & Duties: An Overview of the Attorney-Child Relationship*, 26 LOY. U. CHI. L.J. 259, 264 (1995) (noting that the concept of "parens patriae . . . represented an advance in society's protection of children. . . . [And] the beginning of society's recognition that the legal system might need to interfere with the family relationship in some cases to protect the health, safety, and general well-being of children").

419. At a minimum there is no constitutional bar to doing so. See *Oregon v. Mitchell*, 400 U.S. 112 (1970) (holding that preventing those age 18-20 from voting does not violate equal protection). An argument could be made for more rigorous standards for children, rather than outright exclusion. These standards might take the form of substituted judgment by a child's legal guardians, or as suggested by the *Lee* court, legal proceedings in the style of a commitment procedure. See *Lee*, 891 F. Supp. at 1434-35. This Comment does not advocate such a position and renders no opinion as

Despite the language of some physician-assisted suicide laws, competency is not solely determined by adulthood.<sup>420</sup> Because of the importance of competency, laws that do not further address the issue probably do not intend to suggest that adulthood is the only criterion.<sup>421</sup> At most, adulthood simply provides a useful point from which competency can be presumed.<sup>422</sup> At a minimum, it is evidence in favor of concluding that the requesting patient has the ability to understand, formulate, and communicate health care decisions.<sup>423</sup> This is the essence of competency, and it is the conclusion that must be drawn before a requesting patient is allowed to proceed.<sup>424</sup>

The different ways in which this conclusion is reached clearly reflect the emphasis placed on competency.<sup>425</sup> Laws that textually require nothing beyond adulthood seem to place the least value on competency, although considering that many of these further claim to prize the requesting patient's free will and well being, such omissions probably represent sloppy drafting.<sup>426</sup> Those that require psychological evaluations only if the assisting doctor suspects a mental defect place a similarly diminished value on competency.<sup>427</sup> On the other hand, laws that require psychological evaluations and clearly

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to its feasibility.

420. See S. 334, Jan. Sess. (Conn. 1995) (providing that the requesting patient be "eighteen years of age or older and be able to understand the nature and consequences of such medication").

421. Discussions about physician-assisted suicide generally presume that patient competence is a prerequisite. See, e.g., Note, *Physician-Assisted Suicide and the Right to Die with Assistance*, 105 HARV. L. REV. 2021, 2022 (1992) (noting that "[i]n general, competent patients who suffer from a terminal illness have a right to die by having life-saving treatment withheld or withdrawn") (emphasis added).

422. A majority of statutes require psychological evaluations only for those patients an assisting doctor *suspects* may be incompetent, which suggests that competency is presumed in favor of the requesting patient.

423. See *In re Estate of Longeway*, 549 N.E.2d 292, 303 (Ill. 1989). The court noted that "to make an 'informed' decision to accept or refuse treatment, the patient must have a full understanding of the nature of the illness and the prognosis, the information necessary to evaluate the risks and benefits of all the available treatment options, and the competency to make a reasoned and voluntary decision. *Id.* Cf. *People v. Nemke*, 263 N.E.2d 97, 101 (Ill. 1970) (age may be considered in determining competency).

424. See *supra* text accompanying note 137. But see S. 1007 42d Leg., 2d Reg. Sess. § 36-3101(8) (Ariz. 1996) (defining "qualified patient" as a "capable adult").

425. Compare S. 2985, 1996 Leg., Jan. Sess. (R.I. 1996) (defining competent and requiring psychological evaluations in all cases), with H.R. 474, 1995 Leg. Sess. § 5-701(J) (Md. 1996) (requiring that a patient be "mentally competent" while neither defining what that means, nor requiring that the assisting physician's own assessment of mentally competent be confirmed by anyone).

426. See, e.g., H.R. 2965, 69th Leg. Assembly (Or. 1997) (defining competence for the existing ODWDA).

427. See Pugliese, *supra* note 8, at 1325-26.



define the goals of those sessions place a comparatively higher value on patient competency.<sup>428</sup>

If the decision to request assistance in suicide is the product of depression or some other mental defect, the patient is not considered competent.<sup>429</sup> Many laws treat the existence of depression as conclusively rendering a patient incompetent.<sup>430</sup> This could have the effect of making physician-assisted suicide laws moot; since a suffering, terminally ill person is likely to experience some degree of depression.<sup>431</sup> But not everyone agrees that depression automatically renders one legally incompetent.<sup>432</sup> Case law supports this conclusion, stating that the existence of a mental defect, even severe depression, does not automatically render a person incapable of making decisions having serious legal consequences.<sup>433</sup> A person is incompetent only where the defect is a primary, motivating factor

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428. See, e.g., S. 2985, 1996 Leg., Jan. Sess. § 23-4.12-4 (R.I. 1996).

429. See, e.g., H.B. 109, 64th Biennial Sess. § 5280(3) (Vt. 1997) (requiring a counselor, if called, to determine that the "patient is not suffering from a psychiatric or psychological disorder or depression which causes the patient to have impaired judgment").

430. See, e.g., S. 2985, 1996 Leg., Jan. Sess. § 23-4.12-1 (R.I. 1996).

431. See *Lee v. Oregon*, 891 F. Supp. 1429, 1435 (D. Or. 1995), *vacated and remanded*, 107 F.3d 1382 (9th Cir.), *amended by* No. 95-35804, 1997 U.S. App. LEXIS 5429 (9th Cir. March 21, 1997). See James Henderson Brown, et al., *Is It Normal for Terminally Ill Patients to Desire Death?*, 143 AM. J. PSYCHIATRY 208 (1986) (suggesting that while the terminally ill are no more likely to have a tendency toward suicide, those who do are very likely to experience depression).

432. See Lawrence J. Nelson et al., *Forced Medical Treatment of Pregnant Women: "Compelling Each to Live as Seems Good to the Rest"*, 37 HASTINGS L.J. 703, 760 n. 279 (1986) (urging that "[a]n adult can be depressed or confused to some extent, yet remain competent to refuse treatment" (citing cases)).

433. See, e.g., *Thor v. Superior Court*, 855 P.2d 375 (Cal. 1993) (holding that a depressed person was competent to decide to forgo life-sustaining treatment). See also *Rumbaugh v. Procnier*, 753 F.2d 395 (5th Cir. 1985). In *Rumbaugh*, a convicted murderer waiting on death row decided not to pursue an appeal of his execution order. *Id.* at 396. Against his wishes, his parents were pursuing an appeal. *Id.* at 397. In a competency hearing to decide whether he could dismiss his appeals, or whether his parents should proceed as next friend, the defendant took the stand and declared "I've . . . made the decision to take matters into my own hands" and "I'll just make them kill me." *Id.* The defendant then lunged at a United States Marshall with a makeshift knife shouting "Shoot!" *Id.* The court upheld his competency in spite of a finding of severe depression. *Id.* at 402-03. The court stated that "[we cannot] conclude as a matter of law that a person who finds his life situation intolerable and who welcomes an end to the life experience is necessarily legally incompetent to forgo further legal proceedings." *Id.* at 403.

Another court, through testimony of a psychologist and psychiatrist, found a defendant competent by a preponderance of the evidence, in spite of his depression and low intelligence. See *United States v. Frank*, 933 F.2d 1491, 1494 (9th Cir.), *amended and superseded by* 956 F.2d 872 (9th Cir. 1991) (en banc).

behind the decision.<sup>434</sup> Even when the mental defect influences the decision, it will be allowed if the decision is rational.<sup>435</sup>

Ensuring competency and rationality is the primary motivation behind regulating the timing of physician-assisted suicide laws.<sup>436</sup> Waiting periods focus less on a patient's ability to make rational, sound decisions than on actually ensuring that he do so.<sup>437</sup> These periods are created to give a patient time to reflect and perhaps consult with family or close friends.<sup>438</sup> It is hoped that these provisions prevent a patient from making hasty, emotional decisions.<sup>439</sup> Deadlines, on the other hand, are specifically designed to ensure competency and voluntariness.<sup>440</sup> Minimizing the amount of time between a patient's final request and a doctor's prescription for a lethal substance helps ensure that a patient has not lapsed into incompetence by the time he is given the means to end his life.<sup>441</sup> Some have suggested that protections must go further, actually guaranteeing competency at the time the patient uses his fatal prescription.<sup>442</sup>

Requiring proof of competency at the moment a patient uses his fatal prescription presents several problems. First, from a practical perspective, once a patient is given the means to end his life, how can it be taken away? The obvious answer is to strictly control the timing of the end of the patient's life by restricting access to the lethal substance until the actual moment of use.<sup>443</sup> However, such a solution is worse than the problem. As a matter of privacy, a patient deserves

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434. See Baron, *supra* note 153, at 18.

435. *Id.*

436. See Matthew P. Previn, *Assisted Suicide and Religion: Conflicting Conceptions of the Sanctity of Human Life*, 84 GEO. L.J. 589, 613 (1996) (urging state hearings and "short waiting periods [between the time of request and administration of physician-assisted suicide] to safeguard against a decision made in haste or in a period of temporary depression).

437. See *id.* at 612-13 (advocating a short waiting period to ensure voluntariness, competence, family notification, and consultation with a second physician); see also Jody B. Gabel, *Release from Terminal Suffering?: The Impact of AIDS on Medically Assisted Suicide Legislation*, 22 FLA. ST. U. L. REV. 369, 420 (1994) (discussing mandatory procedural safeguards, including a waiting period, in the ODWDA).

438. See Previn, *supra* note 436, at 612-13.

439. See Sitcoff, *supra* note 34, at 709.

440. *Id.* at 710 (arguing for deadlines or "maximum waiting periods").

441. *Id.* See also *Lee v. Oregon*, 891 F. Supp. 1429, 1437 (D. Or. 1995) (stating that Oregon's Measure 16 provides a means to commit suicide with no legal protection to an "over-inclusive" class of persons who could be competent, incompetent, unduly influenced or abused), *vacated and remanded*, 107 F.3d 1382 (9th Cir.), *amended by* No. 95-35804, 1997 U.S. App. LEXIS 5429 (9th Cir. March 21, 1997).

442. *Lee*, 891 F. Supp. at 1437.

443. See Sitcoff, *supra* note 34, at 709-10.

to be free of state interference at the end of his life.<sup>444</sup> Perhaps more importantly, limiting the time during which a substance must be used would be a coercive force causing the patient to use the substance.<sup>445</sup> Many patients request assistance in ending their lives as a way to obtain the peace needed to face their final time.<sup>446</sup> For them, impending days of unbearable suffering overshadow a current time of relative comfort.<sup>447</sup> What they are really searching for is the knowledge that they have the power to exit should conditions become unbearable.<sup>448</sup> In fact, many patients who are given prescriptions never actually use them.<sup>449</sup> However, imposing a time limit on the use of a prescribed substance puts patients who have already spent the time, energy and money to secure potential release, into danger of losing that release.<sup>450</sup> Rather than face an uncertain but foreboding future, most would probably choose an immediate end.<sup>451</sup>

## 2. Restrictions on Physicians

Appropriately, the proposed physician-assisted suicide legislation minimally restricts physicians.<sup>452</sup> However, concerns about a physician's ability to make difficult diagnoses concerning pain and suffering are not unfounded.<sup>453</sup> Thus, as is almost universally agreed,

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444. There is a necessary trade off between state protection and privacy. *See* Baron et al., *supra* note 153, at 11. This Comment suggests that the level of protection offered by such a provision is so attenuated that it should not restrict a patient's privacy expectations.

445. *See* QUILL, *supra* note 93, at 171, stating:

[I]f she had not had the assurance of a controlled death when her suffering became intolerable, much of the quality of the three months that she did have would have been contaminated by fear and searching for a potential way out. She might even have taken an earlier escape through suicide, since she would have had to fear becoming too weak to act on her own if she waited too long.

*Id.*

446. *Id.*

447. *Id.*

448. *See id.*

449. *See* Back et al., *supra* note 85, at 922.

450. It is elementary that limitations periods create strong incentives to exercise rights in danger of being lost. *Cf.* *Delta Air lines, Inc. v. August*, 450 U.S. 346, 352 (1981) (noting that Rule 68 provides an incentive to settle where there is a strong probability that the plaintiff will recover).

451. *See* QUILL *supra* note 93, at 171.

452. *See* Baron et al., *supra* note 153, at 17 (stating that while certain conditions, such as a special relationship, would be desirable, they are not required by the proposed model law).

453. *Good Care of the Dying Patient*, *supra* note 402, at 475 (noting the lack of precise scientific data concerning pain prevalence and incidence, some difficulties physicians face in pain management, and concluding that "[t]he prescription of pain

requiring the consent of two physicians is good policy.<sup>454</sup> Accordingly, requiring at least one of the doctors to have a heightened level of expertise in comfort care or care of the dying would produce several benefits. First, it would add an additional level of specialization to the diagnosis.<sup>455</sup> Second, it would help ensure that patients receive adequate palliative care.<sup>456</sup> Lastly, it would make it more likely that requesting patients are well-informed about the alternatives to physician-assisted suicide.<sup>457</sup>

Requiring a special relationship between the doctor and patient, on the other hand, would be problematic.<sup>458</sup> The motivation underlying such a requirement is fear that an assisting doctor, who has not developed a special relationship with the patient, will act too quickly and without adequate consideration of the patient's medical history and individual needs.<sup>459</sup> While individualized attention should be present in any major medical decision, the reality is that, in today's system of managed health care, it is a luxury that relatively few people enjoy.<sup>460</sup> In addition, even for those having a "primary physician," that doctor might object to rendering assistance on moral grounds.<sup>461</sup> This would leave many patients at the mercy of their physicians' moral beliefs and put objecting doctors in an awkward position.<sup>462</sup> A further problem

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medications to the point of obtundation in the last days of life may more commonly reflect provider behavior rather than patient preferences or needs").

454. See, e.g., Previn, *supra* note 436, at 613 (stating that the patient should consult a second physician); see also QUILL, *supra* note 93, at 163 (noting that consultation with another physician is highly recommended).

455. See QUILL, *supra* note 93, at 162 (highlighting the importance of comfort care to the physician's role).

456. *Id.*

457. *Id.* at 163 (noting that documentation and additional consultation help the patient to make a well-informed decision).

458. See Baron et al., *supra* note 153 at 17 (stating that ethical constraints may prevent some physicians from assisting suicide).

459. See QUILL, *supra* note 93, at 162-63 (suggesting that a relationship between the physician and the patient makes the situation more manageable).

460. Paul W. Newacheck et al., *Monitoring and Evaluating Managed Care for Children with Chronic Illnesses and Disabilities*, 98 PEDIATRICS 952, 954 (1996) (stating that "[c]ustomary doctor-patient relationships may be disrupted for many families as they enter organized systems of care").

461. See Baron et al., *supra* note 153, at 17 (suggesting that a physician may not think physician-assisted suicide constitutes an ethical alternative); see also QUILL, *supra* note 93, at 163 (noting that no physician should be forced to assist a patient's suicide if it violates the physician's "fundamental values").

462. *Id.* (commenting that, to avoid the ethical constraints, a patient may need another physician to provide that person with the means for suicide); see also QUILL, *supra* note 93, at 162-63 (finding that an alternative physician may facilitate the means for suicide).

lies in defining what constitutes primary responsibility.<sup>463</sup> Such vague terminology presents a potential anchor for litigation without affording much real protection.<sup>464</sup> Requiring a special relationship between the physician and his patient represents another area where statutory law injects itself into an area better left to the policies of health care providers.<sup>465</sup>

### 3. General Procedural Safeguards

Lawmakers impose additional procedural safeguards to ensure that the patient's participation is voluntary.<sup>466</sup> Rules governing the request for assistance are particularly important and should be carefully considered.<sup>467</sup> Requiring written requests is a good idea for a few reasons. They provide an enduring record of the transactions and encourage a patient to consider his decision carefully.<sup>468</sup> A writing is also generally thought to be more indicative of a person's true intent than his spoken words.<sup>469</sup> However, the term "written" should be expanded to include "recorded."<sup>470</sup> Excluding videotaped requests prevents the physically disabled from requesting assistance, should they desire.<sup>471</sup> In addition, oral requests serve an important function. Just as deference is given to juries and judges who observe the live

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463. See, e.g., *Boyd v. Albert Einstein Med. Ctr.*, 547 A.2d 1229, 1233 (Pa. Super. Ct. 1988) (defining the role of a "primary physician" for the purpose of determining agency under an HMO agreement).

464. See Fredrick Schauer, *Philosophy of Language and Legal Interpretation*, 58 S. CAL. L. REV. 399, 404 (1985) (noting that in the context of Constitutional law "relatively precise language forestalls litigation with respect even as to matters of great moment, while relatively vague language encourages litigation").

465. Cf. *Planned Parenthood v. Danforth*, 428 U.S. 52, 64 (1976) (viability of a fetus is a matter better left to a physician's judgment than to legislation). See also Robert C. Louthian III & Elizabeth M. Mills, *Physician Recruitment After Hermann Hospital*, 4 ANN. HEALTH L. 1, 19 (1995) (IRS should not interfere with a hospital's judgment about who receives tax exempt funds when the funds further an exempt purpose).

466. See, e.g., Gabel, *supra* note 437, at 374 (specifying that AIDS cases, in particular, require special attention to ensure that the procedure is voluntary).

467. See Sitcoff, *supra* note 34, at 701-03 (discussing the ODWDA and the numerous safeguards surrounding procedure).

468. Cf. *State v. Downs*, 672 P.2d 416, 418 (Wash. Ct. App. 1993) (noting that a writing provides strong evidence that the defendant waived his right to a jury trial).

469. See *id.* (asserting that a writing requirement ensures the waiver of a jury trial is "knowing, voluntary and intelligent").

470. See Baron et al., *supra* note 153, at 29 (permitting video and audio taped requests in a proposed model law to allow physician-assisted suicide). Cf. Sitcoff, *supra* note 34, at 705 (citing the Michigan Act, which attempts to accommodate patients that cannot write their signatures by allowing another person to sign the directive so long as the signing is in the presence of the patient).

471. *Id.*

testimony of witnesses, requiring an oral request provides an extra measure of protection against fraud or duress by allowing a physician to actually see the patient make the request.<sup>472</sup>

Equally important to the form of making requests is the requirement that people witness them.<sup>473</sup> Witnessing significant legal documents has a long, established tradition.<sup>474</sup> The witnesses ensure that the patient's request is voluntary, and not the result of duress or impaired judgment.<sup>475</sup> The witness also provides the physician with a measure of protection against future liability for his actions.<sup>476</sup> At least one witness should have no familial, professional, or financial relationship with any of the persons performing duties or requesting assistance.<sup>477</sup> Otherwise, the objectivity of the witness is questionable, rendering the value of his role negligible.<sup>478</sup> However, allowing a family member to serve as an additional witness brings needed support and a familiar face to what otherwise might be a host of strangers.<sup>479</sup>

There seems to be little consensus among laws concerning what constitutes an effective revocation of a request.<sup>480</sup> Balancing the need to protect patients from duress and hasty judgments with the desire to avoid overly burdensome procedures, the degree of procedure required to revoke should mirror the amount required for making requests.<sup>481</sup>

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472. Cf. *People v. Calvert*, 629 N.E.2d 1154, 1158 (Ill. App. Ct. 1994) (refusing to disturb a jury's findings of fact while noting the jury's ability to personally observe the testimony of witnesses).

473. See Gabel, *supra* note 437, at 428 (noting that a qualified witness should view the signing of the request).

474. See, e.g., GEORGE E. GARDNER, *HANDBOOK ON THE LAW OF WILLS* 199 (Walter T. Dunmore ed., 2d ed. 1916) (noting that since the nineteenth century, statutes have required that wills be witnessed).

475. See Gabel, *supra* note 437, at 428.

476. See generally Baron et al., *supra* note 153, at 12.

477. See Alison C. Hall, *To Die With Dignity: Comparing Physician-Assisted Suicide in the United States, Japan and the Netherlands*, 74 WASH. U. L.Q. 803, 838 n.231 (1996) (listing the requirements for a witness according to the Hemlock Society).

478. See 1 A. JAMES CASNER, *ESTATE PLANNING* 134 (4th ed. 1980) (recommending as a minimum standard that witnesses to a will should have "no interest vested or contingent in the property disposed of by the testator's will").

479. See QUILL, *supra* note 93, at 164 (encouraging the involvement of family in the process, if the patient wishes).

480. Compare Death with Dignity Act, H.R. 4134, 88th Leg., Reg. Sess. § 5 (Mich. 1995) (permitting revocation "at any time" and "in any manner"), with Terminally Ill Patient Act of 1995, S. 5596, 54th Leg., Reg. Sess. § 8 (Wash. 1995) (requiring a patient to clearly state his intentions).

481. The more procedures a person has to endure, the more likely it is that the person has carefully considered his decision, and is resolved to it. See Richard Hyland, *Life, Death, and Contract*, 90 NW. U. L. REV. 204, 216 (1995) (noting that formalities, such as consideration in contract law, are evidence that a person has given due thought to a decision and intends that his actions have legal consequences). Accordingly, it is

In other words, the more formal the request procedures, the more explicit the revocation. Conversely, physician-assisted suicide laws with looser requirements for requesting assistance should allow revocation easily.<sup>482</sup> Because physician-assisted suicide laws require the patient to actually administer the lethal substance himself, it is questionable whether revocation communicated "in any manner" is necessary.<sup>483</sup> In fact, well meaning persons may selectively interpret a patient's "communications," forcing revocation and thwarting a patient's true wishes.<sup>484</sup> In no event, however, should a request be constructively revoked for "declaring an inconsistent intent."<sup>485</sup> Such a procedure would have a silencing effect on patients, who would be unable to discuss the pros and cons of their decision for fear that showing a lack of resolve might forbid them from proceeding.<sup>486</sup> As a matter of procedure, revocation should annul all procedures previously met.<sup>487</sup> If a patient changes his mind, he should begin again, with the procedures set forth in the statute.<sup>488</sup>

Safeguards requiring physician disclosures through essentially codifying rules of informed consent are valuable guides for both courts and doctors.<sup>489</sup> Such rules clarify the kinds of information a patient must be given before his request and consent can be considered

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appropriate to require a clear expression that the person has changed his mind before he is not permitted to proceed. Because the patient must personally perform some explicit act in order to receive the lethal dose of medication, there is little danger of coercion. See *infra* Appendix A §14.

482. See, e.g., S. 1007, 42d Leg., 2d Reg. Sess. (Az. 1996) (section 36-108(A) requires that a patient make two requests, one written and one oral, and § 36-3109 permits a patient to rescind "at any time and in any manner").

483. Some drafters of physician-assisted suicide laws hold the opposite view. See, e.g., Gabel, *supra* note 437, at 428-29 (commenting that the Model Act provides numerous other safeguards to ensure that the physician adheres to the patient's wishes).

484. See Craig P. Goldman, *Revising Iowa's Life-sustaining Procedures: Creating a Practical Guide to Living Wills in Iowa*, 76 IOWA L. REV. 1137, 1162 (1991). Goldman notes that in the context of a living will, allowing family members to decide a revocation, "in any manner by which [he] can ascertain the declarant's intent" poses a problem that a bereaved family member may find "revocation" in the twitch of a finger. *Id.* This could give family members an effective "veto power" over a patient's decision. *Id.*

485. S. 2985, 95th Leg., Jan Sess. § 23-4.12-3(a)(3)(D) (R.I. 1996) (requiring a patient's request be "repeated without self-contradiction").

486. *But see* QUILL, *supra* note 93, at 161-62 (encouraging a patient to discuss the decision).

487. See, e.g., Death with Dignity Act, H.R. 4134, 88th Leg., Reg. Sess. § 5 (Mich. 1995) (providing that if a directive is revoked, "it shall be as if the directive [for physician-assisted suicide] was never executed or the request never communicated").

488. See *id.*

489. See Baron et al., *supra* note 153, at 12-13 (noting that clear procedures will prevent a flood of litigation and avoid a "slippery slope").

valid.<sup>490</sup> While informed consent to physician-assisted suicide is essential, the Rhode Island procedure is unduly cumbersome, time consuming, and difficult to coordinate.<sup>491</sup> Such hyper-attention to recording doctor-patient interaction is a much better shield against a physician's liability than a tool for increasing the patient's understanding.<sup>492</sup>

While no law requires actual family notification, all laws obligate a physician to suggest that a requesting patient notify his family of his request for assistance in suicide.<sup>493</sup> A required statement like this is different from an informed consent disclosure, in that the information itself does not aid a patient in making his decision.<sup>494</sup> Instead, this particular requirement reflects the belief that under ideal conditions, family members should participate in a decision of this magnitude.<sup>495</sup> However, limiting the requirement to a mere suggestion of family notification takes the provision out of the legal realm and turns it into a statement of policy.<sup>496</sup> Statutory law is an inappropriate place to do this. This sort of standard would be much more suitable as a health care provider's own guideline, rather than as an apparently binding rule of law.<sup>497</sup> To couch non-binding suggestion in legal terms opens the door to pointless litigation and ambiguity without affording any real benefit. Physician-assisted suicide laws should not obligate a physician to suggest family notification. Family notification should either be required or not.

#### 4. Immunity and Liability

It is remarkable that a majority of physician-assisted suicide laws include a subjective standard for determining civil liability for

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490. See Gabel, *supra* note 437, at 399-400 (listing requirements that a doctor should follow before administering the procedure).

491. See S. 2985, 1996 Leg., Jan. Sess. § 23-4.12-4(d)(3) (R.I. 1996) (requiring that patient requests for physician-assisted suicide be either video or audio taped, or written and signed, as well as witnessed).

492. *But see* Baron et al., *supra* note 153, at 12 (discussing procedural safeguards that protect both the patient and doctor).

493. See, e.g., Death With Dignity Act, H.R. 663, 118th Leg., 1st Leg. Sess. (Me. 1997); see also QUILL *supra* note 93, at 164 (encouraging family discussion).

494. Informed consent requires that a physician provide a patient with information *necessary* to make the decision. See, e.g., *In re Estate of Longeway*, 549 N.E.2d 292, 303 (Ill. 1989).

495. See QUILL, *supra* note 93, at 164 (encouraging a doctor to involve the patients' family to comfort and support the patient).

496. Policy is defined as the principles that guide the government in the management of public affairs. BLACK'S LAW DICTIONARY 1157 (6th ed. 1990).

497. See Nelson et al., *supra* note 432, at 760 (citing the right of a health care provider to impose treatment as it sees fit).



physicians.<sup>498</sup> Subjective standards are almost unknown in the area of medical malpractice.<sup>499</sup> This is because a subjective standard creates an almost irrefutable presumption in favor of the professional.<sup>500</sup> Making a subjective test the standard for liability in a physician-assisted suicide law is especially striking since concerns for the patient's well being are surely no less important than in other instances of medical negligence.<sup>501</sup>

Because physician-assisted suicide laws create an exception to existing criminal law, lesser criminal penalties are needed to deal with breaches of procedure and instances of duress.<sup>502</sup> Relying solely on existing criminal law is unsatisfactory for two reasons. First, the existing penalties may be significantly more severe than warranted by the breach.<sup>503</sup> Second, depending on the language of the physician-assisted suicide law, a minor breach of procedure might not be enough to establish criminal liability under the existing law.

## V. PROPOSAL

The current laws governing physician-assisted suicide neither prevent the practice nor effectively control it.<sup>504</sup> The "officially-sanctioned" method, the double effect, is unsatisfactory because the practice cannot truly be limited to the theory.<sup>505</sup> Allowing physician-assisted suicide under an unregulated defense in the style of necessity would leave Illinois citizens with an underground version of the Dutch system.<sup>506</sup> Because of the potential for abuse under the current

498. See *supra* Part III.B.1(d) (discussing physician liability and noting that many statutes regarding physician-assisted suicide rely on the physician's judgment to determine when administration of physician-assisted suicide is appropriate, rather than an objective, 'reasonable physician' standard of care).

499. See PROSSER & KEETON, *supra* note 40, § 32, at 186-87 (claiming that the doctor must perform with the skill and care ordinarily employed by members in good standing).

500. See Rich, *supra* note 117, at 97-98 n.99 (arguing that a subjective standard renders a plaintiff's argument about information regarding a decision inconsequential).

501. *But see* Baron et al., *supra* note 153, at 19 (arguing that a subjective standard adequately protects the patient).

502. *See id.*

503. Compare Death with Dignity, A.B. 32, 1997-98 Leg., 93d Reg. Sess. § 156.27 (Wis. 1997) (punishing "any person who willfully conceals, cancels, defaces, obliterates, or damages the request for medication of another without the requester's consent" with a maximum fine of \$500 and / or a maximum prison sentence of thirty days), with WIS. STAT. § 940.12 (1996) (making assisting a suicide a class D felony).

504. The law does not effectively criminalize physician-assisted suicide. See *supra* Part IV.B. The law does not effectively or adequately allow physician-assisted suicide. See *supra* Part IV.C.

505. See *supra* Part IV.C (discussing the double effect).

506. See *supra* Part III.C.2 (discussing the Dutch system, which allows physicians to

system, physician-assisted suicide should be explicitly legalized. Statutory legalization addresses physician-assisted suicide concerns squarely and strikes a balance that the public has demonstrated it wants between an accepted procedure and the legitimate role of the state.<sup>507</sup>

This Comment proposes an Illinois Physician-Assisted Suicide Act.<sup>508</sup> This Act is created to allow qualified patients to receive a safe, effective, medical means to suicide.<sup>509</sup> Each of the provisions of the proposed law are designed to end otherwise untreatable suffering and to protect a patient's right of self-determination. Although this Comment argues that physician-assisted suicide laws are constitutional, the terms of this law are designed to address certain constitutional and procedural concerns raised by the *Lee* court.<sup>510</sup>

### A. *The Requesting Patient*

In sharp contrast to the majority of physician-assisted suicide laws, but consistent with their basic goals, this Comment proposes that the primary limitation on requesting patients should not be their proximity to death, but rather their unbearable suffering.<sup>511</sup> A requesting patient must still meet the medical definition of terminal, however.<sup>512</sup> By shifting the focus of a patient's qualifications from his remaining time to his suffering, the proposed law avoids the implication that a person's life decreases in value as it nears death.<sup>513</sup> Instead, the proposed law recognizes that a patient's interest in ending his extreme suffering is greater than the state's interest in preserving his life when the cause of the suffering will eventually result in death. In order to

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actually administer the lethal drug, and rests in physicians the power to determine if and when a patient should be put to death).

507. Because there is no public will to enforce laws criminalizing physician-assisted suicide and because a majority of people favor making the practice legal, physician-assisted suicide should be legalized and regulated. *See supra* Part IV.B. This argument is distinguishable from similar arguments relating to the legalization of currently illegal drugs, in that such laws are merely difficult to enforce, and are supported overwhelmingly by the public.

508. *See infra* Appendix A.

509. *See infra* Appendix A §1.

510. *Lee v. Oregon*, 891 F. Supp. 1429, 1432-37 (D. Or. 1995) (holding that the Act failed to rationally relate to any state interest that ensured that the patient made a voluntary decision), *vacated and remanded*, 107 F.3d 1382 (9th Cir.), *amended by* No. 95-35804, 1997 U.S. App. LEXIS 5429 (9th Cir. March 21, 1997).

511. *See infra* Appendix A.

512. This definition imposes no time limit on when a patient might die. *See supra* Part III.B.1.a. *See infra* Appendix A §2.b.

513. *See Euthanasia in the Netherlands*, *supra* note 264, at 262 (noting that a doctor who performs euthanasia can judge a patient's condition accurately by monitoring their ability to form the intent to request the procedure). *See infra* Appendix A §2.b.

avoid uncertainty in causation, the term "terminally ill" should be expanded to include a physical condition.<sup>514</sup>

In qualifying a patient's competency, adulthood is a useful starting point.<sup>515</sup> Making physician-assisted suicide available to minors under strict procedures may be possible, but it is unnecessary for constitutional purposes. Such a law would also be of dubious policy, balancing the potential dangers against the small number of people likely to participate.<sup>516</sup> Still, adulthood should be far from conclusive. Screening by licensed counselors should be done as a matter of course.<sup>517</sup> Recognizing, however, the strong causal link between a mental defect and the terminal condition, patients should not be summarily excluded simply because a mental defect exists. A patient should only be excluded from receiving assistance if his decision to request assistance is primarily motivated by the mental condition. Only patients deemed unable to understand, formulate and communicate health care decisions should be rejected. In the event a patient is deemed incompetent, his request must be considered void, and the responsible counselor should make a reasonable effort to notify the family of the requesting patient.<sup>518</sup> Ordinarily, such a notification would be a violation of the doctor-patient privilege, but it is both legal and justified to protect the patient under the circumstances.<sup>519</sup>

Regulations of timing serve a useful, though limited, purpose. For any physician-assisted suicide law using extreme suffering as its primary qualification, waiting periods should be kept to a minimum. Nevertheless, a mandatory period of reflection is appropriate in a decision of this nature. Accordingly, instead of the usual fifteen day waiting period, this Comment proposes seven days for reflection.<sup>520</sup> On the other hand, deadlines and other micro-management of the final moments are avoided in the proposed law.<sup>521</sup> This decision represents

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514. See *infra* Appendix A § 2.a.i.

515. See *infra* Appendix A § 3.a.i.

516. See Back et al., *supra* note 85, at 921 (noting that the majority of persons requesting physician-assisted suicide were over 65 years of age).

517. See *infra* Appendix A §6.

518. See *infra* Appendix A §7.3.

519. See generally *Lee v. Oregon*, 891 F. Supp. 1429, 1433-37 (D. Or. 1995) (commenting about the patients' competence in making such a decision), *vacated and remanded*, 107 F.3d 1382 (9th Cir.), *amended by* No. 95-35804, 1997 U.S. App. LEXIS 5429 (9th Cir. March 21, 1997).

520. See *infra* Appendix A §7.3.

521. See *infra* Appendix A.

both a desire to prevent any coercive pressures and to preserve a patient's privacy at the end of his life.

### B. Physicians

Regulations concerning the physician are confined to making sure that the diagnoses concerning suffering are correct. To achieve this result, at least one physician is required to have special expertise in this area.<sup>522</sup> In addition, because of the difficulty physicians face in diagnosing depression and its effect on a patient's decision, a licensed counselor should make such determinations in every case.<sup>523</sup> Provisions that would require a special relationship between the patient and the assisting doctor are not included in the proposed law.<sup>524</sup>

### C. Procedural Safeguards

Because the ultimate consequence of a physician-assisted suicide law is death, all procedural requirements should be written with an eye toward preventing duress, coercion, and fraud. Special attention needs be given to family, professional, and financial relationships among all participants. Although it is appropriate to create strict guidelines to eliminate conflicting interests, care should be taken to avoid making requirements that afford little protection while creating a risk of unforeseen lawsuits.

## VI. CONCLUSION

Physician-assisted suicide is essentially legal in Illinois. Although it is not practiced openly, physician-assisted suicide is commonly performed by physicians believing themselves to be justified by the "double effect." The existing Illinois ban on physician-assisted suicide is not enforced and offers scant protection to patients. The result is that in Illinois, as in the Netherlands, physician-assisted suicide occurs at the sole discretion of physicians, and without effective safeguards. To protect its citizens, and to prevent the dangers resulting from incomplete regulation, the Illinois General Assembly should adopt the proposed legislation authorizing a safe, dignified, and effective form of physician-assisted suicide. The Illinois Assembly should not turn away from its responsibility for Nancy DeSoto.

PETER G. DANIELS

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522. See *infra* Appendix A §17.

523. See Pugliese, *supra* note 8, at 1325-29 (discussing the requirements that any physician-assisted suicide bill should contain).

524. See *infra* Appendix A.

## APPENDIX A

## The Illinois Physician-Assisted Suicide Act

## 1. Purpose

The Purpose of this Act is permit a physician to provide a terminally ill and suffering patient with a safe, effective, medical means to end his own life. This law recognizes that a person should not receive assistance in suicide if there is a means reasonably available to alleviate a person's suffering. This act extends criminal, civil, and professional immunity to physicians and counselors who assist a requesting patient in suicide according to this Act.

This Act is intended to create minimum standards and guidelines. It is designed to confer a right to assisted suicide to a limited few and only under limited circumstances. This Act recognizes that the decision to end one's own life must be rational and freely made.

Because only a person who is suffering may request assistance under this Act, the time it takes to receive assistance should be kept to a minimum. This means that legal interference should be confined solely to protecting a requesting person's free will and well being. The safeguards provided in this act establish the necessary protection of a requesting person's well being. Thus, additional legal measures such as judicial proceedings should not interfere unless there is a clear danger that a person is not acting according to his own free will.

This law is intended to abrogate *Burnett v. People*, 68 N.E. 505 (1903), and any other settled decision of the State of Illinois or a predecessor jurisdiction making it unlawful for a physician to assist a person in suicide.

## 2. Definitions

## a) "terminally ill" means

i) the patient suffers from a disease or other physical condition that will eventually result in that patient's death, except that "condition" does not mean

a) mere advanced age; or

b) the fact that the patient is currently alive

ii) For the purposes of this Act, a patient's death need not be imminent for that person to be considered "terminally ill."

## b) "suffering" means

- i) either that a patient is
  - a) experiencing extreme physical pain and/or
  - b) experiencing extreme physical discomfort
- ii) and neither of which can be adequately alleviated through reasonably available and reasonably known medical means.
- c) “providing a medical means for a requesting patient to end his own life” means
  - i) any of the following
    - a) providing the requesting patient with any lethal substance or device and/or
    - b) prescribing to the requesting patient any lethal substance or device
  - ii) which, in accordance with reasonable medical standards, will enable the patient to end his own life in a comfortable and dignified manner.
- d) a “competent patient” means a patient who is:
  - i) conscious;
  - ii) capable of understanding his terminal diagnosis;
  - iii) capable of understanding his available alternatives to assisted suicide;
  - iv) capable of understanding that he is requesting assistance in suicide;
  - v) capable of understanding his own death; and
  - vi) able to clearly communicate health care decisions.
- e) a “disinterested person” is one who
  - i) neither believes nor has reason to believe:
    - a) that he will inherit anything under the requesting patient’s will or
    - b) that he is related to the requesting patient or
    - c) that he is an heir of the requesting patient or
    - d) that he has any pecuniary interest in the patient’s death other than any standard medical fees for either performing any services pursuant to this act or providing either the lethal substance or device.
- f) “related” means
  - i) With respect to the requesting patient, any of the following
    - a) a brother, sister, parent, child, grandchild, great grand-child, aunt, uncle, cousin, second cousin, third cousin, grand parent, great grand parent, step-brother, step-sister, step-parent, step-child, step-

grandchild, step-great grand-child step-aunt, step-uncle, step-cousin, step-second cousin, step-third cousin, step-grand parent, step-great grand parent; or

- ii) a spouse or former spouse of any person described in sec. (2)(f)(1)(a) of this Act; or
  - iii) a spouse or former spouse of the requesting patient.
  - g) "immediate family" means
    - i) either a brother, sister, parent, grand-parent child, grand-child, or spouse of the requesting patient.
  - h) "recorded" means either
    - i) written;
    - ii) video taped; or
    - iii) otherwise permanently documented in a manner approved by a court of this State.
3. Procedure for Requesting Patient
- a) Any Persons who is
    - i) at least 18 years of age;
    - ii) not pregnant; and
    - iii) competent.
  - b) May request medical assistance to suicide if:
    - i) the requesting patient has been diagnosed by the assisting physician to be:
      - a) terminally ill;
      - b) suffering; and
      - c) competent
    - ii) the requesting patient executes a recorded first request substantially similar to that provided under this Act;
    - iii) the requesting patient both agrees to and actually does submit to an examination by another physician for the purpose of confirming the assisting physician's diagnosis that the requesting patient is:
      - a) terminally ill;
      - b) suffering; and
      - c) competent
    - iv) the requesting patient both agrees to and actually does submit to an examination by a counselor for the purposes of
      - a) confirming the assisting physician's diagnosis that the requesting patient is competent; and

- b) determining whether the patient's request for assistance in suicide is primarily by any of the following
    - (1) duress;
    - (2) fraud; or
    - (3) coercion
  - c) determining whether the patient's request for assistance in suicide is motivated primarily by any of the following
    - (1) duress; or
    - (2) clinical depression or any other emotional or psychological disorder
  - v) then executes a recorded second request substantially similar to that provided under this act not sooner than 7 days (168 hours) after the first written request.
4. Any disinterested person licensed under the Medical Practice Act of 1987 or a successor statute, may provide a medical means for a requesting patient to end his own life if:
- a) the assisting physician is satisfied and confirms in writing a form substantially like that provided by this Act:
    - i) that in his professional medical judgment the requesting patient is:
      - (1) terminally ill;
      - (2) suffering; and
      - (3) competent
    - ii) that the patient's request is not primarily motivated by
      - a) clinical depression or any other emotional or psychological disorder
    - iii) the patient's request is not motivated by either
      - a) fraud;
      - b) duress; or
      - c) coercion of any kind
  - b) The requesting patient executes a signed first request substantially like that provided by this Act
  - c) The requesting patient executes a signed second request not sooner than 7 days (168 hours) after the first request, substantially like that provided by this Act.
5. The assisting physician's diagnosis
- a) that the patient is



- i) terminally ill;
    - ii) suffering; and
    - iii) competent to understand what he is requesting and its consequences;
  - b) that the patient's request is not primarily motivated by
    - i) clinical depression or any other emotional or psychological disorder; and
  - c) the patient's request is not motivated by
    - i) fraud, duress, or coercion of any kind,
  - d) must be confirmed in writing by a disinterested physician licensed under the Medical Practice Act of 1987 in a form substantially like that provided by this Act.
6. The assisting physician's diagnosis
  - a) that the patient is competent to understand what he is requesting and its consequences;
  - b) the patient's request is not primarily motivated by
    - i) clinical depression or any other emotional or psychological disorder; and
  - c) the patient's request is not motivated by
    - i) fraud, duress, or coercion of any kind,
  - d) must be confirmed in writing by a disinterested counselor licensed under the Medical Practice Act of 1987, in a form substantially like that provided by this Act.
7. Effect of a finding of incompetence
  - a) The physician or counselor diagnosing the requesting patient as incompetent must
    - i) note the diagnosis in the patient's medical records;
    - ii) destroy the patient's written request;
    - iii) make a good faith effort to notify other physician's or counselors who have signed examination papers under this Act; and
    - iv) make a good faith effort to notify the family of the requesting patient of the request and of the finding of competency.
8. The assisting physician and independent physician must inform the requesting patient
  - a) Of his terminal diagnosis;
  - b) Of his estimated life expectancy;
  - c) Of the risks associated with the prescribed lethal substance;

- d) That the likely effect of the prescribed lethal substance is death;
  - e) Of alternatives to medical assistance to suicide including; and
    - i) comfort care and support services such as hospice
    - ii) treatment options or cure possibilities reasonably known and available.
9. The assisting physician must, upon providing a medical means to assist a requesting patient in suicide shall forward a copy of all documents required under this Act to the Oversight Board.
10. A disinterested physician who assists another in ending his life and who complies with the terms of this Act and who reasonably believes that all of the terms of this Act are satisfied
- a) will not be criminally liable for such actions under
    - i) either
      - a) 720 ILCS 5/9-1 Murder;
      - b) 720 ILCS 5/9-2 Second Degree Murder;
      - c) 720 ILCS 5/9-3 Involuntary Manslaughter and Reckless homicide;
      - d) 720 ILCS 5/12-1 Assault;
      - e) 720 ILCS 5/12-2 Aggravated Assault;
      - f) 720 ILCS 5/12-3 Battery;
      - g) 720 ILCS 5/12-4 Aggravated Battery;
      - h) 720 ILCS 5/12-4.1 Heinous Battery;
      - i) 720 ILCS 5/12-4.5 Tampering with Food, Drugs or Cosmetics;
      - j) 720 ILCS 5/12-4.6 Aggravated Battery of a Senior Citizen;
      - k) 720 ILCS 5/12-5 Reckless Conduct;
      - l) 720 ILCS 5/12-19 Abuse and Neglect of a long term care facility resident;
      - m) 720 ILCS 5/12-21 Criminal Neglect of an Elderly Person;
      - n) 720 ILCS 5/12-31 Inducement to Commit Suicide;
    - or
    - ii) 720 ILCS 5/8-1 Solicitation of any offense listed in sec. (9)(a)(1) of this Act or
    - iii) 720 ILCS 5/8-1.1 Solicitation of murder;
    - iv) 720 ILCS 6/8-1.2 Solicitation of murder for hire;
    - v) 720 ILCS 5/8-2 Conspiracy to commit any offense listed in (9)(a)(1) of this Act;

- vi) 720 ILCS 5/8-4 Attempt to commit any offense listed in sec. (9)(a)(1) of this Act; or
  - vii) any other criminal offense of this State or federal law
  - b) will not be civilly liable for such actions if
    - i) the physician performs his duties under this act in accordance with the reasonable standards of his profession; and
    - ii) the patient in properly using the means prescribed actually dies
  - c) will not suffer professional disciplinary actions nor lose any professional privileges.
11. A disinterested physician who confirms the assisting physician's diagnosis under this Act
- a) will not be criminally liable for such actions under
    - i) either
      - a) 720 ILCS 5/9-1 Murder;
      - b) 720 ILCS 5/9-2 Second Degree Murder;
      - c) 720 ILCS 5/9-3 Involuntary Manslaughter and Reckless homicide;
      - d) 720 ILCS 5/12-1 Assault;
      - e) 720 ILCS 5/12-2 Aggravated Assault;
      - f) 720 ILCS 5/12-3 Battery;
      - g) 720 ILCS 5/12-4 Aggravated Battery;
      - h) 720 ILCS 5/12-4.1 Heinous Battery;
      - i) 720 ILCS 5/12-4.5 Tampering with Food, Drugs or Cosmetics;
      - j) 720 ILCS 5/12-4.6 Aggravated Battery of a Senior Citizen;
      - k) 720 ILCS 5/12-5 Reckless Conduct;
      - l) 720 ILCS 5/12-19 Abuse and Neglect of a long term care facility resident;
      - m) 720 ILCS 5/12-21 Criminal Neglect of an Elderly Person;
      - n) 720 ILCS 5/12-31 Inducement to Commit Suicide;
    - ii) 720 ILCS 5/8-1 Solicitation of any offense listed in sec. (8)(a)(1) of this Act or
    - iii) 720 ILCS 5/8-1.1 Solicitation of murder or
    - iv) 720 ILCS 6/8-1.2 Solicitation of murder for hire or
    - v) 720 ILCS 5/8-2 Conspiracy to commit any offense listed in (8)(a)(1) of this Act or

- vi) 720 ILCS 5/8-4 Attempt to commit any offense listed in sec. (8)(a)(1) of this act or
  - vii) any other criminal offense of this State or federal law
  - b) will not be civilly liable for such actions if
    - i) the physician performs his duties under this act in accordance with the reasonable standards of his profession.
  - c) will not suffer professional disciplinary actions nor lose any professional privileges
12. A disinterested counselor who performs all required duties and who complies with the terms of this Act
- a) will not be considered criminally liable for such actions under
  - b) under
    - i) either
      - a) 720 ILCS 5/9-1 Murder;
      - b) 720 ILCS 5/9-2 Second Degree Murder;
      - c) 720 ILCS 5/9-3 Involuntary Manslaughter and Reckless homicide;
      - d) 720 ILCS 5/12-1 Assault;
      - e) 720 ILCS 5/12-2 Aggravated Assault;
      - f) 720 ILCS 5/12-3 Battery;
      - g) 720 ILCS 5/12-4 Aggravated Battery;
      - h) 720 ILCS 5/12-4.1 Heinous Battery;
      - i) 720 ILCS 5/12-4.5 Tampering with Food, Drugs or Cosmetics;
      - j) 720 ILCS 5/12-4.6 Aggravated Battery of a Senior Citizen;
      - k) 720 ILCS 5/12-5 Reckless Conduct;
      - l) 720 ILCS 5/12-19 Abuse and Neglect of a long term care facility resident;
      - m) 720 ILCS 5/12-21 Criminal Neglect of an Elderly Person;
      - n) 720 ILCS 5/12-31 Inducement to Commit Suicide;
    - ii) 720 ILCS 5/8-1 Solicitation of any offense listed in sec. (8)(a)(1) of this Act or
    - iii) 720 ILCS 5/8-1.1 Solicitation of murder or
    - iv) 720 ILCS 6/8-1.2 Solicitation of murder for hire or
    - v) 720 ILCS 5/8-2 Conspiracy to commit any offense listed in (8)(a)(1) of this Act or
    - vi) 720 ILCS 5/8-4 Attempt to commit any offense listed in sec. (8)(a)(1) of this Act or

- vii) any other criminal offense of this State or federal law
- c) will not be civilly liable for such actions if
  - i) the counselor performs his duties under this act in accordance with the reasonable standards of his profession.
- d) will not suffer professional disciplinary actions nor lose any professional privileges

### 13. Manner of requests

- a) All requests for medical assistance to suicide must be in writing or on videotape and be in accord with this subsection.
  - i) If in writing
    - a) must be signed by the requesting person;
    - b) must be signed by the assisting physician; and
    - c) must be signed by each witness.
  - ii) If on videotape
    - a) must be verbally acknowledged on videotape by the requesting person;
    - b) must be verbally acknowledged on videotape by the assisting physician; and
    - c) must be verbally acknowledged on videotape by each witness.
- b) All recorded requests for medical assistance to suicide must be made in a form substantially similar to that provided by this Act.
- c) All recorded requests for medical assistance to suicide must be witnessed by two persons,
  - i) one of whom must be disinterested;
  - ii) neither of whom is a physician or counselor who performs any other duties under this Act with respect to the requesting patient; and
  - iii) must be made in a form substantially similar to that provided by this Act; and
- d) Must be received by the State Medical Licensing Board

### 14. Clear, final act required

- a) A patient requesting assistance under this Act must consciously perform a clear, final act that evidences his intention to end his life as well as his understanding that by performing the act, he is ending his life; and
- b) only the requesting patient can perform the final act which actually causes his death.

## 15. Waiting period

- a) Under no circumstances shall a physician provide a requesting patient with the means to end his life in less than seven (7) days (168 hours) of his first written request.

## 16. Right to revoke request

- a) A patient may revoke his request for assistance at any time by notifying the licensing entity in writing.
- b) If a patient revokes a request, and desires assistance, he must issue a new request for that assistance.
- c) If a patient who has revoked a request, again desires assistance, he must make a new request and begin a new 7 day waiting period
- d) a patient is entitled to make an unlimited number of new requests.

## 17. Either the assisting physician or the confirming physician must

- a) treat the terminally ill in the ordinary course of practice or
- b) treat patients using pain management or comfort care or a similar treatment in the ordinary course of practice.

## 18. Duties of the Illinois Medical Licensing Board

- a) The Board shall collect and maintain copies of all documents required under this act for a period of not less than 15 years.
- b) Documents required under this act shall be organized and filed according to the name of the requesting patient.
- c) The board shall make copies of a requesting patient's file available only to the following persons who display valid photo identification
  - i) An immediate family member of a requesting patient;
  - ii) any person who has signed a document required under this act on behalf of a requesting patient; or
  - iii) A law enforcement official in the course of a legitimate investigation.
- d) No other person shall have the authority to review a requesting patient's file

## 19. Affect on insurance

- a) Making a request under this Act shall not be a condition, term or factor to be considered to the issuance or maintenance of any insurance policy in Illinois
- b) Not making a request under this Act shall not be a condition, term or factor to be considered to the issuance or maintenance

of any insurance policy in Illinois

20. No duty to perform physician-assisted suicide

- a) No physician or counselor or any other person will be required to participate in any activity authorized by this Act.
- b) No Medical organization will be required to participate in any activity authorized by this Act
- c) Medical organizations may prohibit participation in any activity under this Act on premises owned by the organization
- d) No medical organization may require nor forbid a physician to participate in any activity authorized by this Act

21. General

- a) Under no circumstances should it be considered to be inherently, prima facie or presumed to be unreasonable for a physician to assist a patient under the terms of this Act.
- b) A patient who receives assistance in ending his life under this act is considered for all relevant purposes to have died from the terminal condition
- c) Any physician or counselor who is not disinterested and performs any of the duties under this Act is presumed to have exerted undue influence over the patient and is stripped of all immunities conferred by this law unless that person affirmatively rebuts this presumption
  - i) through clear and convincing evidence for any civil or administrative or professional proceeding
  - ii) beyond a reasonable doubt for any criminal proceeding
- d) Under no circumstances may any person other than that person ending his life under the Act either
  - i) request the assistance or
  - ii) perform the clear final act

22. Penalties

- a) Any person who employs fraud, duress, or coercion with the intent of influencing a person to request assistance under this Act
  - i) shall be guilty of a class 2 felony; and
  - ii) shall not be subject to any immunities conferred under this Act
- b) Any person who knowingly forges a request for assistance to suicide
  - i) shall be guilty of a class 2 felony; and

- ii) shall not be subject to any of the immunities conferred under this Act
- c) An Assisting Physician who fails to forward copies of all documents required under this Act to the Oversight board within 15 days
  - i) shall be guilty of a class A misdemeanor; but
  - ii) shall otherwise be entitled to the immunities conferred under this Act
- d) The penalties in this Act do not preclude criminal penalties otherwise available and not inconsistent with the terms of this Act.

### 23. Severability

- a) Any part of this Act which is found to be invalid as to a particular person or a particular circumstance will remain valid for all other persons and all other circumstances
- b) Any part of this Act adjudged by a court of competent jurisdiction to violate either the Illinois Constitution or United States Constitution, will not affect any other provision of this Act unless
  - i) it would be impracticable to do so
  - ii) the remaining provisions do not adequately protect the public.



## APPENDIX B

## Physician's Diagnosis Form

To the best of my knowledge and after a reasonable inquiry, I believe that [Requesting patient's name]

is 18 years of age or older

has made a valid request for medical assistance to suicide

In my professional medical judgment as a physician licensed under Medical Practice Act of 1987, [Requesting Patient' name]

suffers from a disease, illness or condition that will eventually result in this person's death

is experiencing extreme physical pain or discomfort

is competent to understand that he or she is requesting medical assistance to suicide and that this assistance will provide him or her the means to end his or her own life

is not primarily motivated to make a request for medical assistance to suicide by clinical depression or any other emotional or psychological disorder

is not motivated to make a request for medical assistance to suicide by fraud, duress, coercion of any kind

is not pregnant

I have informed [Requesting Patient' name],

of his or her terminal diagnosis

of his or her estimated life expectancy

of the risks associated with the prescribed lethal substance

that the likely effect of the prescribed lethal substance is death

of alternatives to suicide including comfort care and support services such as hospice

---

Physician's Name (printed)

---

Physician's Signature

---

Date

APPENDIX C  
Counselor's Diagnosis Form

To the best of my knowledge and after a reasonable inquiry, I believe that [Requesting patient's name]

is 18 years of age or older

has made a valid request for medical assistance to suicide

In my professional medical judgment as a Counselor licensed under \_\_\_\_\_, [Requesting Patient' name]

is competent to understand that he or she is requesting medical assistance to suicide and that this assistance will provide him or her the means to end his or her own life

is not primarily motivated to make a request for medical assistance to suicide by clinical depression or any other emotional or psychological disorder

is not motivated to make a request for medical assistance to suicide by fraud, duress, coercion of any kind

\_\_\_\_\_  
Counselor's Name (printed)

\_\_\_\_\_  
Counselor's Signature

\_\_\_\_\_  
Date

APPENDIX D

Patient’s First Request for Medical Assistance to Suicide

I, [Requesting Patient’s Name], am 18 years of age or older and not pregnant.

I am suffering from \_\_\_\_\_, which my physician has determined is a terminal condition. I understand that this condition will eventually result in my death.

I am also suffering from severe pain and / or severe physical discomfort which cannot be soothed by any way that I know of.

**Because my pain or physical discomfort cannot be soothed by any other way, I now request a medical means to commit suicide.**

I am fully competent, and not primarily motivated to request medical assistance to suicide by depression or any other mental disorder.

I understand and have been fully informed by the physician who will prescribe a substance that allows me to end my own life

of my estimated life expectancy

of the risks associated with the substance my physician has prescribed to allow me to end my own life

that the likely and intended effect of the substance my physician has prescribed for me is my death.

of alternatives to suicide such as comfort care which includes medication to relieve my pain or discomfort and support services such as Hospice.

Requesting Patient’s Name (Printed)	Requesting Patient’s Signature	Date
Assisting Physician’s Name (Printed)	Assisting Physician’s Signature	Date
Witness’ Name (printed)	Witness’ Signature	Date
Witness’ Name (printed)	Witness’ Signature	Date

## APPENDIX E

## Patient's Second Request for Medical Assistance to Suicide

I, [Requesting Patient's Name], am 18 years of age or older and not pregnant.

I am suffering from \_\_\_\_\_, which my physician has determined is a terminal condition. I understand that this condition will eventually result in my death.

I am also suffering from severe pain and / or severe physical discomfort which cannot be soothed by any way that I know of.

**Because my pain or physical discomfort cannot be soothed by any other way, I now request a medical means to commit suicide.**

I am fully competent, and not primarily motivated to request medical assistance to suicide by depression or any other mental disorder.

I understand and have been fully informed by the physician who will prescribe a substance that allows me to end my own life and another physician

of my estimated life expectancy

of the risks associated with the substance my physician has prescribed to allow me to end my own life

that the likely and intended effect of the substance my physician has prescribed for me is my death.

of alternatives to suicide such as comfort care which includes medication to relieve my pain or discomfort and support services such as Hospice.

I have consulted with a with a counselor before making this decision.

Requesting Patient's Name (Printed)	Requesting Patient's Signature	Date
Assisting Physician's Name (Printed)	Assisting Physician's Signature	Date
Witness' Name (printed)	Witness' Signature	Date
Witness' Name (printed)	Witness' Signature	Date

